Brighton and Sussex University Hospitals NHS Trust

Meeting of the Board of Directors

09:00 to 11.00am on Wednesday 29th November 2017
Boardroom, St. Mary's Hall, Royal Sussex County Hospital

AGENDA – MEETING IN PUBLIC

1.	09:00	**Welcome and Apologies for Absence**		Chair
2.	09:00	**Declarations of Interests**		All
3.	09:05	**Minutes of Board Meeting held on 27th September 2017** To approve	Enclosure	Chair
4.	09:05	**Matters Arising from the Minutes** To note	Enclosure	Chair
5.	09:10	**Chief Executive's Report** To receive and agree any necessary actions	Enclosure	MG
		PERFORMANCE		
6.	09:20	**Quality Report** • **Learning from Deaths Policy** • **Safeguarding Children Annual Report** To note and agree any necessary actions	Enclosure	NR/CD GF NR/DFi
7.	09:30	**Organisational Development and Workforce Report** To note and agree any necessary actions	Enclosure	DFa
8.	09:40	**Performance Report** To note and agree any necessary actions	Enclosure	PL
9.	09:50	**Financial Performance Report** To note and agree any necessary actions	Enclosure	KG
		OTHER ITEMS		
10.	10.00	**Nursing Staffing and Capacity Levels Report** To note and agree any necessary actions	Enclosure	NR
11.	10.10	**Other Business**	Verbal	Chair
12.	10.20	**Resolution into Board in Private:** To pass the following resolution, "that the Board now meets in private due to the confidential nature of the business to be transacted"	Verbal	Chair

13.	10.20	**Date of Next Meeting** The next meeting in public of the Board of Directors is scheduled to take place in the Boardroom, St. Mary's Hall, Royal Sussex County Hospital, on 31st January 2018.		Chair
14.	10.20	**Close of Meeting**		Chair
15.	10.30	**Questions from members of the public** Following the close of the meeting there will be an opportunity for members of the public to ask questions about the business considered by the Board.	Verbal	Chair

Andy Gray
Corporate Governance Director

Brighton and Sussex University Hospitals NHS Trust

Minutes

Minutes

Minutes of the Board of Directors (Public) meeting held on 27th September 2017 at 10.00 in the Boardroom, St. Mary's Hall, Royal Sussex County Hospital

Present:

Mike Viggers	Chairman
Kirstin Baker	Non-Executive Director
Graham Hodgson	Non-Executive Director
Professor Malcolm Reed	Non-Executive Director
Mike Rymer	Non-Executive Director
Martin Sinclair	Non-Executive Director
Patrick Boyle	Non-Executive Director Advisor
Lizzie Peers	Non-Executive Director Advisor
Jon Furmston	Non-Executive Director Advisor
Marianne Griffiths	Chief Executive
Denise Farmer	Chief OD and Workforce Officer
Karen Geoghegan	Chief Finance Officer
Evelyn Barker	Managing Director
George Findlay	Chief Medical Officer
Nicola Ranger	Chief Nursing and Patient Safety Officer
Pete Landstrom	Chief Delivery and Strategy Officer

In attendance:

Andy Gray	Corporate Governance Director
Louise Guss	Corporate Governance Consultant
Hilary Merret	Good Governance Institute

GENERAL BUSINESS

PB9/17/1 Welcome and Apologies

1.1 Apologies were received from Joanna Crane.

PB9/17/2 Declarations of interest

2.1 There were no declarations of interest

PB9/17/3 Minutes of Previous Meeting

3.1 The minutes of the meeting held on 26th July 2017 were approved as a correct record.

PB9/17/4 Matters Arising

4.1 The matters arising were noted.

PB9/17/5 Chief Executive's Report

5.1 Marianne Griffiths introduced her report and highlighted three main areas. In relation to **A&E expansion**, including 70 bed Short Stay Unit Marianne confirmed that following NHS Improvement's approval in July, Brighton and Hove City Council's Planning Committee has now approved plans to build a new Short Stay Unit above the County Hospital's A&E Department's vehicle drop off area. The 70 bed unit will provide care for both medical and surgical patients who require a stay of two days or less in hospital.
Marianne extended her thanks both to the Council planners who were supportive of the application, and to Capital staff who worked hard to deliver what was needed to secure this approval.

5.2 Marianne confirmed the improvements secured in achieving **Hyper-Acute Stroke Unit** status. After years of working closely with our local Clinical Commissioning Groups to improve stroke care for patients across Sussex, Brighton and Sussex University Hospitals (BSUH) has achieved Hyper-Acute Stroke Unit (HASU) status.
The additional funding made available by the CCGs has enabled the Trust to employ more therapy staff and provide a truly seven-day service for patients.

5.3 In relation to **Care Quality Commission (CQC) assessment**, Marianne confirmed that following their inspection of BSUH in April 2017, the CQC published their latest report on 10 August and was pleased to confirm that inspectors recognised "significant improvements" at the Trust over the past year. The CQC now rates the Trust as 'requires improvement'.

5.4 The inspectors found improvements at both hospitals and found that the quality of caring was "good" across all services. Marianne stated that while the Trust still has improvements to make, work is ongoing and that this inspection result is a good start.

5.5 Kirstin Baker extended her thanks to all staff who have worked hard to make the improvements noted.

PERFORMANCE

PB9/17/6 Quality Report

6.1 George Findlay introduced the Quality Report.

6.2 He noted that **crude non-elective mortality** for the period June to August was 2.66%. The HEDs Comparative database reports a crude mortality rate of 3.74% for the past 12 month. This compares to a rate of 3.6% for the 12 months ending June 2016.

6.3 In relation to **Hospital Standardised Mortality Ratio** (HMSR), George noted that HSMR is for the period to June when 79 patients died against an expected number of 95.

6.4 George went on to confirm that the Trust Mortality Review Group (TMRG) is overseeing the implementation of the new national requirements regarding Learning from Deaths. Two members of staff are now qualified as Structured Judgement Review trainers. In October, 25 clinicians will be attending training for undertaking Structured Judgement Reviews.

6.5 George advised that a mortality data set called HED is used for comparative information (as opposed to Dr Foster).

6.6 **ACTION: Consideration to be given to whether this is the most appropriate dataset to use going forwards.** **GF**

6.7 In relation to **Central Alert System (CAS) Safety Alerts**, George confirmed that there was one outstanding safety alert for the Trust at the end of August - restricted use of open systems for injectable medications. This alert builds on the 2007 National Patient Safety Agency alert promoting safer use of injectable medications.

6.7 Theatres have confirmed that they are no longer using open systems for injectable medicines. However some areas use open systems for contrast and saline. The Lead Nurse is in discussions with an external company about getting these into a closed system. In the short term the Trust would have to order them in separately; in the longer term they would be included into the procedure packs.

6.8 In relation to **inpatient falls**, George confirmed that the adult inpatients falls rate for the period June to August was 3.34 falls per 1000 bed stay days. The actual number of falls month on month has significantly fallen over the past 12 months. Since the launch in 2009-10 the falls rate has been reduced and this reduction has been sustained by implementing a strategy based on making fall safe behaviour a habit.

6.9 On the **Family and Friends Test**, George reminded Board members that patients who access hospital services are asked whether they would recommend the Trust to their friends or family if they needed similar treatment. Patients who access inpatient, outpatient, day-case, A&E and maternity are all offered the opportunity to respond to the question. For the Trust, scores are above 95% for inpatients, maternity (ante-natal care and delivery care); and below 95% for A&E, maternity (post-natal care and post-natal community care, and out-patients.

6.10 George confirmed however that the response rates for in-patients to the test remains poor, at just above 11%, and improvements are required. Patrick Boyle, Non-Executive Director Advisor, expressed the view that the 11% response rate is poor and that the Board should gain more knowledge around this and Patient Experience.

6.11 **ACTION: Presentation on Patient Experience to next Board meeting by Nicola Ranger.** **NR**

6.12 John Furmston, Non-Executive Director Advisor asked if any analysis had been done regarding HSMR rates per specialism, and between WSHT and BSUH. In reply George confirmed that this was difficult to identify, but that no sub-groups were particularly worrying in terms of data. George did confirm that there is a proven link between overcrowded services and poor patient outcomes, and that was why there is particular focus upon patient flows. In relation to comparison of data across WSHT and BSUH, George confirmed that this was something for the future and that a discussion will take place on the benefit of such work.

6.13 Mike Rymer, Non-Executive Director, asked if in relation to mortality data, sites that performed well were 'masking' the results for sites that performed less well. George confirmed that the data was presently not site specific, but that the Trust was aiming for that granularity in due course.

6.14 Lizzie Peers, Non-Executive Director Advisor, stated that she was pleased to

see information on the Patient Voice survey, and wondered which areas the Trust would identify for improvement. Nicola Ranger confirmed that Patient Voice is unique to BSUH and that there is work to be done to think about how many questions we are asking patients. Presently, patients are asked for feedback via the inpatient survey, Friends and Family Test, and Patient Voice, and feedback has reflected some patients feeling this is too much and duplicative. Work is ongoing to combine the surveys, aiming to focus upon the areas that matter most to patients.

6.15 Patrick Boyle enquired how confident the Executive team is around serious incident reporting. George Findlay and Nicola Ranger agreed that significant assurance was provided on reporting via the recent CQC visit and that their report made reference to improved reporting. It was also confirmed that the Trust performs largely at benchmark in this area. Patrick went on to ask about tissue viability and reference in the Quality Report to an increased rate of pressure damage on the rates reported in the last year. It was confirmed that there has been a change in reporting in a number of areas and that this may have impacted the data presented.

6.16 **ACTION: Nicola Ranger to update on the impact of changed reporting on tissue viability data at next meeting.** **NR**

PB9/17/7 Organisational Development and Workforce

7.1 Denise Farmer introduced her report on organisational development and workforce as at 31st August 2017.

7.2 In relation to **workforce capacity**, Denise reported that the Trust Establishment whole time equivalent (WTE) is 8,195; an increase of 185 WTE from August 2016. Staff in post currently stands at 7,280 WTE which equates to a vacancy rate of 11.2%. Whilst this shows an increase in vacancy rate of 2.5% from August 2016 (then 8.7%) this figure has reduced by 0.6% from its peak of 11.8% in June 2017. Denise confirmed that there are currently 915 WTE of vacancies, of which 418 WTE are Nursing, 188 WTE are Admin & Clerical, 125 WTE are S,T&T, 120 WTE are Ancillary Support and 64 WTE are Medical. The highest vacancy rate is within Ancillary Support (17.7%). Denise confirmed that work is ongoing to reconcile the high level of vacancies against the unfunded posts, and to develop appropriate recruitment strategies.

7.3 Denise stated that Bank spend was £1.59m during the month of August which is up from August 2016 (£1.07m). The average spend over the previous 12 months was £1.44m per month. Over the first five months of this Financial Year, Bank spend has increased on the same month in the previous year for every month with the exception of May 2017, which was marginally down.

7.4 Agency spend also showed a substantial increase in August 2017, at £1.17m from £0.56m in August 2016. The average Agency spend over the past 12 month period was £0.94m per month. Agency spend has been higher than the same month in the previous year, for each of the past four months.

7.5 In relation to **staff turnover**, Denise reported that in August 2017, the Trust's 12 month Turnover rate (external leavers excluding Training Grade Doctors) remained at 14.3%; an increase of 1.4%, from 12.9% in August 2016, when Turnover was at its lowest over the review period. The Scientific, Therapeutic and Technical staff group was reported to have both the highest overall Turnover rate (16.0%) and showed the highest level of increase from August 2016 (up 3.3%). The Turnover rates for both Nursing and Admin & Clerical staff also remain high, standing at 14.8% and up over 1% on August 2016.

7.6 In relation to **recruitment**, Denise confirmed that the Trust is continuing to develop robust Recruitment and Retention strategies, including international recruitment trips, the first of which is potentially scheduled for November. Denise added that her team are investigating a number of different recruitment strategies.

7.7 Denise confirmed that in early October the Trust will be taking part in the annual **National NHS Staff Survey** which will be sent to all substantive eligible staff in the Trust and it will close on 1 December 2017. Results for the Trust should be received in early 2018.

7.8 Denise noted that a primary focus of the Trust's work to improve **staff engagement** is to enable all staff to feel that care is the organisations top priority. Staff engagement is a True North objective and is a key priority. She confirmed that a workshop with leaders from a number of directorates has been held and that during the next two months the Trust will be engaging with front line staff to agree our action plan.

7.9 Kirstin Baker, Non-Executive Director, enquired about equality and diversity progress in the Trust. Denise confirmed that her team are presently commissioning some support and will be engaging with the BME and other networks and that in due course E&D improvement actions and targets will be finalised and confirmed.

7.10 Patrick Boyle enquired as to safety issues around staff capacity, turnover and sickness seeking confirmation on levels of confidence regarding safe operating levels. In response, Nicola Ranger confirmed that actual staff-to-patient ratios are generally good, at a maximum 1:8 (1 member of staff to 8 patients), with many wards having a ratio of 1:6. Nicola confirmed that this gives the Trust greater flexibility during challenging periods. It was agreed that while this was the case, it was acknowledged that staff retention and recruitment remains a significant challenge, and is particularly significant at specific sites e.g. the Princess Royal Hospital. It was agreed that it would be helpful for Board members to have sight of key metrics.

7.11 **Action: Denise Farmer to develop a set of key metrics to be shared with Board members.** **DF/AG**

7.12 In relation to **mandatory training**, Jon Furmston asked for confirmation regarding what steps were taken if a staff member did not complete required training and this created a safety risk – were these staff members stopped from performing their roles. Denise confirmed that she is confident this is the case, but that work is still required to ensure that the processes required to make those systems robust is completed.

PB9/17/8 Performance report

8.1 Pete Landstrom reported on Month 5 performance.

8.2 In relation to **Accident and Emergency (A&E)** he confirmed that the Trust was non-compliant against the National target in August, with 83.6% of patients waiting less than four hours from arrival at A&E to admission, transfer, or discharge. There were 7 patients who waited longer than 12 hours in the A&E department from the decision to admit.

8.3 Pete confirmed that this is an improvement of 1.73% compared to July-17, and 2.45% August-16, but does remain significantly below the constitutional target

of 95%.

8.4 The seven reported 12 hour trolley waits in August, were the first at the Trust since January-17, all of the delays occurred on the 8th August, as a result of post Pride weekend demand pressure and short term capacity issues. Pete confirmed that Performance at PRH in July was 89.8% compared to 91.5% in July and that the Royal Alex Children's Hospital and Sussex Eye Hospital continued to exceed the National Target.

8.5 Pete stated that to support improvement in performance at the County Hospital site, the redesign and expansion of the Urgent Care Centre (UCC) is currently underway and is on track to be completed by the end of September 2017.

8.6 Continuing, Pete confirmed that waiting for admission to an inpatient ward remained the highest single reason for patients waiting longer than 4 hours in A&E. Difficulties in access to beds due to formal delayed transfers of care (DTOC) patients reduced slightly in August to 7.82%. In real terms, this reflects an average of 60-70 beds occupied by patients who could be cared for in a non-acute setting.

8.7 In relation to **cancer metrics**, Pete confirmed that the Trust was compliant against 7 out of 9 metrics in July, and was below the Single Oversight Framework trajectory requirement for 62 day treatment (85.0%). Actual performance for July against this metric was 68.8%

8.8 The position for July shows the Trust was non-compliant against standards relating to 62 days from GP referral to treatment (68.8% against a national standard of 85.0%) and 62 day referral to treatment from screening (80.0% against a 90% national standard).

8.9 Total treated patients for July was below forecast at 109.0 against a forecast plan of 132.0.

8.10 In relation to **Referral to Treatment** (RTT) measures Pete reported that the Trust was non-compliant against the National Constitutional Target of 92% in August with 86.8% of patients waiting less than 18 weeks. This represents a marginal (-0.2%) decrease from the published July 2017 position. The essential closure of at least one theatre at any point during the month of August, to support the on-going theatre maintenance programme, in addition to the expected seasonal reduction in elective activity has impacted on the August incomplete performance.

8.11 There were 84 patients waiting more than 52 weeks for treatment as of the end of August which remains a significant concern for the Trust. The majority of these cases are stoma reversal patients and steps are being taken to address this.

8.12 In connection with **diagnostic waiting times**, Pete advised Board members that the Trust compliance for August was 1% over 6 week waiters across all diagnostic mode 1% national target. This represents 78 out of a total of 7,533 patients. It was confirmed that BSUH performed better than regional peers in July (the latest comparable national data); with South of England Region aggregate compliance of 2.2% and National compliance at 1.8%, compared to BSUH July performance of 0.60%. Just over a third of Trusts were non-compliant in July 2017.

8.13 Mike Viggars, Chairman, thanked Pete and his team for the work that has been undertaken to 'clean' the waiting lists and asked if there was confidence

that it had had the desired effect. Pete confirmed that the confidence level in the data was much higher following the work.

8.14 Marianne Griffiths expressed her gratitude for the excellent and effective leadership shown by CCG colleagues, working in partnership to improve RTT rates.

8.15 Kirstin Baker asked what we have learned from the surge in demand and our response during and following the Pride weekend in August. In response, Pete confirmed that bed availability and discharge were the main pinch points. The Trust identified that the system response was good, and that we need to work to enable such a response on an every-day basis.

PB9/17/9 Financial performance report

9.1 Karen Geoghegan, Chief Finance Officer reported on the Month 5 financial position, and confirmed that the Trust is reporting a deficit of £28.39m against the deficit plan of £28.76m, a favourable year-to-date variance of £0.37m.

9.2 Karen also advised Board members that a **Control Total** deficit of £65.4m has been set by the Trust in agreement with NHSI. The Trust is reporting a £28.39m deficit, £0.4m better than plan. The **capital programme** is underspent and **cash receipts** are higher than planned. The **Efficiency and Transformation Programme** is delivering below plan year-to-date. The Trust is forecasting delivery of the Control Total deficit at the end of the year. In relation to the Trust's use of resources rating, the actual/forecast ratings would be 3 based on the average scores of the components parts, but because there are 3 ratings of 4 in both year-to-date and forecast the scores are overridden to an overall 4.

9.3 In relation to trust **income**, Karen reported that for the year-to-August Income reports an underperformance of £0.6m, an improvement of £1.2m on the previous month. She confirmed that the year-end projection is to secure less income than plan by £3.3m, principally due to CDF drug expenditure being lower than was included in the plan with a corresponding reduction in associated funding.

9.4 In relation to **agency costs**, Karen confirmed that the cost of £4.8m represents 3.2% of the total pay bill and is well within the year-to-Month 5 agency cap of £5.3m. However, agency expenditure increased in-month and is greater than in same period in 16/17. Karen explained that this is due to an inability to substantively fill posts.

9.5 Regarding **capital**, Karen confirmed that the capital programme is behind plan. The re-phasing of the 3Ts Programme expenditure accounts for a significant part of this, the Operational programme is in many areas at work plan stage rather than implementation. Karen reported that the Emergency Department, Backlog Maintenance and Pathology schemes are pending approval from NHSI and DH.

9.6 Finally, Karen confirmed that the **Efficiency Programme** is making good inroads and becoming embedded. The programme is forecast to achieve the savings target.

9.7 Marianne Griffiths added that because the trust has hit financial targets for Q1 and is on track to achieve targets in Q2, the interest rate charged has been reduced from 6 to 3.5%. It is planned to negotiate a further reduction in rate to 1.5% once we have shown financial stability. We will continue to work with the

relevant Department of Health team to achieve this.

PB9/17/10 Infection Prevention and Control Annual Report

10.1 Nicola Ranger introduced the infection prevention and control annual report, which is a statutory requirement.

10.2 Nicola confirmed that during the relevant time, there were 3 Trust apportioned MRSA bacteraemias reported against a zero target, and 51 Trust apportioned clostridium difficile toxin positive cases were reported against a ceiling target of 46. Nicola also confirmed that there were 3 periods of increased incidents related to clostridium difficile, one of which was escalated to an outbreak. Additionally, the Trust reported 20 Trust apportioned MSSA bacteraemias. During this period, the Trust also successfully implemented a hand hygiene Standard Operating Procedure for hand hygiene compliance – which includes a range of frequencies of auditing.

10.3 Nicola also identified that the report has identified that too many staff experienced needle-stick injuries, and that focused work to address this is ongoing.

10.4 It was agreed following discussion that some work should be undertaken to identify national good practice in cleaning.

10.5 **Action: Arrange a presentation to Trust Board on infection control.** **NR/AG**

10.6 Nicola and Denise advised Board members that a campaign will be launched this week to promote the take-up of staff flu-jabs.

OTHER ITEMS

PB9/17/11 Emergency Planning Resilience and Response Assurance Report

11.1 Evelyn Barker, Managing Director, presented the annual report upon Emergency Planning, Resilience and Response (EPRR).

11.2 Evelyn advised that every year Trusts must complete the NHS England EPRR assurance self-assessment. Following a long period of under-resourcing within the Resilience Team and an increase in workload, last year, unfortunately for the first time, BSUH were rated as non-compliant.

11.3 Evelyn advised that with increased staffing resources and a detailed action plan BSUH were able to achieve substantial compliance ahead of schedule in May this year.

11.4 Evelyn confirmed that it is now time for the Trust to undertake a self-assessment for July 2017-2018 and the Resilience team is pleased to be able to report that we remain substantially compliant with 1 red and 4 amber ratings. The amber ratings are for business continuity (2 ambers), mass countermeasures and evacuation with lockdown being our one red rating.

Action plans are now in place relating to these areas and work is continuing. Due to the size, design and location of the Trust, the issues regarding the ability to ensure lockdown in the event of a major incident are particularly challenging.

PB9/17/12 Any Other Business

12.1 There were no other items of business.

PB9/17/13 Resolution into Board in Private

13.1 The Board resolved to meet in private due to the confidential nature of the business to be transacted.

PB9/17/14 Date of the next meeting

14.1 The next meeting will be held on 29th November 2017 in the Boardroom, St Mary's Hall, Royal Sussex County Hospital, Brighton.

PB9/17/15 Questions from members of the public

15.1 A member of the public asked that when the Board discussed in private a paper on Radiotherapy in West Sussex, they would kindly take note that the West Sussex patient/public member of the Sussex Radiotherapy Services Programme Board supports any option that results in the delivery of a 2 linac unit at St Richard's Hospital, without an interim solution, but with the agreement of Portsmouth Hospitals and other interested parties.

15.2 The Chairman thanked the member of the public for their question and confirmed that this would occur.

Andy Gray
Corporate Governance Director
September 2017

Signed as an accurate record of the meeting

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Chair

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Date

MATTERS ARISING
Board of Directors

AGENDA ITEM: 4

Meeting	Minute Ref	Action	Person Responsible	Deadline	Status
26th April 2017	PB4/17/4	Executive Director of Nursing to report to the Board on the outcome of the acuity and dependency review.	Nicola Ranger	January 2018	Agenda for January 2018 meeting
	PB7/17/6	The theme around access and mortality would be incorporated in the next learning from deaths report.	George Findlay	November 2017	Agenda item November 2017
27th September 2017	PB9/17/6	Quality Report: Consideration to be given as to whether HED is the most appropriate dataset to use going forwards.	George Findlay	November 2017	Matters arising update November 2017
27th September 2017	PB9/17/6	Presentation on Patient Experience to Non-Executive Directors.	Nicola Ranger	November 2017	Presentation made to the Quality and Risk Committee October 2017
27th September 2017	PB9/17/6	Update to be provided upon the impact of changed reporting on tissue viability data.	Nicola Ranger	November 2017	Matters arising update November 2017
27th September 2017	PB9/17/7	A set of OD and workforce metrics to be developed for sharing with Board members.	Denise Farmer	January 2018	• Workforce Board report metrics updated completed. • Additional more granular reporting to F&I Committee completed. • Metrics for Leadership and Culture programme to be developed as part of programme management process – update to January board.
27th September 2017	PB9/17/10	A presentation to be arranged to Non-Executive Directors re Infection Prevention and Control.	Nicola Ranger	November 2017	Taking place on 28th November 2017

Brighton and Sussex University Hospitals NHS Trust

To: Trust Board

Date of Meeting: 29th November 2017 Agenda Item: **5**

Title
Chief Executive's Report
Responsible Executive Director
Marianne Griffiths, CEO
Prepared by
CEO
Status
Public
Summary of Proposal
Update for Board Members
Implications for Quality of Care
None applicable to this report
Link to Strategic Objectives/Board Assurance Framework
None applicable to this report
Financial Implications
None applicable to this report
Human Resource Implications
None applicable to this report
Recommendation
The Board is asked to: NOTE this report
Communication and Consultation
N/A
Appendices
Report

Report to the Board of Directors, 29 November 2017
Chief Executive's report

1. Progress on HIV – moving towards zero

As we approach World Aids Day on 1 December, I want to report on the remarkable progress made by our sexual health team in tackling HIV in Brighton and Sussex over the last couple of years.

Current treatments reduce the amount of HIV virus in the bloodstream down to undetectable levels, which makes it impossible to transmit HIV to someone else, and patients who are tested get into treatment quickly. The team has reached the World Health Organization's 90 90 90 targets (90% of HIV infected people tested, 90% in treatment and 90% with undetectable levels of HIV in their bloodstream). As a result, the rate of HIV infection is slowing and those with HIV in treatment now live long, healthy lives.

The team now want to move beyond 90-90-90. Their ambition is to get to zero: zero new infections, zero HIV related deaths and zero HIV stigma. They are – with the Martin Fisher Foundation (named after our late HIV professor) – funding innovative methods to increase testing, which is the absolute key to the success of their mission. We are hoping BBC South East will highlight one of these methods - a unique hi-tech vending machine that dispenses HIV testing kits – in its news bulletins on World Aids Day.

I also want to highlight the role the team played in spotting cases of deliberate HIV infection and then supported their patients to raise their cases with the police. The conviction at Lewes crown court earlier this month was a legal first, and the team has been described in the press as 'NHS heroes'.

2. Staff engagement

We have made a real effort to engage with staff and in particular to complete the NHS Staff Survey. It is a vital tool for us to learn from our staff and inform our thinking and priorities. But the Trust's completion rate last year was below average.

We have used drop in sessions, weekly messages, videos and animations, drop in sessions (with cake) and regular reminders to individual departments to get the message across that we really value staff feedback and to assure individuals both that the survey is confidential and that we will act on the survey results. With over a week to go before the survey closes, we have already surpassed last year's total and are hoping we can get above the national average by the end of next week.

We have continued to introduce Patient First to staff across the Trust, through a mixture of open 'drop in' sessions and by executive team members attending different department and team meetings.

The feedback we have received has been really positive and there appears to be a real enthusiasm and hunger amongst our staff to support and make improvements in patient care – and to get rid of the rocks in their shoes.

After a brief interlude, we have also breathed some fresh life back into our staff 'star of the month' awards. We have been making our way around different departments to hand over certificates – and more cake – to individuals and teams who have gone that extra mile for their patients and made a real difference to our patient care.

3. Ministerial visit

We hosted a visit by Minister of State for Health Phillip Dunne MP in late October. The Minister asked for us to arrange a tour around the County A&E department and the Royal Alexandra Children's Hospital and for a session with a mix of different staff members.

At the end of his visit he said: "I had a constructive meeting with a diverse group of hard working staff and was very pleased to learn about the improvements to the Emergency Department and new leadership appointments that are supporting the continued improvement of services for patients."

A big 'thank you' is due to all those who were involved in hosting this visit and participating in the open discussion as such short notice.

4. Senior appointments and new structure

Lee Martin has joined us as our new Chief Operating Officer (COO).

He will be leading the overall operations of the Trust, including making the new divisional structure go "live" on 1 December. Lee joins us from London North West Healthcare NHS Trust, one of the largest integrated care organisations in the country, where he led successful improvement programmes right across the patient pathway. He has extensive experience in senior healthcare management within the NHS and internationally.

He studied leadership and change at Harvard University, has completed the NHS Top Leaders programme, the Military Strategic Leadership programme and is a qualified executive coach. Lee is a Fellow of the Institute of Leadership and Management and a Fellow of the Chartered Management Institute.

Dr Rob Haigh also joined us last month as our new Medical Director. Dr Haigh will be supporting our Chief Medical Officer Dr George Findlay and has been meeting and getting to know trams across the Trust.

Part of Dr Haigh's role is to ensure that we always learn from our mistakes and work together to eliminate errors, so that we provide the best possible standards of patient care.

5. Trust awards

Our Royal Sussex County Hospital A&E department has been Highly Commended at the annual Health Service Journal Awards and won First Place in the Royal College of Emergency Medicine's Quality Improvement Project of the Year Award.

Both awards recognise the impact of their flexible, annualised self-rostering system which has enabled the department to overcome staffing problems such as high vacancy rates. The changes have made staff feel more valued, made A&E a more attractive place for junior doctors to work and have significantly improved the quality and safety of care that patients receive in our A&E department.

We also had two teams – the Alex's HDU team and the County's theatre team shortlisted for Nursing Times Awards, which were held last month. While they were not the eventual winners, just being shortlisted is a real achievement and a recognition of their excellent work.

Our Clinical Media Centre has also won platinum and gold at the Institute of Medical Illustrators awards for the clinical photography of Lucy Francis, and our anaesthetists won 1st prize at the annual conference of the Enhanced Recovery after Surgery Society (ERAS UK).

6. Flu campaign

We have been encouraging as many of our staff as possible to have a flu jab this year. The national NHS has warned that the coming flu season is likely to be severe and we have a free vaccination available for every member of staff.

We have held drop in sessions and had a team of roving vaccinators who have vaccinated individual teams and departments. We have shared with staff the research findings that only 23% of people with the flu develop symptoms – which means 77% of people with the flu are walking around and spreading it without knowing it. We have also reminded staff that for every flu jab we give at the Trust, we will donate to Unicef a tetanus vaccination to a child in the developing world.

The results so far are encouraging. Over 43% of all front line staff have already been vaccinated – which compares with a total of 39% vaccinated last year. And our drop in sessions and encouragement to take up a jab continue.

7. Willow Room reopens

We reopened the Willow Room at the Princess Royal Hospital after refurbishment in October. The Willow Room is a peaceful place where parents experiencing stillbirth can spend time with their babies and families before and after the birth, away from the busy labour ward.

The trauma parents go through with stillbirth is unimaginable and this facility helps our incredible maternity teams offer them support and comfort in the most difficult of times.

The complete makeover, supported by the local charity Oscar's Wish Foundation, has made it a more comforting and relaxing place.

8. Children in Need

Singer-songwriter Katie Melua visited the Royal Alexandra Children's Hospital this month with a BBC TV crew to learn more about the Wishing Well programme, which is supported by Children in Need.

Katie was able to see first-hand how the programme brings music onto the high-dependency, medical and surgical wards, and the musicians and Alex staff are able to ease their isolation and frustrations and help to stimulate their curiosity and their recovery. She
met children on wards and their families and staff.

It is another example of the innovative care that our staff have introduced for our patients. It makes a real difference and was featured in this month's Children In Need programme on BBC 1.

9. £1 million upgrade works at Princess Royal Hospital A&E

We have started improvement works at the PRH A&E department. The £1 million investment will bring significant benefits for patients who need urgent treatment at the hospital.

We are building two extra consulting rooms, along with six larger trolley spaces that will be equipped with piped oxygen and suction apparatus, along with full monitoring equipment. This will improve patient safety and make it easier to assess, treat and discharge emergency patients. We will also create a new spacious resuscitation area and a new rapid assessment area with room for two beds, where patients can be more readily be treated.

Alongside these physical improvements, we are increasing the nursing and senior medical cover in the A&E department.

The end result will be a better patient experience where patients are seen quickly and safely and which reduces the length of time they spend in A&E. The works are expected to be completed by Christmas.

Marianne Griffiths
Chief Executive
November 2017

Brighton and Sussex University Hospitals NHS Trust

To: Board of Directors

Date of Meeting: 29 November 2017 Agenda Item: **6**

Title
Quality Report Month 8
Responsible Executive Director
Dr George Findlay (Chief Medical Officer) and Nicola Ranger (Chief Nursing and Patient Safety Officer)
Prepared by
Mark Renshaw, Deputy Chief of Safety
Status
Public
Summary of Proposal
The report describes performance against safety and quality key performance indicators in Month 8, in the domains of safety, effectiveness and patient experience
Implications for Quality of Care
The report includes exceptions in respect of pressure damage which is at its highest since 2012-13 and implementation of the alert - Restricted use of open systems for injectable medications.
Link to Strategic Objectives/Board Assurance Framework
This report incorporates key national, regional and local quality indicators relating to quality and safety providing assurance for the Board and highlighting issues of concern. **A safety and quality scorecard is appended**
Financial Implications
Future reports will include KPIs that have potential financial impact (e.g. CQUIN)
Human Resource Implications
Safer staffing levels are incorporated in the safety and quality scorecard
Recommendation
The Board is asked to NOTE the report.
Communication and Consultation
Not applicable
Appendices
None

1 INTRODUCTION

1.1 This report brings together key national, regional and local indicators relating to quality and safety. The purpose of the report is to bring to the attention of the Trust Board quality performance within Brighton and Sussex University Hospitals NHS Trust (BSUH).

1.2 The paper describes performance on an exceptional basis determined by RAG (red/amber/green) ratings based on national, regional or local targets.

2 KEY QUALITY OBJECTIVES

2.1 Dashboard Definitions

2.1.1 A Safety and Quality Scorecard is appended to the Board report. Key indicators are detailed in table 1. Figures are in-month figures (e.g. the number of falls reported in June) unless otherwise stated.

2.1.2 Exception reports are included under the relevant section of this report (i.e. under the broad headings Effectiveness, Safety and Experience).

2.1.3 Only the current financial year and year to date values are RAG rated, with the exception of those metrics reported in arrears with no data in the current financial year where the most recent data-point of last year is RAG rated.

2.2 Overview of Key Quality Objectives

2.2.1 The following table shows performance against key, top level quality indicators.

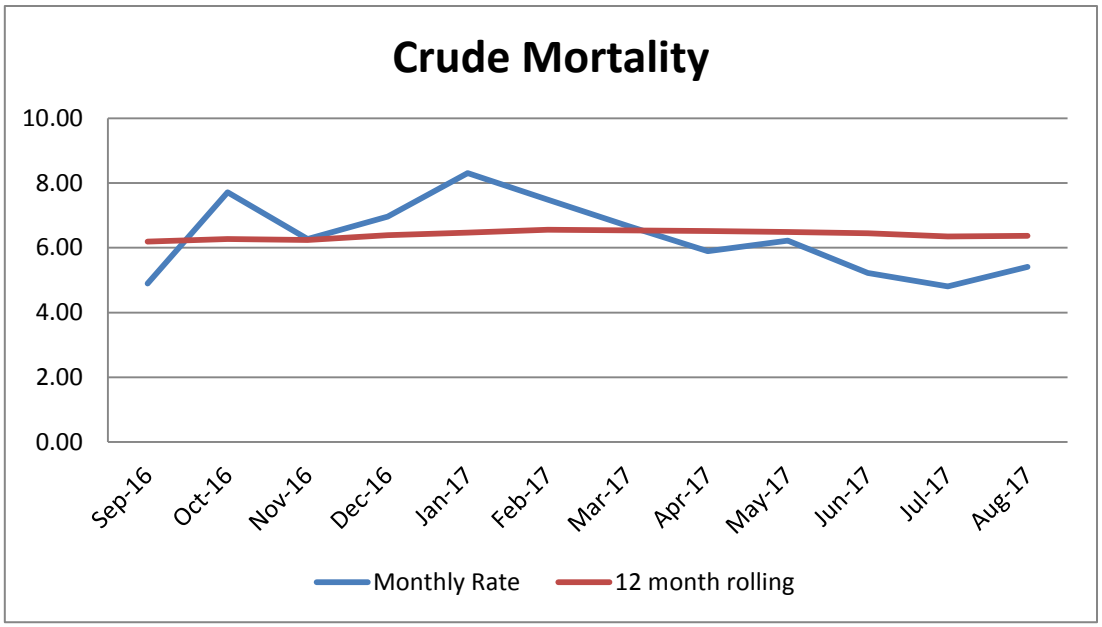
Table 1: key performance indicators

Indicator	August	September	October
Trust crude mortality rate (non-elective)	5.41%		
Hospital Standardised Mortality Ratio	96.37		
Safety Thermometer (Harm-Free Care)	95.6	95.4	94.5
Number of Serious Incidents Requiring Investigation	4	5	5
Never Events	0	0	1
Grade 3 and 4 Pressure Ulcers	0	2	0
Falls resulting severe harm or death	1	3	2
Numbers of hospital attributable MRSA	0	0	0
Numbers of hospital C. diff cases	4	4	4
The Friends and Family Test: Percentage Recommending Inpatients	96.2%	94.4%	96.2%
The Friends and Family Test: Percentage Recommending A&E	86.2%	89.4%	89.6%
Mixed Sex Accommodation breaches (number of breaches)	21	67	
Number of formal complaints	49	50	54

3 EFFECTIVENESS

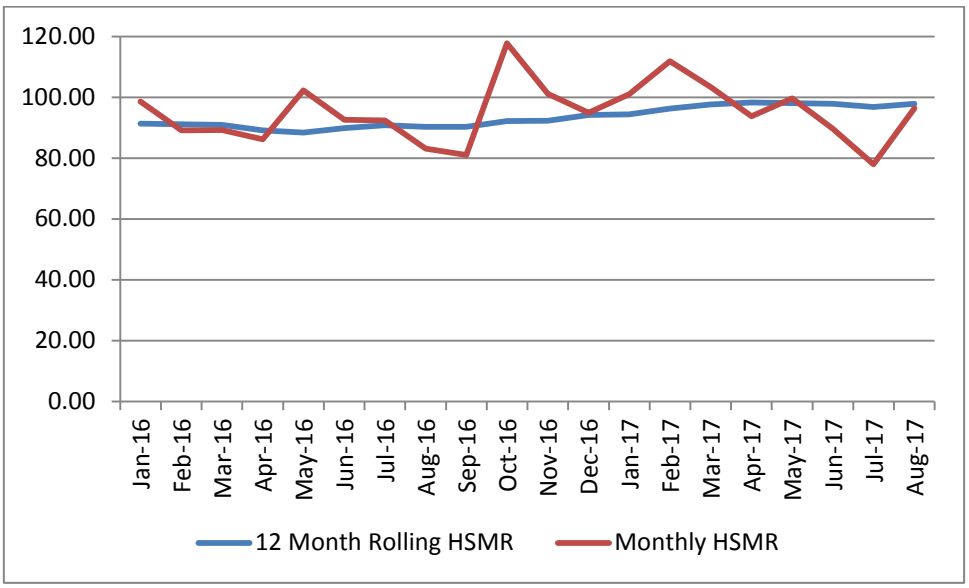
3.1 Crude Trust Mortality – Non-Elective

3.1.1 The HEDs Comparative database reports a crude mortality rate of 6.4% for the past 12 month. This compares to a rate of 6.30% for the 12 months ending August 2016.



3.2 Hospital Standardised Mortality Ratio (HSMR)

3.2.1 HSMR is only available for the month of August when 78 patients died against an expected number of 80.9 (HSMR 96.4). In the 12 months to August the HSMR was 97.85[1] (LCI 92.8, UCI 103.1). The graph below illustrates that the both the rolling and monthly HSMR have gradually risen since January 2016.



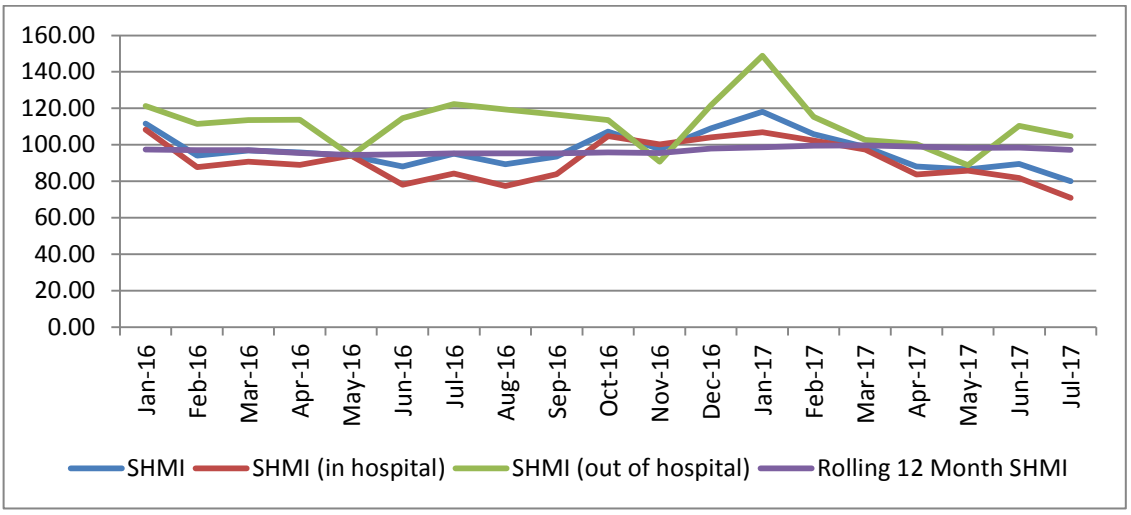
Twelve months ago the annual HSMR was 90.33 (LCI 85.6, UCI 95.3).

[1] *A value greater than 100 means that the patient group being studied has a higher mortality level than NHS average performance*

3.3 Summary Hospital-Level Mortality Indicator (SHMI)

3.3.1 The latest SHMI for the 12 months up to July 2017 reports a SHMI of 97.3, i.e. mortality is 2.7% below the expected value. The Table below details the in and out of hospital SHMI since the start of 2016. It illustrates that in hospital deaths are 8% below the expected number, whilst out of hospitals deaths are 20% above the expected rate. The trend line for SHMI, SHMI in hospital and SHMI out of hospital are all coming down.

Discharge Month	SHMI	SHMI (in-hospital)	SHMI (out of hospital)	Rolling 12 Month SHMI
Jan-16	111.71	108.28	121.21	97.46
Feb-16	94.14	87.80	111.45	97.14
Mar-16	96.84	90.79	113.51	97.11
Apr-16	95.77	89.06	113.81	95.55
May-16	93.96	93.99	94.02	94.50
Jun-16	88.19	78.02	114.67	94.76
Jul-16	95.13	84.23	122.33	95.32
Aug-16	89.27	77.44	119.33	95.33
Sep-16	93.50	83.82	116.56	95.28
Oct-16	107.21	104.78	113.48	95.88
Nov-16	97.63	100.15	90.72	95.49
Dec-16	108.97	104.16	121.56	97.93
Jan-17	118.09	106.91	148.84	98.58
Feb-17	105.79	102.35	115.30	99.54
Mar-17	98.82	97.40	102.73	99.73
Apr-17	88.18	83.65	100.35	99.07
May-17	86.59	85.78	88.89	98.36
Jun-17	89.43	81.77	110.48	98.50
Jul-17	80.08	70.98	104.72	97.27
Total	**96.63**	**91.97**	**119.50**	**97.27**



4 SAFETY

4.1 Central Alert System (CAS) Safety Alerts

4.1.1 The outstanding safety alert - NHS/PSA/D/2016/008 - Restricted use of open systems for injectable medications was closed as compliant during November.

4.2 Serious Incidents Requiring Investigation (SIRIs)

4.2.1 There were fourteen Serious Incidents declared during the period August to October. The outcome in two of these incidents is currently graded as catastrophic, a further six are classified as moderate. Below is a list of all fourteen SI's:

Title of investigation	Harm Caused
Pneumonia Death	Death
Fall on Plumpton	Moderate
12 hour breach	No Harm: Impact not Prevented
Analysis of Carbapenemas-producing Enterobacteriaceae specimens from two patients	No Harm: Impact not Prevented
Fall on Plumpton	Moderate
Patient ingested cleaning fluid	Severe
Disinfection failure of Endoscope Washer	Low
12 hour breach	No Harm: Impact not Prevented
Fall on Pyecombe	Moderate
Trisome 18 screening lapse	No Harm: Impact not Prevented
12 hour breach	No Harm: Impact not Prevented
Never Event - Wrong site surgery	Moderate
Fall on Level 8 ward	Death
Fall in A&E	Moderate

4.3 Infection prevention and control

4.3.1 There have been 32 cases of hospital-attributable Clostridium difficile YTD.

4.3.2 Root cause analysis' (RCA) identified that there had been lapses in care, primarily in relation to cleaning standards; a trial of ultraviolet cleaning has been successfully completed, asa adjunt to cleaning and a business case is being developed.

4.3.3 The allocated Trust target limit for 2017/18 is set at 46 for the year. This equates to a rate of infection of 3.69 per 100,000 bed days.

4.3.4 There have been no hospital acquired MRSA bacteraemias for the period July to September.

4.4 Inpatient Falls

4.4.1 The adult inpatients falls rate for the period August to October was 3.23 falls per 1000 bed stay days.

4.4.2 In the 2015 report on inpatient falls produced by the Royal College of Physicians the national average is reported as 6.63 falls per 1000 bed stay days.

4.4.3 The rate of falls for this financial year is 3.21 falls per 1000 bed stay days, this is currently 8.6% lower than last year's rate

4.5 Tissue Viability

4.5.1 There were two grade 3 pressure damage incidents during the period August to October.

4.5.2 In the same period 47 incidences of grade 2 hospital acquired pressure ulcers were reported. Damage to the sacrum, buttocks and heels remains the most common form of pressure damage. Inadequate documentation of skin assessment and changes of position is a recurring theme.

4.5.3 The rate of pressure damage per 1000 bed stays days during the period August to October was 0.72; this is 36% higher than the last financial year.

4.6 NHS Patient Safety Thermometer

4.6.1 The NHS Patient Safety Thermometer is used across all adult and neonatal wards. This tool looks at point prevalence of four key harms - falls, pressure ulcers, urinary tract infections and deep vein thrombosis (DVT) and pulmonary embolism (PE) in all patients on a specific day in the month. A dashboard is available to each ward showing Trust-wide and ward-level data for each individual harm as well as the harm-free care score. These numbers are also shared via the new ward screens.

4.6.2 Over the past 12 months the rate of harm free care has increased. The harm-free care score for the past 12 months was 95.4 against the target of 95%. The national average is 94.2%.

4.6.3 National data relating to the NHS safety thermometer is available below:

http://www.safetythermometer.nhs.uk/

4.7 Exception Reports Relating to Patient Safety

The current rate of pressure damage for this financial year is 0.66 per 1000 bed stay days. The last time the rate was this high was in 2012-13 when the rate was 0.64.

5. PATIENT EXPERIENCE

5.1 PALS and Complaints

5.1.1 1,281 concerns were received by the Trust from 1 August – 31 October 2017.

5.1.2 Of these, 1,128 concerns were resolved via local resolution and 154 required a written response from the Managing Director. Year to date 95% of Early Resolutions have been resolved within 25 working days and 48% of formal complaints have been closed within 40 working days.

5.1.3 Currently the Trust has six formal complaints remaining open over six months (five of which are Digestive Diseases complaints) and the Complaints team has sought support from the Medical Director in resolving the outstanding cases. The Trust currently has 23 complaints exceeding the 40 working day timescale.

