NHS
Sussex Community
NHS Foundation Trust

BOARD OF DIRECTORS – MEETING IN PUBLIC		**Chair:** Giles York
Time: 10:00 – 13:00	**Date:** 28 March 2024	**Venue:** J1 Boardroom, Jevington Building, Brighton General Hospital

AGENDA

Item number	Item	Enc.	Time	Presenter
Introduction and Celebration				
1	Employee and Team of the Month	Y	10.00	Chair
2	Welcome, apologies and declarations of interest	N	10.15	Chair
3	Minutes of the previous meeting	Y	10.15	Chair
4	Matters arising and action log	Y	10.15	Chair
Strategy				
5	Chief Executive's report *To receive*	Y	10.20	CEO
6	2024/25 Corporate Objectives *To approve*	Y	10.25	CFO
7	Improvement Programmes *To review/discuss*	Y	10.30	CN
8	Workforce Equality, Diversity and Inclusion Action Plan *To approve*	Y	10.40	CPO
Performance and Assurance				
9	Staff Survey Results 2023 *To review/discuss*	Y	10.50	CPO
10	Annual Green Plan Progress Report *To receive*	Y	11.00	CFO
11	Integrated Performance Report Month 11 *To review/discuss*	Y	11.10	Executive Directors

12	People Committee Chair's Report *To receive*	Y	11.40	Committee Chair
13	Resources Committee Chair's Report *To receive*	Y	11.50	Committee Chair
Quality				
14	FTSU Guardian Report Q1 & Q2 2023/24 *To receive*	Y	12.00	CN
15	Patient Safety Incidents Report Q3 2023/24 *To receive*	Y	12.10	CMO
16	Mortality Review Report Q3 2023/24 *To receive*	Y	12.20	CMO
17	Quality Improvement Committee Chair's Report *To receive*	Y	12.25	Committee Chair
Governance				
18	Guardian of Safe Working Report Q3 2023/24 *To receive*	N	12.35	CMO
19	Charitable Funds Committee Chair's Report *To receive*	Y	12.45	Committee Chair
20	Audit Committee Chair's Report *To receive*	Y	12.50	Committee Chair
21	Any other business	N	13.00	Chair

Note: Questions from Governors and/or the public will be taken on each item during the meeting. Any other, general questions should be submitted to the following email address for a response outside the Board meeting:

SC-TR.SCTMembership@nhs.net

Resolution: That the remainder of the meeting shall be held in private because publicity would be prejudicial to the public interest, by reason of the confidential nature of the business to be transacted in accordance with the Public Bodies (Admissions to Meetings) Act 1960 s1(2)

Next meeting: 30 May 2024, J1 Boardroom, Jevington Building, Brighton General Hospital

NHS
Sussex Community
NHS Foundation Trust

Board Meeting in Public		Chair: Giles York
Time: 10:00 – 13.00	**Date:** 25 January 2024	**Venue:** J1 Boardroom, BGH

MINUTES

Item number	Item
1	**Welcome, Apologies and Declarations of Interest**

Members:
Giles York, Trust Chair (GY)
Siobhan Melia, Chief Executive (SM)
Mandy Chapman, Non-Executive Director (MC)
Gill Galliano, Non-Executive Director (GG)
Veronika Neyer, Non-Executive Director (VN)
Lesley Strong, Non-Executive Director (LS)
Mark Swyny, Non-Executive Director (MS)
Dipesh Patel, Associate Non-Executive Director (DP)
Donna Lamb, Chief Nurse (DL)
Caroline Haynes, Chief People Officer (CH)
Mike Jennings, Chief Financial Officer (MJ)
Karen Eastman, Chief Medical Officer (KE)
Kate Pilcher, Chief Operating Officer (KP)

In attendance:
Zoe Smith, Trust Secretary (ZS)

Apologies:
Diarmaid Crean, Chief Digital and Technology Officer (DC)

No new declarations of interest were recorded.

2	**Employee and Team of the Month Awards**

Giles York (GY) announced the winners of the November and December Employee and Team of the Month awards.

November Employees of the Month were Michael and Andy Goodwin, porters at Brighton General Hospital. Michael and Andy received two nominations praising their

helpfulness and courtesy. Both nominations identified them 'unsung heroes' who embodied the Trust values of working together and delivering excellence.

Team of the Month for November was the Urgent Community Response team, Brighton and Hove. The team's nomination highlighted the team's role in supporting complex patients. In a recent example of the team's compassionate and holistic care, the team had provided care to a highly vulnerable patient. This included advocating for the patient with local authority partners to ensure that their holistic needs were met as best they could be in the community.

December Employee of the Month was Georgia Malins, a paramedic with the Urgent Community Response team in Worthing. Georgia, who had recently stayed with a patient waiting for an ambulance for four hours after her shift ended, was nominated for her outstanding patient care.

December Team of the Month was the Musculoskeletal (MSK) Waiting Well Pilot. Patients had responded extremely positively to the pilot. It had enabled some patients to be expedited and others to be discharged without seeing a clinician following a phone call and provision of support and information. It was noted that the learnings from the pilot could be applied widely across a variety of teams and services to support patients to wait well.

All winners were warmly congratulated on their awards and thanked by the Board for their outstanding work.

3	**Minutes of the previous meeting on 30 November 2023**

The minutes of the previous meeting on 30 November 2023 were agreed as an accurate record of the meeting.

4	**Action Log and Matters Arising**

The action log was reviewed and updated. All actions proposed for closure were agreed. There were no matters arising.

5	**Chief Executive's Report**

Siobhan Melia (SM) presented the new Chief Executive's (CE) report to the Board meeting in public. The report was highlighted as part of changes in the approach to Board business intended to focus discussion on strategic matters and promote transparency.

SM highlighted the increased scale and system contribution of the Trust's urgent community response (UCR) and virtual wards services. In addition to having 286 community beds open, with 97% occupancy and good flow of admissions/discharges,

the Trust was also providing 112 virtual ward beds and its urgent community response teams were seeing 431 patients in the community. SM thanked staff who were working hard to ensure patients received an effective and responsive service.

SM said that she was delighted to report on the recent opening of the Child Development Centre at Crawley Hospital. There would be an official opening in early March 2024.

Referring to the discussion at the November Board meeting of the temporary closure of Zachary Merton Community Hospital due to patient and staff safety concerns, SM said a report to the Trust on the fabric of the building was expected at the end of January 2024 following a thorough survey.

Turning to national issues, SM highlighted delay in the issue of national planning guidance. Trust planning discussions were progressing, however, it was difficult to undertake some organisational processes including setting budgets and corporate objectives with the usual degree of accuracy. Changes may be required once national guidance is released.

SM provided a verbal update on the recent Sussex NHS Chief Executive Officer's (CEO's) and Chair's forum. The forum had discussed the development of two Sussex provider collaboratives through which provider Trusts would work together to join up patient pathways and reduce unwarranted variation. An acute provider collaborative would be chaired by the CEO of University Hospitals Sussex NHS Foundation Trust and a primary and community care collaborative would be chaired by SM. SM said that NHS Sussex was advertising for a director to be responsible for both collaboratives and that Caroline Haynes (CH) would represent the Trust on the CMO/strategy lead group reporting into the primary and community care collaborative. A meeting of committees in common would provide the overarching governance and mitigate the risk of pathway fragmentation between the two collaboratives. Draft Terms of Reference for a Board sub-committee of each NHS statutory body to make up this meeting were being circulated. Updates would be provided through future CE reports.

Lesley Strong (LS) registered her congratulations on the Trust's management of winter pressures. SM gave credit to Kate Pilcher (KP) and the operational teams and asked KP to pass on the Board's thanks.

KP said that there had been 15 admissions and 20 discharges from Trust intermediate care unit (ICU) beds the previous day. The Board noted this along with the more than 500 people receiving virtual ward/UCR care in their own homes, highlighting the important role of community services.

GY asked about the surveyor's report on Zachary Merton. Mike Jennings (MJ) said that following receipt of the report, the Trust's estates team would scope and cost the remedial works required.

LS asked what assumptions the Trust was making in the absence of planning guidance. MJ said that local assumptions were being applied to develop a Trust plan despite the lack of certainty on the financial envelope and national priorities. Mark Swyny (MS) said that the Resources Committee had been assured that the Trust's assumptions were sound and that work has started.

Veronika Neyer (VN) and Karen Eastman (KE) were welcomed as new Board members.

The Board **noted** the CE's report.

6	**Corporate Objectives and Board Assurance Framework Q3 2023/24**

SM presented the update on Corporate Objectives and the Board Assurance Framework (BAF) reporting good progress against all the corporate objectives.

Thinking forward to the 2024/25 corporate objectives, SM noted the need to balance measurability with assurance that strategic goals would be delivered. For example, whilst the Trust had exceeded its 2023/24 target for delivering new innovations it was important these were also scaled up to deliver the desired benefits. This would be discussed further at the March Board along with a review of the strategy deliverable metrics.

SM highlighted the year-to-date leavers figure under the Great Place to Work strategy deliverable noting that the Trust looked set to meet or exceed its year one ambition to reduce the number of leavers.

MS said that numbers were important to understand the scale of the Trust's ambition and that the three-year strategy would not be fully delivered in year one. In relation to innovation, MS said that the Resources Committee would like to hear more about how innovations were being embedded to make a difference.

Action: Resources Committee to discuss how innovations are being embedded to make a difference.

There was discussion of the Return on Investment in Robotic Process Automation strategy deliverable metric. GY requested that the Resources Committee discuss this further.

Action: Resources Committee to discuss the Return on Investment in Robotic Process Automation strategy deliverable metric.

LS asked about outcomes and the difference being made by the Trust's work on service inequities.

SM confirmed that there would be a final report on achievement against 2023/24 corporate objectives at the May Board meeting in public. The 2024/25 corporate objectives would be discussed by Board in February and March.

Turning to the BAF, SM highlighted key changes since November 2023 including the increase in the Cyber Resilience risk score to 12 and expanded actions to reduce the Data Quality and Effective Use of Data risk. Reflecting on the pace of progress with business intelligence data dashboards, SM said that this needed to be a priority for the Trust. SM noted that the target score for the Estates Risk had increased from six to nine and the target date extended, and that there was a new risk within the BAF relating to Climate Change.

MS reported on Resources Committee discussion of BAF risks stating that the Committee had been comfortable with the increase in the Cyber Resilience risk score but wanted to understand more about the move away from Cyber Essentials + as well as greater assurance that the planned mitigations for this risk were sufficient, notwithstanding the 'unknown unknowns' of cyber risk. The Committee had also discussed the Estates risk and whether there was more volatility in this risk than suggested by the stable risk score, as well as the Climate Change risk which it felt needed to be more clearly about adaptation and the potential impact on staff, patients and the Trust's ability to deliver services in the lifetime of the current strategy.

SM welcomed further Resources Committee discussion of Cyber Resilience risk mitigations and assurances, noting that the Executive Management Group (EMG) had requested a clearer articulation of the Estates risk, informed by real-time estates risks and operational risks with an estates cause.

GY highlighted the challenge of the Trust's estate which was of varying degrees of age and quality and the link to the Trust's strategic goal of being A Great Place to Work. MJ said that a plan was being developed, discussed at the Resources and People Committees, to take a broader view of the state of the Trust's estate including patient and staff perspectives. CH said that the impact of estates issues of staff was significant and frequently discussed at Workforce Group and People Committee.

In relation to Climate Change, MJ agreed that the BAF risk needed to be rearticulated in the context challenges for the Trust in adapting to climate change and the risk of that impacting on staff, patients and services.

Mandy Chapman (MC) reported on People Committee discussions of the Workforce Risk. The Committee had debated whether the risk score should be reduced in view of improvements in workforce metrics. However, as the ongoing medium-term risk of the Trust not having the right numbers of staff with the right skills remained, it had

agreed to maintain the score at 16 pending development of the long term workforce plan. CH said that the Trust also needed to better understand how its staff were deployed which would be achieved through the procurement of a new rostering system to cover all staff.

The Board **noted** the update on Corporate Objectives and the BAF Q3 2023/24.

7	**Improvement – Strategic Improvement Programmes**

Donna Lamb (DL) presented the Improvement – Strategic Improvement Programmes report noting that this was the first time this report had been shared with the Board.

DL highlighted the Trust's self-assessment against the NHS Impact Framework, noting that improvement was happening at all levels of the organisation. The self-assessment finding was that the Trust was in the 'developing/progressing' stage in all five components of the framework.

Turning to the detail on the strategic improvement programmes, DL said that they were at different stages of maturity and asked the Board to consider its role and the role of Board committees in gaining assurance of the programmes.

Gill Galliano (GG) welcomed the report and asked about metrics; how would the Trust know when each programme had been delivered. DL said that some programmes were still in the process of agreeing the change priorities and this would inform the metrics. Agreeing that the Trust's aspiration should be explicit, DL said that there also needed to be acknowledgement of the baseline.

Dr Karen Eastman (KE) said that there was an exciting opportunity to explore metrics around personalised care, for example, supported self-management.

MS said that the metrics needed to articulate the aim of each improvement programme in its entirety and that the anticipated timeframe for achievement of benefits should be stated. MS asked whether the Programme Roadmap bar charts indicated that most were still in analysis phase. MJ said that the bar charts showed the phase that each project within a programme was in and that project progress was shown in the Milestone Achievement charts.

MC suggested encouraging improvement within the Trust by communicating clearly where there had been 'quick wins', as well as positive impact of improvement activity.

LS asked how the Board could find out more about the full breadth of Trust improvement activity. DL committed to consider how this could be shared with the Board.

Action: Consider how to share information on improvement taking place outside of the strategic improvement programmes with the Board.

GY welcomed the new report. It was agreed that the four strategic improvement programmes would be regularly reported to the Board, which would delegate to its sub-committees any areas for particular focus.

Action: Agree frequency of Board reporting of the strategic improvement programmes and wider improvement roster and add to Board calendar of business.

The Board **noted** the Improvement – Strategic Improvement Programmes report.

8	**Integrated Performance Report – Month 8 (November 2023)**

MJ introduced the Integrated Performance Report (IPR) drawing Board members attention to the Trust's Year in Numbers showing the difference its staff made to the people of Sussex and the breadth and volume of the Trust's activity.

GG commended staff on managing increased workload without a commensurate increase in resources.

6.1 Quality Report

DL highlighted the Quality Spotlight report on Infection Prevention and Control (IPC) outbreaks.

Referring to national media coverage of measles, DL confirmed that there had been no national incident declared. National guidance had been issued and a Trust incident management meeting had been stood up to coordinate the its response to the guidance. This had not identified any issues of concern. DL reported that had been no measles outbreaks in Sussex or the South-East region as at 14 January 2024.

6.2 Operational Performance Report

KP presented the Operational Performance report noting ongoing improvement in the average length of stay metric.

