Care that counts.
Improving health. Changing lives.

Annual report and summary financial statements 2010/11
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Introduction

When we formed our new trust in October 2010 by integrating South Downs Health NHS Trust and West Sussex Health (which had provided community services for NHS West Sussex, formerly West Sussex PCT), we brought together the services and staff from two organisations with the shared aim of offering new and improved healthcare services to our communities.

Our new trust is underpinned by our belief that by operating across a wider geographical area we can bring greater clinical expertise and economies of scale, whilst offering local flexibility through close working with primary and social care partners, and with the voluntary sector.

Our annual report and summary financial statements offer an overview of the work we’ve done and are doing to improve the health and wellbeing of our communities across Brighton & Hove and West Sussex. It introduces you as well to the new strategic direction and objectives adopted by the board to guide our work up until 2016. We have high expectations, but we know our patients and partners expect this and that our staff are committed to nothing less.

As we look forward, we know that we will operate in challenging economic circumstances, as will our partners and service users. At the same time, we need to respond to ever greater expectations for service access and quality on the part of our patients and carers, the Department of Health, our regulators, and our commissioners and staff.

Given these challenges, and our aim to become one of the leading community health providers in the country, we know that our ambitions and plans must be based on the ongoing support, commitment and hard work of everyone involved in health and social care across the areas we serve, notably our staff, but also:

- Our PCT commissioners at NHS Brighton and Hove and NHS West Sussex and the emerging GP commissioning consortia in our area.
- The doctors, nurses, therapists and support staff at our NHS partners, notably Brighton and Sussex University Hospital NHS Trust, Western Sussex Hospital NHS Trust, Surrey and Sussex Healthcare NHS Trust, Sussex Partnership NHSFT and South East Coast Ambulance NHSFT.
- Local primary care providers, from GPs and pharmacists, to dentists and optometrists and the staff who support them.
- Brighton & Hove City Council and West Sussex County Council.
- Our voluntary and community sector partners, including local LINKs.
- Our patients and patient groups

We thank them for their engagement with and support for our work.

Our future as a new trust delivering excellent healthcare in the community is now much stronger and is clearly mapped towards NHS foundation trust status (see later). It is ambitious but deliverable and will enable us to support patients more effectively. We could not be where we are today without our excellent staff, who ensure 9,000 patients every day get the care they need.

We thank them for their dedication and effort and look forward to a successful future.

Simon Turpitt, Chair

Andy Painton, Chief Executive
About the trust

Who we are and what we do
Sussex Community NHS Trust is the main provider of community healthcare across Brighton & Hove and West Sussex. We explain in this section of the report what we mean by community healthcare.

We employ more than 4,000 staff to provide essential medical, nursing and therapeutic care to over 9,000 people a day. We work with adults, children and families across Brighton & Hove and West Sussex. The proposal to integrate community services in East Sussex was not taken forward, mostly to allow us to focus our attention on our NHS foundation trust application.

In general, NHS care is provided close to where people live and work in the community by family doctors (GPs) and by community trusts like us. The big NHS acute hospitals work alongside primary and community services to offer specialist treatment and urgent emergency care that cannot be provided in the community.

Our teams work with our patients to help them plan, manage and adapt to changes in their health. We do this in a range of settings.

These include: mainly in our patients’ own homes; in GP surgeries; in the community hospitals, clinics and urgent care centres we run; in residential care homes, and in local acute hospitals.

We manage 358 inpatient beds (equivalent to a medium-sized district general hospital) for patients who are not well enough to be at home, but who do not need an acute hospital stay. These are located as below:

**West Sussex:** Arundel, Bognor Regis, Crawley, Horsham, Kleinwort (Haywards Heath), Midhurst, Salvington Lodge (Worthing), Zachary Merton (Littlehampton).

**Brighton & Hove:** Knoll House and Newhaven rehabilitation centre. We provide therapy and nursing support to Highgrove and Cravenvale care homes as part of our intermediate care service.

We also care for children and younger adults in our child development centres and at other centres including Chailey Heritage clinical services, Holly Lodge, Finches and the Cherries.

In line with government policy, good clinical practice and public expectations, we work with our local NHS partners to keep patients out of hospital where possible, or to get them back home from hospital without delay when this is safe and effective. If a patient needs ongoing care after a hospital stay, we can provide this either in their own home or in one of the intermediate care beds we run.

How we do it
If the previous section broadly describes our work, more specifically we cover:

- Community rehabilitation and support for people with complex health needs and long-term conditions, and end of life care.
- Community rapid response to assess and care for patients, helping to keep them out of hospital.
- Intermediate care, offering short term recovery and rehabilitation, again keeping patients out of hospital, or helping them to return home.
- Integrated discharge, working with patients, carers and hospital staff, to help a patient return home from a hospital stay as soon as possible.
• Health promotion, supporting people to improve their health and wellbeing.

This work is done by doctors, nurses and therapists, often combining to bring a multi-disciplinary approach and provide an integrated, seamless service to our patients. Our aim is to give people more choice about the care they receive and more certainty that when they need us, wherever they are, we will meet their needs with services that are safe, effective, compassionate and respectful.

The teams providing these services are supported by experts in areas such as infection control, medicines management, governance, information technology (IT), human resources (HR), service experience, finance and estates.

Adult community nurses
Care for patients with conditions such as multiple sclerosis (MS), Parkinson’s, tuberculosis (TB), motor neurone disease and chronic obstructive pulmonary disease (COPD)

Child development centres
Children & young people short break respite care

Children’s community nursing
Chronic pain management

Community equipment
Continence care

Dermatology
Diabetes services

Dietetics
Falls and fracture prevention

Health visiting
Healthcare at Ford prison

Intravenous (IV) nursing
Looked after children

Minor injury units
Musculoskeletal therapy

Neuro-rehabilitation

Occupational therapy
Palliative/end of life care
Phlebotomy

Physiotherapy
Podiatry

Prosthetics and orthotics
Psychological services

Respiratory & heart failure service

Rheumatology
School nursing

Screening services
Sexual health, including the community HIV team, teenage pregnancy and an erectile dysfunction service

Smoking cessation

Special care dental services
Specialist children’s services, including Chailey Heritage clinical services

Speech & language therapy

Tissue viability
Wheelchairs and specialist seating

X-ray
What we spend 2010/11

In 2010/11 our budget totalled £189m. Our funding came from NHS West Sussex (£125m) and NHS Brighton and Hove (£64m).

The overall NHS Brighton and Hove budget for 2010/11 was £461m. In percentage terms the main allocations were roughly as follows (see their website www.brightonandhovepct.nhs.uk for full expenditure details):

- Acute hospital care 42 per cent.
- Community healthcare 18 per cent.
- Primary care 14 per cent.
- Mental health 12 per cent.

The overall NHS West Sussex budget for 2010/11 was £1,280m. In percentage terms the main allocations were roughly as follows (see their website www.westsussex.nhs.uk for full expenditure details):

- Acute hospital care 52 per cent.
- Community healthcare 8 per cent.
- Primary care 13 per cent.
- Mental health 8 per cent.

What we spend 2011/12

For 2011/12 our budget is around £184m. The reduction in funding from 2010/11 reflects the transfer of adult neuro-rehabilitation beds to Brighton and Sussex University Hospitals, the reduction in PCT income, and the requirement on all NHS trusts to make efficiency savings, as set out in the Department of Health’s operating framework for 2011/12.

We will also incur further cost increases over the year, such as increased energy costs.

The communities we serve

The health of a community is often measured in terms of life expectancy, which is in turn influenced significantly by how wealthy the community is.

West Sussex is generally a healthy and wealthy county. Life expectancy for men and women is longer than the national average. However, there are variations in life expectancy of up to 13 years, depending on where people live. The population of West Sussex is relatively older than the rest of England, so the need to care for an older population has a major influence on how we work, the services we deliver, and how we plan for the future.

Brighton and Hove has an unusual population compared with the national picture, with relatively large numbers of younger people (20 to 44 years), and relatively fewer children and older people. At the same time it has relatively more people (particularly women) aged 85 years or over.

The city is also one of the most deprived areas in south east England. Life expectancy is below the national average for men and just above for women, and health inequalities exist within and between neighbourhoods. Almost half of the population has current or future health needs linked to lifestyle, including sexual health, teenage conceptions, alcohol related illness, substance misuse, cancer, smoking, circulatory disease, mental health and suicide.

The challenges we face

To deliver the mission and vision we describe in the next section of the report, we know we must truly become one organisation, secure better clinical engagement, align all initiatives across the trust and develop the commitment, capability and capacity of our workforce. In the process we will be better-placed to approach our challenges and opportunities.
A new mother getting support from a health visitor
Where we are going: our strategic direction

In 2011 the SCT board endorsed mission and vision statements for the trust, and set our strategic direction and objectives up until 2016. This represents a critical moment in our development, and shows how we aim to build and justify a reputation as one of the best community trusts in the land, meeting and exceeding the expectations of the people we serve. We aim to become an NHS foundation trust by 2013.

Our mission & vision
An organisation’s mission and vision statements should provide a short, simple expression of what it does and where it wants to be, together with a framework for developing strategy, planning and decision-making. We invite our service users, commissioners and staff to hold us accountable for how we behave and perform in the light of our mission and vision.

Our purpose: what we do
As described in this report, we have many staff with different specialities providing different services in a variety of locations. This range of activity is underpinned by our core purpose, which we have distilled into four key areas:

- We care for patients in the community, managing clinical risk with regard to the conditions we treat and because our patients and staff are spread across a wide geographical area.
- We provide care that helps keep a patient out of hospital when they don’t need to be there.
- We provide care that helps patients to leave hospital when they are ready.
- We work with people to improve their lives through self-care and prevention.

How we do it
To deliver our purpose, we work through the following mechanisms:

- Single point of access, making it easier for patients, carers, GPs and other healthcare providers to use our services in the right way at the right time.
- Rapid response, quickly assessing and meeting the needs of patients.
- Early supported discharge, getting a patient home from hospital.
- Multi-disciplinary teams, combining specialists from different backgrounds and organisations to manage patients with increasingly acute needs.
- Flexible bed-based services, making best use of our inpatient beds.