5.1.4 68 complaints citing the poor attitude of staff have been reported from 1 August – 31 October 20

5.2 Friends and Family Test (FFT)

Patients who access hospital services are asked whether they would recommend the Trust to their friends or family if they needed similar treatment. Patients who access inpatient, outpatient, day-case, A&E and maternity are all offered the opportunity to respond to the question. Scores were above 95% for inpatients, maternity and below 88.4% for A&E, which represents an improvement of 1% since the last report.

Table 4: Friends and Family Test

	Percentage recommending BSUH in August - October
Inpatient care	95.6%
A&E	88.4%
Maternity	95.7%
Outpatient	95.1%

Friends and Family Test Response Rates:

5.2.4 Response rates for in-patients remains poor, at just above 11%.

5.4 Patient Voice

5.4.1 The Patient Voice survey is offered on all adult wards. In the past 12 months 8534 questionnaires have been returned. Performance all 13 questions has improved over the past 12 months.

5.5 Exception Reports Relating to Patient Experience

5.5.1 Response rates for the Friends and Family Test are low and require improvement in all areas. The Charitable Funds Committee agreed in principle funding for the service provided by Healthcare Communications (as for A&Es and maternity), which will provide multiple means of obtaining patient feedback. The funding source has yet to be confirmed.

5.5.2 Mixed sex accommodation breaches have reduced month by month and in August BSUH reported 2, unfortunately this rose to 67 in September and reduced to 58 in October, primarily in cardiac and neurosurgery. Although there has been increased management of single sex accommodation by the Clinical Site Team and wards, the increase experienced has been when the Trust was in Business Continuity and Black escalation.

6. CARE QUALITY COMMISSION (CQC)

6.1.1 The CQC feedback and Trust response are discussed in a separate Board agenda item.

7. RECOMMENDATION

7.1 The Board is asked to note the contents of this report.

Brighton and Sussex University Hospitals NHS Trust

To: Trust Board

Date of Meeting: 29th November 2017 Agenda Item: **6**

Title
Learning from Deaths Policy
Responsible Executive Director
George Findlay: CMO
Prepared by
Dr Stephen Drage; Deputy Medical Director, Safety and Quality
Status
Summary of Proposal
In March 2017 the National Quality Board (NQB) published the National Guidelines on Learning from Deaths document, in order to improve standards of identifying, reporting, investigating and learning from deaths. In response, this policy describes three levels of mortality review with increasing levels of scrutiny depending on the concerns raised about the care leading up to death, and the opportunities for learning that this represents. The policy requires the development of a number of new processes and enhancement of existing ones. Developing these processes will take time and at the time of writing this policy not all of the procedural elements required to deliver this policy are in place. Where this is the case this is made clear in the policy along with the actions required to fully embed these procedures. The policy will be updated in line with further developments in the organisation.
Implications for Quality of Care
Information identified during mortality reviews will be used to inform local and Trust wide porgrammes to improve the quality of patient care
Link to Strategic Objectives/Board Assurance Framework
True North Objective: Reducing Avoidable Deaths
Financial Implications
Development of central mortality review team: business case in preparation
Human Resource Implications
As above
Recommendation
The Board/Committee is asked to: APPROVE this policy
Communication and Consultation
Mortality review leads have been involved in development, specialized areas have been asked for comment and Divisional Leads have been given opportunity to comment. Patients were involved in developing the national guidance.
Appendices
Learning from Deaths Policy

Brighton and Sussex University Hospitals NHS Trust

Brighton and Sussex University Hospitals

TW220 Learning from Deaths Policy:

Identifying, Reporting, Investigating and Learning from Deaths

Version:	1.4
Category and number:	TW220
Approved by:	Quality and Performance Committee
Date approved:	[insert date]
Name of author:	Deputy Medical Director: Safety and Quality
Name of responsible committee/individual:	Trust Mortality Review Group/Medical Director
Date issued:	Draft 20th October 2017
Review date:	September 2020
Target audience:	Clinical staff/Divisional and Departmental Management Teams/Trust Board
Accessibility	Electronic version only.

Contents

1 Introduction

For some people under the care of Brighton & Sussex University Hospitals (BSUH), death is an inevitable outcome. Many people experience excellent care from BSUH staff in the period leading up to their death. However, some patients experience poor quality care resulting from multiple contributory factors. By reviewing deaths we can ascertain whether the patient received the highest possible standards of care before they died. If not we can put in place actions to ensure future patients have a better experience. Moreover, it gives us the opportunity to thank staff and reinforce good practice when patients receive excellent care at the end of their lives.

In March 2017 the National Quality Board (NQB) published the National Guidelines on Learning from Deaths document, in order to improve standards of identifying, reporting, investigating and learning from deaths. In response, this policy describes three levels of mortality review with increasing levels of scrutiny depending on the concerns raised about the care leading up to death, and the opportunities for learning that this represents.

The policy requires the development of a number of new processes and enhancement of existing ones. Developing these processes will take time and at the time of writing this policy not all of the procedural elements required to deliver this policy are in place. Where this is the case this is made clear in the policy along with the actions required to fully embed these procedures. The policy will be updated in line with further developments in the organisation.

2 Purpose of this policy

BSUH will implement the requirements outlined in the Learning from Deaths guidance as part of the organisation's existing procedures to learn and continually improve the quality of care provided to all patients.

This policy sets out the procedures for identifying, recording, reviewing and investigating the deaths of people in the care of BSUH. The scope of this policy refers to patients who are in-patients at the time of their death and those people who have died following recent treatment in BSUH whose deaths are notified to us by outside agencies. As part of a continuous improvement process for mortality review we would seek to broaden the scope of this policy to include review of deaths in patients who have recently received treatment at BSUH or are under active follow up by our services.

The policy also describes how BSUH will support people who have been bereaved by a death at the Trust, and also how those people should expect to be informed about and involved in any further action taken to review and/or investigate the death. It also describes how the Trust supports staff who may be affected by the death of someone in the Trust's care.

It sets out how the Trust will seek to learn from the care provided to patients who die, as part of its work to continually improve the quality of care it provides to all its patients.

This policy should be read in conjunction with the following Trust policies:

C018 Verification Certification and Notification of Death

TW018 Religion and Belief Policy

SQ005 Duty of Candour– Policy for communicating with patients or relevant persons following a notifiable patient safety incident, complaint or claim

SQ006 Investigation of Incidents, Complaints and Claims using Root Cause Analysis

SQ008 Policy and Procedure for the Internal and External Reporting of Incidents and Management of Serious incidents

HR010 Support arrangements for staff dealing with difficult situations

3 Definitions

The National Guidance on Learning from Deaths includes a number of terms. These are defined below.

Death certification: The process of certifying, recording and registering death, the causes of death and any concerns about the care provided. This process includes identifying deaths for referral to the coroner.

Case record review: A structured desktop review of a case record/note, carried out by clinicians, to determine whether there were any problems in the care provided to a patient. Case record review is undertaken routinely to learn and improve in the absence of any particular concerns about care. This is because it can help find problems where there is no initial suggestion anything has gone wrong. It can also be done where concerns exist, such as when bereaved families or staff raise concerns about care.

Mortality review: A systematic exercise to review a series of individual case records using a structured or semi-structured methodology to identify any problems in care and to draw learning or conclusions to inform any further action that is needed to improve care within a setting or for a particular group of patients.

Structured judgement review (SJR): A form of structured case record review developed by the Royal College of Physicians as part of the National Mortality Case Record Review Programme. It provides reviewers with a structured format for performing a case notes review ensuring that all relevant aspects of care are included. The SJR data collection form is attached in Appendix 1.

Serious Incident: Serious Incidents in healthcare are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant, or the potential for learning is so great, that a heightened level of response is justified. Serious Incidents include acts or omissions in care that result in unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm – including those where the injury required treatment to prevent death or serious harm – abuse, Never Events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services, and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services. See the Serious Incident framework for further information.

Investigation: A systematic analysis of what happened, how it happened and why, usually following an adverse event when significant concerns exist about the care provided. Investigations draw on evidence, including physical evidence, witness accounts, organisational policies, procedures, guidance, good practice and observation, to identify problems in care or service delivery that preceded an incident and to understand how and why those problems occurred. The process aims to identify what may need to change in service provision or care delivery to reduce the risk of similar events in the future. Investigation can be triggered by, and follow, case record review, or may be initiated without a case record review happening first.

Death due to a problem in care: A death that has been clinically assessed using a recognised method of case record review, where the reviewers feel that the death is more likely than not to have resulted from problems in care delivery/service provision. (Note, this is not a legal term and is not the same as 'cause of death'). The term 'avoidable mortality' should not be used, as this has a specific meaning in public health that is distinct from 'death due to problems in care'.

Quality improvement: A systematic approach to achieving better patient outcomes and system performance by using defined change methodologies and strategies to alter provider behaviour, systems, processes and/or structures.

Patient safety incident: A patient safety incident is any unintended or unexpected incident which could have led or did lead to harm for one or more patients receiving NHS care.

4 Responsibilities, Accountabilities and Duties

Trust Board

Responsibilities of the Board are to ensure that:

- there is **an identified executive director** to take responsibility for the learning from deaths agenda **and a non-executive director** to take oversight of progress;

- the **Trust has an effective policy** for identifying, reporting, investigating and learning from deaths;
- the Trust pays particular attention to the care of patients with a **learning disability or mental health needs**;
- the Trust has a systematic approach to **identifying those deaths requiring review** and selecting other patients whose care they will review;
- the Trust adopts a robust and **effective methodology for case record reviews** of all selected deaths (including engagement with the LeDeR programme) to identify any concerns or lapses in care likely to have contributed to, or caused, a death and possible areas for improvement, with the outcome documented;
- **case record reviews and investigations are carried out to a high quality**, acknowledging the primary role of system factors within or beyond the organisation rather than individual errors in the problems that generally occur;
- **mortality reporting in relation to deaths, reviews, investigations and learning is regularly provided to the board** in order that the executives remain aware and non-executives can provide appropriate challenge. The reporting should be discussed at the public section of the board level with data suitably anonymised;
- **learning from reviews and investigations is acted on** to sustainably change clinical and organisational practice and improve care, and **reported in annual Quality Accounts**;
- **relevant learning is shared** across the organisation and with other services where the insight gained could be useful;
- sufficient numbers of **nominated staff have appropriate skills** through specialist training and protected time as part of their contracted hours to review and investigate deaths;
- the **Trust delivers timely, compassionate and meaningful engagement with bereaved families and carers** in relation to all stages of responding to a death;
- **where necessary an independent investigation** (commissioned and delivered entirely separately from the organisation(s) involved in caring for the patient) **is carried out.** For example, in cases where it will be difficult for an organisation to conduct an objective investigation due to its size or the capacity and capability of the individuals involved; and,
- the **Trust works with commissioners to review and improve their respective local approaches** following the death of people receiving care from their services.

Executive Director with responsibility for Learning from Deaths

- Provide executive leadership and take overall responsibility for delivering the Learning from Deaths agenda.
- Ensure that the Trust Board and relevant sub committees fulfil their duties in line with the policy
- Work closely with the appointed Non-Executive Director to carry out their responsibilities.

Non-Executive Director with responsibility for Learning from Deaths
Their responsibility is to take oversight of the processes surrounding the Learning from Deaths agenda:

- Understand the processes for learning from deaths, ensuring they are robust and can withstand external scrutiny, by providing challenge and support.
- Champion and support learning and quality improvement.
- Provide assurance around published information by ensuring that published information is a fair and accurate reflection of the Trust's achievements and challenges

Quality and Risk Committee
Responsibilities of this Board sub-committee are to:

- Receive quarterly updates on mortality review from the Trust Mortality Review Group.
- Scrutinise and challenge reports and data in relation to mortality review and Trust mortality rates.
- Provide assurance to the Board on the adherence to this policy and the overall standards of clinical care to patients.

Trust Mortality Review Group (TMRG)
Responsibilities of this operational committee are to:

- Oversee the implementation of this policy
- Scrutinise national mortality data (HSMR/SHMI) for trends and concerns
- Decide and commission the appropriate level of mortality review in line with Trust Policy (Section 6)
- Ensure that **all departments have appropriate mortality review procedures** in place.

- **Review coroners Prevention of Future Deaths notices ('Regulation 28 letters')**, decide if any further review is required and to ensure there is an appropriate action plan in place
- **Ensure appropriate training** in mortality review techniques is available to relevant staff
- Receive reports from the **LeDeR programme**, **neonatal death reviews**, **maternal death reviews** and the **child death overview panel.** The committee will ensure that there is an appropriate action plan in place for any recommendations.
- Engage in **regular communications with Divisional management teams** and departmental mortality leads to share lessons emerging from mortality reviews

Deputy Medical Director: Safety and Quality (DMD S&Q)

- Chair the TMRG and ensure the committee discharges its functions as described above.
- Ensure high quality communication between the committee and relevant stakeholders to ensure the dissemination of important leaning points/recommendations.
- Ensure concerns arising from mortality review are escalated to the appropriate forum (eg: Divisional Management Team, Trust Executive Committee or Quality and Risk Committee.)
- Supported by the Safety & Quality team to ensure that the processes and procedures required to deliver the learning from deaths process are implemented (eg: training in mortality review, development and maintenance of a mortality review database).

Medical Examiners (ME) [1]

Discuss all adult deaths with the referring doctor, review the case notes and speak to the bereaved in order to elicit concerns.

- Identify concerns about a death that require further review and escalate in line with Trust Policy (Section 6)
- Ensure that deaths requiring coronial review are appropriately referred
- To ensure accurate and complete recording of the cause of death on the Medical Certificate of Cause of Death

[1] At the time of writing the ME system is not yet fully functional at Princess Royal Hospital but recruitment to more ME posts are planned to develop this service. A small selection of deaths may be referred directly to the coroner.

Independent Mortality Review Team[2]

A small team of doctors, nurses and allied health professionals trained to carry out high quality Structured Judgement Reviews.

- Undertake high quality SJRs in line with Trust Policy (section 8)
- Advise the TMRG on emerging themes from SJRs
- Provide training on the SJR method

Divisional Management Team

- Ensure that all departments in the Division have a mortality review process in line with the guidance in this policy,
- Ensure that the actions arising from mortality reviews, incident investigations and coronial Prevention of Future Deaths notifications are carried out in a timely fashion.
- Ensure that all relevant staff are made aware of learning points arising from mortality review and where appropriate this information is disseminated to all departments in the Division
- Ensure that concerns arising from departmental mortality reviews are escalated for review by TMRG where appropriate.

Departmental Mortality Review Meetings

- Undertake departmental mortality review in line with guidance set out in appendix 2.
- Appoint a senior doctor (consultant or Staff/Associate specialist) lead for Learning from Deaths/Mortality Review who will ensure the guidance in appendix 2 is followed.

Departmental Mortality Lead

- Ensuring their departmental mortality review process adheres to the guidance set out in this policy.
- Escalate any causes for concern to the TMRG for consideration of higher level review.
- Share any learning/recommendations arising from mortality review (either local reviews, those passed on by TMRG or arising from SI investigations) with relevant members of staff in their department.

[2] At the time of writing this team has not been formally created however a programme of training is underway.

- Provide the TMRG with monthly data on the number of deaths in that department and the number of deaths undergoing structured mortality review.
- Provide the TMRG with their departmental criteria for case selection for mortality review and the structured mortality review tool used by the department.

Safety & Quality Team

- Action recommendations for mortality review as requested by the ME or TMRG
- Maintain accurate records relating to outcome and number of SJRs
- Provide the TMRG with monthly mortality reports to include mortality statistics and alerts
- Provide data as requested on mortality for governance and assurance purposes
- Provide administrative support to the TMRG & Serious Incident Review Meeting (SIRM)
- Receive Datix® incident reports and escalate incidents where harm has been caused to the members of the SIRM

Medico-Legal Team

- Co-ordinate responses to Regulation 28 notifications from HM Coroner
- Support the DMD S&Q to notify the HM Coroner where a death is considered to be preventable
- Notify the TMRG/SIRM where the HM Coroner has raised a concern regarding a death

Learning Disabilities Team

- Identify deaths of patients with a Learning Disability and undertake SJRs whilst the LeDer Programme is being developed.

Consultants

- All consultants have a responsibility to take part in mortality review. This is a routine supporting professional activity and part of good medical practice.

- Consultants who have a larger role in mortality review (ie: departmental mortality leads or those undertaking many structured mortality reviews) should have this work recognised in their job plans.
- Consultants will be responsible for leading and supporting improvement work arising from mortality review in their department.
- Consultants are responsible for raising concerns about a death using the Datix® incident reporting system and discussing the concerns with their departmental lead consultant.

Staff

All staff are responsible for raising concerns in relation to a patient's death.

- Concerns should reported by using the Datix® incident reporting system or by reporting concerns to their line manager.
- Doctors involved in referring deaths to the Medical Examiner or coroner should inquire whether any of the staff involved in the patient's care have concerns that need to be raised during this referral process.
- Staff also have a responsibility to keep up to date and review any information about learning points arising from mortality review that is distributed by their departmental mortality lead or TMRG.
- All staff are expected to be actively involved with improvement plans put in place following the mortality review process.

5 Identification and recording of deaths

Deaths in in-patients are identified by ward staff and reported to the Bereavement Office as described in the Trust's Verification, Certification and Notification of Death Policy (C018). The Trust does not receive routine notification of deaths in patients who have been discharged from hospital or who are under out-patient follow up by the Trust's departments. Where the Trust receives notification from an outside agency of concerns relating to a death in a patient who has received care from BSUH these cases will be reviewed in TMRG.

6 Review and investigation of deaths

The three level review process is summarised in in Figure 1. This does not need to be a sequential process; for example where serious concerns are raised an SI investigation may be recommended before even the ME review has occurred. Similarly, where an SI or coronial inquiry is underway there may still be merit in undertaking a departmental mortality review.

- **1st Level Review:** Medical Examiner (ME)

All deaths notified to the bereavement office will be discussed with the duty ME by a doctor from the deceased's medical team. This doctor should give a detailed account of the patient's medical history and any concerns about the deceased's care including any patient safety incidents and concerns raised by relatives or staff.

The ME will scrutinise the deceased's medical record to corroborate the referring doctor's account and confirm the proposed cause of death, if appropriate.

The ME will contact the deceased's next of kin, as detailed in the medical record, and discuss any concerns. Where the next of kin do not speak English or have other communication difficulties the Medical Examiners will utilise the Trust's interpretation services.

The ME will record their inquiries in a bespoke form within the Trust's Datix® incident reporting database. This form allows the ME to record their recommendations for further review which are automatically notified to a member of the Safety and Quality Team who will action those recommendations.

At the conclusion of their review the ME may advise coronial referral or issue of the Medical Certificate of Cause of Death (MCCD); **in addition** they may recommend the following:

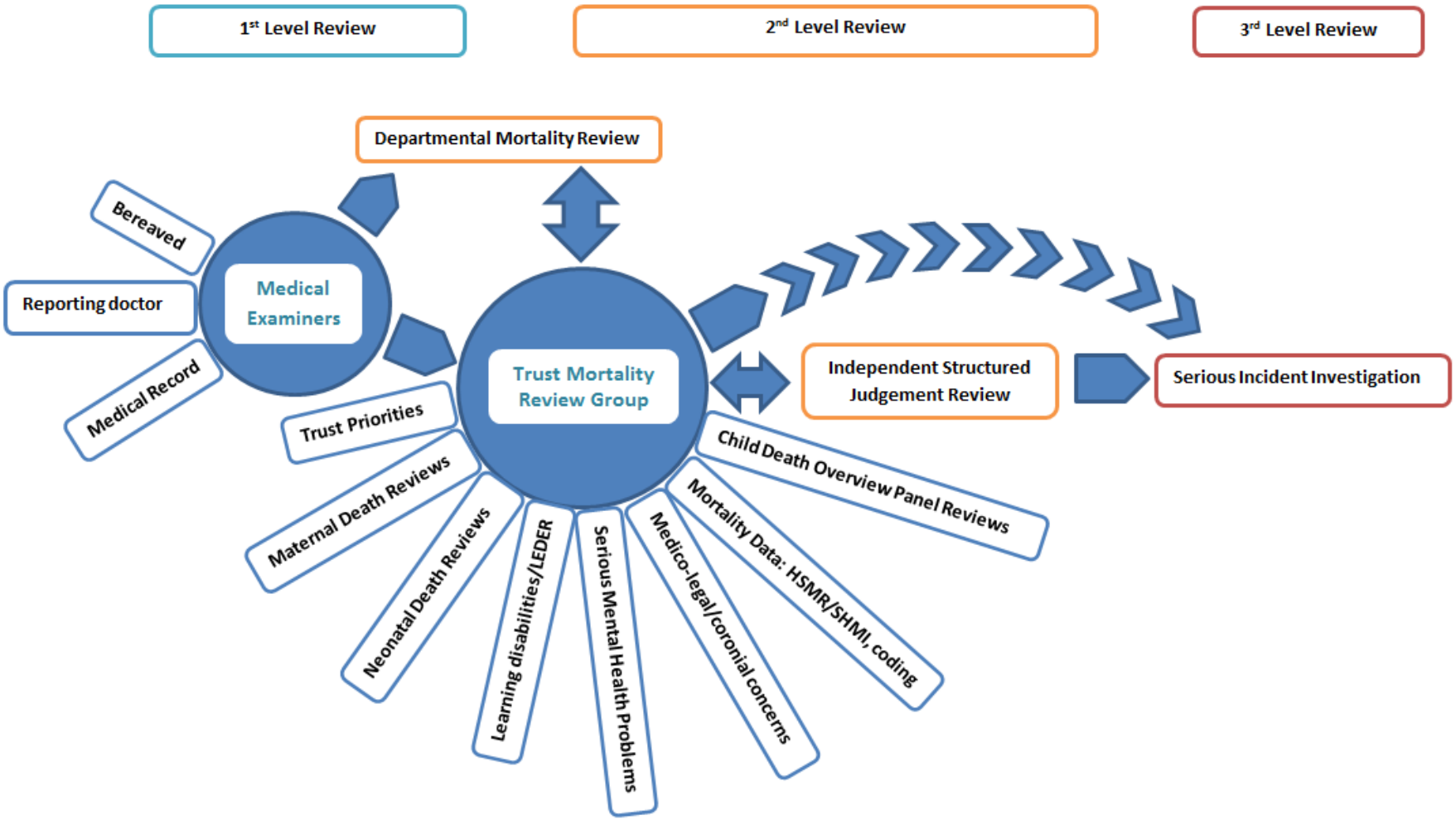
- **No further review required:** where no concerns are identified, issue of the MCCD or coronial referral continues as usual. A department or TMRG may still choose to perform a 2nd level review even if no concerns are identified by the ME if the deceased fell into either the departmental or TMRG categories for review (for example: had a condition of educational interest or were part of a national mortality data alert).
- **Departmental Mortality Review:** where the ME has identified minor concerns, potential learning points for the department or areas of particularly good practice.
- **TMRG Review:** for more serious concerns, where there is wider organisational learning or the patient was in a predefined group of interest (including those with learning difficulties and serious mental health conditions).
- **Completion of a patient safety incident report (Datix®):** where the ME believes there has been a patient safety incident this should be recorded as separate incident on the Datix® incident reporting system.

- **2nd Level Review:** Case Record Review
  There are two forms of second level review; Departmental Mortality Review and Independent Structured Judgement Review**.**
  - **Departmental mortality review**
    A guide for departmental mortality review is attached in appendix 2.

Each department will publish their criteria for which deaths will undergo departmental review and report these to TMRG. Each department will use a structured format for mortality review. The Royal College of Physicians Structured Judgement Review (RCP SJR) Tool is the recommended format for mortality review but it is recognised that some departments already use other structured review tools. If a department wishes to use a format other than the RCP SJR this must be agreed by the TMRG. Training in use of the RCP SJR method will be offered to all departmental mortality leads.
Results of departmental reviews will be shared with staff in that department at regular mortality meetings.

Where a patient safety incident is identified as part of a departmental SJR this should be reported on the Datix® incident reporting system to allow a full investigation to take place.

Figure1: BSUH Mortality Review Process



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- **Independent Structured Judgement Review**
  Where significant concerns are raised or the death falls into one of the predefined categories of interest the TMRG will commission an independent SJR from a team of trained mortality reviewers. To ensure objectivity the reviewers will be instructed not to review deaths where they were involved in the patients care or where the patient had significant contact with the reviewer's department.
  Categories where TMRG may request an independent SJR include

  - Concern raised by the bereaved, staff or Medical Examiner
  - Concern raised by the coroner or BSUH medico-legal team
  - Concern raised by external agency or other healthcare provider
  - Death in a patient with learning difficulties or severe mental health issues
  - Mortality alerts arising from national mortality data (HSMR/SHMI)
  - To support Trust priorities/'True North' objectives
  - A random sample of deaths

  SJRs are recorded on a bespoke form within the Datix® incident reporting database. Results of the SJRs are shared with the TMRG, relevant departmental mortality leads and Divisional Management teams. Where appropriate the reviews will be shared with other Trust committees or (suitably anonymised) with external agencies. It should be noted that any mortality review undertaken by the Trust is discoverable by HM Coroner to inform their inquiry.

  Examples of the learning generated and actions taken are presented to the Trust board on a quarterly basis. Themes arising from reviews will be shared with the Trust's Patient's First improvement programme to inform the wider quality improvement agenda.

  Where there are significant concerns or where concerns have been raised by the bereaved, the next of kin will be informed by the independent reviewer that a review is taking place and offered the opportunity to share any further concerns so that these can be addressed as part of the review. The bereaved will also be offered a summary of the final SJR and the opportunity to discuss it with the independent reviewer.

  Where significant concerns have been raised or there are challenging issues raised by a case, the independent reviewers may choose to ask for a second opinion from another trained reviewer and/or a multidisciplinary review by the TMRG members before finalising the review.

Where a patient safety incident is identified during an SJR this should be reported on the Datix® incident reporting system to allow a full investigation to occur.

- **3rd Level Review:** Serious Incident Investigation and Coronial Inquiry
  - **Serious Incident Investigation**
    If, at any stage of the review process, it becomes clear that the patient's death was likely to have been due to a problem in care, the case will be referred for consideration of Serious Incident investigation in line with:
    - *Policy and Procedure for the Internal and External Reporting of Incidents and Management of Serious incidents (SQ008)*,
    - *Policy for Investigation of Incidents, Complaints and Claims using Root Cause Analysis (SQ006)*
    - *Duty of Candour– Policy for communicating with patients or relevant persons following a notifiable patient safety incident, complaint or claim (SQ005)*.

    Where any staff identify that a death was likely to have been preventable or due to a problem in care, then this must be reported as a patient safety incident using the Datix® incident reporting database and will be progressed in line with Trust policy as detailed above.

  - **Coronial Inquiry**
    Deaths in certain circumstances will trigger a coronial inquiry and Inquest hearing. Whilst these occur independently of the organisation, the Trust has a duty to provide any information required to assist HM Coroner with an inquiry. This information will include any mortality review or incident investigation that has occurred in the Trust. Where HM Coroner raises further concerns as part of the judicial process or chooses to issue a Prevention of Future Deaths notification (Coroners' Regulation 28 (2013)), these concerns will be reviewed by the TMRG and consideration given as to how to respond to these concerns. Responses to Regulation 28 notifications will be co-ordinated by BSUH Medico-legal services and these recommendations reviewed by the TMRG.

7 Special situations

Learning disabilities
The NQB Learning from Deaths guidance describes the requirement for additional scrutiny for deaths in patients with learning disabilities. BSUH are actively engaged in the national LeDeR (Learning Disabilities mortality

Review) programme but at the time of writing the programme is not active in our region. While LeDeR is developed the Trust will ensure all deaths in patients with learning disabilities are identified by close working with the Trust's Learning Disabilities Team and also by ensuring that MEs are instructed to identify patients with likely learning disabilities during the 1st Level review process. All patients considered to have a learning disability will undergo an Independent Structured Judgement Review irrespective of whether concerns have been raised. Any other agency involved in the patients care will also be notified in order that they may carry out their own review.
Once the LeDeR programme is established the Trust will follow this process and any recommendations reviewed by TMRG.

Mental health
Another vulnerable group are those with significant mental health problems, whose deaths deserve close scrutiny. Medical Examiners will also be required to identify patients with significant mental health concerns. The NQB Learning from Deaths Guidance does not specifically define which deaths should undergo closer review but examples where closer scrutiny is required are:

- **Chronic mental health problems affecting daily living:** for example chronic schizophrenia resulting in homelessness or requiring supported living.
- **Patients receiving depot anti-psychotic medication** or second line antipsychotics, eg: Clozapine, at the time of death
- **Detention under any section of the Mental Health Act** at the time of death or in the period leading up to death.
- **Death as a direct consequence of mental health problems** ie: suicide, complications of self-harm, side effects of treatment.
- **Admission to the Trust from psychiatric in-patient care** eg: a patient developing pneumonia while a voluntary in-patient in a mental health hospital.

Some of these categories require referral to HM Coroner and an Inquest will be mandated. However, a local Independent Structured Judgement Review will also be carried out to identify any local learning points. Any Mental Health Trust involved in the patient's care will be informed of the death by the TMRG to enable them to carry out their own review. Where serious concerns are raised the relevant Clinical Commissioning Group (CCG) will be informed to enable a multi-agency review.

Children, young people and infants
Processes for mortality review in children, young people and infants are under review nationally following the Wood Review (2016). At the time of writing child deaths review processes for children, young people and infants remain

the responsibility of the Local Children's Safeguarding Board who will convene a Child Death Overview Panel (CDOP) to scrutinise deaths. BSUH fully supports the CDOP and any recommendations the Trust receive via the Children's Directorate or the Trust's Safeguarding Children Lead will be noted by TMRG and shared amongst the Children's Directorate.

While new regulations are awaited the Trust will review all deaths in children, young people and infants in a similar way to those in adults using a structured review tool. The national standardised Perinatal Mortality Review Tool (PMRT), developed by the National Perinatal Epidemiology Unit (NPEU), will be used to review all neonatal deaths. A similar tool will be developed locally for the review of all deaths in in-patients who are children and young people or infants.

In view of the complexity of child death reviews and in particular child safeguarding issues, the reviews of child deaths should be undertaken by specialists in Child Health. The Trust's team of independent mortality reviewers will not be expected to carry out mortality reviews on children unless they are from a Child Health background.

All deaths of children, young people and infants who are in-patients should be reported using the Datix® incident reporting system. Considerations around whether a child death requires 3rd level review (coronial referral and/or SI investigation) are the same as for all other in-patients.

Maternity

MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) reports have shown that there are frequently modifiable factors that lead up to stillbirth or maternal deaths. All stillbirths and maternal deaths in the Trust will undergo a structured review by a panel of specialists in maternal and fetal health. They will report data to MBBRACE-UK and will make recommendations which will be reviewed by TMRG and implemented by the Women's Directorate.

All maternal deaths will be reported using the Datix® incident reporting system. Considerations around whether a maternal death requires 3rd level review (coronial referral and/or SI investigation) are the same as for all other in-patients.

8 Support for the bereaved and involvement in the mortality review process

Support for the bereaved

- **Bereavement Office**: staff offer practical help and support for the bereaved in relation to death certification, the deceased's property, legal aspects and funeral arrangements.

- **Hospital chaplaincy service** offers religious and spiritual support. Where necessary the chaplaincy service will provide the bereaved with links to

outside agencies or charities who can offer on-going support.

- **Patient Advice and Liaison Service (PALS)**: Where the bereaved have specific concerns or questions about the care their loved one received they will be directed to PALs who will liaise with the relevant department/s in order to resolve concerns.

Involvement in Mortality Review Process
It is of the utmost importance that the bereaved are involved in the review process. Not only do they hold important information that will inform any investigation but they also have the right to understand in full what happened to their loved one. The bereaved will be involved in the mortality review process at the following points:

- **Medical Examiner Review**: MEs will speak to the next of kin of the deceased and ask if they had any concerns. If concerns are raised the ME will trigger the process outlined above. The ME will ask the relative if they have any objections to being contacted by a reviewer/investigator to discuss their concerns further. Where appropriate the ME will also advise the bereaved to contact PALS as a point of contact with the Trust.

- **Independent Structured Judgement Review**: when a SJR commences because serious concerns have been raised by the bereaved, they will be contacted by the reviewer to further establish the concerns and the circumstances of those concerns. The bereaved will be offered a summary of the SJR and given the opportunity to meet the reviewer to discuss the review.

- **Serious Incident Investigation/Coronial Inquiry**: in both circumstances there are well established pathways for involving the bereaved an eliciting their concerns. The bereaved will receive a copy of the final SI report and offered a meeting to discuss its findings with the investigator.

9 Support for staff

Training
Staff involved in mortality review will be offered training in Structured Judgement Review. At present we are utilising training from external bodies but we will develop an internal training programme as our mortality review processes mature.

Psychological support
Staff may be affected by the death of a patient in their care. The support offered by the Trust is detailed in policy HR010 Support arrangements for staff dealing with difficult situations. The Trust offers psychological support from the Health Employee, Learning and Psychotherapy (HELP) service. This service, which is accessible to all staff, offers group debriefing following distressing events and individual support.
In addition to caring for the bereaved, the chaplaincy team also offer religious

and spiritual support to staff alongside the HELP service.

10 Data Collection and Reporting

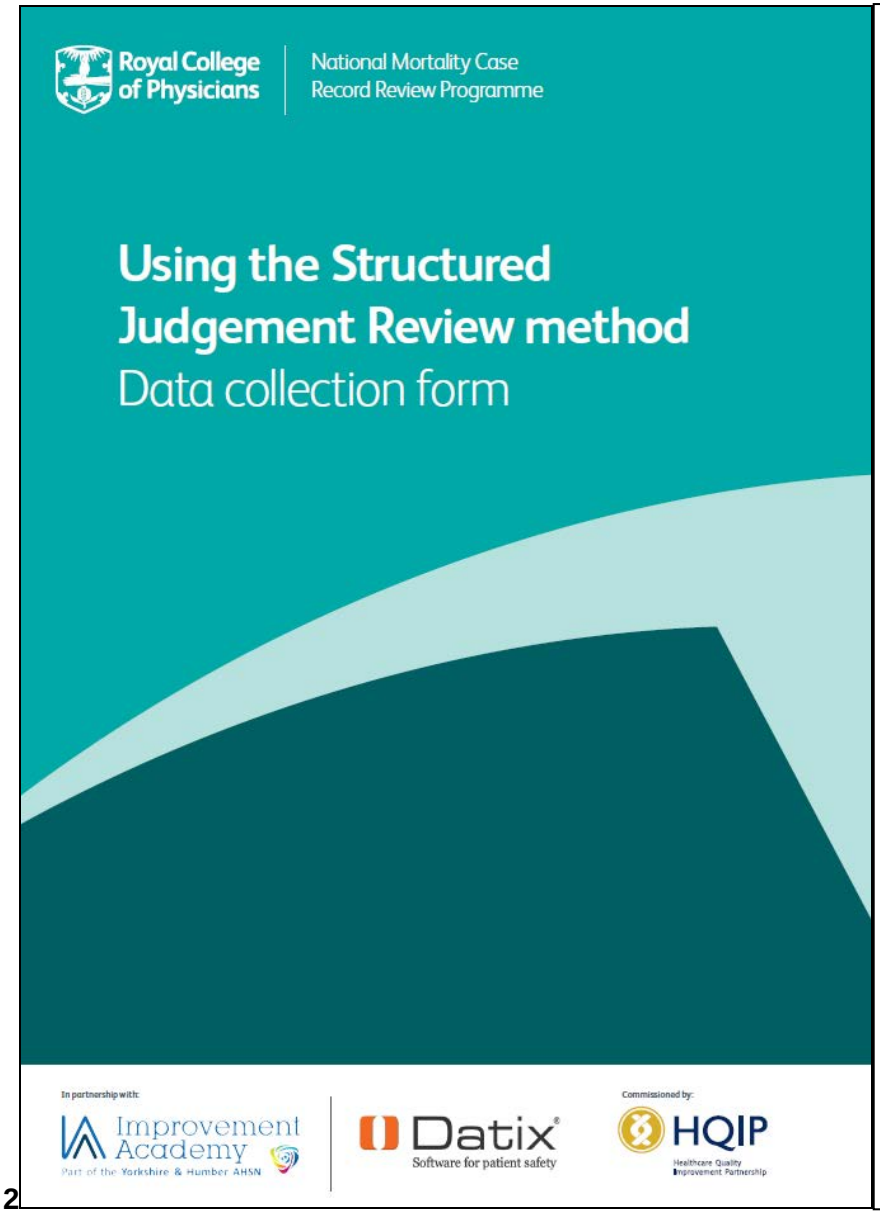
The Learning from Deaths Guidance 2017 specifies the following data collection and reporting arrangements:

Data and learning points (suitably anonymised) arising from mortality review will be presented to the **public board on a quarterly basis**. This data should include the total number of the Trust's in-patient deaths (including Emergency Department deaths) and those deaths that the Trust has subjected to case record review. Of these deaths subjected to review, an estimate will be presented of how many deaths were judged more likely than not to have been due to problems in care**.**

The **annual Trust Quality Account** will include details of learning points and actions taken as a result of mortality review.

A detailed review of nationally published mortality statisitics (ie: HSMR/SHMI) will occur in TMRG on a monthly basis.

Appendix 1



National Mortality Case Record Review Programme: structured case note review data collection

Please enter the following.

Age at death (years):

Gender: M/F

First 3/4 digits of the patient's postcode:

Day of admission/attendance:

Time of arrival:

Day of death:

Time of death:

Number of days between arrival and death:

Month cluster during which the patient died:
Jan/Feb/Mar Apr/May/June Jul/Aug/Sept Oct/Nov/Dec

Specialty team at time of death:

Specific location of death:

Type of admission:

The certified cause of death if known:

endix 2

Guidance for reviewers

1 Did the patient have a learning disability?

- No indication of a learning disability.
  Action: proceed with this review.
- Yes – clear or possible indications from the case records of a learning disability.
  Action: after your review, please refer the case to the hospital's clinical governance group for linkage with the Learning Disability Mortality Review Programme.

2 Did the patient have a serious mental health issue?

- No indication of a severe mental health issue.
  Action: proceed with this review.
- Yes – clear or possible indications from the case records of a severe mental health issue.
  Action: after your review, please refer the case to the hospital's clinical governance group.

3 Is the patient under 18 years old?

- No, the patient is 18 years or older.
  Action: proceed with this review.
- Yes – the patient is under 18 years old.
  Action: after your review, please refer the case to the hospital's clinical governance group for linkage with the Child Death Review Programme.

Structured case note review data collection

Phase of care: **Admission and initial management (approximately the first 24 hours)**

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase.

1 = very poor care **2 = poor care** **3 = adequate care** **4 = good care** **5 = excellent care**

Please circle only one score.

Phase of care: **Ongoing care**

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase.

1 = very poor care **2 = poor care** **3 = adequate care** **4 = good care** **5 = excellent care**

Please circle only one score.

Phase of care: **Care during a procedure (excluding IV cannulation)**

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase.

1 = very poor care **2 = poor care** **3 = adequate care** **4 = good care** **5 = excellent care**

Please circle only one score.

Phase of care: **Perioperative care**

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase.

1 = very poor care **2 = poor care** **3 = adequate care** **4 = good care** **5 = excellent care**

Please circle only one score.

Phase of care: **End-of-life care**

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase.

1 = very poor care **2 = poor care** **3 = adequate care** **4 = good care** **5 = excellent care**

Please circle only one score.

Phase of care: **Overall assessment**

Please record your explicit judgements about the quality of care the patient received overall and whether it was in accordance with current good practice (for example, your professional standards). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this overall phase.

1 = very poor care 2 = poor care 3 = adequate care 4 = good care 5 = excellent care

Please circle only one score.

Please rate the quality of the patient record.

1 = very poor 2 = poor 3 = adequate 4 = good 5 = excellent

Please circle only one score.

Assessment of problems in healthcare

In this section, the reviewer is asked to comment on whether one or more specific types of problem(s) were identified and, if so, to indicate whether any led to harm.

Were there any problems with the care of the patient? (Please tick)

No ☐ (please stop here) Yes ☐ (please continue below)

If you did identify problems, please identify which problem type(s) from the selection below. Please indicate whether it led to any harm and in which phase(s) of care the problem was identified. Please tick all that relate to the case.

Problem types

1. **Problem in assessment, investigation or diagnosis** *(including assessment of pressure ulcer risk, venous thromboembolism (VTE) risk, history of falls)* **Yes** ☐ **No** ☐

   Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐

   In which phase(s) did the problem occur?

   Admission and initial assessment ☐ Ongoing care ☐

   Care during procedure ☐ Perioperative care ☐

   End-of-life care ☐

2. **Problem with medication / IV fluids / electrolytes / oxygen** *(other than anaesthetic)* **Yes** ☐ **No** ☐

   Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐

   In which phase(s) did the problem occur?

   Admission and initial assessment ☐ Ongoing care ☐

   Care during procedure ☐ Perioperative care ☐

   End-of-life care ☐

3. **Problem related to treatment and management plan** *(including prevention of pressure ulcers, falls, VTE)* **Yes** ☐ **No** ☐

Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐

In which phase(s) did the problem occur?

Admission and initial assessment ☐ Ongoing care ☐

Care during procedure ☐ Perioperative care ☐

End-of-life care ☐

4. **Problem with infection management** **Yes** ☐ **No** ☐

Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐

In which phase(s) did the problem occur?

Admission and initial assessment ☐ Ongoing care ☐

Care during procedure ☐ Perioperative care ☐

End-of-life care

5. **Problem related to operation / invasive procedure** *(other than infection control)* **Yes** ☐ **No** ☐

Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐

In which phase(s) did the problem occur?

Admission and initial assessment ☐ Ongoing care ☐

Care during procedure ☐ Perioperative care ☐

End-of-life care ☐

6. **Problem in clinical monitoring** *(including failure to plan, to undertake, or to recognise and respond to changes)* **Yes** ☐ **No** ☐

Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐

In which phase(s) did the problem occur?

Admission and initial assessment ☐ Ongoing care ☐

Care during procedure ☐ Perioperative care ☐

End-of-life care ☐

7. **Problem in resuscitation following a cardiac or respiratory arrest** *(including cardiopulmonary resuscitation (CPR))* **Yes** ☐ **No** ☐

Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐

In which phase(s) did the problem occur?

Admission and initial assessment ☐ Ongoing care ☐

Care during procedure ☐ Perioperative care ☐

End-of-life care ☐

8. **Problem of any other type not fitting the categories above** *(including communication and organisational issues)* **Yes** ☐ **No** ☐

Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐

In which phase(s) did the problem occur?

Admission and initial assessment ☐ Ongoing care ☐

Care during procedure ☐ Perioperative care ☐

End-of-life care ☐

Brighton and Sussex University Hospitals NHS Trust

Appendix 2 - Guidance for Departmental Mortality Review

This guidance should be read in conjunction with the Trust policy TW220 Learning from Deaths.

It is acknowledged that most for most departments it is not practical to review all deaths. Therefore, there should be a clear method for selecting deaths for review and criteria should include:

- Concerns raised by staff or the bereaved
- Significant incidents/events
- Coronial Inquests (ideally mortality review should occur prior to the coronial inquest)
- Cases highlighted by a Medical Examiner
- Educational interest
- Issues of departmental interest eg: subject of improvement projects
- Random sample
- Cases highlighted by the TMRG in relation to a mortality outlier alert

Departments with a predominantly outpatient workload should review relevant deaths in patients known to their service. Again criteria for case selection must be published.

Where multiple specialities have been involved, the speciality in charge of a patient's care at the time of death will be responsible for co-ordinating the review. Other departments may be asked to take part in discussion or to take over the review depending on the circumstances of the death.

In some cases there may be higher level reviews (Eg: second level independent structured judgement review, SI investigation or coronial inquest) also in progress, however, departmental review should continue as it is likely that different issues will be identified by different reviewers. Points raised by departmental review will inform the recommendations of higher level reviews.

Method of review

Reviews should follow a structured format and should cover the most relevant sections of the patient's medical history. Usually this will be the whole final hospital admission but may need to cover other aspects. The review should cover all aspects of the hospital admission and not just the aspects relevant to the department

carrying out the review. It is acknowledged that staff may not have expertise in other specialist areas but they will be able to comment on the general aspects of care. If there are concerns raised about another department's care then the case should be referred to the relevant Departmental Mortality Review Lead and/or the Trust Mortality Review Group depending on the severity of the concerns.

It is recommended that the Royal College of Physicians Structured Judgement Review (SJR) Tool is used. However, some specialities have specific requirements in addition to those covered by the SJR. These departments may develop their own mortality review forms which incorporate the elements of the SJR. Any department not using the SJR should confirm with TMRG that their process is at least equivalent to RCP SJR.

Where there is concern that a death was likely due to a problem in care or potentially avoidable it should be referred to TMRG for second level review and/or Serious Incident Investigation. Where a patient safety incident has been identified then this should be reported using the Datix® incident reporting system.

Staff

Reviews may be carried out by any member of qualified healthcare staff. Often this will be medical staff but if there are concerns about nursing care or care by other healthcare professions then it may be relevant for these groups to carry out the review. Where a trainee doctor carries out the review they should be supervised by a Consultant. The reviews require a thorough review of the case record and so should be carried out prior to any Mortality Review meeting.

Departmental Mortality Review Meetings

The purpose of these meetings (also known as 'M&M' meetings) is to discuss the findings of case record reviews (SJR or equivalent), share learning, identify improvements and celebrate good practice. Meetings should be multidisciplinary, should be minuted and have a record of attendance. The frequency of these meetings will be dependent on the volume of deaths in a speciality. For most specialities a monthly meeting would be a minimum frequency. TMRG will provide Departmental Mortality Leads with information arising from second level reviews and SI investigations and this should also be shared at Departmental Mortality Review meetings.

Training

Training in mortality review (SJR) is available from the Royal College of Physicians and will be offered to Departmental Mortality Leads. As the programme becomes more established training will be made available to other staff involved in mortality review

Appendix 3 - Due Regard Assessment Tool

To be completed and attached to any policy when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	**Does the document/guidance affect one group less or more favourably than another on the basis of:**		
	• Age	**Yes**	Special scrutiny is applied to the deaths of children, young people and infants.
	• Disability	**Yes**	Patients with learning disabilities and serious mental health concerns are positively identified as vulnerable groups whose deaths need special scrutiny in order to improve the care of future patients with these problems
	• Gender	No	
	• Gender identity	No	
	• Marriage and civil partnership	No	
	• Pregnancy and maternity	**Yes**	Special scrutiny is applied to maternal deaths
	• Race	No	
	• Religion or belief	No	
	• Sexual orientation, including lesbian, gay and bisexual people	No	
2.	**Is there any evidence that some groups are affected differently and what is/are the evidence source(s)?**	**Yes**	Evidence is detailed in the NQB Learning form Deaths Guidance 2017 explaining why deaths certain groups are subject to increased scrutiny
3.	**If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?**		
4.	**Is the impact of the document/guidance likely to be negative?**	No	
5.	**If so, can the impact be avoided?**	N/A	
6.	**What alternative is there to achieving the document/guidance without the impact?**	N/A	
7.	**Can we reduce the impact by taking different action and, if not, what, if any, are the reasons why the policy should continue**	N/A	

	in its current form?		
8.	**Has the policy/guidance been assessed in terms of Human Rights to ensure service users, carers and staff are treated in line with the FREDA principles (fairness, respect, equality, dignity and autonomy)**	**Yes**	

Appendix 4 - Version Control Sheet

Version	Date	Author	Status	Comment

Brighton and Sussex University Hospitals NHS Trust

To: Trust Board

Date of Meeting: 29th November 2017 Agenda Item: **6**

Title
Safeguarding Children Annual Report: September 2016 – September 2017
Responsible Executive Director
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Prepared by
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Status
Public
Summary of Proposal

Purpose:

The BSUH Trust Board has the overarching leadership with respect to safeguarding children and child protection and this report ensures that they are aware of the range of activities which have taken place within the Trust and their external partners and to understand how BSUH fulfils its statutory duties.

