Brighton and Sussex University Hospitals NHS Trust

Annual Report and Accounts

2017/18

Contents

PERFORMANCE REPORT

Overview

The purpose of this section of the Annual Report is to provide a summary of the purpose and activities of Brighton and Sussex University Hospitals NHS Trust, the Trust's priorities and objectives for 2017-18, the key risks to achieving these objectives and how we have performed in relation to these during the year.

Chief Executive's statement

This Annual Report marks the completion of the first year of our new executive team's leadership of Brighton and Sussex University Hospitals. The past 12 months have been a period of learning for all of us – the new executive team getting to the root of the challenges facing the trust and the organisation coming to understand the approach we are taking to address them – but, above all, it has been a period of huge positivity and of hugely positive change.

Credit for that lies entirely with the fantastic people who work in our hospitals. From day one here we have been overwhelmed by the welcome and openness extended to us and we are regularly humbled by the resilience and determination of staff to do the very best for their patients in even the most testing of circumstances. The Care Quality Commission's recognition of the "significant improvements" made when they visited in April 2017 is testament to that attitude; it is no surprise that the inspectors recognised quality of care as "good" across all services too.

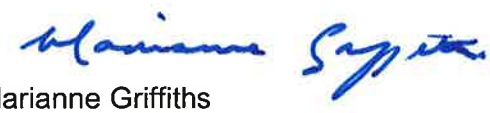
That is a great foundation for improvement and has been at the heart of the continuing progress we have made together over the 12 months since. For example, we have earned Hyper-Acute Stroke Unit status, which means we can now provide a full seven-day service for patients. Our Accident & Emergency team at the Royal Sussex County Hospital developed a flexible, annualised self-roster system that ensures consultant cover 24 hours a day, every day, an innovation that was named as the Royal College of Emergency Medicine's Quality Improvement Project of the Year. And we opened one of the first Emergency Ambulatory Care Units in the country to bring medical and surgical teams together in treating emergency patients, enabling more responsive care, freeing up space in A&E and reducing pressure on other wards.

Our job as an executive team is to unlock more of this vast potential, so our primary focus is on empowering the innovative and resourceful people of this great organisation to identify and deliver more and more positive change. We have implemented a new divisional structure that streamlines decision-making and have secured funding to invest in a leadership development programme. We have scrapped vacancy control panels for a broad range of nursing posts to improve recruitment and we have agreed realistic cost improvement programmes developed with our directorates that mean we are on track to meet our deficit reduction target.

Most importantly, though, we have introduced a new, long-term approach to transforming hospital services for the better, called Patient First.

Patient First is a programme of continuous improvement that empowers front-line staff to identify and drive through sustainable change, equipping them with the training, tools and freedom to work out where the opportunities lie, and the skills and support to deliver on them. Patient First has been embraced by staff across the organisation and the enthusiasm they have shown will be crucial to building a transformational culture that puts the patient at the heart of everything we do and creates a positive, open working environment in which everyone feels inspired to do the best possible job for every patient every day.

Of course, we know there is much more to do, but we are looking forward to the challenge. Thank you to all staff for their incredible efforts over the past year. We are extremely fortunate to have such exceptional people throughout our hospitals. They are the reason so much has been achieved in the past 12 months, and the source of our confidence in the improvements that are still to come.



Marianne Griffiths
Chief Executive

Date: 25 May 2018

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.

Vision, Priorities and Objectives – The Patient First approach

"everyone passionate about delivering excellent quality every time"

In 2017-18 a long-term approach to transforming hospital services for the better, known as **Patient First**, was introduced to Brighton and Sussex University Hospitals. Whether it's small steps or complex change, Patient First is a continuous process of improvement within existing processes and pathways that leads to measurable improvements for our patients and staff.

It is all about empowering front-line staff to make improvements themselves – by providing the training, the tools and the freedom to work out where the opportunities are; and the skills and support to make change happen and to make it sustainable.

The Patient First triangle has been created to explain the different layers of the Patient First programme.

The patient, is at the apex of the triangle to make it explicit that everything we do should contribute to improving the experience and outcomes of the people in our care. This is the True North of the organisation – the one constant to which we must always set out direction of travel in order to achieve our vision.

Patient First has four **strategic themes** that guide the initiatives we put in place across the hospitals:

- Our people
- Quality improvement
- Sustainability
- Systems and partnerships

Each of the strategic themes has a number of **breakthrough objectives** that will take us furthest and fastest towards our overall True North. This means that:

- Our True North focus around the PATIENT is on patient satisfaction
- Around OUR PEOPLE, it's about improving staff engagement
- In QUALITY IMPROVEMENT, it's reducing mortality and avoiding harm
- For SUSTAINABILITY, it's on managing our budget
- And for SYSTEMS AND PARTNERSHIPS, it's improving patient flow.

True North Domain	Breakthrough Objective	Executive Lead
Patient	Reduction in negative feedback where staff attitude is cited as an issue	Nicola Ranger (Chief Nursing Officer)
Sustainability	Achieve the Efficiency plan for 2017/18	Karen Geoghegan (Chief Financial Officer)
People	Staff believe that Care is the top priority for the organisation	Denise Farmer (Chief Workforce Officer)
Quality	Improvement in recognition and management of deteriorating patients	George Findlay (Chief Medical Officer)
Systems & Partnerships	Reduction in the numbers of patients waiting >4hrs in A&E who are not admitted	Pete Landstrom (Chief Delivery Officer)
Systems & Partnerships	Ensure no patients wait over 52 weeks for elective treatments	Pete Landstrom (Chief Delivery Officer)

The Patient First triangle also illustrates the **strong foundations** on which the programme must be built and for BSUH these are which are improving quality, underpinned by financial sustainability, the best leadership, culture and workforce. In addition, we need to play our part our in local Sustainability and Transformation Programme (STP) – a programme of work across Sussex and East Surrey to develop shared proposals, across all health and care organisations, to improve services. And ensure we progress our 3Ts redevelopment of the Royal Sussex County Hospital site.

The delivery of the Patient First programme is supported by **five pillars**, which support the strategic themes and will help us achieve our objectives:

1. **Kaizen office** – Kaizen is a Japanese concept that, loosely translated, means continuous improvement. The principle is at the heart of the philosophy that made Toyota and others, including the Virginia Mason Medical Centre, so successful and sustainable. It is about getting front-line staff to approach problem-solving and route cause analysis from a different, ceaselessly inquisitive perspective.

2. **Patient First Improvement Systems (PFIS)** – the PFIS is the Lean management programme designed to develop our people's ability to solve problems and improve performance. During the programme, teams receive specialist training to introduce tools and techniques that will help eliminate waste from everyday processes and begin to improve them on a continuing basis.

3. **Capability** – The Patient First Capability Programme provides the skills and training necessary to help teams understand and use the principles and tools available through Patient First.

4. **Improvement projects** – our improvement approach involves using "Lean" principles pioneered by Japanese car producer Toyota after the Second World War. Lean is a systematic method of illuminating waste from a process. In a hospital setting, examples of waste could include moving patients from department to department or ward to ward unnecessarily, holding more supplies than we actually need, or delays in discharge or diagnostic tests.

5. **Strategy deployment** – where theory becomes reality. Strategy deployment is the process through which we identify and review the True North objectives for each strategic theme and cascade these throughout the organisation. It provides a framework to enable staff at all levels to be clear about our priorities, our progress against them and how best they can contribute.

Performance and key issues and risks

The Patient – True North objective: an overall score of over 96% for patient satisfactions when measured through the Friends and Family Test.

Our long-term objective is to achieve an overall Friends and Family test score in excess of 96%. In the medium term, we want to reduce the number of occasions where staff attitude is cited as an issue. Currently our A&E score is 90%, 4% higher than the England average, while our inpatient score is 96%, in line with the England average.

Our People – True North objective: to be in the top 20% in the country for staff engagement.

Our long-term objective is to achieve a staff engagement score within the top 20% in the country. In the medium term, we want to increase the number of staff who believe care is this organisation's top priority. In the last year, the staff survey score for "I believe care is this organisation's top priority" has increased by 4%, from 62% in 2016 to 66% in 2017. Levels of staff engagement are low due to inconsistent leadership, poor Care Quality Commission (CQC) ratings and a long-term lack of investment in the hospitals and services. This is changing. Our Executive Team, led by Chief Executive, Marianne Griffiths, has been in place for one year with a commitment for at least another two years. The Executive Team has reviewed leadership structures across the Trust, appointed new senior leaders and is investing in their learning and development to provide better organisational leadership.

The 3Ts hospital redevelopment is a £485 million project to replace some of the NHS's oldest buildings and provide purpose-built, future-ready clinical facilities. These will enable existing staff to provide high quality care more easily, while making the organisation more attractive for new recruits.

Quality Improvement – True North objective: to be in the top 20% of trusts for preventable mortality and provide 100% harm free care.

Our long-term quality objective is to be in the top 20% for HSMR and provide harm free care. In the medium term we are focused on improving our recognition and management of deteriorating patients. We are running campaigns throughout our hospitals to educate staff on the prevention of pressure sores. On our Emerald Unit for dementia care, the team's dedicated falls prevention campaign has reduced patient falls by 67% to below the national rate in the last year. High patient numbers and continued challenges with staffing numbers both present risks to us achieving these objectives.

Sustainability – True North objective: to reduce our deficit until we balance our budget.

Our long-term sustainability objective is to balance our budget. In the medium term, we are committed to annual budget plans that reduce our deficit. In 2017/18 we met our control target. As an NHS organisation, there are multiple risks to meeting our control targets, from national changes and restructures to meeting local staffing needs and the increasing costs of goods and services. Our control targets take these risks into account and we have plans in place for dealing with financial uncertainties.

Systems and Partnerships – True North objective: to have 95% of A&E patients waiting less than four hours to be admitted or discharge and to reduce referral to treatment below 18 weeks for 92% of patients.

Our long-term systems and partnerships objectives are to have 95% of A&E patients waiting less than four hours and to maintain a referral to treatment (RTT) time below 18 weeks for 92% of patients. In the medium term, we are concentrating on reducing the numbers of patients who visit A&E and wait over four hours and then aren't admitted and are committed to ensuring no patients wait over 52 weeks for elective treatments.

Trust performance for RTT increased to 87% by July 2017/18 but following significant emergency pressure in the winter of 2017/18 undertook a planned reduction in routine elective inpatients to ensure clinically urgent, cancer and emergency patients were prioritised which impacted on RTT performance by year end which reduced to 83.1%.

A&E performance was also challenging throughout 2017/18. However, the Trust achieved an average 2% improvement in our performance throughout the year relative to 2016/17 (including Brighton Station Walk in Centre). The Trust has worked collaboratively with partners, developed estate, and enhanced internal process improvements through a nationally recognized Kaizen improvement programme, which will continue to mature and deliver improvements into 2018/19.

Going Concern

These accounts have been prepared on the basis the Trust is a going concern as there is no indication that the healthcare and other services will not continue to be provided by the public sector for the foreseeable future and that continuing financial support will be provided by Department of Health (DH).

The Trust is aware, however, of the following conditions which give rise to a material uncertainty and may cast significant doubt about the Trust's ability to continue as a going concern.

Against a challenging operational and commissioning landscape the Trust delivered an actual deficit for the year of £64.1m. After adjusting for the impact of impairments and adjustments in relation to the donated asset reserve the adjusted retained deficit is £55.6m.

The Trust delivered the control total as planned; returning a deficit of £63.8m against the planned deficit of £65.4m. As a result, the Trust received confirmation of an allocation from the STF Incentive Fund of £8.3m from NHS Improvement (NHSI); improving the performance against the control total by the same amount and decreasing the reported deficit to £55.6m. Delivery of the 2017/18 financial plan was supported by £20m of savings. The DH provided deficit funding of £63.8m as revenue support loans in year bringing the total revenue support loan funding to £171m as at 31st March 2018.

On the 1st April 2017 the Trust entered into a management contract with Western Sussex Hospitals NHS Foundation Trust and NHSI for a minimum of three years. The Executive Team and Chairman of Western Sussex Hospitals NHS Foundation Trust are also the Executive Team and Chairman of this Trust. This arrangement is intended to provide some strong and stable leadership to the Trust for the contract period. New regulatory oversight arrangements have also been agreed which will provide a focus on supporting the Trust to exit from Financial Special Measures and Quality Special Measures.

The Trust agreed a revision to the financial control totals for 2017/18 and 2018/19 with NHSI. The methodology is based on a series of negotiated principles which include limiting the financial efficiency requirement upon the Trust over this period. The agreed control total for 2018/19 is a planned deficit of £65.4m. Delivery of the plan is underpinned by an efficiency expectation of £30m; for which schemes have been fully identified.

The Trust has submitted its operational and financial plans for 2018/19. The plans reflect agreed continued revenue deficit support funding from the DH. The deficit support funding is authorised by the DH monthly in advance and is conditional on the achievement of the agreed financial control total for the year. Deficit support funding totalling £11.5m for April and May 2018 has been provided to the Trust.

The Trust has agreed an Aligned Incentive Contract with local Clinical Commissioning Groups for 2018/19; with a value of £286m. The Trust has agreed a Payment by Results contract with NHS England Specialised Commissioning for 2018/19; with a value of £161.6m.

The Trust's 2018/19 cash flow forecast is based on the assumptions in the 2018/19 financial plan. The key assumptions underpinning the cash flow are:

a) Receipt of £65.4m revenue support loan from the DH to finance the revenue deficit;
b) Receipt of £102m PDC from DH to fund the 3Ts capital build; and
c) Receipt of £21m loan funding from DH to support the Emergency Backlog Maintenance and Emergency Department schemes.

The new Executive leadership of the Trust agreed the following priorities with NHSI at the start of the management contract:

- Moving out of Quality Special Measures
- Improvement and delivery of A&E performance

- Moving out of Financial Special Measures
- Addressing underlying Leadership and Cultural challenges
- Assuring delivery of 3Ts programme and integration into the Trust

The Trust's financial priority for the next year is to deliver its control total deficit as agreed with NHSI. This includes the further development and embedding of robust and transparent processes introduced in 2017/18.

Taking into account all these factors, the assumption that the healthcare and other services will continue to be provided by the public sector for the foreseeable future and that the DH will continue to provide financial support, the Directors consider the Trust will continue to operate as a going concern.

BEST OF BSUH

Grade A stroke service

Improvements in our stroke services secured national recognition during the year. Brighton and Sussex University Hospitals were granted Hyper-Acute Stroke Unit (HASU) status last in August and rated Level A by the Royal College of Physicians Sentinel Stroke National Audit Programme (SSNAP) survey in spring 2018.

We have employed more therapy staff and provide a truly seven-day service for our patients – and undertake new procedures in the treatment of stroke. Our Intra Arterial Thrombectomy (IAT) service enables our interventional neuroradiologists and expert team to remove clots through mechanical means.

Working with the teams in the Emergency Department, stroke patients now also get faster treatment and faster admission onto the stroke unit than ever before.

Royal Sussex County Hospital A&E

Changes and improvements in the department have led to massive improvements in patient care – and the benefits have been recognised in a swathe of national awards. At the forefront of the Patient First programme, the department has introduced a flexible, annualised self-rostering system for doctors that has had stunning results – including 24 hour a day consultant cover – while a system to book patients into the hospital means patients see a doctor more quickly and this has sped up the time it takes to refer patients on to other departments.

The rostering project won First Place in the Royal College of Emergency Medicine's Quality Improvement Project of the Year Award and was short-listed for a Health Service Journal Award. The 'single clerking' process was shortlisted for a prestigious British Medical Journal award.

Emergency Ambulatory Care Centre opened

The first phase of our £30 million physical improvements to the A&E department was opened by two of Brighton and Hove Albion's top players, Anthony Knockaert and Bruno in March. The new Emergency Ambulatory Care Unit (EACU) at the Royal Sussex County Hospital is one of the first units in the country to combine medical and surgical teams to treat emergency patients who do not need to stay in overnight. This allows patients to move quickly from their initial diagnosis to receiving treatment, which both frees up space in A&E and reduces demand on other wards.

The Emergency Ambulatory Care unit has 9 treatment rooms, 6 treatment spaces, 3 procedure rooms, 2 side rooms and an IV therapy area that can accommodate 14 patients.

Eastbourne Radiotherapy Centre opened

A new centre run by BSUH opened in July 2017 and provides local cancer patients with state-of-the art treatment. The £14.5 million centre at Eastbourne District Hospital is an extension of the Brighton-based Sussex Cancer Centre. The Eastbourne centre is equipped with two of the latest linear accelerators (LINACs) which enable patients to receive the best-possible radiotherapy treatment – and to receive it closer to home.

The centre's opening means patients can receive all their care in the local hospital, instead of having to travel to Brighton or Maidstone every day for treatment. The new machines provide faster, more precise treatment, which will allow more patients to receive better cancer treatment.

The centre is a key part of the strategy to improve radiotherapy services across Sussex and will treat 60-80 patients every day.

Princess Alexandra visits Royal Alexandra Children's Hospital

In July, Her Royal Highness Princess Alexandra visited the Royal Alexander Children's Hospital to mark the tenth anniversary of the hospital's opening on the Royal Sussex County site. The princess had formally opened the new hospital in 2007 and she has been the children's hospital's Patron since 1954.

The Alex cares for 45,000 children every year from right across the South East and the Care Quality Commission rated it as Outstanding rating last summer – a reflection of the skill, compassion, and exemplary care that all the staff provide for their patients.

During the visit, Her Royal Highness spent time visiting staff, patients, and their families during a tour of the dedicated Children's Emergency Department and the hospital's surgical ward and critical care unit, before being welcomed at a reception hosted by the trust and Rockinghorse, our children's charity.

World first innovation: the HIV self-testing kit vending machine

Our HIV team - with the Martin Fisher Foundation - installed a hi-tech vending machine that dispenses HIV testing kits in the reception area of the Brighton Sauna in June 2017. This world-first innovation was used over 200 times in the first six months, reaching people who would not normally attend a sexual health clinic and allowing them to test themselves.

Current treatments that reduce the amount of HIV virus in the bloodstream down to undetectable levels, and our HIV team has had a big impact on slowing the rate of transmission of HIV by increasing testing across health care settings in the city, getting people into treatment and using PrEP (pre-exposure prophylaxis).

The HIV team's ambition is to get to zero: zero new infections, zero HIV related deaths and zero HIV stigma. The self-testing machine was shortlisted for a British Medical Journal award for best innovation.

TAVI: Ten years of pioneering heart surgery in Brighton

December marked the tenth anniversary of Brighton's first TAVI operation, a revolutionary technique that has allowed hundreds of seriously ill patients to have major heart surgery. Instead of cutting into a patient's chest to perform open-heart surgery, surgeons reach the heart by cutting a hole in the groin and inserting a new valve from there.

Surgeons at the Royal Sussex County Hospital have carried out over 800 TAVI operations since their first operation in December 2007.

The procedure can be carried out under local anaesthetic in less than an hour and patients recover more quickly when compared to open-heart surgery, with patients often leaving hospital in less than a week.

Heart valve disease is a common, treatable heart condition but many patients do not suffer severe or visible symptoms, or put the symptoms – shortness of breath, fatigue, dizziness and chest pain – down to the natural ageing process. Its prevalence is expected to double in the next three decades.

Our Patients

In January 2018 the Trust started work with the NHS England toolkit, Always Events®, looking at aspects of patient experience that are so important to patients and family members that health care providers must aim to perform them consistently for every individual, every time. 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. In 2017/18 we have been able to resolve 75% of informal concerns raised with our PALS team in two working days.

We recognise that when things do not go as smoothly as we would hope, when patients and their relatives have a service which can support them and help resolve concerns in a timely fashion it can make their experience a little easier. Happily, we have also seen an increase of 35% in contacts to the Trust from patients and their relatives giving thanks for the care they or their loved one has received.

In 2017/18 we have continued to work with Healthwatch, our health watchdog, to peer review anonymised information about our complaints. During this time Healthwatch volunteers have undertaken a quarterly review providing feedback to the Trust on the standard and quality of the response which is used to inform future complaints practice.

In addition, the Friends and Family Test (FFT) is an initiative to provide a national benchmark for all NHS hospitals. All adult inpatients that have stayed at least one night in hospital, attended out patients or attended A&E are asked the question: "How likely are you to recommend your ward/Outpatients or 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.

Whilst we have improved our FFT score in 2017/18 we hope to sustain our target of an FFT score of 96% across the Trust. We are introducing an electronic FFT data collection system following an increase in patient participation in Maternity and ED services which already use the service. This will enable more of our patients to provide feedback regarding our services.

Percentage Recommending

	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18
National	95.79 %	95.90 %	95.91 %	95.63 %	95.62 %	95.60 %	95.62 %	95.59 %	95.39 %	95.50 %	95.53 %
BSUH	96.67 %	96.88 %	95.43 %	95.01 %	96.18 %	94.36 %	96.15 %	94.69 %	93.65 %	95.63 %	97.10 %

For 2017/18 our overall Friends and Family Test results for inpatients were:

	Inpatients									
	Total responses in each category for each ward						Total Number of people eligible to respond	% Response Rate	Inpatient Percentage Measures	
	1 - Extremely Likely	2 - Likely	3 - Neither likely nor unlikely	4 - Unlikely	5 - Extremely unlikely	6 - Don't Know		Inpatient	Recommend %	Not Recommend %
Apr-17	441	140	12	5	3	0	7609	7.9%	96.7%	1.3%
May-17	877	116	18	5	0	9	8495	12.1%	96.9%	0.5%
Jun-17	916	192	25	7	10	11	8662	13.4%	95.4%	1.5%
Jul-17	667	189	24	5	6	10	8151	11.1%	95.0%	1.2%
Aug-17	768	189	20	6	6	6	8612	11.6%	96.2%	1.2%
Sep-17	812	192	31	9	12	8	7915	13.4%	94.4%	2.0%
Oct-17	699	176	9	7	12	7	8377	10.9%	96.2%	2.1%
Nov-17	931	228	35	9	15	6	8261	14.8%	94.7%	2.0%
Dec-17	623	158	24	8	7	14	7255	11.5%	93.6%	1.8%
Jan-18	792	172	16	7	4	17	8000	12.6%	95.6%	1.1%
Feb-18	508	128	10	2	3	4	7371	8.9%	97.1%	0.8%
YTD 2017-18	8034	1880	224	70	78	92	88708	11.7%	95.5%	1.4%

Annual NHS Inpatient Survey results

On an annual basis BSUH surveys a selection of adult inpatients; this survey is undertaken on our behalf by a company called Picker, who also provides this service for around 2/3rds of NHS trusts. In 2017 we surveyed 1239 adult inpatients in the month of July and 496 patients returned a completed questionnaire. As this survey is nationally undertaken every year we are able to compare how we have improved care over a long period of time. The survey looks at eight key areas:

- Admission to Hospital
- The Hospital and Ward
- Doctors
- Nurses
- Your care and treatments
- Operations and procedures
- Leaving Hospital
- Overall

Following last year's Picker results focus was placed on discharge and developing the discharge process for patients; we have seen 76% of the scores for questions in the Leaving Hospital section of the survey in 2017 show improvement or consistency. Whilst we are still below the national average for communications pre-operatively, we have improved our score from 2016 on several of these questions.

Overall in 2017 the trust has seen 56% of the results improve or remain at the same score.

When we compare ourselves with our 2016 results and questions where we scored significantly worse than the 'Picker average' we can show the following improvements;

- The time it takes for patients to receive elective treatment (RTT) improved by a total of 8% over two questions
- Not always being involved in planning their discharge from hospital score improved by 8% and not given notice of when they will be discharged from hospital also saw an improved score
- Surgical operations not fully explained questions saw an 8% improvement over 2 questions.