In relation to patients not meeting criteria to reside, KP said that this was increasing rapidly, from 36.2% in November to around 43% for January to date. SM said that the impact of this was causing a patient safety risk in West Sussex and that she was involved in escalated calls with the local authority and Integrated Care System (ICS) partners.

Board members discussed the high proportion of the Trust's ICU beds occupied by patients not meeting criteria to reside, noting that the same issue was also affecting virtual wards and UCR. Actions taken included putting the Trust's therapy team into

business continuity to focus on urgent needs of patients in the community and patients due to come out of ICU and acute beds. Asked about contributory factors, KP said there was a shortage of adult social care capacity to do discharge assessments as well as some community equipment delays. The Board noted the impressive work of the Trust on flow and admissions/discharges in the context of the number of patients not meeting criteria to reside.

KP reported that the external provider commissioned by the Trust to undertake 300 neurodevelopmental (NDP) pathway second assessments had now started. Patient and family feedback had been positive but NDP waiting lists were still a significant issue; while 70% of children were waiting less than a year, a small percentage including some children with the most complex needs, were still waiting more than two years for their second assessment. MS asked about the reason for the limited number of external assessments commissioned. KP said that there were both cost and capacity constraints and that the number would be reconsidered at a contract mid-point review.

LS commented that commissioning additional capacity was a short-term measure and that a long-term plan was needed. KP agreed that this was needed at pace and confirmed that national and local conversations with commissioners were taking place.

Members noted the importance of investing in waiting well initiatives for this pathway given the high proportion of positive diagnoses.

In relation to talking therapies, 53.5% of patients had moved to recovery in November which was above the Trust's target, however, performance had been below average for the last ten months. Performance in this metric had been affected by work to reduce waiting times for talking therapies but was now back in the expected range.

Turning to virtual wards, KP confirmed that UCR Plus capacity was included in November virtual ward performance. Virtual ward capacity (109) now exceeded target (100) and occupancy was showing an improved position but was still behind target.

LS asked if the size of the virtual wards team had been increased. KP said that it had in the short-term and discussions were now taking place about next year.

Referring to the 16 scored operational risk of insufficient capacity for clinical demands in the Diabetes Care for You (DCFY) podiatry team, KP said that there had been improved recruitment performance but not to the right levels of seniority which meant that the team were still having to risk stratify patients. A fragile position across podiatry, both within the Trust and nationally, was noted. SCFT operational and recruitment teams were working together to try to expedite recruitment in this area.

6.3 Workforce Report

CH presented the Workforce Report highlighting:

- The rate of staff sickness had increased both within the Trust and across the region. This was expected over winter and the Tust was performing better than the region.
- Improvement in performance and development review (PDR) compliance – CH thanked Scott Hart for his work in supporting corporate services to improve their compliance.
- Low vacancy rate and temporary workforce usage – temporary workforce was a national and regional area of focus. Reduced use of temporary workforce was positive in both financial and quality terms.

In relation to leavers with less than one year's service, CH said that data on this, scrutinised at People Committee, showed significant improvement.

SM commended the reduced vacancy and turnover rates.

6.4 Finance Report

MJ presented the Finance Report highlighting the Spotlight Report on the 2024/25 capital regime. The Trust's nominal allocation of the Sussex system capital envelope for the year was £1.6m less than the amount it had considered its minimum requirement. This would impact on what could be delivered in terms of estates, digital and clinical equipment. MJ emphasised that this was a budgetary constraint and the Trust had sufficient cash to cover higher capital expenditure.

In relation to financial performance, MJ said that the Trust was slightly behind plan at the end of November. Asked about his level of confidence in delivery of the year end break-even position, MJ said that it was probable but there remained some significant risks outside of the Trust's control including the potential for further industrial action.

The Board **noted** the Integrated Performance Report.

9	**People Committee Chair's report**

MC reported on the People Committee's January meeting highlighting improvements in People metrics and continued areas of focus including international recruitment.

MC reported that the Committee had received an update from the Trust's long-term workforce plan project which had highlighted the need for this to reflect wider plans to deliver service strategies as well as enabling strategies for digital and estates. CH and SM commented on EMG discussion of the need further work to fully understand the Trust's future workforce requirements.

GY suggested that integrated community teams might provide a starting point. SM said that the Trust needed consider what was within its gift and what levers it could operate. KP reflected on Resources Committee discussions of the Trust's role in responding to and/or shaping the commissioning environment in which it operates. KE

noted that the Life Stage Framework self-assessment process would inform future service delivery plans, including the use of digital.

MC said that the Trust needed to have clarity about the inputs to the plan and then debate possible outputs.

The Board **noted** the People Committee Chair's report.

10	**Resources Committee Chair's Report**

MS reported on the Resources Committee's January 2024 meeting including discussion of the Trust's current key contracts, noting that changes in the provider selection regime would potentially reduce contractual risk. The Committee had encouraged the Trust to consider where it could lead and influence the wider system.

In relation to MSK procurement, MS confirmed that the Phase one Invitation to Tender (ITT) had been submitted before Christmas. The next stage of the procurement would close by the end of March.

MS said that the Committee had noted the financial challenges facing the Trust.

In relation to estates, the Committee had identified a need to better articulate the Trust's future estate needs in the context of the overall strategy for community services. It was agreed that the Board should discuss this further.

Action: Board seminar session to be scheduled to consider estates and other enabling strategies in the context of the overall strategy for community services.

MS reported on the Committee's discussions of the lessons learned from the Zachary Merton asset transfer including the need for greater visibility of estates related risks and coordination with teams outside of estates, including the IPC team. It was confirmed that a survey had been carried out prior to the transfer, however, this had not foreseen the building's response to the extremely wet weather or the urgency with which works would be required. The Trust would review the level of survey detail required in future as well as considering how wider in-house expertise could contribute to a more rounded understanding of the condition of assets.

The Board **noted** the Resources Committee Chair's report.

11	**Quality Improvement Committee Chair's Report**

LS reported on the Committee's January 2024 meeting. The Committee had reviewed an expanded set of quality metrics, triangulated with staffing metrics, and provided assurance to the Board that the Trust was providing safe care.

LS confirmed that the Trust had fully implemented the new Patient Safety Strategy Incident Response Framework (PSIRF) by the deadline and had also implemented the switch from Datix to InPhase.

The Committee had reviewed an interim Safer Staffing report in January ahead of the March report to Board. There was a high vacancy rate for Nursing Associates, as many went on to train as Registered Nurses, and the committee had endorsed the approach of converting some Nursing Associate roles while retaining roles where possible as part the career path from Health Care Assistant.

The Committee had received a presentation of a formal complaint received from a relative of a patient who was at the end of their life and had gained assurance of learning, actions taken and compassionate handling of the complaint.

The Patient Safety Partner members of the Committee had completed six months service and a review of the roles would be undertaken.

The Committee had received the evaluation of the Electronic Prescribing and Medicines Administration project previously discussed by the Board. The project had achieved or partially achieved 77% of the benefits expected and another evaluation would be undertaken at the end of the calendar year.

The Board **noted** the Quality Improvement Committee Chair's report.

12	**Emergency Preparedness Resilience and Response Annual Report**

KP presented the Emergency Preparedness Resilience and Response (EPRR) Annual Report noting that the Trust was not a Category one responder but that it was important that it responded in a way proportionate to the services it provided.

KP outlined the ways in which the Trust had delivered EPRR requirements during the year and progressed its EPRR approach. She provided assurance that the Trust had a robust governance approach and sufficient resources allocated to EPRR.

KP said that there were three live risks relating to emergency planning on the Trust's risk register, all low or moderate. A new risk relating to industrial action had been accepted during the year. There were also a number of accepted risks reflected in the Local Health Resilience Partnership (LHRP) register.

The continued roll out of the business continuity management programme had been a key focus. A Trust-wide Business Continuity Plan had been ratified in August and there was a much-improved compliance rate for team business continuity plans.

In relation to training and exercising, all new on-call staff were trained and were required to attend a three yearly refresher. There had been an increase in the number

of Strategic and Operational on-call staff, and a decrease in tactical on-call. Strategic on-call staff now received NHS Sussex training for consistency across the system.

KP reported that the Trust was fully compliant with NHS England EPRR core standards as assessed by NHS Sussex, with more core standards applicable to the Trust this year than ever before.

CH thanked the EPPR team for their handling of an incident affecting the recruitment system. The team had provided calm support in a difficult situation.

GY commended KP and the team on achieving full compliance with the core standards and said that he took assurance from the reporting of incidents. He suggested that non-executive directors could be involved in exercises where possible.

The Board **noted** the EPRR annual report.

13	**Fit and Proper Persons Test Framework for Board Members**

Zoe Smith (ZS) presented a briefing on the Fit and Proper Persons Test Framework for Board members.

The Board heard that the framework, which provided additional guidance on the application of the pre-existing Care Quality Commission Fit and Proper Person Test requirements, had been effective since September 2023 for new Board members and leavers, and it would be fully implemented for all Board members by March 2024.

SM noted that the framework, to be overseen by the Chair, was much more robust and required references to be written for all Board leavers regardless of whether they were joining another NHS organisation or not.

The Board **noted** the briefing on the Fit and Proper Persons Test Framework for Board members.

14	**Audit Committee Chair's Report**

GG reported on the January 2024 meeting of the Audit Committee which had started to consider the Trust's internal audit plan for 2024/25 and the timetable for the production of the annual report and accounts.

The Trust's new external audit firm had been in attendance and were working with the Finance team to start on the Value for Money audit and preparations for the annual external audit.

The Board **noted** the Audit Committee Chair's report.

15	**Charitable Funds Committee Chair's Report**

MC reported on the Charitable Funds Committee's January meeting and drew members attention to the Charity Update. MC said that the Charity had now converted the majority of its investments to cash deposits. The market value of the investments had been higher than anticipated which was positive for the general fund. MC highlighted that the Community Link Worker project funded by a grant from the Lawrie Legacy had now started. GY reported on a recent meeting with the Charity Manager, commending her energy and enthusiasm. The Board **noted** the Charitable Funds Committee Chair's report.	
16	**Report from the Council of Governors meeting 16.12.23 and update on governor nominations and elections**
GY presented the report from the Council of Governors December 2023 meeting, highlighting governor attendance at Trust and community events, governor involvement in the development of the Trust's quality priorities and positive feedback on the 2023 governor development day, attended by Stephen Lightfoot, NHS Sussex Chair, as well as governors from partner organisations. The Board **noted** the report from the December 2023 Council of Governors meeting and the update on governor nominations and elections.	
17	**Any Other Business**
There was no other business.	

Close of meeting

SUSSEX COMMUNITY FOUNDATION TRUST BOARD ACTION LOG 28/03/24

Meeting Date	Action №	Agenda Item №	Action	Action Owner	Due date	Progress	Status	Date closed
1/25/2024	006	6	Resources Committee to discuss how innovations are being embedded to make a difference.	MJ/MS	3/25/2024	Discussed at Resources Committee in February 2024.	PROPOSE TO CLOSE	
1/25/2024	007	6	Resources Committee to discuss the Return on Investment in Robotic Process Automation strategy deliverable metric.	MJ/MS	3/25/2024	For discussion by Resources Committee in March 2024.	PROPOSE TO CLOSE	
1/25/2024	008	7	Consider how to share information on improvement taking place outside of the strategic improvement programmes with the Board.	DL	3/25/2024	Further detail on wider improvement work included within the March 2024 Improvement Programmes report (item 7)	PROPOSE TO CLOSE	
1/25/2024	009	7	Agree frequency of Board reporting of the strategic improvement programmes and wider improvement roster and add to Board calendar of business.	ZS	3/25/2024	Improvement report is scheduled for every public Board meeting. Added to Board Calendar of Business.	PROPOSE TO CLOSE	
1/25/2024	010	10	Board seminar session to be scheduled to consider estates and other enabling strategies in the context of the overall strategy for community services.	ZS	3/25/2024	Added to Board Calendar of Business for July 2024.	PROPOSE TO CLOSE	

Sussex Community NHS Foundation Trust

Report to:	Trust Board	**Meeting date**:	28 March 2024			
Report title:	CEO's Report	**Agenda number**:	5			
Author(s):	Mike Jennings, Deputy Chief Executive	**Owner(s)**:	Siobhan Melia, Chief Executive			
Purpose:	**Decision/Approval**		**Assurance**		**Briefing**	X

Link to Trust Strategic Goals:		
A Great Place to Work	X	
Continually Improve	X	
Digital Leader	X	
Reducing Service Inequities		
Sustainability	X	

Link to corporate objectives and BAF risks

The CEO's report provides a summary of the Trust's key activities and issues of note from January 2024 to date. The updates in the March CEO's report are particularly relevant to the strategic goals indicated above.

Link to Care Quality Commission (CQC) questions:

The CEO's report is provided for information. While it is not designed to provide specific assurance, the report's content may provide additional evidence across the range of CQC key questions (Caring, Effective, Responsive, Safe, Well Led).

Executive summary:

This report provides a summary of the Trust's key activities and issues of note from January 2023 to date.

Outcome/action requested:

The Board is asked to note the CEO's report.

Equality, diversity and/or reducing inequities:

There are not considered to be any equality or diversity implications arising from this report.

Previously reviewed by:

N/A

Chief Executive's Board Report

March 2024

This report provides a summary of the Trust's key activities and issues of note from January 2024 to date.

Operational update

We are continuing to see sustained, increased demand across our services, with industrial action in February contributing to wider system pressures.

Our Urgent Community Response (UCR) teams continue to receive an increased number of referrals, particularly in support of admissions avoidance. However, an increase can also be seen when looking at supported discharge. So far, in 2024, our UCR teams have received an average of 426 admission avoidance referrals and 159 supported discharge referrals a week. That includes 218 supported discharge referrals in the last week of January, the highest number for at least two years.

Within our UCR service I am pleased to report that we are working closely with South East Coast Ambulance Service (SECAmb) and successfully launched a new joint web portal across all UCR teams in Sussex. The new portal was rolled out in a staged approach, with all teams live by 1 March. The portal builds on an already established daily joint meeting, which on average was identifying nine additional referrals a week for the UCR service. That has already more than doubled since the portal was introduced. This has meant our teams are able to access referrals more quickly and are able to respond and provide care to patients who may not require an ambulance response but still require urgent care at home.

In January and February 2024 we've seen a high level of demand across our Urgent Treatment Centres and Minor Injuries Units. We saw more than 23,500 patients across this two-month period which is an increase of 9.5% when compared to the same period last year.

Our MSK Physio service in coastal West Sussex has also continued to see a rise in activity. In the 12 months to the end of February the number of patient appointments is up almost a quarter on the year before.