The report highlights any areas of potential risk related to safeguarding children.

Failure to comply with the legal requirements of safeguarding children could risk the Trust's registration with the Care Quality Commission.

Key messages for the Board:

This paper demonstrates that:

- Safeguarding children and promoting their welfare continues to be addressed
- The organisation meets the statutory requirements in relation to Disclosure and barring service checks & the Board needs to ratify the process.
- The Trust has undertaken a Section 11 of the Children Act 2004 (HMSO 2004) audit & meets the requirements, demonstrating a safe service, acknowledging and addressing the challenges relating to safeguarding children.
- The internal governance arrangements and statutory requirements for safeguarding children and child protection are met and monitored, however IT support is required.
- B&H MASH requires approx. £23000pa from BSUH corporate funds to support continuing health input to multi-agency working.
- BSUH continues to respond to issues relating to specific issues such as FGM, Child sexual exploitation, children not brought for appointments and those with self-harming behaviour.
- Systems, processes and policies are constantly under review to ensure that they comply with local and national guidance including learning from serious case reviews.
- The training figures for all eligible staff are improving.

However

- Safeguarding activity across the organisation is increasing, demonstrated by a significant increase in the information being shared, referrals, concerns and daily contact through the safeguarding office and team.
- As recommended by the internal report (in 2015) the safeguarding structure requires review to ensure it is fit for purpose, can respond to increased demand, minimises risk and addresses succession planning.

Implications for Quality of Care
Significant
Link to Strategic Objectives/Board Assurance Framework
Corporate Objective: BSUH must ensure a culture exists where safeguarding is everybody's business and ensure that there are robust systems in place & the best and safest care is given to safeguard our most vulnerable patients (children and adults, including those with learning disabilities).
Financial Implications
N/A
Human Resource Implications
Safeguarding is a duty for every member of staff
Recommendation
The Board is asked to: NOTE the Annual Report for September 2016 to September 2017
Communication and Consultation
Appendices
Safeguarding Children Annual Report September 2016 – September 2017 NB Embedded documents are included in full at the end of the report

Brighton and Sussex University Hospitals NHS Trust

Child Protection and Safeguarding Children
Annual Report to the Board

September 2017

Introduction

'The welfare of children is paramount' as defined by The Children Act 1989 and 2004 and supported by principles identified in the Working Together to Safeguard Children (2015) that:-

- *Safeguarding is everyone's responsibility: for services to be effective each professional and organisation should play their full part*

- *A child-centred approach: for services to be effective they should be based on a clear understanding of the needs and views of children*

As required by Section 11 of The Children Act 2004, BSUH addresses the statutory duty to promote a culture where safeguarding is everyone's business and poor practice is identified and tackled by having effective safeguarding arrangements in place to safeguard vulnerable adults and children. These arrangements include:

- Senior management commitment to safeguarding children
- Identification of a Named Doctor, Named Nurse & Named midwife for Safeguarding Children.
- Sound governance & accountability
- Safe recruitment,
- Effective training for staff & learning form serious case reviews and research,
- Supervision arrangements,
- Listening to the '*voice of the children'* when considering developments
- Working in partnership with other agencies,

BSUH continues to follow the Sussex Child Protection and Safeguarding Procedures when required. Staff are supported by a small safeguarding children team and have access to a range of internal BSUH policies, standards, procedures and systems which promote the delivery of safe care and support for children and their families.

The action plan addressing the recommendations from the BSUH safeguarding review undertaken during 2015 is progressing and should be completed by the end of 2017.

The BSUH Board should review this annual safeguarding report for the period September 2016 - September 2017 to assure themselves that patient safety, staff activity, governance arrangements, risks are identified and addressed, safeguarding data are transparent and clear and that there is a plan for 2017/18.

Contextual summary of issues and relevant documents published in 2016/2017 with BSUH actions

The numbers of people affected by child abuse is huge & upsetting. Around one in five adults aged 16 to 59 (an estimated 6.2 million people) had experienced some form of abuse as a child, according to the Crime Survey for England and Wales (CSEW) for the year ending March 2016.

The survey showed 9% of adults aged 16 to 59 had experienced psychological abuse, 7% physical abuse, 7% sexual assault and 8% witnessed domestic violence or abuse in the home.

More than half (51%) of adults who were abused as children experienced domestic abuse in later life.

Although BSUH is a tertiary referral centre, staff most frequently work with Brighton & Hove city safeguarding teams.

In June 2017 Brighton & Hove had 380 children who were subject of a child protection plan making it the 10th highest out of 151 Local Authorities in England up from 25th in 2016.

Quarter	Sept 2010	Sept 2011	Sept 2012	June 2013	June 2014	June 2015	June 2016	June 2017
Total No of children with a CP Plan for B&H	411	395	340	300	328	385	381	**380**
B&H per 10,000	88	85	N/A	59.9	59.9	57.1	74.7	**74.2**
National average per 10,000	N/A	36	N/A	37.8	37.9	42.1	42.9	**43.1**
Statistical neighbour						44.4	42.1	**45.3**
League table (n=152)			8th	15th	24th	33rd	25th	**10th**

There were 438 chidren in care in June 2017.
There were 209 electively Home Educated children numbers in June 2017

Of the 3,023 referrals received by B&H during the year ending June 2017:

- 5.2% were unborns
- 4.8% were aged under 1
- 16.9% were aged 1 to 4
- 265.0 were aged 5 to 9
- 36.0% were aged 10 to 15
- 10.8% were aged 16 and over

10.6% referrals were from Health Services in general.

A further pressure is the ongoing increase in Unaccompanied Asylum Seeking children (UASC) to 37 at 30 June 2017. This is the highest number of UASC's that have been the responsibility of Brighton & Hove since 2008 reflecting the growing number fleeing war and persecution. It is likely in the current political climate the numbers of UASC are likely to continue to grow.

The National context

Local safeguarding needs to be seen in the context of national reports, serious case reviews and the political arena. *Child sexual exploitation* has been highlighted again by allegations within the

football community. The danger of online sexual abuse needs to be recognised and understood as the internet is an everyday factor in the lives of children and young people. FGM, modern slavery and issue related to the war in Syria which has brought traumatised refugees seeking help & links with the local serious case review W&X.

PREVENT has continued to be high on the agenda during the last year. NHS Trusts are now obliged to 'have due regard to the need to prevent people from being drawn into terrorism', in accordance with the 'Prevent duty' outlined in Section 26 of the Act. WRAP (Workshop to Raise Awareness of Prevent) training has continued over the last year with sessions delivered during the mandatory training and ad hoc sessions. It should be noted that Brighton is a high priority area and the recent serious case review W&X indicates the need to be vigilant and assess children who may be traumatised as well as abused. Training for trainers has recently been undertaken to increase opportunities for training in individual/key areas.

The Independent inquiry into sexual abuse (IICSA) is investigating how institutions in England and Wales may have failed to protect children from sexual abuse (previously the Goddard inquiry). Various aspects are being pursued including the '*Truth Project'* which affords any qualifying victim and survivor an opportunity to tell a representative of the IICSA anything that they wish. Those who want to be involved contact the project using the simple on-line form or by calling an information line. There will be a psychotherapist available to support those involved.

- BSUH may be involved with the '*Truth Project'* when it arrives in Brighton in Jan 2018.
- BSUH continues to store notes which may be required by the IICSA and this will have a financial impact.
- BSUH training continues to include how to recognise and respond the concerns relating to sexual abuse & exploitation & various newsletter items have concentrated on CSE.
- There are close links with the sexual abuse referral centres (SARC)
- The sexual health team are represented on the local initiatives called '*Operation Kite',* the Named Nurse attends the LSCB CSE/CSA early identification Prevent & protect subcommittee.
- BSUH have also been part of an LSCB audit into 10 cases of CSE which illustrated good working relations & communication. The '*see me, hear me'* framework needs to be embedded to make sure the child's voice is heard.

2017 DOH Child sexual exploitation report & more information about the Truth project.


CSE_Guidance_Core _Document_13.02.2C


https___www csacentre org uk_inde


What is the Truth Project.pdf

Modern Slavery Act 2015

According to the Home Office (2016) Modern slavery is a serious and brutal crime in which people are treated as commodities and exploited for criminal gain. The Modern Slavery act received royal assent in 2015 & expanded to cover **all** victims of modern slavery including human trafficking, forced labour and domestic servitude. In the UK there were 3,805 people reported as potential victims in 2016 (NCA, 2017). Recent figures from the National Crime Agency (NCA) show the number of identified cases of modern slavery has doubled in the last year.

- A BSUH raising awareness session in Sept 2106 was undertaken and updates included in the safeguarding newsletter.
- The BSUH web page has links to the directory of help. https://www.modernslaveryhelpline.org/

Female Genital Mutilation (FGM)

FGM is illegal and it is an offence to undertake the operation, assist a girl to mutilate her own genitalia, and to assist someone to undertake female genital mutilation of a UK national outside the UK. Anyone found guilty of the offence faces a maximum penalty of 14 years in prison. Up to 6,500 girls are at risk of female genital mutilation (FGM) in the UK each year.

Mandatory reporting by NHS hospitals continues and BSUH has a process for this data collection. There are links with the Brighton VAWG (Violence against women and girls) and front Door for families to ensure a strategic approach.

BSH Disclosures	2014	2015	2016	2017 to date
	22	26	22	13

- The BSUH Trust FGM policy is in date and includes a risk assessment and information relating to support of women affected by FGM. It is linked to the Pan Sussex child protection procedures and various professional documents.
- The Safeguarding Team continue to provide support when required.

CP-IS (Child Protection Information service)

CP-IS is the national system connecting local authorities child social care IT systems with those used by the NHS in unscheduled care settings. This is to provide better care and earlier intervention for children who are considered to be at risk and are subject to a Care plan or are 'Looked After'. (https://systems.hscic.gov.uk/cpis).

- BSUH has implemented the new system using smart cards which eventually started in Sept 2017 due to technical delays involving the B&H Local Authority.
- It has been noted that IT support is required including the ongoing recording and ability to audit the compliance. This development has been registered with the IT department as it is being done manually at the moment which is inefficient and open to error.
- The original well organised flagging system continues to be used as a backup system and to ensure non acute areas have access to the information.

B&H MASH (Multi-agency Safeguarding Hub) has been renamed *'Front door for families'.*

B&H Local Authority has reviewed their organisation of MASH, early help provision and the Family Information Service (FIS) and has instigated a one number quick access system via the 'Front door for families'.

- The MASH continues to function well and the agreed contribution from individual Trusts of £20,000pa recurring from April 2016 is required with an additional sum as a contribution to the cost of the premises which will commence in 2018.
- There are discussions and a pilot of the MASH concept within West Sussex funded by the local CCG. The Named Nurse has consistently indicated that BSUH cannot contribute to 2 MASH systems.

SECTION ONE
Corporate responsibilities & statutory Leads during October 2016 – September 2017
Child Protection / Safeguarding Children workload

Corporate Responsibilities

The Chief Executive is the Accountable Officer of the Trust and as such has overall responsibility for ensuring it meets statutory and legal requirements and adheres to guidance issued by the Department of Health, Department for Education and Skills, Commissioners and local Safeguarding Children Boards.

The Safeguarding Children Lead Director is the Chief Nurse who is accountable to the Chief Executive and has delegated responsibility for safeguarding children and young people. The Chief Nurse oversees safeguarding children arrangements within the Trust and is the named person on its Local Safeguarding Children Board, supported by the Named professionals.

Each Trust has a statutory duty to provide a Named Nurse and Doctor and a Named Midwife if providing midwifery care. They are accountable to the Nurse Director & their role is to support other professionals in their agencies to recognise the needs of children, including rescue from possible abuse or neglect. Named professional roles should always be explicitly defined in job descriptions. Professionals should be given sufficient time, funding, supervision and support to fulfil their child welfare and safeguarding responsibilities effectively (Working together 2015).

BSUH Safeguarding Named Professionals			WTE
Lead Director	Chief Nurse Sherree Fagge (to May 2016) Interim Chief Nurse Helen O'Dell (from May 2016) Chief Nurse Nicola Ranger (from July 2017)		1.0
Named Doctor	Consultant paediatrician	Leonie Perera	4 pa
Named Nurse	Nurse Consultant Safeguarding Children & Young People	Debi Fillery	1.0
Safeguarding nurse	Sarah Stenning (0.6) maternity leave & Sarah Matthews (0.4) + (0.6 maternity leave cover)		1.0
Liaison nurse	Geraldine Fraher (from Mid July 2016)		0.72
Named Midwife	Community midwifery matron (Job share)	Marion Wilyman John Bell	1.0 but no ring fenced time
Safeguarding Midwife	Midwife	Fiona Rose	0.8
HR Lead	HR Director	Helen Wetherill supported by Abbi Denyer	1.0
Prevent Lead	Caroline Davis		

The Named Doctor provides clinical advice and Level 3 training to medical colleagues. She also oversees the consultant-delivered child protection medical service which has developed over the past couple of years. 92 were undertaken in 2016 and so far 58 in 2017 (see chart). She is the primary chair at weekly peer review meetings of cases to maintain consistency and quality within the process and report writing. Suggested amendments or clinical suggestions made by the quorate are passed by her to the examining consultant.

She has an overview of complex cases, attending strategy meetings to support colleagues, or occasionally as their proxy. In 2016/17 in addition to the routine review of cases, a huge amount of time was spent coordinating 2 complex cases of possible illness fabrication which went to

court. This required expertise, tenacity and long hours to bring all the different aspects to a successful outcome.

A BSMS IRP project (looking at skull fractures in young children) has been rolled out to multiple centres as part of PERUKI network. She has written numerous paediatric child protection guidelines for the trust. She has recently carried out an audit of trust chaperone policy amongst RACH consultant and nurse practitioner colleagues- results being analysed.

Hospital settings have an important impact on children harmed by parents and carers. Concern arises from the capacity of these settings to respond effectively to individual needs despite increased NHS policy awareness and actions on safeguarding. There has been a gradual recognition within the wider health policy arena that safeguarding (both adults and children) is linked with quality, governance, safety and dignity, thus widening the scope of the work.

The safeguarding children team is available to respond to the needs of the children, their families and the staff by giving support and case supervision, training and follow up of complex cases including strategy meetings and visits to adult areas.

Supporting graphs for the BSUH Board s

They undertake a daily ward round within the Children's hospital to ensure staff feel supported and safeguarding issues are co-ordinated. A total of 633 consultations were undertaken in 6 months from Jan 2017- June 2017 (see chart) which is an increase on 2016.

During 2016/7 the team reviewed the content of the training package addressing the intercollegiate recommendations and linked with the adult safeguarding team to create a day combining the main features and preventing duplication. The number of training sessions has also increased to ensure the workforce have basic and advanced knowledge and skills. This has resulted in better compliance with targets but increased the time commitment for the team (see chart).

The safeguarding team is the last resort of support when dealing with those children who are not brought for appointments. A snap shot of the work illustrates that numerous phone call are required to follow up the family in order to get the child seen (see chart). This is important to ensure children get the care they require and prevent neglectful behaviour but has increased workload.

The information noted above illustrates the increasing workload and the lack of succession planning within the safeguarding children team has been highlighted in previous Board reports, to the Quality and Risk committee and is backed up by the publication of the Internal Review This recommendation/action is outstanding. Consideration also needs to be given to the safeguarding provision in adult A&E and the domestic abuse agenda.

SECTION TWO
Governance & multiagency working during 2016-2017

The BSUH Safeguarding Children Committee
Meets quarterly Chair Lead Director currently the Chief Nurse

1. Ensures internal governance arrangements are in place and effective and reports to the Board once a year. In 2017 has also been asked to report to the quality & performance committee twice a year & the CCG assurance group quarterly.
2. Works towards completing the BSUH safeguarding action plan.
3. Addresses the NHS England safeguarding-accountability-assurance-framework.July 2015
4. Maintains and monitors the Section 11 audit with evidence available electronically and updated as required
5. Addresses & disseminates learning from SCR & audit.

Policies & guidance introduced or updated

1) All policies related to safeguarding children are currently up to date.
2) Paediatric on line clinical guidance is available
3) Information sharing posters are being renewed.
4) The safeguarding children web page is up to date with links to various resources.

Communication & IT

- The safeguarding liaison service changes during 2015/16 have embedded over the past year however the annual leave cover has been a challenge within such a small team.
- Information sharing between the Trust and the community heath visitors and school nurse continues to be undertaken by manually posting attendance summary sheets which is not the most efficient route. Work to address this electronically has not been successfully completed.
- The BSUH staff safeguarding web site continues to be updated and acts as a resource.
- The monthly newsletter is circulated to PIM, NMB and the wider BSUH staff members via the e comms team.
- The BSUH public web page continues to have information pertinent to the public and how to report concerns.
- CP-IS is in place within childrens emergency department using smart cards. This needs rolling out in adult A&E in RSCH & PRH. IT support is required to ensure monitoring is enabled electronically.
- The manual flagging system continues as a robust safeguarding checking system for all areas for those children/YP with a CP plan.
- Symphony IT system has been re-introduced replacing the Alert IT system. There is a promise that the new upgraded system will include safeguarding prompts.

Safeguarding Supervision

- There have been no additions to the process of Supervision in 2107 due to lack of capacity.
- There has been one serious incident reported and investigated, relating to a child admitted with a life threatening event (ALTE) which has raised issues about the reporting of paediatric. There is an action plan. And the learning has been circulated.
- The Named Doctor continues to give safeguarding supervision to medical staff on an ad hoc basis, and participates in the Monday teaching sessions
- The weekly Medical peer review meeting attended by consultant paediatricians promotes a culture of learning and professional support and ensures a consistent quality approach to the examination and report writing.
- The Named Nurse continues to give safeguarding supervision to nursing/midwifery staff who carry high risk caseloads and on a case by case basis to all staff as required.
- The safeguarding midwife gives supervision to the substance misuse midwife.
- Daily safeguarding ward visits continue at RACH enabling improved case discussion for nurses on approximately 633 children (up from 450).
- Documentation of discussions is filed in the child's notes.
- The Named professionals receive supervision from the designated professionals.
- The monthly feedback to the Chief nurse's meeting (PIM & NMB) also initiates discussion about safeguarding children issues which should be disseminated to the Directorate teams via their quality and safety meetings.
- Perplexing cases consultation group is available but needs more support.

Audits undertaken

Section 11 audit & challenge Overview of CP medicals LSCB notes audit x 2 (Neglect & children with a disability) FGM audit	Ward discussion overview Training evaluation NICE questions Child referral form from adult area quality audit

Training

The Trust learning and development strategy responds to statutory guidance and links with the Intercollegiate guidance & indicates how this mandatory requirement for all employees should be achieved.

All levels have explicit learning outcomes and a recommended length of time.

The total BSUH workforce requires some level of statutory safeguarding children training.

1. Level 1 (At induction & All non clinical staff) requires 3 yearly update.
2. Level 2 (All clinical staff who see adults) requires 3 yearly update
3. Level 3 (All clinical staff who see children **and unscheduled care - PRH A+E**) require annual update

The training sessions can be booked on IRIS, the BSUH training network.

- The name nurse also helps facilitate a 10 day safeugarding children course linked to the University with BSUH staff attending.
- The use of e learning is offered www.e-lfh.org.uk
- Themed sessions were offered during the year:-
  1. Sept 2016 themed domestic abuse session
  2. May 2017 feedback on SCR
  3. Oct 2017 Toxic trio training day.
- The sessions continue to be well evaluated. (The CCG audited the training during 2016)

IRIS training reports indicate that the training figures at BSUH are improving but targets are not fully achieved.

Compliance Total (86%), level 1 (75%) level 2(71%), level 3 (79%)

Personal compliance should be monitored via the appraisal system.

Partnership working

- Safeguarding is a shared responsibility dependant on excellent interagency and joint professional working. Strategic work is often set by local LSCB (Local Safeguarding Children's Board) in B&H and West Sussex which allows constructive challenge and the continual improvement of care.
- The lead Director attends the B&H LSCB as the statutory BSUH Board member accompanied by the Named professionals as advisors.
- 4 B&H LSCB sub groups have a BSUH representative including monitoring & evaluation, training & development, Health advisory group and multi-agency liaison.
- There is very good attendance at the meetings and project involvement from the BSUH named professionals which requires up to 150hrs pa plus travel time.
- Links to West Sussex and East Sussex Local Safeguarding Children Boards have continued via the Designated Nurses and Designated Doctors for Child Protection for West and East Sussex.
- The BSUH Nurse Consultant attends a health sub group of the West Sussex LSCB. This group is chaired by the West Sussex designated Nurse for safeguarding children. The group meets quarterly &. provides a forum which can share learning from practice, inform and influence the WSSCB.
- The BSUH Nurse Consultant is also a member of the various VAWG (Violence against women and girls) strategic meetings.

Reports written by the named Nurse & contribution include:-

1. The section 11 audit completed for B&H LSCB

2. A report for B&H LSCB on the safeguarding children audits undertaken by BSUH
3. Contribution to 2 B&H audits (Neglect & children with disabilities)
4. Contribution to serious case review x 2 + domestic abuse homicide review
5. A BSUH safeguarding update to contribute to the LSCB annual report.

External regulation and inspection by LSCB, Care Quality Commission (CQC), commissioners (CCG) & JTAI (Joint targeted area inspections).

External monitoring of safeguarding arrangements based on the Section 11 (s11) of the Children Act (2004) is a responsibility of the LSCB (Local Safeguarding Children Board), Ofsted and the Care Quality Commission (CQC).

The bi-annual S11 audit was completed in 2016 and a peer challenge review was undertaken in October 2016. BSUH actions related to addressing the training figures.

The CQC action plan for BSUH relating to safeguarding children also required improvement of training figures & addressing issue of siting of the adult research facility based on Level 10 of RACH and the move of children's ENT services.

The CCG exception reports are provided on a quarterly basis and the main issues have related to training figures and the internal safeguarding review action plan.

The JTAI themed inspections may occur at any time and include an evaluation of the multi-agency 'front door' for child protection, involving Social services , Health, Police, Probation and Education. The current topic for deep dive is about children who have been neglected. The future topics may involve sexual abuse within familial settings, or CSE and domestic abuse. Information required from BSUH include governance arrangements, annual reports, provider policies & processes relating to the topic & may include staff focus groups.

The Wood Report; Review of the role and functions of Local Safeguarding Children Boards (LSCB) (**March 2016)** www.gov.uk/government/publications/wood-review-of-local-safeguarding-children-boards suggests that changes to the LSCB are required.

- All key partners & local organisations will be expected to cooperate with the multi-agency arrangements.
- There may be changes to the membership of the LSCB however if current arrangements are the most effective form of joint working they will be able to continue them.
- Legislation and statutory guidance will be published to underpin the new framework. Arrangements for inspection and review will be established.

Serious Case Review & themed reviews

Serious Case Reviews are held to investigate cases in order to learn from the event in a constructive way in order to improve services and multiagency working.

BSUH will include these learning points within the training for 2018.

Within B&H SCR W&X was published in July 2017 and the main aspects of learning include:-

- Working with children & young people who have experienced trauma.
- Working with minority ethnic groups reflect concerns regarding resourcing and strategies
- to support women and children from minority cultural backgrounds;
- Professionals' understanding of culture,

- identity, gender, religion, beliefs and divided loyalties;
- Statutory agencies knowledge about, and understanding of, local minority ethnic and faith community groups and how best to work together to safeguard children, including those at risk of exploitation into radicalisation.

W&X Briefing for frontline staff.pdf

West Sussex SCR includes SCR Key relating to child sexual exploitation SCR Key.

NB: The current SCR system will be replaced with a system of national and local reviews.

This will ensure that reviews are proportionate to the case they are investigating, and improve consistency, speed and quality (this will include accrediting authors).

A National Panel will be established. This will be responsible for commissioning and publishing national reviews and investigating cases which will lead to national learning.

Local partners will be required to carry out reviews into cases which are considered to lead (at least) to local learning. These should be published.

The planned '*What Works'* Centre for children's social care will analyse and share lessons from local and national reviews.

Safeguarding Children Human Resources Report

Safer recruitment

BSUH work to ensure that those working or in contact with children are safely recruited and make sure that we do everything we can to prevent appointing people who pose a risk to children is an essential part of safeguarding practice and BSUH recruit staff and volunteers following safer recruitment procedures.

All staff at the Trust are employed in accordance with the NHS pre-employment check standards. All relevant staff employed at the Trust undergo a DBS check prior to employment change or role or promotion and those working with children have an enhanced level of assessment.

Care needs to be taken as the DBS cannot access criminal records held overseas. A DBS check may not provide a complete view of an applicant's criminal record if they have lived outside the UK.

The issue of rechecking the disclosure and barring status of staff has taken place in the safeguarding children committee. The current system of checking was debated and felt to be a safe option as DBS checks are only one aspect of ensuring effective and safe recruitment practices. Checking employment history and gaps, reviewing references & undertaking annual appraisals can assist decision making and in this way the Trust can assure themselves as far as possible that all employees are of good character and are fit to work in their service.

Allegations against staff

The guidance on managing allegations against staff is being updated.

During the period 2016/17 there have been 8 incidents which have been discussed with the Local Authority Designated Officer (LADO) team. 1 was information sharing with social services,

1 was a possible historical allegation requiring information sharing, 1 did not reach a child protection threshold, 5 required investigation.

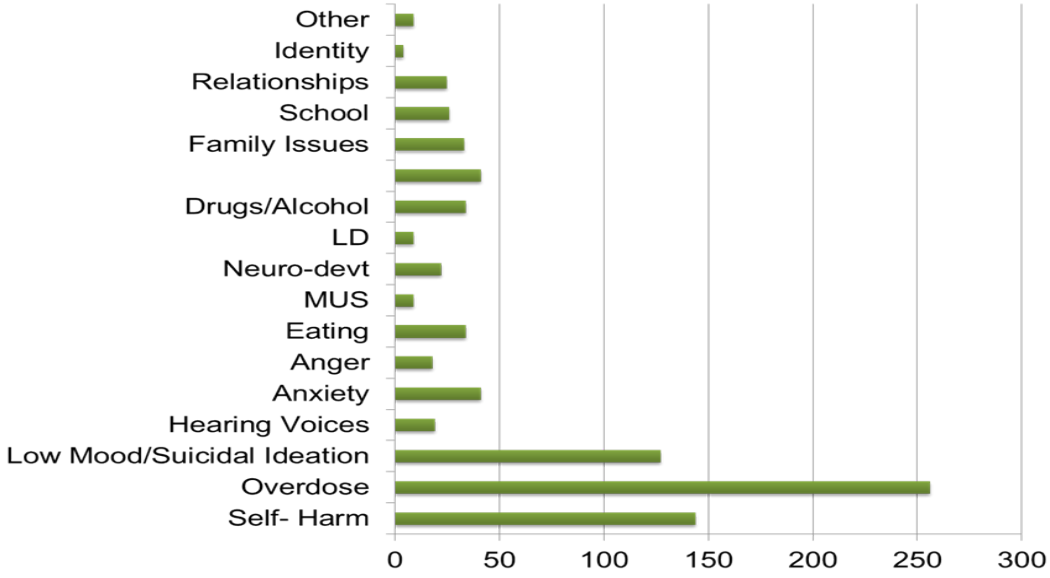
Paediatric Mental Health Liaison Services Report (PMHLT) Jo Bullen.

The issues surrounding mental health have been raised in the news & in July 2017 the University of Manchester published findings from a study of suicide by children and young people aged under 25 in England and Wales during 2014 and 2015. Information collected on 922 suicides includes: 9% of under 20s who died had been looked after children, and self-harm was reported in 52% of under 20's and 41% of 20-24 year olds who died. Suicide by children and young people (PDF).

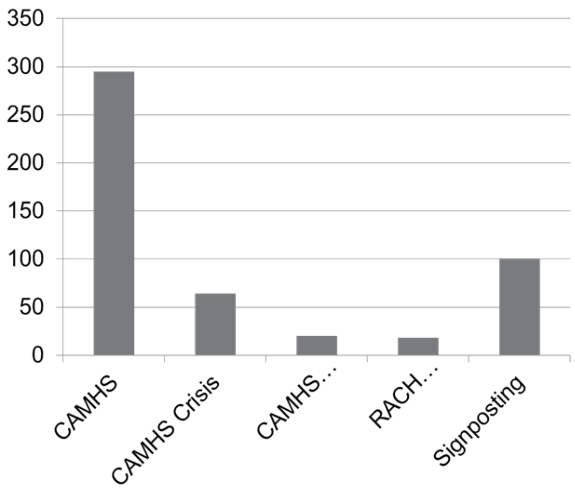
The B&H commissioner has recognised the importance of funding the service of mental health support for children in B&H with long term health issues linked with BSUH and of the PMHLT which is the multi-disciplinary team (occupational therapy, nursing, psychiatry) that started working at the Royal Alexandra Children's Hospital in Nov 2016.

The service has been invaluable and operates between 9am-8pm Mon – Fri and 10am-6pm Sat, Sun and bank holidays and offers a service to the Royal Alexandra Children's Hospital patients, families and staff.

- The PMHLT provide specialist mental health and risk assessment, forward care planning & sign-posting for children, young people and their families experiencing mental health related difficulties.
- Total referrals in Nov 2015 – Oct 2017: 716. Of those referrals 128 (17.9%) were Safeguarding Referrals.
- Reason for assessment include:-



- Discharge pathway included:

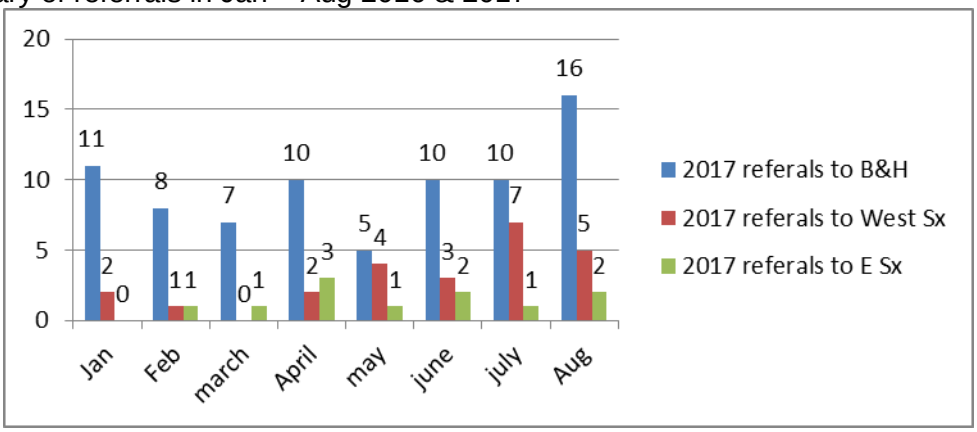


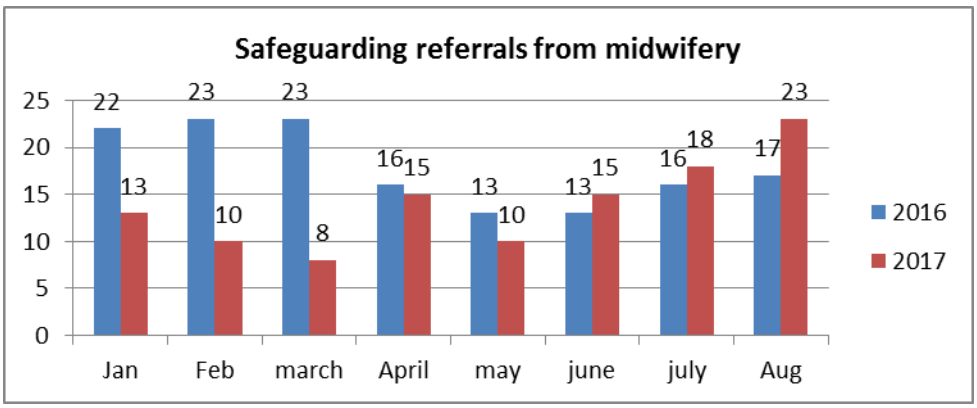
Maternity Report

Achievements and Progress in relation to Maternity October 2016 - October 2017

- Historically the Named Midwife role is combined with other management roles however there is growing recognition that this is a challenge; with most of the responsibility falling to the safeguarding midwife. The complexity of cases is rising and this aspect needs review.
- All those involved have worked hard to minimise the risks associate with the complex safeguarding cases within this maternity service but the issue has been raised with the Head of Midwifery and the Chief Nurse.

- The specialist midwives for substance misuse & teenage pregnancy support the safeguarding midwives with specific vulnerable women.
- A repeat audit of the FGM monitoring & documentation has been undertaken following on from changes made in previous years. The number of women disclosing FGM is small in comparison to other areas which have a more diverse population.
- Changes to the maternity booking system to improve information gathering about fathers has been successful (an action from SCR Liam). Other improvements include having a specific section in the notes for safeguarding as this has been recognised as necessary to improve communication and planning.
- The Level 3 safeguarding and domestic abuse training compliance is steady at 80%
- Summary of referrals in Jan – Aug 2016 & 2017





Maternity Action plan 2017-2018

- To review the named midwife role
- There is an ongoing plan from 2016/17 to recruit a 0.6 WTE Mental Health midwife and this individual will support the safeguarding agenda for this caseload of women.
- There is a need to monitor and adapt midwifery services due to the impact of changes to Health Visitor and Family Nurse Practitioner services.
- A review of safeguarding supervision is required to ensure staff are supported and a quality service is maintained.
- To continue to monitor and audit the pre-birth safeguarding workload and make recommendations as required (ongoing).
- To implement any recommendations from the West Sussex SCR child P which should be published soon.
- To consider how IT solutions can support midwives in their safeguarding role (eg having accessible community computers which link to the BSUH systems for the midwifery booking process and sending referrals.)

Domestic Violence and Abuse Report (DVA)

- Each year an estimated 1.9m people in the UK suffer some form of domestic abuse - 1.3 million female victims (8.2% of the population) and 600,000 male victims (4%)
- Seven women a month are killed by a current or former partner in England and Wales
- 130,000 children live in homes where there is high-risk domestic abuse
- 62% of children living with domestic abuse are directly harmed by the perpetrator of the abuse, in addition to the harm caused by witnessing the abuse of others
- On average high-risk victims live with domestic abuse for 2.3 years and medium risk victims for 3 years before getting help
- On average victims experience 50 incidents of abuse before getting effective help

SafeLives Ending domestic abuse Safelives

Early intervention by all agencies is imperative and BSUH continues to support staff with the strategies & projects in place as itemised below.

Achievements and Progress in relation to Domestic Abuse October 2016 - October 2017

1) The BSUH domestic abuse policy is in place and next due for an update in 2019.

2) The NICE Quality Standard – Gap analysis – Domestic violence has been reviewed by the Named Nurse and the Named Nurse for adult safeguarding & action plan formulated.

gap anlysis update 2017.doc

6 monthly report april - sept 2017.doc›

3) The Domestic abuse aspect of training has been increased in all levels of safeguarding training for all staff in recognition of the prevalence of domestic abuse across all patients and staff. Within the last 6 months The HIDVA has trained 142 midwives, 133 staff at induction, 112 staff on the level 2 sessions. (see report above)

4) The B&H CCG have agreed to continue funding the Health independent domestic abuse advocate/advisor until March 2019, as it has improved the numbers of staff trained and subsequently the referrals to the HIDVA have increased.

5) Posters and the use of ‘amber cards’ and ‘bar code tissues’ help promote the service.

6) The HIDVA has worked hard to maintain visibility which has been affected by the building works in A&E.

7) The total referrals to HIDVA service in April – Sept 2017 was 95 (previous 6 months – 78)

8) The HIDVA has delivered a presentation to professionals to raise awareness of DVA at World Elder Abuse Awareness Day & been part of the LSCB toxic trio study day in Oct 2017 aimed at hospital staff (30 attended)..

9) The Named Nurse for safeguarding Children continues to represent BSUH on various strategic groups relating to Domestic abuse and to Violence against Women and Girls (VAWG). BSUH needs to consider how this vital aspect of safeguarding is managed due to the increasing level of work.

10) The quarterly meeting between safeguarding children and safeguarding vulnerable adults and domestic abuse continues..

11) Unfortunately due to competing work pressures the safeguarding team has been unable to attend the twice monthly MARAC which co-ordinates planning for high-risk cases of domestic abuse, stalking and 'honour'- based violence. To reduce the risks, the information about victims and their families from BSUH has been shared electronically. The BSUH commitment is considered to total 3 days pcm.

12) The safeguarding children team has agreed to facilitate flagging of those people who are discussed at MARAC once a system has been designed to ensure correct information is provided.

Domestic Abuse Action plan 2017-2018

- To review how BSUH supports the domestic abuse strategic agenda & recognises the Named nurse as the lead professional
- To review and continue the BSUH commitment to attend the B&H MARAC.
- To continue to link with the B&H VAWG strategy
- To continue to support the current domestic abuse training available within BSUH
- To work with the CCG to provide evidence of the success of the HIDVA project so that funding will continue.
- To instigate flagging for those people who are discussed at MARAC once a system has been designed to ensure correct information is provided.
- To contribute to the Heath Hub related to domestic abuse.

SECTION 3….. Key issues & Action plan for Sept 2017 – Sept 2018

In all areas BSUH staff should place the child at the centre of care which is underlined by the NICE guidance on child abuse and neglect (Oct 2017).

The CQC awarded The Children's Hospital '*outstanding'* status which was a fantastic achievement.

Although the Safeguarding agenda is constantly changing the overriding message is that safeguarding is everyone's business irrespective of role or position.

In adult areas we should think holistically and keep in mind the motto '*see the Adult, See the Child'.*

In 2018 it is expected that the new 'Working Together' document will be published and there will be changes to the LSCB's (moving to become the new Safeguarding partnerships) and the transition from Serious Case Reviews to National and Local Reviews. (https://consult.education.gov.uk/child-protection-safeguarding-and-family-law/working-together-to-safeguard-children-revisions-t/supporting_documents/Transitional.pdf)

In addition to general statutory requirements which apply to the whole Trust, there are specific action plans for various specialities within the BSUH Trust itemised and monitored in the Safeguarding children committee action plan which will obviously respond to additional issues which arise through out the year.

- To continue to have a Non-executive Board member linked to paediatrics and safeguarding children.
- To continue to have Directorate assurance & evidence that 'safeguarding children' is discussed and that staff are aware of their role and responsibilities.
- To complete the action plan relating to the recommendations from the safeguarding review by Dec 2017.
- To complete the review of the safeguarding children team in the light of the safeguarding review comments about succession planning and ability to cope with the work load by Dec 2017.
- To ratify the decision relating to the disclosure and barring processes and repeating the assessment every 3 years for those in high risk roles.
- To continue to contribute to the B&H MASH funding. (approx. £25,000pa)
- To complete the review of paediatrics at PRH A&E.
- To address the placement of ENT services within the Royal Alexandra Children's Hospital.
- To review the information sharing processes and ensure efficient IT systems.
- To continue to raise awareness and embed the skills and knowledge around learning from serious case reviews, CSE, FGM, modern slavery and continue to implement Govt and local initiatives relating to safeguarding children.
- To monitor the CP-IS process and work toward making it an electronic system linked with symphony.

- Continue & complete the work itemised in the current Safeguarding Children & Young People Committee action plan.
- To ensure the maternity action plan is addressed and the named midwife role is reviewed.
- To consider the Named Nurse as the lead for Domestic abuse and ensure the domestic abuse action plan is addressed & that the IDVA service is supported.

Debi Fillery
Nurse Consultant Safeguarding Children and Young People
Oct 2017

For a full copy of the annual action plan please contact Debi Fillery, Nurse Consultant, Safeguarding Children or Nicola Ranger, Lead Director for Safeguarding.

Brighton and Sussex University Hospitals NHS Trust

Child Protection and Safeguarding Children
Annual Report to the Board

September 2017

Embedded documents are attached separately in the order in which they appear in the report:

- 2017 DOH Child sexual exploitation report & more information about the Truth project (3 documents)
- Supporting graphs
- W&X Briefing for frontline staff
- Domestic violence – gap analysis update
- Domestic violence – 6 monthly report

Department for Education

Child sexual exploitation

Definition and a guide for practitioners, local leaders and decision makers working to protect children from child sexual exploitation

February 2017

Contents

Introduction

Child sexual exploitation is a crime with devastating and long lasting consequences for its victims and their families. Childhoods and family life can be ruined and this is compounded when victims, or those at risk of abuse, do not receive appropriate, immediate and on-going support. The first response to children, and support for them to access help, must be the best it can be from social workers, police, health practitioners and others who work with children and their families.

In *Putting Children First* (July 2016) the Government set out its ambitions to support vulnerable children to lead safe and positive lives, to become successful adults and to have the kind of happy childhood that we want for all our children. We want children and families to have confidence in turning to practitioners for help and protection from abuse, neglect and exploitation. This help and protection should be provided in a timely, enduring and flexible manner, and be the best it can possibly be. This requires children, parents and carers affected by child sexual exploitation to feel part of the solution and confident they will be believed. Practitioners should work together to reduce the immediate risk of harm to children and collaborate to develop long term strategies to improve children's life chances.

This applies as much to child sexual exploitation as to other forms of abuse or neglect. The hidden nature of child sexual exploitation and the complexities involved means professional curiosity, and always being alert to the issue, is vital.

About this advice

This advice is non-statutory, and has been produced to help practitioners, local leaders and decision makers who work with children and families to identify child sexual exploitation and take appropriate action in response. This includes the management, disruption and prosecution of perpetrators.

This advice replaces the 2009 guidance *Safeguarding children and young people from sexual exploitation*. It should be read alongside *Working Together to Safeguard Children* (most recent updates available on gov.uk) which continues to provide statutory guidance covering the legislative requirements on services to safeguard and promote the welfare of children, including in relation to child sexual exploitation.

A child is anyone who has not yet reached their 18th birthday. Throughout this advice the terms 'child' and 'children' are used to refer to all those under the age of 18.

Who is this advice for?

This advice is intended to help all those working with children, and their parents and carers, to understand child sexual exploitation and what action should be taken to identify

and support victims. The online annexes to this document set out work to tackle perpetrators, another critical element of an holistic response.

Section A is for everyone whose work brings them into contact with children and families, including those who work in early years, children's social care, health, education (including schools), the police, adult services and youth offending teams. This section sets out first the background to the nature of child sexual exploitation, followed by a series of guiding principles. It is relevant to those working in the statutory, voluntary or the independent sectors, and applies in relation to all children and young people irrespective of whether they are living at home with their families and carers or away from home.

Section B is for those in strategic and management roles who are planning responses to child sexual exploitation within local authorities and other agencies working in partnership. It is relevant for Local Safeguarding Children Boards and any new arrangements required in legislation. However, all practitioners may find this information useful to support effective front-line practice on child sexual exploitation.

This advice is not intended to be a 'step by step' approach to addressing child sexual exploitation. It sets out the definition of child sexual exploitation; highlights potential vulnerabilities and indicators of abuse; and sets out appropriate action to take in response, using professional judgment and curiosity. Although it focuses on child sexual exploitation, the principles outlined here are those set out in *Working Together* covering all forms of exploitation, abuse and vulnerability in childhood and adolescence. The signs of abuse rarely present in clear, unequivocal ways (The Munro Review of Child Protection, 2011). What is important is that those working with children and families understand the totality of a child's experience in order to assess the nature and level of risk faced by children and respond swiftly and proportionately.

Section A – advice for all practitioners who work with children

What is child sexual exploitation?

Child sexual exploitation is a form of child sexual abuse. Sexual abuse may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside clothing. It may include non-contact activities, such as involving children in the production of sexual images, forcing children to look at sexual images or watch sexual activities, encouraging children to behave in sexually inappropriate ways or grooming a child in preparation for abuse (including via the internet).

The definition of child sexual exploitation is as follows:

Child sexual exploitation is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology.

Like all forms of child sexual abuse, child sexual exploitation:

- can affect any child or young person (male or female) under the age of 18 years, including 16 and 17 year olds who can legally consent to have sex;
- can still be abuse even if the sexual activity appears consensual;
- can include both contact (penetrative and non-penetrative acts) and non-contact sexual activity;
- can take place in person or via technology, or a combination of both;
- can involve force and/or enticement-based methods of compliance and may, or may not, be accompanied by violence or threats of violence;
- may occur without the child or young person's immediate knowledge (through others copying videos or images they have created and posting on social media, for example);
- can be perpetrated by individuals or groups, males or females, and children or adults. The abuse can be a one-off occurrence or a series of incidents over time, and range from opportunistic to complex organised abuse; and
- is typified by some form of power imbalance in favour of those perpetrating the abuse. Whilst age may be the most obvious, this power imbalance can also be due to a range of other factors including gender, sexual identity, cognitive ability, physical strength, status, and access to economic or other resources.

Child sexual exploitation is a complex form of abuse and it can be difficult for those working with children to identify and assess. The indicators for child sexual exploitation can sometimes be mistaken for 'normal adolescent behaviours'. It requires knowledge, skills, professional curiosity and an assessment which analyses the risk factors and personal circumstances of individual children to ensure that the signs and symptoms are interpreted correctly and appropriate support is given. Even where a young person is old enough to legally consent to sexual activity, the law states that consent is only valid where they make a choice and have the freedom and capacity to make that choice. If a child feels they have no other meaningful choice, are under the influence of harmful substances or fearful of what might happen if they don't comply (all of which are common features in cases of child sexual exploitation) consent cannot legally be given whatever the age of the child.

Child sexual exploitation is never the victim's fault, even if there is some form of exchange: all children and young people under the age of 18 have a right to be safe and should be protected from harm.

One of the key factors found in most cases of child sexual exploitation is the presence of some form of exchange (sexual activity in return for something); for the victim and/or perpetrator or facilitator.

Where it is the victim who is offered, promised or given something they need or want, the exchange can include both tangible (such as money, drugs or alcohol) and intangible rewards (such as status, protection or perceived receipt of love or affection). It is critical to remember the unequal power dynamic within which this exchange occurs and to remember that the receipt of something by a child/young person does not make them any less of a victim. It is also important to note that the prevention of something negative can also fulfil the requirement for exchange, for example a child who engages in sexual activity to stop someone carrying out a threat to harm his/her family.