As part of the survey Picker asks which questions the patient feels are the most important and then correlate this with our overall rating for that question. This helps us to identify the areas that matter the most to patients, which are not always the ones that have the lowest scores. None of the areas where BSUH did worse than the Picker average were flagging as of high importance from a patient perspective. The areas that we will focus on improving in the year ahead are:

- Patients being involved in decision making on the wards
- Working with patients to improve the quality of information they are provided whilst on the ward
- Ensure patients have the opportunity to give their view on the quality of care they received

Complaints

Changes to the identification of feedback received within patient experience, see differences in the data sets and therefore, in figures for formal and informal concerns at BSUH from previous reports.

	2014/15	2015/16	206/17	2017/18
Total number of complaints	560	511	501	507
Number of contacts to the Ombudsman	11	32	18	13
Ombudsman referrals upheld against the Trust	1	2	3	0
Ombudsman referrals partially upheld against the Trust	5	4	10	3

In 2017/18, 8% of the 4800 enquiries received in patient experience required formal investigation under the NHS Complaints Procedure. A total of 507 formal complaints were received in 2017/18 a 10% increase in the last 3 years.

There was a 28% reduction in the number of contacts made to the Parliamentary Health Services Ombudsman (PHSO) in 2017/18 compared to 2016/17. 2.5% of all formal complaints were referred to the PHSO with 0.5% being upheld. (Please note that these may relate to complaints made to the Trust in earlier years even though reported in the current financial year.)

Informal Concerns

Our Patient Advice and Liaison Service (PALS) triage concerns raised by patients, their relatives and carers in order to help assist them as quickly as possible

2014/15	2015/16	2016/17	2017/18
4066	4352	4465	4293

Compliments

2014/15	2015/16	2016/17	2017/18
500	540	609	929

Our People

Brighton and Sussex University Hospitals NHS Trust is the proud employer of almost 9,000 people. Each and every one of those people enables us to provide high quality care to the people of Brighton and Hove and East and West Sussex.

(Subject to audit)

Average number of employees (WTE basis)				
			2017/18	2016/17
	Permanent Number	Temporary Number	Total Number	Total Number
Medical and Dental	1,157		1,157	1,131
Admin, clerical & estates	1,305		1,305	1,349
Allied Health Professionals	429		429	417
Ancillary Support	658		658	612
Healthcare Science	383		383	376
Healthcare Assistants	776		776	754
Nursing Pre-Reg Learners	33		33	35
Registered Midwives	194		194	199
Registered Nurses	2,088		2,088	2,164
Scientific, therapeutic & technical staff	336		336	340
Bank Staff		1,543	1,543	1,381
Other		1	1	0
Total average numbers	7,359	1,544	8,903	8,758

The Trust's sickness absence rate is 4.26% for the year 2017/18.

In February 2017 the Trust launched the Trac.systems applicant tracking system in order to maximise efficiency, recruit the best possible employees and get those people into post faster. Prior to introducing Trac on average it took 12-16 weeks to get people into post; the target rate is now 30 days with a 100% target and Trust wide performance at February 18 was 80% with Soft Facilities Management at 100%.

Since July 2017 HR Employment Services have hosted several large-scale recruitment events to support Nursing and Soft FM teams. Pooled recruitment events were introduced for nursing resulting in the appointment of 161 Band 2 HCAs and 61 Band 5 Nurses and more recently 4 Trainee Nurse Associates. Our Pre-Registration Diploma in Nursing (PRDN) adverts continue to pull in the greatest number of applications and we are attracting a lot of interest from applicants at Kingston and other London based universities. The feedback we have received from these applicants is that they appreciate having a specified advert for PRDNs and they have received positive feedback from fellow students regarding the recruitment event and support offered regarding preceptorship.

For Soft FM there has been significant change in the success of the recruitment campaigns since January 18 with 2 successful recruitment days held at Brighton (rather than Haywards Heath) and supported by HR for the collation of the documentation. Coupled with a huge push in advertising the vacancies via leafleting, banners, posters, stands in shopping centres, the use of

'hard copy' application forms the numbers in the pipeline has significantly improved with 43 people currently in the recruitment process.

Medical Recruitment

Since April 2017 the Trust has recruited 23 substantive consultants and is currently recruiting a further 10 to replacement and new posts. Over the last year Medical Recruitment have worked in partnership with the Emergency Medicine department to advertise and recruit innovative posts to fill junior doctor rota gaps. Ensuring that posts are attractive to applicants is crucial and the Emergency Medicine department has been nationally recognised for the use of self-rostering and protected time for teaching, simulation and projects. These Clinical Fellow posts have been very successful and the initiative has reduced the use of locum cover within the department. Medical Recruitment are working with other departments such as Medicine to use a similar model for hard to recruit to posts and Princess Royal Hospital now has four posts with dedicated time for simulation projects whilst also helping to support the medical rota. The Trust is advertising for two Chief Registrar posts for Medicine, a national scheme partially funded by Health Education England that will support medical rotas but also to lead projects relating to quality improvement and education for junior doctors.

All posts are advertised including fixed-term appointments and secondments and all recruitment is subject to equal opportunities monitoring on an annual basis.

The Trust will comply with all the requirements of NHS Employment Standards and ensure that all necessary checks and clearances are carried out prior to employing an individual.

Equality Diversity and Inclusion

BSUH is committed to delivering accessible, equitable and fair services for our patients, service users and their relatives. The Trust is also committed to providing a workplace that is free from discrimination for our staff, and where everyone is given equal opportunities to develop and progress.

These commitments are central to the Trust's values and are underpinned by the Equality Act 2010, the NHS Constitution and the Care Quality Commission's regulatory framework standards.

During 2017/18 there has been much work to support the Equality, Diversity and Inclusion agenda, some notable achievements include:

- We have released our community information site, called the 'Equality Hub' (https://equalityhub.org).
- Continuing to review, plan and replace signage at the RSCH site.
- Providing training regarding the needs of Transgender patients for paediatric staff.
- Continual support of the Annual Trans and Non-Binary Conference in Brighton and Hove.
- Continuing engaging with local disability groups through the Trust's disability and service user group.
- Completed a review of mandatory and induction training for our staff.
- The Trust has signed up for a new recruitment service (VERCIDA), which will help to reach a much wider applicant pool for our vacancies.
- The Trust has signed up to the Inclusive Employers programme, which is an excellent source of best practice.

- Working with Western Sussex Hospitals Foundation Trust to deliver a stronger equality, diversity and inclusion agenda.
- Retendered the communication support contract which includes; face-to-face overseas and British Sign Language interpretation, written translation, and telephone and video interpretation.

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).

Our major achievement in this reporting year is to move to 'substantially compliant' in the Emergency Planning Resilience and Response Assurance round. We aim to at least equal that in 2018-19.

- We have introduced a Business Continuity Strategy and are currently formulating Service Level plans to support it.
- We have run two communications cascade exercises this year reducing the amount of time it takes to inform key players in an incident.
- We also ran a successful major incident table top exercise based on a terrorist attack and supported a winter pressure workshop.
- We have supported senior management in operational issues including generator failures, IT outages, adverse weather, and a critical capacity incident
- We have trained a whole new cadre of decision loggists for use in incidents and redesigned the Decision Log.
- We have on request trained new senior management in resilience issues. We continued to support the induction programme although regrettably we have now been removed from the day.
- We are working with the Sussex Trauma Network to support their ambitions.
- After training we have increased our use of social networking to enhance our messages internally and externally. We have worked with the Communications Team to ensure we are on message.
- We have maintained our capability to respond to a Chemical, Biological, Radiological, or Nuclear attack or accidental exposure to a hazardous material.
- We have cooperated with the production of an Audit Report
- We continue to support and contribute to the work of Sussex Resilience Forum and we are a key member of Sussex Local Health Resilience Partnership.

We are also producing an updated 'Major Incident and Mass Casualty Plan' to include new advice drawn from lessons learnt around the most recent UK terror attacks.

Research and Innovation

The aim of Brighton and Sussex University Hospitals' research strategy is two-fold. We have developed an all-encompassing research programme that supports the delivery of a rich portfolio of National Institute for Health Research adopted projects. These are predominantly multi-centre studies conducted through strategic partnerships with academic, industry, charities and other NHS Trusts.

Secondly, we have developed an infrastructure by way of a Clinical Research Facility and a Clinical Trials Unit to enable leading researchers from the Trust and its core academic partner Brighton & Sussex Medical School to deliver ground-breaking research aligned to our major research themes of cardiovascular disease, HIV and infectious disease, liver disease, neurology, rheumatology and paediatric medicine.

Clinical research is essential for improving care for patients, providing evidence on the efficacy of new healthcare treatments and furthering our understanding of the underlying causes of illness. That said it is only possible to answer those important questions if the public and patients continue to volunteer to take part in research studies. It is commonly cited that patients cared for in a research study and more generally those treated in a research-active environment have better outcomes. Whilst this is often the case for those engaged in clinical trials that offer novel treatment options many patients who volunteer to take part in research projects that have no discernible benefits. These are the patients who complete questionnaires, donate blood and tissue samples, and attend the hospital to have scans and physiological measurements that offer little or no direct benefits.

Regardless of this over 3500 patients volunteered to participate in one of the 180 clinical research projects being conducted at our hospitals in Brighton and Haywards Heath during 2017/18. On behalf of all the researchers working for the Trust a big thank you is extended to all of the patients, carers and parents who have given up their time to support our research programme.

It's because the Trust has such an engaged local patient population that it is able to attract funders and research sponsors to locate their studies here. It is difficult to highlight all of the excellent work and achievements of the past year. In summarising a few points of note: our researchers have secured new grants from industry to run a HIV/Hepatitis drug trial and two cardiovascular disease interventional projects; an American National Institute of Health funded project developing tools to detect foetal alcohol syndrome in new born babies; and an Arthritis UK funded study looking into causes of chronic fatigue.

In terms of translational research study highlights are cardiac team are one of only two hospitals in the UK running 4 heart valve repair and replacement trials that are testing devices for the first time in humans first in humans. We were the only site in the UK to treat a patient in a first in human trial of a new drug for blood cancer.

3Ts Redevelopment

The redevelopment programme at the Royal Sussex County Hospital is in the full construction phase for both the helideck and the larger of the two new clinical buildings it will deliver. The programme of works has been planned to ensure all clinical services can be delivered on site throughout the redevelopment.

Stage 1 Building
The Stage 1 Building will be an eleven-storey structure standing on the south east quarter of the hospital site. It will house a mixture of specialist, general and outpatient services in state-of-the-art, clinical accommodation.

At the beginning of the year two small buildings remained to be deconstructed ahead of full construction starting on site. These were removed and piling works commenced. In total 412 piles were installed of between 15 and 35 metres length. These act as the foundation support for the outer framework of the building. They also held back the surrounding soil whilst the space for the building's plant rooms and underground car parks was excavated. In total 90,000 cubic metres of soil and chalk were removed, the equivalent of 40 Olympic swimming pools.

The foundation slab for the building has been completed and work has started on both the upper basement and ground floors of the building. By the end of 2018 the framework for the entire

building will be in place. The building will then be clad and fitted out, ready to receive the transfer of services in the winter of 2020/21.

Helideck
The helideck is being built three storeys above the top of the Thomas Kemp Tower, making it eighteen storeys high compared to the front of the hospital. It is also, as far as can be ascertained, the highest helideck in the NHS, measuring from sea level.

At the start of the year the roof was being prepared for construction to begin. Since then approximately 100 tonnes of scaffold have been added to the roof to enable the use of two motorised platforms, required for the construction of the helideck. The framework for the helideck's dedicated lift is being installed on the side of the Thomas Kemp Tower.

Work on the structure of the helideck is progressing well, with only the framework's final support beams, the deck's surface and the high strength safety netting to be installed. These elements will be completed in the coming year and the helideck lift's framework will be incorporated into fabric of the tower block. An existing lift will be extended upwards to the roof of the tower to act as a back-up, should there be a problem with the main lift. The helideck will come into operation at the end of 2018.

Future Programme
Wards and services from the Barry Building and surrounding facilities will move into the Stage 1 Building when it is complete in the winter of 2020/21. This will clear the way for the construction of the Stage 2 Building on the south west quarter of the site.

A&E Redevelopment

In 2017/18 approval was given for capital investment to support the redevelopment of Emergency Care services at the Royal Sussex County Hospital in Brighton. Emergency care is currently delivered in cramped and outdated facilities which are not in line with national standards for delivering high quality emergency care and the department struggles to meet the national performance standards. Existing capacity in the emergency department is not sufficient to meet current demand and the present configuration of services does not optimise the flow of patients through the Emergency Department into the main hospital.

The proposed redevelopment will radically change to the way in which Emergency Care is delivered in Brighton, will help address the current operational and performance challenges, and will significantly improve patient experience. The ED will be refurbished through a phased series of works in the following patient areas designed to deliver the proposed model of care, streamline departmental subdivisions and minimise soft space and circulation:

- Patient Assessment & Treatment
- Majors
- Resus
- Acute Assessment/Observation
- Ambulatory Care
- Capacity for up to 70 new short stay beds over two floors, within a new building located over the existing A&E and Urgent Care public and ambulance entrances.

The building will be delivered such that ED continues to be fully operational during the construction works, and ambulance access is protected.

Our Charity

The BSUH Charity has existed in its current form for over 20 years and has received many kind donations over that time which have had a significant impact on the care we provide to our patients.

As the Trust's own dedicated charity, BSUH Charity supports 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. The kind donations received are then used to enhance the care and services provided to BSUH patients above and beyond what we can do with core government funding.

Our Charity vision: Improving the experience of every patient

Our core priorities:

- Creating more patient friendly environments
- Providing equipment for diagnosis and treatment
- Supporting staff development to provide even better care
- Advancing our understanding through research projects

Some of the ways we've helped to make it even better for our patients this year are:
Staff in the Sussex Eye Hospital have solved the problem of patients experiencing discomfort after operations as the building is so cold. A blanket warmer with the capability to safely and evenly warm 10-12 blankets at a time has been purchased. The warm blankets ensure continuity of warmth from when patients leave operating theatres and are transferred to recover on Pickford Ward.

The Children's and Young Person's Diabetes Team have purchased portable, Ketone Meters. The new meters allow the team to quickly assess Ketone levels at the bedside for patients with a simple prick of the finger. The new meters provide a quick and efficient way to obtain Ketone levels, allowing staff to make informed and faster decisions about the diagnosis and treatment of patients with diabetes.

The first phase of the Ultimate Urgent Care Centre Campaign – Welcoming Waiting area - is complete. Patients now enjoy a professional-looking waiting area with comfortable seating and creative décor. Fundraising is still on-going for Phase 2, which will support Rapid Assessment Kits: kits of the tools needed for efficient and effective patient care in every consultation room, at every treatment pod.

The successful Charity of the Year partnership with the Southern Co-Op store on Franklyn Road in Haywards Heath has been renewed. The Co-Op raised £490.00 last year to improve the experience of our patients at the Princess Royal Hospital.

Community Fundraising thrived this year, with nine fundraisers running the Brighton Half Marathon on Team BSUH Charity. The team raised over £3,000 for many areas within the Trust such as the Urgent Care Centre, The Alex, The Elton John Clinic, and ICU.

Partner charities
We are grateful for the work our partner charities do to raise funds for BSUH hospitals and patients.

Our historical partner charities are listed below.

- Early Birth Association (Reg Charity No 286727)
- Friends of Brighton and Hove Hospitals (Reg Charity No 209414)
- League of Friends of the Princess Royal Hospital (Reg Charity No 257130)
- League of Friends of the Hurstwood Park Neuro Centre (Reg Charity No 263171)

- Rockinghorse (Reg Charity No 1018759)
- Sussex Cancer Fund (Reg Charity No 1147195)
- Sussex Stroke and Circulation Fund (Reg Charity No 297807)
- The Sussex Heart Charity (Reg Charity No 1120998)

Performance Analysis

Key Performance Measures

National Standards and Waiting Times

Indicator	Standard/Threshold	**2017-18**	2016-17
18w RTT - Percentage of admitted RTT pathways completed within 18 weeks	90%	70.72%	66.1%
18w RTT - Percentage of non-admitted RTT pathways completed within 18 weeks	95%	79.18%	78.3%
18w RTT - Percentage of incomplete pathways waiting less than 18 weeks	92%	85.5%	78.0%
18w RTT - Numbers of over 52-week waiters at month end	0	9	95
Diagnostic Tests waiting longer than six weeks - percentage of all waiters	1%	2.0%	1.9%
Operations cancelled on the day not re-booked within 28 days	5%	12%	10.47%
Number of urgent operations being cancelled for the second time	0	16	14
A&E - Percentage of patients who spent four hours or less in A&E	95%	84.28%	82.69%
A&E - Numbers of patients who have waited >12 hours in A&E from decision to admit	0	146	50
Cancer: Two week wait referral to date first seen	93%	94.15%	93.3%
Cancer: Two week wait referral to date first seen - breast symptomatic	93%	95.84%	97.18%
Cancer: 31 day wait from diagnosis to first treatment	96%	99.20%	98.1%
Cancer: 62 day wait for first treatment from urgent GP referral	85%	76.62%	76.69%
Cancer: 31 day wait for second or subsequent treatment - surgery	94%	99.11%	95%
Cancer: 31 day wait for second or subsequent treatment - chemotherapy	98%	99.50%	99.18%
Cancer: 31 day wait for second or subsequent treatment - radiotherapy	94%	99.53%	97.99%
Cancer: 62 day wait for first treatment from referral from NHS cancer screening service	90%	69.95%	76.23%
Cancer: 62 day wait for first treatment from referral following consultant decision to upgrade	90%	84.55%	86.1%

Indicator	Standard/ Threshold	**2017-18**	2016-17
Emergency re-admissions within 30 days of discharge (%)	10.5%	8.56%	11.96%
Stroke: % of patients who spend > 90% of time on stroke unit	80%	81.92%	85.71%
Stroke: % admitted directly to stroke unit	90%	63.35%	67.52%
Stroke: % scanned in less than one hours of hospital arrival	50%	70%	67.31%
Stroke: % of patients scanned within 24 hours	100%	100%	98.95%
Stroke: % of high risk TIA cases treated in 24 hours	60%	77.53%	85.31%
Stroke: % of low risk TIA patients seen in seven days	100%	99.48%	98.76%
Delayed Transfers of Care (DToC)	3.5%	6.37%	8.05%
Number of falls resulting in moderate or severe injury, or death	-	21	19
Number of cases of MRSA bloodstream infections	0	1	2
Number of C. Difficile infections	46	56	51
"Never Events" reported	0	4	5
Summary Hospital Mortality Indicator (SHMI)	100	98.19	97.59
Hospital Standardised Mortality Ratio (HSMR) - all week	100	98.4	93.75
Hospital Standardised Mortality Ratio (HSMR) - weekends	100	96.36	102.58
Emergency Caesarean Section rate	13%	17%	14.52%
Percentage of completed VTE risk assessments	95%	93.14%	91.5%
Number of single sex accommodation breaches	0	661	923*

*Prior to May 2016 the Trust reported in line with a local agreement that was established between NHS Sussex and BSUH in 2011 and is now out of date. This stated that if there was a screen dividing women and men, they could sleep in the same bays. In the reporting year NHSI, our CCG and deputy chief nurse agreed that this did not address the issue and we began reporting all incidents of mixed sex, if not for clinical reasons, hence the significant increase in numbers reported. There is an ongoing piece of work across Sussex to look at how this is reported, as each Trust seems to use different criteria. Ongoing work is being undertaken across the Trust to reduce the frequency of mixed sex accommodation breaches.

Operational Performance 2017-18

Brighton and Sussex University Hospitals uses a Performance Framework and associated governance to ensure sustained delivery of key measures based on the principles of the Balanced Scorecard. This framework ensures scrutiny, assurance, and where necessary, remedial actions and follow through to compliance recovery. The structure of this framework has been developed in quarter 4 of 2017/18 and ensures oversight through:

- Care Group review of departmental/ward delivery
- Divisional Management Board review of associated Care Groups
- Divisional Performance Reviews (SDRs) undertaken by the Trust Executive
- monthly performance review by Trust Board

Each layer of review and action considers both the key access targets and outcomes objectives used to assess operational performance under the Single Oversight Framework, and a wider set of balanced scorecard indicators that have been selected to provide a more complete view of operational risks and interdependencies. The review process is underpinned by an extensive suite of business intelligence tools designed to show outcomes, but also the drivers of potential compliance risks such as changing demand profiles.

Regulatory standards

The operational performance of Brighton & Sussex University Hospitals is measured against key access targets and outcomes objectives set out in the Single Oversight Framework* drawn up by NHS Improvement, the overseer of health care organisations. These are:

- A&E maximum waiting time of 4 hours from arrival to admission/transfer/discharge
- Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway
- All cancers – maximum 62-day wait for first treatment from:
  - urgent GP referral for suspected cancer
  - NHS cancer screening service referral
- Maximum 6-week wait for diagnostic procedures

Performance summary:

NHS Improvement Single Oversight Framework	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	2017/18 YTD	2017/18 Target
A&E: maximum waiting time of 4 hours from arrival to admission/transfer/discharge	85.28%	85.98%	86.54%	81.88%	83.61%	84.26%	86.95%	86.26%	82.78%	82.63%	81.99%	83.19%	84.18%	95%
All cancers : 62-day wait for first treatment following urgent GP Referral	86.1%	81.1%	74.3%	68.8%	81.4%	78.2%	80.3%	68.2%	80.2%	74.1%	72.8%		77.1%	85%
Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway	85.19%	86.12%	86.87%	87.01%	86.80%	86.04%	86.11%	86.32%	84.50%	84.60%	83.61%	83.12%	83.12%	92%
Maximum 6-week wait for diagnostic procedures	0.47%	0.90%	0.72%	0.60%	1.04%	0.72%	0.86%	1.30%	3.40%	4.31%	3.48%	6.06%	6.06%	<1%

A&E

It has been a challenging environment throughout 2017/18, with performance below National 95% target throughout the year. However, for the BSUH A&E catchment there was a marginal improvement to 84.3% average performance 2017/18 compared to 82.6% (which includes attendance figures for Brighton Station Walk in Centre 2017/18).

The Trust has undertaken a focussed programme of work from Quarter 3 2017/18 to improve performance through nationally recognised improvement methodologies with support from the in-house Kaizen team to target process improvements throughout the patient emergency pathway. The Trust has also undertaken development of estate and

configuration of the emergency departments to increase capacity and enhance flow (such as for ambulatory care patients and GP streaming in 17/18), with large scale additional bed capacity planned at the Royal Sussex County Hospital in 18/19.

Additionally, the Trust has engaged and co-ordinated aligned resilience plans in the wider Local Health Economy, through the Brighton CCG chaired Local A&E Delivery Board, and wider regional acute partners for escalation to target reduced delayed transfers of care, to free up bed capacity and enhance patient flow.

RTT
The Trust saw significant improvements in RTT performance from 73.5% April 2016, to 85.2% April 2017, through focussed recovery actions to reduce 18 week waits in challenged specialties. Performance continued to improve to 87% July 2017 and sustained at 86% until November 2017. Winter pressure has deleteriously affected RTT performance however, with planned reductions in routine elective inpatient activity in favour of clinically urgent, cancer or emergency patients between December2017 to March 2018. This has meant the Trust performance at the end of 2018/19 was 83.1%.

Cancer 62-day Performance
The Trust met the 85% 62-day target in April 2017 and has achieved an average of 77.1% (to February 2018) in 2017/18, a marginal improvement from 76.3% April 2016 to Feb 2017.

Diagnostic 6-week waiters
The Trust performed well against 6-week target to November with on average over 6-week waiters of 0.83% against the 1% national target. The Trust observed a decline in performance from December however, with a range of capacity issues arising throughout winter, particularly relating to equipment failure within imaging services, resulting in March performance of 6.06% against the 1% target. The Trust has in place robust recovery plans into the first quarter of 2018/19 with plans to replace equipment and enhance capacity through substantive recruitment plans.