To understand more about what this means in practice, please see the features across the next few pages of this report.
Our strategic objectives

1. Develop flexible & innovative care based on patient-centred design
2. Improve patient experience and raise the quality of care
3. Sustain and improve our financial strength
4. Become a thriving foundation trust supported by excellent staff and public engagement

Our strategic direction
Our vision putting excellent community care at the heart of the NHS points to where we want to get to, and what we want to be. To move us in this direction, the board has set four strategic objectives for 2011/16:

1: Develop flexible & innovative care based on patient-centred design.
2: Improve patient experience and raise the quality of care.
3: Sustain and improve our financial strength.
4: Become a thriving foundation trust supported by excellent staff and public engagement.

Our customer charter
Our customer charter sets out our promise to our patients and their carers, and helps define how we will value and serve them as customers. It says:

We want you to:
- Know who we are, and
- Know how we can help you support your lifestyle choices, and
- Feel confident in our ability to care for and provide an excellent service for you.

To achieve this we will:
- Be welcoming and approachable.
- Communicate clearly, listen, and check our understanding.
- Be respectful and protect your dignity.
- Keep you informed.
- Take responsibility and demonstrate a ‘can do’ attitude.

The charter was developed by staff and patients in West Sussex, but has been adopted by the trust as a whole. We will deliver training to embed the charter, so it becomes part of our everyday activity and ethos, supported by a programme of staff communication and engagement, led by a nominated executive director.

Becoming an NHS foundation trust
We aim to achieve NHS foundation trust status by 2013. We see this challenging process as an opportunity to overhaul our strategic framework and develop an integrated business plan, in line with the guidance of the regulator, Monitor (set up in January 2004 to authorise and regulate NHS foundation trusts). It’s an opportunity, too, to raise the profile of the trust and strengthen our relationships with our stakeholders, including patients and staff.

We have appointed outside help to review the effectiveness of the board using the conceptual and evidenced-based framework Healthy NHS Board: principles for good governance. Our ultimate goal is to create and embed a culture of high performance across the organisation.
One of our key purposes is managing clinical risk in the community. Here we give examples of how we do this.

A breath of knowledge: community respiratory service

Breathing is something most of us take for granted. But when it goes wrong, the impact can be terrifying.

Our community respiratory service helps take the fear away by providing swift, practical help for people in Brighton and Hove living with chronic, long-term conditions like asthma and chronic obstructive pulmonary disease.

Our specialist nurses, physiotherapists, occupational therapists and rehabilitation assistants work with patients to assess need, agree treatment plans and provide ongoing treatment and support.

And, crucially, they can be there if things take a turn for the worse, helping patients to manage their condition and to stay at home and out of hospital.

“If one of our patients experiences a sudden worsening of their condition, we are at the end of the phone to provide help and support,” says lead clinical specialist and service manager, Libby Nice.

“Our goal is to improve our patients’ long-term lung health through tailored exercise programmes, education and practical help,” she adds.

“We want to keep people at home, where they want to be, rather than in hospital. And we know our service works.”

Specialist respiratory nurse Gemma Langridge has been with the service’s rapid response unit since October 2010.

“We’re available every day and we aim to get to patients a maximum of two hours after they call us,” she says.

“When we arrive we carry out a thorough assessment and make sure they have the medication they need.

Libby (left) and Gemma, from the community respiratory service
We can refer patients to our own occupational therapists for equipment needs and anxiety management, and to physiotherapists for chest clearance and breathlessness management. We can also send them to the pulmonary rehabilitation service to boost their stamina across a 10-week period.

“We’re all about helping patients remain at home, independent and free from anxiety. It’s hugely rewarding, as you really feel you are making a difference to people who, without our help, would be in and out of hospital.”

Fred’s story
Fred Jones, 76, has had chronic breathing problems, including emphysema, for over 18 years. He was first referred to our community respiratory team five years ago following a hospital stay.

“From the off, the pulmonary nurses were brilliant – they changed my inhalers and arranged for me to have equipment at home to help me to get around,” he says.

Two years ago, the team referred him to their twice-weekly pulmonary exercise classes. “Since then my strength has improved a lot. Meeting up with other people in similar positions has helped with my depression, too,” he adds.

A friend in need: community neurological rehabilitation team

“You can feel overwhelmed, isolated and literally without a voice after a stroke,” says Kirsty Maguire, speech & language therapist with our community neurological rehabilitation team (CNRT).

Many stroke patients will have speech and language difficulties, known as aphasia,” she explains.

“We provide expert help to stroke patients who have returned home following their hospital stay but I was concerned about the recovery prospects of people after they leave our care. Not all of them were able to get on with life unsupported. I was sure more could be done.”

Kirsty’s response, with the support of colleagues Ana Amaya (speech & language therapist) and Jo Butler (rehabilitation support worker) was to set up a befriending scheme through which stroke patients who’d made good progress would help those at the start of the journey towards recovery.
From direct personal experience, befrienders can offer information and support. More than this, they offer hope and can help rebuild self-esteem.

Kirsty’s first batch of befrienders completed their training in 2010. Now there’s a team of 14 volunteers able to visit patients in Brighton and Hove once a week across six months, although they can choose to give more time. The CNRT, meanwhile, supports the befrienders via a monthly ‘catch-up’ meeting.

The scheme is gathering its own momentum, says Kirsty. “Many patients who have had a befriender are saying they would like to become one themselves.”

Nicole’s story
Nicole Munn had a stroke three and a half years ago, aged 45, when her youngest son was two. She completed her befriender training in 2010 and sees four people who have speech and language difficulties resulting from stroke for at least two hours each a week.

“I help by speaking and listening to them and giving them self-confidence” she says. “Some befriendees live alone, so it helps to have someone to practice speaking with. It takes time to realise that if you’re struggling to find the right word, your brain will eventually find an alternative.

“I take the bus into town with one of them and encourage all to go out each day, even if it’s just down the road, and to speak to someone, even if it’s just ‘hello’.

As a mother of a young child, I’ve had to get on with things, but if you don’t have that, it’s all too easy to stay at home and not see anyone.”

Stroke care ranks amongst the best
Stoke support services in Brighton and Hove were rated amongst the best in England by the independent watchdog, the Care Quality Commission.

We are improving the provision of stroke rehabilitation services across West Sussex, so we offer equal access to quality services.
One of our key purposes is preventing avoidable admissions to hospital. Here we give examples of how we do this.

**A fresh take on intravenous therapy**

If intravenous therapy (IV) nurse specialist Dawn Hart has her way, we’ll overhaul the way we care for patients who need prescribed medications delivered directly into the bloodstream via a vein.

Since joining SCT in January 2009 she has promoted the use of midlines in our local hospitals for short term IV therapy treatments. As a result, she says, hospitals are now much happier to discharge patients with them more quickly than ever before.

“Midlines are the up and coming device for the community IV patient,” she says. “They can be left in place for several weeks rather than three days like a cannula. And they don’t need an x-ray after insertion.

“Using a midline can make the difference between staying in hospital, or being able to return home.”

Dawn promotes the use of midlines in our local hospitals for short term IV therapy treatments. As a result, she says, hospitals are now much happier to discharge patients with them more quickly than ever before.

Longer term vascular access devices such as PICCs (peripherally inserted central catheter) and STLs (skin tunneled line) are used for the delivery of treatments such as chemotherapy and these lines need to be ‘flushed’ every week between treatments.

To do this, we run a number of weekly ‘flush’ clinics for this group of patients so they can book an appointment that suits, rather than waiting in for a nurse to come to them or travel to hospital.

Tracy Beech, 38, has been receiving chemotherapy for Hodgkin’s disease since late October, and has attended a ‘flush’ clinic since early November.

“I go alternate Wednesday mornings to have my line flushed and make sure that there is no sign of infection. It takes about half an hour, and Dawn or her nurse colleague Kelly Roberts always ask me how I’ve been. They’re so lovely and really look after you.

“Having chemo can be a daunting, even lonely experience. It’s good to be looked after by people who really understand the side effects and are so encouraging and supportive.”
A joined-up approach to urgent care

One Call/One Team
If excellent healthcare should be seamless for patients, look no further than our new One Call/One Team service.

The service brings together different organisations and healthcare experts to help people with an urgent care need to stay at home or to support them as they return home from hospital.

Operating around the clock, One Call’s patient line takes calls from patients and NHS staff across coastal West Sussex. Meanwhile the GP line mainly receives calls from GPs, paramedics, accident & emergency staff and community nurses.

“Our phone lines are staffed by clinicians who are able to quickly assess what patients need for urgent treatment,” says Nicki Leighton, who leads this multifaceted service.

“Life-threatening situations are always dealt with via 999 and a hospital admission,” she adds. “But by working together we are able to work out the best course of action for patients who, whilst serious, do not necessarily need to go to accident & emergency.

“A GP seeing a patient on an urgent home visit can phone One Call and request a paramedic to visit the patient within the hour. Our aim is to meet patient’s urgent care needs in the right place, at the right time, first time.”
The concept behind One Call/One Team is elegantly simple – to offer a single point of access to all community and hospital urgent care services. But getting it right is inevitably complicated.

A team effort is involved, and the range of expertise is impressive. “One phone call to us and we can call upon paramedics, geriatricians, GPs and others to formulate a package of care,” says Nicki.

“One of our main challenges is to raise awareness about what we can do. We aim to dispel the myth that it is easier to admit a patient to hospital than to look after them in the community, although if hospital turns out to be the best option we can help organise admission and transport there.

“Managing demand

Our recently established demand, capacity & resilience team is making a big difference to the ways the local health system copes with surges in demand.

The numbers of people requiring treatment can fluctuate. A rush of seasonal flu cases, for example, can see a lot more patients suddenly entering the system, with a knock-on effect all round. We can predict some of this, but it’s not a precise science. So our demand, capacity & resilience team is a vital part of a more flexible and responsive way of working.

The team provides local health providers with a single point of contact to raise issues when pressure in the system grows and is helping us develop systems and processes to support services to accommodate demand.

One Call/One Team teamwork at its best

The team is made up of:
- Sussex Community NHS Trust
- Coastal West Sussex Federation
- NHS West Sussex
- South East Coast Ambulance NHSFT
- West Sussex County Council
- Western Sussex Hospitals NHS Trust
- West Sussex Forum
- Harmoni

“Our aim is to meet patient’s urgent care needs in the right place, at the right time, first time”

Some of our One Call/One Team contingent

“One phone call to us and we can call upon paramedics, geriatricians, GPs and others to formulate a package of care”
One of our key purposes is minimising the time a patient spends in an acute hospital. Here we give examples of how we do this.