Whilst there can be gifts or treats involved in other forms of sexual abuse (e.g a father who sexually abuses but also buys the child toys) it is most likely referred to as child sexual exploitation if the 'exchange', as the core dynamic at play, results in financial gain for or enhanced status of, the perpetrator.

Where the gain <u>is only for</u> the perpetrator/facilitator, there is most likely a financial gain (money, discharge of a debt or free/discounted goods or services) or increased status as a result of the abuse.

If sexual gratification, or exercise of power and control, is the only gain for the perpetrator (and there is no gain for the child/young person) this would not normally constitute child sexual exploitation, but should be responded to as a different form of child sexual abuse.

How common is child sexual exploitation?

The signs and indicators of all forms of abuse can be difficult to detect and child sexual exploitation is no exception. A variety of factors can make it difficult to accurately assess how prevalent child sexual exploitation is. Many children who are sexually exploited may have been victims of other forms of abuse; the grooming methods that may be used can mean that children who are sexually exploited do not always recognise they are being abused, which can also affect detection rates. What is clear is that child sexual exploitation can occur in all communities and amongst all social groups and can affect girls and boys. All practitioners should work on the basis that it is happening in their area.

Who is vulnerable to child sexual exploitation?

Any child, in any community: Child sexual exploitation is occurring across the country but is often hidden so prevalence data is hard to ascertain. However, areas proactively looking for child sexual exploitation are uncovering a problem. All practitioners should be open to the possibility that the children they work with might be affected.

Age: Children aged 12-15 years of age are most at risk of child sexual exploitation although victims as young as 8 have been identified, particularly in relation to online concerns. Equally, those aged 16 or above can also experience child sexual exploitation, and it is important that such abuse is not overlooked due to assumed capacity to consent. Account should be taken of heightened risks amongst this age group, particularly those without adequate economic or systemic support.

Gender: Though child sexual exploitation may be most frequently observed amongst young females, boys are also at risk. Practitioners should be alert to the fact that boys may be less likely than females to disclose experiences of child sexual exploitation and less likely to have these identified by others.

Ethnicity: Child sexual exploitation affects all ethnic groups.

Heightened vulnerability factors: *Working Together* makes clear the requirements for holistic assessment. Sexual exploitation is often linked to other issues in the life of a child or young person, or in the wider community context. Practitioners should be alert to the fact that child sexual exploitation is complex and rarely presents in isolation of other needs and risks of harm (although this may not always be the case, particularly in relation to online abuse). Child sexual exploitation may be linked to other crimes and practitioners should be mindful that a child who may present as being involved in criminal activity is actually being exploited.

Practitioners should not rely on 'checklists' alone but should make a holistic assessment of vulnerability, examining risk and protective factors as set out in the statutory guidance *Working Together.*

Sexual exploitation can have links to other types of crime. These include:

- Child trafficking;
- Domestic abuse;
- Sexual violence in intimate relationships;
- Grooming (including online grooming);
- Abusive images of children and their distribution;
- Drugs-related offences;
- Gang-related activity;
- Immigration-related offences; and
- Domestic servitude.

The following vulnerabilities are examples of the types of things children can experience that might make them more susceptible to child sexual exploitation:

- Having a prior experience of neglect, physical and/or sexual abuse;
- Lack of a safe/stable home environment, now or in the past (domestic violence or parental substance misuse, mental health issues or criminality, for example);
- Recent bereavement or loss;
- Social isolation or social difficulties;
- Absence of a safe environment to explore sexuality;
- Economic vulnerability;
- Homelessness or insecure accommodation status;
- Connections with other children and young people who are being sexually exploited;
- Family members or other connections involved in adult sex work;
- Having a physical or learning disability;
- Being in care (particularly those in residential care and those with interrupted care histories); and
- Sexual identity.

Not all children and young people with these vulnerabilities will experience child sexual exploitation. **Child sexual exploitation can also occur without any of these vulnerabilities being present.**

Potential indicators of child sexual exploitation

Children rarely self-report child sexual exploitation so it is important that practitioners are aware of potential indicators of risk, including:

- Acquisition of money, clothes, mobile phones etc without plausible explanation;
- Gang-association and/or isolation from peers/social networks;
- Exclusion or unexplained absences from school, college or work;
- Leaving home/care without explanation and persistently going missing or returning late;
- Excessive receipt of texts/phone calls;
- Returning home under the influence of drugs/alcohol;
- Inappropriate sexualised behaviour for age/sexually transmitted infections;
- Evidence of/suspicions of physical or sexual assault;
- Relationships with controlling or significantly older individuals or groups;
- Multiple callers (unknown adults or peers);
- Frequenting areas known for sex work;
- Concerning use of internet or other social media;
- Increasing secretiveness around behaviours; and
- Self-harm or significant changes in emotional well-being.

Practitioners should also remain open to the fact that child sexual exploitation can occur without any of these risk indicators being obviously present. Practitioners should also be alert to the fact that some risk assessments have been constructed around indicators of face-to-face perpetration by adults and may not adequately capture online or peer-perpetrated forms of harm. It is also important to remember that risk assessments only capture risk at the point of assessment and that levels of risk vary over time, and that the presence of these indicators may be explained by other forms of vulnerability rather than child sexual exploitation.

The first step for practitioners is to be alert to the potential signs of abuse and neglect and to understand the procedures set out by local multi-agency safeguarding arrangements. Those working with children and families should access training through those multi-agency arrangements to support them in identifying vulnerability, risk and harm. This will help practitioners to know what action to take and to develop a shared understanding about what best practice looks like.

How are children sexually exploited?

Child sexual exploitation takes many different forms. It can include contact and non-contact sexual activities and can occur online or in person, or a combination of each.

The following illustrative examples, although very different in nature and potentially involving different sexual or other offences, could all fall under the definition of child sexual exploitation:

- A 44 year old female posing as a 17 year old female online and persuading a 12 year old male to send her a sexual image, and then threatening to tell his parents if he doesn't continue to send more explicit images;
- A 14 year old male giving a 17 year old male oral sex because the older male has threatened to tell his parents he is gay if he refuses;
- A 14 year old female having sex with a 16 year old gang member and his two friends in return for the protection of the gang;
- A 13 year old female offering and giving an adult male taxi driver sexual intercourse in return for a taxi fare home;
- A 21 year old male persuading his 17 year old 'girlfriend' to have sex with his friends to pay off a drug debt;
- A mother letting other adults abuse her 8 year old child in return for money;
- A group of men bringing two 17 year old females to a hotel in another town and charging others to have sex with them; and
- Three 15 year old females being taken to a house party and given 'free' alcohol and drugs, then made to have sex with six adult males to pay for this.

These examples are not exhaustive: other forms of child sexual exploitation occur and new forms continue to develop. Nor are they mutually exclusive – some children will suffer abuse across a range of scenarios, either simultaneously or in succession.

Most child abuse occurs within the home. In cases of child sexual exploitation the risk of harm is generally external or in the community.

Child sexual exploitation may occur without the child being aware of events, or understanding that these constitute abuse. Online exploitation includes the exchange of sexual communication or images and can be particularly challenging to identify and respond to. Children, young people and perpetrators are frequently more familiar with, and spend more time in, these environments than their parents and carers. Those who work with and care for children can struggle to remain up-to-date with the latest sites and potential connection points, so practitioners should always seek specialist support if unsure about online environments. Online child sexual exploitation allows perpetrators to initiate contact with multiple potential victims and offers a perception of anonymity, with children and young people, and perpetrators, potentially saying and doing things online they wouldn't do offline. Where exploitation does occur online, the transfer of images can be quickly and easily shared with others. This makes it difficult to contain the potential for further abuse.

Children can be perpetrators as well as victims

Children can be both experiencing child sexual exploitation and perpetrating it at the same time. Examples might include a child who is forced to take part in the exploitation of another child under duress, or a child who is forced to introduce other children to their abuser under threats to their family's safety. These situations require a nuanced

approach that recognises and engages with the young person's perpetration within the context of their own victimisation.

Children who perpetrate child sexual exploitation require a different response to adult perpetrators. Responses may involve criminal justice pathways at times, however every child who displays harmful sexual behaviour should also have their safeguarding and welfare needs actively considered in line with *Working Together*.

Different agencies should work together to: (a) identify any prior victimisation and understand how this has contributed to the perpetration; and (b) map the environments and contexts in which peer-perpetrated child sexual exploitation occurs, looking at the social norms or power dynamics at play which may have influenced the perpetration of abuse. Dependent on the issues emerging, this will likely need both an individually-based response and wider work to address harmful social norms or power dynamics that enable the abuse to occur.

How does child sexual exploitation affect children?

The long-term consequences of any form of child abuse can be devastating and early identification and providing support as soon as problems emerge is critical.

Child sexual exploitation damages children and like any form of abuse it can have long-lasting consequences that can impact on every part of a child's life and their future outcomes. Child sexual exploitation has been shown to affect:

- Physical (including sexual) and mental health and well-being;
- Education and training and therefore future employment prospects;
- Family relationships;
- Friends and social relationships, current and as adults; and
- Their relationship with their own children in the future.

Child sexual exploitation is complex and children are often reluctant to disclose experiences of exploitation due to misplaced feelings of loyalty and shame. Many may not recognise what they are experiencing as abuse or that they require support or intervention, believing they are in control or in a healthy consensual relationship.

Online annexes to this document set out in greater detail the context of adolescent development and risk.

How to respond: working with young people

Child sexual exploitation is never the victim's fault: As stated above, all children and young people have a right to be safe and should be protected from harm.

"What I want is staff who sit down and talk to you calmly and they don't judge you … you want someone to understand why you did what you did"

"Instead of shouting at me and saying 'why did you do it?' …[They should be] letting you get your point across first, then putting their point across and about how they see it differently, instead of just saying that was wrong" (young person cited in Warrington 2013)

Early sharing of information is key to providing effective help where there are emerging problems. As above, it is essential to have in place effective child protection services and procedures for sharing information. For guidance on sharing information, which includes a myth-busting guide, see *Information Sharing: Advice for practitioners* providing safeguarding services to children, young people, parents and carers. Wherever possible practitioners should share confidential personal information with consent. However, where there are concerns that a child is suffering, or is likely to suffer, significant harm, practitioners should be willing to disclose information without consent where the public interest served by protecting the child from harm outweighs the duty of confidentiality. Section B below sets out the framework that is required to support effective practice.

Safeguarding children is everyone's responsibility. As above, all practitioners should assume that in the course of their work with children they will encounter children at risk of sexual exploitation. All practitioners working with children and families need to **know where to get help**: Local multi-agency safeguarding arrangements will set out the process for referring concerns about the welfare of children to local authority children's social care. Anyone can make a referral and ask for advice. If a child is considered to be in immediate danger the police should be contacted.

***Any practitioner* working with a child who they think may be at risk of child sexual exploitation should follow the guidance set out in *Working Together* and share this information with local authority children's social care. You should refer any concerns about a child's welfare to local authority children's social care. If you believe a child is in immediate risk of harm, you should contact the police.**

Managers of services should ensure they are facilitating this type of sharing culture within their agencies and across their local multi-agency partnerships.

- All practitioners working with children and families should respond in ways that are:
- **Child-centred**: recognising children and young people's rights to participate in decisions about them in line with their maturity, and focusing on the needs of the child. Other considerations, such as the fear of damaging relationships with

children or adults, get in the way of protecting children from abuse and neglect. Practitioners should view a referral as the beginning of a process of inquiry, not as an accusation. Victims may be resistant to intervention and some may maintain links with their abusers, even after attempts to help protect them;

- **Developed and informed by the involvement of a child's family and carers wherever safe and appropriate:** a holistic assessment will take account of the wishes and feelings of children and the views of their parents/carers;
- **Responsive and pro-active**: everyone should be alert to the potential signs and indicators of child sexual exploitation, as well as other forms of abuse, and exercise professional curiosity in their day to day work. It is better to help children and young people as early as possible, before issues escalate and become more damaging;
- **Relationship-based:** practitioners should establish and maintain trusting relationships with children and young people, and continue to exercise professional curiosity and create safe spaces for disclosure; and
- **Informed by an understanding of the complexities of child sexual exploitation:** it is important to avoid language or actions that may lead a young person to feel they are not deserving of support or are in some way to blame for their abuse.

"All young people can be worked with. It's about finding the right worker..[and the professional] staying strong, staying tough and going along the roller-coaster ride with the young person…The worker needs to always be there to support you whenever you need it…It doesn't go away overnight. It takes time." (young person quoted in the consultation exercise for this advice, 2016)

What does the particular nature of exploitation mean for practice?

It is important that continued contact is not misinterpreted as informed choice or an indication of absence of harm. Practitioners should maintain their relationships with children and young people, and continue to exercise professional curiosity and create safe spaces for disclosure. Continued contact with perpetrators should be seen as part of the complex power dynamic of the abusive relationship, similar to that in some situations of domestic abuse. Practitioners should continue to reach out to victims and not make the offer of services dependent on formal disclosure. Many victims are only able to disclose after the provision of support, often months or even years down the line.

"I was throwing hints to people an all. I was throwing hints 'cause I didn't want it comin' out of my own mouth. I wanted people to work it out … I was getting myself drunk so I could come out with it, 'cause I couldn't say it when I was like sober. I was like 'I can't say it'" (young person cited in Beckett 2011)

Parents/carers, teachers, youth workers, other professional workers or, as is often the case, a mixture of the above may have a valuable perspective to add. This will inform the contextual understanding and help to identify changes that represent something more than adolescent behaviours (see online annexes covering adolescent development) and make sense of the range of vulnerabilities the child or young person may be facing. As *Working Together* makes clear, it is important all such perspectives, alongside that of the child/young person, are incorporated in all risk assessments.

Working with families

Parents and carers can feel excluded in work with children and young people who are, or who are at risk of being, sexually exploited by perpetrators external to the family. Where assessment shows it is safe and appropriate to do so, parents and families should be regarded as a part of the solution. It is crucial to work with them not only to assess the risks of harm faced by the young person or child but to help them understand what the young person has experienced, the risks they face and how they can be supported and protected. The parents may need direct support and help to improve family relationships and keep their child safe.

Section B – advice for managers and strategic leaders

Local authorities have overarching responsibility for safeguarding all children in their area. Their statutory functions under the 1989 and 2004 Children Act(s) include specific duties in relation to children in need and children suffering, or likely to suffer, significant harm (under sections 17 and 47 of the Children Act 1989).

Local agencies, including the police and health services, also have a duty under section 11 of the Children Act 2004 to ensure they consider the need to safeguard and promote the welfare of children and young people when carrying out their functions.

Under section 10 of the Children Act 2004, these agencies are required to cooperate with local authorities to promote the wellbeing of children and young people in each local authority area. Practitioners are responsible for ensuring they fulfil their role and responsibilities in a manner consistent with the statutory duties of their employer.

An effective local multi-agency plan to combat child sexual exploitation requires clear leadership, guidance and support, delivered according to the overarching *Working Together* principles. It requires contributions from all multi-agency partners in accordance with local multi-agency arrangements. The effectiveness and implementation of multi-agency plans and arrangements to tackle child sexual exploitation should be monitored by the Local Safeguarding Children Board or its successor body. This should include ensuring joint-agency training is available.

Those planning an effective local multi-agency response to child sexual exploitation should follow the process for managing risk of harm to children and putting their needs first, as set out in *Working Together*.

Specifically, an effective response is one that:

- Is collaborative and multi-agency (including statutory, voluntary and community sectors) with clear roles and responsibilities and clear lines of communication and accountability;
- Has clear and purposeful leadership across local safeguarding partners;
- Is locally informed and based on an up-to-date understanding of the local problem profile, but also informed by national learning;
- Is underpinned by effective information sharing and intelligence sharing. All multi-agency partners should follow the guidance set out in *Working Together,* for example taking part in strategy discussion and child protection conferences;
- Locates child sexual exploitation within a wider context of risk and harm, and moves beyond a case by case response to identify wider patterns of concern;

- Encompasses preventative, protective (immediate safeguarding) and responsive approaches, focusing on both victims and perpetrators (and recognising the potential for overlap between the two);
- Provides help and ongoing support that is responsive to individual need, strengths-based in approach and available over the longer-term (recognising that disclosure, resilience-building and recovery can take time);
- Supports staff to 'work with risk,' where required, in order to support a young person to become an active partner in their recovery and reintegration and achieve longer term meaningful change rather than temporary enforced compliance;
- Provides a response to children and young people with harmful sexual behaviours that recognises their vulnerabilities and needs, is holistic and provides early help and specialist services to these children and young people and their parents/carers; and
- Provides a system for flagging or applying appropriate markers on to systems in order to ensure effective record keeping and retrieval and assist information sharing (this should be based on the policy definition of child sexual exploitation and not just the criminal offences of that name).

The child sexual exploitation context

- **Viewing child sexual exploitation within a wider continuum of exploitation, violence and abuse**: Child sexual exploitation is not a catch all category for all forms of sexual harm in adolescence. It should therefore be viewed within the wider continuum of sexual abuse and other relevant issues such as trafficking, modern slavery, domestic abuse and other gendered violence and going missing. The necessary focus on child sexual exploitation should not overshadow a focus on other manifestations of abuse.
- **Abuse outside of families:** Though child sexual exploitation can occur in the family, in most cases the response to exploitation may require services to consider a broader perspective than intra-familial child abuse. The response may need to address risk of harm posed outside the family home and draw in partners such as local businesses, licensing authorities, and other sectors. This reflects the context in which perpetrators are operating.
- **Agencies should move beyond a reactive approach:** (one that removes the individual from harm) to one that also addresses the existence of harm and/or proactively prevents that harm.
- **Local understanding:** Every area should have its own data and intelligence, of which child sexual exploitation should form a part. Local multi-agency plans should be based on an inter-agency assessment of the local profile of perpetration. This

requires effective local arrangements for sharing and collating intelligence and other information about communities, environments, perpetrators and victims.

- **Engaging with diversity:** The evidence base demonstrates that some cohorts of children and young people – males, children with disabilities, Lesbian, Gay, Bisexual and/or Transgender and Black and Minority Ethnic children, for example – may be less likely to have their abuse identified or responded to. Local areas should ensure responses are accessible, relevant and sensitive to the needs of all children and young people.
- **Cross-area working:** Cases of child sexual exploitation frequently cross local authority, police force and even country boundaries in terms of the movement of both perpetrators and victims. A singular area focus cannot therefore adequately capture patterns of harm and risk.
- **Inter-agency working:** While significant progress has been made here, challenges remain. Important areas for improvement include:
    - the practical implementation of information sharing guidance;
    - common risk assessment processes, as set out in *Working Together*, that follow an evidence-based model which looks at risk factors, vulnerability, protective factors and resilience and which prioritises professional judgement and does not rely on simplistic scoring;
    - clarity about professional roles and thresholds for action across universal, targeted and specialist services;
    - more effective sharing and recording of intelligence;
    - better co-ordination of statutory and voluntary sector services; and
    - more streamlined management of multiple agencies' engagement with victims and their families.

- Enhancing children's and young people's **resilience and strengthening the protective factors** around them are critical strands of prevention. Resilience is about being able to overcome adversities and avoid negative consequences. It is not a character trait; it involves both internal capabilities and external resources. Resilience is therefore never a substitute for support.
- **Openness to learning and improvement**: There has been considerable learning in recent years around how better to identify and respond to child sexual exploitation. Sources of support and how to access learning in this area can be found in the online annexes.

Prevention

The harmful effects of child sexual exploitation are serious and far-reaching for victims, their families and wider communities. The ideal is therefore to prevent the abuse happening in the first place. This section focuses on how we can protect children and young people through awareness-raising and resilience-building work.

A local multi-agency plan should:

- Educate all children and young people about the nature and risks of child sexual exploitation and other forms of related harm (both online and offline) and how to access support;
- Recognise that children and young people can be both victims and perpetrators of child sexual exploitation;
- Promote the resilience of children and young people and their families and strengthen the protective factors around them;
- Identify and support those settings, such as schools and colleges, in which children and young people can form healthy and safe relationships;
- Supplement universal initiatives with targeted work with groups of particularly vulnerable children and young people, such as those in care, whilst being careful not to stigmatise specific groups;
- Provide complementary messages to parents and carers about risks to their children (online and offline) and how to access support if they have concerns.
- Consider the levels of knowledge and understanding of the wider workforce, so that everyone working with children and young people can play their role in prevention; and
- Educate the wider community so they can identify and report concerns and seek support.

Although messages and methods of delivery will vary according to the nature and needs of the audience, all education and awareness raising initiatives should:

- Be grounded in an evidence-based understanding of child sexual exploitation (both online and offline);
- Challenge myths and misconceptions about who is perpetrating and experiencing this form of abuse;
- Send a clear message that all forms of child sexual exploitation are abuse;
- Recognise the potential overlap between victims and perpetrators;
- Challenge any victim-blaming and promote the rights of all victims to protection and support;

- Provide information on where and how to report concerns and access support; and
- Be inclusive and accessible to the intended audience, in terms of language and delivery methods and ensure information is tailored and relevant to diverse groups such as Lesbian, Gay, Bisexual, Transgender, Black and Minority Ethnic and/or deaf or disabled children and young people.

Educating practitioners

- **Readiness of the professional workforce**: *Working Together* recognises that everyone who works with children has a responsibility for keeping them safe – that includes all those those who work in social care, adult services, education, health settings, early years, youth work, youth justice, the police, and voluntary and community workers. Local safeguarding arrangements should provide high-quality training and other learning and developmental activities that are rooted in evidence, tailored to different professional groups and responsive to local learning needs.
- **Staff support and supervision**: Creating the right organisational environment and ensuring good quality professional leadership and practice supervision are essential for developing and sustaining effective practice. Supervision can help to:
    - ensure progress and actions are reviewed so cases do not ‘drift’;
    - maintain focus on the child or young person;
    - test the evidence base for assessment and intervention;
    - address the emotional impact of the work on the practitioner; and
    - support reflective practice and help practitioners recognise where personal values and attitudes might be leading to risky practice, assumptions or ‘blind spots’.

All practitioners working with children and young people, whether in specialist or universal roles, should:

- Ensure they are aware of local multi-agency protocols in relation to child sexual exploitation;
- Recognise learning and development around this as an essential part of their role;
- Discuss learning needs in relation to child sexual exploitation with their supervisor or manager;
- Identify and access training opportunities that reflect their professional role (online annexes provides an overview of key messages that training should cover);
- Reflect on learning from training and other activity with their manager, and consider how it will impact on practice;

- Review their learning needs over time, striving to continuously improve their knowledge, skills and understanding; and
- Actively engage in supervision and use it as an opportunity to test out thinking, have practice constructively challenged and discuss support needs.

Professional training and local protocols should clearly outline the roles and responsibilities of different practitioners in safeguarding children from harm (see *Working Together*). Training should address the complexities of identifying and responding to child sexual exploitation, emphasising:

- Practitioners' safeguarding responsibilities and local reporting routes;
- Child sexual exploitation is a form of child sexual abuse;
- Child sexual exploitation can take many different forms (online and offline) and affect any child or young person;
- All under 18s are entitled to protection and support and that safeguarding duties do not depend on a child or young person's desire to be safeguarded;
- The need to understand the impact of trauma on behaviour and presentation;
- The need to look beyond presenting behaviours and exercise 'professional curiosity';
- The need to apply professional judgment, supported by effective supervision and robust tools, in decision-making and practice;
- The power of professional reactions to facilitate or close down access to support and protection;
- The practical implementation of information sharing guidance where there are concerns about child sexual exploitation; and
- The development of practical skills in facilitating conversations with children and young people, and with their parents/carers.

Training alone is not sufficient to ensure a skilled and confident workforce, however. Training should be accompanied by:

- Opportunities to learn from other practitioners – for example, shadowing, co-working and peer observation;
- Ongoing high-quality supervision;
- A focus on reflective practice to help practitioners navigate complexity; and
- A recognition of the emotional impact that such work can have on practitioners, and access to support in order to manage this.

Educating children and young people

Although there is not as yet any proven blueprint for the most effective means of communicating messages around child sexual exploitation to children and young people, the evidence base highlights some important principles:

- **The need for early and continuous education**: We are increasingly learning about cases of child sexual exploitation that involve younger children, particularly in the online sphere. If children and young people are not educated about the risk of child sexual exploitation (and other forms of sexual abuse) before perpetrators approach them, they are left unprotected. Schools may want to consider how to build in effective, age-appropriate education, which sensitively supports younger children on these issues and which forms part of a planned programme of study across key stages. This should be accompanied by wider resilience-building work.
- **Use all potential avenues of communication**: Schools, colleges and other educational settings have a critical role to play. Personal, social, health and economic (PSHE) lessons are an obvious route for educating children and young people about the risks of child sexual exploitation and other forms of harm, as are pastoral services and school nurse services. Consideration should also be given to how messages can be delivered outside mainstream education, for example, in youth clubs, community settings or the family home.
- **Adopt a holistic approach**: Risk of child sexual exploitation should be addressed as part of a wider programme of work on sexuality and sexual development, choice and consent, healthy relationships, harmful social norms and abusive behaviours and online safety. This should build on existing initiatives (around online safety for example) and ensure messages dovetail across these different programmes of work. Educative work should engage both boys and girls and should address both risk of perpetration and risk of victimisation (and the potential for overlap).
- **Contextual considerations**: Messages around child sexual exploitation should be delivered within a safe non-judgmental environment, by credible individuals who are confident discussing the issues and able to challenge unhelpful perceptions. Where specific vulnerabilities are identified (going missing, gang-association or drug/alcohol misuse, for example) more targeted educative work should be undertaken, while taking care to avoid stigmatisation or labelling. Accessible and appropriate support should be immediately available should any issues of concern be identified during education activity.

Educating parents and carers

Parents and carers have a critical role to play in helping to protect children and young people from child sexual exploitation. They can educate their children about sex, healthy relationships and abuse, enhance resilience, provide a safe base and ensure open

channels of communication. They are also well placed to support early identification by identifying emerging vulnerabilities or potential indicators of abuse and seeking support before risks escalate. In order to support them, practitioners should ensure that parents/carers:

- Understand the risks of both online and offline child sexual exploitation and recognise this as something that could affect their child;
- Know the potential indicators of child sexual exploitation;
- Know where and how to access support;
- Are reassured that services will, as appropriate, work in partnership with them to try to protect their child;
- Have support to manage the emotional impact of child sexual exploitation on their child, themselves and on family relationships; and
- Have support that is tailored to their specific circumstances and needs, for example, support that recognises their culture or faith, and are helped to overcome any barriers such as language.

Educating communities

Harnessing the wider community: Those who do not necessarily 'work with children' also have a contribution to make to tackling child sexual exploitation. Hoteliers, taxi drivers, park wardens, refuse collectors and retail workers (amongst others) may hold vital information about the movement of victims and perpetrators. Emergency services, including the Fire and Ambulance Services, and local community and religious groups can also play a key role. Educating those who work in local services and businesses (including the night-time economy) about what to look for, and how to report concerns, can significantly enhance local disruption and protective capabilities.

This focus should also include members of the wider local community who may observe concerns within their areas – for example, those living near a party house location who may see victims coming and going. Educating people about child sexual exploitation, the things to look out for and where to report concerns, will significantly enhance the protective capabilities of our communities.

Department for Education

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Centre of expertise on child sexual abuse

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Key messages from research on child sexual exploitation:

Commissioning health care services

Nicola Sharp-Jeffs, Maddy Coy and Liz Kelly

March 2017

This briefing paper is for commissioners of health services. It brings together key messages from research on child sexual exploitation (CSE) and should be read in conjunction with guidance for professionals. [Links to English guidance and Welsh guidance].

Key messages

- Child sexual exploitation can happen to young people from all backgrounds. Whilst young women are the majority of victims, boys and young men are also exploited.
- Sexually exploited young people will access a broad range of healthcare in different settings, including sexual health, Accident and Emergency (A&E), walk-in centres, GPs, Child and Adolescent Mental Health Services (CAMHS) and services for self-harm and drug and alcohol use.
- Sexually exploited young people and those at risk should have easy access to services along health care pathways at the point of need.
- Commissioners can undertake an audit of available services to check whether such points exist and to ensure that they are sufficient to meet demand
- Local assessments of scale, evidence gathered for Joint Needs Assessments and problem profiles developed by the police will offer Commissioners a picture of the level of support that needs to be provided.
- Commissioners can put in place measures that will encourage health professionals to view the young person holistically and to see beyond the presenting clinical issue
- Commissioners can play a crucial role in ensuring that required standards are being met by making adequate resources available and championing good practice.
- Investment in specialist services can yield financial benefits.
- Health care professionals can contribute to multi-agency work to protect young people, identify patterns in abuse and disrupt perpetrators. Commissioners can play a role in assisting health staff balance maintaining confidentiality and safeguarding through this mechanism.
- Commissioners of health services can play a wide-ranging role in prevention and early intervention: from promoting early identification of CSE through universal services to targeted opportunities.

Child Sexual Exploitation

'Child sexual exploitation is a form of child sexual abuse where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator.' (New England definition 2017)

There is no one way that CSE is perpetrated (Child Exploitation and Online Protection Centre, 2011; Berelowitz et al. 2012; Gohir, 2013; Research in Practice and University of Greenwich, 2015). Grooming is common in some forms of CSE, but it is not always present (Beckett, 2011; Melrose, 2013). Online and offline exploitation can overlap (Fox and Kalkan, 2016). That children and young people may appear to co-operate cannot be taken as consent: they are legally minors

and subject to many forms of coercion and control. These abuses of power are similar to those which are recognised in domestic violence and they may lead to children and young people being unable to recognise what is happening to them as abuse.

Whilst all of the research evidence to date shows that girls and young women are the majority of victims, boys and young men are also exploited. The average age at which concerns are first identified is at 12 to 15 years, although recent studies show increasing rates of referrals for 8 to 11 year olds, particularly in relation to online exploitation (Department for Education, 2017). Less is known about the exploitation of those from Black and Minority Ethnic (BME) and Lesbian, Gay, Bisexual and Transgender (LGBT) communities (Ward and Patel, 2006; Gohir, 2013; Coy, 2016a; Sharp, 2013; Fox, 2016).

There is no 'typical' victim. That said, some young people may be more vulnerable than others, and a range of indicators have been highlighted to which professionals should be alert. These include: prior abuse in the family; deprivation; homelessness; misuse of substances; disability; being in care; running away/going missing; gang-association (Beckett et al. 2013; Brown et al. 2016; Coy, 2009; Franklin, Raws and Smeaton, 2015; Harris and Robinson, 2007; Klatt et al. 2014; Jago et al. 2011; Smeaton, 2013). It is not known whether these also apply to young people where exploitation begins or wholly occurs online, although some factors appear to be involved in both contexts (Whittle et al. 2013). Indicators are not evidence that sexual exploitation has taken place. All they suggest is that practitioners need to use professional curiosity and judgement to explore what is going on with each young person.

Supporting health care needs

Sexually exploited young people may access a broad range of healthcare in a variety of different settings, for needs that include:

- sexual health (Kirtley, 2013; Nelson, 2016) e.g. sexually transmitted infections; testing for urinary tract infections; (emergency) contraception; pregnancy tests; terminations; heavy bleeding; and abdominal pains (Berelowitz et al 2012; Department of Health, 2014; Jay, 2014; Myers and Carmi, 2016).
- physical injuries, including those incurred through self-harm and injury (Berelowitz et al. 2012; Kirtley, 2013; Marshall, 2014).
- drug and alcohol misuse (Berelowitz et al 2012; Child Exploitation and Online Protection Centre, 2011; Coy, 2009; Department of Health, 2014; Jay, 2014; McClelland, 2011).
- psychological impacts, including anxiety, depression, flashbacks, post-traumatic stress and psychosis (Royal College of Psychiatrists, 2012; Marshall, 2014).

Healthcare staff in all settings should assume that sexual exploitation is happening in their area (Beckett and Schubotz, 2014; Berelowitz et al. 2012; Hughes and Thomas, 2016; see also Office for Standards in Education, Children's Services and Skills 2016) and plan accordingly. Plans to address sexual exploitation should recognise that known CSE cases are likely to be an under-estimation of the problem given under-reporting and under-identification of the issue (Public Health England, 2017).

Assessing need and planning approaches

Young people who are sexually exploited require easy access to health services at all points along care pathways. Commissioners can undertake an audit of available services to check whether such points exist and to ensure that they are sufficient to meet demand. For instance, inquiries into sexual exploitation have reported difficulties for young people in accessing Child and Adolescent Mental Health Services (CAMHS), identifying barriers such as insufficient resources, strict access criteria and long wait times for assessment and treatment (Allnock et al. 2015; Martin et al. 2014; Goddard et al., 2015).

Local assessments of scale, evidence gathered for Joint Needs Assessments and problem profiles developed by the police will offer Commissioners a picture of the level of support that needs to be provided. The practice-based knowledge of agencies working directly with sexually exploited young people (including Rape Crisis Centres and Sexual Assault Referral Centres) is a further valuable resource. Commissioners can also invite young people with experience of CSE services into conversations about whether and how current provision is meeting their needs (Office for Standards in Education, Children's Services and Skills, 2016; Webb and Holmes, 2015).

If there are not enough resources locally to provide support then commissioners can consider jointly commissioning them across geographical areas (Allnock et al. 2015). One possibility is an integrated approach, combining joint commissioning arrangements between the police, social care and education. The advantage of this is that health services can be organised to respond to young people efficiently and address their multiple needs (Nelson, 2016). Collaboration through the pooling of budgets will enhance planning and can result in clearer referral pathways (Research in Practice, 2015). When health professionals are working closely with the police, for example, young people may have better access to pre-trial therapy as well as access to therapeutic services during court cases and in the aftermath (Beckett and Warrington, 2015).

Ensuring the needs of victims are met

Traditional approaches to child protection are stretched by the complex dynamics of sexual exploitation and the range of needs that sexually exploited young people have (Pearce, 2014). Young people may not think of themselves as victims and may believe that they are in love (Pearce, 2009). Sexual exploitation is a process, and enabling young people to find a way out can be similar to supporting victims of domestic violence: focussing on strengths, assessing risk and widening space for action – a process of 'sustained safeguarding' (Pearce, 2009). Intensive support provides young people with the sense of security they need and acts as a counterbalance to the 'pull' of exploiters (Coy, 2009; Gilligan, 2016; Shuker, 2013).

Commissioners can put in place measures that will encourage health professionals to view the young person holistically and to see beyond the presenting clinical issue (Research in Practice, 2015). All members of health care staff have a role to play in identifying signs of sexual exploitation. Therefore a key activity is to review the availability of specialist training to frontline practitioners and ensure that it is delivered on a regular, ongoing basis. Local strategic approaches to child safeguarding and local specialist services that work with sexually exploited young people are often an excellent resource from which to commission training, because of their experience and expertise.

Commissioners can also play a crucial role in ensuring that required standards are being met by making adequate resources available and championing good practice. Additional resourcing

in safeguarding leadership across primary care, community health and the hospital sector has been found to effectively support the development of frontline professional confidence and expertise (Office for Standards in Education, Children's Services and Skills, 2016). Relationship-based work on sexual exploitation has a high emotional impact, so resources are also required to ensure health professionals have regular supervision.

Another important consideration for Commissioners is whether specialist child sexual exploitation services are included within referral pathways. Specialist teams in the voluntary or statutory sector are consistently identified as being able to work with young people for longer (Gilligan, 2016; Pearce, 2014). They are also able to undertake proactive outreach work, including daily phone calls and text messages, door-stepping and other ways of maintaining contact, even where this support is initially, or repeatedly, rejected (Coy, 2016b; Oxford Brookes University, 2015; Warrington, 2013).

This highlights how contracts for specialist services need to be of sufficient length that they can build trusting relationships with young people. While commissioning long term services may appear costly, re-referrals and ongoing crises are more so (Webb and Holmes, 2015). Investment in specialist services can yield financial benefits with one cost-benefit analysis showing a potential saving of £12 for every £1 invested (Barnardo's, 2011).

Multi-agency working

At a strategic level, work to address the sexual exploitation of young people needs to connect with other forms of child sexual abuse (CSA). This is because many young people who are sexually exploited have histories of other forms of sexual abuse (Coy, 2009; Hickle, 2016) which may amplify current health concerns. Connections also need to be made with local approaches to violence against women and girls (Brayley and Cockbain, 2014; Coy, 2016b) as well as issues such as going missing, youth offending and substance misuse. Multi-agency working is therefore important and Commissioners can encourage this.

Inquiries into CSE have reported reluctance to share information, due to the important focus on confidentiality and building trust with children and young people (Barnardo's 2012; Berelowitz et al. 2015; Champion, 2014; Dodsworth and Larsson, 2014; Pearce, 2014). One of the consequences of failing to link information is that intelligence may not be shared in ways that would enable health services to contribute to the identification and disruption of perpetrators (Jago et al. 2011) including where the perpetrator is implicated in more than one case. However, sharing information in multi-agency contexts is not an intervention in and of itself; it must be linked to protective and/or preventative action. Commissioners can play a role in assisting health staff to balance maintaining confidentiality and safeguarding (Department of Health, 2014).

Whilst all the research evidence to date shows that the majority of offenders are men, sexual exploitation can also involve peers in complex ways – as facilitators, abusers or bystanders (Firmin, 2011; Beckett et al. 2013). Other useful intelligence that can be recorded and shared by health care professionals may include locations where sexual exploitation takes place e.g. house parties.

Prevention and early intervention

Prevention and early intervention work is another important element of strategic approaches to sexual exploitation. Commissioners of health services can play a wide-ranging role; from promoting early identification of CSE through universal services such as school nursing and

health visiting through to targeted opportunities such as liaising with local authority partners such as licensing to disrupt perpetrators (Public Health England, 2017).

Another role is to lead public health campaigns that involve young people, families/carers and professionals. Raising awareness can increase knowledge and confidence about how to keep young people safe (D'Arcy et al. 2015; Bovarnick and Scott, 2016). These will be more effective if the messages and materials are 'sense checked' with young people who have been sexually exploited. Programmes and/or materials aimed at young men about sexual consent, sexualisation of young women's bodies and standards of masculinity are also important prevention initiatives (End Violence Against Women Coalition, 2011). Commissioners of health services can also promote young people's health in schools and colleges, supporting them in the delivery of Sex and Relationships Education (Public Health England, 2017). Yet another approach may be to train and support young people who have experienced exploitation to become peer 'health advocates' and raise awareness about the health impact of CSE (Hagell, 2013).

Key messages from research on child sexual exploitation – also available

- Staff working in health settings
- Police
- Strategic commissioning of police services
- Social workers
- Strategic commissioning of children's services
- Professionals in school settings
- Multi-agency working

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Centre of expertise on
child sexual abuse

www.csacentre.org.uk

18645az17

IICSA INDEPENDENT INQUIRY INTO CHILD SEXUAL ABUSE

What is the Truth Project?

We believe that every victim and survivor of child sexual abuse has the right to speak truth to authority and to be respectfully heard without challenge.

Truth Project affords any qualifying victim and survivor an opportunity to tell a representative of the Independent Inquiry into Child Sexual Abuse anything that they wish. Some participants give a full narrative of what happened to them and how they were failed by institutions or by institutional response; some tell us what they feel it will be important for us to recommend; for many it's somewhere in the middle. Most people choose to attend a private session to tell us their experience in person but some prefer to do this in writing or by another remote method. We can support them in either case.

Who qualifies to participate?

This Inquiry is investigating how institutions in England and Wales may have failed to protect children from sexual abuse.

We want to hear from anyone who has experienced sexual abuse at the hands of someone in a position of authority; or if someone in authority failed to act appropriately on any report of sexually abusive events; or if someone, who **should have been able to**, failed to recognise reasonable signs of sexual abuse. The abusive events may have happened anywhere (in an institutional setting, at home, in public etc) but there must have been an organisational failure in one of the ways indicated above.

For example, someone may have been abused on the organisation's property or grounds, or first came into contact with the person who abused them in an organisation, or someone from an organisation knew what was happening, or they told someone in authority (such as a social worker, teacher, priest or police officer) and an appropriate course of action was not followed. Or they may have suffered sexual abuse by a family member, or friend of the family, or even someone they didn't know and this was not responded to appropriately. Or someone who cared for them (a teacher, medical professional, social worker etc) didn't notice something

they should have noticed that should have triggered some action in relation to their wellbeing.

When we say 'organisation' we mean a range of things. These include, but are not limited to: Children's homes; Schools; Children's clubs such as sports or activity clubs; Youth detention centres; Churches or religious organisations; Media; The Armed Forces; Charities; Social services, the police, and other government run services or organisations; or any similar institution.

What will happen to what participants tell us?

We have established this project to allow victims and survivors of childhood sexual abuse to tell us what you think it's important for us to know and this will form part of our thinking for future recommendations to make children safer. They can also decide whether their experience is shared with the Inquiry's Research Project which analyses trends and will produce anonymised data that will also assist in making future recommendations.

The Inquiry must pass on all allegations of child abuse to the police. We will, however, only pass on contact details to the police if the participant agrees for us to do so or, exceptionally, if we believe there is a child protection concern or someone is at current risk of serious harm.

How do they register and what happens then?

They contact us using our simple on-line form or by calling our information line and we get back to discuss next steps. They won't be asked to tell us any details of abusive experience(s) at this point. We will tell them what sessions are available and where (you can choose the location nationally) and a booking will be made. 4 weeks before session, a support worker will get in touch to arrange all travel and accommodation (for the participant and any supporter they might want to bring along), to see how they're feeling about the session and answer any questions. The supporter will be in touch as often as is wanted over the next 4 weeks - or not at all if that suits better.

The same worker will meet the participant on the day of the session, take them through the process and contact them after to see how they're doing. There is also a

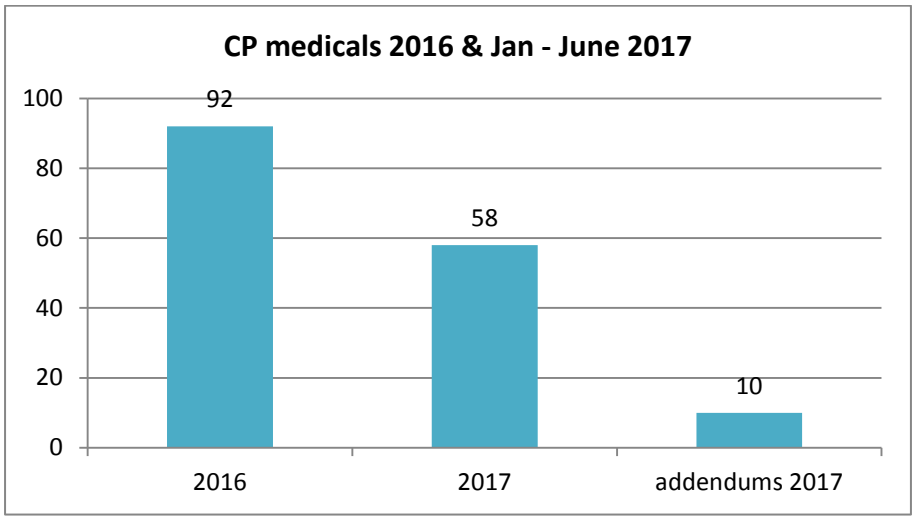
pyschotherapist available on the day to help with any difficult feelings that a participant might want to talk through. At every stage they are completely in control - we won't ask questions except where we need to clarify something they've told us to make sure we have it right and they can stop or withdraw at any point.

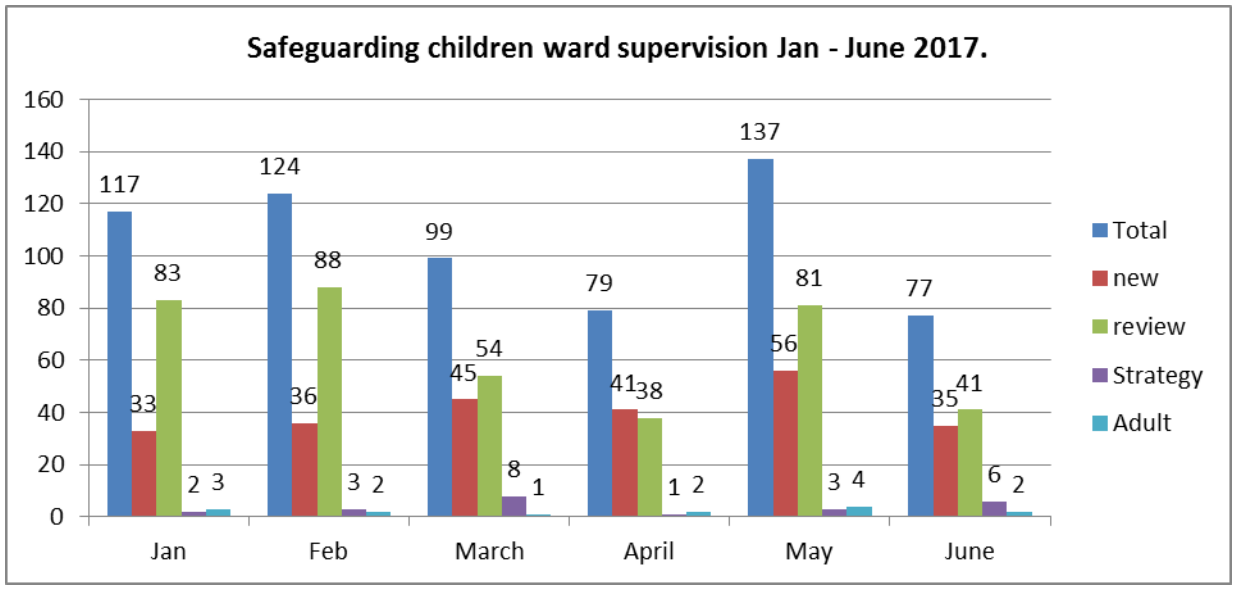
IICSA Truth Project will be open in Brighton on 22nd Jan 2018 for an initial 2 weeks and at various locations around Sussex thereafter.