Financial Performance 2017-18

The key highlights for the Trust's financial performance for the year were:

- Actual performance - against a challenging operational and commissioning landscape the Trust delivered a deficit for the year of £64.1m. After adjusting for the impact of impairments and adjustments in relation to the donated asset reserve the adjusted retained deficit is £55.6m.

- Control total performance - as a result of the new management arrangements, the Trust was able to agree a revised control total for 2017/18. The control total was set at a deficit of £65.4m and was based on a series of negotiated principles. The Trust delivered the control total as planned; achieving a comparable deficit of £63.8m.

- Sustainability and Transformation Funding (STF) – having delivered the control total the Trust received confirmation from NHS Improvement that it was eligible for an allocation from the STF Incentive Fund. The allocation was £8.3m; improving the performance against the control total by the same amount and decreasing the reported deficit to £55.6m.

- Efficiency Programme - underpinning both the control total achievement and in-year investment in services was the delivery of £20.0m of savings; in line with the plan. During the year significant investment was made in the development of a Programme Management Office to both improve and embed robust governance arrangements and to support the identification and delivery of sustainable savings opportunities.

- Capital - expenditure on capital schemes of £60.6m, including £41.2m on the 3Ts building development, £3.9m on estates, £7.1m on Information Technology, £2.9m on replacement equipment and £5.5m on service development.

	£m
2017/18 Control Total Deficit	63.8
STF Funding	-8.2
Reported Financial Performance	55.6
Impairments & Donated Asset Movement	8.5
Reported Deficit	64.1

Financial outlook

The Trust has submitted its operational and financial plans for 2018/19. The control total, as agreed with NHS Improvement, is a planned deficit of £65.4m. This incorporates a stretch target to support the Trust's ambition to exit financial special measures during 2018/19. Delivery of the plan is underpinned by an efficiency expectation of £30m; for which schemes have been fully identified.

Financial Risks & Recovery Actions

There are a number of risks to delivering the financial plan; the most significant of which are listed below.

- Commissioner affordability and the Trust's income expectation - work to develop an Aligned Incentive Contract with CCGs commissioners has concluded which will help mitigate risk for the Trust and the health system. The Trust continues to work with NHS England to reach an agreement for 2018/19.

- Delivery of the efficiency programme - plans to deliver the £30m efficiency requirement have been fully identified but there are risks to delivery. Robust governance processes have been developed and embedded and the aim is identify further opportunities to mitigate any risks that emerge during the year.

- Workforce Expenditure – availability and cost of staff continues to be a risk. Improving and widening the use of e-rostering will be an important investment to support both management and the control environment during 2018/19.

- System Resilience and Management of Patient Flow - delivery of planned activity volumes is predicated on workforce and bed capacity plans. Changes in patient demand or patient throughput can significantly impact bed capacity and workforce with consequent impact on the cost base for delivering emergency activity and ability to achieve planned elective volumes.

Summary

2017/18 was a successful yet challenging year. The Trust made significant progress in understanding and stabilising the financial position, identifying and delivering the planned savings, improving the control environment and most importantly delivering the agreed financial target. 2018/19 will bring further challenges but, given the improvement work undertaken during 2017/18, the Trust will better able to respond.

Care Quality Commission Inspection

The Care Quality Commission (CQC) recognised "significant improvements" at the Trust and increased the rating of our hospitals to "requires improvement" following its inspections of the Royal Sussex County Hospital and the Princess Royal Hospital in April 2017.

The inspectors took account of those services that performed well at the 2016 inspection and only inspected emergency care, medical services, surgery, critical care, maternity and gynaecology and outpatients and diagnostics. Because of recent changes in the executive, the inspectors did not complete a full assessment of trust wide leadership.

The inspectors found improvements at both hospitals and found that the quality of caring was "good" across all services: patients received compassionate care, were involved in decisions about their treatment and care and were very positive about the care they received. They recognised that staff had responded positively to their findings the previous year and made real, tangible efforts to provide better care for patients. The inspectors also noted improvements in the culture of the Trust over the past year.

The CQC improved the rating at the Royal Sussex County Hospital in thirteen specific measures and moved maternity and gynaecology services up from 'requires improvement' to 'good'. Their rating of the Princess Royal Hospital was 'good' for nearly half of all measures

against which the hospital was assessed (16 out of 35) and no areas were rated 'inadequate'.

These improvements provide the foundations upon which the Trust can continue to improve. The CQC identified a number of areas that required attention. For example, the Royal Sussex County Hospital continues to be rated 'inadequate' on safety. The CQC also highlighted that the lack of consistent leadership had prevented the Trust from making further improvements between the two inspections.

The new executive leadership team developed an action plan in response to this inspection. Our objectives focus on improving the care we deliver and the experience patients receive when they visit one of our hospitals. Our Trust-wide action plan focuses on adoption of the safer sharps initiative, staff development, fire safety and improvements to information available to patients that do not speak English as a first language. We are also making a number of other improvements at our individual hospitals.
The plan was submitted and accepted by the CQC in August 2017. Our aim is to ensure that the CQC rates the Trust as "good" by the time of its next inspect and we are committed to creating a culture of continuous improvement through the introduction of Patient First.

Our Commitment to Sustainability

Cutting carbon emissions as part of the fight against climate change and the significant impact on human health is a key priority for the Trust. BSUH is working with colleagues from other NHS organisations within Sussex and East Surrey.

The STP's collective carbon footprint is estimated at 100,000 tonnes CO2e per annum (BSUH accounts for just over a quarter of the total). This is primarily driven by energy consumption across the estate but it is also estimated the system produces over 10,000 tonnes of physical waste with staff driving over 20 million business miles each year.

Following an initial review to merge data and existing plans, four key environmental sustainability workstreams will be established:

1. Utilities: Options for driving energy and water efficiency across estate (including water industry deregulation options). Investigate opportunity to create single investment vehicle to achieve cost and carbon savings across estate.

2. Waste and Resources: Assess potential for harmonised waste policy, targets and operational procedures, collective contract tendering and centralised Waste Bureau service to manage service.

3. Staff Travel: Scope opportunity for single Travel Transformation Plan to reduce staff travel time, cost and carbon across system and centralised Travel Bureau function to implement project work and support staff.

4. Commercial Transport: Assess potential for consolidation of commercial courier services delivered by and provided to all STP organisations.

Our sustainability plan for 2018-19 includes:

- Reduce the use of disposable cups and sell reusable environmentally friendly cups (which are biodegradable and free of Bisephenol A - BPA) with incentive to return and refill.
- Replace our current takeaway cups with a biodegradable recyclable cup.
- Replace our polystyrene and plastic containers with biodegradable sugar cane containers.
- Replace our takeaway cutlery with biodegradable sugar resin alternative
- Removal of plastic straws and stirrers – replace with paper straw for those who need a straw on medical grounds.
- Encourage recycling on site with our waste partners.
- Reuse our coffee grounds in all restaurants as fertiliser/eco product.
- Work with local suppliers in local area to supply our fruit, vegetables, fish and milk.
- Promote Soil Association, MSC Fish and Red Tractor products.
- To apply for awards recognising the drive towards healthier eating.

ACCOUNTABILITY REPORT

Corporate Governance Report

Directors' Report

Our Board of Directors 01 April 2017 to 31 March 2018

NON-EXECUTIVE DIRECTORS

Mike Viggers, Chairman
Chair of the Finance and Investment Committee

Joanna Crane
Non-Executive Director

Mike Rymer
Non-Executive Director and Deputy Chair

Martin Sinclair
Non-Executive Director

Malcolm Reed
Non-Executive Director

Kirstin Baker
Non-Executive Director

Graham Hodgson
Non-Executive Director (to 30 November 2017)

EXECUTIVE DIRECTORS

Marianne Griffiths, Chief Executive

Pete Landstrom, Chief Operating Officer and Chief Delivery and Strategy Officer

Denise Farmer, Chief Workforce and Organisational Development Director

Dr George Findlay, Chief Medical Officer

Karen Geoghegan, Chief Financial Officer

Nicola Ranger, Chief Nurse

Evelyn Barker, Managing Director (to 19 January 2018)

How the Trust is governed

The Trust is governed in accordance with its establishment order and *Standing Orders, Scheme of Reservation, Scheme of Delegation, Standing Financial Instructions.*

In seeking to ensure appropriate governance arrangements the Trust Board must critically appraise its systems, processes, skills and reporting mechanisms. The Trust's governance

arrangements need to take into account guidance from the Department of Health, NHS Improvement and NHS Providers on integrated governance.

In light of the Management Contract with Western Sussex Hospitals NHS Foundation trust the Board reviewed its Board and Committee governance and implemented a revised Board Committee structure in April 2017. This is detailed in the 'Board Committees' section of this report.

The Board

The Chair and Non-Executive Directors are appointed through an NHS Improvement led appointments process.

The Directors of the Trust for the period of this report are shown in the table below together with their attendance at Board meetings for the period.

The Trust has 6 independent Non-Executive Directors, one of whom is nominated by the Universities of Brighton and Sussex, in addition to the Chairman.

The Board Nomination and Remuneration Committee appoints the Trust Executive Directors.

All these appointments are subject to annual appraisal. The Chairman is appraised by NHS Improvement; the Non-Executive Directors by the Chairman; the Chief Executive by the Chairman; and Executive Directors by the Chief Executive.

All members of the Board complete a *Fit and Proper Person* declaration on appointment and then annually, in addition to other employment checks.

How the Board Operates

The Board sets the Trust's strategic aims and provides active leadership of the Trust. It is collectively responsible for the exercise of its powers and the performance of the Trust, relevant statutory requirements and contractual obligations, and for ensuring the quality and safety of services. It does this through the approval of key policies and procedures, the annual plan and budget for the year, and schemes for investment or disinvestment.

The Non-Executive Directors play a key role in taking a broad, strategic view, ensuring constructive challenge is made and supporting and scrutinising the performance of the Executive Directors, whilst helping to develop proposals on strategy.

Board meetings are held in Public every two months and there is the opportunity for members of the public to ask questions of the Board.

Board meetings follow a formal agenda which includes Patient Safety and Experience and a range of Strategic and Operational items including; clinical governance, financial and non-financial performance, together with performance against quality indicators set by the Care Quality Commission (CQC), NHS Improvement and by the Executive. These include measures for infection control targets, patient access to the Trust, waiting times, length of stay, complaints data and the results of the Friends and Family Test.

Attendance at the Board of Directors

Attendance of Board members at the Board of Directors in 2017/18 is detailed below:

Name	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Mike Viggers	√	√	√	√	X	√	√	√	√	√	√	√
Kirstin Baker	√	√	√	√	√	√	√	√	√	√	X	√
Joanna Crane	√	X	√	√	X	X	√	√	√	√	√	√
Graham Hodgson*	√	√	√	√	√	√	X	X				
Malcolm Reed	√	√	?	√	?	√	X	X	X	√	X	X
Mike Rymer	√	√	√	√	√	√	√	√	√	√	√	√
Martin Sinclair	√	√	√	√	√	√	√	√	√	√	√	√
Marianne Griffiths	√	X	√	√	√	√	√	√	√	√	√	X
Evelyn Barker **	√	√	√	√	√	√	√	√	√			
Denise Farmer	√	√	√	√	√	√	√	√	√	√	√	√
George Findlay	√	√	√	X	√	√	√	√	√	√	√	√
Karen Geoghegan	√	√	√	√	X	√	√	√	√	X	√	√
Pete Landstrom	√	X	√	√	√	√	X	√	√	√	√	√
Nicola Ranger***		√	√	X	√	√	X	√	√	√	√	√

Notes:
*Graham Hodgson left the trust in November 2017
**Evelyn Barker left the trust on the 19th January 2018
***Nicola Ranger joined the trust in May 2017

Board Advisors

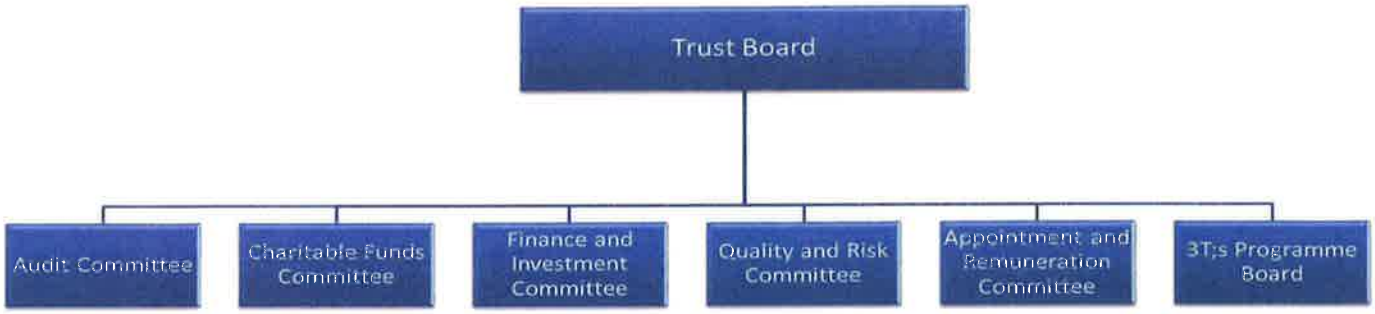
From 1st April 2017 Western Sussex Hospitals NHS Foundation Trust (WSHFT) commenced a formal 3-year management contract to operate Brighton and Sussex University Hospitals NHS Trust. As part of the Board arrangements the Non-Executive Directors for WSHFT attend BSUH Board and Committee meetings as Board Advisors but with no formal accountability or voting rights, except if they are a formal Non-executive at both Trusts.

Board of Directors Committee structure

The Board Committees were revised on the 1st April 2017 into the following structure to ensure that all governance domains and the business of the Trust are adequately assured.

Each committee is chaired by a Non-Executive Director, with strong Executive and Non-Executive membership and reporting directly to the Board of Directors.

Table 1: governance structure



Audit Committee

An independent Audit Committee is the central means by which the Trust Board ensures effective control arrangements are in place. The Committee comprises of three Non-Executive Directors in line with best practice outlined in the NHS Code of Governance. The Audit Committee reviews, monitors and reports to the Board on the attainment of effective control systems and financial reporting processes.

The Audit Committee receives and considers reports from Internal Audit, External Audit and Counter Fraud Services.

The Audit Committee membership and attendance in respect of the period 01 April 2017 to 31 March 2018 is set out in the table below:

Register of Members attendance at Audit Committee meeting for the period 01 April 2017 to 31 March 2018

	May	July	October	January	Total
Martin Sinclair	√	√	√	√	4 of 4
Kirstin Baker	√	√	X	√	3 of 4
Joanna Crane			√	√	2 of 2
Lizzie Peers (Advisor)	√	√	X	√	3 of 4
Jon Furmston (Advisor)	√	√	√	√	4 of 4

The Chief Financial Officer, Chief Workforce and Organisational Development Director, Local Counter Fraud Services, Internal and External Auditors are regular attendees at meetings of the Committee. The Committee requests other senior Trust officers to attend for specific items.

The Trust External Audit provider are Ernst and Young LLP while Grant Thornton provide the Internal Audit Service. The Counter Fraud Service is maintained in-house.

The Audit Committee Agenda is based upon an agreed annual work-plan. In order to maintain independent channels of communication the members of the Audit Committee hold a private meeting collectively with External Audit, Internal Audit and Counter Fraud ahead of

each Audit Committee. This provides all parties the opportunity to raise any issues without the presence of management.

The Audit Committee is responsible to the Board for reviewing the adequacy of the governance, risk management and internal control processes within the Trust. In carrying out this work the Audit Committee obtains assurance from the work of the Internal Audit, External Audit and Counter Fraud Services.

The Audit Committee review the financial year end Annual Report, Annual Accounts and Annual Governance Statement with the External Auditor prior to Board approval and sign off. The Audit Committee agrees the schedule of Internal Audit reviews at the start of the year and receives the reports of those audits and tracks the implementation of recommendations at each of its meetings.

Quality and Risk Committee

The Quality and Risk Committee supports the Board in ensuring that the Trust's management of clinical and non-clinical processes and controls are effective in setting and monitoring good standards and continuously improving the quality of services provided by the Trust.

Finance and Investment Committee

The Finance and Investments Committee supports the Board to ensure that all appropriate action is taken to achieve the financial objectives of the Trust through regular review of financial strategies and performance, investments, and capital and estates plans and performance.

The Committee is Chaired by the Chair of the Trust and all Non-Executive and Executive Directors are invited to attend.

Charitable Funds Committee

The purpose of the Charitable Funds Committee is to monitor progress and performance against the strategic direction of the Charitable Trust's fundraising activity as determined by the Board as Corporate Trustee; to approve and monitor expenditure of charitable funds in line with specified priority requirements; and to monitor the management of the Trust's investment portfolio ensuring that the Trust at all times adheres to Charity Law and to best practice in governance and fundraising.

Appointment and Remuneration Committee

The Committee sets the terms and conditions of the Executive Directors. This committee's membership is Non-Executive Directors only.

In attendance at meetings are the Chief Executive, Chief Workforce and Organisational Development Director and the Corporate Governance Director.

During the period the Committee did not procure any external advice relating to pay and the Trust does not operate performance related pay.

Appointments and appraisal

The Chair and Non-Executive Directors are appointed through an NHS Improvement led appointments process.

The Chairman, other Non-Executive Directors, and the Chief Executive are responsible for deciding the appointment of Executive Directors.

The Chief Executive undertakes an appraisal on the performance of the Executive Directors, which are formally reported to the Appointment and Remuneration Committee.
The Chair conducts the Chief Executive's appraisal which is reported in the same way. The Chair also undertakes the appraisal of the Non-Executive Directors while the Chairs appraisal is undertaken by the regulator, NHS Improvement.

Statement of compliance with the NHS Constitution

The Board of Directors takes account of the NHS Constitution in its decisions and actions, as they relate to patients, the public and staff. The Board of Directors is compliant with the principles, rights and pledges set out in the Constitution.

Statement on Directors Disclosures

The Annual Report is required to include a statement that for each individual, who is a director at the time the report is approved, as follows:

- So far as each director is aware, there is no relevant audit information of the which the (external) auditor is unaware; and
- the director has taken all the steps that they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the auditor is aware of that information.

All Directors have confirmed the above statement.

Declarations of Interest

All Board members have declared their relationship, under the terms of a management contract, with Western Sussex Hospitals NHS Foundation Trust as an 'Interest' in order to provide transparency on Board decision making.

The Chair has not declared any significant commitments that require disclosure, other than that highlighted above relating to the management contract.

The Trust holds a register of company directorships and other significant interests, held by directors, which may conflict with their management responsibilities. The Trust Board receives an Annual Report on Board Declarations in the public part of its meeting.
Details of declarations are held on a Trust Register and are available from the Director of Corporate Governance upon request.

Corporate Governance Code

The Board is satisfied that it complies with the Corporate Governance Code.

Emergency Planning and Business Continuity

All NHS Trusts are required to undertake an annual EPRR assurance assessment and report the outcome to commissioners and NHS England for approval. Brighton and Sussex University Hospitals is confirmed as Substantially compliant (2017/18) against the emergency planning standards set by NHS England.

The Emergency Preparedness Resilience and Response (EPRR) assurance ensures the Trust has plans in place to continue the delivery of critical services during periods of disruption, such as a major incident or business continuity period.

The EPRR assurance process highlighted some additional opportunities for further improvement and these have been included in a detailed Emergency Planning and Business Continuity work programme.

Marianne Griffiths
Chief Executive

25 May 2018

Statement of the 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 NHS Improvement. These include ensuring that:

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

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

Marianne Griffiths
Chief Executive

25 May 2018

Statement of Directors' Responsibilities in Respect of the Accounts

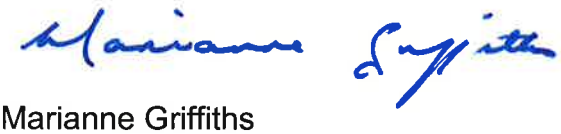
The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of the Treasury, directs that these accounts give a true and fair view of the state of affairs of the Trust and of the income and expenditure, recognised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



Marianne Griffiths
Chief Executive
25 May 2018

Karen Geoghegan
Chief Financial Officer
25 May 2018

1. Scope of responsibility

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

1.2 The Trust's Standing Orders and Scheme of Delegation outline the accountability arrangements and scope of responsibility of the Board of Directors ('the Board'), Executive Directors and Trust officers.

1.3 The Board receives regular minutes and reports from each of the nominated committees that report into it. The terms of reference of the committees of the Board are regularly reviewed to ensure that governance arrangements continue to be fit for purpose.

1.4 The Trust works in close partnership with other health and social care organisations in the area, but notably with the Brighton and Hove Clinical Commissioning Group. In addition, the Trust attends the Brighton and Hove City Council, Health and Adult Social Care Overview and Scrutiny Committee.

2. Management contract with Western Sussex Hospitals NHS Foundation Trust

2.1 Following the Trust being placed in quality and financial special measures, and to provide leadership from a Trust designated outstanding by the CQC, Brighton and Sussex University Hospital NHS Trust (BSUH), Western Sussex Hospitals NHS Foundation Trust (WSH) and NHS Improvement made an interim agreement in November 2016 to provide support from WSH to BSUH, with the intention of developing a long-term arrangement from April 2017.

2.2 The three parties made a long-term agreement in March 2017 for a period of three years and the WSH leadership team, Executive and Non-Executives, were appointed to lead the Trust from 1st April 2017. This Agreement identified five key priorities:

- delivering the improvements necessary to enable BSUH to exit Financial Special Measures;
- delivering the improvements necessary to enable BSUH to exit Quality Special Measures;
- addressing the underlying issues at BSUH relating to leadership and culture which were inhibiting the delivery of improvements to services;
- effective implementation of a three-year plan to improve accident and emergency performance; and
- effective oversight of the 3Ts Programme (The Royal Sussex County Hospital is undergoing a £485 million programme to replace all the buildings on the front of the main hospital site. We call the programme the '3Ts redevelopment', which reflects our role in teaching, trauma and tertiary care.

3. The purpose of the system of internal control

3.1 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 2018 and up to the date of approval of the annual report and accounts.

4. Capacity to handle risk

Trust Board

4.1 The Trust has a Risk Management Strategy and Policy, endorsed by the Board of Directors and reviewed and monitored through the Trust Quality and Risk Committee to the Board. The Risk Management Strategy and Policy are due for review following changes to the Trusts' Quality and Corporate Governance Structures. The Board of Directors recognise that risk management is an integral part of good management practice and to be most effective should be embedded in the Trust's culture. The Board is therefore committed to ensuring that risk management is embedded as part of the Trust's philosophy, practice and planning and is not viewed or practiced as a separate programme and that responsibility for implementation is accepted at all levels of the organisation.

Non-executive Directors

4.2 The Audit Committee is chaired by a nominated Non-Executive Director. All Non-Executive Directors have a responsibility to challenge robustly the effective management of risk and to seek reasonable assurance of adequate control. One Non-Executive member of the Audit Committee is also a member of the Quality and Risk Committee to ensure that there is a positive link between the two key risk oversight committees.

Chief Nurse

4.3 The Chief Nurse is accountable for the strategic development and implementation of organisational risk management and ensuring there is a robust system in place for monitoring compliance with standards and the Care Quality Commission (CQC) registration legal requirements.

4.4 The Chief Nurse is also responsible for managing Infection Prevention and Control, Safeguarding Arrangements, complaints, patient information and medical legal matters.