As mentioned in our January board meeting, following the opening of our Children's Development Centre on 8 December we arranged a formal opening event which took place on Wednesday 6 March. Partners from across Sussex joined us, along with children and their families, to formally celebrate the new facility and see the difference the new space will make to the care we provide. The development project had been underway for a number of years, and I am incredibly pleased to see it come to fruition, and to see firsthand the positive impact it's having on our patients in Crawley and the surrounding areas.

Estate update

In our January board meeting I updated on the temporary closure of Zachary Merton Hospital as we were awaiting a comprehensive condition survey and report. We have received the report from the independent consultant and are now awaiting a detailed analysis to understand the extent of the works required. A second dependency before we can determine the timing and extent of any maintenance works is the completion of the operational plan

across Sussex, which will give us certainty on the availability of capital funding – NHS planning has been delayed for the coming financial year, but the final plans are expected to be agreed during April.

Areas of focus

On 7 March the results from the 2023 NHS Staff Survey were published. I am pleased that 72% of colleagues in the Trust took part in the survey, making this the third year running our response rate has stayed above 70%. We will be continuing to highlight the impact the results have within our Trust to encourage more colleagues to respond each year.

When looking at our results, it's positive to see that we have significantly improved on all parts of the People Promise. I am also incredibly proud that we have made improvements on the three headline results:

- 74% of colleagues would recommend the organisation as place to work. This is an increase of five percentage points from last year.
- 80% of colleagues would recommend our Trust as place to receive treatment.
- 82% of colleagues believe the care of patients/service users is our organisation's top priority.

Our teams are reviewing their local results to identify the areas they have done well in and the areas they may want to focus on for the coming year. At a corporate level, our People Directorate are continuing to analyse the Trust-wide results and we will be using these to help inform key areas of focus for the organisation.

Recognising the contributions our staff networks make to the Trust is incredibly important as we continue to strive to create a great place to work for our people. I am pleased to formally share that we have a new Chair of our Black, Asian and Minority Ethnic Network and would like to welcome Karleen Parchment, Assistant Director of Nursing, to the role. Karleen will continue to build on the work led by Dr Vivek Patil to provide support and guidance to colleagues. The network has updated its name to reflect the inclusive and collaborative nature of the network community and is known as EMBRACE (Ethnic Minorities Broadening Racial Awareness Cultural Exchange).

In February, we recognised and celebrated LGBT+ History Month within the Trust. This year's theme focused on 'Medicine – #UnderThe Scope' and our LGBTQIA+ Network held events virtually and in person for colleagues to attend, this included a themed quiz to mark the end of the month which colleagues across the Trust attended.

We also celebrated the contribution apprentices make to our workforce as part of National Apprenticeship Week. We have 132 clinical and non-clinical apprentices within the Trust who are gaining work experience whilst working towards their qualifications and we will be looking to increase this number over the coming year.

Engagement activities

We were delighted to welcome NHS England's Deputy Chief Scientific Officer, Vicki Chalker, to Chailey Clinical Services in February. Vicki met with Donna Lamb, our Chief Nurse, and healthcare scientists to see the Rehabilitation Engineering Service and Chailey Communication Aid Service. The team were able to demonstrate the innovative approaches they use to create and provide assistive technologies to children and young people.

In March, we held our Joint Board of Directors and Council of Governors meeting. The meeting, which takes place twice a year, provides an important opportunity for the Council of

Governor's to seek assurance on Trust performance and discuss key issues. We were pleased to hear feedback from our governors and hear the outcome of our recent governor nominations and election process. I am pleased to welcome four new public governors to our Council of Governors who will be taking up their roles from 1 April. Welcome to Colin Oliver-Redgate for Arun, Victor Mac Fadden for Brighton and Hove, Hazel Hellier for Crawley and Jurgen Gainz for Mid Sussex.

Regional and national issues

Planning guidance

As detailed in the last board report, we continue to await the operational planning and contracting guidance for 2024/25. We have received high level guidance nationally to support financial planning and are using this to guide our financial plans based on existing priorities. Alongside other providers in Sussex we have submitted our draft operational and financial plan to NHS Sussex who are submitting a system return. Final plans are being developed and approved in April.

Regional update

We are working closely with NHS Sussex to support the delivery of the system strategy 'Improving Lives Together'. We are supportive of a new governance structure which is being introduced to support closer system working and provide shared direction across the system.

As part of this structure a Community Provider Collaborative is being developed which will oversee transformational work and key components of the 'Improving Lives Together' strategy. This development will see a shift in decision making, empowering providers to make changes and improve services so we can continue to improve outcomes and patient experiences across all our services.

The development of Integrated Care Teams (ICTs) is also a key element of the 'Improving Lives Together' strategy and builds on the existing projects and programmes which have focused on integrated care in Sussex. Led by NHS Sussex, ICTs will bring together organisations such as those in community care, mental health, primary care, the voluntary sector and more, to work more closely together to best meet the needs of our local communities. This is particularly important for SCFT as our teams already working within the community will play a core role in the ICTs. As the Chief Executive responsible for overseeing the delivery of ICTs in Sussex, on behalf of Sussex healthcare, I welcome these developments and look forward to working more collaboratively for the benefit of all our communities in Sussex.

Sussex Community NHS Foundation Trust

Report to:	Trust Board	**Meeting date**:	28 March 2024
Report title:	Corporate Objectives 2024/25	**Agenda number**:	6
Author(s):	Mike Jennings, Chief Financial Officer, Deputy Chief Executive & other Executive Directors	**Owner(s)**:	Mike Jennings, Chief Financial Officer, Deputy Chief Executive & other Executive Directors

Purpose:	**Decision/Approval**	X	**Assurance**		**Briefing**		

Link to Trust Strategic Goals: *(If yes, please explain any links)*

A Great Place to Work	X	
Continually Improve	X	
Digital Leader	X	
Reducing Service Inequities	X	
Sustainability	X	

Link to corporate objectives and BAF risks

Corporate Objectives exist to drive delivery of the Trust's Strategic Goals and are therefore framed within them. Corporate Objectives set demonstrable steps toward achievement of the Strategic Goal 'Criteria for Success' and the achievement of benefits for patients and/or staff. The proposed Corporate Objective for A Great Place to Work, the implementation a new staff electronic rostering system across our entire workforce, helps to mitigate the Trust's Workforce BAF risk.

Link to Care Quality Commission (CQC) questions:

Caring		
Effective	X	Delivering evidence-based care and treatment
Responsive	X	Equity in Experiences and Outcomes
Safe	X	Safe and Effective Staffing
Well-Led	X	Learning, Improvement and Innovation

Executive summary:
Corporate objectives are specific, realistic and measurable goals which an organisation plans to achieve within a given period of time. They should be tangible deliverables that are clearly based upon the Trust's vision and strategy and the agreed success criteria that the strategy sets out. Whereas the strategy covers a three-year period, corporate objectives are set annually. There is a significant body of work on-going across Trust Improvement Programmes and through Enabling Strategies. It is from this body of work that the Corporate Objectives for 2024/25 have been derived therefore avoiding introducing new/additional work requirements. This forms a reinforcing circle and ensures alignment of work with Strategic Goals as well as refining and refocus efforts. The development of Corporate Objectives for 2024/25 was discussed by the Board in February and with the Council of Governors at the Joint Board and Council of Governors meeting on 13 March 2024. Taking into account feedback from those meetings, the executive have now set the final corporate objective definitions, and identified success measures that will demonstrate delivery during the coming year. The Corporate Objectives 2024/25 are now presented for Board approval
Outcome/action requested:
The Board is asked to review and approve the Corporate Objectives 2024/25.
Equality, diversity and/or reducing inequities:
Improving health and care outcomes, including meeting the needs of diverse communities and tackling health inequalities, is integral to the Trust's strategy, along with reducing disparities in staff experience.
Previously reviewed by:
The Corporate Objectives 2024/25 have previously been reviewed by the Executive Management Group, the Trust Board and Trust Board & Council of Governors.

Sussex Community
NHS Foundation Trust

Our Strategy

2022-2026

Corporate Objectives 2024-25

Created :22nd March 2024

Excellent care at the heart of the community

Overview

Overview of the principles to be used to develop Corporate Objectives 2024-25

- Corporate Objectives should exist to drive delivery of the Trust's Strategic Goals. They will therefore be framed within them.
- There is a significant body of work on-going across Improvement Programmes and through Enabling Strategies. It is from this body of work that Corporate Objectives will be derived therefore avoiding the potential to introduce new/additional work requirements. This will form a reinforcing circle and ensure alignment of work with Strategic Goals and refine and refocus efforts where alignment is low.
- Corporate Objectives should be written in such as to ensure they set demonstrable steps toward achievement of the Strategic Goal 'Criteria for Success' and be clear as to the benefit for patients and/or staff.

Overview of the timeline to develop Corporate Objectives 2024-25

- **Through March** – Draft Corporate Objectives have been refined and KPIs developed by the Executive supported by Committee chairs, as well as shared with the Council of Governors at the joint CoG/Trust Board.
- **March Trust Board** – Corporate Objectives and success measures are presented to the Board for approval.

Draft Corporate Objectives

Overall alignment

	Strategic Goals				
	A great place to work	Reducing service inequities	Continually improve	Digital leader	Sustainability
Caroline Haynes We will improve staff deployment and have the right people with the right skills in the right place at the right time by implementing a new staff electronic rostering system across our entire workforce					
Karen Eastman We will offer improved access to our services by implementing a methodology to understand the demographic data behind our DNA rate to engage with patients at greater risk of DNA					
Kate Pilcher We will support people to access urgent and emergency care in the right place, at the right time by developing a consistent out of hospital model.					
Donna Lamb We will improve access, make best use of team capacity and improve patient experience by developing and implementing a pathway specific best practice model for virtual consultations, supported by tools and training					
Mike Jennings We will identify unwarranted variation and areas to improve outcomes for patients by empowering staff to be data curious through new interactive dashboards					

A GREAT PLACE TO WORK

	Criteria for Success				
	Fewer people will leave our Trust, and through improvement in how we recruit, and more agile ways of working, we will have a reduced vacancy rate.	As we deliver new and innovative patient pathways, we will enable our people to work in ways that prioritise skills, values, tasks and competencies and complement traditional roles.	Our people will know where they are, and where they are going on our career framework. Continuous opportunities to learn and develop will be enabled by our Learning Academy which will utilise the breadth of knowledge and opportunities across our system.	Our people will have a greater sense of belonging, as we reduce the disparities in the experiences they have at work and continue to ensure they have the freedom and support to speak up.	Through a more coordinated and proactive approach to occupational health and wellbeing more people will feel supported to be well at work.
We will improve staff deployment and have the right people with the right skills in the right place at the right time by implementing a new staff electronic rostering system across our entire workforce					
We will offer improved access to our services by implementing a methodology to understand the demographic data behind our DNA rate to engage with patients at greater risk of DNA					
We will support people to access urgent and emergency care in the right place, at the right time by developing a consistent out of hospital model.					
We will improve access, make best use of team capacity and improve patient experience by developing and implementing a pathway specific best practice model for virtual consultations, supported by tools and training					
We will identify unwarranted variation and areas to improve outcomes for patients by empowering staff to be data curious through new interactive dashboards					

REDUCING SERVICE INEQUITIES

	Criteria for Success			
	Patients will have access to our services in ways which actively account for underlying inequalities, thereby targeting resources where they are needed most.	There will be greater consistency in the type and capacity of our services across geographies, we will have reduced unwarranted variation in their design by working with our partners.	The time from identifying inequities in our services to addressing them will be shorter, as we effectively use data and intelligence alongside feedback from our patients, our staff and our partners.	Service managers will have timely demographic information to improve service monitoring, which will promote better decision making about access. Every service will be able to describe their patient profile and tell us how they have used this to make a difference to what they offer.
We will improve staff deployment and have the right people with the right skills in the right place at the right time by implementing a new staff electronic rostering system across our entire workforce				
We will offer improved access to our services by implementing a methodology to understand the demographic data behind our DNA rate to engage with patients at greater risk of DNA				
We will support people to access urgent and emergency care in the right place, at the right time by developing a consistent out of hospital model.				
We will improve access, make best use of team capacity and improve patient experience by developing and implementing a pathway specific best practice model for virtual consultations, supported by tools and training				
We will identify unwarranted variation and areas to improve outcomes for patients by empowering staff to be data curious through new interactivedashboards				

CONTINUALLY IMPROVE

	Criteria for Success			
	Quality Improvement (QI) methodology and approaches will be embedded throughout the organisation enabled by access to learning, guidance and mentoring to improve care for the people who use our services.	Patients and their families, including children and young people, will be more involved in how we design and plan improvements in our services, as well as in decisions about their own care.	We will learn through an open approach when things go well and when things go wrong; we will drive safety through learning which will have, at its heart, the voice of our patients.	Research activity will increase as we continue to promote, undertake and use research as part of how we improve.
We will improve staff deployment and have the right people with the right skills in the right place at the right time by implementing a new staff electronic rostering system across our entire workforce				
We will offer improved access to our services by implementing a methodology to understand the demographic data behind our DNA rate to engage with patients at greater risk of DNA				
We will support people to access urgent and emergency care in the right place, at the right time by developing a consistent out of hospital model.				
We will improve access, make best use of team capacity and improve patient experience by developing and implementing a pathway specific best practice model for virtual consultations, supported by tools and training				
We will identify unwarranted variation and areas to improve outcomes for patients by empowering staff to be data curious through new interactive dashboards				

DIGITAL LEADER

	Criteria for Success				
	More patients will be in control of how they interact with our services, with at least half of our services able to communicate to patients online, for example with the NHS app.	More of our services will make effective use of remote monitoring enabling patients to live independently, safe in the knowledge that face-to-face consultations will be used whenever they are required.	A true shared care record will be available to all staff across the NHS in Sussex to both improve the safety and effectiveness of clinical decisions and provides real time operational data to manage our patients' pathways.	Identified repetitive tasks will be automated and complex systems will be more intuitive and quicker, reducing the burden on our patients and staff saving time and releasing time to focus on what matters.	Our systems and data will be resilient and secure as technology becomes ever more integrated in how our services operate.
We will improve staff deployment and have the right people with the right skills in the right place at the right time by implementing a new staff electronic rostering system across our entire workforce				■	■
We will offer improved access to our services by implementing a methodology to understand the demographic data behind our DNA rate to engage with patients at greater risk of DNA				■	■
We will support people to access urgent and emergency care in the right place, at the right time by developing a consistent out of hospital model.		■			
We will improve access, make best use of team capacity and improve patient experience by developing and implementing a pathway specific best practice model for virtual consultations, supported by tools and training		■	■		■
We will identify unwarranted variation and areas to improve outcomes for patients by empowering staff to be data curious through new interactive dashboards					■