A home before home
Day and night our team at Salvington Lodge near Durrington cares for up to 27 inpatients, helping them get well enough to return home.

At the helm of the multi-skilled team is modern matron Simon Neale. “Our 15 nurses and 25 support staff offer a quick, intensive burst of nursing as well as physiotherapy and occupational therapy,” he says.

Salvington Lodge is one of the trust’s community hospitals, through which we manage our intermediate care service beds across our area.

Here we care for patients who are recovering after a spell in one of the local acute hospitals, such as Worthing Hospital or the Royal Sussex County Hospital, or who need extra nursing care but do not need to be admitted to these larger acute hospitals. We also provide palliative care as and when needed.

Simon is proud that his staff are happy to go the extra mile for patients. “It’s often the little things that count to the mainly elderly patients we look after – and their families. We aim to treat people with dignity and respect and to help them feel safe and special while in our care,” he says.

An excellent recent report by the independent healthcare watchdog the Care Quality Commission, says Simon, pays tribute to the service offered by the whole team. “I get great satisfaction from being part of a hospital that gives such excellent care to our patients across West Sussex,” he says.

Vikki Peters can confirm all this – and more. This April she ran the Brighton marathon to raise funds for Salvington Lodge in memory of her grandfather, who spent his final days at the hospital.

“When my granddad was at Salvington, the staff were so friendly and welcoming and gave us all such wonderful care and support. They really helped my family during a very difficult time. I just wanted to give something back,” she says.

Vikki’s 26-mile run raised a grand total of around £450, all of which is now on its way to the hospital.

Vikki Peters, a friend of Salvington Lodge
“We’re so grateful for donations like Vikki’s,” says Simon. “We haven’t yet decided exactly how it will be spent, but we can always use money to improve what we offer our patients.”

Smoothing the path for diabetic children

Two of our children’s nurses are working to transform our care of children and young people with type 1 diabetes by introducing an innovative insulin pump.

“The pump delivers a more accurate dose of insulin than traditional injections,” says paediatric diabetes nurse Harriet Godwin. “And the better we manage insulin during a person’s early years, the lower the risk of diabetes-related problems in later life,” adds team-mate Inderdai Gilbert, better known as Dolly.

And when these problems can include heart disease and stroke, which can in turn require hospital treatment, you can see why getting it right early on has benefits all round.

The team’s patients are aged from 3-17 years old. All have type 1 diabetes – a lack of insulin in the body unrelated to lifestyle choices or obesity.

And the team’s dedication does not go unnoticed by the youngsters and their families. Pam Weisner, whose 16-year-old daughter has diabetes, said: “I cannot give enough praise to the excellent service Harriet gives. She is really good at her job and my daughter thinks the world of her.”

The mobile phone-sized insulin pumps deliver a measured dose of fast-release insulin into the bloodstream through a tube.

“Insulin pumps are not for everyone as they need careful management,” says Harriet. This means that of the team’s current 100 or so patients, only around a quarter have so far opted for the electronic device over traditional injections.

“Younger patients get used more easily to pushing the keys on the pumps,” adds Dolly.

“But older patients can find having an external device an embarrassment, even though it can safely be detached for a short time each day.”

Other potential problems – like a kink in the tube – mean the initial management of patients who use the devices is intense.

“For the first week or two we speak to the family every day, says Harriet. “After that we tend to see them in clinic every three months. But we are always on hand to help.”

Dolly adds: “It’s rewarding to watch our patients grow up healthy in spite of this potentially life-threatening condition. It’s also satisfying to be able to offer them new treatment options.”
One of our key purposes is educating to improve lives through self-care and prevention. Here we give examples of how we do this.

**Time to Talk**

If you’re unable to work because of stress or depression, it can damage your health and wellbeing in so many ways.

So we’re proud that in the 30 months up to December 2010, our West Sussex based Time to Talk (T2T) service helped 395 people to return to work, a performance that put T2T into the top five of comparable services across the UK.

T2T offers psychological therapies and practical help to adults with stress, depression, and anxiety.

Abby Quick, a trainee cognitive behavioural therapist (CBT) with T2T, uses CBT to boost the coping skills of clients, some of whom are either having difficulties at work or are looking for a job.

Abby explains: “CBT theory suggests that our life experiences do not directly cause us distress. It’s our interpretations of them that can negatively influence our emotions and ultimately our responses and behaviours.

“We work jointly alongside our patients – considering both past and current factors that have influenced their individual belief systems.”

“CBT is a collaborative journey of self-discovery that aims to alleviate distress and promote independence through the development of long-term coping strategies. It is a proven, highly effective treatment.”

Employment specialist Paul Griffin is another vital piece in the employment jigsaw for T2T clients.

“I can help anyone who has issues at work,” he says. “From mediating between you and your employer to supporting you to get legal help. And if you are looking for a job, I can give you information on getting help with interview skills etc.

“During our initial consultation I give clients ideas of what I can do for them. I then provide help as needed, over the phone or face-to-face. It’s all about helping you find your own way out of your situation.”
Jo’s story
Jo Hollands, 26, says Paul and Abby’s help has been a life-saver.

“My GP referred me to the service last September. I have always been prone to depression and anxiety, but working long hours in a difficult situation was making things worse.

“During my initial phone conversations with T2T, my work issues came up and I was referred to Paul, who called me a day later. I was also referred to Abby for CBT.

“Without Paul and Abby’s help I would have withered away. I’ve had CBT sessions with Abby and would recommend it to anyone. And Paul has given me the confidence to find a new job where I feel much more valued and settled.”

T2T employs 160 staff, 140 of whom are directly involved in offering psychological therapies to adults across West Sussex with stress, depression, and anxiety.

These include group and 1-to-1 supported self help, cognitive behaviour therapy, interpersonal therapy and counselling. Services are provided in GP surgeries or community venues, with day time and evening appointments.

If you live in West Sussex and would like to use our Time to Talk please talk first to your GP.

Kick the smoking habit
Stephen Warden, 69, is a positive inspiration, having quit smoking after half a century of addiction.

And when smoking is the nation’s single biggest cause of preventable disease, disability, and death, Stephen’s example really matters.

“At one time I was on up to 80 cigarettes a day, but haven’t touched tobacco for five months now. I feel so much better. I’d recommend it to any smoker,” says Stephen.

“I couldn’t have done it without your help,” he adds, attributing his success to the specialist advice and support from our stop smoking team.

Stephen is just one of the nearly 6,000 people we helped to give up tobacco in Brighton and Hove and West Sussex last year.

Our teams use a combination of information, encouragement (either in groups or one-to-one sessions) and medication to support smokers through the inevitable ups and downs.

“With our assistance, you are four times more likely to succeed at quitting than by going it alone,” says the service manager Andy Vincent.

If you want help to quit:
• Brighton and Hove residents please call 01273 267397.
• West Sussex residents please call 0300 100 1823.

You’re the expert
The expert patient programme (EPP) is a free NHS course designed to help people with a long-term health condition develop the motivation and skills needed to take control of their lives.

“The emphasis of EPP is on boosting people’s self-confidence and providing them with the information they need to take control of their futures and develop equal partnerships with health and social care professionals,” says service lead Karen Aylmore.

For more information on EPP email: sc-tr.epp@nhs.net
We strive to deliver safe and effective healthcare because it’s the right thing to do and because we need to meet legislative requirements and good clinical practice.

We also need to be accountable for our work and how we manage taxpayers’ money. This section of the annual report covers some of the ways we manage and account for our performance. Please note that because we are a new trust, and because the environment in which we work is changing, it is hard to make clear and simple comparisons with performance in previous years.

Registration with the Care Quality Commission

The Care Quality Commission (CQC) is the independent regulator of health and social care in England. It requires NHS trusts to meet essential standards of quality and safety. All NHS trusts must be registered with the CQC’s new, tougher regulations. Sussex Community NHS Trust secured CQC registration, enabling us to be established last October.

The CQC continuously monitors compliance, which means we need to be able to demonstrate that we meet the required standards. Our board receives regular reports at its public meetings on our CQC compliance, and non-executive directors hold the executive directors to account where areas of concern arise.

Because a number of outstanding actions were listed on the NHS West Sussex Standards for Better Health registration, ten of the CQC’s core outcomes were registered as fully compliant and six as non-compliant. Good progress has been made against all outstanding action plans, but the board required additional evidence to confirm a final position by the end of the financial year and will continue to monitor any impact on our registration status.

Balancing the books

NHS trusts are required to deliver a small financial surplus at the end of the financial year. We achieved this, and continued to deliver high quality care, despite having to reduce our spending over 2010/11 by around £9.6m.

For 2011/12 our budget is £184m, and over the year we will have to reduce our costs by around £14.5m to balance the books. Our approach is shaped by what the NHS calls QIPP, standing for quality, innovation, productivity and prevention. QIPP aims to ensure that the NHS reduces inefficiencies whilst maintaining quality as described by Lord Darzi in his report High Quality Care for All. Through our QIPP work we will work within the resources we get from our commissioners, reducing costs yet delivering quality care and improved patient experience.

Key performance indicators

Our performance is reported regularly to the board, as can be seen on our website at www.sussexcommunity.nhs.uk under About Us.
Infection rates
Patient safety is a top priority, and one key issue reviewed by the board is the number of patients who acquire a healthcare related infection whilst in our care.

Clostridium difficile (often called C. Diff) are bacteria that are naturally present in the gut of many people, and do not generally cause problems. However, some antibiotics used to treat infections can interfere with the balance of ‘good’ bacteria. When this happens, C.diff bacteria can cause illness such as diarrhoea and fever. Infections can be reduced by good hygiene, such as washing hands regularly and cleaning surfaces.

- In 2010/11, only 18 patients acquired a C.Diff infection in our units.

MRSA (which stands for methicillin-resistant staphylococcus aureus) is a common skin bacterium that is resistant to a range of antibiotics. MRSA infection happens when the bacteria gets into the body through a break in the skin. People in hospital can be at risk of MRSA infections because they often have an entry point for the bacteria, such as a wound or a catheter. They also tend to be older, sicker and weaker than the general population, which makes them vulnerable.

- In 2010/11, just three patients were diagnosed as having an MRSA infection in one of our bedded units. No new cases were recorded from November 2010 until the end of the financial year in April 2011.