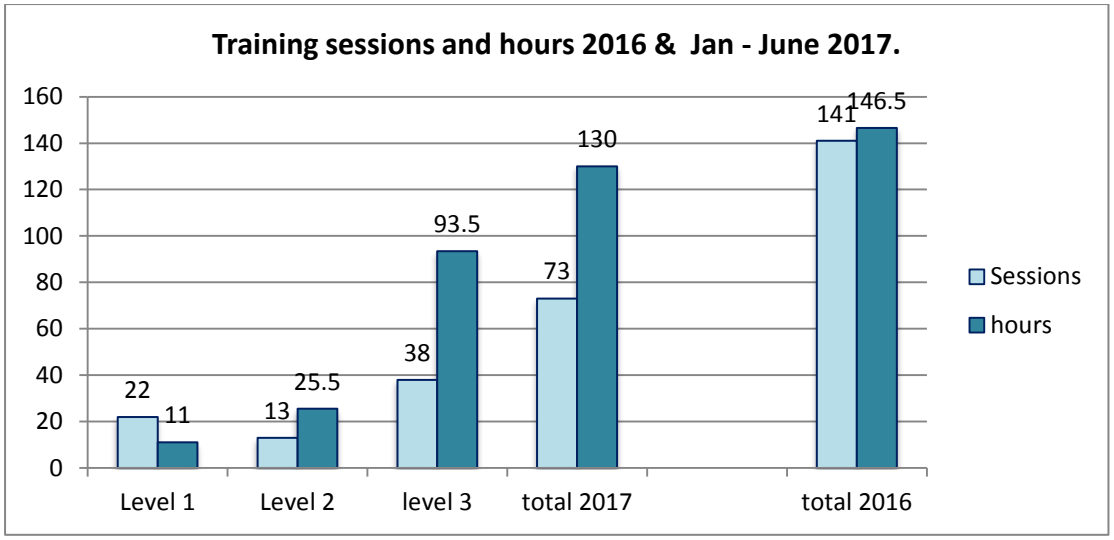
For more information about Truth Project activities in London and South East England, contact:

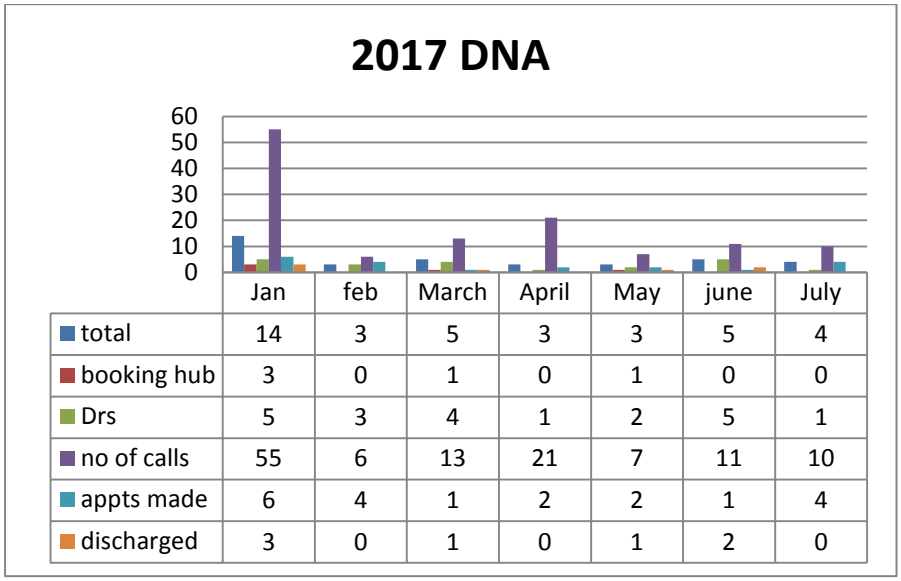
Michael May at michael.may@iicsa.org.uk

Supporting graphs for the BSUH Board safeguarding children report 2017.









	Jan	feb	March	April	May	june	July
total	14	3	5	3	3	5	4
booking hub	3	0	1	0	1	0	0
Drs	5	3	4	1	2	5	1
no of calls	55	6	13	21	7	11	10
appts made	6	4	1	2	2	1	4
discharged	3	0	1	0	1	2	0

Learning Together from Serious Case Reviews

This short briefing summarises what a Serious Case Review has shown about the child protection system in Brighton & Hove.

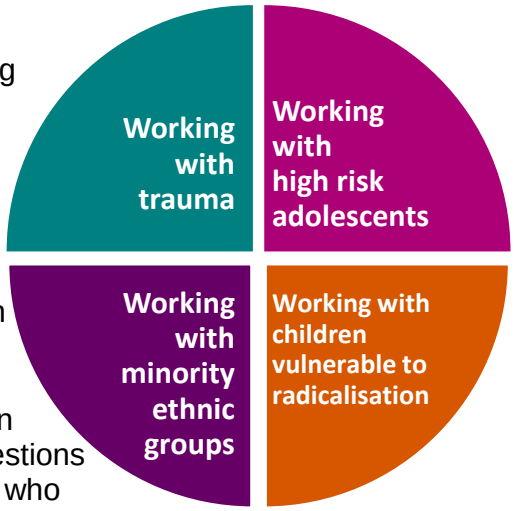
It is important if Brighton & Hove is to become a safer place for children to live for everyone to embrace the learning from the review and take the necessary steps to help put right the issues identified.

Siblings W&X: Brighton & Hove Safeguarding Children Board undertook a Serious Case Review (SCR) to evaluate multi-agency responses to vulnerable young people at risk of exploitation through radicalisation. It follows the deaths of two brothers, 'W' & 'X,' in Syria in 2014. They had received services from local agencies in the Brighton & Hove area before leaving the UK.

If you work with children & families in Brighton & Hove, there may also be additional specific actions & recommendations for your agency and your role. Please ask your manager, or contact your representative on the LSCB. **You can read the full report at** **brightonandhovelscb.org.uk/serious-case-reviews-2/july-2017-siblings-wx**

Key Learning Points:

This Serious Case Review identified 13 findings about the safeguarding system in Brighton & Hove, grouped into four priority areas:



Findings relate to the issues of working with families with unresolved trauma who have a longstanding mistrust of authorities; 'blind spots' in how agencies view and respond to the behaviour of adolescents; adopting reflective practice against constant reactive crisis management; and balancing the need to protect the welfare of children with national security imperatives.

Findings also highlight the differing processes for safeguarding children who go missing abroad as opposed to missing in the UK and raise questions about the effectiveness of information sharing regarding young people who come to police attention. The findings also talk to professionals understanding and knowledge of how young people are radicalised and how to best support them, as well as their understanding of Government policies with regard to racialisation.

Findings related to working with minority ethnic groups reflect concerns regarding resourcing and strategies to support women and children from minority cultural backgrounds; professionals' understanding of culture, identity, gender, religion, beliefs and divided loyalties; and statutory agencies knowledge about, and understanding of, local minority ethnic and faith community groups and how best to work together to safeguard children, including those at risk of exploitation into radicalisation.

One finding considers the system strengths in the city following the discovery that the two siblings and another young person had gone missing. It recognises changes to processes, practice and working relationships to help prevent other young people at risk of radicalisation and travelling to Syria.

History: The review concerns two siblings, W & X, who originated from a country in North Africa /Middle East and received services from our local agencies. Both siblings travelled to Syria aged less than eighteen years old and both are reported to have died in 2014. It was understood that the boys were with the Al-Nusra Front, which in 2013 pledged allegiance to Al Qaeda.

W & X were part of a larger sibling group. Many practitioners in the city, from a variety of services, worked with the family. The heart of this review examines the siblings and their family's experiences. This includes their experience of being subjected to racist and religiously motivated abuse and attacks, domestic and physical abuse. The review also considers the youngest four siblings' involvement in anti-social and suspected criminal activities.

In early 2014 it was discovered that three siblings were not in the UK and after a period of uncertainty over their whereabouts, the police learnt they had travelled to Turkey and were suspected of being in Syria. Before this, none of the professionals involved with the family considered that any of the siblings were at risk of being exploited by radicalisation, or at risk of travelling to Syria to join fighting. Some professionals understood that an older sibling had travelled to Turkey to assist in the delivery of aid a few months earlier. Around that time there was a referral to the Channel panel for child X, where there was no evidence identified of him being at risk of being drawn into terror related activities. During 2014 the focus of intervention changed following the discovery that three of the siblings had gone to Syria. At that point multi-agency involvement addressed the risks to the remaining siblings of radicalisation and in particular the possibility of them travelling. Also at that stage, agencies became aware of potential risks to other young people in Brighton & Hove, particularly in the siblings' peer group.

Many of the review's findings relate to the challenges for professionals to provide effective help and support to children who have suffered trauma in their early childhood. Such trauma can provide the context for children becoming vulnerable to exploitation as well as becoming involved in various risk taking and anti-social behaviours.

Unresolved trauma & distrust of statutory services:

Childhood trauma is an important public health concern, with adverse childhood experiences being one of the strongest predictors for difficulties in future life.

At the start of the timeframe under review, the children in the family were aged twelve to seventeen years old. Agency records show that the family had been subject to a long history of contact with agencies. What the review has not been able to determine is whether anyone working with the family fully understood their life experiences. The mother spoke to reviewers of the trauma for the whole family, of the changes in their lives brought about by political events in their home country, and the impact of leaving an educated high status section of society and moving to Brighton where they suffered from racism. Whilst the mother did not describe feeling any lack of trust or faith in practitioners, she did acknowledge that the impact of her family living with threats to their safety was traumatic. Comments made in media reports, in agency records, and by other members of the community suggest that by January 2012 the children may have held a feeling of distrust in the ability of local professionals to help to them. The lack of any prosecution may have left the children feeling that the authorities were unable to protect them.

How would a fuller understanding of the experiences of this family have helped with dealing with the prevailing concerns?

How do you built a trusting relationship with the people you are working with?

Do you feel confident to tackle entrenched defence mechanisms?

Working with trauma

Child Protection & Safeguarding Adolescents

Traditionally the focus of the child protection system has been on parenting capacity and the safety and wellbeing of younger children. The more recent focus on child sexual exploitation has led to the increasing recognition of adolescent neglect as a safeguarding issue, particularly when it contributes to the risk of child sexual exploitation and, more recently, to radicalisation. The review highlights some 'blind spots' in how agencies view and respond to behaviours of adolescents. It talks to a range of behaviours that some young people are involved in locally, which can expose them to harm and which could be related to vulnerabilities caused by earlier life experiences and/or parenting issues.

What do you consider are the indicators and risk factors of exploitation?

Does the concept of being able to label a situation as exploitation hide what is actually happening for the child or young person?

Working with high risk adolescents

Adolescents & Reactive Crisis Management

One of the notable features of this case was that prior to the review period, the siblings engaged with youth services, attended some activities and engaged with practitioners, disclosing they were suffering physical abuse. However, by the time of the period under review, the four youngest siblings had become increasingly hard to engage. Whilst this was likely to relate to family members' own history and experience of earlier professional involvement, the lifestyle of the four youngest siblings was also a feature. This involved frequently being out until the early hours of the morning; returning home with friends; missing school; involvement with other young people in group anti-social and criminal behaviour (including violent offences against others); substance misuse and suspected drug dealing. Professionals were unable to progress work with the family and instead found they were responding to constant incidents.

Working with high risk adolescents

In your practice, how do you balance addressing the immediate issues with the longer term needs of the family?

Missing in UK vs Missing Aboard

When it was recognised that children in Brighton & Hove may be at risk of travelling to Syria, initial child protection conferences were held on each child identified. This did not, however, include young people who were already missing, thought to be abroad and already in Syria.

Do you know what to do if you think a young person you are working with has left the UK?

Working with high risk adolescents

Information Sharing & Agency Perception of Relevant Information

In this case there seemed to be differing views or perceptions of the siblings. Some professionals, including social workers and youth offending officers, held a view that the younger male children in the family were victims of racism and this had led them to retaliate and get involved in anti-social behaviour and minor criminality. On the other hand, information held within police systems depicted them as being suspected of involvement in aggressive and violent offences

Working with high risk adolescents

Do you feel that you are provided with the full information held about a young person you are working with by the other safeguarding agencies?

Working with children vulnerable to radicalisation

Countering Propaganda

Another feature of this case was the identification of the increasing risk to, the vulnerability of, some children and young people via the internet and social media. Online environments are a major recruitment method, potentially exposing young people to extremist content and persuading them towards a radical outlook. It was recognised that it is difficult for parents and professionals to be confident that they know what is influencing children on the internet and through social networks.

Do you feel that you are sufficiently aware of the levels of radical material available via the internet / on social media?

As a professional, do you have the confidence to discuss the potential for radicalisation via the internet with parents, carers and family?

Working with children vulnerable to radicalisation

Links between Racism and Vulnerability to Exploitation

In this case, it is noted that, early experiences of racism in nursery schools and primary schools was described as leading to children becoming alienated, which it turn led them to have low personal self-esteem and, as a consequence, they became more vulnerable to searching for ways to feel better about themselves through other means. There was concern expressed by community members that schools are not able to protect Muslim children sufficiently from racism and that with the ending of required reporting of incidents, there is no longer awareness of the level of hate incidents within schools.

Do you feel that you have the ability to recognise and identify bullying, and prejudiced based incidents, including those which are racist and religiously motivated?

As a professional, do you think you can establish a positive working relationship with a Muslim family, while still considering the current requirements under Prevent?

Working with children vulnerable to radicalisation

Recognition of Risk of Radicalisation and Link to Safeguarding

In this case there had been no specific concerns with regard to W & X in relation to radicalisation.

It is understood that this had not been raised as a concern to the police, and that other agencies working with the family had not anticipated or registered any suggestion that the siblings were considering travelling abroad. There were no overt intentions or behaviours, albeit it was noted that when they were involved with the police in 2012, the siblings made angry and abusive comments to officers which did have radical connotations. These were viewed at the time as being the way in which they were expressing their aggression. The review iterates the importance of not just focusing on the individuals but also on the potential links between young people and wider safeguarding issues.

Do you feel that current Safeguarding Procedures work successfully alongside the Prevent processes?

Are you confident that a young person identified via Prevent will be appropriately referred to safeguarding teams for assistance if required?

Working with children vulnerable to radicalisation

Welfare of Children and National Security Imperatives

This case highlighted issues about information sharing between agencies, and how this led to misconceived perceptions about “withheld details”. Police information provided at the initial child protection conference, which was attended by Prevent officers as opposed to those from the local Safeguarding Investigation Unit, did not include all the routine information expected at such meetings. There is inconsistency in how safeguarding concerns relating to extremism are recorded. In terms of reporting and monitoring, the Prevent duty requires all agencies to record Prevent safeguarding concerns even if they do not refer to the police or the Channel process.

Are you confident to challenge other partner agencies with regard to the level of information they have provided?

Do you feel that you have a full understanding of your reporting role within the Prevent duty?

Working with children vulnerable to radicalisation

Brighton & Hove Systems Strengths

This review found that there has been good response following the discovery that the two siblings and another young person had gone missing. It recognises changes to processes, practice, and working relationships to help prevent other young people at risk of radicalisation and travelling to Syria. The report highlights the good use of legal interventions, namely Wardship proceedings to thwart children identified as vulnerable to radicalisation from travelling to war zones.

Are you confident of being able to promote the use of appropriate legal proceedings to prevent and disrupt the potential radicalisation of a young person?

Domestic Violence and Abuse among Families from Ethnic Minorities

Working with minority ethnic groups

This case heightened agency suspicions that coercion and control aspects of domestic abuse were a feature of this family's dynamics, compounded by the mother's social isolation and lack of support. It was recognised that these circumstances would have made it extremely difficult for the mother to co-operate with professionals. In this case, even though the mother and her children (on advice from professionals) lived separately from the father, he was still known to continue to have access to the children. At that time police lacked means to stop the father visiting, despite it being against his bail conditions, because police bail, prior to being charged, does not provide effective powers when contravened. There is no evidence seen by the review to suggest that professionals sought to support the mother to take out an injunction against him, with power of arrest.

Do you have sufficient awareness of the appropriate support services available to domestic abuse victims from minority ethnic groups?

Do you regularly advise on the use of civil injunctions and other court orders to prevent/reduce further incidents of domestic abuse?

Culture, Identity, Gender, Religion, Beliefs and Divided Loyalties

Working with minority ethnic groups

This case highlighted that professionals were not curious enough about what life was like for this family before arriving in the city, including why they left their country of origin and the political links of the wider family. In this case there was inadequate consideration of the role of identity, religion, culture, family and community in the lives of the children and their parents including the existence, or not, of Islamist thinking. The issue of identity for adolescents is developmentally significant, especially if they perceive themselves as different to those around them. Practitioners may not know how best to support children and families from different cultures and countries who may be subject to conflicting identities and political or religious loyalties.

Do you have the ability to consider looking at the personal identity of the young person you are working with?

Are you able to comprehend the difference between cultural and religious beliefs that may have impact on the young person's concept of appropriate behaviour?

Professional Understanding and Knowledge of BAME Communities

Working with minority ethnic groups

Whilst the case showed that on occasion the local authority does liaise with community groups in a variety of ways, community members reported that they did not feel listened to or heard.

They did however feel they are consulted about various policy and service developments.

It is a concern that there is a perception from local communities that when racial harassment incidents are reported to statutory agencies, in some instances, nothing is heard back of the outcome of the investigation and there is little sense of things changing.

Do you think that your role as a statutory agency worker has an impact on your ability to work with a BAME family?

How can you develop a better working relationship and build trust with community groups and BAME families?

Staff Seminars: We will be holding some three hour long seminars for staff from all agencies working in Brighton & Hove to come together and look at the findings from this review in more depth. These are free to attend, although space is limited, and these will run as part of the Safeguarding Sussex Week:

- Tuesday 28 November 2017, 1.30-4.30
- Thursday 30 November 2017, 9.30-12.30

Find out more and book your place at: learning.brighton-hove.gov.uk

The LSCB also support multi-agency training courses on and See our upcoming training at brightonandhovelscb.org.uk/events or book on through the Brighton & Hove Learning Gateway

Reporting Concerns

If you are concerned about a child contact the Front Door For Families on 01273 290400 including if you think they are at risk of being exploited into radicalisation or violent extremism

Any worker who believes a crime is being committed, or planned, or is aware of any terrorist activity, should contact Sussex Police Prevent team without delay on 101 ext. 550543

If you want advice from the Prevent team regarding concerns about an individual please email Channel.Prevent@brighton-hove.gcsx.gov.uk

Further Reading & Useful Links

- Safe in the City Website for local guidance on preventing terrorism and extremism and reporting racist and religiously motivated hate crime
- Pan Sussex Child Protection & Safeguarding Procedures: Children & Young People Vulnerable to Violent Extremism
- Brighton & Hove LSCB Website
- Tower Hamlets' Advice Leaflet for Parents and Childline's advice for children
- NSPCC advice on protecting children from radicalisation, and helpline 0808 800 5000.
- Channel Duty Guidance 2015; Prevent Duty Guidance 2015 and Departmental advice for schools and childcare providers
- Home Office e-learning
- Educate Against Hate gives parents, teachers and school leaders practical advice on protecting children from extremism and radicalisation.
- Extreme Dialogue provide short films and educational resources to help start safe, constructive discussions around extremism and radicalisation in schools or community settings
- FAST (Families Against Stress and Trauma) is a charity based in south London that works nationally with families who have been affected by the trauma of losing loved ones to hateful ideologies and groups, or who may be worried about their loved ones possible involvement with terrorism
- The Department for Education and the Home Office have published advice to help local authorities support British children who return to the UK from Syria
- BAWSO provide specialist services for BAME families and have written about Domestic Abuse from a BAME Perspective
- Women's Aid have advice for BAME women trying to escape from domestic abuse

Brighton & Hove LSCB local safeguarding children board

Feedback: As staff and frontline managers you will know about the quality and impact of your own services, and those of the partner agencies you work with. The LSCB Learning & Improvement Framework highlights that it is important to the LSCB to have a constant feedback loop from the frontline to keep senior management and those with governance responsibilities 'reality-based'; not just in terms of what is or is not working, but to assist with ideas for improvement so that changes can be made systematically.

We would like to hear your thoughts, feedback and comments on findings presented to you in this briefing and any feedback on the style of the briefing itself.

Brighton and Sussex University Hospitals NHS Trust

NICE Quality Standard – Feb 2016 – Domestic violence and abuse

NICE Quality Standard – Gap analysis – Domestic violence and abuse

Why this quality standard is needed

At least 1.4 million women and 700,000 men aged between 16 and 59 experienced domestic abuse in England and Wales in 2013/14 – 8.5% of women and 4.5% of men[1]. At least 29.9% of women and 17.0% of men in England and Wales have experienced domestic abuse at some time[2]. These figures are likely to be an underestimate, because all types of domestic violence and abuse are under-reported in health and social research, to the police and to other services[3].

Both men and women perpetrate and experience domestic violence and abuse, but it is more common for men to perpetrate violence and abuse against women. This is particularly true for severe and repeated violence and sexual assault.

A report from Lancaster University – Cost of domestic violence up-date – estimated the costs associated with domestic violence and abuse in the UK in 2008 to be £15.7 billion. This included over £9.9 billion in 'human and emotional' costs, more than £3.8 billion for the criminal justice system, civil legal services, healthcare, social services, housing and refuges, and more than £1.9 billion for the economy (based on time off work for injuries).

Multi-agency partnership working at both an operational and strategic level is the most effective approach for addressing domestic violence and abuse. Training and ongoing support from within an organisation are also needed for individual practitioners. Without training in identifying domestic violence and abuse and responding appropriately after disclosure, healthcare professionals may fail to recognise its contribution to a person's condition and to provide effective and safe support.

The quality standard is expected to contribute to improvements in the following outcomes:

- harm from domestic violence and abuse
- mortality from domestic violence and abuse
- emergency attendances for domestic violence and abuse
- quality of life
- personal safety
- duration of domestic violence and abuse
- re-occurrence of domestic violence and abuse.

NICE Quality Standard – Feb 2016 – Domestic violence and abuse

How this quality standard supports delivery of outcome frameworks

NICE quality standards are a concise set of prioritised statements designed to drive measurable improvements in the 3 dimensions of quality – patient safety, patient experience and clinical effectiveness – for a particular area of health or care. They are derived from high-quality guidance, such as that from NICE or other sources accredited by NICE. This quality standard, in conjunction with the guidance on which it is based, should contribute to the improvements outlined in the following 2 outcomes frameworks published by the Department of Health:

- Public Health Outcomes Framework 2013–16
- Adult Social Care Outcomes Framework 2015–16.

Tables 1 and 2 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

Table 1 Public health outcomes framework for England, 2013–16

Domain	Objectives and indicators
1 Improving the wider determinants of health	***Objective*** Improvements against wider factors that affect health and wellbeing and health inequalities ***Indicators*** 1.11 Domestic abuse 1.12 Violent crime (including sexual violence)
2 Health improvement	***Objective*** People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities ***Indicator*** 2.23 Self-reported well-being

NICE Quality Standard – Feb 2016 – Domestic violence and abuse

Table 2 The Adult Social Care Outcomes Framework 2015–16

Domain	Overarching and outcome measures
4 Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm	***Overarching measure*** 4A The proportion of people who use services who feel safe ***Outcome measures*** **People are free from physical and emotional abuse, harassment, neglect and self-harm** **People are supported to plan ahead and have the freedom to manage risks the way that they wish** 4B The proportion of people who use services who say that those services have made them feel safe and secure *Placeholder 4C. Proportion of completed safeguarding referrals where people report they feel safe*
Indicators in italics in development	

NICE Quality Standard – Feb 2016 – Domestic violence and abuse

Quality Statement	Is it met? Y/N/Partially/ Planned / NA to secondary care	Comments (Examples of good practice or deficiencies identified)	Action required	Timescale	Person responsible
Statement 1. People presenting to frontline staff with indicators of possible domestic violence or abuse are asked about their experiences in a private discussion.	partially	There is a BSUH policy, there is some training but not all staff may consider asking the question BSUH to consider improving the training about asking about domestic abuse Include safeguarding questions relating to domestic abuse on symphony	To discuss at the safeguarding committee and promote asking about domestic abuse and raise awareness.	Achieved June 2016 June 2018	Safeguarding committee Debi Fillery Jo Henderson Matrons
Statement 2. People experiencing domestic violence and abuse receive a response from level 1 or 2 trained staff.	met	If staff are aware that domestic abuse is happening then they will respond. To ensure all staff are able to recognise domestic abuse	To discuss at the safeguarding committee and promote asking about domestic abuse and raise awareness.	June 2016	Safeguarding committee Debi Fillery Jo Henderson Matrons
Statement 3. People experiencing domestic violence or abuse are offered referral to specialist support services.	met	If staff are aware that domestic abuse is happening then they will respond by referring to local domestic abuse services. RISE & Worth.	To discuss at the safeguarding committee and promote asking about domestic abuse and raise awareness.	June 2016	Safeguarding committee
Statement 4. People who disclose that they are perpetrating domestic violence or abuse are offered referral to specialist services.	met	If staff are aware that domestic abuse is happening they may not know what services are available for perpetrators but will know to refer to local domestic abuse services. RISE & Worth.	Increased training Bar code or tissue with telephone numbers available. HIDVA in place in A&E, maternity and Sexual	June 2016	Safeguarding committee

NICE Quality Standard – Feb 2016 – Domestic violence and abuse

			health service will give advice about other areas. Safeguarding teams available for advice & support		

Link to tools and resources for implementation: http://www.nice.org.uk/guidance/ph50/resources

Brighton and Sussex University Hospitals NHS Trust

To: Meeting of the Board of Directors

Date of Meeting: 29th November 2017 Agenda Item: **7**

Title
Organisational Development and Workforce Performance Report
Responsible Executive Director
Denise Farmer, Chief Workforce and OD officer
Prepared by
Helen Weatherill, HR Director
Status
Public
Summary of Proposal
This report details the Trust's performance in relation to workforce supply, development and engagement of its workforce to improve the organisations culture.
Implications for Quality of Care
There is a direct correlation between a highly engaged, performing workforce and quality of care.
Link to Strategic Objectives/Board Assurance Framework
Supports the delivery of the Trust's current corporate objectives: excellent outcomes; great experience; empowered skilled staff; high productivity
Financial Implications
Supports effective and efficient financial performance
Human Resource Implications
As above
Recommendation
The Board is asked to: NOTE this report
Communication and Consultation
n/a
Appendices
Workforce scorecard data

To: Board of Directors **29th November 2017**

From: Denise Farmer, Chief Workforce and OD Officer **Agenda Item: 7**

FOR INFORMATION

ORGANISATIONAL DEVELOPMENT AND WORKFORCE REPORT

1. INTRODUCTION

1.1. This paper sets out the key headlines relating to the Trust's workforce at 30 October 2017.

2. Workforce Capacity

2.1. The Trust Establishment stands at 8,198 WTE. There are 7,306 WTE staff in post which equates to a vacancy rate of 10.9%. Of the 892 WTE vacancies; 375 WTE are Nursing and Midwifery, 186 WTE are Admin & Clerical, 134 WTE are Scientific, therapeutic and technical staff (ST&T)**,** 126 WTE are Ancillary Support and 71 are Medical. The highest vacancy rate is within Ancillary Support (18.6%).Given that some have been vacant for some time we are reviewing which ones we are actively recruiting to.

2.2 Bank spend was £1.4m during the month of October 2017 which is a reduction from October 2016 (£1.7m). There had been a steady increase in spend between June to September 2017 so this month represents the first reduction to be seen in four months. The average spend over the previous 12 months was £1.47m per month.

2.3 Agency spend has also seen a decrease to £0.8m in October 2017 from £1m at the same time last year. There had also been a steady increase in spend in Agency since May 2017 therefore this figure represents the first decrease to be seen in five months. Part of the decrease in spend is as a direct result of the working being undertaken to reduce the non-framework premium agency usage.

3. Staff Turnover

3.1. The Trust's 12 month Turnover rate (external leavers excluding Training Grade Doctors) was14.2%. ST&T remains the staff group with the highest Turnover (16.2%).

3.2. Since July 2017 there has been an overall increase in the net gain between substantive starters and leavers; in October we recruited 14.7 WTE more qualified nurse starters than leavers.

4. Workforce Efficiency

4.1. The Trusts 12 month sickness absence rate is currently 4.31%. A sickness absence rate of 4.31% represents 314 WTE lost to sickness absence based upon staffing levels (September 2017).

4.2. Focused work through the workforce efficiencies working group has been undertaken to identify opportunities to improve upon the current absence rates. Firstly a review of the current sickness absence policy is underway. A

survey has been distributed to managers and the HR team seeking their views on the current process, its ease in application and identifying where improvements can be made. This data is currently being analysed and proposals to amend the current process will be taken to the policy group. Initial thoughts are involvement of HR at an earlier stage, possible reduction in the number of episodes and longer monitoring periods should be implemented.

4.3. Alongside the review, the Employee Relations Team have identified 134 cost centres where absence rates are above the Trust average of 4.2%. The team have been ascertaining the reasons for absence rates and working with managers to ensure that sickness is being robustly managed. Long term absence accounts for 2.3% of the current sickness absence rate. There has been focus on all absence in excess of six months and these all have a management plan in place. The team is now focusing upon those absences of three-six months to ensure that managers are dealing with the absence appropriately and robustly.

4.4. Between September 2017 to date, in excess of 100 managers have attended sickness absence management training as well as specific training being delivered to teams and departments. Attendance is now being analysed to ensure that directorates can identify managers who have not yet attended training but are required to do so.

5. Workforce Skills and Development

5.1. **Appraisals**

5.1.1 The Trust appraisal rate is 76.1%. Finance had the highest compliance rate at 92.2% which was an increase in compliance of 27.2% from August to October. A total of 5 Directorates increased compliance in October and 16 Directorates had deterioration with Estates & Facilities the lowest at 49.7%.

5.1.2 Of the 342 ward and departments 157 (46%) are at, or above 85% compliance and appraisal training continues to be available for managers. This will be an area of focus for incoming divisional teams.

5.2 **Statutory and Mandatory Training**

5.1.1 The Trusts statutory and mandatory compliance rate for October 2017 was 79%.

5.1.2 Of the 22 Directorates 8 are above 85% compliance, 6 are below 80% with Estates & Facilities at 61.6%

5.2 STAM Improvement Work

5.2.1 Over recent years the Trust has been on a journey to improve statutory and mandatory delivery and compliance. Various approaches have been adopted to increase compliance, including blended learning approaches through investment in e-learning. Further focus is required to improve and sustain acceptable compliance rates, the current Trust wide compliance rate is 79%, and the target rate is 90%. A working group is reviewing data to better inform and shape approaches to improving and sustaining compliance going forwards. Operational Leads and Line Managers will be instrumental in achieving this 90% compliance target.

5.2.2 Face to face methods of training also provide additional opportunities for engaging with staff across the Trust to share important messages and learning with wider audiences.

5.3 Induction Refresh

5.3.1 A refresh of the current Corporate Induction is currently underway and this will enable a restructuring of the programme to further support cultural change across the Trust by creating a landscape of positivity for new starters. The Trust induction and welcome extended to new starters, forms part of the employee engagement journey and is therefore imperative that the introduction into the organisation is welcoming, engaging and informative.

5.3.2 A working group shaped the programme outline, the central theme of the new programme will be Patient First and "People" – staff, patients and visitors, and creating a healthy experience for those working within the Trust and visiting it.

5.3.3 To accommodate further learning and interaction a market place will be present during the breaks where staff can engage with additional teams, resources and support groups.

5.3.4 Approximately 100 new employees are on boarded each month. External support has been commissioned to develop subject matter experts' content to further embed the Patient First principles into their respective sessions, improve delivery and encourage audience participation and engagement. This new programme will be launched early in 2018.

6 Staff Survey

6.1 The National NHS Staff Survey was launched on 3 October 2017. It was sent to all substantive eligible staff in the Trust and will close on 1 December 2017. The current response rate is 39.5%. Compared to other Acute Trusts surveyed by Picker, BSUH are ranked midpoint between the best and worst performing Acute Trusts

6.2 Following staff feedback from last year, 80% of surveys were distributed via paper and were delivered to wards and departments directly by the HR team and the remaining 20% were sent online via Trust email accounts. Each department received a welcome pack incorporating posters to display in key areas, briefing packs for managers and frequently asked questions for staff. Drop in cake events were held by HR the last two weeks of October across all sites and locally in departments. Further events are being held directly after the patient first briefings and ad-hoc for departments on request.

6.3 Weekly messages are being sent to the Department/Ward Managers, Directorate Leads and the Executive Team to report overall Trust, Divisional and cost centre level survey participation scores. Cost centre breakdowns include a highlight of the top and bottom areas within each Directorate. Divisional scores are ranked best to worst and ranking position is compared against the previous week to encourage competition and participation. Directorates with the highest ranking and percentage increase are highlighted and congratulated in the message.

6.4 Reminders, including a second copy of the survey, have been issued the week commencing 15 November 2017 along with new promotional material to be displayed locally. HRBP's have been working with Directorate Leads on tailored plans to distribute reminders to ensure maximum impact for each directorate. It was encouraging to see some Directorate Lead Nurses/Managers collecting the reminders themselves or committing to personally delivering them to staff.

6.5 The Communications Team continues to publicise the survey and any events; they have ensured it appears in the weekly Chief Executive message and in BUZZ. The Chief of Workforce and Organisational Development sent a message to the leadership network at the end of October to promote staff participation. The survey is also placed on the agenda for any Trust meetings, and was discussed in detail at TEC last week.

7 Divisional Clinical Structures and Leadership

7.1 The new Divisional structure will commence on 1st December 2017. This is a very important milestone in the Trust's overall improvement plan.

7.2 A number of vacancies remain, however recruitment is underway and various interim solutions have been identified to ensure that the Divisions are able to function effectively.

7.3 The Clinical Leaders programme has now commenced and initial feedback has been very positive. The second cohort of senior nursing and managerial leaders will commence in January.

8 Future Programme Management of Workforce and OD Programmes

8.1 The workforce and OD agenda at BSUH is complex and challenging. To support the transformation required, two separate but interconnecting programmes have been established.

8.2 The first programme is the Workforce Efficiencies and Transformation programme and the key objective of this programme is to improve workforce efficiencies through the sustained improvement of workforce KPIs ie the reduction in vacancies, turnover, temporary staffing spend and sickness absence. This programme is now well embedded in the overall efficiencies programme and governance structure.

8.3 The second programme is the Workforce Organisational Development programme and the key objective of this programme is deliver the cultural change agenda including the necessary improvements in culture, staff engagement, leadership and management capability and capacity, equalities, health and well-being, performance management and education including STAM, appraisal and induction.

8.4 As part of this work, the Trust's Key Workforce Performance Indicators targets have been reviewed against national and local targets. The trajectories are currently being finalised, however the targets will be as follows:

KPI	Target	Current performance
Sickness absence – in month	3.3%	4.3%
Sickness absence – 12 month	3.3%	4.4%
Appraisal up to date	90%	76.2%
STAM up to date	90%	79%
Turnover rolling 12 month average	8.5%	14.2%

9.0 Staff Engagement and Communications

9.1 **Patient First**

9.1.1 Support for Patient First continues with a range of communications and engagement activities taking place since the last report. The aim is to ensure staff are aware of Patient First, believe it will support improvement and can see how they are involved.

9.1.2 All staff drop-in sessions, hosted by members of the executive team, are taking place weekly at the county site and Princess Royal. The executive team are also attending team meetings across the trust in order to introduce the principles of Patient First.

9.1.3 An information resource has been created on the Trust's website and content also leads the weekly staff newsletter, *Buzz.*

9.1.4 Looking ahead, further materials are being developed to support the overall awareness objectives.

9.2 **Additional Internal priorities**

9.2.1 Support to encourage completion of the national staff survey has continued throughout the month with regular promotion in the weekly newsletter as well as on social media. This has included a video message from the chief executive. The campaign designed to support the national flu campaign has also received significant airtime over the past two month.

9.3 **Reach**

9.3.1 The average number of page views (visits to the digital version of Buzz) for October is 1013, which is marginally up on the previous

month. 250 printed copies are also circulated around the organisation.

9.3.2 The chief executive's message was opened by 4,000 on average each week, which is again, in line with the previous month's figure.

9.3.3 The five most popular Facebook posts are:

9.3.4 Virtual Reality flythrough of Phase one of the new hospital build (8,700 reach)

9.3.5 We are proud of our improvements in recognising and treating sepsis - with 84% of patients diagnosed with sepsis getting antibiotics within one hour. #sepsis (6,800 reach)

9.3.6 Please allow extra time for parking over the next month while we continue to do the building work on site. (6,300 reach)

9.3.7 Dr Rob Galloway video of the promotion of the trust's counselling support, mental health awareness day (3,200 reach)

9.3.8 A&E team wins Royal College of Emergency Medicine award (2,900 reach)

9.4 **Employee of the Month**

9.4.1 Our Employee of the Month scheme was relaunched at the end of October with a celebration of winners who all reflect the Trust's values of communication, kindness and understanding, fairness and transparency, working together and excellence. All have gone above and beyond to ensure patients receive the highest quality service. They are:

- Hannah Robertson, Cardiac Care Unit
- Simon Lewis, Biomedical Science
- Tomotherapy Radiotherapists, Preston Park
- A&E team, Princess Royal Hospital
- Tracey Lawrence, Patient Access, Cancer
- Andrew Abbs, Courtyard one and two
- The winners have been presented with their awards and stories publicised in the Trust's weekly newsletter, *Buzz.*

BSUH Workforce Scorecard

October 2017

Key Performance Indicators		Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	12mth position	Target	Amber	Trend
1 Workforce Capacity	*NB*																	
FTE - Budgeted		8,025.4	8,043.0	8,049.7	8,105.1	8,107.1	8,107.1	8,142.1	8,147.3	8,223.2	8,195.3	8,194.4	8,218.4	8,198.1	8,144.2			
FTE - Substantive contracted		7,363.4	7,357.2	7,299.9	7,310.6	7,315.5	7,320.5	7,285.0	7,259.1	7,250.7	7,251.8	7,279.4	7,285.2	7,306.7	7,293.5			
FTE - Substantive contracted variance from Budget		662.0	685.8	749.8	794.5	791.6	786.6	857.1	888.2	972.5	943.5	915.0	933.2	891.4	850.8			
Vacancy Factor (Substantive contracted FTE)		8.2%	8.5%	9.3%	9.8%	9.8%	9.7%	10.5%	10.9%	11.8%	11.5%	11.2%	11.4%	10.9%	10.4%	**7.8%**		
Spend - Bank as a % of total staffing		5.7%	4.0%	4.3%	4.7%	5.2%	5.0%	4.5%	4.1%	5.2%	5.2%	5.3%	5.8%	4.8%	4.8%			
Spend - Agency as a % of total staffing		3.5%	3.3%	3.0%	3.4%	3.1%	4.5%	2.4%	3.1%	3.3%	3.2%	3.9%	4.3%	2.8%	3.4%			
2 Workforce Efficiency	*NB*																	
Absence - Sickness (12 month)	1	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%	4.2%	4.2%	4.2%	4.3%	4.3%	4.3%			**4.1%**		
Absence - Sickness in month		4.8%	4.6%	4.6%	4.8%	4.7%	4.2%	3.7%	3.9%	3.9%	4.1%	4.2%	4.4%		4.3%			
Absence - Maternity in month		2.8%	2.8%	2.8%	2.6%	2.5%	2.4%	2.4%	2.5%	2.5%	2.4%	2.4%	2.5%		2.5%			
Absence - Annual Leave in month		5.6%	4.7%	7.5%	5.8%	6.7%	7.8%	7.9%	7.4%	6.8%	6.9%	9.0%	6.8%		6.9%			
Absence - Special, Study & Other Leave in month		2.6%	2.5%	2.6%	2.6%	2.7%	2.8%	2.8%	2.8%	2.9%	2.9%	3.0%	3.0%		2.8%			
Absence - Total in month		15.7%	14.6%	17.4%	15.8%	16.5%	17.2%	16.7%	16.6%	16.1%	16.2%	18.6%	16.7%		16.5%			
Sickness - Short Term (< 28 days)		2.2%	2.1%	2.1%	2.2%	2.2%	1.9%	1.7%	1.9%	1.9%	1.9%	1.9%	2.0%		2.0%			
Sickness - Long Term (> 27 days)		2.5%	2.5%	2.5%	2.5%	2.5%	2.2%	1.9%	2.0%	2.1%	2.1%	2.2%	2.3%		2.3%			
Sickness - Stress in month		0.7%	0.8%	0.6%	0.7%	0.8%	0.9%	0.7%	0.9%	0.9%	0.8%	0.9%	0.8%		0.8%			
Sickness - Gastro Intestinal in month		0.4%	0.4%	0.5%	0.3%	0.4%	0.3%	0.2%	0.3%	0.3%	0.3%	0.3%	0.4%		0.3%			
Sickness - Other Musculoskeletal in month		0.5%	0.4%	0.4%	0.4%	0.3%	0.3%	0.3%	0.3%	0.4%	0.5%	0.5%	0.4%		0.4%			
Sickness - Cough, Cold & Flu in month		0.6%	0.7%	0.8%	0.8%	0.6%	0.3%	0.3%	0.3%	0.2%	0.2%	0.3%	0.4%		0.5%			
Sickness - Back in month		0.3%	0.2%	0.2%	0.2%	0.3%	0.3%	0.2%	0.3%	0.2%	0.2%	0.2%	0.2%		0.3%			
Episodes - New sickness episodes in month		1,461	1,501	1,620	1,658	1,238	1,362	1,087	1,235	1,214	1,145	1,245	1,153		1,327			
Episodes - On-going sickness episodes in month		305	285	340	301	331	381	347	309	316	303	270	290		315			
Episodes - Total sickness episodes in month		1,766	1,786	1,960	1,959	1,569	1,743	1,434	1,544	1,530	1,448	1,515	1,443		1,641			
Triggers - 3 sickness episodes in 6 months breaches		658	675	768	866	897	915	818	771	687	558	561	535		726			
Triggers - 5 sickness episodes in 12 months breaches		662	662	697	720	715	691	680	682	672	661	638	652		678			
Triggers - Long term sickness breaches		124	113	139	121	126	131	95	133	125	133	158	139		128			
Triggers - Total sickness management breaches		1,444	1,450	1,604	1,707	1,738	1,737	1,593	1,586	1,484	1,352	1,357	1,326		1,532			
Triggers - Number of staff breaching one (or multiple) triggers		974	971	1,079	1,138	1,153	1,145	1,078	1,080	1,013	947	949	920		1,037			
Maternity - Number of staff on maternity leave		235	241	233	214	210	204	201	203	207	196	199	204		212			
Turnover - Trust (12 month)		13.4%	13.6%	14.0%	14.2%	14.3%	14.4%	14.5%	14.6%	14.5%	14.3%	14.3%	14.1%	14.2%	14.2%	**12.9%**		
Turnover - Medical & Dental		8.4%	8.7%	9.3%	8.3%	8.5%	8.4%	8.5%	8.7%	8.6%	8.1%	9.0%	9.3%	10.0%	8.8%			
Turnover - Nursing & Midwifery		14.2%	14.3%	14.8%	15.0%	15.3%	14.9%	15.2%	15.8%	15.6%	15.5%	14.8%	14.3%	14.2%	15.0%			
Turnover - Scientific, Therapeutic & Technical		14.3%	14.7%	15.1%	15.4%	15.0%	16.3%	16.2%	15.8%	16.1%	15.3%	16.0%	15.9%	16.2%	15.7%			
Turnover - Admin, Clerical & Estates		13.5%	13.3%	13.8%	14.3%	14.4%	14.4%	14.3%	13.8%	14.1%	14.3%	14.8%	14.9%	15.1%	14.3%			
Turnover - Support Staffing		11.8%	12.3%	12.3%	12.6%	12.7%	12.7%	13.1%	12.9%	11.8%	11.4%	12.4%	12.4%	12.4%	12.4%			
3 Training & Personal Development	*NB*																	
% of appraisals up to date (excl Medical staff)		73.4%	75.7%	77.2%	79.2%	81.0%	85.0%	82.8%	81.3%	80.9%	80.2%	77.7%	76.2%	76.1%	79.4%	**100%**		

Notes: 1 Absence data is available one month in arrears.

Brighton and Sussex University Hospitals NHS Trust

To: Board of Directors

Date of Meeting: 29th November 2017 **Agenda Item: 8**

Title
Month 7, 2017-18 Performance Report
Responsible Executive Director
Pete Landstrom, Chief Delivery & Strategy Officer
Prepared by
Giles Frost, Interim Director of Performance and Information
Status
Disclosable
Summary of Proposal
The paper sets out organisational compliance against national and local key performance metrics. The report summarises in year performance for Brighton & Sussex University Hospitals Trust, as detailed in dedicated performance scorecards relating the NHSI Single Oversight Framework, National Constitutional Targets, and when relevant other operational indicators.
Implications for Quality of Care
Describes Quality Outcome KPIs
Link to Strategic Objectives/Board Assurance Framework
Compliance with National NHS Constitutional Standards
Financial Implications
Describes Operational KPIs which impact on Financial Sustainability and Efficiency
Human Resource Implications
Describes Operational KPIs which impact on Workforce
Recommendation
The Board is asked to: NOTE the Trust position against the NHS Single Oversight Framework; and the compliance against the National Constitutional Standards for 6 out of 8 Cancer metrics, and the 6 week Diagnostic waiting time metric, and non-compliance against the A&E and RTT waiting time metrics.
Communication and Consultation
Not applicable
Appendices
(1) Operational Performance Scorecard

To: Trust Board	**Date: 29th November 2017**
From: Pete Landstrom, Chief Delivery & Strategy Officer	**Agenda Item: 8**
FOR INFORMATION	

PERFORMANCE REPORT: MONTH 7, 2017/18

1 INTRODUCTION

1.1 This report summarises both current in year and projected performance for Brighton & Sussex University Hospitals NHS Trust, with further detail provided in the appendices relating to the Operational Performance Scorecard

1.2 This paper provides the Board with an update on performance on a specific basis against the NHS National Constitutional Standards.

2 SUMMARY PERFORMANCE

2.1 Operationally October saw an improvement in A&E, continued compliant diagnostic performance, the number of long waiting patients over 52 weeks reduced and marginal RTT 18 week performance improvement.

2.2 Under the Single Oversight Framework, the Trust was compliant with the National Constitutional Target in Diagnostic waiting times. A&E 4 hour, RTT 18 week, and Cancer 62 day treatment performance were below National Constitutional Targets.

2.3 Key operational indicators during October to note:

- 13,484 A&E attendances compared to 14,093 in October 2016 (a reduction of 4.3%).
- 4,727 non-elective spells compared to 4,764 in October 2016 (representing a decrease in activity of 0.8%).
- Formally reportable Delayed Transfers of Care reduced to 6.7%. This is a reduction from 8.0% in August 2017, and from 8.9% Oct-16.

- Average length of stay for patients reduced to 5.33 days for non-elective medicine in October 2017, compared to 5.48 days in September 2017, and 5.5 days in October 2016.

3 KEY AREAS OF PERFORMANCE

3.1 A&E Compliance

3.1.1 The Trust was non-compliant against the National four hour standard in October, with 87.0% of patients waiting less than four hours from arrival at A&E to admission, transfer, or discharge. This is a significantly improved position from September (84.3%). There were 0 patients who waited longer than 12 hours in the A&E department from the decision to admit.

3.1.2 Performance against the four hour standard during the week ending 22nd October deteriorated from 87.52% to 83.85% as Emergency Department attendances rose to a year high of 271 attendances at RSCH Monday 16th October, however performance recovered to 88.7% for the last week of October.