SUSTAINABILITY

	Criteria for Success					
	Our carbon footprint will have reduced by a further 10% against our 2010 baseline. Guided by our Green Plan, 80% of our fleet will be fully electric, sustainability principles will be embedded into the design of care pathways and Chailey Clinical Services will be net zero.	We will support our ICS to co-ordinate a partnership approach to environmental sustainability to maximise our collective and positive impact.	Construction to redevelop the Brighton General Hospital Site will have begun, marking a new future for community health services in East Brighton.	Our workforce will be more agile in how and where they work as we will have invested in digital systems and practices that enable them to do so.	We will understand and benchmark the value of our services in ever greater detail using new systems and the expanded use of the NHS community services data set, we will use this information with partners to improve the value delivered in our services.	Our buying power will have increased as we will be working at scale with our partners to deliver maximum value for our patients using collaborative procurement.
We will improve staff deployment and have the right people with the right skills in the right place at the right time by implementing a new staff electronic rostering system across our entire workforce						
We will offer improved access to our services by implementing a methodology to understand the demographic data behind our DNA rate to engage with patients at greater risk of DNA						
We will support people to access urgent and emergency care in the right place, at the right time by developing a consistent out of hospital model.						
We will improve access, make best use of team capacity and improve patient experience by developing and implementing a pathway specific best practice model for virtual consultations, supported by tools and training						
We will identify unwarranted variation and areas to improve outcomes for patients by empowering staff to be data curious through new interactive dashboards						

Success Measures

Caroline Haynes We will improve staff deployment and have the right people with the right skills in the right place at the right time by implementing a new staff electronic rostering system across our entire workforce	Q1 – Complete system procurement and set mobilisation plan with supplier Q2 – Mobilise tranche 1 of services on to system Q3 – mobilise tranche 2 Q4 – mobilise tranche 3, report on benefits realised to date.
Karen Eastman We will offer improved access to our services by implementing a methodology to understand the demographic data behind our DNA rate to engage with patients at greater risk of DNA	Q1 – Methodology created and data review Q2 – Did Not Attend (DNA) data segmented to identify the demographics Q3 - Identify greatest impacts in services and demographics and create plan to improve access and reduce rates for those who DNA Q4 – Implement plans and report on DNA rates
Kate Pilcher We will support people to access urgent and emergency care in the right place, at the right time by developing a consistent out of hospital model.	Q1 – Standardise Urgent Community Response service models, define outcomes Q2 – review and improvement of Admissions Avoidance Single Point of Access (AASPA) Q3 – Standardise Urgent Treatment Centre (MIU) and Minor Injuries Unit (MIU) service models Q4 – Review progress against defined outcomes
Donna Lamb We will improve access, make best use of team capacity and improve patient experience by developing and implementing a pathway specific best practice model for virtual consultations, supported by tools and training	Q1 - Agree scope and project plan and launch pilot in 5 services Q2 – Support materials reviewed and updated and staff toolkit launched Q3 – Learning from pilots shared, patient toolkit launched, phase 1 started Q4 – Phase 1 completed – patient experience report produced, evidence of increase in virtual consultations
Mike Jennings We will identify unwarranted variation and areas to improve outcomes for patients by empowering staff to be data curious through new interactive dashboards	Q1- Identification of priority services lines for new dashboard, development of training materials and programme Q2 – Production of tranche 1 dashboard – launch of training Q3 – tranche 2 service dashboards – data for improvement event at leadership conference Q4 – tranche 3 service dashboards – evidence of number of dashboards/services supported, and utilisation rates

Report to:	Trust Board	**Meeting date**:	28 March 2024
Report title:	Improvement update and strategic improvement programmes	**Agenda number**:	7
Author(s):	Michelle Eades, Acting Deputy Director Development & Partnerships, Gillian McTaggart, Associate Director Quality Improvement, Vanessa Dallas, Associate Director Service Development and PMO	**Owner(s)**:	Donna Lamb - Chief Nurse

Purpose:	**Decision/Approval**		**Assurance**	x	**Briefing**	

Link to Trust Strategic Goals: *(If yes, please explain any links)*		
A Great Place to Work	x	Supports training, development and encourages innovation and leadership
Continually Improve	x	Improvement leadership
Digital Leader	x	Supports digital innovation
Reducing Service Inequities	x	Supports inclusive stakeholder engagement
Sustainability	x	Sustainability metrics linked to improvement programmes

Link to corporate objective and BAF risks
Supports the delivery of all corporate objectives

Link to Care Quality Commission (CQC) questions:		
Caring		
Effective	x	Delivering evidence based care and treatment, monitoring and improving outcomes
Responsive	x	Person-centred care, listening to and involving people,
Safe	x	Learning culture

Well-Led	x	Shared direction and culture, capable, compassionate and inclusive leaders, learning, improvement and innovation

Executive summary:

Improvement is a key thread of our Trust Strategy which states our commitment to continuously improving services and supporting our people to have the skills to meet the needs of our local population.

This report provides an update from the Improvement Leaders Group and a summary of the consolidated list of improvement work that is underway in the trust. This shows the total number of improvements and the level at which they are taking place, with the largest volume of improvement work being undertaken at service and team level within our operational teams.

The Life Stage Service framework self assessment audit tool is designed to understand the trusts baseline alignment with the ambitions set out in the LSF strategy document. This has been completed by frontline clinical teams with incredibly high level of engagement. The key improvements actions or projects from each team are being collated to include in business planning where appropriate. Further detailed data analysis is underway to triangulate the output of the tool with staff survey results, workforce and incident data amongst others. The outputs of the analysis will provide significant data led opportunities for improvement at both team, area and trust wide level.

This paper also provides a detailed update for the four strategic Improvement Programmes (Urgent and Emergency Care, Community Nursing, Planned Care and Workforce Systems).

Outcome/action requested:

The Trust Board is asked to review the information in the report and specifically:

1. Note the progress with the consolidated view of improvement work underway and the completion of the Life Stage Service Framework self assessment audit tool.

2. Note the updates from the strategic Improvement Programmes and agree further reporting, including role of the Board sub-committees.

Equality, diversity and/or reducing inequities:

No EIA has been completed but the principles of equality are fundamental to improvement.

Previously reviewed by:

Executive Management Group has reviewed the strategic improvement programme reports.

Sussex Community
NHS Foundation Trust

SCFT Improvement update

Date: March 2024

Presented by: Donna Lamb, Chief Nurse

Excellent care at the heart of the community

Improvement Leaders Group - update

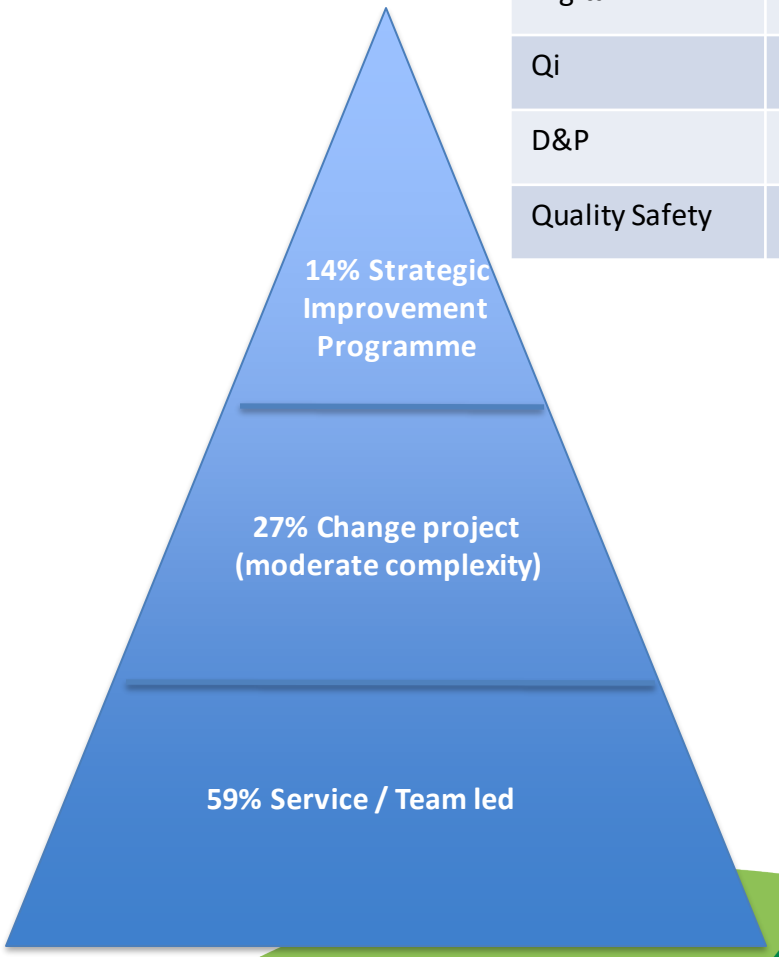
- The Improvement Leaders Group (ILG) continues to provide leadership to the improvement agenda. Key areas of work include:
- The production of a first draft Improvement Portal mock up; a further workshop will be held to refine this further before sharing wider with colleagues for feedback
- The consolidation of a register of all known improvement work underway (a summary table is on slide 3), noting:
  - The consolidated list reflects the large number of live improvement work/projects across all levels of the Trust, with alignment to the Trusts goals and objectives
  - Review of the multiple stakeholders involved demonstrates that the Strategic Improvement Programmes have the highest levels of cross-working between different teams and departments, reflecting that these work programmes are resource intensive due to the high complexity of changes
  - There are a large number of projects being led through Qi and Digital teams, and locally within teams/services. The digital clinical safety and innovations work are listed separately whereas the Qi work is more embedded within the existing reporting structures and localities.
  - It appears that a very small number of projects may have been double counted; the next step is to further refine the register of improvement work at the March ILG meeting to produce an updated and more robust version
  - The ILG plan to also review the categories of improvement programme definitions
- The ILG have been requested to support the initial planning discussions for the 2024 SCFT Leading for Improvement conference

Single view of improvement work

The 212 improvement projects can be categorised by both locality and improvement teams involved:

Programme/Portfolio	No.
Strategic Improvement: Community Nursing	8
Strategic Improvement: Planned Care	13
Strategic Improvement: Urgent and Emergency Care	30
Strategic Improvement: Workforce	8
Chief Nurse	7
Estates	1
People	7
Children and Specialist	29
East	20
West Sussex	13
Digital Innovations	32
Frontline Digitisation	17
Digital Transformation	4
Quality and Safety	9
Qi	14

Improvement team	Projects supported
Operations	152
Digital	95
Qi	74
D&P	36
Quality Safety	17



Life Stages Framework (LSF) Self-Assessment – developed to build improvement into everything we do

- The self-assessment audit tool was designed to understand the trusts baseline alignment with the ambitions set out in the LSF strategy document. A series of "we statements" were developed for front line clinical teams to rate themselves against e.g. “we will ensure all our patients have care plans documented and shared with them in an accessible format“.

- The audit tool provided same day results for staff on SCHOLAR. Teams were encouraged to identify 3 key improvements actions or projects. These actions are currently being collated by general managers and included in business planning where appropriate.

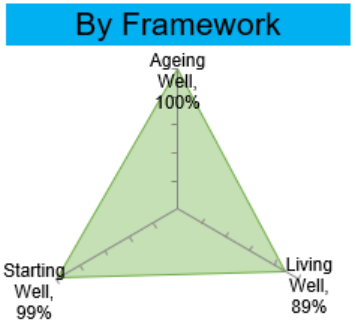
- Engagement from all parts of the organisation has been incredibly high, 96% of all individual teams in scope have submitted a self-assessment.

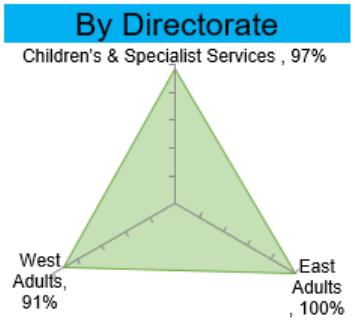
- Detailed data analysis is underway, triangulating LSF output with staff survey results, workforce and incident data amongst others. The outputs of the analysis will provide significant data led opportunities for improvement at both team, area and trust wide level.

- As far as we know, SCFT is the first community provider nationally to have conducted a trust wide audit based on locally developed standards for community care delivery. This is an innovative approach to understanding our internal variation as set out by standards of care developed with patients, carers and staff.

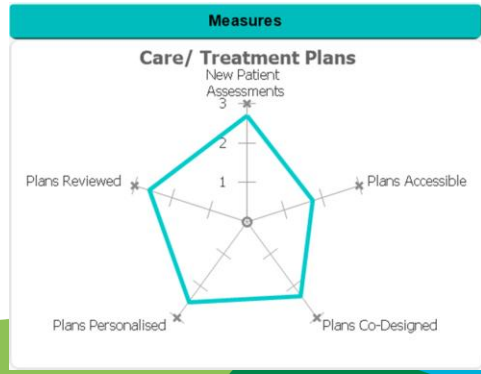
- The audit outputs will support trust wide improvement on different levels.
  - Team and locality level via business planning
  - Trust wide improvement through the quality account priorities.

- Initial trust wide improvement themes emerging from the data include:
  - Personalised care
  - Patient transitions
  - Patient communication
  - Digital access (appointment management and virtual consultation)





Audit output example



NHS IMPACT baseline for improvement

- The NHS IMPACT baseline for improvement was completed in August 2023 and collected a rapid and measurable overview of improvement across the entire NHS, including NHS England national and regional teams.
- By focusing on resources and methodologies, the Baseline for Improvement acted as an initial 'needs assessment' enabling informed decisions and to identify areas of existing capability.
- The Baseline for Improvement is complementary to the NHS IMPACT Self-Assessment which is a developmental tool for organisations and systems to use to assess their current position against the five components of NHS IMPACT and to frame their improvement development plans. This has already been carried out by the ILG who are currently developing local improvement plans.

Results summary for all provider organisations (SCFT fulfil all four criteria):

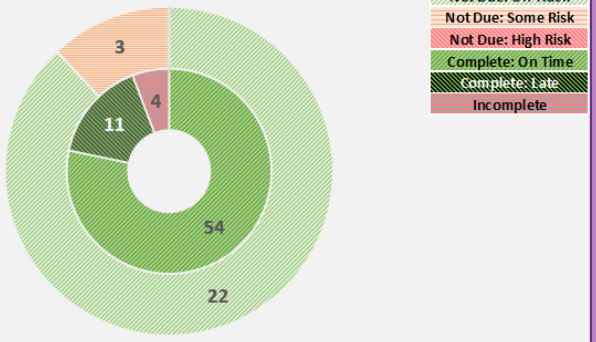
Leadership	Tools	Governance	Capability
Exec responsibility	Improvement methods	Reporting	Staff training
96%	95%	84%	41%
Most providers have an exec responsible and accountable for improvement.	Most providers are using an agreed improvement method or approach with quality, service improvement and redesign (QSIR) the most cited followed by LEAN.	Have a quality strategy with a measurement framework monitored by the board (in addition to the regulatory requirement for a quality account).	Include improvement training as part of staff induction.