Serious incidents
Another way of measuring patient safety is the number of serious incidents that occur in our services, how quickly we investigate and how we learn from them. Over the year the number of new serious incidents reported was 32. Nine of these were in the former South Downs Health area, and 23 in the former West Sussex Health area. All of those in the former South Downs Health area were investigated and reported to NHS Brighton and Hove within 60 days of incident; the corresponding figure in the former West Sussex Health area was 74 per cent.

Our Being Open policy encourages staff to report incidents openly and honestly. To support this we raise awareness, provide training and have developed a new database to improve reporting and allow better analysis. The trend over the previous year shows a decline in the frequency of incidents at this time.

Improving the patient experience
Providing a good experience of care is a priority, and our performance is again regularly reviewed by the board.

One figure the board reviews regularly refers to patients whose transfer of care is delayed, either from our own units or to our units from other settings. We are sorry that we did not hit our target in this area over the year. However, our performance on delayed transfer of care has improved, thanks in part to the hard work of our demand, capacity and resilience team described earlier.
Smoking cessation
Across West Sussex and Brighton and Hove, the NHS works to help people give up smoking. Our own stop smoking service works directly with quitters, and trains and supports other NHS organisations to deliver their own stop smoking services. Although around 6,000 people were helped to give up during the year, we collectively did not hit our challenging target for the number of quitters. However, we performed better than the NHS average for the number of people who are still not smoking four weeks after committing to quit.

Anyone wanting to quit can contact the service direct on 01273 267397 (Brighton and Hove residents) or 0300 100 1823 (West Sussex residents).

Protecting your confidentiality
Our staff need to collect information from patients to provide patient care, but we then need to manage this information carefully to protect patient confidentiality. All staff must ensure that they collect and use confidential information in line with the highest standards, whether the information is held on paper (forms, files, diaries, reports) or electronically (laptops, USB sticks, CDs, tape, microfiche).

If there’s a loss of patient data or a breach of confidentiality, we investigate and take rectifying steps if needed. We judge as well whether the loss should be declared a serious incident, and reported to the South East Coast strategic health authority and the independent information commissioner. In 2010/11 we declared six such incidents. In one case, a member of staff left confidential paperwork on top of a car and drove off. In another, patient records went missing after they had apparently been removed by a staff member without signing them out.

Patients, service users and the community
We are always pleased to see members of the public at meetings in public of the SCT board. These meetings take place every month at various locations. The board papers are published online in advance of the meetings.

The engagement of local people and service users helps shape our services. We have set up a steering group to produce a patient experience strategy and are planning a generic patient experience survey with core questions that services can tailor to fit their own needs. We have a group of service users who contribute to our work, for example by speaking at staff induction and reviewing services.

Our teams gather patient feedback in a variety of ways, and we are analysing the results of a review of patient experience activity and a survey of patient support groups attached to the trust. Most services measured their patients’ experience over the year through surveys, questionnaires, patient forums, user groups and individual interactions. Feedback has led us to improve information in our osteoporosis & falls prevention service in Brighton and Hove, and change clinic times to accommodate patients who use bus passes with restricted hours.

Anyone can express a view about our services, find out more or get a problem dealt with through our patient advice & liaison service (PALS). Over 2010/11, our PALS service dealt with 245 enquiries on a range of topics (see below). And if you are unhappy about the quality of service you receive, you can also use our complaints process. We take all complaints seriously, investigate them fairly and in full and make changes where appropriate. We make it clear that if a user makes a
complaint this will not affect their quality of care. In 2010/11 we received 244 complaints about our services.

Our PALS and complaints teams both dealt with enquiries about speech & language therapy and our wheelchair service. In response, the wheelchair service has cut waiting times by doing telephone assessments and arranging for patients to be seen ‘out of area’. Our speech & language therapy service has improved communication with service users.

Eliminating mixed-sex accommodation
We have eliminated mixed sex accommodation in our trust. There may be men and women patients on the same ward, but they will not share the same sleeping area, toilets or bathrooms. Every unit has separate facilities close to their bed.

Equality and equity
Improving health and reducing health inequalities is central to our work. We have a duty to recognise and meet the diverse needs and human rights of service users, local communities and staff. We produced our single equality scheme in May 2010, initially as an umbrella scheme for the two predecessor organisations and subsequently as a unitary scheme. This seeks to ensure that we meet our equality duties under the law and take a strategic approach to identifying and meeting people’s diverse requirements across gender, age, race and ethnicity, gender identity, religion and belief, disability and sexual orientation. Our equality & diversity board monitors progress against the actions listed in the scheme.

We continue to work with partners, staff, service users and representative groups to ensure we meet our equality duties. This includes producing the 2010 equality charter for Brighton and Hove, and being at Brighton Pride 2010 to promote SCT as a committed employer of and provider of service to the lesbian, gay, bisexual and transgender (LGBT) community. Other milestones passed include:

• Securing Stonewall support to establish a trust-wide LGBT network, which had its first meeting in February 2011.
• Our black and minority ethnic network led consultation on the single equality scheme.
• Creating a database to match service use against local demography.
• Analysis of workforce and service user data to help establish equality and human rights objectives for 2012.

We can provide all patient information in translation, large print, Braille, easy-read format or on audio tape. We have a contract to provide interpreters for patients who speak other languages.

Emergency preparedness
The emergency plans of our predecessor organisations were combined into one plan over the year to ensure we can respond to major incidents in our local area or over a wider area. Business continuity plans have been put into a common format across the new trust and self assessed for alignment to the British Standards Institute BS25999. Our major incident plan is regularly tested.

We coped well during the period of heavy snowfall in December 2010. Problems experienced during the previous period of heavy snow were not repeated, for example, snow was rapidly cleared from the Brighton General Hospital site.
Sustainability
We produce waste that needs special treatment, use cars to move staff and equipment and have over 90 locations we need to heat, light and power. All this creates environmental problems, including carbon dioxide emissions. This reality, together with legal duties and our need to cut costs, drives our five-year sustainability plan adopted by the board in July 2010. This commits us to:
• Reduce carbon emissions by 25 per cent.
• Achieve zero general waste to landfill.
• Reduce our business mileage by one quarter.
• Encourage sustainable procurement.
We have signed up to the NHS Good Corporate Citizenship assessment framework, and our sustainability steering group, chaired by an executive director, oversees our work across key areas. We have recruited an environmental manager, set a carbon baseline, and are developing an environmental management system to ensure compliance with all environmental legislation. A network of green champions and beacon sites is helping to raise awareness and promote greener behaviour. Through simple good housekeeping, Portslade health centre (in collaboration with the GP practice sharing the premises) has cut energy use by 15 per cent since January 2010.

The patient environment action team (PEAT)
The PEAT programme was established nationally in 2000 to assess NHS organisations on the environment in which patients are treated, the quality of food and privacy and dignity. Every inpatient location with more than ten beds is assessed annually and rated excellent, good, acceptable, poor or unacceptable. PEAT is a self assessment process, with validation visits to a small number of sites. All our centres received assessments of good or excellent for 2010/11, with more ratings of good and excellent than in 2009/10.

Our partnerships
Our partners include:
• GPs in their practices across our area.
• Brighton and Sussex University Hospitals, Surrey and Sussex Healthcare and Western Sussex Hospitals).
• Other NHS partners (notably Sussex Partnership NHS Foundation Trust and South East Ambulance NHS Foundation Trust).
• Our social care partners, notably Brighton & Hove City Council and West Sussex County Council, and local hospices.
• People working for the local community, including elected representatives, local involvement networks (LINks), and local patient groups.
• The voluntary and community sector across the area we serve, including HIV groups, and groups working with older people.
• And of course, our service users and their carers.
We play our part in local health and wellbeing partnerships, which have oversight of services in their areas and which contribute to the strategic plan for improving wellbeing.

Partnership with local councils is vital to the delivery of services for children, and we work together to develop a single, strategic plan, use common tools and processes, and make best use of our resources. Our aim is to improve the ways we support the most vulnerable families and children at the earliest opportunity, and to provide seamless services.
Highly motivated and skilled staff are key to the delivery of our strategy and we recognise and value our staff as our greatest asset.

We seek to recruit high quality staff, and then develop them by giving appropriate support and by clarifying expectations through jointly agreed objectives, supervision and performance reviews. We seek as well to show staff how much we value them through good quality management, excellent internal communications and appropriate means of reward and recognition, including achievement awards.

**From integration to transformation**

Our people management agenda during 2010 was dominated by the creation of the new trust. This complex and far reaching change required human resources (HR) management at every level, including work to integrate policies and management practice, manage the legal process of transfer, and support managers and staff in a changing and changed situation.

We’ve worked hard to define and shape the culture of the trust and to embed this culture and new ways of working across the organisation. Changes to leadership structures have sought to give frontline staff increased flexibility, scope and responsibility within a devolved accountability structure. We published our strategies for workforce and organisational development in October 2010, aligned our HR teams to the new clinical management structure, and developed a business partner approach to support our line managers.

Like many NHS trusts, controlling what we spend on staffing is vitally important. We have achieved savings during the year through holding vacancies, but we have made sure that this has not put patients or services at risk through our establishment management programme, which involves executive level scrutiny of the risks involved if any post is left unfilled.

**Workforce information**

Providing workforce data has been a challenge because our predecessor organisations ran separate electronic staff record (ESR) databases. The processes of integration have increased the number of workforce data requests, and the time needed to report them. Significant work is needed to develop the ESR systems to reflect our new trust, streamline reporting and integrate the two databases.
effectively while continuing to produce regular information reports.

**Key HR targets**
The board receives regular reports on HR management and performance against workforce targets. The year end figures for some key areas were:

- Annualised turnover rate 13.5 per cent, half a per cent above target.
- Sickness rate 3.59 per cent, just over our target of 3.5 per cent (a reduction compared with previous months). This equates to an average of 9.2 work days lost per employee through sickness this year.
- Vacancy rate for permanent staff 15.9 per cent.

Over the year our recruitment team:

- Advertised 1,005 posts.
- Dealt with 9,286 job applications.
- Carried out 1,891 criminal records bureau checks.

South Downs Health was the first NHS organisation in England to be recognised by the government for its work to address age discrimination, and achieved the Two Ticks symbol in 2000 for its commitment to the employment of disabled people. We maintain these commitments, having an older workers’ policy, no fixed retirement age and flexible retirement options.

We take the health and welfare of our staff seriously, and in 2010 brought the whole of our occupational health service back inhouse. We focused our health and wellbeing efforts on the top 20 hotspots for staff sickness.