Chief Financial Officer

4.5 The Chief Financial Officer oversees the adoption and operation of the Trust's Standing Financial Instructions including the rules relating to budgetary control,

procurement, banking, losses and controls over income and expenditure transactions, and is the lead for counter fraud.

4.6 The Chief Financial Officer attends the Trust's Audit Committee but is not a member, and liaises with internal audit, external audit and the Trust's Counter Fraud Specialist, who undertake programmes of audit with a risk-based approach.

5. The Risk and Control Framework

5.1 The Board of Directors approved a revised corporate governance framework in April 2017.

5.2 The Trust's corporate governance structure is designed to ensure appropriate oversight and scrutiny and to ensure good corporate governance practice is followed.

5.3 In addition, the clinical structure of the Trust was revised from twelve directorates to five clinical divisions in September 2017 with the aim of providing greater oversight.

5.4 Each clinical division is led by a Divisional Director of Operations, a Chief of Service and a Head of Nursing.

5.5 Through quarter two of 2017/18 a fundamental external review of the Trust's quality governance structure was undertaken which identified areas which could be strengthened. This centred around the creation of an Executive-led Quality Steering Group with sub-groups based on the Lord Darzi recommended areas (Patient Safety; Clinical Outcomes and Effectiveness; Patient Experience and Engagement) together with a related group to provide management oversight of risk and compliance.

5.6 This new structure was implemented through quarter four of this year.

5.7 The Trust has a Risk Strategy and Policy that was approved in September 2016 and which will be revised, in 2018, in line with the new arrangements set out as above.

5.8 Risk management training forms part of the essential training package that all staff are required to complete. All new members of staff attend a mandatory induction event which covers key elements of risk management. The Trust provides statutory and mandatory training that all staff must attend.

5.9 Risks are raised and captured to a central risk management database known as Datix.

5.10 All staff are responsible for responding to incidents, hazards, complaints and near misses in accordance with appropriate Trust policies. Local management teams oversee local risk registers and the management and escalation, as appropriate, of risks.

5.11 The Trust has developed a new Board Assurance Framework (BAF), effective from quarter three, through which the Board is provided 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.

5.12 The BAF has been aligned to the Trust's True North and Breakthrough Objectives, which includes the Trust's 3Ts capital programme, as part of the Patient First programme. The revised was reviewed and approved by both the Audit Committee and Trust Board.

5.13 The BAF also highlights estates backlog maintenance issues as a risk being tracked by the Trust Board.

5.14 During the period of this report the Trust regrettably had four Never Events. Never Events and Serious Incidents are subject to a thorough internal review to identify root causes and learning. All Serious Incidents including Never Events were reported as required to the Clinical Commissioning Group, NHS Improvement and to NHS England. A full investigation is undertaken and the outcome and recommendations reported to the Trust Board.

5.15 The Trust was placed in Quality Special Measures following a Care Quality Commission inspection in 2016 which rated the Trust as Inadequate.

5.16 The Trust was placed in Financial Special measures following deterioration in its financial position during 2016.

5.17 The Trust remains in Special Measures for both Quality and Finance but it is striving hard to exit both of these regimes and good progress has been made within this year.

5.18 As a key element in mitigating these risks the Trust has launched its Patient First programme, which, as it becomes embedded, will help to ensure continued focus on improving quality, the patient experience and ensuring the trust is sustainable.

5.19 In addition the Trust has developed an in-house Programme Management Office providing robust focus and governance in supporting the delivery of the annual Cost Improvement Programme.

5.20 All cost improvement proposals are subject to a Quality Impact Assessment which are reviewed by the Chief Medical Officer and Chief Nurse. Any schemes deemed to be high impact are also reviewed by the Trust's Quality and Risk Committee prior to implementation.

5.21 The issue of IT system and data security has been a focus of the Audit Committee. The IT Directorate manage, progress and report on actions to mitigate the risks around data security and cyber security in monthly governance meetings. These meetings ensure that the significant number of operational and technical solutions that are now in place to mitigate risks are well progressed.

6. Quality Account

6.1 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.

6.2 In developing the Quality Account 2017/18, quality improvement priorities for 2018/19 have been identified following discussion in the Trust and with Commissioner and patient representatives. The Quality Accounts will be considered by the Quality and Risk Committee prior to submission to the Board for approval in June 2018.

6.3 To assure the Board that the Quality Accounts present a balanced view and that there are appropriate controls in place to ensure the accuracy of data, the Board has:

- Appointed the Chief Medical Officer supported by the Trust Medical Director and Trust Nurse Director to lead and advise us on all matters relating to the preparation of the Trust's annual Quality Accounts.

- Established a Quality Steering Group to provide focus on continuously improving clinical practice.
- Put in place a system to receive and act upon feedback on the Accounts from local stakeholders.

6.4 All policies are ratified by the Trust's Executive Committee and include an Equality Impact Assessment which identifies any risk of individuals or groups being disadvantaged by that policy together with actions being taken to mitigate that risk.

7. Care Quality Commission (CQC) Registration

7.1 The Care Quality Commission (CQC) conducted an inspection of the Trust in April 2016 and the Trust was rated *inadequate* in June 2016. A follow up (partial) inspection took place in April 2017 which recognised significant improvements.

7.2 The Trust remains in Quality Special Measures. However, during their inspection in April 2017 inspectors found improvements at both hospitals and noted that the quality of caring was "good" across all services.

7.3 Specific areas to highlight at the Royal Sussex County Hospital were:

- The CQC improved our rating on thirteen specific measures
- Maternity and gynaecology services moved up from 'requires improvement' to 'good'
- Urgent and emergency care services moved from 'inadequate' to 'requires improvement'
- Outpatients and diagnostic testing also moved up to 'requires improvement'
- Services for children and young people and End-of-life care were not inspected, as they were rated Outstanding and Good respectively in 2016.

7.5 Specific areas to highlight at the Princess Royal Hospital:

- The hospital stayed in the 'requires improvement' band but saw an increase in the number of measures on which it was rated 'good' of almost 25%
- No areas of inspection were considered 'inadequate' (down from two in 2016)
- Maternity and gynaecology services moved up from 'requires improvement' to 'Good'

7.6 The Trust continues to work with regulators and other stakeholders to drive further improvement. The Trust has developed a fully integrated action plan and scrutiny and oversight is not only provided through reporting to the Trust Board but also to an independently chaired Quality Oversight Committee. The Committee membership includes NHS Improvement, Care Quality Commission, Clinical Commissioning Group, NHS England, Healthwatch and others.

8. Compliance with equality, diversity and human rights legislation

8.1 Control measures are in place to ensure that all the Trust's obligations under equality legislation are complied with and all policies and consultation documents are subject to the due regard process to ensure no group is unintentionally disadvantaged.

8.2 The Equality and Diversity agenda will be overseen by a cross organisational steering group chaired by the Chief Executive with Non-Executive Director attendance.

8.3 The Trust has a clear focus on safety and quality and our patient-centred values are applied by staff while at work every day, regardless of who they are and where they come from. More than 95 nations are represented among our 8,200 staff, all of whom by working for Brighton and Sussex University Hospitals NHS Trust have chosen to dedicate their professional lives to caring for people.

8.4 Ensuring high quality, safe services are available to all sections of the community and provided by a workforce that reflects the diversity of our population is an essential part of this journey. Each year the Trust produces an annual report on our performance for equality and diversity in relation to staff and patients. This report provides us with an opportunity to celebrate the progress we have made so far, provide key information in relation to equality and diversity and express our commitment to removing inequalities and promoting equality and diversity at the Trust.

8.5 In addition to our annual report we have live equality and diversity objectives that have been developed to enable us to improve outcomes in areas where data has highlighted room for improvement.

9. Compliance with NHS Pension Scheme Regulations

9.1 As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments in to the Scheme are in accordance with the Scheme rules and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the regulations.

10. Compliance with climate change adaptation reporting to meet the requirements under the Climate Change Act 2008

10.1 The Trust has plans in place in accordance with emergency preparedness and civil contingency requirements to ensure that this organisation's obligations under the Climate Change Act, we are also fully compliant with the CRC Energy Efficiency Scheme

11. Review of economy, efficiency and effectiveness of the use of resources

11.1 The Board of Directors developed its objectives for the period of this report using the principles embedded within its Patient First Programme and has identified 'True North' objectives for the Trust. All objectives are quantifiable and measurable and performance is reviewed through an appropriate sub-committee such as the Audit Committee or Quality and Risk Committee as well as the Board.

11.2 The Board receives a monthly report from the Chief Financial Officer on financial performance. Financial performance is highlighted and reviewed at the Trust Executive Committee to ensure that all senior leaders have visibility on the position and the actions required. Financial performance is further scrutinised in detail at the Finance and Investment Committee.

11.3 The Trust has developed a robust structure for the identification and delivery of efficiency programmes. A new Programme Management Office has been developed and has gained real traction across the Trust. The Finance and Investment Committee pays particular attention to the delivery of the efficiency programme through its monthly meetings.

11.4 The Trust continues to operate under the Financial Special Measures regime and as part of this the Trust reports to a monthly Integrated Performance meeting with its regulators.

11.5 The Trust's financial position has been stabilised and the Trust has achieved its agreed Control Total for 2017/18. The Trust continues to work closely with its Regulator (NHS Improvement) to support delivery of a sustainable solution.

12. Review of Effectiveness of risk management and control

12.1 As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed in a number of ways;

- The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance on controls reviewed as part of the internal audit work-plan.
- Executive Directors within the Trust who have responsibility for the development and maintenance of the system of internal control provide me with assurance.
- External auditors provide assurances through their opinion on the financial statements, their value for money conclusion and their report on the annual Quality Account.
- Other external agencies including NHS Improvement, the Care Quality Commission and Commissioners.

12.2 The Board and its sub-committees form an important aspect of control and I have been advised during my review by the work of both the Audit Committee and Quality and Risk Committee.

12.3 The Finance and Investment Committee is chaired by the Trust Chair and plays a key role in assuring me on the delivery of the Trusts financial position.

12.4 During the year covered by this report a revised Board Assurance Framework has been developed to align to the new Patient First programme and the identified True North and associated objectives. This plays a key role in identifying risks to achieving the goals of the organisation and how those are mitigated.

12.5 My review is also informed by:

- The Trust processes for monitoring the CQC Integrated Action Plan
- Annual Staff Survey
- Learning from complaints
- Programme of work undertaken by internal and external auditors a well as Counter Fraud

- External Assurance visits such as the following:
- Major Trauma Peer Review and recognition of progress made
- Emergency Care Improvement Programme (ECIP) review of urgent care at PRH with positive comments on systems and process

12.6 Through Quarter 1 of this year the Trust commissioned an external review of its Quality Governance Structure to ensure it was as effective as it could be. The report, and recommendations therein, have been accepted by the Board and at the time of writing a new Executive oversight structure is being implemented. This includes an Executive-led Quality Steering Group with the following four sub-groups led by Trust Directors; Patient Safety Group, Clinical Outcomes and Effectiveness Group, Patient Experience and Engagement Group and a Risk and Compliance Group.

12.7 I believe that these changes, along with the new divisional structure we have put in place, will further strengthen our governance processes.

13. Audit Committee

13.1 The Audit Committee is a sub-committee of the Board of Directors and reports directly to it. Its membership comprises of Non-Executive Directors.

13.2 The Audit Committee is responsible for overseeing the activities of Internal Audit, External Audit and Counter Fraud. For each of these it:

- approved the annual work plans at the beginning of the financial year and updates to these throughout the year
- has received reports on the work undertaken to date and the findings
- has reviewed the management response to reports, in particular the implementation of recommendations to date via tracker reports.

13.3 The Audit Committee is also responsible for reviewing evidence of the overall effectiveness of the system of internal control, governance and risk management.

13.4 The Internal Audit programme is risk based and includes matters of interest or concern identified by management and Non-Executive members of the Audit Committee. However, the plan is left flexible to allow the Committee to respond effectively if urgent issues arise.

13.5 Non-Executive Directors will be sponsoring a number of key audits.

13.6 Many of the key internal control processes were tested through the year by Internal Audit. The Audit Committee reviews all action plans arising from Internal Audits to ensure compliance.

13.7 The Audit Committee operates alongside the Quality and Risk Committee to maintain oversight of material risks affecting the Trust and the means by which risk is monitored and controlled. In support of this one Non-Executive Director member sits on both the Audit committee and Quality and Risk Committee.

13.8 The Audit Committee reviews the Annual Accounts before approval and provides a report to the Trust Board on its activities following each Committee meeting.

13.9 The Non-Executives of the Audit Committee meet prior to each Committee in private with Internal Audit, External Audit and Local Counter Fraud Services to assure themselves of the Trust's approach to audit and risk issues.

14. Internal Audit

14.1 Internal Audit provide an independent and objective opinion on the degree to which risk management, control and governance support the achievement of the Trust's objectives.

14.2 Based on the work undertaken for the period 1 April 2017 to 31 March 2018, the Head of Internal Audit has stated in his Head of Internal Audit Opinion that, 'Our overall opinion for the period 1 April 2017 to 31 March 2018 based on the scope of reviews undertaken and the sample tests completed during the period, is that nothing came to our attention which suggests controls were not suitably designed and operating effectively in the Trust's systems of internal control, governance and risk management except in the area of Cyber Security where some weaknesses in the design and/or application of controls put the achievement of particular objectives at risk.'

14.3 During the period 1 April 2017 to 31 March 2018 the Audit Committee met four times and received progress reports from Internal Audit. Internal Audit Reports are ranked Red, Amber or Green, and any report rated as Red is raised with the Audit Committee in detail. Of the 11 audits relevant to this period two were rated as Green, seven as Amber, one as Red and one report is pending. The Red rated audit related to a review of Cyber Security preparedness for which a robust action plan has been developed and will be monitored by the Audit Committee.

15. External Audit

15.1 External Audit report to the Trust on the findings from their audit work, in particular their review of the financial statements and the Trust's economy, efficiency and effectiveness in its use of resources.

16. Counter-fraud

16.1 The Trust is required under Service Condition 24 of the Standard NHS Commissioning Contract to ensure appropriate counter fraud measures are in place.

16.2 The Local Counter Fraud Specialist (LCFS) adopts a risk-based approach to counter fraud work, identifying 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.

16.3 The LCFS 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.

17. Information Governance

17.1 The Trust is required to disclose any Level 2 Information Governance breaches. There were no Level 2 Information Governance breaches reported in the period of this report.

17.2 The Trust has continued to work towards achieving the standards set out in the Information Governance Toolkit via the Information Governance Committee structure which reviews and agrees key information policies within the Trust.

17.3 There has been considerable focus on increasing the training provision within the Trust and as of January 2018 84% of eligible staff had received IG training through either annual refresher or at induction.

18. Significant issues

18.1 I have considered the factors described in the NHS Improvement guidance on the 2017/18 annual governance statement in respect of significant issues.

18.2 I have identified significant issues in this statement, which prejudice the achievement of Trust priorities, in respect of operational performance and safety and quality as follows:

- Performance against the 4-hour Accident & Emergency standard;
- Performance against Referral to Treatment (RTT) standards and;
- Performance against Cancer constitutional standards and;

18.3 These significant issues were also associated with the Trust being placed in Quality and Financial Special Measures.

18.4 The Trust's external auditor, Ernst and Young LLP (EY) has concluded that it is not satisfied that, in all significant respects, Brighton and Sussex University Hospitals NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

18.5 The external auditor has therefore concluded there is evidence of weaknesses in proper arrangements for informed decision making, sustainable resource deployment and working with partners and other third parties.

18.6 The external auditor went on to comment that "The Trust has made good progress during the year in addressing weaknesses in organisational and governance arrangements. Following the implementation of the three-year management agreement with WSHT in April 2017 pervasive changes have been made to both the overall management and governance structure of the Trust and its underpinning management and governance arrangements and processes. The Trust has made these changes to specifically address the CQC recommendations arising from the 'inadequate' rating and overall special measures designation, and to improve financial resilience and sustainability.

18.7 The new arrangements have, however, not been in place for the whole year and are not yet embedded. This is work in progress and the Trust accepts that it needs to continue improving arrangements to take informed decisions deploy resources in a sustainable manner and work with partners and other third parties."

18.8 The Trust has delivered its control total financial target for the period and has made good progress during the year in introducing arrangements both to stabilise its financial position and improve its future efficiency. Its financial plans for 2018/19 have been agreed with NHSI and are based on reasonable assumptions. There remains significant further work to do, however, both to address the Trust's recurrent financial deficit and improve service performance to target levels.

Accountable Officer

The Accountable Officer is Marianne Griffiths, who is the signatory to the Annual Governance Statement.

Accountable Officer Organisation: Brighton and Sussex University Hospitals NHS Trust

Signature: Marianne Griffiths

Date: 25/5/2018

Remuneration and Staff Report

Annual statement on remuneration

It is the responsibility of the Appointment and Remuneration Committee of Non-Executive Directors to oversee the pay arrangements of Executive Directors, details of the committee can be found within the 'How the Trust is Run' section of this report.

Brighton and Sussex University Hospitals Trust is being operated under the terms of a management contract with Western Sussex Hospitals NHS Foundation Trust employment contracts of all Executive Directors are held by Western Sussex Hospitals NHS Foundation Trust.

Senior Managers remuneration policy

All Directors performance is subject to an annual appraisal the outcome of which is reported to the Appointment and Remuneration Committee by the Chief Executive. This is prior to any decision being made on Executive remuneration.

For the Chief Executive Officer, their appraisal is undertaken by the Chair of the Trust with a report then submitted to the Committee.

The annual appraisal method is chosen as it is an effective way to assess performance against a range of performance targets and leadership responsibilities and includes feedback from Non-Executive Directors and peers as part of a 360-degree feedback process.

In coming to any decision on remuneration, the Committee takes account of the circumstances of the Trust, the size and complexity of the role, any changes in the Directors portfolio, the performance of the individual and any appropriate national guidance. Senior managers are remunerated based on these decisions.

In considering Senior Managers Pay the Committee took note of national benchmark data provided by NHS Providers and the requirement to consider any pay above a threshold of £147,500.

Future policy table

Please see in the following table details of the components of the remuneration package for senior managers. This is made up of:

Components of Senior Managers remuneration:
Base Salary
Performance related pay (where appropriate).

Base salaries are set in line with market information and are designed to ensure retention, or recruitment, of the calibre and experience required to deliver the aims of the Trust. Salaries are revised annually and uplifted only if:

- There is demonstrable evidence that an uplift is required to keep in line with the market
- A change in portfolio necessitates an uplift

The performance related pay scheme is based on the NHS Pay framework for Very Senior Managers. The Appointment and Remuneration Committee would, annually, consider whether the overall performance of the Trust warrants consideration of a performance related element being paid and if so the parameters of such an award.

Service contracts obligations and Policy on payment for loss of office

HM Treasury has issued specific guidance on severance payments within 'Managing Public Money' and special severance payments when staff leave requires Treasury approval.

All contracts are permanent with no fixed end date. There are no contractual provisions for payments on termination of contract.

Statement of consideration of employment conditions elsewhere

In considering any decision on remuneration the Committee takes note of both the organisational and national context.

Pay multiples (subject to audit)

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. For Brighton and Sussex University Hospitals NHS Trust this is the highest paid employee because Executive Directors are employees of Western Sussex Hospitals NHS Foundation Trust.

The banded remuneration of the highest paid employee in Brighton and Sussex University Hospitals NHS Trust in the financial year 2017-18 was £190-£195k (2016-17 £220-£225k). This was 8 times (2016-17 9 times) the median remuneration of the workforce, which was £23.2k (2016-17 £24.5k). Total remuneration includes salary, non-consolidated 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.

In 2017-18 no employees (2016-17 0) received remuneration in excess of the highest paid employee. Remuneration ranged from £9k to £194k (2016-17 £9k to £221k).

Salary and Pension entitlements of senior managers (subject to audit)

Trust Non- Executive Directors 2017/18

Name and title	(a) Salary (bands of £5000) £000	(b) Expenses payments (taxable) to nearest £100* £	(c) Performance pay and bonuses (bands of £5000) £000	(d) Long term performance pay and bonuses (bands of £5000) £000	(e) All pension-related benefits (bands of £2500) £000	(f) TOTAL (a-e) (bands of £5000) £000
Mike Viggers Chairman (from 1 April 2017)	35 - 40					35 - 40
Malcolm Reed Non-Executive	5 - 10					5 - 10
Joanna Crane Non-Executive (from 1 April 2017)	5 - 10					5 - 10
Jon Furmston Non-Executive (from 1 April 2017)	5 - 10					5 - 10
Lizzie Peers Non-Executive (from 1 April 2017)	5 - 10					5 - 10
Mike Rymer Non-Executive (from 1 April 2017)	5 - 10					5 - 10
Patrick Boyle Non-Executive (from 1 April 2017)	5 - 10					5 - 10
Martin Sinclair ** Non-Executive	5 - 10					5 - 10
Kirstin Baker ** Non-Executive	5 - 10					5 - 10
Graham Hodgson Non-Executive (to 30 November 2017)	0 - 5					0 - 5

Trust Non-Executive Directors 2016/17

Name and title	(a) Salary (bands of £5000) £000	(b) Expenses payments (taxable) to nearest £100* £	(c) Performance pay and bonuses (bands of £5000) £000	(d) Long term performance pay and bonuses (bands of £5000) £000	(e) All pension-related benefits (bands of £2500) £000	(f) TOTAL (a-e) (bands of £5000) £000
Julian Lee, Chair (to 17/5/2016)	0-5					0-5
Malcolm Reed Non-Executive	5-10					5-10
Antony Kildare Non-Executive Interim Chair (from 18/5/2016)	35-40					35-40
Christine Farnish, Non-Executive (to 18/5/2016)	0-5					0-5
Farine Clarke, Non-Executive (to 28/7/2016)	0-5					0-5
Kirit Patel, Non-Executive (to 28/6/2016)	0-5					0-5
Martin Sinclair, Non-Executive (from 15/5/2016)	5-10					5-10
Kirstin Baker, Non-Executive (from 15/5/2016)	0-5					0-5
Graham Hodgson, Non-Executive (from 1/7/2016)	0-5					0-5

The Trust entered into a management contract with Western Sussex Hospitals NHS Foundation Trust from 1 April 2017. The Executive Team and Chairman of Western Sussex Hospitals NHS Foundation Trust are also the Executive Team and Chairmen of the Trust. The disclosure below shows the proportion of salary attributable to the Trust in table 1 and the full salary and pension for both organisations in tables 2 and 3.

Expenses incurred by Non-Executive Directors have been reimbursed by Western Hospitals NHS Foundation Trust and have not been apportioned between the two organisations and are not therefore reported separately for the Trust.

Trust Executive Directors 2017/18 – Table 1

Name and title	(a) Salary (bands of £5000) £000	(b) Expenses payments (taxable) to nearest £100* £100	(c) Performance pay and bonuses (bands of £5000) £000	(d) Long term performance pay and bonuses (bands of £5000) £000	(e) All pension-related benefits (bands of £2500) £000	(f) TOTAL (a-e) (bands of £5000) £000
Marianne Griffiths Chief Executive (from 1st April 2017)	130 - 135	41				135-140
Karen Geoghegan Chief Financial Officer (from April 2017)	95-100	3				95-100
Peter Landstrom Chief Delivery and Strategy Officer (from April 2017)	75-80	29				80-85
Nicola Ranger Chief Nursing and Patient Safety Officer (from April 2017)	80-85	20				80-85
Dr George Findlay Chief Medical Officer (from April 2017)	90-95	159		20-25		130-135
Denise Farmer Chief Workforce and Organisational Development Officer (from April 2017)	80-85	28				85-90

Pension benefits include benefits accrued as a result of total pension in the pension scheme and not just service in a senior capacity to which disclosure applies. Pension benefits are not therefore able to be split between the Trust and Western Sussex Hospitals NHS Foundation Trust.