SCFT strengths include improvers network, life stage framework, ability to demonstrate 'top down' and 'bottom up' improvements.

Strategic Improvement Programme Updates

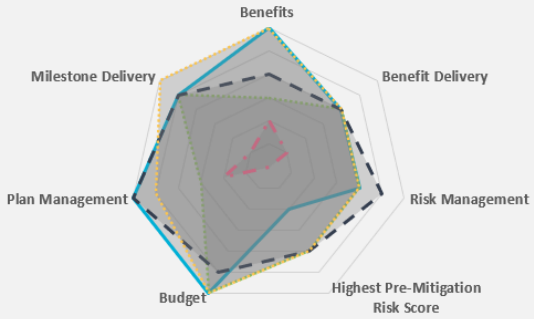
Urgent and Emergency Care Improvement Programme Status

Programme: Urgent & Emergency Care | Programme ID: 1 | March 2024

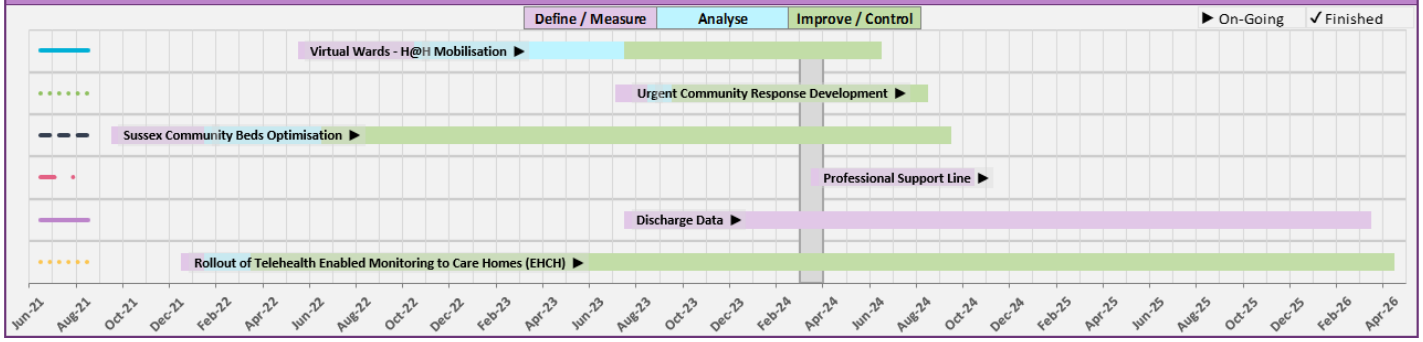


Not Due: On Track
Not Due: Some Risk
Not Due: High Risk
Complete: On Time
Complete: Late
Incomplete

Programme Maturity



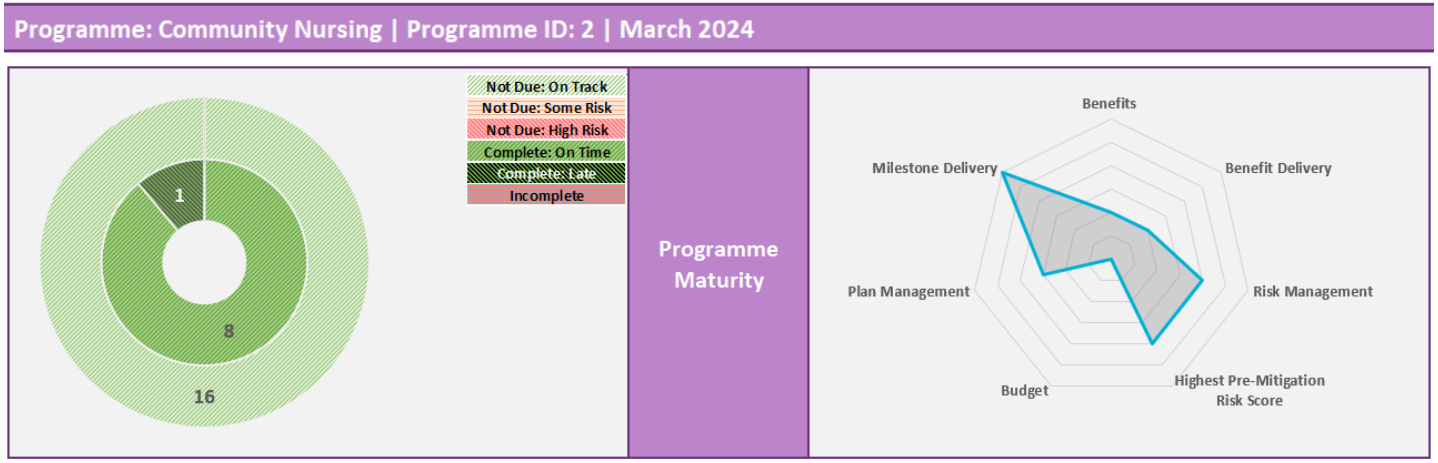
Programme Roadmap

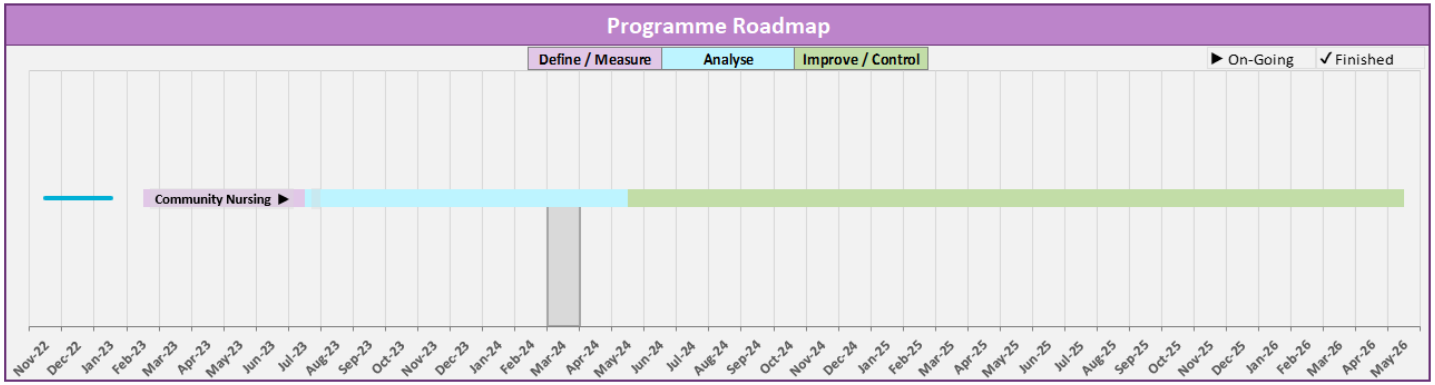


Programme Status

- A new project for provision of a Professional Support Line has been added to the programme following approval at EMG.
- Whilst there is a reduced overall risk to milestones there is some risk with milestones in the UCR project due to a delay in developing the UCR live dashboard and the focus on contributing to future UEC pathways.
- There is also some risk in the Telehealth project milestone to access data from acute partners. The priority of the data to support the UEC improvement programme is being discussed in March as part of the prioritisation review with the digital data team and the Performance team have joined the Steering Group to provide updates on progress with the digital enablers for projects.
- The end date of the Community Beds programme final phase has been extended to Sept 24. This is to allow time to embed changes and establish robust arrangements to monitor these changes and to oversee ongoing improvements.

Community Nursing Improvement Programme Status





Programme Status

- The improvement programme is maturing with workstream leads identified and in place.
- Initial programme meetings have taken place to engage the leads, agree the governance and supporting structures and the steps to identify the improvements for the first phase.
- Phase 1 is due to start implementing improvements from June 24.
- The supporting governance is established with a Community Nursing Development Group which consists of community nurses from across the trust. They will be the clinical reference group to assess and assure the proposed improvements against best practice and provide wider engagement and communications.
- The programme Steering Group recognise the need for widespread engagement with stakeholders to fully realise benefits and are developing comms and engagement plans to support this.

Community Nursing Improvement Programme metrics

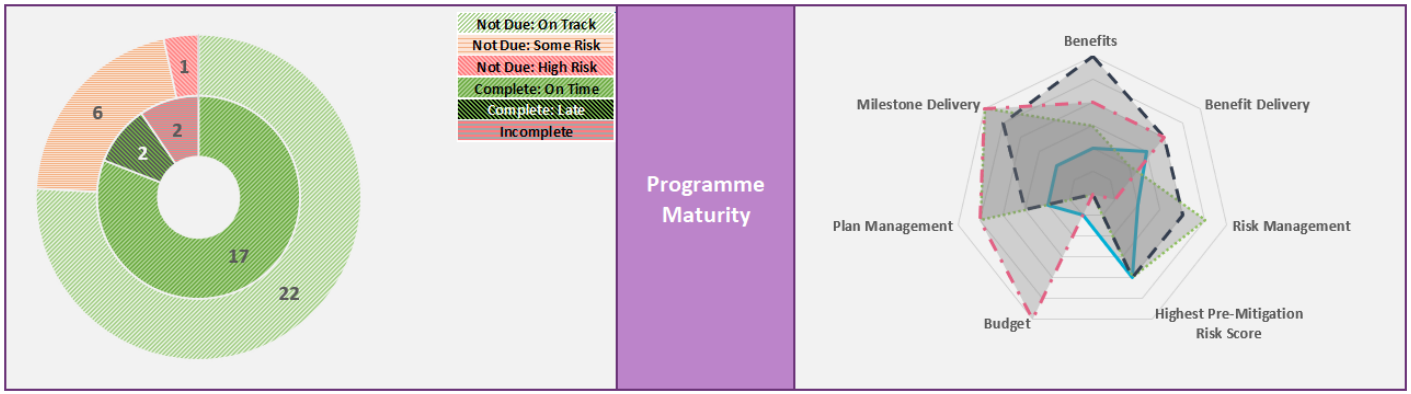
- The programme group have met and reviewed the initial measure and agreed three further metrics for the programme as set out in the table below.

Project	Metric
Community Nursing	• Average length of stay on Community nursing caseload (target average of 70 days) • Caseload numbers by clinical WTE • Average time on caseload in days • Number of face to face contacts per unique service user

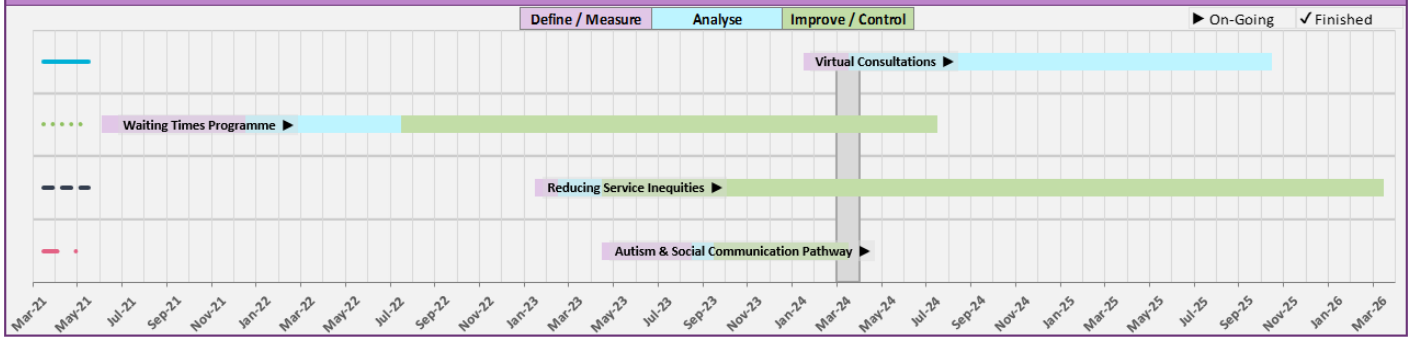
- The new measures have been identified to help to identify the key themes and trends during phase 1, and to help to identify the most appropriate metrics and targets to measure and monitor the programmes impact as it moves through phased delivery.
- The new measures do not have targets set at this early stage and, as the improvements to be implemented are identified by the workstreams, the measures will be reviewed.
- These measures will be reported to the programme through the Community Nursing Improvement Programme performance dashboard report which has been developed in discussion with the Performance team. The initial dashboard report will be available in April 2024.
- This will provide a baseline of current status and support conversations with the workstreams to understand current practice and challenges.

Planned Care Improvement Programme Status

Programme: Planned Care | Programme ID: 3 | March 2024



Programme Roadmap

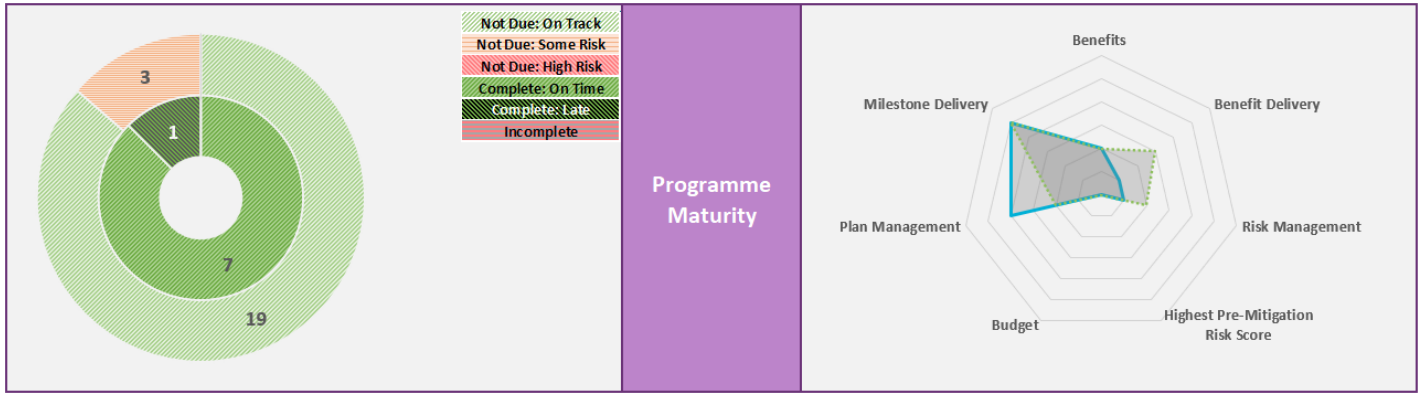


Programme Status

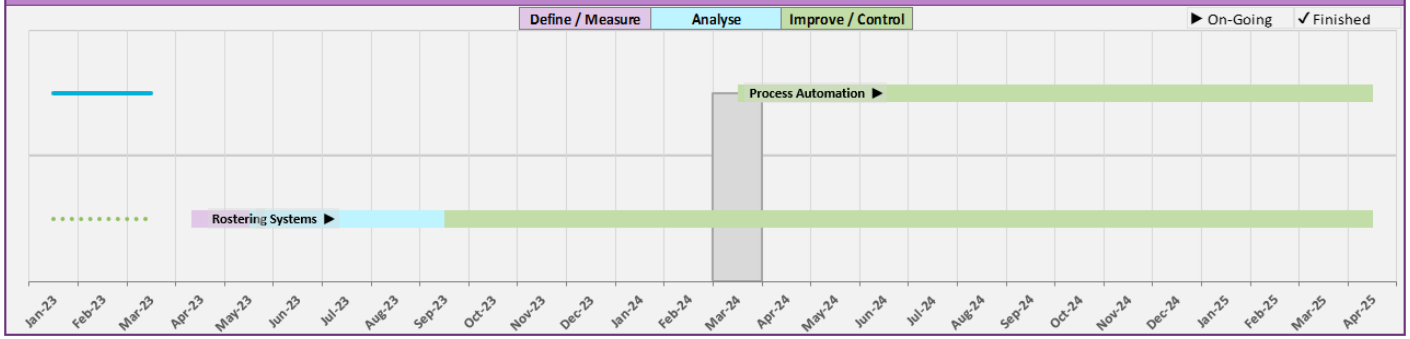
- The private provider for additional autism capacity has commenced assessments and is on schedule to complete the first 160 assessments by the end of April.
- The evaluation of the Phase 1 Waiting Times will be reviewed at the Steering Group in March alongside the scope for the next phase to improve the management of waiting times.
- The milestones at risk relate to the team timetables work in the Waiting Times programme, this follows on from the clinical need matrix and app and is supported by Qi.
- There is risk in the provision of automated population health data to support the Reducing Service Inequities work.
- The initial set of service reviews have all completed which fully meets this corporate objective. Key learning is being collated and the next wave of services for 2024/25 are being identified.
- The scope for the Virtual consultation work is agreed and plans are being developed.