**Leadership, staff supervision and development**

Our senior leaders come together regularly in a senior leadership forum, sharing best practice, and contributing to the development of the trust and its services. In 2010 we established a clinical engagement board to ensure that our clinical leaders are directly involved in shaping our services. In 2010 we launched a development programme for the board, including 360 degree feedback for executive and non-executive directors.

An interim supervision policy was developed for the new trust during the year, recognising the benefit of supervision in supporting staff in their roles.

We’re working to improve performance on appraisals following an audit showing that only 49 per cent of staff had been appraised within the last year.

A wide range of mandatory training supports staff to deliver safe services. Programmes cover areas such as fire safety, infection control, resuscitation, manual handling, safeguarding children & vulnerable adults, equality & diversity, and health & safety. Training is delivered flexibly, including group and online options. Again, we’re working to ensure that all staff do the appropriate training.

**2010 staff survey**

The annual staff survey conducted by the Care Quality Commission gives us an important insight into what our staff think about working for us. The 2010 survey covered all occupational groups, from doctors and nurses to clerical workers and other support staff. It asked questions in areas such as appraisals, training, making a difference to patients, job satisfaction, management, stress, and experience of violence and abusive behaviour.
Over 2,000 of our staff responded, a response rate of 57 per cent. Their answers were benchmarked over time and against similar organisations. Whilst our ranking showed improvement in some areas, we had lost ground overall since 2009. This is disappointing, though not surprising, given that our integration and the restructure of many services was underway as the survey took place. However, the results give us a focus and direction for making progress, and we are taking steps to deliver improvements.

Positive feedback showed that our staff are:

• Less likely than the NHS average to experience work-related stress or say they intend to leave their jobs.
• More likely to say that their role makes a positive difference.
• More satisfied with the quality of work and patient care they deliver when compared with the 2009 staff survey.

But our staff also say that we are not performing well enough in key areas such as appraisals and internal communications, and that they felt less able to contribute towards improvements at work compared with the 2009 staff survey.

Working with staff representatives
We have good relationships with staff representatives. We have an integrated joint staff negotiating committee (JCNC) and have aligned lead representatives to care groups, increased frequency of our meetings, and a task and finish work group to oversee the integration process. Staff representatives are directly involved and consulted over every organisational change.

HR action plan 2011/12
Our HR and organisational development strategy is being refreshed in line with our overall business and clinical strategies and a detailed action plan will be agreed by the board. Key priorities already identified include to:

• Complete the restructure of all services following integration.
• Develop a five-year workforce plan that predicts staff numbers and costs on an annual basis.
• Engage with staff through effective appraisal and supervision.
• Improve internal communications.
• Improve leadership through talent management and succession planning.
• Boost productivity by improving staff health and wellbeing, and reducing absence.
• Implement schemes to reduce staff numbers in line with QIPP without compromising quality, avoiding compulsory redundancies where possible.
• Reduce the costs and volume of agency staff use.
• Recognise and acknowledge the contribution of staff through achievement awards and by sharing best practice from plaudits.
Managing the trust: governance arrangements

The board
Sussex Community NHS Trust is run by a board of directors, who set strategic direction and then monitor performance and progress. The board meets in public twelve times a year. You can see details of the board meetings, including public papers, on our website www.sussexcommunity.nhs.uk. The board is made up of:

- Non-executive directors, who use the skill and experience gained from the private, public and voluntary sectors to help run the trust, but who do not have day-to-day managerial responsibilities within the trust, and
- Executive directors, who are paid employees with clear areas of work responsibility within the trust.

Mo Marsh left the board during the year, as her term of office as a non-executive director came to an end after eight years. Dr Sarah Crosbie also left the board as her role as interim medical director ended with the substantive appointment of Dr John Omany. The board thanks them both for the substantial contribution they both made as board members.

The members of the board as at March 2011 were:

**Chair**
Simon Turpitt
Appointed April 2008 - April 2012
Spent most of his working life in industry, for 15 years as managing director of a multi-million pound food manufacturing company supplying supermarkets and catering outlets. Has lived and worked in different countries helping new businesses to start or deliver change management, and also developing strong business and customer relations.

**Non-executive directors**
James Cook
Appointed February 2009 - January 2013
A chartered accountant (KPMG) who has held senior financial and general management positions in a number of multinational companies. Built and managed new businesses and has extensive experience of mergers and acquisitions and negotiations.

Professor Darrell Evans (associate non-executive director)
Appointed July 2010 - June 2011
Professor of developmental tissue biology, head of anatomy and associate dean at Brighton and Sussex Medical School. Involved in the development of the medical school curriculum and management of the first two years of the medical course. Researches on musculoskeletal tissue development and repair, and teaching pedagogy. International profile in the field of anatomy.

Mark McJennett
Appointed April 2010 - April 2014
Background in industry, particularly multi-outlet retail management, sales and marketing. Has worked extensively and is a specialist in the area of consumer insight. Former sales and marketing director with the brewing and public house company Shepherd Neame before launching his own sales and marketing company in 2007. Non-executive director of a social housing trust.
Andrew McStravick  
Appointed April 2010 - April 2014  
Over 20 years’ experience in organisational management and business transformation. Led a series of corporate restructuring and merger integration programmes whilst director, group operations at the London Stock Exchange. Now an independent consultant, helps companies deliver strategic change and operational excellence, and provides specialist advice on regulatory compliance and operational risk management.

Colvin Rae  
Appointed December 2007 - November 2011  
Spent almost 20 years as a senior executive in international banking. In excess of ten years as CEO specialising in change management/business turnaround in a number of high profile businesses. Held senior executive positions at the London Stock Exchange and Royal Sun Alliance delivering business transformation. Now managing director of a consultancy helping organisations deliver sustainable change.

Chief Executive  
Andy Painton  
Became chief executive in June 2009. 12 years’ director and chief executive experience, most recently with Stonham housing association, England’s largest provider of care and support to vulnerable, single homeless people. Led a restructure which saw Stonham emerge as a market leader in its field.

Executive directors  
Clodagh Warde-Robinson  
Deputy chief executive/executive director of strategy and new business  
Held senior executive positions at Goldman Sachs and Lehman Brothers International. Experience of community and health-based projects, having been director of an innovative HIV/AIDs initiative in Uganda and acted as a business consultant for non-governmental organisations and social enterprises. MBA qualification from Oxford University. Prior to her current role, which she took up in early 2010, was a non-executive director with South Downs Health.

Dr John Omany  
Executive medical director  
Palliative care consultant, trained as an oncologist. Part-time medical director of Surrey PCT. Previous roles as medical director of Surrey Health and Woking PCT and medical director of Woking and Sam Beare hospices. End of life care clinical advisor at South East Coast strategic health authority.

Andrew Harrington  
Executive director of operations and clinical services/ chief nurse  
Joined South Downs Health as interim director of nursing and governance in 2009. Moved into current role in 2010. Responsible for nurse leadership, clinical education and training. More than 20 years’ clinical and managerial experience began at Croydon’s Mayday University Hospital, where he trained as a general nurse. Has specialised in palliative care.
**John O’Sullivan**  
Executive director of finance and facilities  
Has been finance director since 1997, responsible for finance, information, purchasing and agreements about the levels of service we provide. Acting chief executive between March 2006 and May 2009. Has worked in the NHS for 26 years, all his career, and has previously worked at regional level and in community and acute services.

**Board committees**  
The board is supported in its work by a number of permanent sub-committees. When SCT was set up in October 2010, the following supporting committees were established: Integrated Governance & Audit, Finance, Remuneration, South Coast Audit consortia board, and Charitable Funds.

This committee structure was an interim arrangement to allow the new trust to meet its organisational requirements, operational governance requirements, clinical governance requirements and corporate governance requirements.

Towards the end of the 2010/11, the board adopted a new structure, which includes: Audit, Quality & Risk, Finance, Remuneration, South Coast Audit consortia board.

For details of membership, please go to our website www.sussexcommunity.nhs.uk

**Our business structure**  
As an interim first step as the trust was set up in October 2010, we established three care groups and two strategic business units to deliver our services and secure clinical engagement. The care groups were: long-term conditions/end of life care and rehabilitation & enablement; urgent care and treatments outside of acute hospital; public health/health improvement/children’s services. The strategic business units were Chailey Heritage clinical services and dentistry.

We also established a clinical engagement board (CEB) made up of a broad range of clinical and allied health professionals to enable our clinical leaders to champion patient safety and quality. As we move into 2011/12, and in line with the requirement to reduce costs and deliver greater efficiencies, this structure is under review. Our CEB remains prominent and influential within the trust and connects into professional networks across Sussex. The revised structure will be published on our website www.sussexcommunity.nhs.uk
How the trust spends its money

In 2010/11 Sussex Community NHS Trust had an income of £189m. We provide healthcare services for two main commissioners: NHS West Sussex and NHS Brighton and Hove provide 84 per cent of our income.

Our commissioners are funded by the government and are currently responsible for buying the healthcare services in their regions. We also provide specialist and rehabilitation services nationally and receive income from other primary care trusts (PCTs) for this.

**Breakdown of our spending**
The pie chart below details how we spent the income we received in 2010/11:

- Pay: the largest element of expenditure is paying the salaries of our 4,286 staff. This includes employer’s pension and national insurance contributions.
- Clinical supplies, including drugs, dressings and patient appliances such as wheelchairs, and prosthesis.
- Non clinical supplies include catering and cleaning costs, as well as staff and patients’ clothing.
- Premises costs include rent, rates, utilities as well as the cost of repairs and maintenance to the buildings we use.
- Establishment costs include printing and stationery, advertising, telephones and other general administration costs.
- Depreciation & impairments represent the annual reduction in value of the trust’s buildings and equipment.
- Other expenditure includes training and development, costs of audit, transport and expenditure on consultancy.

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staffing costs</td>
<td>£136.4m</td>
</tr>
<tr>
<td>Clinical supplies</td>
<td>£17.5m</td>
</tr>
<tr>
<td>Premises</td>
<td>£17.5m</td>
</tr>
<tr>
<td>Other</td>
<td>£7.3m</td>
</tr>
<tr>
<td>Establishment</td>
<td>£5.3m</td>
</tr>
<tr>
<td>Depreciation &amp; impairments</td>
<td>£3.2m</td>
</tr>
<tr>
<td>Non clinical supplies</td>
<td>£1.6m</td>
</tr>
</tbody>
</table>
Financial review 2010-11
We have a strong track record in achieving our financial targets and are pleased to report that in 2010/11 the trust has delivered all four main financial duties. These are summarised in the table below.