Trust Executive Directors 2016-17

Name and title	(a) Salary (bands of £5000) £000	(b) Expenses payments (taxable) to nearest £100* £	(c) Performance pay and bonuses (bands of £5000) £000	(d) Long term performance pay and bonuses (bands of £5000) £000	(e) All pension-related benefits (bands of £2500) £000	(f) TOTAL (a-e) (bands of £5000) £000
Gillian Fairfield, Chief Executive (1/4/16-28/2/17)	220-225					220-225
Evelyn Barker, Chief Executive (from 23/1/17)	35-40				20-22.5	55-60
Spencer Prosser, Chief Financial Officer	155-160					155-160
Mark Smith, Chief Operating Offer (to 27/1/17)	120-125				25-27.5	150-155
Sherree Fagge, Chief Nurse (to 4/9/2016)	55-60				15-17.5	75-80
Helen O'Dell, Chief Nurse (from 11/7/2016)	85-90				107.5-110	195-200
Robert McEwan Chief Operating Officer (from 17/2/2017)	25-30					25-30
Dr Steve Holmberg, Medical Director (to 11/3/2017)	175-180					175-180

Trust and Western Hospitals NHS Foundation Trust Executive Directors 2017-18 – Table 2

Name and title	(a) Salary (bands of £5000) £000	(b) Expenses payments (taxable) to nearest £100* £100	(c) Performance pay and bonuses (bands of £5000) £000	(d) Long term performance pay and bonuses (bands of £5000) £000	(e) All pension-related benefits (bands of £2500) £000	(f) TOTAL (a-e) (bands of £5000) £000
Marianne Griffiths Chief Executive (from 1st April 2017)	265 - 270	81	20 – 25		150 – 152.5	450 – 455
Peter Landstrom Chief Delivery and Strategy Officer (from April 2017)	155 - 160	58	5 – 10		122.5 –125	290 – 295
Karen Geoghegan Chief Financial Officer (from April 2017)	190 – 195	5	5 – 10		190 – 192.5	390 -395
Dr George Findlay Chief Medical Officer (from April 2017)	185 – 190	317		45 – 50	55-57.5	320 – 325
Nicola Ranger Chief Nursing and Patient Safety Officer (from April 2017)	160 - 165	39			145 – 147.5	310 – 315
Denise Farmer Chief Workforce and Organisational Development Officer (from April 2017)	165 - 170	56	5 – 10			180 – 185

Trust and Western Hospitals NHS Foundation Trust Pension Benefits – Table 3

	(a) Real increase in pension at pension age	(b) Real increase in pension lump sum at pension age	© Total accrued pension at pension age 31 March 2018	(d) Lump sum at pension age related to accrued pension at 31 March 2018	(e) Cash equivalent transfer value at 1 April 2018	(f) Cash equivalent transfer value at 31 March 2017	(g) Real increase in cash equivalent transfer value	(h) Employer's contribution to stakeholder pension
Name and title	(bands of £2500) £000	(bands of £2500) £000	(bands of £5000) £000	(bands of £5000) £000	£000	£000	£000	£000
Marianne Griffiths Chief Executive (from 1st April 2017)	7.5 - 10	22.5 - 25	40 - 45	130 - 135	986	776	203	Nil
Peter Landstrom Chief Delivery and Strategy Officer (from April 2017)	5 – 7.5	10 - 12.5	25- 30	60 - 65	342	257*	82	Nil
Karen Geoghegan Chief Financial Officer (from April 2017)	10 -12.5	17.5 - 20	50 - 55	135 - 140	913	706*	200	Nil
Dr George Findlay Chief Medical Officer (from April 2017)	2 - 2.5	0 – 2.5	50 - 55	120 - 125	889	803*	78	Nil
Nicola Ranger Chief Nursing and Patient Safety Officer (from April 2017)	7.5-10	0	50 - 55	125 -1 30	897	860	28	Nil
Denise Farmer Chief Workforce and Organisational Development Officer (from April 2017)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Nil

*Cash equivalent Transfer value as at 31St March 2017 has been restated to include benefits from the 2015 Pension Scheme that were incorrectly excluded from the 2016/17 annual report of Western Hospitals NHS Foundation Trust.

Staff Report

Staff Policies applied during the financial year

BSUH has been a 'Two Tick' employer since 2002 (now Disability Confident Employer Level 2). All new employees are given the opportunity to indicated if they need additional support under these schemes. We widely advertise this on our website, in our recruitment literature and on our Equality information site. Our commitment is also highlighted within our Equality, Diversity and Human Rights Policy. This applies equally for current staff moving from one position to another and external candidates.

For those staff who have become disabled during their employment we apply the Equality, Diversity and Human Rights Policy, Sickness Absence Policy and, if required, the Disability and Reasonable Adjustments guidelines. They would work with their line manager and HR to ensure that modifications to role/hours still enable the department/service to function whilst supporting the staff member to continue to be a valued employee.

Gender distribution of staff

- All staff: 68.6% female; 31.4% male
- (Non-Medical) Senior Managers (AFC Band 8a+): 65% female; 35% male
- Board Members: 46.7% female; 53.3% male

Staff costs (subject to audit)

	Costs (£'000)		
Staff Group	**Permanent**	**Other**	**Total**
Nursing and Midwifery	117,204	17,329	134,534
Healthcare Assistants and other support staff	12,832	1,900	14,732
Medical	103,952	5,923	109,875
Scientific, Therapeutic and Technical	26,014	1,147	27,161
Healthcare Science	19,779	1,936	21,715
Administration and Estates	48,236	3,250	51,486
Other	703	45	749
Total	**328,720**	**31,531**	**360,251**

Number of senior managers by pay band

	WTE	**Heads**
AFC Band 8a	188.2	209
AFC Band 8b	93.3	99
AFC Band 8c	38.2	39
AFC Band 8d	17.9	19
AFC Band 9	10.0	10
VSM	9.1	12
Total	**356.7**	**388**

Sickness absence

The Trust's sickness rate is 4.26% for the year 2017/18. This rate has been fairly stable for the previous twelve months, remaining at 4.3% but reducing to 4.2% overall between April and June 2017. Of the overall sickness rate 2% is attributable to short term sickness and 2.26% is due to long term sickness.

The Trust continues to invest in staff health and wellbeing, recognising that it is a key component of staff engagement. Our health and wellbeing plans for 18/19 will focus on two key themes in sickness absence within our Trust and the NHS as whole: mental health, specifically work-related stress and musculoskeletal problems.

In addition, one our schemes in making staffing more efficient will include reducing sickness absence with a target of 3.3%.

Expenditure on Consultancy

The Trust spent £2.2m on external consultancy in 2017/18. This compares to £4.5m in 2016/17.

Off-payroll engagements

As an organisation subject to HMT Guidance *'Managing Public Money'*, Brighton and Sussex University Hospitals NHS Trust has a responsibility in safeguarding public interest.

In May 2012, HMT carried out a review on the tax arrangements of senior public sector appointees. The aim of the review was to ascertain the extent of arrangements which could allow public sector appointees to minimise their tax payments and make appropriate recommendations to address the problem.

The Trust operates a policy covering off payroll engagements. This policy provides guidance to ensure compliance with HMT's recommendations on tax arrangements for the following public-sector appointees:

- Board members
- Senior officials with significant financial responsibility
- Engagements of more than six months in duration, for more than a daily rate of £245

The table below relates to all off-payroll engagements as of 31 March 2018 for more than £245 per day that lasts for longer than six months:

	Number
Number of existing engagements	2
Of which the number that have existed:	
For less than one year at the time of reporting	2

All existing off-payroll engagements have been subject to a risk-based assessment of whether evidence is required that the individual is paying the right amount of tax and, where necessary, assurance has been sought.

There were no new off-payroll engagements, or those reaching six months in duration, between 1 April 2017 and 31 March 2018, for more than £245 per day which last for longer than six months.

There were no off-payroll engagements of board members and/or senior officials with significant financial responsibility between 1 April 2017 and 31 March 2018.

Exit Packages (subject to audit)

Exit Packages for the year totalled £274k for 5 staff.

		Maincode 01	Maincode 02	Maincode 03	Maincode 04	Maincode 05	Maincode 06	Maincode 07	Maincode 08
Exit package cost band	Sub code	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	Cost of special payment element included in exit packages
		Whole Numbers Only	£'000s	Whole Numbers Only	£s	Whole Numbers Only	£'000s	Whole Numbers Only	£s
<£10,000	100								
£10,000-£25,000	110								
£25,001-£50,000	120	2	80						
£50,001-£100,000	130	3	194						
£100,001-£150,00	140								
£150,001-£200,000	150								
>£200,000	160								
Total	170		274						

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS redundancy arrangements for staff covered by Section 16 (a) (England) of the NHS terms and conditions of service. Exit costs in this note are the full costs of departures in the year. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS Pensions Scheme. Ill retirement costs are met by the NHS Pensions Scheme and are not included in the table.

National NHS Staff Survey 2017

The National Staff Survey is undertaken each year by all NHS Trusts within England and Wales with the aim of capturing staff views on their experiences at work and NHS services. For the 2017 survey, roll out to all substantive staff in the Trust was undertaken between October and December for the 2nd year. In previous years, a sample size of 800 staff was randomly selected. Picker, the Trust's survey provider, administered the survey for the Trust and responses were received from 4,274 staff.

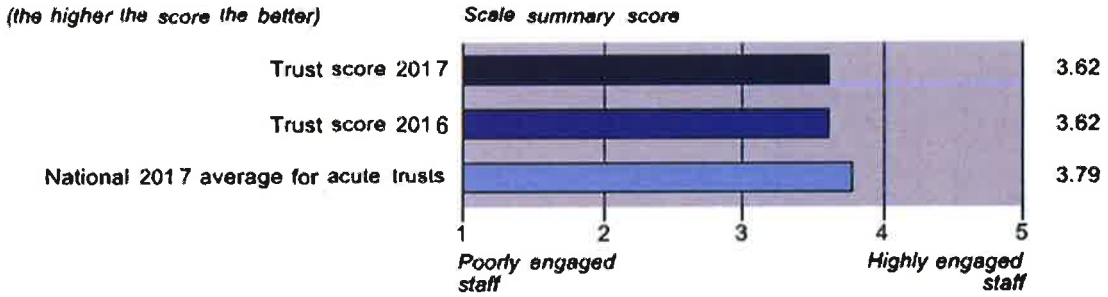
We are pleased that the Trust's response rate for 2017 was 56.3% which is a significant improvement on 2016 when it was 39.9% rate. The Trust's response rate is in the highest 20% of acute trusts in England.

Our overall staff engagement score, ranked on a scale of 1 to 5 (low to high), was 3.62 which although this remains the same as 2016 we are pleased with the significant positive improvement of +4% in the Trust's breakthrough objective "Care of patients/service users is the organisation's top priority". In the Key Finding in the advocacy domain, which is (KF1) "Staff recommendation of the organization as a place to work or receive treatment" the Trust's score improved from 3.42 to 3.49.

All staff were encouraged to participate in the Staff Survey throughout the survey period which was October to December 2017. There were dedicated survey events offering free refreshments including 'tea and cake', and various internal communications across the Trust, including "Buzz" the staff newsletter.

		Your Trust in 2017	Average (median) for acute trusts	Your Trust in 2016
Q21a	"Care of patients / service users is my organisation's top priority"	68%	76%	64%
Q21b	"My organisation acts on concerns raised by patients / service users"	62%	73%	61%
Q21c	"I would recommend my organisation as a place to work"	47%	61%	42%
Q21d	"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	58%	71%	55%
KF1	Staff recommendation of the organisation as a place to work or receive treatment (Q21a, 21c-d)	3.49	3.76	3.42

OVERALL STAFF ENGAGEMENT



There was an increase in the percentage of staff who agreed that care of our patients is our organisations top priority (up 4%) and who would recommend BSUH to friends and family as a place to work (up 5%) or receive treatment (up 3%). These are key engagement metrics which form part of the Trust's True North objectives relating to our people.

Other areas where we saw some improvement were:

- Staff feeling supported by their managers
- Organisation interest in and action on health and wellbeing
- Percentage of staff appraised in last 12 months

There was also a reduction in the percentage of staff experiencing harassment, bullying or abuse from other staff in the last 12 months.

As part of our Patient First Improvement System roll-out we are already working with particular wards where this is a significant problem, using new problem-solving methods to help us to understand the root causes and make action plans for how we can tackle this. We will also be talking to other staff groups to see how we can target those most affected by particular issues.

The Human Resources team have prepared and circulated divisional staff survey reports, and 'At a Glance' divisional posters, detailing scores contributing to the staff engagement score and divisional top and bottom five staff survey results. Along with regular feedback obtained from the staff mini-surveys these will inform discussion with Divisional Management Teams to improve overall staff engagement.

In early 2018 the Trust introduced mini-surveys after statutory and mandatory training asking staff to complete the nine questions that make up the composite staff engagement scores. The results will be shared across the Trust's divisions helping to shape and focus improvement plans.

Future Priorities and Looking Ahead to 2018/19

The 2017 survey highlights key areas for improvement in staff engagement and we will focus on the following key areas in 2018:

- Continuing working towards achieving the Trust's breakthrough objective "care of staff/patient users is the organisations top priority".

- Instigating corporate improvement plans to address three key issues arising from the results which are ensuring that communication between senior management and staff is effective; initiatives to improve staff health and well-being and aiming to prevent and reduce violence and aggression issues against staff, in particular from patients, relatives and members of the public.

- An Equality, Diversity and Inclusion initiative being led by the Chief Executive as part of the Trust's Leadership, Workforce and Culture programme.

- Introducing a new Trust Ambassador initiative across the Trust to help improve staff engagement.

- Developing a programme to reduce MSK injury and work-related stress to support delivery of the Trusts Health & Well-Being CQUIN target.

- Continue the roll-out of the Patient First and Strategic Development programmes to improve opportunities for staff to contribute ideas towards making improvements in the workplace and ensure this is linked to the achievement of the breakthrough objective.

- Raising the profile of the annual staff survey and its importance and working to ensure feedback and involvement of staff across the Trust.

Audit Certificate and Report

INDEPENDENT AUDITOR'S REPORT TO THE DIRECTORS OF BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS NHS TRUST

Opinion

We have audited the financial statements of Brighton and Sussex University Hospitals for the year ended 31 March 2018 under the Local Audit and Accountability Act 2014. The financial statements comprise the Trust and Group Statement of Comprehensive Income, the Trust and Group Statement of Financial Position, the Trust and Group Statement of Changes in Taxpayers' Equity, the Trust and Group Statement of Cash Flows and the related notes 1 to 45. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the 2017-18 HM Treasury's Financial Reporting Manual (the 2017-18 FReM) as contained in the Department of Health and Social Care Group Accounting Manual 2017/18 and the Accounts Direction issued by the Secretary of State with the approval of HM Treasury as relevant to the National Health Service in England (the Accounts Direction).

In our opinion the financial statements:

- give a true and fair view of the financial position of Brighton and Sussex University Hospitals NHS Trust as at 31 March 2018 and of its expenditure and income for the year then ended; and
- have been prepared properly in accordance with the National Health Service Act 2006 and the Accounts Directions issued thereunder.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report below. We are independent of the trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard and the Comptroller and Auditor General's (C&AG) AGN01 and we have fulfilled our other ethical responsibilities in accordance with these requirements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Use of our report

This report is made solely to the Board of Directors of Brighton and Sussex University Hospitals NHS Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014 and for no other purpose. Our audit work has been undertaken so that we might state to the Directors of the Trust those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Directors, for our audit work, for this report, or for the opinions we have formed.

Material uncertainty related to going concern

We draw attention to note 1.1.2 in the financial statements, which discloses that the Trust incurred a 2017/18 deficit of £63.8 million net of Sustainability and Transformation Funding of £8.3 million, has received total revenue support loan funding from the Department of Health of £171 million and plans to deliver a deficit of £65.4 million in 2018/19. As stated in note 1.1.2, these events or conditions, along with the other matters as set forth in note 1.1.2, indicate that a material uncertainty exists that may cast

significant doubt on the Trust's ability to continue as a going concern. Our opinion is not modified in respect of this matter.

Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The directors are responsible for the other information.

Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in this report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of the other information, we are required to report that fact. We have nothing to report in this regard.

Opinion on other matters prescribed by the Health Services Act 2006

In our opinion the part of the Remuneration and Staff Report to be audited has been properly prepared in accordance with the Health Services Act 2006 and the Accounts Directions issued thereunder.

Matters on which we are required to report by exception

We are required to report to you if:

- in our opinion the governance statement does not comply with NHS Improvement's guidance; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014.

We have nothing to report in these respects.

In respect of the following we have matters to report by exception:

- Referral to the Secretary of State

We refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

On 7 June 2016 we referred a matter to the Secretary of State under Section 30(b) of the Local Audit and Accountability Act 2014 on the basis that at that time we had reason to believe the Trust was likely to breach its break-even duty. The Trust's actual deficit for 2016/17 was £68.5 million. At 30 April 2018, the financial statements for 2017/18 show an in-year £55.6 million deficit. The Trust has now incurred a deficit in financial years 2015/16, 2016/17 and 2017/18. The cumulative breakeven position at the end of 2017/18 financial year is a £163.9 million deficit. On 16 May 2018 we made a further referral to the Secretary of State under Section 30(a) to confirm that the Trust has now breached its break-even duty.

- Proper arrangements to secure economy, efficiency and effectiveness

We report to you, if we are not satisfied that the Trust has put in place proper arrangements to secure economy efficiency and effectiveness in its use of resources.

Basis for qualified conclusion on reporting by exception

The Trust was subject to an inspection by the Care Quality Commission in August 2016 that rated the Trust as 'inadequate' overall. As a consequence the Trust was placed in special measures. After a significant deterioration in the Trust's forecast financial outturn for 2016/17 the Trust was placed in financial special measures in October 2016. These designations were in place at the end of 2017/18.

The Trust reported a deficit of £55.6 million in its financial statements for the year ending 31 March 2018, thereby breaching its duty under paragraph 2 (1) of Schedule 5 the National Health Service Act 2006, to break-even. The Trust has not yet succeeded in addressing the underlying deficit in its budget and is forecasting a further deficit of £65.4 million for 2018/19.

The Trust has not yet fully addressed previously identified weaknesses in strategic planning, leadership capacity, risk management, financial and performance reporting, contract management and working effectively with commissioners, data quality and asset management. Whilst the Trust has made improvements in these areas and revised arrangements, they have not been in place for the whole year, are not embedded and are not yet delivering significant demonstrable improvements in associated outcomes.

This is evidence of weaknesses in proper arrangements for informed decision making, sustainable resource deployment and working with partners and other third parties.

Qualified conclusion (Adverse)

On the basis of our work, having regard to the guidance issued by the Comptroller and Auditor General in August 2017, we are not satisfied that, in all significant respects, Brighton and Sussex University Hospitals NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

Responsibilities of the Directors and Accountable Officer

As explained more fully in the Statement of Directors' Responsibilities in respect of the Accounts, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. In preparing the financial statements, the Accountable Officer is responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accountable Officer either intends to cease operations, or have no realistic alternative but to do so.

As explained in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibility for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the

aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at https://www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in August 2017, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

We are required under section 21(3)(c), as amended by schedule 13 paragraph 10(a), of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21(5)(b) of the Local Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Certificate

We certify that we have completed the audit of the accounts of Brighton and Sussex University Hospitals NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Suresh Patel

Ernst & Young LLP (Local Auditor)

Southampton

29 May 2018

The maintenance and integrity of the Brighton and Sussex University Hospitals NHS Trust web site is the responsibility of the directors; the work carried out by the auditors does not involve consideration of these matters and, accordingly, the auditors accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the web site.

Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

FINANCIAL STATEMENTS

Overall Financial Performance

The key highlights for the Trust's financial performance for the year were:

- Actual performance - against a challenging operational and commissioning landscape the Trust delivered a deficit for the year of £64.1m. After adjusting for the impact of impairments and adjustments in relation to the donated asset reserve the adjusted retained deficit is £55.6m.

- Control total performance - as a result of the new management arrangements, the Trust was able to agree a revised control total for 2017/18. The control total was set at a deficit of £65.4m and was based on a series of negotiated principles. The Trust delivered the control total as planned; achieving a comparable deficit of £63.8m.

- Sustainability and Transformation Funding (STF) – having delivered the control total the Trust received confirmation from NHS Improvement that it was eligible for an allocation from the STF Incentive Fund. The allocation was £8.3m; improving the performance against the control total by the same amount and decreasing the reported deficit to £55.6m.

- Efficiency Programme - underpinning both the control total achievement and in-year investment in services was the delivery of £20.0m of savings; in line with the plan. During the year significant investment was made in the development of a Programme Management Office to both improve and embed robust governance arrangements and to support the identification and delivery of sustainable savings opportunities.

- Capital - expenditure on capital schemes of £60.6m, including £41.2m on the 3Ts building development, £3.9m on estates, £7.1m on Information Technology, £2.9m on replacement equipment and £5.5m on service development.

	£m
2017/18 Control Total Deficit	63.8
STF Funding	-8.2
Reported Financial Performance	55.6
Impairments & Donated Asset Movement	8.5
Reported Deficit	64.1

Going Concern

These accounts have been prepared on the basis the Trust is a going concern as there is no indication that the healthcare and other services will not continue to be provided by the public sector for the foreseeable future and that continuing financial support will be provided by Department of Health (DH).

The Trust is aware, however, of the following conditions which give rise to a material uncertainty and may cast significant doubt about the Trust's ability to continue as a going concern.

Against a challenging operational and commissioning landscape the Trust delivered an actual deficit for the year of £64.1m. After adjusting for the impact of impairments and adjustments in relation to the donated asset reserve the adjusted retained deficit is £55.6m.

The Trust delivered the control total as planned; returning a deficit of £63.8m against the planned deficit of £65.4m. As a result, the Trust received confirmation of an allocation from the STF Incentive Fund of £8.3m from NHS Improvement (NHSI); improving the performance against the control total by the same amount and decreasing the reported deficit to £55.6m. Delivery of the 2017/18 financial plan was supported by £20m of savings. The DH provided deficit funding of £63.8m as revenue support loans in year bringing the total revenue support loan funding to £171m as at 31st March 2018.

On the 1st April 2017 the Trust entered into a management contract with Western Sussex Hospitals NHS Foundation Trust and NHSI for a minimum of three years. The Executive Team and Chairman of Western Sussex Hospitals NHS Foundation Trust are also the Executive Team and Chairman of this Trust. This arrangement is intended to provide some strong and stable leadership to the Trust for the contract period. New regulatory oversight arrangements have also been agreed which will provide a focus on supporting the Trust to exit from Financial Special Measures and Quality Special Measures.

The Trust agreed a revision to the financial control totals for 2017/18 and 2018/19 with NHSI. The methodology is based on a series of negotiated principles which include limiting the financial efficiency requirement upon the Trust over this period. The agreed control total for 2018/19 is a planned deficit of £65.4m. Delivery of the plan is underpinned by an efficiency expectation of £30m; for which schemes have been fully identified.

The Trust has submitted its operational and financial plans for 2018/19. The plans reflect agreed continued revenue deficit support funding from the DH. The deficit support funding is authorised by the DH monthly in advance and is conditional on the achievement of the agreed financial control total for the year. Deficit support funding totalling £11.5m for April and May 2018 has been provided to the Trust.

The Trust has agreed an Aligned Incentive Contract with local Clinical Commissioning Groups for 2018/19; with a value of £286m. The Trust has agreed a Payment by Results contract with NHS England Specialised Commissioning for 2018/19; with a value of £161.6m.