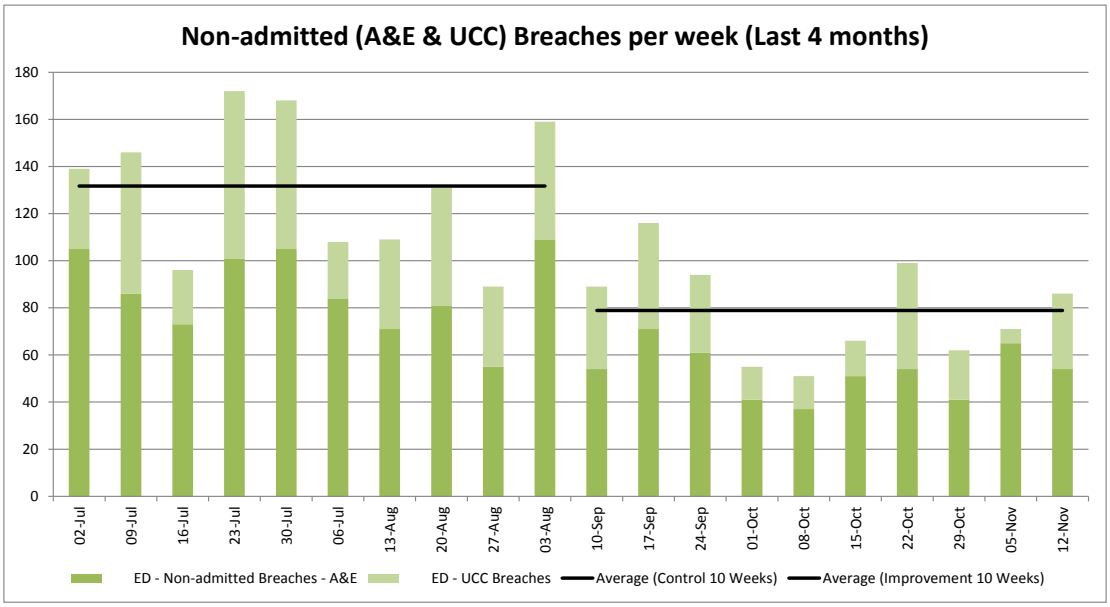
3.1.3 The Trust A&E performance is an aggregate of the Royal Sussex County Hospital Emergency Department, the Princess Royal Hospital Emergency Department, the Children's Emergency Department at the Royal Alexandra Children's Hospital, and the Emergency Eye Department at the Sussex Eye Hospital. The Trust has, in accordance with NHSI guidance, also included attendances at the Brighton Station Walk in Centre for the first time from October 2017. This is to ensure greater consistency with A&E performance reporting for the catchment population.

3.1.4 Within the overall 87.0% performance, there remains variation by A&E site. Performance by site in October 2017 is outlined overleaf:

Site	Total Patient Attendances	Total Patients Waiting >4hrs	% Patients <4 hours
Royal Sussex County Hospital	7018	1696	75.8%
Princess Royal Hospital	3222	340	89.4%
Royal Alexandra Children's Hospital	2355	2	99.9%
Sussex Eye Hospital	1064	2	99.8%
Brighton Station Walk in Centre	1985	1	99.9%
Total Trust	13015	2048	84.3%

3.1.5 Performance at RSCH, whilst remaining extremely challenging, saw an improvement of 3.2% compared to September 2017.

3.1.6 The overall improvement follows a Trust and System improvement event and improvement plan commenced and implemented September. This targeted as a breakthrough objective a reduction in non-admitted patient breaches. As the chart below illustrates, there has been a significant improvement in the number of non-admitted breaches as part of this focussed improvement programme at the Royal Sussex County Hospital. This represents 530 fewer non admitted breaches over the last 10 weeks relative to the preceding 10 weeks.



3.1.7 Performance at PRH reduced in October to 89.4% compared to 93.5% in September.

3.1.8 The Royal Alex Children's Hospital and Sussex Eye Hospital continued to exceed the National Target.

3.1.9 As noted in the September board paper, the redesign and expansion of the Urgent Care Centre (UCC) was completed by the end of September 2017 and additional cubicle capacity is now operational. Planning for the £30m redesign of the County site Emergency Department and Emergency Floor development continues. This includes works to level four of CIRU to enable the additional Ambulatory Care capacity with a December completion date, however works to level five have been re-scheduled until mid-January for up to a four week period to reduce the operational risks during the Christmas and New Year period.

3.1.10 The development of a GP streaming model at PRH is underway and the development of two new GP rooms is scheduled to be complete by the end of November 2017; additional GPs have also recently been appointed. A refurbishment of the majors cubicles and the building of a new assessment area is scheduled to complete before Christmas.

3.1.11 Waiting for admission to an inpatient ward remained the highest single reason for patients waiting longer than 4 hours in A&E. Difficulties in access to beds due to formal delayed transfers of care (DTOC) patients decreased in October to 6.7%, with the wider system and CCG actively supporting the Trust to achieve a significant reduction and then to maintain lower levels of DTOCs. This work commenced towards the end of September and is ongoing as part of the overall improvement plan for urgent care and A&E.

3.1.12 Nationally and regionally A&E delivery has continued to be challenging. National performance did however improve to 90.1% for all attendances in October 2017. Regionally, compliance for the South of England was 89.1%, with NHS England South Surrey & Sussex Trusts (excluding WSHFT) generating aggregate compliance of 91.5%.

3.2 Cancer

3.2.1 The Trust was compliant against 6 out of 9 metrics in September, and was below the Single Oversight Framework trajectory requirement for 62 day treatment (85.0%). Actual performance for September against this metric was 78.3%.

3.2.2 The position for September shows the Trust was non-compliant against the following standards:

- 62 days from screening referral to treatment (78.4% against a national standard of 90.0%)
- 62 days from upgrade to treatment (60.0% against a locally set standard of 90.0%)
- 62 days from GP referral to treatment (78.3% against a national standard of 85.0%)

3.2.3 Total treated patients for September was above forecast at 127.0 against a forecast plan of 118.0.

3.2.4 Within the 62-day treatment pathways several clinical specialties particularly impacted the achievement of the overall standard. These were:

- Breast – diagnostic staffing shortages have resulted in the cessation of the one-stop clinic assessment, which has lengthened the diagnostic phase for clinically judged lower risk patients. Recruitment processes are continuing to address this shortfall.
- Colorectal – treatments undertaken on several patients who had long pathways through patient choice, DNA's and multiple investigations.
- Gynaecology a late referral from ESHT (day 46) which required a very complex procedure requiring 2 surgeons.
- Head & Neck – several late referrals from neighbouring DGHs constrained the Trust's ability to treat patients within 62 days.
- Lung – late referrals from BSUH to Guy's where the surgical capacity was limited in being able to treat in a timely manner.

3.2.5 For context, the latest national performance data for September 2017 shows 82.0% of patients were treated within 62 days (target 85.0%) for urgent GP referrals, compared to BSUH performance of 78.3%, with 59.1% of Trusts in England non-compliant against this standard.

3.2.6 The work undertaken to better manage the Cancer PTL from the start of 2016/17 has led to a reduction in total patients being tracked (through earlier non-diagnosis of cancer, or treatment) by 42% from approx. 1,600 to 730. This has also meant that the volume of patients who have already breached the standard and been diagnosed has fallen by 51 to around 25. This is positively impacting on prospective 62 day performance.

3.2.7 As noted in the last board paper, the Trust received notification from NHS Improvement of the success of our bid for funding to support the cancer delivery on 3rd October. The Trust was allocated £210,000. This is being used to reduce waiting times for CT and ultrasound guided biopsies for cancer patients as well as reducing the waiting list for Endoscopy for all patients – moving towards a pathway redesign for patients referred to Digestive Diseases.

3.2.8 MacMillan Cancer Support have indicated support for a funding application for a fixed term contract project manager to help investigate, support, implement and evaluate pathway developments in the most challenged tumour sites. This will help gather national studies (such as the Accelerate, Coordinate, Evaluate [ACE] programmes) on optimal pathway redesign and embed the changes in the BSUH way of working.

3.2.9 Action plans are being implemented across each of the most challenged tumour sites, in addition to Pathology and Radiology reporting turnaround improvements. These are continuing to be monitored and overseen by the Trust Cancer Lead alongside directorate lead managers.

3.3 Referral to Treatment (RTT/18 Weeks)

3.3.1 The Trust was non-compliant against the National Constitutional Target of 92% in October with 86.11% of patients waiting less than 18 weeks against a national average of 89%. This is however, a marginal improvement since end September (86.04 %).

3.3.2 There were 59 patients waiting more than 52 weeks for treatment as of the end of October, a further improvement from the end September. The abdominal directorate are utilising additional theatre sessions each week at the County Site to continue to target the 52 week abdominal backlog.

3.3.3 The Trust continues to monitor directorate performance against planned trajectories at weekly RTT meetings, with associated recovery actions where off track and have begun specialty specific pathway management sessions. 670 staff members (clinical and non-

clinical) have now also received RTT awareness training, which is on-going and proving to have a beneficial effect on data accuracy and performance reporting.

3.3.4 The aggregate performance comprises several clinical specialties where waiting times are below the standard. Directorates with the biggest challenges and backlog remains with Neurosurgery, Head and Neck and the Abdominal Division. Ophthalmology also remains a challenge within Head and Neck and focussed work has begun to aid recovery.

3.3.5 Latest published national data relates to September 2017 and shows a further decrease in national compliance, to 89.1%. This figure is exclusive of independent sector providers and does not reflect a number of large acute NHS providers that currently are not reporting RTT positions as part of agreed 'special measure' arrangements. Approximately 46% of Trusts were non-compliant in September.

3.4 Diagnostic Test Waiting Times

3.4.1 The Trust compliance for September was 0.86% over 6 week waiters across all diagnostic modes, which is compliant against the <1% national target. This represents 63 out of a total of 7,334 patients.

3.4.2 BSUH performance compared favourably against regional peers in September (the latest comparable national data); with South of England Region aggregate compliance of 2.6% and National compliance at 2.0%, compared to BSUH September performance of 0.72%. Just over a third of Trusts were non-compliant in September 2017.

4 RECOMMENDATION

4.1 The Board is asked to **NOTE** the Trust position against the NHS Single Oversight Framework; and the compliance positions against the National Constitutional Standards.

Pete Landstrom
Chief Delivery & Strategy Officer
21st November 2017

Brighton and Sussex NHS University Hospitals

OPERATIONAL PERFORMANCE SCORECARD

OCTOBER 2017

		Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	2017/18 Target	Trend
NATIONAL AND OPERATIONAL PERFORMANCE TARGETS																						
O01	A&E : Four-hour maximum wait from arrival to admission, transfer or discharge	83.9%	86.3%	85.1%	84.1%	81.2%	83.7%	82.6%	82.1%	80.4%	77.2%	80.3%	84.4%	85.3%	86.0%	86.5%	81.9%	83.6%	84.3%	87.0%	95%	
O01A	A&E : 12 hour maximum wait from arrival to admission, transfer or discharge	9	2	2	0	1	1	2	0	5	28	0	0	0	0	0	0	7	6	0	0	
O02	Cancer: 2 week GP referral to 1st outpatient	88.6%	93.8%	95.1%	94.7%	94.1%	94.5%	95.1%	94.1%	93.9%	90.7%	93.3%	93.4%	93.4%	94.1%	94.7%	94.8%	93.8%	95.1%		93%	
O03	Cancer: 2 week GP referral to 1st outpatient - breast symptoms	97.8%	94.8%	98.8%	98.4%	96.6%	97.4%	99.4%	98.9%	97.7%	96.9%	95.9%	93.7%	96.4%	98.2%	95.0%	94.4%	96.1%	96.2%		93%	
O04	Cancer: 31 day second or subsequent treatment - surgery	95.7%	95.5%	100.0%	91.3%	97.8%	97.8%	92.1%	89.7%	96.6%	95.7%	94.4%	93.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		94%	
O05	Cancer: 31 day second or subsequent treatment - drug	97.9%	97.6%	99.0%	100.0%	100.0%	98.7%	100.0%	98.2%	100.0%	100.0%	98.9%	100.0%	100.0%	100.0%	97.5%	100.0%	100.0%	100.0%		98%	
	Cancer: 31 day second or subsequent treatment - radiotherapy	94.4%	100.0%	98.4%	97.7%	97.8%	96.3%	97.3%	97.8%	99.3%	98.2%	99.4%	100.0%	100.0%	99.4%	99.3%	100.0%	98.6%	100.0%		94%	
O06	Cancer: 31 day diagnosis to treatment for all cancers	100.0%	97.3%	99.1%	98.4%	98.6%	98.2%	98.6%	97.3%	97.2%	98.0%	97.1%	98.3%	99.1%	99.5%	100.0%	98.6%	99.2%	98.3%		96%	
O07	Cancer: 62 day referral to treatment from screening	75.0%	66.0%	62.0%	73.0%	87.5%	74.2%	75.0%	96.6%	84.2%	87.2%	76.0%	73.3%	87.2%	76.7%	71.8%	80.0%	77.8%	78.4%		90%	
O08	Cancer: 62 day referral to treatment from hospital specialist	100.0%	100.0%	100.0%	50.0%		50.0%	100.0%	100.0%	100.0%	100.0%	0.0%	100.0%	88.9%	75.0%	100.0%	94.7%	85.7%	60.0%		90%	
O09	Cancer: 62 days urgent GP referral to treatment of all cancers	78.1%	77.2%	81.1%	74.5%	74.7%	85.9%	77.9%	76.5%	66.7%	78.1%	68.5%	76.5%	86.1%	81.1%	74.3%	68.8%	81.4%	78.3%		85%	
O14	RTT - Incomplete - 92% in 18 weeks	73.5%	74.8%	75.3%	75.3%	75.1%	76.8%	77.8%	80.1%	79.6%	81.4%	82.1%	84.2%	85.2%	86.1%	86.9%	87.0%	86.8%	86.0%	86.1%	92%	
	RTT - Incomplete - 52Week Waiters	100	87	92	211	226	184	185	161	150	152	143	95	94	102	96	80	84	71	59	0	
O15	RTT delivery in all specialties (Incomplete pathways)	14	14	14	16	16	15	16	12	12	13	13	9	10	10	13	13	12	12	13	0	
O16	Maximum 6-week wait for diagnostic procedures	6.6%	2.6%	1.6%	2.1%	2.8%	1.0%	1.9%	1.1%	1.4%	0.8%	0.6%	0.4%	0.5%	0.9%	0.7%	0.6%	1.0%	0.7%	0.9%	<1%	
O17	Cancelled operations not re-booked within 28 days	7	2	3	2	8	2	8	2	5	8	4	3	3	1	4	5	7	9	5	0	
O18	Urgent operations cancelled for the second time	0	0	0	0	0	0	0	0	0	8	3	0	0	0	2	1	2	5	3	0	
O19	Clinics cancelled with less than 6 weeks notice for annual/study leave	65	86	77	67	50	52	32	44	32	30	41	49	48	41	49	38	43	32	62	-	
O20	Mixed Sex Accommodation breaches	57	69	76	77	113	80	41	137	72	61	92	48	76	48	39	22	21	67	57	0	
O33	Delayed transfers of care	5.9%	6.7%	6.9%	6.8%	7.4%	9.6%	8.9%	9.5%	8.7%	9.8%	9.7%	9.9%	8.1%	7.4%	7.2%	8.4%	7.8%	8.0%	6.7%	3%	
IMPROVING CLINICAL PROCESSES																						
O23	% hip fracture repair within 36 hours	79.00%	81.00%	77.00%	75.00%	67.00%	90.00%	88.00%	81.00%	87.00%	90.00%	73.00%	77.00%	76.90%	74.40%	67.00%					90%	
O24	Patients that have spent more than 90% of their stay in hospital on a stroke unit*	81.63%	84.48%	86.79%	83.58%	84.75%	92.16%	81.67%	92.31%	80.39%	93.48%	89.58%	84.85%	75.00%	80.70%	83.08%	85.00%	76.47%	85.37%		80%	

Brighton and Sussex NHS University Hospitals

OPERATIONAL PERFORMANCE SCORECARD

OCTOBER 2017

		Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	2017/18 Target	Trend
OPERATIONAL EFFICIENCY																						
O36	Average length of stay - Elective	2.36	2.33	2.37	2.22	2.49	2.06	2.57	2.16	2.45	2.44	2.36	2.31	2.43	2.12	2.51	2.22	2.35	2.54	2.57		
O37	Average length of stay - Non-elective Surgery	4.59	4.47	3.89	4.14	4.59	4.17	4.49	4.26	4.36	4.43	4.54	4.15	3.91	4.22	4.26	4.09	4.39	4.57	4.22		
O38	Average length of stay - Non-elective Medicine	5.82	5.49	5.24	4.92	5.08	5.80	5.50	6.15	5.69	6.41	5.84	5.95	5.45	5.11	5.24	5.42	5.75	5.48	5.33		
O39	Day case rate (CQC day case basket of procedures) source: HED (reported 2-3 months in arrears)	87.4%	89.3%	89.3%	85.6%	85.8%	86.0%	81.0%	85.5%	84.5%	87.6%	85.7%	87.0%	82.7%	87.7%	84.6%	87.2%	87.7%			75.0%	
O40	Elective day of surgery rate (DOSR)	94.7%	93.1%	94.4%	94.2%	93.9%	94.9%	95.1%	93.8%	94.6%	94.0%	94.9%	94.8%	94.8%	95.5%	94.9%	95.3%	95.1%	94.2%	96.8%	90.0%	
O41	Did not attend rate (outpatients)	8.2%	8.7%	8.8%	8.8%	8.5%	8.7%	8.0%	7.7%	8.0%	8.0%	7.5%	7.0%	6.2%	6.8%	6.7%	7.0%	7.5%	7.4%	7.2%	6.00%	
SUSTAINABILITY																						
O43	Bank staff - % of all staff pay	4.2%	4.3%	4.5%	3.5%	3.8%	4.5%	5.7%	4.0%	4.3%	4.7%	5.2%	5.0%	4.5%	4.1%	5.2%	5.2%	5.3%	5.8%	4.8%	7%	
O44	Agency staff - % of all staff pay	3.0%	3.1%	1.8%	2.6%	2.0%	2.5%	3.5%	3.3%	3.0%	3.4%	3.1%	4.5%	2.4%	3.1%	3.3%	3.2%	3.9%	4.3%	2.8%	2%	
O46	% nurses who are registered	73.9%	73.6%	73.0%	73.3%	73.5%	73.7%	73.6%	73.6%	73.7%	73.5%	73.5%	73.4%	73.0%	72.4%	72.1%	72.0%	71.8%	71.5%	71.8%	74%	
O47	% Staff appraised	69.8%	70.6%	70.2%	70.4%	66.9%	71.9%	73.4%	75.7%	77.2%	79.2%	81.0%	85.0%	82.8%	81.3%	80.9%	80.2%	77.7%	76.2%	76.1%	85%	
O48	Sickness Absence: % Sickness(reported one month in arrears)	4.3%	4.3%	4.3%	4.3%	4.3%	4.2%	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%	4.2%	4.2%	4.2%	4.3%	4.3%	4.3%		3.5%	
O49	Staff Turnover: Turnover rate (YTD position)	12.8%	12.8%	13.2%	13.6%	12.9%	13.3%	13.4%	13.6%	14.0%	14.2%	14.3%	14.4%	14.5%	14.6%	14.5%	14.3%	14.3%	14.1%	14.2%	12%	
ACTIVITY																						
A01	Day Cases	3759	3951	4096	4206	4031	4038	3895	4263	3575	3749	3790	4232	3355	4050	4232	3790	4228	3652	4122		
A02	Elective Inpatients	1191	1207	1216	1284	1189	1266	1268	1288	1129	1207	1209	1444	1192	1259	1388	1299	1290	1240	1245		
A03	Non-elective inpatients	4429	4629	4813	4672	4468	4388	4764	4630	4701	4427	4201	4921	4637	4890	4499	4680	4547	4579	4727		
A04	Outpatient First attendances	10498	10612	11826	9928	10914	10811	10962	11779	9325	10315	10328	12344	8620	11132	10935	10169	10496	9950	10321		
A05	Outpatient Follow-up attendances	23633	24089	25211	23974	25719	25335	25025	27606	22352	26786	24337	28242	21604	26190	25085	23710	24294	24133	24731		
A06	Outpatients with procedure	6468	6355	6999	6579	7081	7175	7033	7497	5927	6874	6622	7591	7143	8096	8111	7362	7946	7826	7816		
A07	A&E Attendances	13168	14407	13670	14707	13888	13599	14093	13599	13231	12794	12209	13955	13258	14089	13810	14037	13201	13055	13484		

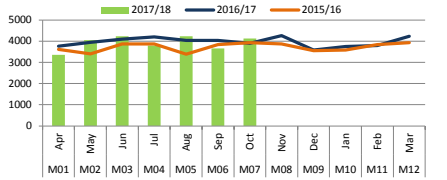
Notes:

1 National reporting for these performance measures is on a quarterly basis. Data are subject to change up to the final submission deadline due to ongoing data validation and verification.
2 Data are provisional best estimates and will be amended to reflect the position signed-off in the relevant statutory returns in due course.
3 Staff sickness is reported one month in arrears.

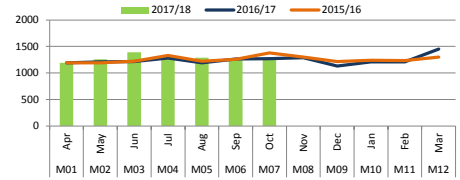
Brighton and Sussex NHS University Hospitals

Activity Trends

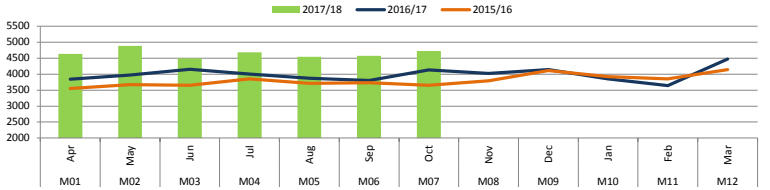
Day Cases



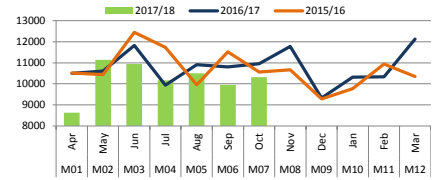
Elective Inpatients



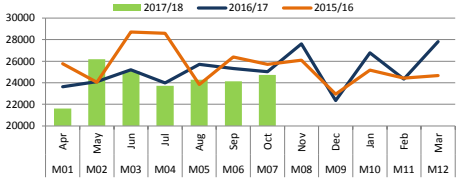
Non-elective Inpatients



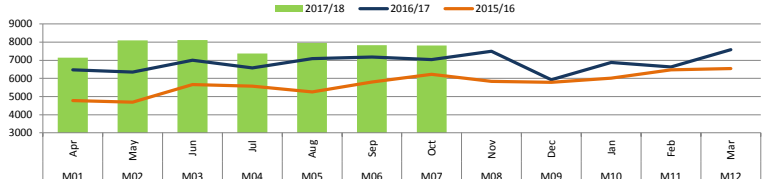
First Outpatients



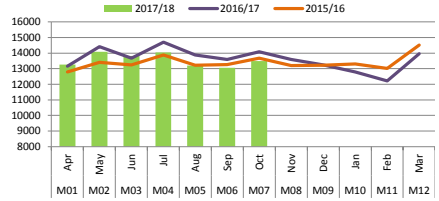
Follow-up Outpatients



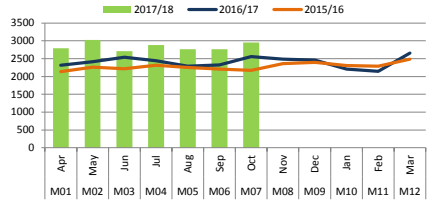
Outpatients with Procedure



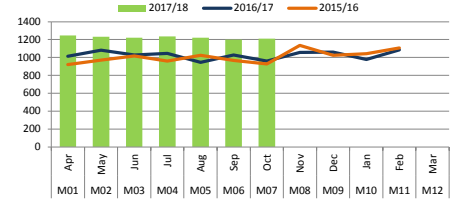
A&E Attendances



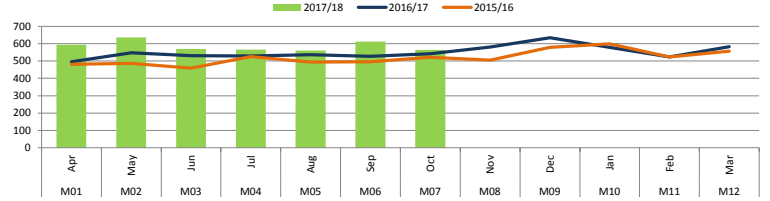
Emergency Admissions (age 0-64)



Emergency Admissions (age 65-84)



Emergency Admissions (age >85)



Brighton and Sussex University Hospitals NHS Trust

To: Trust Board

Date of Meeting: 29th November 2017 Agenda Item: **9**

Title
Finance Report on Month 7 2017/18 Position
Responsible Executive Director
Karen Geoghegan, Chief Financial Officer
Prepared by
Adam Shields, Assistant Director of Finance
Status
Public
Summary of Proposal
At Month 7 the Trust is reporting a deficit of £37.98m against the deficit plan of £38.14m, a favourable year-to-date variance of £0.16m. The Finance Report on Month 7 2017/18 Position provides further detail on the Trust's financial position. The Finance Report on Month 7 2017/18 Position is prepared as part of a suite of reports including: • Contract, Activity and Income Report • Cash Report • Efficiency Programme Report
Implications for Quality of Care
Financial planning principles have been established to ensure that expenditure budgets reflect anticipated activity levels and that agreed staffing levels are maintained.
Link to Strategic Objectives/Board Assurance Framework
Financial Implications
These are noted within the Finance Report on Month 7 2017/18 Position.
Human Resource Implications
N/A
Recommendation
The Board is asked to NOTE the financial performance of the Trust as at Month 7 and the actions necessary to secure delivery of the Control Total.
Communication and Consultation
N/A
Appendices
1. Month 7 I&E position - subjective 2. Month 7 I&E position – objective 3. Finance Report Month 7 2017/18

Brighton and Sussex University Hospitals NHS Trust

To: Trust Board **29/11/17**

From: Adam Shields, Assistant Director of Finance – Planning, on behalf of Karen Geoghegan, Chief Financial Officer **Agenda Item: 9**

FOR INFORMATION AND APPROVAL

Finance Report on Month 7 2017/18 Position

Executive Summary
Month 7 Performance

At Month 7 the Trust is reporting a deficit of £37.98m against the deficit plan of £38.14m, reducing the £0.4m year-to-date favourable variance reported in Month 6 to £0.16m. The in-month deficit of £4.14m is the best performance for the year-to-date and in line with plan expectations.

The forecast outturn is consistent with the agreed control total of a £65.4m deficit. However, there are a number of known risks that require addressing in order to secure delivery. The significant risks and actions being taken to minimise impact are detailed below:

Income

- Planned level of contract income - discussions are ongoing with the lead commissioner in relation to both the minimum income required to deliver the control total and opportunities to work together to increase the CCG affordability envelope.
- Sussex MSK Partnership contract - £1m underperformance to date so sourcing orthopaedic activity from other providers is being investigated.
- CQUIN plan - since last month, a gap analysis has been completed and actions to maximise delivery have been shared at the last Trust Executive Committee.
- Injury Cost Recovery - forecast is a shortfall of £1.1m which requires mitigation in other areas.

Operational costs

- CIP delivery is on plan - progress is regularly monitored through the Programme Management Office and through the executive-led Efficiency and Workforce Steering Group. Remedial action and mitigating schemes are identified at the earliest opportunity to minimise the financial impact of any under-delivery.
- Unfunded posts - reduced from £4.2m there are £1.2m full-year value of unfunded posts, the cost of which is offset by vacancies which are not being backfilled. Recruitment to these vacancies, above the current fill-rate, could impact on our ability to deliver the forecast. The suite of management information on pay is under review, including weekly monitoring of agency usage.
- 3Ts build and estates backlog maintenance - could have an impact on costs above current run-rate. Work to understand the relative priority, impact and funding options is on-going.

The forecast delivery roadmap is the subject of a separate paper.

Introduction

1.1. This report details the financial performance of the Trust to October 2017 and highlights income and expenditure (I&E), capital, cash management, key risks and remedial actions.

2. I&E Summary and Key Financial Metrics

£000s	In-Month			Year-to-Date		
	Plan	Actual	Variance	Plan	Actual	Variance
Income	(48,251)	(46,058)	2,193	(324,541)	(321,329)	3,212
Pay	30,778	29,458	(1,320)	212,947	208,208	(4,739)
Non-pay	18,055	17,782	(273)	127,183	128,436	1,254
EBITDA	582	1,181	599	15,588	15,315	(273)
Non-operating costs	3,344	3,029	(314)	22,857	22,113	(744)
Total	3,926	4,210	284	38,445	37,428	(1,017)
Technical adjustments	(43)	(69)	(26)	(304)	553	858
Adjusted Total	3,882	4,141	259	38,141	37,981	(159)
CIPs (per PMO plan)	2,565	2,424	(141)	8,683	8,778	95
Capital	12,114	5,780	(6,334)	47,071	28,782	(18,289)
Cash				4,294	8,196	3,902

NB In-month and Year-to-Date "Plan" reflect the Trust's agreed Control Total deficit of £65.4m

3. Summary

3.1. The year-to-date position at Month 7 is a favourable variance to budget of £0.16m; with an actual deficit of £37.98m against a deficit plan of £38.14m.

3.2. The £3.88m deficit plan for October is the smallest for any month throughout 2017/18 due to a combination of phasing of the contract income and CIP plans. While the in-month position is £0.26m adverse to plan, the deficit of £4.14m is actually the lowest of any month in the year so far.

3.3. Components of the plan have been refined to reflect the finalised efficiency plans and approved business cases. The overall deficit and monthly phasing remain unchanged, but the values of component quanta – income, pay and non-pay – have been adjusted.

3.4. A detailed analysis of the Trust's I&E performance by subjective category is shown in Appendix 1 and by organisational unit in Appendix 2.

3.5. The Trust's cash position is supported by monthly revenue deficit funding from the Department of Health and capital investment loans and Public Dividend Capital (PDC) for the capital programme. The October revenue funding was £3.6m and the November funding will be £4.0m. The funding will continue monthly throughout the year, up to the level of the planned deficit.

4. Income

4.1. Income analysis for the year-to-date shows underperformance across all categories equating to £3.21m. After adjusting for the impact of budget changes, the most significant adverse variances are on NHSE contract income and Sussex MSK Partnership (SMSKP) contract income – see Table 1.

4.2. The SMSKP underperformance has got proportionately worse in-month, deteriorating from £0.71m at Month 6 to £1.01m. Securing additional orthopaedic activity from other providers is being explored to reduce the shortfall.

4.3. Injury Cost Recovery income underperformance continues in line with the cumulative year-to-date trend. There are no direct remedial actions and other mitigations are required to address this.

Table 1: Income Plan Variances

Income	Variance to Plan, £m	Comment
NHSE contract activity	1.73	
Cancer Drugs Fund (CDF)	1.71	Offset by expenditure below plan
SMSKP contract activity	1.01	
Injury Cost Recovery	0.61	
R&D	0.51	Partly offset by expenditure underspends
NHS Trust - Provider SLAs	0.44	
CQUIN underdelivery	0.24	Across all commissioners
Non-Contract Activity (NCA)	(0.74)	
Donations	(0.84)	Benefit removed in technical adjustments
PbR exclusions	(1.57)	Offset by expenditure above plan
Net of other items	0.12	
	3.21	

NB Figures in brackets in this table reflect overachievement of income against plan

5. Expenditure Year-to-date

5.1. Operating Expenditure is underspent year-to date by £3.46m; a pay underspend of £4.74m is partly offset by a non-pay overspend of £1.25m.

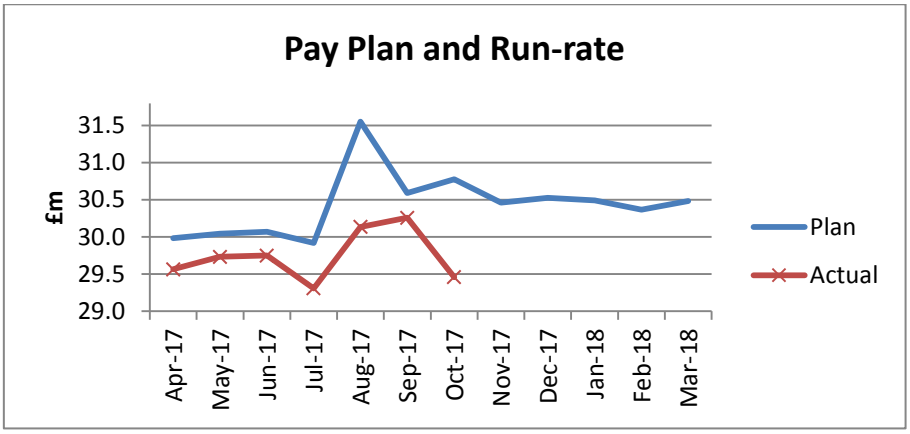
Pay

5.2. The pay underspend comprises underspends in all staff categories with the exceptions of Medical & Dental Staff and Other Staff, as shown in Table 2 overleaf.

Table 2: Pay Plan Variances

£000s	Year-to-Date		
	Plan	Actual	Variance
Medical & Dental Staff	62,804	63,371	566
Nursing & Midwifery	79,848	77,871	(1,977)
Other Healthcare Staff	30,023	28,520	(1,504)
Management	10,202	9,050	(1,152)
Administrative & Clerical	20,475	19,175	(1,301)
Ancillary Staff	8,334	8,215	(119)
Maintenance & Works	1,853	1,572	(282)
Other Staff	(593)	436	1,029
Total pay	**212,947**	**208,208**	**(4,739)**

5.3. The pay run-rate decreased by £0.8m from Month 6 with the most significant expenditure decrease being on Medical and Dental staff (£0.59m). Of the latter, £0.3m related to a reduction in agency expenditure, in part due to investigation of some invoices to the Trust which proved to have been sent in error.



NB The plan spikes in August and October reflect adjustment of the plan as per paragraph 3.3

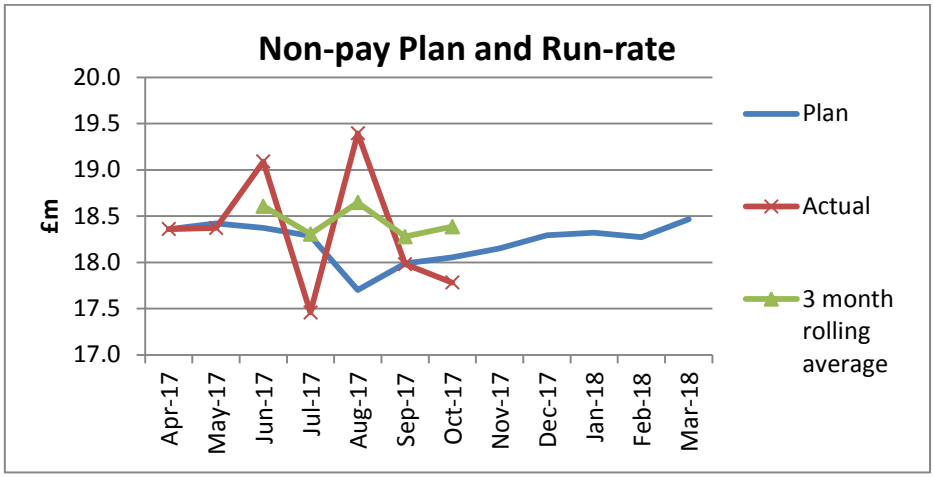
5.4. Nursing and Midwifery expenditure fell by £0.19m in-month, driven by a reduction in expenditure on temporary staffing of £0.23m. Bank staff volumes and costs both reduced; agency WTEs increased, but expenditure fell as actions taken to reduce use of high cost, non-framework agency staff took effect.

5.5. The Trust's overall agency expenditure ceiling for 2017/18 is £12.8m; in line with 2016/17. Agency expenditure is £6.9m as at Month 7; £0.6m lower than the phased agency ceiling of £7.5m. Expenditure represents 3.3% of total pay expenditure.

Non-pay

5.6. Year-to-date non-pay is £1.25m overspend against plan. The main cause is an over spend of £1.24m on "PbR exclusion and CDF drugs" which is offset by income.

5.7. The non-pay run-rate decreased by £0.2m in Month 7. The greatest movement, a £0.26m reduction, was in "Other Non-pay" as non-recurrent costs had been incurred in Month 6 relating to research and redundancies.



NB The plan dip in August reflects adjustment of the plan as per paragraph 3.3

Non-operating costs

5.8. Non-operating costs are underspent by £0.74m year-to-date, primarily due to interest payments being lower than planned.

6. Performance Against Delegated Budgets

6.1. Year-to-date the Clinical Directorates are collectively overspent against delegated budgets by £2.25m; an in-month deterioration of £0.1m. Corporate Directorates are underspent by £1.71m. Details are in Appendix 2.

6.2. Eleven Clinical Directorates have signed off 17/18 activity and finance plans. The exception is the Abdominal Surgery and Medicine Directorate which is currently undergoing an external review. The Directorate Management Team met with the Chief Financial Officer and Finance Director in early October to present details of financial issues faced and a number of actions to enable budget sign-off were identified. Work has progressed on these actions and they will be completed during November.

7. Efficiency Programme

7.1. The PMO has been working with Directorates to develop cost improvement and efficiency plans that deliver £20m of savings. Schemes are now all reflected in delegated budgets with exception of the corporate CIP aligned to finalisation of the corporate sub-structures; work continues to identify actions to convert non-recurrent into recurrent savings in this area.

7.2. The Month 7 position is a £0.1m overachievement of CIPS against the internal plan; the forecast is to deliver the targeted savings. Development of the schemes identified as higher risk will continue and progress will be monitored by the Efficiency and Workforce combined steering group.

Table 3: CIPS Performance

£000s					
Year-to-Date			Full-Year		
Plan	Actual	Variance	Plan	Forecast	Variance
8,683	8,778	95	20,000	20,000	0

7.3. A separate detailed report on the efficiency programme is presented to the Finance and Investment Committee.

8. Risks

8.1. Forecast outturn equates to delivery of the control total, but there a number of emerging risks that may impact on delivery. Details of those risks, and plans to mitigate, are detailed below.

8.2. Income

- Securing the level of contract income included in the forecast; the contracts signed at December 2016 are lower than plan across all commissioners. A series of executive-led discussions with commissioners has been taking place to minimise this gap and mitigate risk to delivery of the forecast income. It is expected that this gap will reduce significantly in the coming weeks as discussions conclude.
- Securing CQUIN payments in-full; against a c£9m plan, £3.3m of risk has been identified, of which £0.7m relates to 16/17. This figure reflects the worst case scenario; further detail can be found in the Trust Contract, Activity and Income Report for Month 7. A CQUIN Programme Board has been set-up to manage this risk and a gap analysis has now been undertaken to identify the actions required to maximise the amount of income secured.
- Injury Cost Recovery income is £0.62m behind plan year-to-date; if this trend continues an income shortfall of £1.05m would result. This cannot be mitigated directly so actions to offset are required in other areas.

8.3. Operating Expenditure

- There remain £1.2m of unfunded posts, the cost pressure from which is currently being offset by vacancies which are not being backfilled. Recruitment into these posts therefore represents a risk that the pay run-rate will increase.
- Work is on-going to finalise agreement on the 17/18 SIFT related BSMS charge.
- Delivery of the £20m CIP target in full, particularly as the target is greater in the second half of the year. CIP delivery is regularly monitored through the PMO and mitigating schemes sought to offset any under-delivery.
- 3Ts build and estates backlog maintenance could mean costs increasing above current run-rate. Work to understand the 6 facet survey and required actions is on-going.

8.4. Non-operating expenditure

- Given the Control Total deficit plan has been delivered for at least four consecutive months, the Trust has secured a reduction in the interest rate payable on working capital loans from 6% to 3.5%. The plan incorporated a drop in rates from 6% to 1.5% from October and the earlier, but lower reduction results in a very minor pressure.

8.5. Further focus is required on the identification and/or quantification of risks, and opportunities, to enable appropriate and early intervention. The forecast delivery roadmap is the subject of a separate paper.

9. Cash

9.1. The Trust received £3.6m of revenue deficit funding in October and a further £4.0m has been paid in November. The full year's revenue deficit funding is equal to the planned deficit of £65.4m. The monthly drawdowns are based on a review by NHS Improvement of revenue results to date and forecast revenue results for the remainder of the year.

9.2. Capital funding is mainly as Public Dividend Capital (PDC). In October the Trust received £9.8m for 3Ts. The next drawdown is planned for December. Funding applications for the other strategic schemes are still pending approval and, as such, the timing of cash flows is uncertain, but the estimated income and expenditure is included in the overall cashflow.

10. Capital

10.1. The strategic capital forecast 17/18 is £83,626m. The 3Ts work is ongoing on the clinical administrative building and the main piling. The work on the Eastbourne Radiotherapy scheme is complete except for some IT licensing, infrastructure work and minor building work. The Emergency Department scheme is progressing, but Department of Health approval and confirmation of the funding source is pending.

10.2. The revised Operational Capital Programme is progressing slowly with some schemes still in the planning stage rather than mobilisation/implementation. Oversight of all aspects of the capital programme is through the executive led Capital Expenditure Group.

11. The Board is asked to:

- Note the financial performance of the Trust as at Month 7 and the actions necessary to secure delivery of the Control Total.

Adam Shields
Assistant Director of Finance – Planning
17/11/17

Appendix 1 - I/E Report Month 7 2017/18

	In Month			Year to Date		
	Plan	Actual	Variance	Plan	Actual	Variance
	£000's	£000's	£000's	£000's	£000's	£000's
NHS Trusts Income	(773)	(597)	176	(5,126)	(4,691)	435
CCG Income	67,348	67,317	(31)	(160,452)	(162,253)	(1,801)
NHSE Income	(104,674)	(102,381)	2,293	(107,197)	(103,420)	3,778
NCA Income	(2,680)	(3,441)	(762)	(2,680)	(3,441)	(762)
SMSKP Income	(15,098)	(14,071)	1,027	(15,098)	(14,071)	1,027
Commissioning Income - Non Activity	(353)	(415)	(63)	(2,597)	(2,621)	(24)
Department Of Health Income	(3)	(3)	(0)	(22)	(38)	(16)
Private Patients Income	(445)	(329)	116	(2,928)	(2,636)	293
Injury Cost Recovery	(208)	(166)	43	(1,459)	(844)	615
Local Authority Income	(385)	(411)	(27)	(2,620)	(2,917)	(298)
Overseas Visitors Income	(18)	(8)	10	(126)	(93)	34
Other Patient Related Income	12,384	11,665	(719)	(937)	(707)	230
Income from Activities	**(44,905)**	**(42,841)**	**2,064**	**(301,241)**	**(297,731)**	**3,510**
Education & Training Income	(2,282)	(2,287)	(4)	(15,865)	(15,825)	41
Research & Development Income	(365)	(286)	79	(2,609)	(2,100)	508
Income Generation	(223)	(225)	(3)	(1,484)	(1,453)	31
Other Income	(476)	(419)	57	(3,342)	(4,220)	(878)
Other Operating Income	**(3,346)**	**(3,217)**	**129**	**(23,300)**	**(23,598)**	**(298)**
TOTAL INCOME	**(48,251)**	**(46,058)**	**2,193**	**(324,541)**	**(321,329)**	**3,212**
Pay - Management	1,523	1,349	(174)	10,202	9,050	(1,152)
Medical and Dental Staff	8,960	8,887	(72)	62,804	63,371	566
Nursing & Midwifery - Registered	9,240	8,840	(400)	64,496	62,518	(1,978)
Nursing & Midwifery - Unregistered	2,147	2,172	25	15,352	15,353	1
Pay Other Healthcare	4,406	4,089	(317)	30,023	28,520	(1,504)
Ancillary Staff	1,210	1,094	(115)	8,334	8,215	(119)
Administrative & Clerical	2,867	2,741	(126)	20,475	19,175	(1,301)
Maintenance & Works	265	218	(46)	1,853	1,572	(282)
Pay - Other Staff	160	66	(94)	(593)	436	1,029
TOTAL PAY	**30,778**	**29,458**	**(1,320)**	**212,947**	**208,208**	**(4,739)**
Drugs - in tariff	1,094	1,039	(55)	7,400	7,180	(220)
Drugs - PbR exclusion and CDF	5,532	5,665	133	37,868	39,110	1,242
Supplies and Services - Clinical - in tariff	4,226	4,268	41	31,089	32,055	966
Supplies and Services - Clinical - PbR exclusion	793	805	12	4,982	4,646	(336)
Supplies and Services General	586	574	(12)	4,117	3,932	(185)
Establishment Expenses	582	418	(165)	3,956	3,639	(318)
Transport Expenses	106	77	(28)	689	642	(47)
Premises	1,680	1,761	81	12,239	12,629	391
Purchase of Healthcare from Non NHS provider	487	519	33	3,880	3,973	94
Consultancy	101	67	(34)	708	534	(174)
Other Non Pay	19	(50)	(68)	135	870	734
CNST Premium	1,794	1,793	(0)	12,555	12,554	(0)
Education and Training	317	272	(45)	2,178	1,892	(287)
Services from Other NHS Bodies	723	542	(181)	5,205	4,590	(615)
Audit Fees	10	22	12	145	132	(13)
Trust Chair & Non-Executive Directors	5	9	4	37	59	22
TOTAL NON-PAY	**18,055**	**17,782**	**(273)**	**127,183**	**128,436**	**1,254**
TOTAL EXPENDITURE	**48,833**	**47,239**	**(1,594)**	**340,129**	**336,644**	**(3,485)**
Depreciation & Impairments	1,884	1,884	0	13,186	13,171	(15)
Interest Payable	935	659	(276)	5,996	5,357	(639)
Interest Receivable	(3)	(2)	1	(20)	(15)	5
Profit / Loss on Disposal of Fixed Assets						
PDC Dividend Payable	528	488	(40)	3,696	3,600	(96)
TOTAL NON OPERATING INC & EXP	**3,344**	**3,029**	**(314)**	**22,857**	**22,113**	**(744)**
TOTAL INCOME & EXPENDITURE	**3,926**	**4,210**	**284**	**38,445**	**37,428**	**(1,017)**
Donations Inc Charitable Funds	**(25)**	**0**	**25**	**(175)**	**(1,019)**	**(844)**
Depn. On Donated Assets	**69**	**69**	**1**	**480**	**466**	**(14)**
Fixed Asset Impairments	**0**	**0**	**0**	**0**	**0**	**0**
NET REPORTED POSITION	**3,882**	**4,141**	**259**	**38,141**	**37,981**	**(159)**

Appendix 2 - I/E Report Month 7 2017/18

	In Month			Year to Date		
	Plan	Actual	Variance	Plan	Actual	Variance
	£000's	£000's	£000's	£000's	£000's	£000's
Abdominal Surgery & Medicine Directorate	1,769	1,787	18	12,481	12,992	511
Acute Floor Directorate	3,443	3,625	182	24,922	25,100	178
Cancer Directorate	1,689	1,490	(199)	11,021	10,754	(267)
Cardiovascular Directorate	3,216	3,373	157	22,771	24,060	1,289
Central Clinical Services Directorate	4,786	4,912	126	33,921	34,248	327
Children's Services Directorate	2,119	2,286	167	15,367	15,584	217
Head & Neck Directorate	1,067	1,136	69	7,580	7,824	244
Musculoskeletal Directorate	2,043	2,026	(17)	14,699	14,086	(613)
Neurosciences & Stroke Services Directorate	1,890	1,869	(21)	13,373	13,621	247
Perioperative Directorate	2,593	2,707	114	18,836	19,099	263
Speciality Medicine Directorate	2,472	1,989	(482)	18,279	18,311	32
Women's Services Directorate	1,700	1,686	(14)	12,132	11,956	(176)
Clinical Services Total	**28,786**	**28,888**	**102**	**205,383**	**207,634**	**2,251**
Facilities and Estates	3,045	2,989	(56)	21,370	21,509	139
Chief Financial Officer	1,122	990	(132)	7,821	6,739	(1,083)
Chief Executive's Office	171	253	82	1,197	1,568	372
Chief Nurse's Office	2,196	2,239	43	15,924	15,679	(245)
Chief Operating Officer	1,228	1,194	(35)	8,592	8,057	(534)
Medical Director's Office	(942)	(1,067)	(124)	(6,312)	(6,208)	104
Strategy & Change	602	540	(62)	4,155	3,695	(460)
Corporate Services Total	**7,422**	**7,138**	**(283)**	**52,747**	**51,039**	**(1,708)**
Central Income	(36,906)	(34,445)	2,461	(246,165)	(242,889)	3,276
Capital Charges & Financing Costs	3,107	2,816	(291)	21,200	20,103	(1,097)
Central Reserves	1,300	(187)	(1,487)	6,050	1,542	(4,508)
Efficiency Programme	217	0	(217)	(769)	0	769
Financial Central Services	**(32,282)**	**(31,816)**	**466**	**(219,684)**	**(221,245)**	**(1,561)**
Directorate Total	**3,926**	**4,210**	**284**	**38,445**	**37,428**	**(1,017)**
Below the line Adjustments	(43)	(69)	(26)	(304)	553	858
Total	**3,882**	**4,141**	**259**	**38,141**	**37,981**	**(159)**

Finance Report Month 7 2017/18

Summary

Brighton and Sussex University Hospitals NHS Trust

Summary

A Control Total deficit of £65.4m has been set by the Trust in agreement with NHSI. The Trust is reporting a £37.98m deficit at Month 7, £0.16m better than plan. The capital programme is underspent and cash receipts are higher than planned. The Efficiency and Transformation Programme is delivering above plan year-to-date. The Trust is forecasting delivery of the Control Total deficit at the end of the year.