Trusts are also required to pay suppliers in line with the Better Payment Practice Code. This means the trust should aim to pay all undisputed invoices within 30 days of receipt of goods or a valid invoice. In 2010/11, 92 per cent of invoices were paid within 30 days (91 per cent in 2009/10).

During 2010/11 the main financial focus was on delivering efficiencies and gaining a better understanding of our costs. At the beginning of the year a savings target of £9.3m was identified to achieve a balanced position. We achieved this target, delivering an income and expenditure surplus for the tenth year in a row.

We effectively managed our cash resources and did not require any short term loans or financial support. We ended the year with a £1.021m undershoot against our EFL target which we had agreed with the Department of Health in advance of the year end.

<table>
<thead>
<tr>
<th>target</th>
<th>2010/11</th>
<th>2009/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income &amp; expenditure position</td>
<td>£675k</td>
<td>surplus</td>
</tr>
<tr>
<td>To operate within an external financing limit (EFL) set by the Department of Health</td>
<td>achieved</td>
<td>achieved</td>
</tr>
<tr>
<td>To remain within a capital resource limit (CRL) set by the Department of Health</td>
<td>achieved</td>
<td>achieved</td>
</tr>
<tr>
<td>Achieve a capital cost absorption rate of between 3.5%</td>
<td>3.5%</td>
<td>3.5%</td>
</tr>
</tbody>
</table>
In 2010/11 the trust spent a net £935k on capital, that is, buildings and larger items of equipment. This represented an under spend of £2.074m against the CRL target of £3.009m. The table on page 35 gives further details of this spend.

2011/12 and beyond

Looking forward, the financial challenges that we face, are similar to other NHS organisations, namely:

- To simultaneously improve the quality of care and reduce costs.
- To develop our relationships with the emerging GP commissioning consortia.
- To be ready for a more competitive environment for our services.

In addition we will be developing our proposal to be a foundation trust which will require us to demonstrate that we are financially viable going forward.

Critical to our success will be the development of more detailed costing models that will enable clinicians to understand the full cost of their services and how these change as activity changes through service line reporting.

The trust is well placed to adapt to the changes. We are implementing a delegated financial management regime that enhances the role of clinicians and staff in financial planning and control and makes a direct link between the funding received from PCTs and the cost of providing each service.

This will enable us to develop a long-term financial model that aligns with our business strategy which will sustain and improve our financial strength.

We will continue to work with partners to ensure that appropriate financial incentives are in place to support new ways of delivering services.
<table>
<thead>
<tr>
<th>Capital Expenditure scheme</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Computer software</td>
<td>£163k</td>
</tr>
<tr>
<td>IT and IT infrastructure</td>
<td>£975k</td>
</tr>
<tr>
<td>Building refurbishments</td>
<td>£526k</td>
</tr>
<tr>
<td>Medical equipment</td>
<td>£48k</td>
</tr>
<tr>
<td>Other equipment</td>
<td>£240k</td>
</tr>
<tr>
<td>Asset transfer &amp; vehicle sales</td>
<td>(£1017k)</td>
</tr>
<tr>
<td>total</td>
<td>£935k</td>
</tr>
</tbody>
</table>
NHS trusts are required by the Department of Health to produce an annual report and set of annual accounts.

The following tables summarise the main financial statements included in the accounts and have been subject to audit. They have been produced following IFRS guidelines. They cover:

- The statement of comprehensive income which records income received and costs incurred during the financial year.
- The statement of financial position which provides a snapshot of the trust’s assets (what it owns) and liabilities (what it owes other organisations) in monetary terms.
- The statement of cash flows which explains any increase or decrease in cash held between years.

A full set of the annual accounts and chief executive’s statement on internal control is available from the director of finance and facilities, Sussex Community NHS Trust, Brighton General Hospital, Elm Grove, Brighton BN2 3EW.

External audit is provided by the Audit Commission, 1st Floor, Millbank Tower, Millbank, London SW1P 4HQ. Fees for 2010/11 were £172k which all related to the provision of statutory audit.

**Chief executive’s statement**

I acknowledge the summary financial statements, which have been prepared by the director of finance as the summary financial statements, which the trust is required to include in the annual report.

Andy Painton
Chief executive
8/6/11

**Director of finance’s statement**

I certify that the summary financial statements included in the annual report have been compiled from and are in accordance with the financial records maintained by the trust and with the accounting standards and policies for the NHS approved by the Secretary of State.

John O’Sullivan
Director of finance and facilities
8/6/11
I have examined the summary financial statement for the year ended 31 March 2011 which comprises the Statement of Comprehensive Income, the Statement of Financial Position and the Statement of Cash Flows.

This report is made solely to the Board of Directors of Sussex Community NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010.

**Respective responsibilities of directors and auditor**

The directors are responsible for preparing the Annual Report.

My responsibility is to report to you my opinion on the consistency of the summary financial statement within the Annual Report with the statutory financial statements.

I also read the other information contained in the Annual Report and consider the implications for my report if I become aware of any misstatements or material inconsistencies with the summary financial statement.

I conducted my work in accordance with Bulletin 2008/03 “The auditor’s statement on the summary financial statement in the United Kingdom” issued by the Auditing Practices Board. My report on the statutory financial statements describes the basis of my opinion on those financial statements.

**Opinion**

In my opinion the summary financial statement is consistent with the statutory financial statements of the Trust for the year ended 31 March 2011.

Paul Grady
District Auditor, Officer of the Audit Commission
9/6/11

Audit Commission
Bridge House
1 Walnut Tree Close
Guildford
GU1 4UA
Sussex Community NHS Trust
Statement of comprehensive income for the year ended 31 March 2011

<table>
<thead>
<tr>
<th></th>
<th>2010-11 £000</th>
<th>2009-10 £000</th>
<th>merged accounts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income from activities</td>
<td>172,630</td>
<td>163,643</td>
<td>53,462</td>
</tr>
<tr>
<td>Other operating income</td>
<td>16,808</td>
<td>17,618</td>
<td>13,806</td>
</tr>
<tr>
<td>Operating expenses</td>
<td>(188,805)</td>
<td>(181,784)</td>
<td>(67,795)</td>
</tr>
<tr>
<td>OPERATING SURPLUS (DEFICIT)</td>
<td>633</td>
<td>(523)</td>
<td>(527)</td>
</tr>
<tr>
<td>Cost of fundamental</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>reorganisation/reconstruction</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Profit/(loss) on disposal of</td>
<td>11</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>fixed assets</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SURPLUS (DEFICIT) BEFORE INTEREST</td>
<td>644</td>
<td>(503)</td>
<td>(507)</td>
</tr>
<tr>
<td>Interest receivable</td>
<td>9</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Interest payable</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other finance costs –</td>
<td>(21)</td>
<td>(21)</td>
<td>(21)</td>
</tr>
<tr>
<td>unwinding of discount</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SURPLUS (DEFICIT) FOR THE</td>
<td>632</td>
<td>(518)</td>
<td>(522)</td>
</tr>
<tr>
<td>FINANCIAL YEAR</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public dividend capital</td>
<td>(1,041)</td>
<td>(1,131)</td>
<td>(1,131)</td>
</tr>
<tr>
<td>dividends payable</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RETAINED SURPLUS (DEFICIT)</td>
<td>(409)</td>
<td>(1,649)</td>
<td>(1,653)</td>
</tr>
<tr>
<td>FOR THE YEAR</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Sussex Community NHS Trust
Statement of financial position as at 31 March 2011

<table>
<thead>
<tr>
<th></th>
<th>2010-11 £000</th>
<th>merged accounts</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>SDH 2009-10 £000</td>
<td>WSH 2009-10 £000</td>
<td></td>
</tr>
<tr>
<td><strong>Non-current assets</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intangible assets</td>
<td>347</td>
<td>291</td>
<td>291</td>
<td>0</td>
</tr>
<tr>
<td>Tangible assets*</td>
<td>34,823</td>
<td>38,206</td>
<td>38,206</td>
<td>0</td>
</tr>
<tr>
<td>Trade and other receivables</td>
<td>376</td>
<td>433</td>
<td>433</td>
<td>0</td>
</tr>
<tr>
<td><strong>TOTAL FIXED ASSETS</strong></td>
<td>35,546</td>
<td>38,930</td>
<td>38,930</td>
<td>0</td>
</tr>
<tr>
<td><strong>Current assets</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stocks and work-in-progress</td>
<td>241</td>
<td>239</td>
<td>239</td>
<td>0</td>
</tr>
<tr>
<td>Debtors</td>
<td>15,141</td>
<td>14,371</td>
<td>5,781</td>
<td>8,590</td>
</tr>
<tr>
<td>Investments</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Cash at bank and in hand</td>
<td>1,834</td>
<td>960</td>
<td>813</td>
<td>147</td>
</tr>
<tr>
<td><strong>TOTAL CURRENT ASSETS</strong></td>
<td>17,216</td>
<td>15,570</td>
<td>6,833</td>
<td>8,737</td>
</tr>
<tr>
<td><strong>TOTAL ASSETS</strong></td>
<td>52,762</td>
<td>54,500</td>
<td>45,763</td>
<td>8,737</td>
</tr>
<tr>
<td><strong>Current liabilities</strong></td>
<td>(17,015)</td>
<td>(17,355)</td>
<td>(7,894)</td>
<td>(9,461)</td>
</tr>
<tr>
<td><strong>Non-current liabilities</strong></td>
<td>(1,257)</td>
<td>(1,326)</td>
<td>(1,326)</td>
<td>0</td>
</tr>
<tr>
<td><strong>TOTAL ASSETS EMPLOYED</strong></td>
<td>34,490</td>
<td>35,819</td>
<td>36,543</td>
<td>(724)</td>
</tr>
<tr>
<td><strong>FINANCED BY TAXPAYERS EQUITY</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public dividend capital</td>
<td>284</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Revaluation reserve</td>
<td>12,256</td>
<td>14,919</td>
<td>14,919</td>
<td>0</td>
</tr>
<tr>
<td>Donated asset reserve</td>
<td>2,888</td>
<td>3,344</td>
<td>3,344</td>
<td>0</td>
</tr>
<tr>
<td>Government grant reserve</td>
<td>163</td>
<td>177</td>
<td>177</td>
<td>0</td>
</tr>
<tr>
<td>Other reserves</td>
<td>(9,673)</td>
<td>(11,603)</td>
<td>(11,603)</td>
<td>0</td>
</tr>
<tr>
<td>Income and expenditure reserve</td>
<td>28,572</td>
<td>28,981</td>
<td>29,705</td>
<td>(724)</td>
</tr>
<tr>
<td><strong>TOTAL TAXPAYERS EQUITY</strong></td>
<td>34,490</td>
<td>35,819</td>
<td>36,543</td>
<td>(724)</td>
</tr>
</tbody>
</table>
USX Community NHS Trust