The Trust's 2018/19 cash flow forecast is based on the assumptions in the 2018/19 financial plan. The key assumptions underpinning the cash flow are:

a) Receipt of £65.4m revenue support loan from the DH to finance the revenue deficit;
b) Receipt of £102m PDC from DH to fund the 3Ts capital build; and
c) Receipt of £21m loan funding from DH to support the Emergency Backlog Maintenance and Emergency Department schemes.

The new Executive leadership of the Trust agreed the following priorities with NHSI at the start of the management contract:

- Moving out of Quality Special Measures
- Improvement and delivery of A&E performance
- Moving out of Financial Special Measures
- Addressing underlying Leadership and Cultural challenges
- Assuring delivery of 3Ts programme and integration into the Trust

The Trust's financial priority for the next year is to deliver its control total deficit as agreed with NHSI. This includes the further development and embedding of robust and transparent processes introduced in 2017/18.

Taking into account all these factors, the assumption that the healthcare and other services will continue to be provided by the public sector for the foreseeable future and that the DH will continue to provide financial support, the Directors consider the Trust will continue to operate as a going concern.

Income and Expenditure

The Trust is reporting income of £562.9m in 2017/18 increased from the £550.4m reported in 2016/17. The majority of the Trust's income is for patient care services and this income grew from ££496.6m to ££513.2m. The table below shows the sources of the Trust's income.

Income	17/18 £'000	16/17 £'000
NHS England	181,014	173,825
Clinical Commissioning Groups	281,988	275,617
Department of Health and Social Care	57	1,545
Other NHS Providers	4,416	6,090
NHS Other	858	340
Local Authorities	4,701	4,490
Non-NHS	30,913	34,676
Research and Development	3,877	5,030
Education and Training	27,961	28,355
Receipt of capital grants and donations	1,037	88
Non-Patient Care Services to Other Bodies	5,102	5,736
Sustainability and Transformation Fund Income	8,280	3,600
Rental Revenue from Operating Leases	466	538
Recoveries in respect of Staff Costs	4,677	2,785
Other Income	7,806	7,654
Total Operating Revenue	**563,153**	**550,369**

Total operating expenses in 2017/18 were £612m a decrease from £627m in 2016/17.

Operating Expenses	17/18	16/17
Purchase of healthcare from and DHSC bodies	4,400	5,934
Purchase of healthcare from non-NHS bodies and non-DHSC bodies	6,588	7,162
Staff and executive Directors' costs	351,676	340,422
Remuneration of non-executive directors	98	67
Supplies and services - clinical	62,586	61,736
Supplies and services - general	7,128	8,155
Drugs costs	79,645	76,423
Inventories Write down	24	175
Consultancy costs	2,197	4,489
Establishment	4,915	4,989
Premises	17,052	18,107
Transport	1,138	1,692
Depreciation and amortisation	19,906	19,995
Net impairments	8,948	20,156
Increase in provision for impairment of receivables	833	11,791
Change in discount rate	30	233
External audit fees	96	122
Internal audit fees	116	121
Clinical Negligence	21,522	19,276
Legal fees	1,471	2,137
Insurance	362	416
Research and development	4,737	7,081
Education and training	9,647	9,018
Rentals under operating leases	4,116	3,898
Redundancy	216	0
Service charges - PFI	1,707	1,407
Car parking and security	390	381
Other	662	2,076
Total	**612,206**	**627,459**

Efficiency

The Trust achieved efficiencies of £20m in 2017/18 against a target of £20m.

Cost Improvement		Plan	Actual	Variance
		£'000	Number	£'000
Commercial	Income (Patient Care Activities)	2,002	2,995	993
Corporate	Pay (WTE reductions)	0	1,640	1,640
Coprorate	Pay (Skill mix)	1,908	1,111	-797
Estates and Facilities	Non pay	380	608	228
Estates and Facilities	Pay (Skill mix)	112	183	71
Income Other	Income (Patient Care Activities)	805	2,068	1,263
Income Other	Non pay	12	14	2
Med Management	Non pay	239	617	378
Non pay	Non pay	1,307	2,747	1,440
Bnurse Workforce efficiencies	Pay (Skill mix)	0	37	37
Private Patients	Income (Patient Care Activities)	150	67	-83
Procurement	Non-pay	3,254	3,159	-95
Summary of trust schemes commencing in outturn year 1	Non-pay	528	496	-32
Trust 2017/18 recurrent unidentified at plan 2	Pay (WTE reductions)	5,347	0	-5,347
Workforce - AHP	Pay (Skill mix)	40	40	0
Workforce - Medical	Non pay	98	0	-98
Workforce - Medical	Pay (Skill mix)	1,112	1,461	349
Workforce - Medical	Pay (WTE reductions)	58	57	-1
Workforce - Multiple	Pay (Skill mix)	1,040	1,118	78
Workforce - Nursing	Non pay	32	0	-32
Workforce - Nursing	Pay (Skill mix)	1,041	1,358	317
Workforce - Nursing	Pay (WTE reductions)	438	40	-398
Workforce - Other	Pay (Skill mix)	60	133	73
Workforce - Other	Pay (WTE reductions)	37	51	14
Total		**20,000**	**20,000**	**0**

Better Payments Practice Code

The Better Payments Practice Code requires that the Trust pays all invoices within 30 days of the receipt of a valid invoice. The performance target is 95% compliance with actual performance below this. Delays to the receipt of payment from debtors and the receipt of funding to support the deficit position reduced the Trusts ability to pay suppliers promptly.

Measure of Compliance	2017/18	2017/18	2016/17	2016/17
	Number	£'000	Number	£'000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	144,804	454,027	151,449	424,709
Total Non-NHS Trade Invoices Paid Within Target	77,691	290,008	52,790	210,711
Percentage of Non-NHS Trade Invoices Paid Within Target	63.9%	65.2%	34.9%	49.6%
NHS Payables				
Total NHS Trade Invoices Paid Within Target	2,971	44,176	2,794	44,931
Total NHS Trade Invoices Paid Within Target	1,251	26,555	956	22,123
Percentage of NHS Trade Invoices Paid Within Target	42.1%	60.1%	34.2%	49.2%

The Late Payment of Commercial Debts (Interest) Act 1998	2017/18	2016/17
	£'000	£'000
Amounts included in finance costs from claims made under this legislation	0	0
Compensation paid to cover debt recovery costs under this legislation	0	24
Total	0	24

Revaluations and impairments

Revaluations and impairments led to a decrease in asset values of £13.7m.

Capital expenditure

Additions to tangible fixed assets in 2017/18 were £60.6m.

Liquidity, cash and working capital

The Trust remained within its external financial limit (EFL) and its year end cash balance increased from £7.4m to £15.9m. Working capital support of £63.8m was received from the Department of Health in 17/18.

Financial outlook

The Trust has submitted its operational and financial plans for 2018/19. The control total, as agreed with NHS Improvement, is a planned deficit of £65.4m. This incorporates a stretch target to support the Trust's ambition to exit financial special measures during 2018/19. Delivery of the plan is underpinned by an efficiency expectation of £30m; for which schemes have been fully identified.

Commissioning arrangements

Key points to note:

- The Trust has 9 main contracts with commissioners agreed for 2017/18 (table 1).
- The contracts and commissioning agreements are mandated 2-year national contracts and include; performance standards, activity and contract values
- Agreed contract values are based on 2016/17 forecast out-turn (FOT) adjusted for growth, commissioner QIPP and agreed development

Brighton and Hove City CCG continues to be the coordinating commissioner on behalf of the other 7 Sussex CCGs. The £259m CCG contract was signed in accordance with the national timetable and was subsequently varied in year to reflect the fixed income agreement struck by the accountable officers in early 2018.

The NHSE Contract for commissioned Specialised Services, Secondary Dental and Screening services was signed in February 2017 following an arbitration settlement. The £159m contract value was underpinned by an agreed work plan and acknowledgment that the original plan would be subject to revision following conclusion and agreement of the national IR Rule allocation changes.

The Trust has 2 commissioned agreements with both Sussex MSK partnerships based on PbR rules and national terms and conditions with a combined value of c£27m. The MSK partnerships are directly commissioned by CCGs as provider for Elective MSK services and subcontract secondary care services to BSUH.

The Local Authority commissions Sexual Health Services form the Trust via a PbR activity-based contract which is entering its final year and is likely to be tendered in 2019/20.

Table 1.

Main Contract	Commissioner	Contract Value	Duration	Contract Type
1. General Acute Services	Sussex Clinical Commissioning Groups (CCG)	£259.6m*	Year 1 of 2-year contract	PbR
2. Specialised Services	NHS England	£159.2m*	Year 1 of 2-year contract	PbR
3. Secondary Dental Services	NHS England	£5.3m	Year 1 of 2-year contract	PbR
4. Public Health Screening Services	NHS England	£5.2m	Year 1 of 2-year contract	Programme Budget
5. Hepatitis C	NHS England	£7.0m	Year 1 of 2-year contract	PbR
6. Sexual Health Services	Brighton Local Authority	£3.9m	3rd year of 3-year contract	Cost/Volume
7. Elective Musco-Skeletal Services	Sussex MSK Partnership – Central	£22m	3rd year of 5-year contract	PbR
8. Elective Musco-Skeletal Services	Sussex MSK Partnership – East	£5m	3rd year of 5-year contract	PbR
9. Community Dermatology Services	Brighton and Hove CCG	£2m	3rd year of 3-year contract	Programme Budget

*Subject to Q1 revision post IR changes

Capital plans and cash position

The initial capital plan for 2018/19 is £155.8m which includes £102m for the 3Ts project, £21m for the Emergency Floor and Backlog Maintenance projects and £32.8m for a range of estates, IT and medical equipment projects. The cash plan that backs these projects is supported by both loan and public dividend 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 and recovery actions

There are a number of risks to delivering the financial plan; the most significant of which are listed below.

- Commissioner affordability and the Trust's income expectation - work to develop an Aligned Incentive Contract with CCGs commissioners has concluded which will help mitigate risk for the Trust and the health system. The Trust continues to work with NHS England to reach an agreement for 2018/19.
- Delivery of the efficiency programme - plans to deliver the £30m efficiency requirement have been fully identified but there are risks to delivery. Robust governance processes have been developed and embedded and the aim is identify further opportunities to mitigate any risks that emerge during the year.
- Workforce Expenditure – availability and cost of staff continues to be a risk. Improving and widening the use of e-rostering will be an important investment to support both management and the control environment during 2018/19.
- System Resilience and Management of Patient Flow - delivery of planned activity volumes are predicated on workforce and bed capacity plans. Changes in patient demand or patient throughput can significantly impact bed capacity and workforce with consequent impact on the cost base for delivering emergency activity and ability to achieve planned elective volumes.

Summary

2017/18 was a successful yet challenging year. The Trust made significant progress in understanding and stabilising the financial position, identifying and delivering the planned savings, improving the control environment and most importantly delivering the agreed financial target. 2018/19 will bring further challenges but, given the improvement work undertaken during 2017/18, the Trust will better able to respond.

Appendices

Appendix 1: Consolidated Financial Statements and Notes to the Accounts

Report from the Chief Financial Officer

In 2017/18 the Trust delivered a deficit of £64.1m after technical adjustments. These technical adjustments related to impairments on the revaluation of the hospital estate including our newly commissioned buildings. The deficit position reflects achievement of the control total agreed with our regulators.

BSUH acts as a Trustee for charitable funds of £12.5m. Income from donations, legacies and grants totalled £1.7m in 2017/18. During the year £1.9m 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 and we look forward to continuing those relationships.

2017/18 was a successful yet challenging year. The Trust made significant progress in understanding and stabilising the financial position, identifying and delivering the planned savings, improving the control environment and most importantly delivering the agreed financial target. 2018/19 will bring further challenges but, given the improvement work undertaken during 2017/18, the Trust will be better able to respond.

Karen Geoghegan
Chief Financial Officer
25 May 2018

BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS NHS TRUST

GROUP FINANCIAL STATEMENTS

YEAR ENDED 31 MARCH 2018

Statement of Comprehensive Income

		Group		Trust	
		2017/18	2016/17	2017/18	2016/17
	Note	£000	£000	£000	£000
Operating income from patient care activities	5	503,802	496,690	503,947	496,583
Other operating income	6	96,627	54,504	59,206	53,786
Operating expenses	8, 10	(649,292)	(628,074)	(612,206)	(627,459)
Operating deficit from continuing operations		**(48,863)**	**(76,880)**	**(49,053)**	**(77,090)**
Finance income	13	398	370	37	31
Finance expenses	14	(9,987)	(6,132)	(9,985)	(6,127)
PDC dividends payable		(5,105)	(6,201)	(5,105)	(6,201)
Net finance costs		**(14,694)**	**(11,963)**	**(15,053)**	**(12,297)**
Other gains	15	32	1,415	32	76
Corporation tax expense		(176)	(144)	-	-
Deficit for the year for the year		**(63,701)**	**(87,572)**	**(64,074)**	**(89,311)**
Other comprehensive income					
Will not be reclassified to income and expenditure:					
Impairments	9	(2,353)	(2,347)	(2,353)	(2,347)
Revaluations	SoCIE	6,633	9,456	6,633	9,456
May be reclassified to income and expenditure when certain conditions are met:					
Fair value gains on available-for-sale financial investments		10	1,339	-	-
Total comprehensive income for the period		**4,290**	**8,448**	**4,280**	**7,109**

Financial performance for the year

Retained deficit for the year	(64,074)	(89,311)
Impairments	8,948	20,156
Adjustments in respect of donated asset reserve elimination	(432)	654
Adjusted retained deficit	**(55,558)**	(68,501)

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

a) 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.

b) 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.

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

The notes on pages 7 to 53 form part of this account.

Statement of Financial Position

		Group		Trust	
	Note	31 March 2018 £000	31 March 2017 £000	31 March 2018 £000	31 March 2017 £000
Non-current assets					
Intangible assets	16	550	681	550	681
Property, plant and equipment	17	422,560	386,493	422,387	386,263
Other investments charitable	20	11,790	11,780	-	-
Other investments	21	-	-	1,101	1,101
Trade and other receivables	24	3,683	3,048	3,683	3,048
Total non-current assets		**438,583**	**402,002**	**427,721**	**391,093**
Current assets					
Inventories	23	9,550	8,816	8,788	8,109
Trade and other receivables	24	45,981	48,406	45,610	50,477
Cash and cash equivalents	26	16,622	8,639	15,872	7,407
Total current assets		**72,153**	**65,861**	**70,270**	**65,993**
Current liabilities					
Trade and other payables	27	(61,967)	(66,125)	(62,265)	(68,026)
Borrowings	30	(24,583)	(5,899)	(24,583)	(5,899)
Provisions	31	(1,725)	(4,136)	(1,725)	(4,136)
Other liabilities	29	(2,837)	(1,546)	(2,837)	(1,548)
Total current liabilities		**(91,112)**	**(77,706)**	**(91,410)**	**(79,609)**
Total assets less current liabilities		**419,624**	**390,157**	**406,581**	**377,477**
Non-current liabilities					
Borrowings	30	(242,341)	(196,742)	(242,341)	(196,742)
Provisions	31	(2,065)	(1,983)	(2,030)	(1,937)
Other liabilities	29	(10)	-	(10)	-
Total non-current liabilities		**(244,416)**	**(198,725)**	**(244,381)**	**(198,679)**
Total assets employed		**175,208**	**191,432**	**162,200**	**178,798**
Financed by					
Public dividend capital		337,972	294,776	337,972	294,776
Revaluation reserve		53,805	51,228	53,805	51,228
Income and expenditure reserve		(229,577)	(167,206)	(229,577)	(167,206)
Charitable Fund reserve		12,514	12,251	-	-
Pharm@Sea Reserve		494	383	-	-
Total taxpayers' equity		**175,208**	**191,432**	**162,200**	**178,798**

The notes on pages 7 to 53 form part of these accounts.

The financial statements on pages 2 to 53 were appproved by the Board on 25 May 2018

Chief Executive Marianne Griffiths Date: 25-May-18

Statement of Changes in Equity for the year ended 31 March 2018

	Group					
	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Charitable Fund reserve	Pharm@Sea reserve	Total
	£000	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2017 - brought forward	**294,776**	**51,228**	**(167,206)**	**12,251**	**383**	**(154,572)**
Surplus/(deficit) for the year	-	-	(64,074)	**(287)**	100	**(64,261)**
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	(1,699)	1,699	-	-	-
Impairments	-	(2,353)	-	-	-	**(2,353)**
Revaluations	-	6,633	-	-	-	**6,633**
Transfer to retained earnings on disposal of assets	-	(4)	4	-	-	-
Consolidation adjustment	-	-	-	550	11	**561**
Taxpayers' equity at 31 March 2018	**294,776**	**53,805**	**(229,577)**	**12,514**	**494**	**(213,992)**

Statement of Changes in Equity for the year ended 31 March 2017

	Group					
	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Charitable Fund reserve	Pharm@Sea reserve	Total
	£000	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2016 - brought forward	**247,752**	**45,624**	**(81,268)**	**12,435**	**328**	**224,871**
Surplus/(deficit) for the year	-	-	(89,311)	1,684	55	**(87,572)**
Other transfers between reserves	-	(1,505)	1,505	-	-	-
Impairments	-	(2,347)	-	-	-	**(2,347)**
Revaluations	-	9,456	-	-	-	**9,456**
Public dividend capital received	47,024	-	-	-	-	**47,024**
Consolidation adjustment	-	-	1,868	(1,868)	-	-
Taxpayers' equity at 31 March 2017	**294,776**	**51,228**	**(167,206)**	**12,251**	**383**	**191,432**

Statement of Changes in Equity for the year ended 31 March 2018

	Trust			
	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2017 - brought forward	**294,776**	**51,228**	**(167,206)**	**178,798**
Deficit for the year	-	-	(64,074)	(64,074)
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	(1,699)	1,699	-
Impairments	-	(2,353)	-	(2,353)
Revaluations	-	6,633	-	6,633
Transfer to retained earnings on disposal of assets	-	(4)	4	-
Public dividend capital received	43,196	-	-	43,196
Taxpayers' equity at 31 March 2018	**337,972**	**53,805**	**(229,577)**	**162,200**

Statement of Changes in Equity for the year ended 31 March 2017

	Trust			
	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2016 - brought forward	**247,752**	**45,624**	**(79,400)**	**213,976**
Deficit for the year	-	-	(89,311)	(89,311)
Other transfers between reserves	-	(1,505)	1,505	-
Impairments	-	(2,347)	-	(2,347)
Revaluations	-	9,456	-	9,456
Public dividend capital received	47,024	-	-	47,024
Taxpayers' equity at 31 March 2017	**294,776**	**51,228**	**(167,206)**	**178,798**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the Group.

Charitable Funds Reserve.
This balance represents the ring-fenced funds held by the Charity consolidated within these accounts. These reserves are classified as restricted or unrestricted. A breakdown is provided in note 21

Pharm@Sea Reserve.
This balance represents the accumulated reserves of the Trust's wholly owned subsidiary, Pharm@Sea Limited.

Statement of Cash Flows

		Group		Trust	
		2017/18	2016/17	2017/18	2016/17
	Note	£000	£000	£000	£000
Cash flows from operating activities					
Operating deficit		(48,863)	(76,880)	(49,053)	(77,090)
Non-cash income and expense:					
Depreciation and amortisation	8.1	19,964	20,051	19,906	19,995
Net impairments	9	8,943	20,156	8,948	20,156
Income recognised in respect of capital donations	6	-	-	(1,037)	(88)
(Increase) / decrease in receivables and other assets		(1,929)	11,546	3,947	1,431
Increase in inventories		(734)	(1,124)	(679)	(991)
Increase / (decrease) in payables and other liabilties		375	(5,184)	(4,315)	5,819
Increase / (decrease) in provisions		(2,062)	4,045	(2,399)	4,045
Tax (paid)/refunded		(183)	26	-	-
Net cash generated used in operating activities		**(24,489)**	**(27,364)**	**(24,682)**	**(26,723)**
Cash flows from investing activities					
Interest received		37	31	37	31
Purchase of intangible assets		-	(88)	-	(88)
Purchase of property, plant, equipment and investment property		(61,407)	(76,771)	(61,406)	(76,771)
Net cash flows from charitable fund investing activities		361	339	-	-
Net cash generated used in investing activities		**(61,009)**	**(76,489)**	**(60,332)**	**(76,740)**
Cash flows from financing activities					
Public dividend capital received		43,196	47,024	43,196	47,024
Movement on loans from the Department of Health and Social Care		65,776	74,316	65,776	74,316
Capital element of PFI service concession payments		(1,490)	(1,543)	(1,490)	(1,543)
Interest paid on PFI service concession obligations		(2,583)	(2,599)	(2,583)	(2,599)
Other interest paid		(6,630)	(3,524)	(6,632)	(3,522)
PDC dividend paid		(4,820)	(6,236)	(4,820)	(6,234)
Net cash generated from financing activities		**93,449**	**107,438**	**93,447**	**107,442**
Increase in cash and cash equivalents		**7,951**	**3,585**	**8,433**	**3,979**
Cash and cash equivalents at 1 April		**8,639**	**4,970**	**7,407**	**3,344**
Unrealised gains on foreign exchange		**32**	**84**	**32**	**84**
Cash and cash equivalents at 31 March	26.1	**16,622**	**8,639**	**15,872**	**7,407**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care (DH) has directed that the financial statements of the shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2017/18 issued by the Department of Health and Social Care. The accounting policies contained in the GAM 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 GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to accounts.

Note 1.1.1 Accounting convention

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

Note 1.1.2 Going concern

These accounts have been prepared on the basis the Trust is a going concern as there is no indication that the healthcare and other services will not continue to be provided by the public sector for the foreseeable future and that continuing financial support will be provided by the Department of Health (DH). A such the accounts do not include the adjustments that would result if the Trust were unable to continue as a going concern

The Trust is aware, however, of the following conditions which give rise to a material uncertainty and may cast significant doubt about the Trust's ability to continue as a going concern.

Against a challenging operational and commissioning landscape the Trust delivered an actual deficit for the year of £64.1m. After adjusting for the impact of impairments and adjustments in relation to donated assets the adjusted deficit is £55.6m.

The Trust delivered the control total as planned; returning a deficit of £63.8m against the planned deficit of £65.4m. As a result the Trust received confirmation of an allocation from the STF Incentive Fund of £8.3m from NHS Improvement (NHSI); improving the performance against the control total by the same amount and decreasing the reported deficit to £55.6m. Delivery of the 2017/18 financial plan was supported by £20m of savings. The DH provided deficit funding of £63.8m as revenue support loans in year bringing the total revenue support loan funding to £171m as at 31st March 2018.

On 1st April 2017 the Trust entered into a management contract with Western Sussex Hospitals NHS Foundation Trust and NHSI for a minimum of three years. The Executive Team and Chairman of Western Sussex Hospitals NHS Foundation Trust are also the Executive Team and Chairman of this Trust. This arrangement is intended to provide some strong and stable leadership to the Trust for the contract period. New regulatory oversight arrangements have also been agreed which will provide a focus on supporting the Trust to exit from Financial Special Measures and Quality Special Measures.

The Trust agreed a revision to the financial control totals for 2017-18 and 2018-19 with NHSI. The methodology is based on a series of negotiated principles which include limiting the financial efficiency requirement upon the Trust over this period. The agreed control total for 2018/19 is a planned deficit of £65.4m. Delivery of the plan is underpinned by an efficiency expectation of £30m; for which schemes have been fully identified.

The Trust has submitted its operational and financial plans for 2018/19.The plans reflect agreed continued revenue deficit support funding from the DH. The deficit support funding is authorised by the DH monthly in advance and is conditional on the achievement of the agreed financial control total for the year. Deficit support funding totalling £11.5m for April and May 2018 has been provided to the Trust.