Workforce Systems Improvement Programme Status

Programme: Workforce Systems | Programme ID: 4 | March 2024



Programme Roadmap



Programme Status

- The Process Automation project scope has been approved and the project has been added to the programme and the initial plan is developed.
- There is some risk to the milestones for Process Automation as the solution and testing is reliant on the supplier.
- The outline business case for the Rostering system has been reviewed at EMG and the full case is being developed.

Appendices

A: Urgent and Emergency care Improvement Programme Definition

Problem Statement

Across the Sussex health and care system there is an increasing number of people using urgent and emergency care services and this is putting significant strain on the workforce and has impacted on the timeliness for people accessing the care they need. This results in high demand for 999 and 111 services, long waits in urgent care departments (A&E, UTC and MIU) and unnecessary admissions to hospital. Pressures are further exacerbated by challenges in timely discharge for patients across the system.

There is limited capacity within community services for admission avoidance and supported discharge and inconsistency in access and provision of care.

Overall Aim

The Urgent and Emergency Care Improvement Programme aims to increase capacity, improve patient flow and embed community services at the centre of an effective urgent and emergency care system. This will support a greater number of people to receive rapid assessment and care in their own home or in the community and avoid going into hospital unnecessarily.

Planned Improvements

Expand and increase the capacity of services in the community to support more people to avoid hospital admission than ever before – by building new and larger Virtual Wards and improving pathways and processes within Urgent Community Response

Speeding up admission into and discharge out of community hospitals – by ensuring patients have access to the right care in the right bed to reduce their length of stay

Better connect our services through better information sharing, data management and closer working with other SCFT services and partner services such as NHS111 and 999 and acute inpatient services to improve flow and outcomes

Reduce unwarranted variation by reviewing practice and operating models and ensuring we spread innovation across our teams and standardise to drive efficiency and productivity

B: Community Nursing Improvement Programme Definition

Problem Statement

The length of stay in our Community Nursing services is longer (on average around 100 days) than comparable services across the country (at around 70 days). As a result, we have larger caseloads and staff tell us they have less time to care than they would like. There is also significant variation between our local teams with average length of stay ranging from over 200 to less than 50 days. This indicates a significant variation in practice, structures and caseload management processes, but with this comes opportunities to improve and learn.

Wound care makes up a large proportion (more than 20%) of community nursing work and but with large caseloads leading to deferrals in this activity, this potentially contributes to delayed healing rates and further extends length of stay. Staff all tell us that the service feels reactive and not proactive, offering too little self-management support which is driving greater dependency and also extending length of stay. This is a contributing factor to staff morale. More than half of sickness is long-term, we have a >12% vacancy rate, and 20% of staff leave within 1 year. Community Nurses have experienced a number of changes in recent years, but many tell us that these have failed to deliver meaningful improvement for them or patients. This is important as staff we need to be fully engaged in this improvement programme.

Overall Aim

Improve Community Nursing processes, pathways and systems to implement best practice to reduce length of stay on caseload and have a positive impact upon patient outcomes and the capacity and demand across all teams.

Planned Improvements

We will reduce the average length of stay in community nursing to 70 days and also reduce the variation between our teams to within normal statistical variation.

· There will be clear admission and discharge processes and criteria for community nursing
· We will ensure better compliance with the deferral policy and reduce the number of deferrals
· There will be more self-management support offered to patients
· There will be more staff undertaking wound care training to ensure better and more consistent practice
· Staff will report they have more time to care and retention rates will improve

C: Planned Care Improvement Programme Definition

Problem Statement

There is significant variation in how we operate and deliver our outpatient type services. This includes critical processes such as triage, patient prioritisation, communication with referrers & patients, bookings, access to and results from diagnostic tests, the management of DNAs, the use of virtual consultations, waiting list validation and leave management and job planning. Variation also exists within services themselves, with limited evidence of consistently applied SOPs or practice guidelines such as new to follow up ratios. Services also do not maximise use of patient initiated follow up to support discharge and self-management This variation in practice is leading to longer waiting times and inefficiency.

Whilst every service is there to meet different patients' needs, the variation in how we operate is unwarranted and not related to patient need, but the structure and infrastructure of our services.

There is also limited development or use of demand and capacity planning or tools. As such services are not always aware of the capacity they have to offer or demand they face. Together with limited use of population health information it is difficult to plan and develop our services to meet changing or growing needs and demands.

Staff tell us it can be hard to plan clinics as clinic space is hard to book and secure, and there is a sense services are reacting to demand, and that SystmOne is not set up to make waiting list management as simple as it could be.

Overall Aim

We will ensure outpatient services are optimised by designing a consistent service model and more standardised approaches and policies to be used by all services. All services will have the key structures and processes needed to operate effectively and efficiently so we reduce waiting lists and waiting times. This will require access to high quality data for clinicians and support to use the data for consistent clinical decision making.

Planned Improvements

We will reduce the number of patients on our waiting lists. There will also be:

- Reduced numbers of patients waiting more than 6 months.
- Reduced waiting times from first and follow up appointment for services.
- Reduction in new to follow up ratios where appropriate, achieved through more active management and getting it right first time.
- A reduction in DNA rates.
- Increased use of patient initiated follow up in outpatient settings.
- Increased use of virtually delivered follow up outpatient appointments.

D: Workforce Systems Improvement Programme Definition

Problem Statement

All staff need to interact with People corporate functions to undertake their job. Digital development of corporate processes and systems have lagged compared to frontline clinical services and are therefore still heavily reliant on manual and human processes. This has led to some poor experience for prospective and existing staff and managers. Not only could this impact on their ability to care, but a reliance on manual processes creates duplication and inefficiencies. Whilst some progress has been made in the last year with the introduction of the Learning Management System and the development of the People's Gateway, we still lack the capability to report centrally on several workforce related issues due to different local practices, variation, lack of standardization, and no 'single source of truth.' Furthermore, variation is costing the organisation, for example financial accrual of untaken annual leave and overpayments due to delays in leavers being processed.

Overall Aim

We will ensure the People Directorate provides an improvement service through increased digital delivery. Processes for supporting staff will be efficient and responsive and we will have the information we require to plan and deliver services that support our workforce and meet our vision within the People's Strategy which is to be a great place to work, measured through an increase in attracting new recruits and our people speaking positively about opportunities for learning and development they have had, their wellbeing is prioritised and they have a sense of belonging.

Planned Improvements

We will improve the corporate experience of our workforce and release capacity to deliver care. We will:
- Improve the experience of the People Directorate by our workforce
- Provide easier access to the information staff need to do their job
- Reduce workforce burden when undertaking corporate tasks
- Help staff to help themselves when undertaking workforce related enquiries
- Reduce duplication and manual processes across the People Directorate
- Identify and release inefficiencies across the People Directorate

The overall outcome is that People functions will become digitalised when achievement of the following benefits have been identified:
Quality; digitalisation of the process will lead to safer rostering/deployment of our workforce into our clinical services, for example, rostering of staff into clinical areas with specific clinical skill & competency requirements and/or identifying training needs for services.
Financial; digitalisation of the process will result in a financial saving for the Trust, for example, a system that ensures all staff utilize full allocation of annual leave reducing incurred costs in future years and reduces over payments of staff leaving the organisation.
Strategic; digitalization of the process will result in the Trust improving the employee experience, staff report improved opportunities to learn and develop through annual NHS staff survey
Improve the visibility and availability of data on our workforce and their needs that will inform our corporate responses.

Sussex Community NHS Foundation Trust

Report to:	Trust Board	**Meeting date**:	28 March 2024
Report title:	Workforce Equality, Diversity and Inclusion Action Plan	**Agenda number**:	8
Author(s):	Hazel Foss, Deputy Director - HR & OD	**Owner(s)**:	Caroline Haynes, Chief People Officer

Purpose:	**Decision/Approval**		**Assurance**	x	**Briefing**	x

Link to Trust Strategic Goals: *(If yes, please explain any links)*

A Great Place to Work	X	The Workforce EDI action plan is a key part of delivering the People Strategy, to achieve our aim to be a great place to work.
Continually Improve		
Digital Leader		
Reducing Service Inequities		
Sustainability		

Link to corporate objectives and BAF risks

The Workforce EDI action plan is a key part of delivering the People Strategy, to achieve our aim to be a great place to work. Improvement in performance against the associated EDI metrics will help to mitigate corporate risks re: workforce supply and retention (for example Apprenticeship attrition rates).

Link to Care Quality Commission (CQC) questions:

Caring		
Effective		
Responsive		
Safe		

Well-Led	x	*Shared direction and culture* We have a shared vision, strategy and culture. This is based on transparency, equity, equality and human rights, diversity and inclusion, engagement, and understanding challenges and the needs of people and our communities in order to meet these. *Freedom to speak up* We foster a positive culture where people feel that they can speak up and that their voice will be heard. *Workforce equality, diversity and inclusion* We value diversity in our workforce. We work towards an inclusive and fair culture by improving equality and equity for people who work for us.

Executive summary:

Sussex Community NHS Foundation Trust's Workforce EDI improvement action plan is broad, with actions embedded as part of the People Strategy delivery plan. The plan is 'live' and updated quarterly. It incorporates actions from the following:

- NHS EDI High Impact Action plan (released June 2023)
- Workforce Race Equality (WRES) action plan
- Workforce Disability Equality (WDES) action plan
- ICB EDI 'high impact' action plan (linked to the national plan)
- Annual Equality Report actions
- SCFT's locally agreed priority 'high impact' actions
- Other ad hoc EDI initiatives and plans as necessary

Many actions link to more detailed plans, projects, and/or groups, including:

- Violence Prevention & Reduction (SCFT and ICB)
- Domestic Abuse & Sexual Violence
- Veterans' Covenant Healthcare Alliance
- Recruitment & onboarding Group
- Wellbeing Group
- Learning & Organisational Development Group
- Reasonable Adjustments workstream
- ICB Occupational Health & Wellbeing Group

The goal of this report is *not* to capture all activity around workforce EDI, but to share progress against the six NHS EDI High Impact Actions, and associated performance metrics.

The actions are:

1. Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.

2. Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity
3. Develop and implement an improvement plan to eliminate pay gaps
4. Develop and implement an improvement plan to address health inequalities within the workforce.
5. Implement a comprehensive induction, onboarding and development programme for internationally-recruited staff.
6. Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.

The aim is to enable the Board to have sufficient visibility on EDI themes, areas of concern, and priority actions, without going into the granular detail of the full action plan.

The Annual Equality Report, Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), gender pay gap reporting, and Staff Survey results include greater detail in relation to workforce EDI performance and themes.

Outcome/action requested:

The Board is asked to note the content of the report.

Trust goals, corporate objectives and strategic risks

The Workforce EDI action plan is a key part of delivering the People Strategy, to achieve our aim to be a great place to work. Improvement in performance against the associated EDI metrics will help to mitigate corporate risks re: workforce supply and retention (for example Apprenticeship attrition rates).

Equality, diversity and/or reducing inequities:

The Workforce EDI plan supports SCFT's goals to be an inclusive employer, particularly the 'Belonging' pillar of the People Strategy.

Previously reviewed by:

A previous version of this report was reviewed by Executive Management Group (EMG) on 12 March 2024, alongside the full Workforce EDI action plan. The full plan was last reviewed by People Committee in November 2023.

Elements of the plan have been reviewed and agreed in the following forums:

- Inclusion Group
- Learning & Organisational Development Group (LOD)
- Workforce Group
- Tackling Inequalities Steering Group (TISG)
- Executive Management Group

NHS
Sussex Community
NHS Foundation Trust

Workforce Equality, Diversity and Inclusion Action Plan: NHS EDI 'High Impact Actions'

Hazel Foss, Deputy Director - HR & OD
March 2024

Excellent care at the heart of the community

NHS High Impact Action 1

Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable

Actions	Success metrics
▪ Every board and executive team member must have EDI objectives that are specific, measurable, achievable, relevant, and timebound (SMART) and be assessed against these as part of their annual appraisal process (by March 2024). ▪ Board members should demonstrate how organisational data and lived experience have been used to improve culture (by March 2025). ▪ NHS boards must review relevant data to establish EDI areas of concern and prioritise actions. Progress will be tracked and monitored via the Board Assurance Framework (by March 2024).	▪ Annual Chair and Chief Executive appraisals on EDI objectives. ▪ Board Assurance Framework (BAF)

Current status (March 2024):

This formed part of discussion at SCFT's Board in September 2023, with a more in-depth Board session focussed on EDI in October 2023.

SMART PDR objectives related to EDI will be finalised and agreed for all Board and Executive members by the end of March 2024.

Data relevant to EDI is shared and reviewed in group and committee forums across SCFT, including the Non-Executive Director led People Committee.

A new NHS Leadership Competency Framework (LCF) for board level leaders is due to be published in August 2024.