Finance and Use of Resources Risk Rating — R

YTD

	Plan	Actual / Forecast	Variance
Year-to-date	4	4	0
Year-end Forecast	4	4	0

Whilst the overall rating below would be 3 based on the average of the components, because there are 3 ratings of 4 the score is overridden to 4.

Control Total (Surplus) / Deficit £k — G

	Plan	Actual / Forecast	Variance
Year-to-date	38,141	37,981	(159)
Year-end Forecast	65,349	65,343	(6)

Based on a deficit plan of £65.35m, the Trust is reporting a deficit of £37.98m compared to the YTD plan of £38.14m. The forecast is to deliver a deficit in line with the plan.

Agency Ceiling £k — G

	Ceiling	Actual / Forecast	Variance
Year-to-date	7,465	6,935	(531)
Year-end Forecast	12,798	11,060	(1,738)

Agency costs of £6.9m represent 3.3% of the total pay bill and are within the year-to-Month 7 agency cap of £7.5m. Agency expenditure reduced in-month and is also lower compared to the same period in 16/17. The total cost of agency, bank and substantive staff was well within the Month 7 pay budget.

Income £k — R

	Plan	Actual / Forecast	Variance
Year-to-date	(324,541)	(321,329)	3,212
Year-end Forecast	(557,900)	(552,173)	5,727

For the year-to-October Income reports an underperformance of £3.2m, an increase of £2.2m on the previous month. Activity is lower than plan in month particularly for Day Cases and the risk provision for contract challenges and adjustments has been increased. The year-end projection is to secure less income than plan by £5.7m, principally due to CDF drug expenditure being lower than was included in the plan. Private Patient & Injury Cost Recovery are also behind plan

Operating Costs £k — A

	Plan	Actual / Forecast	Variance
Year-to-date	340,129	336,644	(3,485)
Year-end Forecast	583,970	578,311	(5,658)

Operating costs to Month 7 are underspending against budgets, wholly due to pay costs, and the majority of the savings plans have now been fully allocated. At present the assumption is that the Trust will identify the required savings, manage the identified risks and reduce expenditure and therefore come in on budget, except for PbR excluded drugs which should be offset by additional income.

Agency Expenditure — G

Expenditure as % of total Pay bill (YTD)	**2015-16**	**2016-17**	**2017-18**
Medical	1.9%	0.9%	0.9%
Nursing	2.5%	0.7%	1.1%
Other staff groups	2.1%	1.1%	1.3%
All Agency	**6.8%**	**2.6%**	**3.3%**

Agency costs have increased as a proportion of the total paybill compared to the same period last year but reduced by £0.44m from last month's level.

Cash £k — G

	Plan	Actual / Forecast	Variance
Year-to-date	4,294	8,196	3,902
Year-end Forecast	3,668	3,668	(0)

Revenue deficit funding continues to be applied for and paid over monthly. The funding for October was £3.6m and the November planned funding is £4.0m. Cumulatively the Trust has received £37.5m to the end of October. Capital funding is as PDC for 3Ts and the Trust received £9.8m PDC. The next funding will be in December. The emergency scheme funding, which is assumed to be PDC, is pending approval from NHSI. The favourable variance from plan was to ensure an adequate level of cash being available in the first two weeks in November based on the current cashflow. The year-end level of cash holding is aligned to the year-end External Financing Limit (EFL) cash control total.

Capital £k — A

	Plan	Actual / Forecast	Variance
Year-to-date	47,071	28,782	(18,289)
Year-end Forecast	107,182	103,264	(3,918)

Year-to-date the capital programme is behind the NHSI plan (adjusted for the 3Ts and Emergency plan changes) for both the Strategic Capital (by £11.6m) and Operational Capital (by £6.5m). This variance includes £7.7m for the Emergency schemes which have not yet been agreed by DH. The full-year forecast variance is in respect of the Operational Capital over programming which will be managed in year as the programme progresses.

Efficiency and Transformation Programme £k — G

	Plan	Actual / Forecast	Variance
Year-to-date	8,740	8,778	38
Year-end Forecast	20,000	20,000	0

Whilst the majority of the efficiency plan schemes have been finalised with the Directorates, there are still some projects that need to be developed. The savings reported year-to-date are above the original NHSI plan target by £0.04m, but above the internal plan by £0.95m (the internal plan reflects revised phasing as schemes were confirmed). The forecast is to achieve the £20m target after risk assessing individual forecasts down by £0.66m.

Key risks include:

1. The contract income plan is significantly higher than the signed off contracts with commissioners. This reflects a higher baseline level of activity than was assumed at the time of contract sign-off (the contract will be subject to variation due to this) although commissioners have shared a contract variation which will address the difference it has yet to be signed off by them. Work is ongoing with local commissioner on a joint view of the year-end position.
2. Not having identified the full CIP plan may mean there's slippage in delivery.
3. Not securing CQUIN income in full. A Programme Board has been established to manage this risk.

Finance Report Month 7 2017/18	Finance and Use of Resources Risk Rating	R

Whilst the overall rating below would be 3 based on the average of the components, because there are 3 ratings of 4 the score is overridden to 4.

Financial Rating YTD	Plan Metric	Plan Rating	Actual Metric	Actual Rating
Capital Service Capacity	(1.2)	4	(1.3)	4
Liquidity	(16.4)	4	(14.5)	4
I&E Margin	(11.83%)	4	(11.86%)	4
Distance from Financial Plan			(0.02%)	2
Agency Spend	(13.77%)	1	(7.11%)	1
2017-18 Finance Rating after overrides		4		4

Area	Metric	Construction	Rating 1 (Best)	2	3	4 (Worst)	Weighting
Financial Sustainability	Capital Service Capacity	Revenue available for capital service / Annual debt service	2.5x	1.75x	1.25x	<1.25x	20%
	Liquidity Days	Working capital balance x 30 / Annual operating expenses	0	(7.00)	(14.00)	<(14.00)	20%
Financial Efficiency	I&E Margin	I&E Surplus or deficit / Total Operating and Non Op income	5%	3%	0%	<0%	20%
Financial Controls	Distance from Financial Plan	YTD Actual I&E Surplus/Deficit - YTD Planned I&E Surplus/Deficit / YTD Planned I&E Surplus/Deficit	0%	(1)%	(2)%	≤(2)%	20%
	Agency Ceiling	YTD Actual Agency Ceiling - YTD Planned Agency Ceiling / YTD Planned Agency ceiling	0%	25%	50%	≤50%	20%

Finance Report Month 7 2017/18 — Surplus — G

Based on a deficit plan of £65.35m, the Trust is reporting a deficit of £37.98m compared to the YTD plan of £38.14m. The forecast is to deliver a deficit in line with the plan.

Year to Date

	Plan £k	Actual £k	Variance £k
(Surplus)/Deficit	**38,141**	**37,981**	**(159)**

Year End Forecast

	Plan £k	Forecast £k	Variance £k
(Surplus)/Deficit	**65,349**	**65,343**	**(6)**

Income YTD for October was less than budget by £3.2m with a year-end forecast of underacheivement of £5.7m. More detail is provided in the Income dashboard.
Expenditure compared to budget is underspent for the period to October 2017, mainly in the areas of pay costs. This is partly offset by overspends in PBRX drugs, clinical supplies and services and other non-pay.

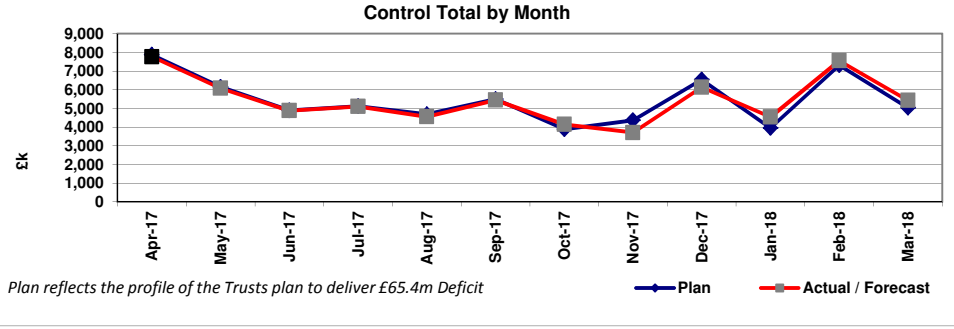
Year to Date

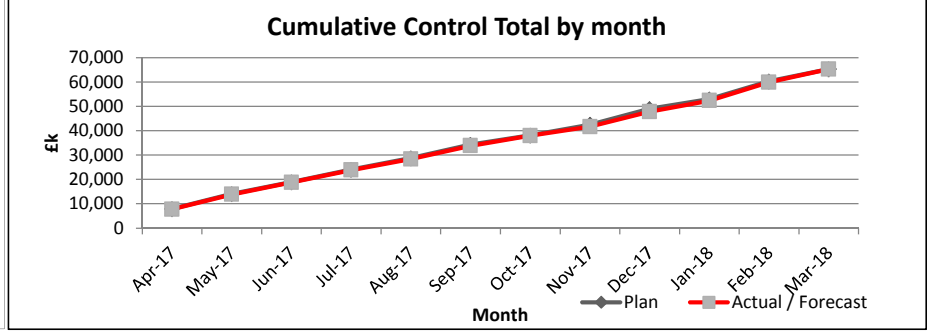
	PY Actual £k	Plan £k	Actual £k	Variance £k
Income	(320,769)	(324,541)	(321,329)	3,212
Pay	201,704	212,947	208,208	(4,739)
Non-Pay - in tariff	92,766	84,333	84,680	347
Non-Pay - PBR exclusions and CDF	34,173	42,850	43,756	906
EBITDA *	**7,874**	**15,588**	**15,315**	**(273)**
EBITDA %	**-2.5**	**-4.8**	**-4.8**	
Profit / Loss on Disposal of Fixed Assets	-	-	-	-
Interest Payable	3,263	5,996	5,357	(639)
Interest Receivable	(22)	(20)	(15)	5
Depreciation	12,630	13,186	13,171	(15)
Impairments		0	0	0
Public Dividend Capital	4,248	3,696	3,600	(96)
Net (Surplus) / Deficit	**27,994**	**38,445**	**37,428**	**(1,018)**
Reverse Impairment	0	0	0	0
Other Adjustments	(442)	(304)	553	858
Reverse IFRS technical charge	0	0	0	0
Performance against Control Total	**27,552**	**38,141**	**37,981**	**(159)**
Surplus %	**-8.6**	**-11.8**	**-11.8**	

Full year

	Plan £k	Actual £k	Variance £k
Income	(557,900)	(552,173)	5,727
Pay	365,282	357,909	(7,374)
Non-Pay - in tariff	144,135	145,494	1,359
Non-Pay - PBR exclusions and CDF	74,553	74,909	356
EBITDA *	**26,070**	**26,138**	**68**
EBITDA %	**-4.7**	**-4.7**	
Profit / Loss on Disposal of Fixed Assets	-	-	-
Interest Payable	10,896	10,143	(753)
Interest Receivable	(35)	(25)	10
Depreciation	22,604	22,471	(133)
Impairments	15,500	15,500	0
Public Dividend Capital	6,336	6,040	(296)
Net (Surplus) / Deficit	**81,371**	**80,267**	**(1,104)**
Reverse Impairment	(15,500)	(15,500)	0
Other Technical Adjustments	(522)	575	1,097
Reverse IFRS technical charge	0	0	0
Performance against Control Total	**65,349**	**65,343**	**(6)**
Surplus %	**-11.7**	**-11.8**	

* **EBITDA** Earnings before Interest Taxation Depreciation and Amortisation





Finance Report Month 7 2017/18 — Contract Performance — A

Contract income is underperforming by £0.2m year-to-date. This is based on 6 months actual activity and an estimate for October. Measuring performance by commissioner is provisional whilst the Identification Rules, which determine which commissioner pays for activity, are finalised. It is anticipated that the values of all commissioner contracts will change once this is completed. There are also a number of outstanding contractual issues to be resolved with commissioners in the coming months. The Trust's income expectation is significantly higher than the signed contracts mainly due to these outstanding items. The Trust is working with commissioners to manage the system wide impact of competing pressures across the LHE.

Contract Agreement 2017/18

Table 1. Total Financial Values By CCG, NHS England and Public Health

	Reported Values for October 2017 £'000			
	FYE Plan	YTD Plan	YTD Actual	YTD Var
Sussex CCG's	276,321	160,452	162,252	1,800
MSK	25,794	15,097	14,071	(1,026)
NHS England (Specialised)	169,549	98,654	96,953	(1,701)
NHS England (Dental & Screening)	9,581	5,608	5,231	(377)
Integrated Sexual Health Services	3,997	2,344	2,644	301
Non Contracted Activity	4,574	2,669	3,437	768
TOTAL COMMISSIONING INCOME	**489,815**	**284,824**	**284,589**	**(235)**

Table 2. Activity and Income by Point of Delivery

	YTD Activity Volumes				YTD Income £'000			
Point of Delivery	**Plan**	**Actual**	**Var**	**%**	**Trust Plan**	**Actual**	**Var**	**%**
Day case	28,070	27,318	(753)	-2.7%	24,880	23,657	(1,222)	-4.3%
Elective Spells	8,926	8,975	49	0.5%	22,719	22,636	(83)	-0.3%
Elective Excess beddays	24,532	24,295	(238)	-1.0%	352	467	115	35.3%
Non Elective Spells	2,627	2,995	368	14.0%	64,196	64,280	84	0.7%
Non Elective Spells - Short Stay	5,598	5,213	(385)	-6.9%	1,904	2,136	231	2.6%
Ambulatory Care	1,331	1,788	457	34.3%	5,026	4,570	(456)	-9.0%
Non Elective excess beddays	9,819	10,971	1,152	11.7%	2,545	2,917	372	10.9%
A&E	99,759	95,027	(4,732)	-4.7%	11,990	12,196	206	2.4%
Outpatients - New	74,393	71,894	(2,499)	-3.4%	12,157	11,390	(767)	-6.2%
Outpatients - Follow Up	171,871	169,272	(2,599)	-1.5%	14,167	14,033	(134)	-0.9%
Outpatient Procedures	49,104	54,375	5,271	10.7%	6,526	7,245	719	10.6%
Outpatient Imaging	51,359	53,951	2,592	5.0%	3,006	3,066	60	2.7%
Direct Access	8,785	8,630	(154)	-1.8%	7,964	8,202	239	3.4%
Critical Care	15,524	15,337	(186)	-1.2%	17,091	17,451	360	2.4%
Maternity Pathway	7,006	6,313	(693)	-9.9%	6,816	6,255	(561)	-10.1%
HIV	16,322	16,580	258	1.6%	2,995	2,980	(15)	-0.5%
Renal	7,006	6,313	(693)	-9.9%	7,355	7,098	(257)	-4.1%
Other	2,363,388	2,252,047	(111,340)	-4.7%	29,552	30,577	1,026	3.4%
PbR Excluded Drugs / Devices					40,274	42,430	2,156	6.5%
CQUINS					5,323	5,323	0	0.0%
Provision for challenge and Risk					(1,298)	(4,321)	(3,023)	255.8%
Phasing correction					(716)		716	-100.0%
					284,824	**284,589**	**(235)**	**0.6%**

Table 3 - Reconciliation to Income Reporting

Contract Monitoring Performance -(unadjusted)	482,916	282,801	279,507	(3,295)
CQUIN 2.5%	9,125	5,323	5,079	(244)
Contract Penalties / Adjustments (Estimated)	(2,225)	(3,299)	(0)	3,298
	488,081	**242,312**	**243,649**	**1,336**
Other Income from Activities				
NHS Trust / FT Income	8,776	5,124	4,698	(426)
Commissioning Income - Non Activity	9,434	5,541	3,859	(1,682)
Department Of Health Income	37	22	38	16
Private Patients Income	5,153	2,928	2,636	(293)
Injury Cost Recovery	2,501	1,459	844	(615)
Other Patient Related (remove MSK included above)	1,628	937	707	(230)
Local Authority Income (remove value included above)	451	279	273	(6)
Overseas Visitors Income	217	126	93	(34)
Income from Activities as reported in Income Section	**518,012**	**301,241**	**297,732**	**(3,509)**

Table 4 - Income from CCG's

	£'000		
	YTD Plan	YTD Actual	YTD Var
NHS BRIGHTON AND HOVE CCG	75,019	75,580	562
NHS COASTAL WEST SUSSEX CCG	8,679	9,570	891
NHS CRAWLEY CCG	1,913	1,779	(135)
NHS EASTBOURNE, HAILSHAM AND SEAFORD CCG	6,373	5,964	(409)
NHS HASTINGS AND ROTHER CCG	2,505	2,633	128
NHS HIGH WEALD LEWES HAVENS CCG	26,340	26,957	617
NHS HORSHAM AND MID SUSSEX CCG	37,656	37,898	242
NHS EAST SURREY	424	309	(115)
Dermatology SCDS	1,542	1,562	20
Commissioning Income CCG's	**160,452**	**162,252**	**1,800**

Finance Report Month 7 2017/18 — Income — A

For the year-to-October, Income reports an underperformance of £3.2m, an increase of £2.2m on the previous month. The analysis of contract income in the table below has been changed to show performance by Commissioner more clearly. CCG over performance is mainly in Elderly Medicine, Cardiology & Critical Care, whilst NHSE is underperforming against Paediatrics & Radiotherapy as well as the CDF. MSK income continues to be behind plan. The year-end forecast is for an adverse variance of £5.7m. The deficit is principally due to CDF drug expenditure being lower than was included in the plan. Income from patient activity is based on 6 months actual activity and an estimate for October. A provision is held for contract adjustments and challenges.

Year-to-Date

	Plan £k	Actual £k	Variance £k
Total Income	**(324,541)**	**(321,329)**	**3,212**

Year-end Forecast

	Plan £k	Forecast £k	Variance £k
Total Income	**(557,900)**	**(552,173)**	**5,727**

CCG activity has been split by Commissioner to highlight the different performance in each group. The query as to where spinal activity should be coded is unresolved, but included against MSK in the forecast. Private Patient income is highly variable with an in-month deficit of £116k. The shortfall in research income is mainly due to commercial trials being lower than planned and is partly offset by reduced costs.

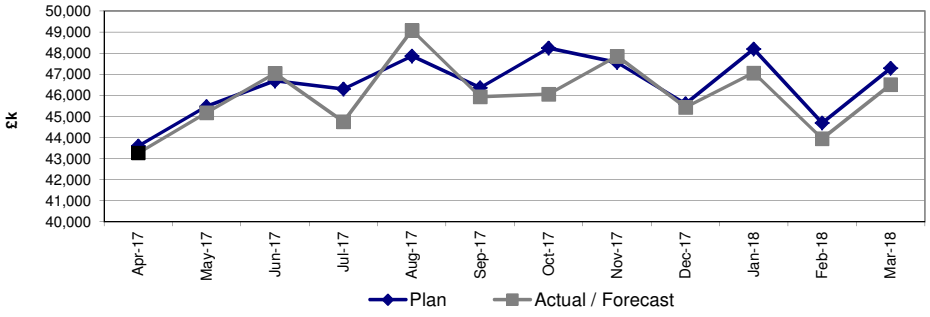
The Trust is in discussions with CCG's over an Aligned Incentive Contract & the forecast is based on the M4 freeze data that supports the negotiation. CDF year end forecast is a deficit of £3.0m. Other income is ahead of plan due to donations from charitable funds (£0.5m) & lower capital charges (£0.6m).

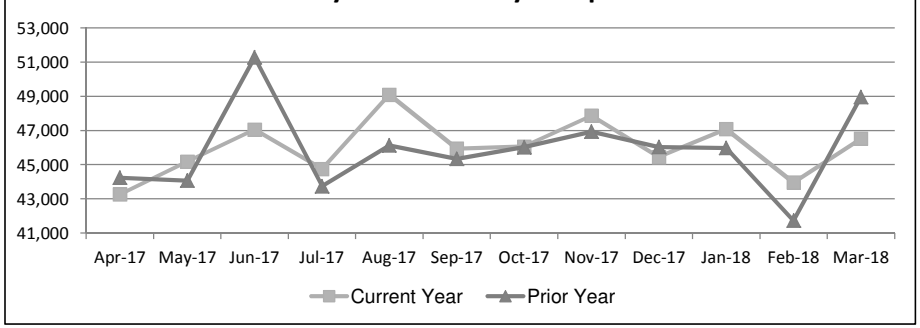
Year-to-Date

	PY Actual £k	Plan £k	Actual £k	Variance £k
Income				
NHS Trusts	(4,808)	(5,126)	(4,691)	435
Clinical Commissioning Groups - Patient Activity	(278,249)	(160,452)	(162,253)	(1,801)
NHSE Income	(3,182)	(107,197)	(103,420)	3,778
NCA Income		(2,680)	(3,441)	(762)
SMSKP Income		(15,098)	(14,071)	1,027
Clinical Commissioning Groups - non Activity	(2,840)	(2,597)	(2,621)	(24)
Clinical Commissioning Groups	(284,271)	(288,023)	(285,806)	2,217
Other NHS	(27)	(22)	(38)	(16)
Private Patients	(2,635)	(2,928)	(2,636)	293
Other Non-NHS	(1,159)	(1,459)	(844)	615
Other Patient Related Income	(829)	(937)	(707)	230
Local Authority Income	(2,630)	(2,620)	(2,917)	(298)
Overseas Visitors Income	(174)	(126)	(93)	34
Income From Activities	**(296,534)**	**(301,241)**	**(297,731)**	**3,510**
Education & Training Income	(16,794)	(15,865)	(15,825)	41
Research & Development Income	(2,914)	(2,609)	(2,100)	508
Transfers from Donated Asset Reserve		0	0	0
Income Generation	(1,462)	(1,484)	(1,453)	31
Other Income	(3,065)	(3,342)	(4,220)	(878)
Other Operating Income	**(24,235)**	**(23,300)**	**(23,598)**	**(298)**
Total Income	**(320,769)**	**(324,541)**	**(321,329)**	**3,212**
Of Which PBRX Drugs/Devices	(35,244)	(39,799)	(42,854)	(3,055)

Year-end Forecast

	Plan £k	Forecast £k	Variance £k
Income			
NHS Trusts	(8,776)	(8,271)	505
Clinical Commissioning Groups - Patient Activity	(276,321)	(277,385)	(1,064)
NHSE Income	(184,177)	(178,601)	5,576
NCA Income	(4,574)	(4,915)	(341)
SMSKP Income	(25,794)	(25,630)	164
Clinical Commissioning Groups - non Activity	(4,387)	(4,314)	73
Clinical Commissioning Groups	(495,252)	(490,845)	4,408
Other NHS	(37)	(53)	(16)
Private Patients	(5,153)	(4,716)	437
Other Non-NHS	(2,501)	(1,444)	1,057
Other Patient Related Income	(1,628)	(1,392)	236
Local Authority Income	(4,448)	(4,967)	(519)
Overseas Visitors Income	(217)	(167)	50
Income From Activities	**(518,012)**	**(511,855)**	**6,157**
Education & Training Income	(27,189)	(27,134)	55
Research & Development Income	(4,432)	(3,757)	676
Transfers from Donated Asset Reserve	0	0	0
Income Generation	(2,545)	(2,524)	21
Other Income	(5,722)	(6,903)	(1,181)
Other Operating Income	**(39,888)**	**(40,318)**	**(430)**
Total Income	**(557,900)**	**(552,173)**	**5,727**





Finance Report Month 7 2017/18 — Operating Costs — A

Operating costs to Month 7 are underspending against budgets, wholly due to pay costs, and the majority of the savings plans have now been fully allocated. At present the assumption is that the Trust will identify the required savings, manage the identified risks and reduce expenditure and therefore come in on budget, except for PbR excluded drugs which should be offset by additional income.

Year-to-date

	PY Actual £k	Plan £k	Actual £k	Variance £k
Pay	**201,704**	**212,947**	**208,208**	**(4,739)**
Non-pay	**126,939**	**127,183**	**128,436**	**1,254**
Operational Costs	**328,643**	**340,129**	**336,644**	**(3,485)**

Year-end Forecast

	Plan £k	Forecast £k	Variance £k
Pay	**365,282**	**357,909**	**(7,374)**
Non-pay	**218,687**	**220,403**	**1,715**
Operational Costs	**583,970**	**578,311**	**(5,658)**

Pay: costs in October were lower than in August and September, partly due to locum credit notes and partly due to to capitalisation of some costs associated with the 3Ts work. The Trust has 945 WTE vacancies (substantive contracted staff vs funded establishment), of which 427 are nurse vacancies. Some are covered by overtime and use of bank and agency staff, but the trend in the first 7 months has been that around 25% of nursing shifts have not been able to be filled.

Non-pay: overspending compared to budget overall, but includes overspends in PbR excluded and CDF drugs which is offset by additional income. The other big category of overspend is supplies and services clinical, offset with underspends across almost all other categories of expenditure. Some of this relates to expenditure above profile on the 3Ts project, offset with income, and some relates to increased activity in some directorates. Premises is over spent due to ongoing non recurrent costs for generator, chiller and boiler hire, together with legionella testing. Other non-pay includes the costs of redundancy/compromise agreements, expenditure on reasearch that is offset with income, and CQC expenditure among other things.

The forecast assumes expenditure will be under plan overall with the exception of overspends on Medical and Dental staff, clinical supplies, premises and other non-pay.

Year-to-date

	PY Actual £k	Plan £k	Actual £k	Variance £k
Pay				
Management	8,292	10,202	9,050	(1,152)
Medical and Dental Staff	60,086	62,804	63,371	566
Nursing & Midwifery - Registered	61,667	64,496	62,518	(1,978)
Nursing & Midwifery - Unregistered	15,102	15,352	15,353	1
Other Healthcare Staff	27,480	30,023	28,520	(1,504)
Ancillary Staff	8,405	8,334	8,215	(119)
Administrative & Clerical	18,655	20,475	19,175	(1,301)
Maintenance Staff	1,548	1,853	1,572	(282)
Other Staff	468	(593)	436	1,029
Total Pay	**201,704**	**212,947**	**208,208**	**(4,739)**
Non-pay				
Drugs & Medical Gases - in tariff	6,520	7,400	7,180	(220)
Drugs & Medical Gases - PbR exclusion and CDF	30,794	37,868	39,110	1,242
Supplies and Services - Clinical - in tariff	4,766	31,089	32,055	966
Supplies and Services - Clinical - PbR exclusion	3,379	4,982	4,646	(336)
Supplies and Services General	821	4,117	3,932	(185)
Establishment Expenses	12,242	3,956	3,639	(318)
Transport Expenses	4,283	689	642	(47)
Premises	1,672	12,239	12,629	391
Purchase of Healthcare from Non NHS provider	342	3,880	3,973	94
Consultancy	11,244	708	534	(174)
Other Non Pay/Reserves	2,173	135	870	734
CNST Premium	5,001	12,555	12,554	(0)
Education and Training	161	2,178	1,892	(287)
Services from Other NHS Bodies	38,774	5,205	4,590	(615)
Audit Fees	4,728	145	132	(13)
Trust Chair & Non-Executive Directors	39	37	59	22
Total Non-Pay	**126,939**	**127,183**	**128,436**	**1,254**
Total Expenditure	**328,643**	**340,129**	**336,644**	**(3,485)**

Full-year

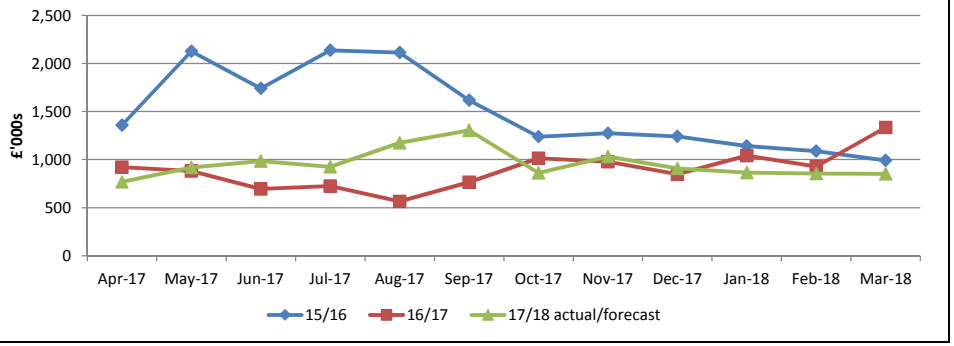
	Plan £k	Forecast £k	Variance £k
Pay			
Management	17,715	15,829	(1,886)
Medical and Dental Staff	107,816	108,883	1,067
Nursing & Midwifery - Registered	110,836	107,893	(2,943)
Nursing & Midwifery - Unregistered	26,394	25,718	(676)
Other Healthcare Staff	51,793	49,471	(2,323)
Ancillary Staff	14,302	14,052	(250)
Administrative & Clerical	35,109	33,130	(1,979)
Maintenance Staff	3,177	2,851	(326)
Other Staff	(1,860)	82	1,943
Total Pay	**365,282**	**357,909**	**(7,374)**
Non-pay			
Drugs & Medical Gases - in tariff	13,120	12,169	(952)
Drugs & Medical Gases - PbR exclusion and CDF	66,020	66,761	741
Supplies and Services - Clinical - in tariff	52,086	54,926	2,840
Supplies and Services - Clinical - PbR exclusion	8,533	8,148	(385)
Supplies and Services General	7,002	6,954	(48)
Establishment Expenses	6,857	6,453	(404)
Transport Expenses	1,139	1,093	(46)
Premises	20,830	22,071	1,241
Purchase of Healthcare from Non NHS provider	6,297	6,517	220
Consultancy	1,214	766	(447)
Other Non Pay/Reserves	1,046	1,237	191
CNST Premium	21,523	21,522	(0)
Education and Training	3,761	3,362	(399)
Services from Other NHS Bodies	8,947	8,087	(860)
Audit Fees	249	235	(14)
Trust Chair & Non-Executive Directors	63	100	37
Total Non-Pay	**218,687**	**220,403**	**1,715**
Total Expenditure	**583,970**	**578,311**	**(5,658)**

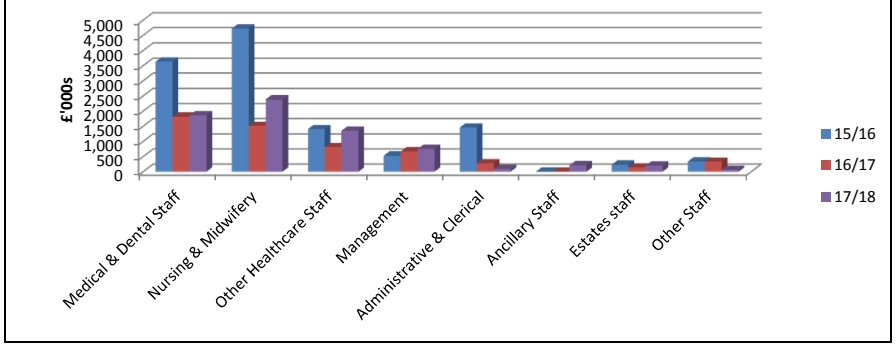
Finance Report Month 7 2017/18 — Payroll and Agency costs — G

Agency costs of £6.9m represent 3.3% of the total pay bill and are within the year-to-Month 7 agency cap of £7.5m. Agency expenditure reduced in-month and is also lower compared to the same period in 16/17. The total cost of agency, bank and substantive staff was well within the Month 7 pay budget.

Year-to-date Agency

	15/16 £k	16/17 £k	Ceiling £k	Actual £k	Variance £k
Medical & Dental Staff	3,635	1,817	2,237	1,865	(372)
Nursing & Midwifery	4,722	1,512	2,830	2,383	(447)
Other Healthcare Staff	1,406	815	1,011	1,355	344
Management	532	671	315	751	436
Administrative & Clerical	1,459	281	690	95	(595)
Ancillary Staff	0	0	309	214	(95)
Estates staff	234	139	58	204	146
Other Staff	338	334	17	68	51
Trust	**12,326**	**5,569**	**7,465**	**6,935**	**(531)**





Payroll
(Excludes non executive directors)

	Prior year actual £k	Plan £k	Actual £k	Variance £k
Medical & Dental Staff	1,143	1,190	1,154	(36)
Nursing & Midwifery	3,554	3,580	3,153	(427)
Other Healthcare Staff	1,131	1,286	1,139	(147)
Management	195	249	195	(54)
Administrative & Clerical	1,119	1,288	1,137	(151)
Ancillary Staff	520	614	507	(108)
Maintenance Staff	67	85	60	(25)
Other Staff	13	12	16	4
Trust	**7,743**	**8,305**	**7,360**	**(945)**

Staff in post including bank staff

	Prior year actual WTE*	Plan WTE	Actual WTE	Variance WTE
Medical & Dental Staff	1,065	1,190	1,129	(61)
Nursing & Midwifery	3,106	3,580	3,378	(203)
Other Healthcare Staff	1,105	1,286	1,146	(140)
Management	188	250	196	(54)
Administrative & Clerical	1,103	1,288	1,200	(89)
Ancillary staff	556	614	578	(37)
Maintenance Staff	71	85	63	(22)
Other Staff	13	12	16	4
Trust	**7,207**	**8,305**	**7,704**	**(600)**

* Before 17/18 Bank staff WTEs were only reported for Nursing & Midwery

Finance Report Month 7 2017/18 — Statement of Financial Position

The Trust Statement of Financial position is produced on a monthly basis and reflects changes in asset values as well as movement in liabilities. The plan is the updated NHSI plan submitted in June 2017 adjusted for the revised 3Ts and Emergency capital forecast submitted to NHSI in the June return.

	1 April 17	Year-to-Date			
	Actual	Plan	Actual	Variance	Notes
	£k	£k	£k	£k	
Property, Plant and Equipment	386,263	419,932	401,895	(18,037)	1
Intangible Assets	681	660	660	0	
Other Assets	4,149	4,321	3,303	(1,018)	
Non Current Assets	**391,093**	**424,913**	**405,858**	**(19,055)**	
Inventories	8,109	8,076	8,350	274	
Trade and Other Receivables	50,477	47,007	48,873	1,866	2
Cash and Cash Equivalents	7,407	4,294	8,196	3,902	
Non Current Assets Held for Sale	0	0	0	0	
Current Assets	**65,993**	**59,377**	**65,419**	**6,042**	
Trade and Other Payables	(69,574)	(72,143)	(69,253)	2,890	2
Borrowings	(7,377)	(7,377)	(7,600)	(223)	3
Other Financial Liabilities	0	0	0	0	
Provisions	(4,136)	(1,071)	(3,007)	(1,936)	
Other Liabilities	0	0	0	0	
Current Liabilities	**(81,087)**	**(80,591)**	**(79,860)**	**731**	
Borrowings	(195,264)	(241,298)	(231,379)	9,919	3
Trade and Other Payables	0	0	(16)	(16)	
Provisions	(1,937)	(1,955)	(1,888)	67	
TOTAL ASSETS EMPLOYED	**178,798**	**160,446**	**158,134**	**(2,312)**	
Financed by:					
Public Dividend Capital	(294,776)	(314,869)	(311,540)	3,329	3
Retained Earnings	167,206	167,206	167,206	0	
(Surplus)/Deficit for Year	0	38,445	37,428	(1,017)	
Revaluation Reserve	(51,228)	(51,228)	(51,228)	0	
TOTAL TAXPAYERS EQUITY	**(178,798)**	**(160,446)**	**(158,134)**	**2,312**	

	Full-Year			
	Plan	Forecast	Variance	Notes
	£k	£k	£k	
Property, Plant and Equipment	450,037	450,420	383	
Intangible Assets	645	645	0	
Other Assets	3,878	2,860	(1,018)	
Non Current Assets	**454,560**	**453,925**	**(635)**	
Inventories	8,241	8,515	274	
Trade and Other Receivables	46,065	45,698	(367)	
Cash and Cash Equivalents	3,668	3,668	0	
Non Current Assets Held for Sale	0	0	0	
Current Assets	**57,974**	**57,881**	**(93)**	
Trade and Other Payables	(69,103)	(66,391)	2,712	
Borrowings	(8,201)	(7,524)	677	
Other Financial Liabilities	0	0	0	
Provisions	(1,071)	(3,007)	(1,936)	
Other Liabilities	0	0	0	
Current Liabilities	**(78,375)**	**(76,922)**	**1,453**	
Borrowings	(291,166)	(257,405)	33,761	
Trade and Other Payables	(200)	(216)	(16)	
Provisions	(1,970)	(1,903)	67	
TOTAL ASSETS EMPLOYED	**140,823**	**175,360**	**34,537**	
Financed by:				
Public Dividend Capital	(338,172)	(371,605)	(33,433)	
Retained Earnings	167,206	167,206	0	
(Surplus)/Deficit for Year	81,371	80,267	(1,104)	
Revaluation Reserve	(51,228)	(51,228)	0	
TOTAL TAXPAYERS EQUITY	**(140,823)**	**(175,360)**	**(34,537)**	

1. Both Strategic and Operational Capital expenditure year-to-date are behind the June phased plan; the full-year forecast assumes that the plan is achieved including the Emergency schemes.
2. The overdue debts position continues to improve with further legacy debts having been paid off, but there is still room for improvement. The trade and payables is also better than plan, but the NHS intra-NHS balances remain significant compared to other non-NHS creditors. This position is forecast to improve by the year-end.
3. The planned PDC drawdown is based on phased 3Ts expenditure and PDC funding for the Emergency schemes. However, the slippage in Operational Capital expenditure has delayed PDC drawdown and the Emergency schemes are not yet approved. The full-year forecast assumes PDC funding for the Emergency schemes, rather than the loan funding assumed in the plan, which is why there is an equal and opposite variance between PDC and loans.

Finance Report Month 7 2017/18 — Cash — G

The plan reflects the June NHSI return and is based on achievement of the control total for the year. Capital funding for 3Ts and the Radiotherapy East scheme is in place for the year; all of the Radiotherapy East Scheme funding has been drawn down, the 3Ts funding is being drawn down to match capital expenditure, subject to utilisation of internal funding sources first. £9.8m was drawn down in October, the next drawdown is planned for December. Funding for the other strategic schemes (ED - £15m, Backlog Maintenance - £19m, and Pathology - £1m) is subject to approval from NHSI, but the associated income and expenditure cashflows are included in the full-year cashflow forecast. In the plan the Emergency Schemes and Pathology were financed by loans, but on the advice of NHSI it is now assumed that the Emergency schemes will be by PDC, and this accounts for the full-year variances in the debt drawdown and PDC. The year-to-date variances on capital and PDC reflect the changed phasing on the capital schemes and the low expenditure on schemes in the year.
Revenue deficit funding is based on the control total deficit of £65.4m for the year, phased according to the monthly deficit. The drawdown is based on the actual revenue results and revised forecast for the year. The Trust has received £37.5m to date; the November drawdown will be £4.0m. The year-to-date cash holding was above plan to ensure that adequate cash was retained for the first two weeks in November. The year-end level of cash holding is aligned to the year-end EFL cash control total, which is slightly above the DH maximum cash holding assumed for an organisation with revenue support.

Year-to-date

	Plan £k	Actual £k	Variance £k
Cash Balance	**4,294**	**8,196**	**3,902**

Year-End Forecast

	Plan £k	Forecast £k	Variance £k
Cash Balance	**3,668**	**3,668**	**(0)**

Year-to-Date

	Plan £k	Actual £k	Variance £k
EBITDA	(15,588)	(15,315)	273
Non Cash I&E Items	0	0	0
Movement in Working Capital	2,402	(6,914)	(9,316)
Provisions	(7,071)	(3,276)	3,795
Cashflow from Operations	**(20,257)**	**(25,505)**	**(5,248)**
Capital Expenditure	(41,550)	(21,071)	20,479
Cash receipt from asset sales	0	0	0
Cashflow before financing	**(61,807)**	**(46,576)**	**15,231**
PDC Received	20,093	16,764	(3,329)
PDC Repaid	0	0	0
Dividends Paid	(3,168)	(2,079)	1,089
Interest on Loans and leases	(4,288)	(3,674)	614
Interest received	23	16	(7)
Drawdown on debt	49,194	39,496	(9,698)
Repayment of debt	(3,160)	(3,158)	2
Cashflow from financing	**58,694**	**47,365**	**(11,329)**
Net Cash Inflow / (Outflow)	**(3,113)**	**789**	**3,902**
Opening Cash Balance	7,407	7,407	-
Closing Cash Balance	**4,294**	**8,196**	**3,902**

Year-End Forecast

	Plan £k	Forecast £k	Variance £k
EBITDA	(26,070)	(26,138)	(68)
Non Cash I&E Items	0	0	0
Movement in Working Capital	203	(6,511)	(6,714)
Provisions	(6,955)	(3,160)	3,795
Cashflow from Operations	**(32,822)**	**(35,809)**	**(2,987)**
Capital Expenditure	(94,270)	(93,759)	511
Cash receipt from asset sales	0	0	0
Cashflow before financing	**(127,092)**	**(129,568)**	**(2,476)**
PDC Received	42,396	76,830	34,434
PDC Repaid	0	0	0
Dividends Paid	(6,336)	(5,448)	888
Interest on Loans and leases	(9,471)	(7,967)	1,504
Interest received	38	26	(12)
Drawdown on debt	102,798	68,458	(34,340)
Repayment of debt	(6,072)	(6,070)	2
Cashflow from financing	**123,353**	**125,829**	**2,476**
Net Cash Inflow / (Outflow)	**(3,739)**	**(3,739)**	**0**
Opening Cash Balance	7,407	7,407	-
Closing Cash Balance	**3,668**	**3,668**	**(0)**

Finance Report Month 7 2017/18 — Rolling Cashflow — A

The rolling cashflow spans two financial years and starts with the current month's actual results which are forecast forward for another eleven months, to provide a full forward year cashflow forecast.

Year-to-Date	Plan £k	Actual £k	Variance £k	Year-End Forecast	Plan £k	Forecast £k	Variance £k
	4,294	8,196	3,902		3,668	3,668	(0)

	Oct-17 £k Act	Nov-17 £k For	Dec-17 £k For	Jan-18 £k For	Feb-18 £k For	Mar-18 £k For	Apr-18 £k For	May-18 £k For	Jun-18 £k For	Jul-18 £k For	Aug-18 £k For	Sep-18 £k For
EBITDA	(1,181)	(467)	(2,864)	(1,313)	(4,312)	(1,867)	(3,267)	(3,470)	(478)	(43)	(1,787)	(1,269)
Non Cash I&E Items	0	0	0	0	0	0	0	0	0	0	0	0
Movement in Working Capital	(3,156)	1,847	(4,912)	12,642	(11,754)	2,580	11,272	(1,321)	(3,733)	(1,082)	(4,723)	3,928
Provisions	(989)	81	35	0	0	0	(5,013)	17	(18)	(3)	(16)	36
Cashflow from Operations	(5,326)	1,461	(7,741)	11,329	(16,066)	713	2,992	(4,774)	(4,229)	(1,128)	(6,526)	2,695
Capital Expenditure	(5,662)	(5,205)	(10,868)	(25,615)	(9,204)	(21,796)	(13,623)	(7,115)	(7,544)	(6,868)	(9,194)	(5,002)
Cash receipt from asset sales	0	0	0	0	0	0	0	0	0	0	0	0
Cashflow before financing	(10,988)	(3,744)	(18,609)	(14,286)	(25,270)	(21,083)	(10,631)	(11,889)	(11,773)	(7,996)	(15,720)	(2,307)
PDC Received	9,752	0	10,487	11,989	18,832	18,758	6,008	7,279	7,336	7,054	7,710	8,298
PDC Repaid	0	0	0	0	0	0	0	0	0	0	0	0
Dividends Paid	0	0	0	0	0	(3,369)	0	0	0	0	0	(3,501)
Interest on Loans and leases	(215)	(1,143)	(215)	(215)	(851)	(1,869)	(215)	(428)	(215)	(215)	(215)	(2,350)
Interest received	2	2	2	2	2	2	4	4	4	4	4	4
Drawdown on debt	3,585	3,990	6,599	4,447	8,035	5,891	4,975	4,975	4,975	4,975	4,975	4,975
Repayment of debt	(124)	(548)	(125)	(124)	(1,242)	(873)	(124)	(548)	(125)	(124)	(436)	(1,598)
Cashflow from financing	13,000	2,301	16,748	16,099	24,776	18,540	10,648	11,282	11,975	11,694	12,038	5,828
Net Cash Inflow / (Outflow)	2,012	(1,443)	(1,861)	1,813	(494)	(2,543)	17	(607)	202	3,698	(3,682)	3,521
Opening Cash Balance	6,184	8,196	6,753	4,892	6,705	6,211	3,668	3,685	3,078	3,280	6,978	3,296
Closing Cash Balance	8,196	6,753	4,892	6,705	6,211	3,668	3,685	3,078	3,280	6,978	3,296	6,817

Finance Report Month 7 2017/18 — Capital — A

The Capital report shows Strategic and Operational Capital expenditure for the year-to-date and the full-year outturn compared to the plan.