The Trust has agreed an Aligned Incentive Contract with local Clinical Commissioning Groups for 2018/19; with a value of £286m. The Trust has agreed a Payment by Results contract with NHS England Specialised Commissioning for 2018/19; with a value of £xxxm .

The Trust's 2018/19 cash flow forecast is based on the assumptions in the 2018/19 financial plan. The key assumptions underpinning the cash flow are:
a) Receipt of £65.4m revenue support loan from the DH to finance the revenue deficit;
b) Receipt of £102m PDC from DH to fund the 3Ts capital build; and
c) Receipt of £21m loan funding from DH to support the Emergency Backlog Maintenance and Emergency Department Schemes.

The new Executive leadership of the Trust agreed the following priorities with NHSI:
- Moving out of Quality Special Measures
- Improvement and delivery of A&E performance
- Moving out of Financial Special Measures
- Addressing underlying Leadership and Cultural challenges
- Assuring delivery of 3Ts programme and integration into the Trust

The Trust's financial priority for the next year is to deliver its control total deficit as agreed with NHSI. This includes the further development and embedding of robust and transparent processes introduced in 2017/18.

Taking into account all these factors, the assumption that the healthcare and other services will continue to be provided by the public sector for the foreseeable future and that the DH will continue to provide financial support, the Directors consider the Trust will continue to operate as a going concern.

Note 1.2 Critical judgements in applying accounting policies

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

Valuation of Buildings

Department of Health guidance specifies that the Group's land and buildings should be valued on the basis of depreciated replacement cost, applying the Modern Equivalent Asset (MEA) concept. The MEA is defined as "the cost of a modern replacement asset that has the same productive capacity as the property being valued." Therefore the MEA is not a valuation of the existing land and buildings that the Group holds, but a theoretical valuation for accounting purposes of what the Group could need to spend in order to replace the current assets. In determining the MEA, the Group has to make assumptions that are practically achievable, however the Group is not required to have any plans to make such changes.

The Group is satisfied that the assumptions underpinning the MEA valuation are practically achievable, would not change the services provided by the Group, and would not impact on service delivery or the level and volume of service provided. The Group does not intend to implement any of the theoretical assumptions that underpin the MEA valuation.

For the purpose of the MEA valuation, the Group has defined all of the Royal Sussex County Hospital, The Royal Alexandra Children's Hospital, the Sussex Eye Hospital and the Royal Princess Royal Hospital as buildings that provide specialist health care services. The MEA valuation in the accounts assumes that the Brighton based hospitals could theoretically be provided from a location on the outskirts of Brighton.

The MEA valuations used by the Group have been provided to the Group by the external valuers, Gerald Eve LLP. The Group has used component lives based upon contractual information provided by Gerald Eve LLP to depreciate buildings and dwellings on a component basis.

PFI

The Group uses the standard Department of Health model to account for its PFI scheme.

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 Assets Under Construction. At 31 March 2018 these amounted to £120.5m (2016-17 - £90.1m). 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.

Provision for Pensions

The Group has estimated the provision for pensions relating to former staff using estimates provided by the NHS Pensions provided at the time of the member's early retirement. These are updated annually using national life expectancy tables and if it becomes apparent that the provision is not sufficient to meet the liability.

Note 1.2.1 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

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. Based on the work undertaken the Group continues to estimate that it holds approximately £45.6m of fully depreciated assets of its capital asset register which no longer exist that are excluded from the financial statements.

Revenue

The basis of calculation for partially completed spells is detailed in note 1.5 below.

Depreciation

The reported amounts for depreciation of property, plant and equipment and amortisation of non-current intangible assets can be materially affected by the judgements exercised in determining their estimated economic lives. Economic lives are determined in a number of different ways such as valuations (external professional opinion) and physical asset verification exercises.

The estimated economic lives of each class of asset are disclosed in note 1.8.6, and the carrying values of property, plant and equipment and intangible assets in note 17.1 and 16 respectively.

Land and Buildings Valuations

All land and buildings are restated at current value by way of annual professional valuations carried out by an independent external valuer.

Provision for impairment of receivables

Provisions are based on a combination of the age of the debt and disputes with debtors. The Group follows the guidance issued in the Department of Health Group Accounting Manual 2017-18 in relation to the recommended rate for Injury Cost Recovery receivables.

Note 1.3 Consolidation

Subsidiaries

Material entities over which the Group has the power to exercise control are classified as subsidiaries and are consolidated in the consolidated financial statements. The Group 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 Group or where the subsidiary's accounting date is not co-terminus.

Charitable Funds

Brighton and Sussex University Hospitals NHS Trust Charitable Funds
The Trust is the corporate trustee to Brighton and Sussex University Hospitals Charitable Funds. The Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.
The charitable fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:
• recognise and measure them in accordance with the trust's accounting policies and
• eliminate intra-group transactions, balances, gains and losses.

Pharm@Sea Limited

Subsidiary entities are those over which the Trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to minority interests are included as a separate item in the Statement of Financial Position.

The amounts consolidated are drawn from the published financial statements of the subsidiaries for the year [except where a subsidiary's financial year end is before 1 January or after 1 July in which case the actual amounts for each month of the trust's financial year are obtained from the subsidiary and consolidated.

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.

Note 1.4 Pooled Budget

The Group has not entered into any pooled budget arrangements during the Financial Year 2017-18

Note 1.5 Income

Income 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 income for the Group is contracts with commissioners in respect of health care services. At the year end, the Group accrues income relating to activity delivered in that year, where a patient care spell is incomplete, measured at the price per day for each patient spell apportioned across the financial years.

Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.
Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and

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.

Revenue grants and other contributions to expenditure

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.6 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement 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.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. There, the schemes are accounted for as though they are defined contribution schemes.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Group commits itself to the retirement, regardless of the method of payment.

Note 1.7 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.8 Property, plant and equipment

Note 1.8.1 Recognition

Property, plant and equipment is capitalised where:
- 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 be provided to, the Group
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- 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 cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

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

Note 1.8.2 Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs 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. Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date.

Revaluations of property, plant and equipment 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. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use.
- Specialised buildings – depreciated replacement cost, modern equivalent asset basis.

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 and, where capitalised in accordance with IAS 23, borrowing costs. Assets are revalued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Group, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the *GAM*, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

At each financial year-end, the Group checks whether there is any indication that its property, plant and equipment or intangible non-current assets have suffered an impairment loss. If there is indication of such an impairment, 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 at the financial year end.

Note 1.8.3 Derecognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:
• the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
• the sale must be highly probable i.e.:
- management are committed to a plan to sell the asset
- an active programme has begun to find a buyer and complete the sale
- the asset is being actively marketed at a reasonable price
- the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
- the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.
Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.8.4 Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.
The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Note 1.8.5 Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the Group. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

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 or, if lower, at the present value of the minimum lease payments, in accordance with the principles of IAS 17. Subsequently, the assets are measured at current value in existing use.

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 initial 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 accrual 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 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 Group 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.

Note 1.8.6 Useful economic lives of property, plant and equipment

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The estimated useful life of an asset is the period over which the Group expects to obtain economic benefits or service potential from the asset. This is specific to the Group and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. The range of useful economic lives are shown in the table below:

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	1	88
Dwellings	4	88
Plant & machinery	5	10
Transport equipment	-	-
Information technology	5	10
Furniture & fittings	7	15

Finance-leased assets (including land) are depreciated over the shorter of the useful economic life or the lease term, unless the Group expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.9 Intangible assets

Note 1.9.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Group's business or which arise from contractual or other legal rights. They are recognised only where 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 the cost is at least £5,000.

Internally generated intangible assets
Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets. Expenditure on research is not capitalised. Expenditure on development is capitalised only where all of the following can be demonstrated:
- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
- the Group intends to complete the asset and sell or use it
- the Group has the ability to sell or use the asset
- how the intangible asset will generate probable future economic or service delivery benefits, e.g., the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Group to complete the development and sell or use the asset and
- the Group can measure reliably the expenses attributable to the asset during development.

Software
Software which is integral to the operation of hardware, e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, e.g. application software, is capitalised as an intangible asset.

Note 1.9.2 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or "fair value less costs to sell".

Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Note 1.9.3 Useful economic lives of intangible assets

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The estimated useful life of an asset is the period over which the Group expects to obtain economic benefits or service potential from the asset. This is specific to the Group and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. The range of useful economic lives are shown in the table below:

	Min life Years	**Max life Years**
Information technology	5	10
Software licences	5	10

Note 1.10 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method.

Note 1.11 Cash and cash equivalents

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

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

Note 1.12 Carbon Reduction Commitment scheme (CRC)

The CRC scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The Group is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO2 emissions are made.

The carrying amount of the liability at the financial year end will therefore reflect the CO2 emissions that have been made during that financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year.

The liability will be measured at the amount expected to be incurred in settling the obligation. This will be the cost of the number of allowances required to settle the obligation.

Allowances acquired under the scheme are recognised as intangible assets.

Note 1.13 Financial instruments and financial liabilities

Recognition
Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Group's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs, i.e., when receipt or delivery of the goods or services is made and the Trust becomes a party to the contractual provisions of the instrument.

De-recognition
All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and measurement
Financial assets are categorised into the following categories: financial asset at fair value through income and expenditure, held to maturity investments; loans and receivables and available-for-sale financial assets. The classification depends on the nature and purpose of the financial asset and is determined at the time of initial recognition.

Financial liabilities are classified as "fair value through income and expenditure".

Financial assets and financial liabilities at "fair value through income and expenditure"

Financial assets and financial liabilities at "fair value through income and expenditure" are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges. Derivatives which are embedded in other contracts but which are not "closely-related" to those contracts are separated-out from those contracts and measured in this category. Assets and liabilities in this category are classified as current assets and current liabilities.

These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the income and expenditure account. Subsequent movements in the fair value are recognised as gains or losses in the Statement of Comprehensive Income.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market.

The Trust's loans and receivables comprise: current investments, cash and cash equivalents, NHS receivables, accrued income and "other receivables".

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Other financial liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Determination of fair value

For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from quoted market prices.

Impairment of financial assets

At the Statement of Financial Position date, the trust assesses whether any financial assets, other than those held at "fair value through income and expenditure" are impaired. Financial assets are impaired and impairment losses are recognised if, and only 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 the Statement of Comprehensive Income and the carrying amount of the asset is reduced directly.

Note 1.14 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.

Note 1.14.1 The Group as lessee

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the Group, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases

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.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Note 1.14.2 The Group as lessor

Finance leases

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

Operating 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 as an expense on a straight-line basis over the lease term.

Note 1.15 Provisions

The Group recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Early retirement provisions are discounted using HM Treasury's pension discount rate of positive 0.10% (2016-17: positive 0.24%) in real terms. All other provisions are subject to three separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

- A short term rate of negative 2.42% (2016-17: negative 2.70%) for expected cash flows up to and including 5 years
- A medium term rate of negative 1.85% (2016-17: negative 1.95%) for expected cash flows over 5 years up to and including 10 years
- A long term rate of negative 1.56% (2016-17: negative 0.80%) for expected cash flows over 10 years.

All percentages are in real terms.

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.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Group pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Group. The total value of clinical negligence provisions carried by NHS resolution on behalf of the Group is disclosed at note 32 but is not recognised in the Group's accounts.

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 NHS Resolution 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 when the liability arises.

Note 1.16 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 33 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 33, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:
• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.17 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.
At any time, the Secretary of State can issue new PDC to, and require repayments of, PDC from the Group. PDC is recorded at the value received.
A charge, reflecting the cost of capital utilised by the Group, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Group during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for
(i) donated assets (including lottery funded assets),
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.
In accordance with the requirements laid down by the Department of Health and Social Care (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.

Note 1.18 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.

Note 1.19 Corporation tax

The corporation tax disclosed in the group accounts relates to tax on the activities of the wholly owned subsidiary, Pharm@Sea. Tax is charged at 20% on the taxable profits of Pharm@Sea. Deferred tax has been provided on the remaining unwound capital allowances.

The Trust has determined that it is has no corporation tax liability because it is not engaged in activity that is subject to corporation tax.

Note 1.20 Foreign exchange

The functional and presentational currency of the Group is sterling.
A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.
Where the Group has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:
• monetary items (other than financial instruments measured at "fair value through income and expenditure") are translated at the spot exchange rate on 31 March.
• non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
• non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.
Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.
Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

Note 1.21 Third party assets
Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Group has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.
Note 1.22 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 Group not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.23 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.
Note 1.24 Transfers of functions to / from other NHS bodies

For property plant and equipment assets and intangible assets, the cost and accumulated depreciation / amortisation balances from the transferring entity's accounts are preserved on recognition in the Group's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the Group makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

Note 1.25 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.

Note 1.26 Charitable Funds Structure

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

Restricted funds are those which are to be used 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.

Note 1.27 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2017/18.

Note 1.28 Standards, amendments and interpretations in issue but not yet effective or adopted

The DHSC GAM does not require the following Standards and Interpretations to be applied in 2017-18. 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 and IFRS 17 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 from Contracts with Customers - 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 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.
- IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRS 22 Foreign Currency Transactions and Advance Consideration – Application required for accounting periods beginning on or after 1 January 2018.
- IFRS 23 Uncertainty over Income Tax Treatments – Application required for accounting periods beginning on or after 1 January 2019.

Note 2 Pooled budget

The Group has not entered into any pooled budget arrangements during the Financial Year 2017-18.

Note 3 Operating segments

The nature of the Group'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 Group wide. As an NHS Group, all services are subject to the same regulatory environment and standards set by the Group's external performance managers. Accordingly, the Group operates one segment and in 2017-18 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:

	2017-18	2016-17
	£m's	£m's
CCG *	283	276
NHS England	185	174
	468	450

This income all relates to patient activity.

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

Note 4 Income generation activities

The Trust 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.

Note 5 Operating income from patient care activities

Note 5.1 Income from patient care activities (by nature)

	2017/18 £000	2016/17 £000
Acute services		
Elective income	77,420	81,298
Non elective income	126,244	118,699
First outpatient income	19,639	19,947
Follow up outpatient income	24,150	27,903
A & E income	20,864	18,567
High cost drugs income from commissioners (excluding pass-through costs)	75,471	67,252
Other NHS clinical income	127,798	126,752
All services		
Private patient income	4,673	4,551
Other clinical income	27,688	31,615
Total income from activities	**503,947**	**496,583**

Note 5.2 Income from patient care activities (by source)

Income from patient care activities received from:	2017/18 £000	2016/17 £000
NHS England	181,014	173,825
Clinical commissioning groups	281,988	275,617
Department of Health and Social Care	57	1,545
Other NHS providers	4,416	6,090
NHS other	858	340
Local authorities	4,701	4,490
Non-NHS: private patients	4,682	4,496
Non-NHS: overseas patients (chargeable to patient)	252	338
NHS injury scheme	1,460	2,625
Non NHS: other	24,519	27,217
Total income from activities	**503,947**	**496,583**
Of which:		
Related to continuing operations	503,947	496,583
Related to discontinued operations	-	-

Note 5.3 Overseas visitors (relating to patients charged directly by the provider)

	2017/18	2016/17
	£000	£000
Income recognised this year	252	338
Cash payments received in-year	183	62
Amounts added to provision for impairment of receivables	87	130
Amounts written off in-year	53	5

Note 6 Other operating income

	2017/18	2016/17
	£000	£000
Research and development	3,877	5,030
Education and training	27,961	28,355
Receipt of capital grants and donations	1,037	88
Non-patient care services to other bodies	5,102	5,736
Sustainability and transformation fund income	8,280	3,600
Rental revenue from operating leases	466	538
Income in respect of staff costs where accounted on gross basis	4,677	2,785
Other income	7,806	7,654
Total other operating income	**59,206**	**53,786**
Of which:		
Related to continuing operations	59,206	53,786
Related to discontinued operations	-	-

Note 7 Fees and charges

	2017/18 £000	2016/17 £000
Income	-	-
Full cost	-	-
Surplus / (deficit)	-	-

Note 8.1 Operating expenses

	2017/18 £000	2016/17 £000
Purchase of healthcare from NHS and DHSC bodies	4,400	5,934
Purchase of healthcare from non-NHS and non-DHSC bodies	6,588	7,162
Staff and executive directors costs	351,676	340,422
Remuneration of non-executive directors	98	67
Supplies and services - clinical (excluding drugs costs)	62,586	61,736
Supplies and services - general	7,128	8,155
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	79,645	76,423
Inventories written down	24	175
Consultancy costs	2,197	4,489
Establishment	4,915	4,989
Premises	17,052	18,107
Transport (including patient travel)	1,138	1,692
Depreciation on property, plant and equipment	19,722	19,830
Amortisation on intangible assets	184	165
Net impairments	8,948	20,156
Increase/(decrease) in provision for impairment of receivables	833	11,791
Change in provisions discount rate(s)	30	233
Audit fees payable to the external auditor		
audit services- statutory audit	84	109
other auditor remuneration (external auditor only)	12	13
Internal audit costs	116	121
Clinical negligence	21,522	19,276
Legal fees	1,471	2,137
Insurance	362	416
Research and development	4,737	7,081
Education and training	9,647	9,018
Rentals under operating leases	4,116	3,898
Redundancy	216	-
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (PFI) on IFRS basis	1,707	1,407
Car parking & security	390	381
Other	662	2,076
Total	**612,206**	**627,459**
Of which:		
Related to continuing operations	612,206	627,459
Related to discontinued operations	-	-

Note 8.2 Other auditor remuneration

	2017/18 £000	2016/17 £000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	-	-
2. Audit-related assurance services	12	13
3. Taxation compliance services	-	-
4. All taxation advisory services not falling within item 3 above	-	-
5. Internal audit services	-	-
6. All assurance services not falling within items 1 to 5	-	-
7. Corporate finance transaction services not falling within items 1 to 6 above	-	-
8. Other non-audit services not falling within items 2 to 7 above	-	-
Total	**12**	**13**

Note 8.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2m (2016/17: £2m).

Note 9 Impairment of assets

	2017/18 £000	2016/17 £000
Net impairments charged to operating surplus / deficit resulting from:		
Unforeseen obsolescence	877	5,700
Changes in market price	8,071	14,456
Total net impairments charged to operating surplus / deficit	**8,948**	**20,156**
Impairments charged to the revaluation reserve	2,353	2,347
Total net impairments	**11,301**	**22,503**

The impairment losses and reversals resulting from the revaluation exercise at the 31 March 2018 were spread across the whole estate. The largest impairments related to the Royal Sussex County Hospital site as follows:

	£000s
Clinical Administration Building	6,118
Cancer Centre	1,418
Radiotherapy Building	3,456

Note 10 Employee benefits

	2017/18 Total £000	2016/17 Total £000
Salaries and wages	264,807	261,805
Social security costs	29,594	28,367
Apprenticeship levy	1,412	-
Employer's contributions to NHS pensions	33,334	33,002
Pension cost - other	10	8
Temporary staff (including agency)	31,531	26,235
Total gross staff costs	**360,688**	**349,490**
Recoveries in respect of seconded staff	-	-
Total staff costs	**360,688**	**349,490**
Of which		
Costs capitalised as part of assets	221	465

Note 10.1 Retirements due to ill-health

During 2017/18 there were 5 early retirements from the Group agreed on the grounds of ill-health (5 in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £404k (£429k in 2016/17).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 11 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 is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 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 report of the scheme actuary, which forms part of the annual NHS Pension Scheme 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 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 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").

The auto enrolment "staging" date for the Group compliance was 1 April 2013. This was followed by a re-enrolment date of 1 April 2016. For those staff not entitled to join the NHS Pension Scheme, the Group utilised an alternative pension scheme called NEST to fulfil its automatic enrolment obligations. NEST stands for National Employment Savings Trust and is a defined contribution pension scheme established by law to support the introduction of auto enrolment.

Contributions are taken from qualifying earnings, which are currently from £5,876 up to £45,000, and are 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.

Date	Employee Contribution	Employer Contribution	Total Contribution
1st March 2013	1%	1%	2%
6th April 2018	3%	2%	5%
6th April 2019	5%	3%	8%

Note 12 Operating leases

Note 12.1 The Group as a lessor

The Group leases space to third parties to provide food, beverages and newspapers, the swimming pool on the St Mary's Hall site in Brighton, office space and use of sites for the location of aerials. The Group also leases space to the wholly owned subsidiary, Pharm@Sea Limited. The terms of these leases vary between one and fifteen years.

	2017/18 £000	2016/17 £000
Operating lease revenue		
Minimum lease receipts	466	538
Total	**466**	**538**

	31 March 2018 £000	31 March 2017 £000
due:		
- not later than one year;	445	522
than five years;	1,203	1,458
- later than five years.	99	157
Total	**1,747**	**2,137**

Note 12.2 The Group as a lessee

The Group leases five 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 Group may not assign any of the leases without the landlord's permission.

Details of the leases are set out below:

	Term Yrs	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
Radiotherapy Centre, Eastbourne	25	24.07.17	23.01.42	N/A	12 months

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.

There are four other properties that the Trust uses where the terms of a lease are under negotiation and are currently agreed annually. The Trust has also entered into licences with 5 local children's centres for the use of their premises for a period of 3 years from April 2016

The costs and commitments incurred in operating lease arrangements where the Group is the lessee are:

	2017/18 £000	2016/17 £000
Operating lease expense		
Minimum lease payments	4,116	3,898
Total	**4,116**	**3,898**

	31 March 2018 £000	31 March 2017 £000
due:		
- not later than one year;	4,268	3,548
than five years;	5,699	4,650
- later than five years.	6,203	5,726
Total	**16,170**	**13,924**
payments to be received	-	-

Note 13 Finance income

Finance income represents interest received on assets and investments in the period.