Elements of the framework will include:

- **Leading for equality**
- **Creating a compassionate and inclusive culture**

NHS High Impact Action 2

Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity

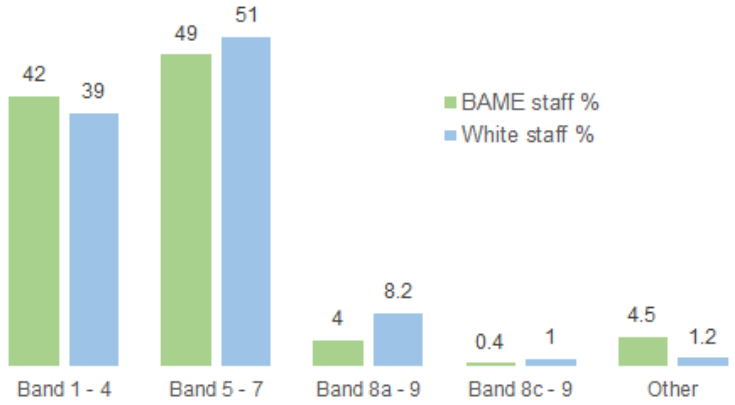
Actions	Success metrics
▪ Create and implement a talent management plan to improve the diversity of executive and senior leadership teams (by June 2024) and evidence progress of implementation (by June 2025) ▪ Implement a plan to widen recruitment opportunities within local communities, aligned to the NHS Long Term Workforce Plan. Include the creation of career pathways into the NHS such as apprenticeship programmes and graduate management training schemes (by October 2024). Impact should be measured in terms of social mobility across the ICS footprint.	▪ Relative likelihood of staff being appointed from shortlisting. ▪ Staff Survey results - access to career progression and training and development opportunities ▪ Improvement in overall race and disability representation ▪ Improvement in senior leadership representation (band 8c and above) ▪ Diversity in shortlisted candidates (metric to be developed in year 2) ▪ National Education & Training Survey (NETS) metric on quality of training

Workforce representation:

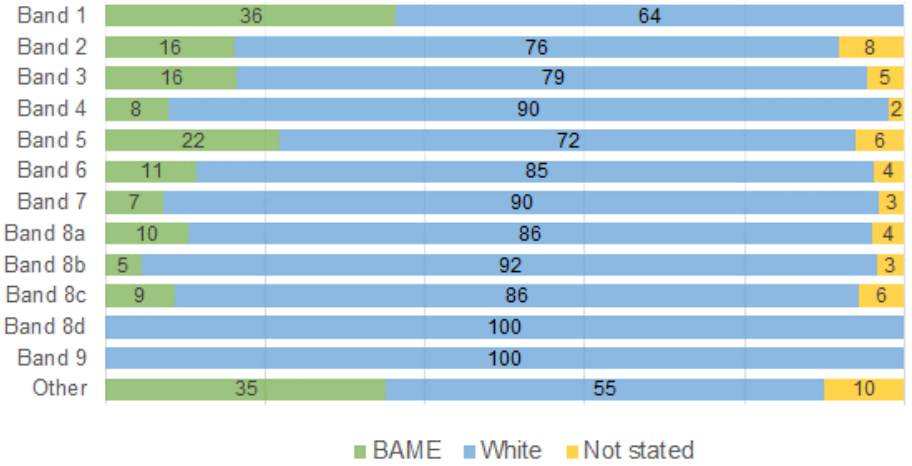
Black, Asian, and minority ethnic (BAME) people make up **13.5%** of the workforce, increasing almost 4% since 2022. In comparison, the percentage of working age BAME people in Sussex is around 8% (though there is variation across localities).

The workforce is representative overall, but work is needed to reflect this at all levels. While numbers of BAME people in bands 8a to 9 grew by almost a third over 21/22, numbers have been relatively static since, with appointments offset by turnover elsewhere.

White people are twice as likely to be represented at bands 8a and above than BAME people, with no BAME staff in bands 8d or 9. The gap is smaller at band 8a (with 4% of BAME staff at this band compared to 5.5% of white staff), suggesting scope to promote from within this pool.



Proportion of staff in each pay band:



Disabled staff are more represented in bands 1 to 4 than in other pay bands.

Rates of staff sharing they are disabled is lower than it should be (8% compared to 22.5% of people who answered the Staff Survey), though this compares favourably to 4.9% NHS-wide.

	2024	2023	2022
BAME workforce:	13.5%	11.4%	9.6%

NHS High Impact Action 2 (cont.)

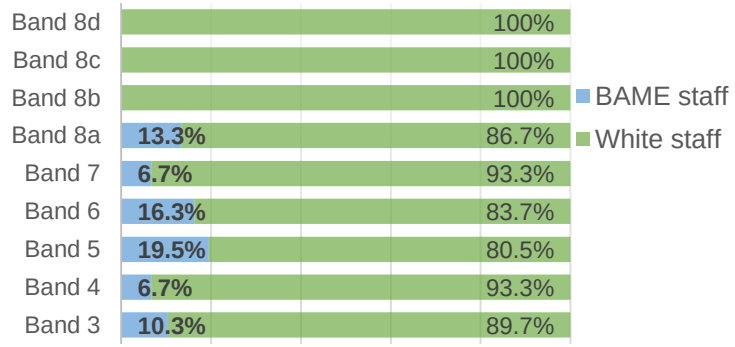
	2018	2019	2020	2021	2022	2023
Relative likelihood of white applicants being appointed from shortlisting compared to BAME applicants	1.80	1.40	1.51	1.39	1.34	2.23

Recruitment disparity:
While numbers of BAME people in the workforce have grown, there is significant disparity in recruitment. White applicants are **2.2 times more likely** to be appointed from shortlisting than BAME applicants. There has been a significant deterioration since 21/22.

Analysis suggests the significant increase in candidates applying from outside the UK is a key factor. Over 98% of applicants requiring sponsorship were BAME. Excluding applicants who required sponsorship, the disparity metric is 1.4. This is not to excuse disparity, but to highlight what may be different compared to 21/22.

There is no disparity in appointment of disabled applicants from shortlisting.

Career progression:
BAME staff are promoted broadly proportionally to the size of the staff group. However, there is variation in the proportion of staff promoted across the pay bands:



Staff believing the org. acts fairly with regard to career progression or promotion (%):

	All staff	White staff	BAME staff	Disabled staff	Non-disabled staff
SCFT staff	63.9%	66.1%	52.2%	60.2%	65.2%
ICS benchmark	57.3%	-	48.7%	55.4%	-
Community Trust benchmark	65.8%	-	48.7%	60.9%	-

Actions to address recruitment disparity:

- **Reporting & monitoring:** monthly reporting in place from Q2.
- **Centralised budget** for sponsorship costs agreed by EMG in October '23, implemented by end Q3.
- **Workstream:** International Workforce Development Group established Sept. '23.
- **Guidance:** New international recruitment guidance from Q2. Guide to effective shortlisting criteria from Q3, to help ensure shortlisting is not overly broad or unfairly restrictive.
- **Training:** Updated offer (from January '24) includes more focus on avoiding bias / discrimination and international recruitment.
- **Performance management:** conduct or performance issues with recruiting managers will be addressed in line with the Disciplinary or Capability policies.

Other key work relevant to this HIA:

- Talent management and development of talent pipelines are a key part of the People strategy and delivery plan, including apprenticeships and new roles.
- Strategic Workforce Plan being developed with initial outputs in Q3.
- Individualised career development offered to BAME staff and Disability & Wellbeing network members, with the aim of creating a talent pipeline.
- Ongoing comms. to encourage staff to share disability status on ESR.
- Inclusive recruitment panels for posts at band 7 and above. From Q4, the process has been be streamlined to better ensure consistency of approach.
- Staff and applicants mapped against Indices of Social Deprivation, with data used to inform recruitment, apprenticeship, widening participation work from Q4.
- Launched PDR function within the new Learning Management System (LMS) in Q4, supporting strategic and inclusive talent management.
- New management and leadership development offer will launch in Q1, including an Advanced Programme focussed on senior leadership.
- 'Career Maps' will be in place in Q1 to support staff navigate options available to them when developing their career.

NHS High Impact Action 3

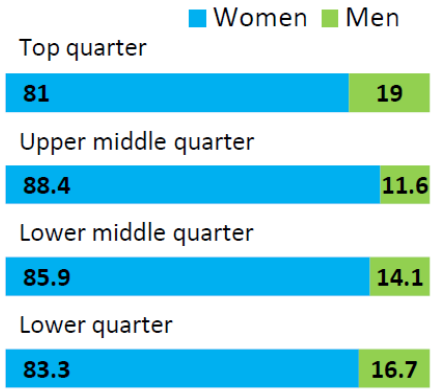
Develop and implement an improvement plan to eliminate pay gaps

Actions	Success metrics
▪ Implement the Mend the Gap review recommendations for medical staff and develop a plan to apply those recommendations to senior non-medical workforce (by March 2024). ▪ Analyse data to understand pay gaps by protected characteristic and put in place an improvement plan. This will be tracked and monitored by NHS boards. Reflecting the maturity of current data sets, plans should be in place for sex and race by 2024, disability by 2025 and other protected characteristics by 2026. ▪ Implement an effective flexible working policy including advertising flexible working options on organisations' recruitment campaigns (March 2024)	▪ Improvement in gender, race, and disability pay gaps

Gender pay gap

Women earn more than men based on median hourly pay. Women represent 81% of the highest pay quartile and men 19%. This means women are technically under-represented in the top quarter, as the workforce is 85% female. There is greater representation of women in the upper-middle quartile (88.4%), where men are under-represented. Due to this, mean earn 8.9% more than women when using mean hourly pay.

	2019/20	2020/21	2021/22	2022/23	2023/24
Mean gender pay gap using hourly pay	8.6%	9.5%	6.7%	7.4%	8.9%
Median gender pay gap using hourly pay	-2.5%	0.1%	-2.1%	-0.4%	-1.7%



% men and women in each pay quartile

At **7.07**, SCFT scored above the community provider average (6.93) for the 'We work flexibly' elements of the 2023 Staff Survey, with significant improvements on last year. **70.3%** of staff said they were satisfied with opportunities for flexible working, though staff identifying as male were more likely to say this, at 73.9%.

Key work relevant to this HIA:

Assessment against Mend the Gap report completed Q2 (July). SCFT's initiatives align with the recommendations, particularly the focus on the flexible working offer, talent management, and other retention initiatives. Analysis of gaps across the range of protected characteristics and staff groups will be completed in Q3 24/25 and actions identified.

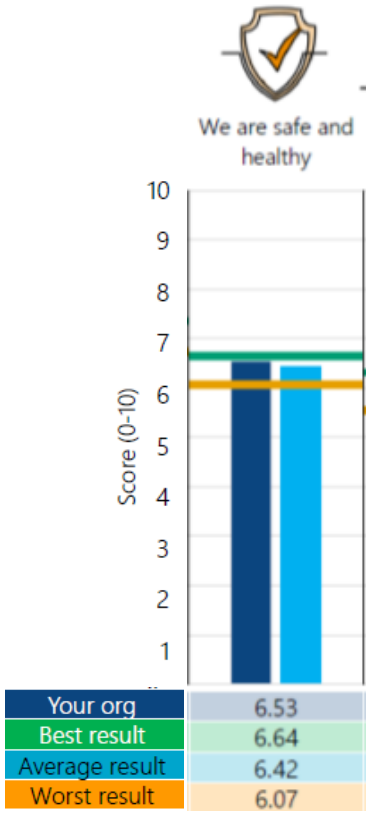
Agile working is a core part of the People Strategy. The Flexible Working and Hybrid Working policies provide guidance for managers on how to effectively identify, apply, and manage agile flexible working patterns. In addition to the underpinning policy enablers, development sessions were run with operational management leads in Q1 and Q2, and at October's 'Great Place to Work' conference, to encourage creativity around agile working. All recruitment adverts mention flexibility as standard. A number of teams ran successful substantive 'any hours' recruitment adverts in Q3 and Q4, with feedback from candidates that they would not have applied to a standard advert.

From Q4, SCFT will carry out an exploratory diagnostic using data, staff engagement and learning from other organisations to understand current position re flexible working, identify areas for improvement, and develop a plan.

NHS High Impact Action 4

Develop and implement an improvement plan to address health inequalities within the workforce

Actions	Success metrics
▪ Line managers and supervisors should have regular effective wellbeing conversations with their teams, using resources such as the national NHS health and wellbeing framework (by October 2023). ▪ Work in partnership with community organisations, facilitated by ICBs working with NHS organisations and arm's length bodies, such as the NHS Race and Health Observatory. For example, local educational and voluntary sector partners can support social mobility and improve employment opportunities across healthcare (by April 2025).	▪ Staff Survey results - organisation action on health and wellbeing concerns ▪ NETS metric on quality of training During 2024/25, NHS England will work with ICBs and other key stakeholders to establish a mechanism for measuring improvements in workforce health inequalities



Workforce health & wellbeing:
SCFT scored above the community provider average for the 'We are safe and healthy' elements of the 2023 Staff Survey, with significant improvements on last year. The number of respondents agreeing 'my organisation definitely takes positive action on health and wellbeing' increased across staff groups from last year, with SCFT comparing favourably to ICS and community provider benchmarks.

The number of people saying they had been unwell due to work-related stress reduced by 3%. 85% of disabled staff who responded said SCFT had made adjustments to support them to do their job.

'My organisation definitely takes positive action on health and wellbeing':

	All staff	BAME staff	Disabled staff
SCFT	**68.9%**	**73.7%**	**66.1%**
ICS median	64.2%	65.8%	60.8%
Community Trusts	61%	64%	56.9%

SCFT's NETS 'positive overall educational experience' score is **85.7%** against an ICS benchmark of 80.3%, performing better than other providers

Key work relevant to this HIA:
Wellbeing conversations are already embedded into PDR, and further enabled by tools such as Health & Wellbeing Passports, the Healthy Teams resource, and stress risk assessments.

SCFT completed a comprehensive review of the wellbeing offer in Q1, informed by a health and wellbeing needs assessment of staff. The actions identified are monitored by Workforce Committee for assurance. Wellbeing Group provides a forum to consider gaps and hotspots in staff experience.

Mental health and MSK pathways are being developed for staff (for Q1 24/25).