Statement of cash flows for the year ended 31 March 2011

<table>
<thead>
<tr>
<th></th>
<th>2010-11 £000</th>
<th>merged accounts</th>
<th>2009-10 £000</th>
<th>SDH 2009-10 £000</th>
<th>WSH 2009-10 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OPERATING ACTIVITIES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash flows from operating activities</td>
<td>1,186</td>
<td>2,046</td>
<td>1,899</td>
<td>147</td>
<td></td>
</tr>
<tr>
<td><strong>CASH FLOWS FROM INVESTING ACTIVITIES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest received</td>
<td>9</td>
<td>6</td>
<td>6</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>(Payments) to acquire tangible fixed assets</td>
<td>(3,149)</td>
<td>(2,133)</td>
<td>(2,133)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Receipts from the sale of tangible fixed assets</td>
<td>2,715</td>
<td>1,147</td>
<td>1,147</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>(Payments) to acquire intangible fixed assets</td>
<td>(163)</td>
<td>(100)</td>
<td>(100)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Net cash inflow/(outflow) from investing activities</td>
<td>(588)</td>
<td>(1,080)</td>
<td>(1,080)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>Net cash inflow/(outflow) before financing</strong></td>
<td>598</td>
<td>966</td>
<td>819</td>
<td>147</td>
<td></td>
</tr>
<tr>
<td><strong>FINANCING</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public dividend capital received</td>
<td>2,987</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Public dividend capital repaid (not previously accrued)</td>
<td>(2,704)</td>
<td>(1,117)</td>
<td>(1,117)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Loans received from DH</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Other loans received</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Loans repaid to DH</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Capital element of finance leases and PFI</td>
<td>(7)</td>
<td>(7)</td>
<td>(7)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Other capital receipts</td>
<td>0</td>
<td>302</td>
<td>302</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>Net cash inflow/(outflow from financing</strong></td>
<td>276</td>
<td>(822)</td>
<td>(822)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>Increase/(decrease in cash)</strong></td>
<td>874</td>
<td>144</td>
<td>(3)</td>
<td>147</td>
<td></td>
</tr>
</tbody>
</table>

These statements have been prepared using accounting policies consistent with International Financial Reporting Standards (IFRS).
**Remuneration report**
The following tables detail the salaries, allowances and pension benefits of senior managers within the trust.

The remuneration and terms and conditions of executive directors are determined by the remuneration committee which is formed of all the non executive directors and the chief executive. The remuneration of non executive directors is determined using a national pay scale and as non executive directors they do not receive pensionable remuneration. Senior managers are subject to nationally determined pay scales. All executive directors are on six month notice periods.

Pay increases of senior staff are limited to those agreed in the national pay circular for staff covered by the Agenda for Change agreement. The trust does not operate a performance related pay scheme. The trust's pension policies are detailed in note 11 of the trust's published annual accounts.

---

### Salaries and allowances of senior managers

<table>
<thead>
<tr>
<th>Directors</th>
<th>Title</th>
<th>Start date</th>
<th>Salary (bands of £5000)</th>
<th>Other Remuneration (bands of £5000)</th>
<th>Benefits in Kind (rounded to nearest £100)</th>
<th>Salary (bands of £5000)</th>
<th>Other Remuneration (bands of £5000)</th>
<th>Benefits in Kind (rounded to nearest £100)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Painton</td>
<td>Chief Executive</td>
<td>01/06/09</td>
<td>120-125</td>
<td>0</td>
<td>0</td>
<td>100-105</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>J O’Sullivan</td>
<td>Director of Finance</td>
<td>14/02/10</td>
<td>95-100</td>
<td>0</td>
<td>0</td>
<td>100-105</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>C Warde-Robinson</td>
<td>Director of Strategy &amp; New Business</td>
<td>01/02/10</td>
<td>105-110</td>
<td>0</td>
<td>0</td>
<td>20-25</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>A Harrington</td>
<td>Director of Operations and Clinical Services</td>
<td>09/10/09</td>
<td>95-100</td>
<td>0</td>
<td>0</td>
<td>90-95</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Dr J Omany</td>
<td>Medical Director</td>
<td>01/03/11 seconded</td>
<td>0-5</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>S Storey</td>
<td>Dir. of HR &amp; Organisational Development</td>
<td>25/11/10 seconded</td>
<td>30-35</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
### Former Directors:

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Leaving date</th>
<th>2010-2011</th>
<th>2009-2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>S Crosbie</td>
<td>Associate Medical Director (Governance)</td>
<td>31/03/11</td>
<td>35-40</td>
<td>50-55</td>
</tr>
<tr>
<td>J Clark</td>
<td>Director of Specialist Services</td>
<td>28/02/11</td>
<td>45-50</td>
<td>45-50</td>
</tr>
<tr>
<td>E Clark</td>
<td>Director West Sussex Health</td>
<td>27/06/10</td>
<td>20-25</td>
<td>0</td>
</tr>
<tr>
<td>T Crayford</td>
<td>Interim Medical Director (Agency)</td>
<td>20-25</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>R Garner</td>
<td>Interim Dir. of Community Care (Health)</td>
<td>03/06/11</td>
<td>65-70</td>
<td>0</td>
</tr>
<tr>
<td>W Jehan</td>
<td>Director of Nursing and Governance</td>
<td>31/06/11</td>
<td>35-40</td>
<td>155-160</td>
</tr>
<tr>
<td>P Larsen</td>
<td>Interim Dir. of Finance</td>
<td>12/02/10</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>J Miller</td>
<td>Acting Director of HR and OD</td>
<td>11/01/11</td>
<td>20-25</td>
<td>0</td>
</tr>
<tr>
<td>P Spicer</td>
<td>Director of HR West Sussex Health</td>
<td>08/06/10</td>
<td>10-15</td>
<td>0</td>
</tr>
<tr>
<td>R Turner</td>
<td>Joint Medical Director (Clinical)</td>
<td>15/08/10</td>
<td>10-15</td>
<td>105-110</td>
</tr>
</tbody>
</table>

### Non Executive Directors:

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Appt. date</th>
<th>2010-2011</th>
<th>2009-2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>S Turpitt</td>
<td>Chairman</td>
<td>01/04/08</td>
<td>20-25</td>
<td>0</td>
</tr>
<tr>
<td>J Cook</td>
<td>Non Executive Director</td>
<td>01/02/09</td>
<td>5-10</td>
<td>0</td>
</tr>
<tr>
<td>DJR Evans</td>
<td>Associate Non Executive Director</td>
<td>01/07/10</td>
<td>0-5</td>
<td>0</td>
</tr>
<tr>
<td>M McLennett</td>
<td>Non Executive Director</td>
<td>01/04/10</td>
<td>5-10</td>
<td>0</td>
</tr>
<tr>
<td>A McStravick</td>
<td>Non Executive Director</td>
<td>01/04/10</td>
<td>5-10</td>
<td>0</td>
</tr>
<tr>
<td>C Rae</td>
<td>Non Executive Director</td>
<td>01/12/07</td>
<td>5-10</td>
<td>0</td>
</tr>
<tr>
<td>M Marsh</td>
<td>Non Executive Director</td>
<td>01/03/03 to 28/02/11</td>
<td>5-10</td>
<td>0</td>
</tr>
</tbody>
</table>
### Directors’ exit packages for staff leaving in 2010-2011

<table>
<thead>
<tr>
<th>Exit package cost band (including any special payment element)</th>
<th>Number of compulsory redundancies</th>
<th>Number of other departures agreed</th>
<th>Total number of exit packages by cost band</th>
<th>Number of compulsory redundancies</th>
<th>Number of other departures agreed</th>
<th>Total number of exit packages by cost band</th>
</tr>
</thead>
<tbody>
<tr>
<td>Directors:</td>
<td>2010-2011</td>
<td>2009-2010</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;£20,001</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>£20,001 - £40,000</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>£40,001 - £100,000</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>£100,001 - £150,000</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>£150,001 - £200,000</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>&gt;£200,000</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total number of exit packages by type (total cost)</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total resource cost (£000s)</td>
<td>209</td>
<td>0</td>
<td>209</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
### Pension benefits of senior managers*

<table>
<thead>
<tr>
<th>Directors</th>
<th>Title</th>
<th>£000</th>
<th>£000</th>
<th>£000</th>
<th>£00</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Painton</td>
<td>Chief Executive</td>
<td>0-2.5</td>
<td>0</td>
<td>0-5</td>
<td>0</td>
</tr>
<tr>
<td>J O’Sullivan</td>
<td>Director of Finance</td>
<td>0</td>
<td>0</td>
<td>35-40</td>
<td>105-110</td>
</tr>
<tr>
<td>C Warde-Robinson</td>
<td>Director of Strategy &amp; New Business</td>
<td>0-2.5</td>
<td>0</td>
<td>0-5</td>
<td>0</td>
</tr>
<tr>
<td>A Harrington</td>
<td>Director of Operations and Clinical Services</td>
<td>5-7.5</td>
<td>15-17.5</td>
<td>25-30</td>
<td>75-80</td>
</tr>
<tr>
<td>Dr J Omany</td>
<td>Medical Director</td>
<td>*** Not available</td>
<td>*** Not available</td>
<td>25-30</td>
<td>75-80</td>
</tr>
<tr>
<td>S Storey</td>
<td>Director of HR and Organisational Dev.</td>
<td>*** Not available</td>
<td>*** Not available</td>
<td>30-35</td>
<td>95-100</td>
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</tbody>
</table>