	2017/18 £000	2016/17 £000
Interest on bank accounts	37	31
Total	**37**	**31**

Note 14.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2017/18 £000	2016/17 £000
Interest expense:		
Loans from the Department of Health and Social Care	7,353	3,522
Main finance costs on PFI and LIFT schemes obligations	1,690	1,774
Contingent finance costs on PFI and LIFT scheme obligations	891	825
Total interest expense	**9,934**	**6,121**
Unwinding of discount on provisions	51	6
Other finance costs	-	-
Total finance costs	**9,985**	**6,127**

Note 14.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2017/18 £000	2016/17 £000
Compensation paid to cover debt recovery costs under this legislation	-	24

Note 15 Other gains / (losses)

	2017/18 £000	2016/17 £000
Losses on disposal of assets	-	(8)
Total gains / (losses) on disposal of assets	-	(8)
Gains on foreign exchange	32	84
Total other gains	**32**	**76**

Note 16 Intangible assets - 2017/18

	Software licences £000	Internally generated information technology £000	Total £000
Valuation / gross cost at 1 April 2017 - brought forward	**679**	**1,068**	**1,747**
Impairments	-	(102)	**(102)**
Reclassifications	(87)	195	**108**
Gross cost at 31 March 2018	**592**	**1,161**	**1,753**
Amortisation at 1 April 2017 - brought forward	**669**	**397**	**1,066**
Provided during the year	29	155	**184**
Impairments	**17**	**(64)**	**(47)**
Reclassifications	**(141)**	**141**	-
Amortisation at 31 March 2018	**574**	**629**	**1,203**
Net book value at 31 March 2018	**18**	**532**	**550**
Net book value at 1 April 2017	**10**	**671**	**681**

Note 16.1 Intangible assets - 2016/17

	Software licences £000	Internally generated information technology £000	Total £000
Valuation / gross cost at 1 April 2016 - as previously stated	**679**	**980**	**1,659**
Additions	-	88	**88**
Valuation / gross cost at 31 March 2017	**679**	**1,068**	**1,747**
Amortisation at 1 April 2016 - as previously stated	**639**	**262**	**901**
Provided during the year	**30**	**135**	**165**
Amortisation at 31 March 2017	**669**	**397**	**1,066**
Net book value at 31 March 2017	**10**	**671**	**681**
Net book value at 1 April 2016	**10**	**671**	**681**

The estimated remaining lives of intangible assets ranges from 5-10 years

Note 17.1 Property, plant and equipment - 2017/18

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2017 - brought forward	**28,206**	**208,091**	**593**	**111,532**	**100,118**	**217**	**35,620**	**4,317**	**488,694**
Additions	-	-	-	59,935	632	-	-	-	**60,567**
Impairments	-	(14,907)	(2)	(70)	-	-	(752)	-	**(15,731)**
Reversals of impairments	60	1,150	2	-	-	-	-	-	**1,212**
Revaluations	2,091	388	25	-	-	-	-	-	**2,504**
Reclassifications	-	24,178	-	(36,831)	10,244	-	2,301	-	**(108)**
Valuation/gross cost at 31 March 2018	**30,357**	**218,900**	**618**	**134,566**	**110,994**	**217**	**37,169**	**4,317**	**537,138**
Accumulated depreciation at 1 April 2017 - brought forward	-	-	-	-	**74,171**	**217**	**23,893**	**4,150**	**102,431**
Provided during the year	-	**7,388**	**14**	-	**8,512**	-	**3,709**	**99**	**19,722**
Impairments	-	(780)	-	-	-	-	-	-	**(780)**
Reversals of impairments	-	(2,493)	-	-	-	-	-	-	**(2,493)**
Revaluations	-	(4,115)	(14)	-	-	-	-	-	**(4,129)**
Reclassifications	-	-	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	-	-	-	-	-	-
Accumulated depreciation at 31 March 2018	-	-	-	-	**82,683**	**217**	**27,602**	**4,249**	**114,751**
Net book value at 31 March 2018	**30,357**	**218,900**	**618**	**134,566**	**28,311**	-	**9,567**	**68**	**422,387**
Net book value at 1 April 2017	**28,206**	**208,091**	**593**	**111,532**	**25,947**	-	**11,727**	**167**	**386,263**

Note 17.2 Property, plant and equipment - 2016/17

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation / gross cost at 1 April 2016 - as previously stated	**28,350**	**188,683**	**544**	**97,720**	**88,426**	**217**	**33,085**	**4,317**	**441,342**
Additions	-	-	-	65,883	1,037	-	764	-	**67,684**
Impairments	(179)	(16,584)	(40)	-	-	-	(5,700)	-	**(22,503)**
Revaluations	21	2,083	40	-	-	-	-	-	**2,144**
Reclassifications	5	33,937	(5)	(52,071)	10,655	-	7,479	-	**-**
Transfers to / from assets held for sale	9	-	54	-	-	-	-	-	**63**
Disposals / derecognition	-	(28)	-	-	-	-	(8)	-	**(36)**
Valuation/gross cost at 31 March 2017	**28,206**	**208,091**	**593**	**111,532**	**100,118**	**217**	**35,620**	**4,317**	**488,694**
Accumulated depreciation at 1 April 2016 - as previously stated	**-**	**-**	**-**	**-**	**64,981**	**217**	**20,724**	**4,019**	**89,941**
Provided during the year	-	**7,325**	**15**	-	**9,197**	-	**3,162**	**131**	**19,830**
Impairments	-	3,702	-	-	-	-	-	-	**3,702**
Reversals of impairments	-	(3,702)	-	-	-	-	-	-	**(3,702)**
Revaluations	-	(7,297)	(15)	-	-	-	-	-	**(7,312)**
Reclassifications	-	-	-	-	(7)	-	7	-	**-**
Disposals/ derecognition	-	(28)	-	-	-	-	-	-	**(28)**
Accumulated depreciation at 31 March 2017	**-**	**-**	**-**	**-**	**74,171**	**217**	**23,893**	**4,150**	**102,431**
Net book value at 31 March 2017	**28,206**	**208,091**	**593**	**111,532**	**25,947**	**-**	**11,727**	**167**	**386,263**
Net book value at 1 April 2016	**28,350**	**188,683**	**544**	**97,720**	**23,445**	**-**	**12,361**	**298**	**351,401**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land £000	excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
At 1 April 2017	5,609	44,865	225	0	660	0	0	0	51,359
Movements									
At 31 March 2018	5,609	44,865	225	0	660	0	0	0	51,359

Additions to Assets Under Construction in 2017-18

Buildings excl Dwellings	49,702
Plant & Machinery	3,038
Information Technology	6,225
Balance as at 31 March 2018	58,965

Note 17.3 Property, plant and equipment financing - 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018									
Owned - purchased	30,257	186,182	618	134,054	28,171	-	9,217	38	**388,537**
On-SoFP PFI contracts and other service concession arrangements	-	31,392	-	-	-	-	-	-	**31,392**
PFI residual interests	-	-	-	-	-	-	-	-	**-**
Owned - government granted	-	-	-	-	-	-	-	-	**-**
Owned - donated	100	1,326	-	512	140	-	350	30	**2,458**
NBV total at 31 March 2018	**30,357**	**218,900**	**618**	**134,566**	**28,311**	**-**	**9,567**	**68**	**422,387**

Note 17.4 Property, plant and equipment financing - 2016/17

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2017									
Owned - purchased	28,106	176,269	593	111,500	25,519	-	11,697	136	**353,820**
On-SoFP PFI contracts and other service concession arrangements	-	30,615	-	-	-	-	-	-	**30,615**
Owned - donated	100	1,207	-	32	428	-	30	31	**1,828**
NBV total at 31 March 2017	**28,206**	**208,091**	**593**	**111,532**	**25,947**	**-**	**11,727**	**167**	**386,263**

Note 18 Donations of property, plant and equipment

The vaue of assets donated by the Brighton and Sussex University Hospitals NHS Trust Charitable Funds during the year was £1,037,000 (2016-17:£86,000).

Note 19 Revaluations of property, plant and equipment

The Group undertakes a full estates revaluation annually. This year the valuation was carried out as at 31 March 2018 by the external valuers Gerald Eve LLP, a regulated firm of Chartered Surveyors. The valuation was carried out in accordance with the requirements of the RICS valuation - Global Standard 2017 and the national standards and guidance set out in the RICS valuation - Professional Standards UK January 2014 (revised 2015, the International Valuation Standards, and IFRS a adapted and interpreted by the Financial Reporting Manual (FReM).

The valuation was carried out on the basis of Fair Value. Fair value is determined as the price that would be received to sell an asset, or paid to transfer a liability, in an orderly transaction between participants at the measurement date. The Fair Value of land and buildings is determined from market based evidence and is therefore akin to Market Value. For non specialised operational assets in accordance with the FReM adaptations this equates to Existing Use Value and for specialised operational assets Fair Value estimated using Depreciated Replacement Cost method 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 88 years. The estimated remaining lives of the other assets are as follows:

	Years
Medical equipment and engineering plant and equipment	1-15
Furniture	1-4
Soft Furnishings	1-4
Ofice and Information Technology Equipment	1-6

The Group has fully depreciated assets with a gross book value of £45.6m that are still in use and remain on the capital asset register.

Note 20 Other investments charitable

	2017/18	2016/17
	£000	£000
Market value at 1 April b/f	**11,780**	**10,441**
Add: Net gain/(loss) on revaluation	10	1,339
Market value at 31 March c/f	**11,790**	**11,780**

Note 21 Other investments / financial assets (non-current)

	2017/18	2016/17
	£000	£000
Carrying value at 1 April - brought forward	**1,101**	**1,101**
Disposals	-	-
Carrying value at 31 March	**1,101**	**1,101**

The other assets represent the cost of investment in Pharm@Sea Limited, the wholly owned subsidiary of the Trust. The company is registered in the UK, company no. 08842973 with a share capital of 1,101,000 of £1 each. The company trades as an outpatients dispensary service at the Royal Sussex County Hospital site. The figures in the note below are based on the draft accounts to the 31 March 2018.

	2017/18	2016/17
	£000s	£000s
Total gross assets of the entity as at 31 March	3,557	4,202
Total gross liabilities of the entity as at 31 March	(2,105)	(1,485)
Total revenues for the year ending 31 March	19,151	18,368
Profit for the year ending 31 March	96	49

Note 22 Analysis of charitable funds reserves

	2018 £000	2017 £000
Unrestricted funds:		
Non-Restricted funds	11,657	10,294
Restricted/Endowment funds	857	1,956
	12,514	**12,250**

Unrestricted income funds are accumulated income funds that are expendable at the discretion of the trustees in furtherance of the charity's objects. Unrestricted funds may be earmarked or designated for specific future purposes which reduces the amount that is readily available to the charity.

Note 23 Inventories

	31 March 2018 £000	31 March 2017 £000
Drugs	2,509	2,037
Consumables	6,279	6,072
Total inventories	**8,788**	**8,109**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £113,846k (2016/17: £112,046k). Write-down of inventories recognised as expenses for the year were £24k (2016/17: £175k).

Note 24.1 Trade receivables and other receivables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade receivables	23,300	21,343
Accrued income	21,806	30,144
Provision for impaired receivables	(4,748)	(7,019)
Deposits and advances	36	-
Prepayments (non-PFI)	3,411	3,724
PDC dividend receivable	307	592
VAT receivable	1,250	527
Other receivables	248	1,166
Total current trade and other receivables	**45,610**	**50,477**
Non-current		
Accrued income	3,232	2,625
Prepayments (non-PFI)	451	423
Total non-current trade and other receivables	**3,683**	**3,048**
Of which receivables from NHS and DHSC group bodies:		
Current	30,855	37,491
Non-current	-	-

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

Note 24.2 Provision for impairment of receivables

	Trust	
	2017/18	2016/17
	£000	£000
At 1 April as previously stated	**7,019**	**7,954**
Increase in provision	833	11,703
Amounts utilised	(3,104)	(12,726)
Unused amounts reversed	-	88
At 31 March	**4,748**	**7,019**

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

Note 24.3 Credit quality of financial assets

	31 March 2018		31 March 2017	
	Trade and other receivables	Investments & Other financial assets	Trade and other receivables	Investments & Other financial assets
Ageing of impaired financial assets	£000	£000	£000	£000
0 - 30 days	238	-	446	-
30-60 Days	148	-	-	-
60-90 days	104	-	620	-
90- 180 days	333	-	2,463	-
Over 180 days	3,925	-	3,490	-
Total	**4,748**	**-**	**7,019**	**-**
Ageing of non-impaired financial assets past their due date				
0 - 30 days	9,748	-	5,893	-
30-60 Days	2,851	-	1,384	-
60-90 days	977	-	1,861	-
90- 180 days	1,376	-	7,307	-
Over 180 days	6,361	-	8,290	-
Total	**21,313**	**-**	**24,735**	**-**

Note 25 Other assets

	31 March 2018	31 March 2017
Current	**£000**	**£000**
EU emissions trading scheme allowance	-	-
Other assets	-	-
Short term PFI finance lease asset	-	-
Total other current assets	-	-
Non-current		
Net defined benefit pension scheme asset	-	-
Other assets	-	-
Total other non-current assets	-	-

Note 26 Non-current assets held for sale and assets in disposal groups

	2017/18	2016/17
	£000	**£000**
NBV of non-current assets for sale and assets in disposal groups at 1 April	-	**63**
Prior period adjustment		-
NBV of non-current assets for sale and assets in disposal groups at 1 April - restated	-	**63**
Assets no longer classified as held for sale, for reasons other than disposal by sale	-	**(63)**
NBV of non-current assets for sale and assets in disposal groups at 31 March	-	-

Note 26.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	Trust	
	2017/18	2016/17
	£000	£000
At 1 April	**7,407**	3,344
Net change in year	**8,465**	4,063
At 31 March	**15,872**	**7,407**
Broken down into:		
Cash at commercial banks and in hand	90	66
Cash with the Government Banking Service	15,782	7,341
Total cash and cash equivalents as in SoFP and SoCF	**15,872**	**7,407**

Note 26.2 Third party assets held by the Group

Where the Group holds cash and cash equivalents which relate to monies held by the Group on behalf of patients or other parties thes monies are excluded from the cash and cash equivalents figure reported in the accounts. There were no such holdings at the year end (2016-17 Nil).

	Trust	
	31 March 2018	31 March 2017
	£000	£000
Bank balances	-	-
Monies on deposit	-	-
Total third party assets	-	-

Note 27.1 Trade and other payables

	Trust	
	31 March 2018 £000	31 March 2017 £000
Current		
Trade payables	18,540	24,710
Capital payables	10,105	10,944
Accruals	19,681	19,500
Social security costs	8,812	8,484
Other taxes payable	3,439	3,442
Accrued interest on loans	1,529	837
Other payables	159	109
Total current trade and other payables	**62,265**	**68,026**
Of which payables from NHS and DHSC group bodies:		
Current	9,480	7,660
Non-current	-	-

Note 27.2 Early retirements in NHS payables above

The payables note above includes amounts in relation to early retirements as set out below:

	31 March 2017 £000	31 March 2017 Number
- to buy out the liability for early retirements over 5 years	-	
- number of cases involved		-
- outstanding pension contributions	4,625	4,500

Note 28 Other financial liabilities

	31 March 2018 £000	31 March 2017 £000
Current		
expenditure	-	-
Other financial liabilities	-	-
Total	-	-
Non-current		
expenditure	-	-
Other financial liabilities	-	-
Total	-	-

Note 29 Other liabilities

	31 March 2018 £000	31 March 2017 £000
Current		
Deferred income	2,837	1,548
Total other current liabilities	**2,837**	**1,548**
Non-current		
Deferred income	10	-
Total other non-current liabilities	**10**	**-**

Note 30 Borrowings

	Trust	
	31 March 2018 £000	31 March 2017 £000
Current		
Loans from the Department of Health and Scoial Care	22,505	4,357
Obligations under PFI service concession contracts (excl. lifecycle)	2,078	1,542
Total current borrowings	**24,583**	**5,899**
Non-current		
Loans from the Department of Health and Scoial Care	214,547	166,920
Obligations under PFI service concession contracts	27,794	29,822
Total non-current borrowings	**242,341**	**196,742**

Note 31 Provisions for liabilities and charges analysis

	Pensions - early departure costs	Legal claims	Other	Total
	£000	£000	£000	£000
At 1 April 2017	**1,967**	**207**	**3,899**	**6,073**
Change in the discount rate	30	-	-	**30**
Arising during the year	-	69	1,195	**1,264**
Utilised during the year	(94)	-	(3,500)	**(3,594)**
Reversed unused	-	(69)	-	**(69)**
Unwinding of discount	51	-	-	**51**
At 31 March 2018	**1,954**	**207**	**1,594**	**3,755**
Expected timing of cash flows:				
- not later than one year;	4	127	1,594	**1,725**
- later than one year and not later than five years;	393	80	-	**473**
- later than five years.	1,557	-	-	**1,557**
Total	**1,954**	**207**	**1,594**	**3,755**

The provision for Early Departure Costs is for the reimbursement of injury benefit allowances to the NHS Pensions 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 NHS Resolution under the non-clinical risk pooling scheme. The timings of the cash flows are based on estimated dates for the finalisation of the claims.

Note 31.1 Clinical negligence liabilities

At 31 March 2018, £273,470k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Brighton and Sussex University Hospitals NHS Trust (31 March 2017: £251,948k).

Note 32 Contingent assets and liabilities

	31 March 2018 £000	31 March 2017 £000
Value of contingent liabilities		
NHS Resolution legal claims	(165)	(132)
Gross value of contingent liabilities	**(165)**	**(132)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(165)**	**(132)**
Net value of contingent assets	-	-

Note 33 Contractual capital commitments

	31 March 2018 £000	31 March 2017 £000
Property, plant and equipment	272,686	299,026
Intangible assets	-	-
Total	**272,686**	**299,026**

Note 34 Other financial commitments

The Group is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangement), analysed by the period during which the payment is made:

	31 March 2018 £000	31 March 2017 £000
not later than 1 year	393	-
after 1 year and not later than 5 years	1,571	-
paid thereafter	1,571	-
Total	**3,535**	**-**

Note 35 On-SoFP PFI, LIFT or other service concession arrangements

Note 35.1 Imputed finance lease obligations

The Trust has the following obligations in respect of the finance lease element of on-Statement of Financial Position PFI scheme.

	31 March 2018 £000	31 March 2017 £000
Gross PFI service concession liabilities	**45,067**	**48,249**
Of which liabilities are due		
- not later than one year;	2,163	3,182
- later than one year and not later than five years;	12,608	11,704
- later than five years.	30,296	33,363
Finance charges allocated to future periods	(15,195)	(16,885)
Net PFI service concession arrangement obligation	**29,872**	**31,364**
- not later than one year;	2,078	1,542
- later than one year and not later than five years;	10,500	11,150
- later than five years.	17,294	18,672

Note 35.2 Total on-SoFP PFI service concession arrangement commitments

Total future obligations under this on-SoFP scheme are as follows:

	31 March 2018 £000	31 March 2017 £000
Total future payments committed in respect of the PFI service concession arrangements	112,268	117,831
Of which liabilities are due:		
- not later than one year;	5,702	5,563
- later than one year and not later than five years;	24,269	23,677
- later than five years.	82,297	88,591

Note 35.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the Groups's payments in 2017/18:

Group and Trust	2017/18 £000	2016/17 £000
Unitary payment payable to service concession operator	5,780	5,548
Consisting of:		
- Interest charge	1,690	1,774
- Repayment of finance lease liability	1,492	1,542
- Service element and other charges to operating expenditure	1,136	1,016
- Revenue lifecycle maintenance	571	391
- Contingent rent	891	825
Total amount paid to service concession operator	**5,780**	**5,548**

Note 36 Financial instruments

Note 36.1 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 NHS Improvement. 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.

The Group may also borrow from government for revenue financing subject to approval by NHS Improvement. Interest rates are confirmed by the Department of Health (the lender) at the point borrowing is undertaken.

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, except where any of these contracts have not been agreed. At the 31 March 2018 all of these contracts had been agreed. The maximum exposures as at 31 March 2018 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 Clinical 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.

Note 36.2 Carrying values of financial assets

	Loans and receivables	Assets at fair value through the I&E	Held to maturity at	Available-for-sale	Total book value
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2018					
Trade and other receivables excluding non financial assets	48,940	-	-	-	**48,940**
Other investments / financial assets	-	1,101	-	-	**1,101**
Cash and cash equivalents at bank and in hand	15,872	-	-	-	**15,872**
Total at 31 March 2018	**64,812**	**1,101**	**-**	**-**	**65,913**

	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total book value
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2017					
Trade and other receivables excluding non financial assets	49,274	-	-	-	**49,274**
Other investments / financial assets	-	1,101	-	-	**1,101**
Cash and cash equivalents at bank and in hand	7,407	-	-	-	**7,407**
Total at 31 March 2017	**56,681**	**1,101**	**-**	**-**	**57,782**

Note 36.3 Carrying value of financial liabilities

	Other financial liabilities	Liabilities at fair value through the I&E	Total book value
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2018			
Borrowings excluding finance lease and PFI liabilities	237,052	-	**237,052**
Obligations under PFI, LIFT and other service concession contracts	29,872	-	**29,872**
Trade and other payables excluding non financial liabilities	49,596	-	**49,596**
Total at 31 March 2018	**316,520**	**-**	**316,520**

	Other financial liabilities	Liabilities at fair value through the I&E	Total book value
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2017			
Borrowings excluding finance lease and PFI liabilities	171,277	-	**171,277**
Obligations under PFI, LIFT and other service concession contracts	31,364	-	**31,364**
Trade and other payables excluding non financial liabilities	56,100	-	**56,100**
Total at 31 March 2017	**258,741**	**-**	**258,741**

Note 36.4 Fair values of financial assets and liabilities

Note 36.5 Maturity of financial liabilities

	31 March 2018	31 March 2017
	£000	£000
In one year or less	271,453	210,492
In more than one year but not more than two years	2,163	3,182
In more than two years but not more than five years	12,608	11,704
In more than five years	30,296	33,363
Total	**316,520**	**258,741**

Note 37 Losses and special payments

Group and trust	2017/18 Total number of cases Number	2017/18 Total value of cases £000	2016/17 Total number of cases Number	2016/17 Total value of cases £000
Losses				
Bad debts and claims abandoned	26	53	-	-
Stores losses and damage to property	4	9	4	40
Total losses	**30**	**62**	**4**	**40**
Special payments				
Ex-gratia payments	64	17	81	25
Total special payments	**64**	**17**	**81**	**25**
Total losses and special payments	**94**	**79**	**85**	**65**
Compensation payments received		-		-

Note 38 Related parties

There were no related party transactions with individuals reported during the year.
The Department of Health is regarded as a related party. During the year the Group has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. For example :

NHS England
Public Health England
Health Education England
NHS Blood & Transplant
NHS Litigation Authority
NHS Business Services Authority
NHS Resolution
Brighton & Hove City CCG
Coastal West Sussex CCG
Crawley CCG
East Surrey CCG
East Sussex Healthcare NHS Trust
Eastbourne Hailsham & Seaford CCG
Frimley Park Hospitals NHS FT
Guys & St Thomas NHS Trust
High Weald Lewes & Haven CCG
Horsham & Mid Sussex CCG
Kings College Hospitals NHS FT
Oxford Health NHS FT
Pennine Acute Hospitals NHS Trust
Portsmouth CCG
Queen Victoria Hospital NHS FT
Royal Surrey County NHS FT
South East Coast Ambulance NHS FT
Surrey Downs CCG
Surrey & Sussex Healthcare NHS Trust
Sussex Community NHS Foundation Trust
Sussex Partnership NHS FT
Wandsworth CCG
West Kent CCG
Western Sussex Hospitals NHS FT

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

Note 39 Events after the reporting date

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

Note 40 Better Payment Practice code

	2017/18 Number	2017/18 £000	2016/17 Number	2016/17 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	144,804	454,027	151,449	424,709
Total non-NHS trade invoices paid within target	77,691	290,008	52,799	210,711
target	53.65%	63.87%	34.86%	49.61%
NHS Payables				
Total NHS trade invoices paid in the year	2,971	44,176	2,794	44,931
Total NHS trade invoices paid within target	1,251	26,555	956	22,123
Percentage of NHS trade invoices paid within target	42.11%	60.11%	34.22%	49.24%

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 valid invoice, whichever is later.

Note 41 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%.

Note 42 External financing

The Group is given an external financing limit against which it is permitted to underspend:

	2017/18 £000	2016/17 £000
Cash flow financing	**99,049**	**115,734**
Other capital receipts	**0**	**0**
External financing requirement	**99,049**	**115,734**
External financing limit (EFL)	111,220	118,187
Under / (over) spend against EFL	12,171	2,453

Note 43 Capital Resource Limit

	2017/18 £000	2016/17 £000
Gross capital expenditure	60,567	67,764
Less: Donated and granted capital additions	(1,037)	(88)
Charge against Capital Resource Limit	59,530	67,676
Capital Resource Limit	70,709	72,885
Under / (over) spend against CRL	11,179	5,209

Note 44 Breakeven duty financial performance

	2017/18 £000
Adjusted financial performance deficit (control total basis)	(55,558)
Breakeven duty financial performance deficit	(55,558)

Note 45 Breakeven duty rolling assessment

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
		£000	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		10,227	4,512	42	3,325	5,114	(450)	(44,819)	(68,501)	(55,558)
Breakeven duty cumulative position	(17,834)	(7,607)	(3,095)	(3,053)	272	5,386	4,936	(39,883)	(108,384)	(163,942)
Operating income		415,950	439,750	574,218	606,074	558,555	520,765	529,475	550,369	563,153
Cumulative breakeven position as a percentage of operating income		-1.83%	-0.70%	-0.53%	0.04%	0.96%	0.95%	-7.53%	-19.69%	-29.11%

Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, the Group'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.