Year-to-date

	Plan £k	Actual £k	Variance £k
Strategic Capital	**37,473**	**25,715**	**(11,758)**
Operational Capital	**9,598**	**3,067**	**(6,531)**
Total	**47,071**	**28,782**	**(18,289)**

Year-end Forecast

	Plan £k	Forecast £k	Variance £k
Strategic Capital	**83,850**	**83,626**	**(224)**
Operational Capital	**23,332**	**19,638**	**(3,694)**
Total	**107,182**	**103,264**	**(3,918)**

Strategic Capital The strategic capital plan is based on the revised forecasts submitted to NHSI for 2017/18 which includes the material changes to the capital programme since the original plan was submitted, particularly for 3Ts. Construction of the Clinical Admin Building on 3Ts is progressing for completion early in the new year. Services in Eastern Road have been lowered and excavation work is progressing well. The Hanbury building work to rectify defects to enable the Radiopharmacy service to obtain a Medicines and Healthcare products Regulatory Agency (MHRA) licence is still ongoing. The main buildings work and installation for the Radiotherapy East scheme is complete, but there remains some IT work to be completed to finalise the scheme. There is expected to be a small underspend (£224k) on the scheme. The ED, Backlog Maintenance and Pathology schemes are subject to approval from NHSI and DH. The Emergency application is with NHSI and the DH for approval. The submission is based on PDC funding, but this may revert to loan funding on final approval. Forecasts for these schemes assume material expenditure in year to match the project as originally submitted, but with the ongoing delays to the approval it is unlikely all this work will be completed in year. For the purposes of this report the full value of the schemes have been included pending approval and any rescheduling of the work though it is unlikely that this level of expenditure on the schemes will be incurred in this financial year. The forecast assumes minimal spend in-year for Pathology.

Operational Capital The plan is based on the plan approved by the Board in June. Re-profiling of the forecast expenditure on all schemes has now been completed based on work programmes and order dates. This shows that almost 50% of the remaining expenditure is to be incurred in February and March 2018, which increases the risk of completion within the financial year. This is particularly relevant for the Estates and Medical Equipment schemes. The approved plan included £5m of over-programming in line with previous years. This has been reduced to £1.8m by the reduction to the planned IT programme; priority one IT schemes have been approved to be implemented, but other schemes have been placed on hold. The position will be subject to change over the next months dependent on progress on schemes.

	Plan £k	Actual £k	Variance £k
Source of Funds - (CRL)	**(26,216)**	**(23,002)**	**(3,214)**
Expenditure			
Strategic Capital			
3Ts	26,010	23,578	2,432
ED	9,044	1,331	7,713
Backlog Maintenance	0	0	0
Pathology	0	0	0
Radiotherapy East	2,419	806	1,613
Total Strategic Capital	**37,473**	**25,715**	**11,758**
Operational Capital			
Major Projects			
LINAC Replacement	1,100	161	939
Acute Floor Reconfiguration	747	532	215
Electrical Substation - TKT Services	929	929	0
Replacement CT PRH	185	1	184
Small Projects			
Medical Equipment Replacement	1,118	259	859
IM&T Infrastructure	2,646	580	2,066
Estates Infrastructure	1,817	190	1,627
Service Development	976	279	697
Charitably Funded Schemes	80	136	(56)
Total Operational Capital	**9,598**	**3,067**	**6,531**
(Under)/Overspend against CRL	**20,855**	**5,780**	**15,075**

	Plan £k	Forecast £k	Variance £k
Source of Funds - (CRL)	**(101,835)**	**(102,067)**	**232**
Expenditure			
Strategic Capital			
3Ts	45,998	45,998	0
ED	14,966	14,966	0
Backlog Maintenance	19,467	19,467	0
Pathology	1,000	1,000	0
Radiotherapy East	2,419	2,195	224
Total Strategic Capital	**83,850**	**83,626**	**224**
Operational Capital			
Major Projects			
LINAC Replacement	1,038	817	221
Acute Floor Reconfiguration	747	635	112
Electrical Substation - TKT Services	929	929	0
Replacement CT PRH	1,296	1,296	0
Small Projects			
Medical Equipment Replacement	3,299	3,277	22
IM&T Infrastructure	6,382	2,974	3,408
Estates Infrastructure	6,153	6,291	(138)
Service Development	3,186	2,919	267
Charitably Funded Schemes	302	500	(198)
Total Operational Capital	**23,332**	**19,638**	**3,694**
(Under)/Overspend against CRL	**5,347**	**1,197**	**4,150**

Finance Report Month 7 2017/18 — Aged Debtors

The Trust debtors are a mixture of invoiced debtors, accrued income and prepayments. The level of invoiced debtors has decreased by £1.3m since the end of September but the value of overdue debts has increased by £1.7m.

Invoiced Debtors	Within Terms 1-30 Days	1 Month Overdue 31-60 Days	2 Months Overdue 61-90 Days	3 Months Overdue Over 90 Days	Total	Current Month Over 30 Days	Prior Month Over 30 Days	Notes
	£k	£k	£k	£k		£k	£k	
CCGs	555	750	(19)	2,377	3,663	3,108	4,052	1
Trusts	589	826	437	3,916	5,768	5,179	5,207	2
Other NHS	591	53	-	740	1,384	793	755	3
Other Debtors	1,680	2,426	71	1,666	5,843	4,163	1,809	4
Private Patients	250	308	67	893	1,518	1,268	1,014	5
Overseas	2	4	19	331	356	354	360	
Total Invoiced Debtors	**3,667**	**4,367**	**575**	**9,923**	**18,532**	14,865	13,197	
Provision for Bad Debts (including RTA Provision)					(4,942)			
Accrued Income					24,165			
Prepayments					8,598			
Other Debtors					2,520			
Total Trade & Other Receivables					**48,873**			

Other Receivables	Current Month	Prior Month
		£k
Accrued Income		
Work In Progress	3,978	3,978
CCG Service Level Agreements	10,823	9,853
Injury Cost Recovery Fund	2,880	2,722
Other	6,484	5,853
Total Accrued Income	**24,165**	**22,406**
Prepayments		
Maintenance & Other Contracts	3,718	3,402
NHS Litigation	2,545	2,181
Other	2,335	2,017
Total Prepayments	**8,598**	**7,600**

1. CCGs. The CCGs overdue balance has improved by a further £1.0m with the settlement of some 3Ts and legacy debts from 16-17 by the main CCG debtor. This leaves £626k 3Ts (£541k disputed), £972k resilience (agreed but not paid), SLA £246k (paid in October) 15/16 arbitration debts 99k, and SLA 16/17 shortfalls £166k as the main overdue balances that are taking a long time to clear. The NCA debtors over 30 days have increased by £15k and the over 90 days have increased by £71k; there is gradual but continuing increase in NCA overdue debts which will be addressed.

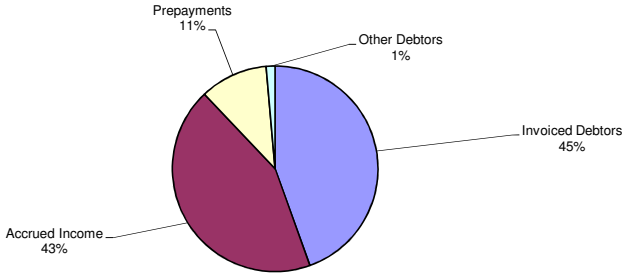
2. Trusts. Local organisations account for 94% (September 94%) of the total debt. The on account payments from the largest debtor (pending resolution of the disagreement on the SLA) have continued and other areas, subject to the organisation's cashflow constraints, will be included in the on account payments pending finalisation of the levels of service between both organisations. Work on the other local organisation's creditor balances is nearing conclusion with the clearance of a credit note against a material invoice (£280k). However despite the work on these balances there has been little movement in the total value of overdue debts.

3. Other NHS. The balance over 90 days includes the legacy EPR debt of £627k.

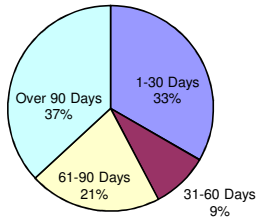
4. Other Debtors. The over 30 days balance has increased by £2.4m; this relates primarily to the outstanding invoice for quarter 1 and 2 GUM activity charges to the local council. The other material debtor in this category is the University of Sussex account which is on hold pending resolution of SIFT payments between the two organisations.

5. Private Patient overdue debts have increased by £254k.

Trade and Other Receivables



Invoiced Debtors Ageing



Abdominal:

Income: Higher than plan due to an increase in Hep C treatment patients and an increase in the drug cost (PbR excluded income). The impact of this on future months is currently being modelled. The favourable PbR excluded income variance is matched by an adverse PbR excluded non-pay cost variance and partially offset by lower than plan private patient income, due to a drop in activity.

Pay: The variance is driven by on-going medical staffing cost pressures, the majority of which are the subject of business cases and funding has been earmarked in Reserves. The adverse variance has reduced from last month as a result of the approval of the Urology Consultants business case.

Non-Pay: The unfavourable variance is driven by the PBR excluded drugs expenditure partially offset by a decrease in outsourcing costs.

	PY Actual £k	Plan £k	Actual £k	Variance £k	RAG
Income	(24,816)	(4,856)	(5,044)	(188)	G
Pay	9,834	9,868	10,363	495	R
Non-Pay (tariff)	3,936	3,025	2,985	(40)	G
Non-Pay (PBR exc & CDF)	3,992	4,444	4,688	244	R
EBITDA *	(7,054)	12,481	12,992	511	R

Acute Floor:

Pay: The variance is due to consultant vacancies mainly in ED which has been reduced by high bank & agency spend in critical care and ED. The overspend in RSCH ITU is due to usage of non-framework agency staff, which is now reducing. ED RSCH had additional shifts over & above template to cover corridor and to staff the UCC. There is high sickness and 1-1 care resulting in high bank spend in AMU.

Non Pay: Drug costs are overspent mainly in ITU over the last few months. The overspend in cleaning materials and M&S disposables is mitigated by an underspend in M&S general.

	PY Actual £k	Plan £k	Actual £k	Variance £k	RAG
Income	(28,685)	(1,023)	(1,022)	1	R
Pay	22,893	23,155	23,217	62	R
Non-Pay (tariff)	3,003	2,693	2,857	164	R
Non-Pay (PBR exc & CDF)	124	96	48	(48)	G
EBITDA *	(2,665)	24,922	25,100	178	R

Cancer: **Income:**

Underperformance in PbR-excluded & Cancer Drugs Fund income and reduced Radiotherapy private patient income has been partially offset by over-delivery on newly renegotiated SLA arrangements for the recharge of consultant time.

Pay: Vacancies within Medical Physics and Radiotherapy due to delays in recruitment brought about by slippage in the opening of new LINACS machine and difficulties in recruiting the associated staff.

Non-Pay: PbR Exclusions & CDF underspend is offset by additional spend on outsourcing to Genesis for Radiotherapy and to Genomic for Breast Screening.

	PY Actual £k	Plan £k	Actual £k	Variance £k	RAG
Income	(27,897)	(12,784)	(12,482)	302	R
Pay	10,141	11,212	10,817	(395)	G
Non-Pay (tariff)	3,476	1,856	1,951	95	R
Non-Pay (PBR exc & CDF)	8,899	10,737	10,468	(269)	G
EBITDA *	(5,382)	11,021	10,754	(267)	G

Cardiovascular:

Income: Income underperformance of £375k for the year to date is due to Private Patient income £295k where current income is c.£200k below this level in 2016/17, and PbR excluded device income £40k.

Pay: Pay overspend for the year to date is £267k, being primarily Nursing £152k and Other Healthcare £112k. To partly mitigate the pay overspend, additional funding of £131k is expected in Month 08 to fund caring for special patients in the Cardiac medical ward and activity in Renal, while costs of around £74k are being incurred to fund overnight stays in Cardiac day-case beds. The usage of these beds also has an effect on income generation as procedures are cancelled when beds are unavailable.

Non-Pay: Non pay is £648k overspent against budget,comprising in tariff supplies of £632k primarily in Cardiac services due to increased activity, and drugs costs in Renal of £89k offset by an early credit note of (£156k) from Diaverum in September 2017.

	PY Actual £k	Plan £k	Actual £k	Variance £k	RAG
Income	(41,114)	(6,952)	(6,577)	375	R
Pay	16,002	16,873	17,139	267	R
Non-Pay (tariff)	8,607	8,362	9,044	682	R
Non-Pay (PBR exc & CDF)	4,372	4,488	4,454	(34)	G
EBITDA *	(12,133)	22,771	24,060	1,289	R

Central Clinical Services

Income: The variance is due to underachieved income in Pathology, due partly to a reduction in tests ordered from other organisations. In addition there is a shortfall of £82k in PBRX income, offset with expenditure.

Pay: The underspend is due to vacancies, very largely Allied Health Professionals, in Imaging (29wte), Pathology (26wte), Physiotherapy (15wte) & Pharmacy (22wte). Although some shifts have been filled by agency and bank staff there were still significant gaps.

Non-Pay: The overspend is mainly in Imaging due to spend on maintenance contracts, increased use of stents, outsourcing costs of Ultrasound, MRI reporting and PET scans.

	PY Actual £k	Plan £k	Actual £k	Variance £k	RAG
Income	(17,000)	(4,578)	(4,240)	338	R
Pay	24,451	25,510	25,203	(307)	G
Non-Pay (tariff)	11,617	12,039	12,494	455	R
Non-Pay (PBR exc & CDF)	821	950	791	(159)	G
EBITDA *	19,889	33,921	34,248	327	R

Children's Services:

Income: In month Commissioning income increased due to backlogs in claiming for Insulin pumps being cleared. This was however offset by credits raised to SASH for renegotiated contract payments.

Pay: Other Pay – overspent due to outstanding CIPs target being allocated to pay budgets pending identification of savings plans. Nursing vacancies continue to drive large underspends with vacancies across the directorate proving hard to fill or being temporarily held.

Non-Pay: Patient appliances £20k overspent in month primarily due to Prosthesis usage. Services from Other NHS Bodies £28k over due to outsourcing.

	PY Actual £k	Plan £k	Actual £k	Variance £k	RAG
Income	(25,028)	(1,457)	(1,328)	129	R
Pay	13,423	13,900	13,915	15	R
Non-Pay (tariff)	2,186	2,068	2,142	74	R
Non-Pay (PBR exc & CDF)	743	856	855	(1)	G
EBITDA *	(8,675)	15,367	15,584	217	R

Clinical Directorate Performance (2 of 2)

Head and Neck:

Income: The PBRX income is above plan and there is unbudgeted Education and Training income. These over achievements are reduced by Private patients' income in Ophthalmology which is low due to long stay patients in the ward and a new system of capturing PP income which has affected income allocation compared to last year.

Pay: Nursing is overspent due to use of bank staff in Ophthalmology. Also there is also an overspend on healthcare scientists due to additional work in Medical Photography and some agency spend to cover vacancies in audiology & ophthalmology.

Non Pay: Pharmacy drugs and PBRX drugs are overspent with a corresponding overachieved PBRX income for the latter. Outsourcing is the other main reason for the overspend

	PY Actual £k	Plan £k	Actual £k	Variance £k	RAG
Income	(15,703)	(2,220)	(2,239)	(20)	G
Pay	6,350	6,180	6,236	56	R
Non-Pay (tariff)	2,175	1,831	1,984	153	R
Non-Pay (PBR exc & CDF)	1,464	1,789	1,843	54	R
EBITDA *	(5,713)	7,580	7,824	244	R

Musculoskeletal:

Income: The only material variance is linked to PBR Excluded Rheumatology Drugs (£182) and relates to a change in the drug regime.

Pay: The Pay underspend is entirely due to Nursing recruitment difficulties at PRH, offset by Medical staffing overspends. Most of medical overspend is on training grade doctors, overall a concern given the level of medical activity. The training grade medical overspend is due to some of them being at a higher banding supplement than anticipated and typically being at a higher point on the pay scale (i.e. are more experienced) than anticipated. However, two junior doctors are wrongly coded in MSK and therefore the total figure for the junior doctors would reduce by around £10k next month once the relevant corrections are made.

Non Pay Tariff: The favourable variance is due to £285k underspent on clinical supplies and services (tariff) due to activity levels.

Non Pay (PBRX/CDF): This variance is directly linked to a change in the regime of Rheumatology PBR Excluded Drugs.

	PY Actual £k	Plan £k	Actual £k	Variance £k	RAG
Income	(28,550)	(5,088)	(5,279)	(191)	G
Pay	9,464	9,649	9,377	(272)	G
Non-Pay (tariff)	6,160	5,119	4,783	(336)	G
Non-Pay (PBR exc & CDF)	4,232	5,019	5,205	186	R
EBITDA *	(8,693)	14,699	14,086	(613)	G

Neurosciences and Stroke Services:

Income: Shows overperformance of (£629k) but this is driven by (£778k) PbR Excluded Income. The remaining £150k shortfall is driven by underperformance in Private Patients & NHS Trust Income combined with a wrongly allocated target for Sussex MSK Income which is now invoiced and accounted for centrally.

Pay: The overall Pay saving is (£168k) YTD, (£59k) in month. Despite a shortfall in established Medical Staffing, Agency and Locum costs have led to a £13k YTD overspend. A&C Staffing is also over by £72k YTD due to additional senior staff. Fortunately savings on Nursing (despite being 42.55 WTE under establishment) have contributed (£235k) YTD in savings.

Non Pay PBR Ex - £778k overspend YTD which is offset by PBR Excluded Income

Non Pay Tariff - £266k overspend YTD which is driven by £116k outsourcing to Non-NHS providers & £84k to Other NHS providers. Additional overspends are £20k on Taxis for staff following restructure & £41k on supplies and services

	PY Actual £k	Plan £k	Actual £k	Variance £k	RAG
Income	(20,945)	(6,509)	(7,138)	(629)	G
Pay	11,088	11,562	11,394	(168)	G
Non-Pay (tariff)	3,631	2,509	2,775	266	R
Non-Pay (PBR exc & CDF)	4,884	5,811	6,589	778	R
EBITDA *	(1,342)	13,373	13,621	247	R

Perioperative:

Income: achievement against income attributed to increased Private patients income (-£305k) due to changes in the data recording system and Education & Training income arrears/new income (-64k).This is partly offset by reduced income from NHS Trust contracts (42k), and lower CEA income (16k).

Pay: Additional theatre sessions run resulted in Medical staff pay costs continuing to overspend (YTD £252k). The service is currently dealing with 3.8% increased activity on 2016/17, mitigated by Admin & Clerical vacancy savings (-37k). There are also underspends against Nursing and Scientific staff costs (-£67k) due to high levels of staff turnover/ vacancies not fully backfilled by temporary staff at Theatres across the two sites.

Non Pay: The overspend on non-pay is also attributed to increased activity/sessions, plus Obstetrics Theatre activity transferred without any budget. As a result Theatres across the two sites are overspending for Clinical and General supplies and Anaesthetics equipment lines. Cessation of cross charges for extra sessions to other specialties has also resulted in a cost pressure for the service. Transfer of budget has been requested.

	PY Actual £k	Plan £k	Actual £k	Variance £k	RAG
Income	(290)	(277)	(592)	(315)	G
Pay	15,138	15,720	15,967	247	R
Non-Pay (tariff)	3,501	3,393	3,724	332	R
Non-Pay (PBR exc & CDF)				0	A
EBITDA *	18,349	18,836	19,099	263	R

Speciality Medicine:

Income: PBRX drug income has reduced in Respiratory, Diabetes and HIV benefitting from switches to generic drugs, although the devices income has increased in Respiratory and Diabetes. SLA income from NHS Trusts and CCGs is behind plan largely due to a lack of medical staff to fulfil the SLA requirements.

Pay: The underspend relates to high levels of Nursing vacancies, not fully covered by flexible staff. There are also some posts being held vacant to achieve CIP targets non recurrently. Pay also includes NHD costs yet to be funded.

Non-Pay: (tariff) overspends are due to archiving costs for HIV \ GUM records, CPAP machine purchases (Respiratory) relating to RTT backlog, drugs pressures in Respiratory and HIV and additional Pathology charges relating to tests for Dermatology.

Non-Pay(PBRX): is underspent because a lower value of drugs & devices have been issued, again potentially benefitting from switches to generic drugs.
There are also outstanding budget increases for Newhaven Downs.

	PY Actual £k	Plan £k	Actual £k	Variance £k	RAG
Income	(39,955)	(9,210)	(9,175)	35	R
Pay	14,613	15,500	15,377	(124)	G
Non-Pay (tariff)	3,899	3,185	3,626	442	R
Non-Pay (PBR exc & CDF)	8,375	8,804	8,483	(321)	G
EBITDA *	(13,068)	18,279	18,311	32	R

Women's Services:

Pay: Underspend is largely driven by nursing & midwifery, due to long term vacancies that are yet to be backfilled. Overspend in Medical & Dental is due to Over established Training grades used to cover consultant vacancies. Bank/Locum spend also used to reduce exposure here.

Non-Pay: Large in month credit for Transport Expenses as the accrual for Q4 16/17 has been dropped as it was already settled centrally. Other non-pay also remains underspent due to credits received for internal recharges for 3T's Clinical Director post.

	PY Actual £k	Plan £k	Actual £k	Variance £k	RAG
Income	(19,209)	(268)	(259)	9	R
Pay	11,010	11,081	10,987	(94)	G
Non-Pay (tariff)	1,334	1,318	1,226	(93)	G
Non-Pay (PBR exc & CDF)	3	1	2	1	R
EBITDA *	(6,862)	12,132	11,956	(176)	G

Finance Report Month 7 2017/18

Departmental Performance

Facilities and Estates: **Income:**
Primarily underachieved due to Security - slippage on car parking income, £19k in month £174k ytd. Movement due to prior month income actual/ takings being £94k - Sept ticket machine down and therefore taking flat fee for daily parking as opposed to hourly.
Pay: Underspend of (£421k) ytd. Security in month (£96k) due to catch up capitalisation of traffic management costs in the 3Ts project. The rest is soft FM ancillary staff due in the main to average vacancies @ 100 wte's vacant in Soft FM / 20 wte's vacant in Estates.
Non-Pay: Overspent by £385k ytd, principally due to Estates – £750k ytd, being reactive spend mainly due to the rental of Barry Building Boilers, Chiller – Sussex Cancer Centre and Load Bank Testing & Generator Maintenance and 16/17 Honeywell invoice not accrued from 16-17 of £141k. Over spend above partially offset by Soft FM (£444k) ytd- of that (£307k) are due to food cost being lower than plan.

	PY Actual £k	Plan £k	Actual £k	Variance £k	RAG
Income	(2,015)	(2,021)	(1,847)	174	R
Pay	10,850	11,105	10,684	(421)	G
Non-Pay	11,045	10,782	11,167	385	R
EBITDA *	**19,881**	**19,865**	**20,004**	**139**	R

Chief Finance Officer:
Income: The variance is due to a salary recharge for the Assistant Director of Finance on secondment to East Sussex Healthcare NHS Trust. Also, there are miscellaneous receipts received relating to Private Patients.
Pay: There are high levels of vacancies particularly within Financial Management, Business Support and Procurement. These vacancies are actively being recruited to.
Non-Pay: This is mainly deriving from Consultancy spend which is significantly lower than the budget because of FTI Consultancy costs being recognised against PMO pay budgets.

	PY Actual £k	Plan £k	Actual £k	Variance £k	RAG
Income	(756)	(735)	(809)	(75)	G
Pay	3,632	4,332	3,889	(443)	G
Non-Pay	4,136	4,244	3,673	(571)	G
EBITDA *	**7,013**	**7,842**	**6,753**	**(1,089)**	G

Chief Executive's Office:
Income: N/A
Pay: £250k overspent, primarily due to the recharge of the Western Executive Board which is partly mitigated by the vacancies across the directorate.

Non-Pay £121k adverse owing to Travel costs for Exec team £35k, fees in relation to Consultancy Services - Clinical & Corporate Governance review £43k, Trust Chair & NEDs costing more by £22k and interim Corporate Governance consultant £22.5k

	PY Actual £k	Plan £k	Actual £k	Variance £k	RAG
Income	(3)	0	0	(0)	G
Pay	1,127	1,027	1,278	250	R
Non-Pay	246	169	291	121	R
EBITDA *	**1,370**	**1,197**	**1,568**	**372**	R

Chief Nurse's Office:
Income: (28k) over plan, due to income target not set for funding received relating to Mouth care Matters project to fund salary costs and related expenses (extended for another year) and Funding from B&HCC for smoking cessation project to cover costs of the team.
Pay: (96k) favourable as a result of vacancies across Nursing, some posts in the process of being recruited to.
Non-Pay: (121k) favourable primarily due to spend on recruitment/placement fees and related T&S on Nursing International recruitment having slipped and occurring later in the year. Other areas contributing to the underspend are NHSLA - low on excess claims in relation to claimant costs, defence and damages (timings issues), CQC, pressure relieving mattresses & Hoist Maintenance which are both low against planned spend.

	PY Actual £k	Plan £k	Actual £k	Variance £k	RAG
Income	(64)	(58)	(86)	(28)	G
Pay	2,322	2,324	2,228	(96)	G
Non-Pay	12,165	13,658	13,536	(121)	G
EBITDA *	**14,422**	**15,924**	**15,679**	**(245)**	G

Chief Operating Officer
Income: Unplanned funding from Surrey & Sussex Healthcare in relation to the Mouth Care Matters project for salary & related non-pay expenses for a B6 ending Oct 17. A Business case is in process to extend funding from B&H CCG for a FTC B6 Home Care liaison discharge Co-ordinator, until the end of March 18.

Pay: There are currently high levels of vacancies within COO, (269k in Clinical Admin Support, 295k in Clinical Ops).
Non-Pay: Mainly caused by invoices received in relation to consultancy fees surrounding RTT

	PY Actual £k	Plan £k	Actual £k	Variance £k	RAG
Income	(6)	(3)	(26)	(23)	G
Pay	8,031	8,235	7,671	(564)	G
Non-Pay	462	360	412	53	R
EBITDA *	**8,487**	**8,592**	**8,057**	**(534)**	G

Medical Director's Office:
Income: £693k underachieved mainly due to Research £470k and Education £197k.
In Research, Commercial trials income less than anticipated but work continues with patient trackers to improve income recovery. In Education, the shortfall is due unachieved Apprenticeship income generation, CPD Cash being offset against expenditure and not as per budget, Non-Medical Placements and SIFT lower than expected.
Pay: (£423) underspent due to vacancies across all specialties but underspend is being reduced by Education's increased expenditure due to junior doctors new contracts as well as additional posts with zero budgets adjustments.
Non-Pay: (£166k) underspent, due to Education (£111k), IT (74k) and Research (£39k) but Safety and Quality is overspent by £57k . Education's Medical postgrad, and undergrad training expenses and CPD cash expenditure lower than expected. IT contracts costs less expected, but there's a risk of future cost pressures included in the forecast pending the outcome of a business case. Research Euro Revaluation adjustments, reduced travel costs and internal recharges less than expected

	PY Actual £k	Plan £k	Actual £k	Variance £k	RAG
Income	(18,906)	(17,735)	(17,042)	693	R
Pay	7,415	7,635	7,212	(423)	G
Non-Pay	5,332	3,787	3,621	(166)	G
EBITDA *	**(6,158)**	**(6,312)**	**(6,208)**	**104**	R

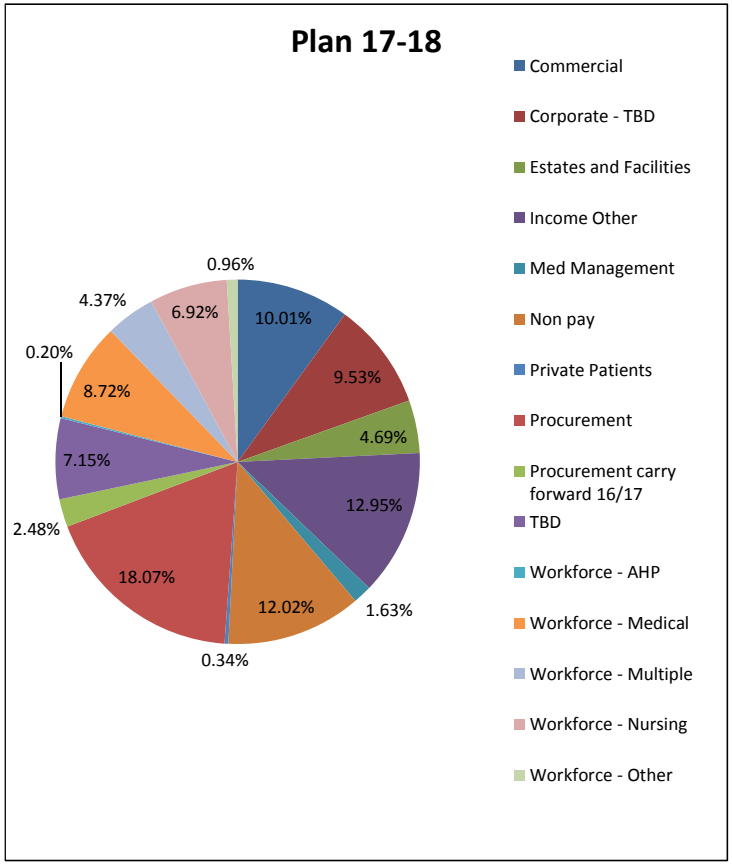
Strategy and Change:
Income: (29k) overachieved, due to unplanned funding from HEKSS for Sussex Trauma Network Education bid
Pay: (339k) favourable, mainly driven by vacancies across the directorate and low spend on STAM in bank temp staffing
Non-Pay: (93k) favourable, owing to low spend on legal costs for employment disputes (volatile), Education & Training spend being low in the transformation team, EBME (usually incurred later in the year), Values & Behaviour, communications & BSUH Improvement Academy. Additionally spend on consultancy in values and behaviour remains low.

	PY Actual £k	Plan £k	Actual £k	Variance £k	RAG
Income	(1,957)	(2,259)	(2,287)	(29)	G
Pay	3,916	4,838	4,499	(339)	G
Non-Pay	1,731	1,576	1,483	(93)	G
EBITDA *	**3,690**	**4,155**	**3,695**	**(460)**	G

Finance Report Month 7 2017/18 — Efficiency and Transformation programme — G

Whilst the majority of the efficiency plan schemes have been finalised with the Directorates, there are still some projects that need to be developed. The savings reported year-to-date are above the original NHSI plan target by £0.04m, but above the internal plan by £0.95m (the internal plan reflects revised phasing as schemes were confirmed). The forecast is to achieve the £20m target after risk assessing individual forecasts down by £0.66m.

		Year to Date			Year End		
		Plan	Actual	Variance	Plan	Forecast	Variance
		£k	£k	£k	£k	£k	£k
Themes							
Commercial	Income (Patient Care Activities)	1,085	1,532	447	2,000	2,001	1
Corporate - TBD	Pay (Skill mix)	842	318	(524)	1,905	1,905	0
Estates and Facilities	Non pay	164	378	214	494	682	188
Estates and Facilities	Pay (Skill mix)	42	167	125	346	251	(95)
Income Other	Income (Patient Care Activities)	466	800	334	2,433	2,514	81
Income Other	Non pay	7	3	(4)	10	10	0
Med Management	Non pay	138	188	50	339	362	23
Non pay	Non pay	574	1,108	534	2,687	2,414	(273)
Private Patients	Income (Patient Care Activities)	75	39	(36)	150	67	(83)
Procurement	Non pay	1,887	1,573	(314)	3,612	3,614	2
Procurement carry forward	Non pay	437	455	18	496	496	0
Workforce - AHP	Pay (Skill mix)	20	20	0	40	40	0
Workforce - Medical	Non pay	97	0	(97)	97	0	97
Workforce - Medical	Pay (Skill mix)	585	838	253	1,485	1,607	122
Workforce - Medical	Pay (WTE reductions)	28	10	(18)	0	105	105
Workforce - Multiple	Pay (Skill mix)	520	627	107	870	1,124	254
Workforce - Nursing	Non pay	12	0	(12)	0	0	0
Workforce - Nursing	Pay (Skill mix)	591	646	55	1,520	1,526	6
Workforce - Nursing	Pay (WTE reductions)	203	19	(184)	42	42	0
Workforce - Other	Pay (Skill mix)	30	34	4	141	141	0
Workforce - Other	Pay (WTE reductions)	12	23	11	59	51	(8)
TBD	Pay (WTE reductions)	869	0	(869)	2,224	1,708	(516)
Efficiency Plan Total		**8,683**	**8,778**	**95**	**20,950**	**20,660**	**(290)**
Plan adjustment to NHSI return/Forecast Risk Adjustment		57	0	(57)	(950)	(660)	290
Efficiency Requirement in NHSI Plan		**8,740**	**8,778**	**38**	**20,000**	**20,000**	0



Brighton and Sussex University Hospitals NHS Trust

To: Board of Directors

Date of Meeting: November 2017 Agenda Item: **10**

Title
Report on Nurse Staffing
Responsible Executive Director
Nicola Ranger (Chief Nursing and Patient Safety Officer)
Prepared by
Caroline Davies, Nurse Director
Status
Public
Summary of Proposal
This report provides the Board with an overview of Nursing and Midwifery staffing levels in in-patient areas. The report details overall fill rates for registered and non-registered staff in April 2017, and provides a detailed explanation, where fill rates were 80% or less, which applied to 6 wards in April 2017. Local, national and international recruitment continues as a high priority to enable substantive positions to be filled reducing the need for bank and agency staff.
Implications for Quality of Care
Safe staffing levels are key to ensuring patient safety and high quality patient experience
Link to Strategic Objectives/Board Assurance Framework
Safe staffing levels support the Trust objectives of: excellent outcomes; great experience; empowered skilled staff; and high productivity
Financial Implications
Shortfalls in staffing levels will be addressed, through the development of business cases
Human Resource Implications
Safer staffing, recruitment and retention are addressed within the report
Recommendation
The Board is asked to NOTE the report.
Communication and Consultation
Not applicable
Appendices
Nil

Report to the Board of Directors

Nurse Staffing and Capacity Levels

November 2017

1. Introduction

The purpose of this report is to present to the board a review of ward nurse staffing level as directed by the National Quality Board (NQB). The NQB has stipulated that; 'Boards must take full responsibility for the quality of care provided to patients, and as a key determinant of quality, take full and collective responsibility for nursing, midwifery and care staffing capacity and capability'. Within their recommendations it states that every six months as required by the NHS England *Hard Truths* report*,* which the board of directors should receive and discuss at a public board meeting a report on staffing capacity and capability. This was requirement came following a number of national reports.

- The Francis report on Mid Staffordshire (2013) resulted in the publication of a number of documents focussing on the importance of safe nurse staffing levels.
- Keogh review into the quality of care and treatment provided in 14 hospital trusts in England (2013)
- Cavendish review (2013), an independent enquiry into healthcare assistants and support workers in the NHS and social care setting.
- Berwick report on improving the safety of patients in England (2013)
- 'How to ensure the right people, with the right skills, are in the place at the right time. A guide to nursing, midwifery and care staffing capacity and capability' (National Quality Board 2013).
- Hard Truths. The journey to putting patients first' (DH, 2013)

As a result of the recommendations 'Safe staffing for Nursing in adult inpatient wards in acute hospitals' (NICE 2014) was developed, this provides detail on the methodology for undertaking a staffing review.

2. Vacancies in October 2017

Registered nurse workforce capacity across the local region and nationally remains a challenge to all health providers. BSUH has a recruitment campaign that is focussed on national and international recruitment to reduce the current RN nurse shortfall. There remains focussed activity on nursing recruitment and retention; with the development of a recruitment and retention strategy, with particular focus on Princess Royal Hospital, as recruitment in this area is proving problematic. HR is supporting sickness management and increasing our bank pool with the aim of to reducing our reliance on agency staffing. Vacancy numbers have increased over the last year in October 2017 there were 140 HCA vacancies, there is active recruitment to these posts and it is hoped that

we will be fully recruited for HCAs in the next 3 to 6 months. The increase has continued during 2017/18, there being 63 more registered nurse vacancies than in April 2017 and 5 more HCA vacancies. Recruitment and retention strategies are discussed later in this paper.

		Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
Reistered Nurses		224	250	266	260	278	293	287
Non-Registered		135	134	130	128	143	136	140
Total		359	384	396	388	421	429	427

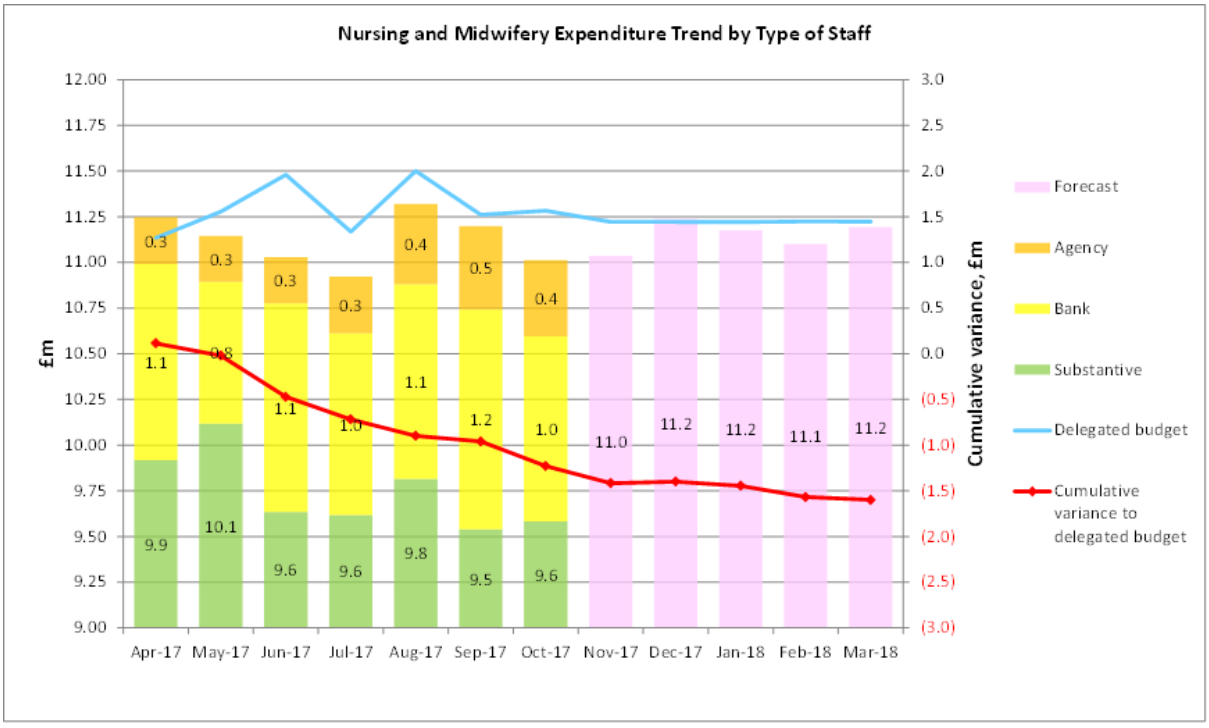
There was an increase in vacancies in January is partly due to an increase in budgeted WTEs due to:

1. Posts being added for Newhaven Downs (30.45wte)
2. The Obstetric Theatres Business Case (15.28wte)

Any shortfalls in staffing are discussed three times daily at the operational meetings and where required staff will be moved to accommodate extra capacity staffing and areas that need additional support.

Bank and agency staff are used as required to ensure the nurse to patient ratio remains within acceptable levels. Directorate Lead Nurses, Matrons and the Practice Educators have also worked on the wards as required.

The graph below reflects the actual spend and percentage of spend for this financial year



Since the beginning of October 2017, we are actively managing the withdrawal from non-framework, high- cost agencies and these are now only used at PRH and in Critical at RSCH, where there are a high number of vacancies. Authorisation for non-framework agency shifts is with the Nurse Director. The Directorate Lead Nurses are monitoring any overtime, following the *managing sickness absence policy* with HR support. In addition, working with the roster-pro lead, it is planned that a new rostering policy will be in place by January 2018, which will enable robust management of rotas and the development of KPIs.

Meetings continue to take place between senior nursing staff and staff side to enable detailed discussions to take place in partnership regarding current and future workforce.
The table below shows the average staffing fill rates across the Trust. As the table below demonstrates challenges remain to registered nurse staffing. The shortfall in registered staffing at night is, partially, compensated for by an 'over- fill' in Healthcare assistants, to support care. However, the Safer Staffing Alliance states there is evidence that care is compromised where there are more than 8 patients (beds) to 1 registered nurse, when any area drops below this level it is escalated to the Directorate Lead Nurse, Nurse Director and on Call Executive, as appropriate. All ward budgets in BSUH follow the guidelines of a minimum ratio of 1:8 during the day and 1:10 at night.

Nurse Staffing Fill Rates April 2017 – Oct 2017

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
Day							
RN	**92.1%**	**92.4%**	**91.7%**	**90.4%**	**90.5%**	**90.2%**	**91.1%**
HCA	**96.6%**	**95.5%**	**95.5%**	**95.1%**	**94.4%**	**95.3%**	**94.6%**
Night							
RN	**93.2%**	**92.6%**	**92.5%**	**91.8%**	**92.0%**	**92.3%**	**93.6%**
HCA	**110.6%**	**112.9%**	**111.7%**	**112.1%**	**113.5%**	**112.0%**	**114.4%**

3. Care Hours per Patient Day (CHPPD)

In Lord Carter's final report, '*Operational Productivity and performance in English acute hospitals: Unwarranted variations'*, better planning of staff resources is crucial to improving quality of care, staff productivity and financial control. The Carter Team found there is not a consistent way to record and report staff deployment, meaning that trusts could not measure and then improve on staff productivity.

The report recommended that all trusts start recording Care Hours Per Patient Day (CHPPD) – a single, consistent metric of nursing and healthcare support workers deployment on inpatient wards

and units. This metric enables trusts to have the right staff mix in the right place at the right time, delivering the right care for patients.

From 1 May 2016, all trusts were requested to report back monthly CHPPD data to NHS Improvement so that they can start to build a national picture of how nursing staff are deployed. Also enabling trusts to see how their CHPPD relates to other trusts within a specialty and by ward in order to identify how they can improve their staffing.

Care Hours per Patient Day (CHPPD) April - Oct 2017

	April	May	June	July	August	September	October
Registered Nurse	**6.8**	**7.1**	**7.0**	**7.0**	**7.0**	**7.2**	**6.9**
Un-Registered	**2.9**	**2.7**	**2.7**	**2.4**	**2.7**	**2.7**	**2.5**
Total	**9.7**	**9.8**	**9.7**	**9.4**	**9.7**	**9.9**	**9.4**

This table reflects that in October each patient had an average of 6.9 hours of a registered nurses time and 2.5 of an un-registered a total of 9.4 hours in a 24 hour period.

BSUH hours will be higher than some other Trusts as there are two adult ICU, cardiac ICU, Children's HDU and neonatal Level 3 (ICU) all areas where staffing is one to one/ one to two care. The table below details the total number of filled and un-filled hours for trained and un-trained staff for the months, including the percentage.

We have areas where the CHPPD are higher as expected e.g. ITU, HDU. Our medical and surgical wards vary between 6.5 hours and 8.8 hours.

The detail below gives a fuller picture of the reasons for a red 'flag' (levels of 80% or below).

	April	May	June	July	Aug	Sept	Oct
No of ward with less Than 80% fill	**6**	**4**	**7**	**9**	**9**	**5**	**6**

The numbers of wards that flagged rose in July and August, when it was more difficult to fill bank and agency shifts due to the school holidays. Mitigations remain that staff are moved to other areas requiring assistance, to ensure all areas are kept safe. Shifts are escalated to bank and agency and, managers, practice educators; nurse specialists provide additional clinical support.

4. Nursing Templates

Calculating staffing requirements is not straight forward and is dependent upon a number of factors. These include; the dependency (acuity) of patients on nursing care and factors such as skill mix of staff available and others including the culture and leadership of the team. The last acuity staffing review was undertaken in January 2017 using the Shelford Model and this review will be undertaken in January 2018 and reported to the Board next spring.

5. Recruitment and retention

Recruitment and retention is becoming more challenging and the Nurse Director for Workforce and Education has developed a recruitment and retention strategy for nursing for both BSUH and Western Sussex Foundation Trust. The projects at BSUH include;

- 12 month rolling recruitment dates set for 2018 with separate dates for HCA and RN (including bank)
- HCA recruitment will be open to all, so that people recruited based on their aptitude rather than previous experience. The care certificate and focussed support will be given to those without experience.
- A new 12 month preceptorship programme for newly qualified nurses – consisting of 10 days of education.
- Rotational programmes are being developed which will include an acute pathway, using high vacancy areas. This will enable nurses to gain a breadth of experience across specialities.
- Improving student experience; to include in-house simulation and training dates, with a plan to recruit these students when they qualify. Currently BSUH only recruit 35% of the nursing student from The University of Brighton.
- Increasing student numbers, the Nurse Director for Workforce and Education is negotiating with the Universities of Surrey, Portsmouth and Southampton as well as Brighton.

Two new committees have been established to support the co-ordinated development of this strategy:

- Nursing and Midwifery Workforce Governance Group; to focus on four key areas; recruitment, retention, grow your own (establishing clear career pathways from apprenticeship to registered nurse) and overseas recruitment.
- The Local Faculty Group; to obtain feedback from our learners on their experiences and this will include all students, overseas recruits, newly qualified nurses and band 4, assistant practitioners

Other actions that have been taken to support the nursing and midwifery workforce include;

- International recruitment in Europe, this market has reduced dramatically, although there continues to be a few new recruits monthly from the EU.
- Outside Europe, on 24th November we are recruiting in the Philippines for 50 nurses, primarily for PRH, as it is harder to recruit there than in Brighton.
- Promoting retire and return – to encourage experienced nurses to extend their careers
- Encouraging flexible working for nurses with caring commitments
- Reviewing other potential options, such as; refer a friend, improvement in the bus service and recruitment bonuses for hard to recruit areas.
- Agency line bookings for areas most challenged, this also supports the withdrawal from the more expensive agencies.

6. Staffing data in each inpatient area

The Trust displays information about the number of nurses, midwifes and care staff present and the number planned, in each clinical area, on each shift. The format of the presentation has been reviewed by service users and some changes made to ensure it is useful for service users. This data is also published on the BSUH external website, in a visible, clear and accurate format for the public.

7. Summary

This report provides information on all wards and departments at BSUH. The Chief Nurse is satisfied that nurse and midwifery staffing in all areas meet safe staffing requirements.
Recruitment of nursing and midwifery staff is essential and will need to continue at pace, locally, nationally and internationally. However, the supply of nurses and midwives is limited and focused activity in the Trust will be on retaining staff, increasing our student numbers and how we develop our own people to become skilled registered practitioners. These measures particularly important as universities are reporting up to a 32% reduction of applicants following the removal of the bursary for student nurses / midwives.