**Former Directors:**

<table>
<thead>
<tr>
<th>Directors</th>
<th>Title</th>
<th>£000</th>
<th>£000</th>
<th>£000</th>
<th>£00</th>
</tr>
</thead>
<tbody>
<tr>
<td>S Crosbie</td>
<td>Joint Medical Director (Governance)</td>
<td>2.5-5</td>
<td>7.5-10</td>
<td>35-40</td>
<td>110-115</td>
</tr>
<tr>
<td>J Clark</td>
<td>Director of Specialist Services</td>
<td>0-2.5</td>
<td>2.5-5</td>
<td>5-10</td>
<td>25-30</td>
</tr>
<tr>
<td>E Clark</td>
<td>Director West Sussex Health</td>
<td>2.5-5</td>
<td>7.5-10</td>
<td>30-35</td>
<td>90-95</td>
</tr>
<tr>
<td>T Crayford</td>
<td>Interim Medical Director (Agency)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>R Garner</td>
<td>Interim Director of Community Care (Health)</td>
<td>0-2.5</td>
<td>2.5-5</td>
<td>15-20</td>
<td>50-55</td>
</tr>
<tr>
<td>W Jehan</td>
<td>Director of Nursing and Governance</td>
<td>0-2.5</td>
<td>0-2.5</td>
<td>25-30</td>
<td>85-90</td>
</tr>
<tr>
<td>P Larsen</td>
<td>Interim Dir. of Finance</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>J Miller</td>
<td>Acting Director of HR and OD</td>
<td>0-2.5</td>
<td>2.5-5</td>
<td>25-30</td>
<td>75-80</td>
</tr>
<tr>
<td>P Spicer</td>
<td>Director of HR West Sussex Health</td>
<td>0-2.5</td>
<td>0-2.5</td>
<td>10-15</td>
<td>30-35</td>
</tr>
<tr>
<td>R Turner</td>
<td>Joint Medical Director (Clinical)</td>
<td>0</td>
<td>0</td>
<td>40-45</td>
<td>125-130</td>
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</tbody>
</table>
Pension benefits of senior managers (Cash equivalent Transfer Values**)

<table>
<thead>
<tr>
<th>Directors</th>
<th>Title</th>
<th>£000</th>
<th>£000</th>
<th>£000</th>
<th>£00</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Painton</td>
<td>Chief Executive</td>
<td>32</td>
<td>17</td>
<td>15</td>
<td>17</td>
</tr>
<tr>
<td>J O’Sullivan</td>
<td>Director of Finance</td>
<td>627</td>
<td>695</td>
<td>0</td>
<td>14</td>
</tr>
<tr>
<td>C Warde-Robinson</td>
<td>Director of Strategy &amp; New Business</td>
<td>17</td>
<td>3</td>
<td>14</td>
<td>18</td>
</tr>
<tr>
<td>A Harrington</td>
<td>Director of Operations and Clinical Services</td>
<td>332</td>
<td>304</td>
<td>28</td>
<td>14</td>
</tr>
<tr>
<td>Dr J Omany</td>
<td>Medical Director</td>
<td>495</td>
<td>*** Not available</td>
<td>*** Not available</td>
<td>0</td>
</tr>
<tr>
<td>S Storey</td>
<td>Dir. of HR and Organisational Dev.</td>
<td>622</td>
<td>*** Not available</td>
<td>*** Not available</td>
<td>*** Not available</td>
</tr>
</tbody>
</table>

**Former Directors:**

<table>
<thead>
<tr>
<th>Directors</th>
<th>Title</th>
<th>£000</th>
<th>£000</th>
<th>£000</th>
<th>£00</th>
</tr>
</thead>
<tbody>
<tr>
<td>S Crosbie</td>
<td>Associate Medical Dir. (Governance)</td>
<td>768</td>
<td>605</td>
<td>49</td>
<td>5</td>
</tr>
<tr>
<td>J Clark</td>
<td>Director of Specialist Services</td>
<td>197</td>
<td>182</td>
<td>14</td>
<td>11</td>
</tr>
<tr>
<td>E Clark</td>
<td>Director West Sussex Health</td>
<td>512</td>
<td>421</td>
<td>36</td>
<td>3</td>
</tr>
<tr>
<td>T Crayford</td>
<td>Interim Medical Director (Agency)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>R Garner</td>
<td>Interim Director of Community Care (Health)</td>
<td>329</td>
<td>328</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>W Jehan</td>
<td>Director of Nursing and Governance</td>
<td>0</td>
<td>689</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>P Larsen</td>
<td>Interim Dir. of Finance</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>J Miller</td>
<td>Acting Director of HR and OD</td>
<td>463</td>
<td>453</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>P Spicer</td>
<td>Director of HR West Sussex Health</td>
<td>163</td>
<td>158</td>
<td>1</td>
<td>13</td>
</tr>
<tr>
<td>R Turner</td>
<td>Joint Medical Director (Clinical)</td>
<td>738</td>
<td>1003</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>
Non executive members do not receive pensionable remuneration and therefore are not included in the above pension benefit tables.

**A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

*** Values marked as “Not Available” where the senior manager is seconded to the trust and we have not been able to obtain all the required disclosure information from their employing organisation.

**Real increase in CETV**
This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

**Register of interests**
At the time of their appointment, all directors are required to declare any significant financial or controlling interests they, or a close relative have, in organisations or companies which could compete for the supply of goods or services to the trust and to declare any such interests that may arise after their appointment. These are recorded in the register of interests and updated regularly. The register is available for inspection by members of the public at any time via the trust’s website or by contacting trust management, J3 Brighton General Hospital, Elm Grove, Brighton, BN2 3EW.
## Declaration of Trust Board Members’ interests

<table>
<thead>
<tr>
<th>Directors</th>
<th>Title</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>S Turpitt</td>
<td>Chairman</td>
<td>Chair of joint board forum (Chailey School and Chailey Clinical Services) – role taken as representative of Sussex Community NHS Trust. Chair of Jewel Bequest Charitable Bequest Trust – joint board with Chailey School as above but for the management and allocation of funding from the charitable trust. Jewel Trust funds should be used for the benefit of children and young people with physical disabilities and complex health needs who are, or who will be, in receipt of services from both CHCS and CHS. Post held until 12/5/2011 when reverted to being a member and the chair moved to the chair of trustees at the Chailey School. Partner is HR manager of Fisher Clinical, which has no contract with Sussex Community NHS Trust. No conflict of interest perceived.</td>
</tr>
<tr>
<td>J Cook</td>
<td>Non Executive Director</td>
<td>Director/shareholder of Euro Finance &amp; Commercial Ltd – management consultancy. Trustee of Foundation 66, a charity supporting drugs and alcohol rehabilitation. No conflict of interest perceived.</td>
</tr>
<tr>
<td>DJR Evans</td>
<td>Non Executive Director</td>
<td>Associate dean of Brighton and Sussex Medical School. No conflict of interest perceived.</td>
</tr>
<tr>
<td>M McJennett</td>
<td>Non Executive Director</td>
<td>Non executive director of Worthing Homes, a social housing provider. Director of the Natural Brewing Company. No conflict of interest perceived.</td>
</tr>
<tr>
<td>A McStravick</td>
<td>Non Executive Director</td>
<td>Runs own company. Non executive director of a motor vehicle insurance company. No conflict of interest perceived.</td>
</tr>
<tr>
<td>C Rae</td>
<td>Non Executive Director</td>
<td>Director/shareholder of Outside the Box Solutions Ltd – management consultancy. Governor of Royal National Lifeboat Institution – a voluntary organisation providing rescue services to all seafarers. No conflict of interest perceived.</td>
</tr>
<tr>
<td>A Painton</td>
<td>Chief Executive</td>
<td>Wife is membership manager of South East Coast Ambulance Service NHS Foundation Trust. No conflict of interest perceived.</td>
</tr>
<tr>
<td>J O’Sullivan</td>
<td>Director of Finance</td>
<td>None</td>
</tr>
<tr>
<td>C Warde-Robinson</td>
<td>Director of Strategy &amp; New Business</td>
<td>None</td>
</tr>
<tr>
<td>A Harrington</td>
<td>Executive Director of Operations &amp; Chief Nurse</td>
<td>None</td>
</tr>
<tr>
<td>Dr J Omany</td>
<td>Medical Director</td>
<td>Medical director of Surrey Primary Care Trust. No conflict of interest perceived.</td>
</tr>
</tbody>
</table>

Signed                                     Chief executive      Date 8/6/11
Annual report survey

Please take a moment to complete the questionnaire below and return it to: Nick Fairclough
Sussex Community NHS Trust, A4, Brighton General Hospital, Elm Grove, Brighton BN2 3EW

Email any general comments about the report to nickfairclough@nhs.net

1 How much of the report did you read? Please tick one box only:

- All of it
- Not all, but more than half
- Less than half of the report
- I didn’t read any of it
- I flicked through it

2 If you read sections, which did you read? Tick boxes as appropriate:

- Introduction
- Improving health. Changing lives
- About the trust
- How we did over the year: our performance 2010/11
- Where we are going: our strategic direction
- Managing our people
- Caring for patients in the community
- Managing the trust: governance arrangements
- Right care right place
- How the trust spent its money
- Keeping patients out of hospital
- Summary financial statements

3 What else should have been included in the report?

4 Was the report easy to read? Please tick one box:

- All of the time
- Mostly yes
- Mostly no
- It was not easy to read
- I didn’t read any of it
5 How interesting was the report to read? Please mark the scale below:

Very poor □  Poor □  Average □  Good □  Very good □

6 Do you read? Please tick one box:

All of the annual reports I receive □  Key partners’ reports, including SCT’s □
None of the reports I receive □

7 How would you rate the design of the report?

Very poor □  Poor □  Average □  Good □  Very good □

8 What did you do with the report? Please tick one box?

Kept it □  Threw it away □  Passed it to a colleague □

9 Do you think the annual report should be (please tick one box)

Sent out as a hard copy □  Available online only □

10 Do you want to receive our 2011/12 annual report?

Yes □  No □

Your name and address:

Please feel free to offer any further comments:

Thanks for your time and support.
Nick Fairclough
Sussex Community NHS Trust, A4, Brighton General Hospital Elm Grove, Brighton BN2 3EW
Please call 01273 242096:

- To get this report in large print or in Braille.
- To get a recording of the report.
- For help to understand this report in a language that isn’t English.

For additional copies of this report please contact:
Nick Fairclough on 01273 242096
nickfairclough@nhs.net

For a copy of the 2010/11 annual accounts, which include the statement of internal control, please contact: Colin Farmer on (01273) 696011 ext 3402
colin.farmer@nhs.net

Sussex Community NHS Trust
Brighton General Hospital, Elm Grove Brighton BN2 3EW.
Tel 01273 696011
www.sussexcommunity.nhs.uk