NHS High Impact Action 5

Implement a comprehensive induction, onboarding and development programme for internationally-recruited staff

Actions	Success metrics
▪ Before they join, ensure international recruits receive clear communication, guidance and support around their conditions of employment ; including clear guidance on latest Home Office immigration policy, conditions for accompanying family members, financial commitment and future career options (by March 2024). ▪ Create comprehensive onboarding programmes for international recruits, drawing on best practice. The effectiveness of the welcome, pastoral support and induction can be measured from, for example, turnover, staff survey results and cohort feedback (by March 2024). ▪ Line managers and teams who welcome international recruits must maintain their own cultural awareness to create inclusive team cultures that embed psychological safety (by March 2024). ▪ Give international recruits access to the same development opportunities as the wider workforce. Line managers must proactively support their teams, particularly international staff, to access training and development opportunities. They should ensure that personal development plans focus on fulfilling potential and opportunities for career progression (by March 2024).	▪ Staff Survey results - belonging for internationally recruited (IR) staff ▪ Staff Survey results - bullying, harassment from team/line manager for IR staff

Staff Survey results indicate that internationally recruited staff are twice as likely to experience harassment, bullying, or abuse from colleagues, and three times more likely to experience discrimination:

	IR staff	Non-IR staff
I have experienced harassment, bullying or abuse at work from managers	3.5%	6.3%
I have experienced harassment, bullying or abuse at work from colleagues	26.3%	11.9%
I have experienced discrimination at work from manager/ team leader or other colleagues	19%	4.6%
I think that my organisation respects individual differences	75.4%	78.9%
Burnout sub-score	5.4%	5.2%

Key work relevant to this HIA:
The International Recruitment offer was reviewed in Q2, informed by feedback from international recruits, and in the context of NHS England guidance on support to international staff. Recruitment ‘on-boarding’ information is available to internationally recruited staff, and comprehensive guidance on how to support this staff group is available from Q4. The updated recruitment training offer (from January 2024) includes an increased focus on international recruitment.

A focus on the first 100 days is a key strategic action under the Welcoming pillar of the People Strategy. This has included a refresh and relaunch of corporate induction (from Q2), and creation of a local induction ‘roadmap’ using the Learning Management System (from Q1 24.25) to ensure new staff get the information they need. A new inclusion training offer will also be in place in Q1.

SCFT’s work to implement the NHS Violence Prevention & Reduction Standard has particular relevance to this HIA.

NHS High Impact Action 6

Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur

Actions	Success metrics
▪ Review data by protected characteristic on bullying, harassment, discrimination and violence. Reduction targets must be set (by March 2024) and plans implemented to improve staff experience year-on-year. ▪ Review disciplinary and employee relations processes. This may involve obtaining insights on themes and trends from trust solicitors. There should be assurances that all staff who enter into formal processes are treated with compassion, equity and fairness, irrespective of any protected characteristics. Where the data shows inconsistency in approach, immediate steps must be taken to improve this (by March 2024). ▪ Ensure safe and effective policies and processes are in place to support staff affected by domestic abuse and sexual violence (DASV). Support should be available for those who need it, and staff should know how to access it. (By June 2024) ▪ Create an environment where staff feel able to speak up and raise concerns, with steady year-on-year improvements. Boards should review this by protected characteristic and take steps to ensure parity for all staff (by March 2024). ▪ Provide comprehensive psychological support for all individuals who report that they have been a victim of bullying, harassment, discrimination or violence (by March 2024). ▪ Have mechanisms to ensure staff who raise concerns are protected by their organisation.	▪ Improvement in Staff Survey results on bullying / harassment from line managers/teams ▪ Improvement in NHS Staff Survey results on discrimination from line managers/teams ▪ NETS Bullying & Harassment score metric

The Staff Survey results provide detailed breakdowns of staff experience of bullying, harassment, violence, and discrimination by protected characteristic(s). Overall, disabled staff report a worse experience in terms of bullying and harassment than other groups, with BAME staff also reporting a worse experience than the overall workforce.

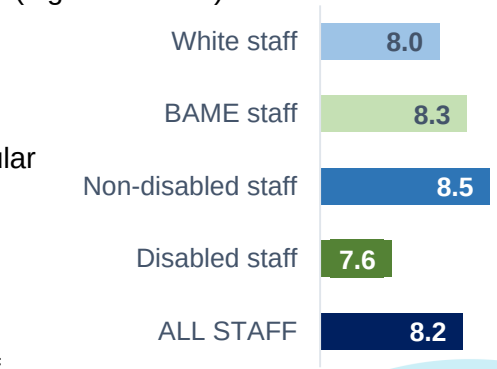
SCFT's NETS 'bullying and harassment' score is **81.82%**, compared to the ICS benchmark of 81.4%.

There is no disparity for BAME or disabled staff in how formal disciplinary and capability processes are applied, with this monitored monthly. Regular reports on the application of the disciplinary policy are shared with People Committee for assurance. The FTSU provides regular reports to the Executive team and feedback is used to inform initiatives.

Key work relevant to this HIA:
The Violence Prevention & Reduction Workstream is a key driver for this work. The workstream has triangulated data and set appropriate actions. While the goal is ultimately to reduce incidents, SCFT have so far not opted to set specific reduction targets as one goal is to increase reporting of incidents (particularly patient on staff incidents, which historically can be under-reported). Staff experience metrics are however being kept under review and incident reduction targets will be considered in future.

SCFT has established a Domestic Abuse steering group, chaired by the CPO who is Executive lead for sexual safety and domestic abuse. Supporting resources are already in place including a Supporting People Experiencing Domestic Abuse Policy, and the wellbeing offer.

Staff Survey 'negative experiences' score (higher = better):



Sussex Community NHS Foundation Trust

Report to:	Trust Board	**Meeting date**:	28 March 2024
Report title:	National NHS Staff Survey Report 2023	**Agenda number**:	9
Author(s):	Denise Harris, Head of Learning and Organisational Development	**Owner(s)**:	Caroline Haynes, Chief People Officer

Purpose:	**Decision/Approval**		**Assurance**	X	**Briefing**	

Link to Trust Strategic Goals:		
A Great Place to Work	X	The National NHS Staff Survey (NSS) provides feedback and data relating to staff experience
Continually Improve	X	The organisational response to the feedback received in the NSS supports continual improvement in the experience for staff working at SCFT
Digital Leader		
Reducing Service Inequities		
Sustainability		

Link to corporate objectives and BAF risks

The National NHS Staff Survey results are beneficial in supporting our aspiration of being a Great Place to Work; the organisation proactively uses the staff survey as one mechanism of listening to feedback and understanding the experience of working at SCFT.

The listening and response cycle that focuses on staff voice, supports the strategic goal of Continuously improve.

Link to Care Quality Commission (CQC) questions:		
Caring	X	We care about and promote the wellbeing of our staff, and we support and enable them to always deliver person centred care.
Effective		
Responsive		
Safe	X	We have a proactive and positive culture of safety based on openness and honesty, in which concerns about safety are listened to, safety events are investigated and reported thoroughly, and lessons are learned to continually identify and embed good practices.

Well-Led	X	We foster a positive culture where people feel that they can speak up and that their voice will be heard. We value diversity in our workforce. We work towards an inclusive and fair culture by improving equality and equity for people who work for us. We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research

Executive summary:

The 2023 National NHS Staff Survey (NSS) results for Sussex Community NHS Foundation Trust (SCFT), show that in comparison with 2022, we performed well and significantly improved our scores in all elements of the People Promise as well as the two staff survey Themes. These scores have been benchmarked against the other fifteen community trusts in England and in comparison, we are above average for all seven NHS People Promise Elements and the two Themes.

This report includes a review of our priorities from the 2021 and 2022 survey results, provides an overview of the results from 2023, and identifies the areas where we are doing well and areas we would like to focus on, with plans to address the areas of priority.

Outcome/action requested:

The Board is asked to discuss the report, to note the results and agree the areas of priority.

Equality, diversity and/or reducing inequities:

The staff survey enables us to understand the experience of all staff and helps identify and understand the difference in experiences of different groups of staff and inform actions to address any differences.

Previously reviewed by:

Chief People Officer

Sussex Community
NHS Foundation Trust

National NHS Staff Survey Results 2023

Excellent care at the heart of the community

Table of Contents

1 Introduction

The annual NHS staff survey provides an insight into staff views of the organisation and their experience of working within it. The survey is a key measure of staff engagement and wellbeing which are essential to the provision of high-quality services. The survey also gives an insight into aspects of the culture of the organisation.

The survey is structured around the seven elements of the NHS People Promise:

- We are compassionate and inclusive
- We are recognised and rewarded
- We each have a voice that counts
- We are safe and healthy
- We are always learning
- We work flexibly
- We are a team

Along with two themes:

- Staff engagement
- Morale

The 2023 NHS National NHS Staff Survey (NSS) results for Sussex Community NHS Foundation Trust (SCFT), show that in comparison with 2022, we have performed well overall and have significantly improved our scores in all seven NHS People Promise Elements and the two NSS Themes. These scores have been benchmarked against the other 15 community trusts in England and in comparison, we are above average in all areas outlined above. Sussex Community NHS Foundation Trust is the largest community trust with over 5,500 staff and this benchmark group includes several with fewer than 2,000 staff.

Our results also compare well with other providers from the Sussex Integrated Care System (ICS) where we scored highest across each of the seven elements of the NHS People Promise.

Along with the benchmarked reports, we have reports and data from the contractor which have been used in compiling this report. This includes comparison of results across the organisation broken down by team and protected characteristics and a free text comments report. Those reports provide invaluable information relating to specific themes i.e. flexible working and variations in experience between groups.

Trusts that employ at least 200 eligible in-house bank only workers were required to extend the survey to those workers in 2023. We had opted to include bank only workers in the survey in 2022 so will be able to analyse the data using 2022 as a benchmark.

This report includes an update on our 2021 priorities and a review of our priorities from the 2022 survey results. It also provides an overview of the results from 2023 and identifies the

areas where we are doing well and areas we would like to focus on, with plans to address the areas of priority.

2 Review of 2021 priorities

The work of improvement in staff experience is continuous and supports the strategic goal of SCFT as a great place to work. This section reflects on the areas of focus identified following the 2021 results and provides an update on the impact of these.

2.1 Work with teams to review local results

Work in this area continues with services identifying the areas for improvement they wish to address locally.

Through inclusion and involvement of all team members, the Service teams identify on average three achievable 'pledges' or 'actions' to take forwards and commit to together. The pledges or actions vary from one team to another, and the way these are presented, is unique to each Service, as these actions or pledges need to be defined by the teams themselves in a way that feels real and authentic.

The pledges or actions for each Service team are kept under regular review throughout the year by the HR Business Partners, Service Leaders, and the Service teams themselves. This is done in an organic manner as a result of responding to other sources of 'voice of staff' such as exit interview data and the National Quarterly Pulse Survey (NQPS).

The impact of this is seen in the overall improvement in the score for *We are a team* from 7.14 in 2021 to 7.29 in 2023. It is also reflected in the *Engagement* score which has moved from 7.25 in 2021 to 7.35 in 2023.

2.2 Maintain and improve the response rate

We achieved 73% response rate in 2021 and had an ambition to improve that to 75% in 2023. The final response was 72% in 2023 which is the highest across all community trusts and compares favourably with the average response for community trusts of 60% response.

This achievement has been acknowledged at a national level and SCFT has been invited to share our approach in national and regional forums.

Work continues on this area with a focus on exploring how to hear from staff members and teams who do not engage with the Staff Survey.

2.3 Reduce the disparity in experience between different staff groups

This area of focus continues and the work to address disparity in experience is highlighted in detail under the 2022 priorities.

2.4 Using Staff Survey data and other sources of feedback when reviewing staff experience

This area of focus also continues and is reflected in Strengthening the communication and feedback loop as a priority area for 2022.

3 Review of 2022 priorities

The three areas of organisational focus identified from the 2022 results supported the strategic goal of SCFT as a great place to work and were aligned with organisational priorities and the People Strategy.

3.1 Working flexibly

Work to support this area of focus has continued as part of the Agile workstream in the People Strategy.

For example, a clinical service trialled an ‘any hours' recruitment advert. The result of this was an increased interest in a ‘hard to recruit’ role. Feedback from candidates indicated they would not have applied to a standard advert. This learning has been shared leading to other services trying the approach.

Other work to support this area is on-going, with, for example, a report on flexible working and flexible retirement that identified examples of good practice and innovative ways of working across the organisation. These experiences and learning are being shared and considered along with the strategic workforce plan to identify where a different approach would support workforce gaps.

The expectation was that the impact of this focus would mean an improvement in our ability to attract and retain our staff. The ambition for this area was to improve the response to the question *Satisfied with opportunities for flexible working patterns* from 66.7% to 70% and for the overall score for the People Promise Element ‘We work flexibly’ to improve from 6.8 to 7.0. The 2023 results show these have has improved to 70.8% and 7.07 respectively.

3.2 Respecting individual differences

This priority built on the 2021 focus to reduce disparities between different staff groups.

Our ambition was to see an improvement in the NSS results from 77.9% saying that the organisation respects individual difference to 79% in 2023. Response to this question has improved to 80.2%. We also expected to see improvements in our WRES and WDES data, for example a narrowing of the gap in experience between all other ethnic groups/white and staff with/without a long-term condition or illness.

This is a mixed picture with an overall improvement in the score for experiences of bullying and harassment being reflected in a narrowing of the gap in both the WRES and WDES data. However, the overall score for equal opportunities is lower in 2023 than in 2022 and the gap in experience between all other ethnic groups/white and staff with/without a long-term condition or illness has widened for this metric.

These results highlight the importance of an on-going focus for this area and work to address discrimination and equality of opportunities remains a priority.

3.3 Strengthening the communication and feedback loop

This priority built on the 2021 focus on expanding and combining sources of feedback from staff.

The impact of work in services and teams to use the NSS and NQPS data alongside other sources of feedback to identify priorities highlights the value of regular communication and updates. This has been used at an organisation-wide level to share good practice, provide examples of changes that have taken place as a result of feedback, and to demonstrate the value of participating in formal surveys.

The establishment of a Voice of Our People group as a forum for different sources of feedback, including formal surveys such as the NSS and NQPS alongside data from exit interviews and feedback from our Staff Networks will continue to build on this area.

Our ambition for this priority was to see an improvement in the Trust Engagement score from 7.2 to 7.3. The final score for 2023 was 7.35. We also saw an improvement in the score for *We each have a voice that counts* from 7.14 in 2022 to 7.22 in 2023.

4 Headline results for 2022

4.1 Response rate

This year we surveyed 5,494 eligible staff. Of these, just over 3,900 responded (72%), an increase from last year, which was 71%. The median response rate for community trusts was 60%. It is of note that we had the second highest response rate for any community trust, maintaining a response rate of over 70% for the third year.

The results by area are shared with the Senior Leadership Team in a series of workshops, the purpose of which is to support leaders to explore the results and identify areas for development. The results are then cascaded through the organisation, and operational, professional and corporate leaders work with teams to understand the results and respond to these with local and meaningful actions. This structured approach enables managers and team leads to explore the results with their team members and create discussions around local areas of focus for improvement.

We have been using the approach of sharing results locally through workshops since 2018. This has impacted positively on the response rate and the gap between the response rate for SCFT and the median for community trusts has increased (Figure 1).

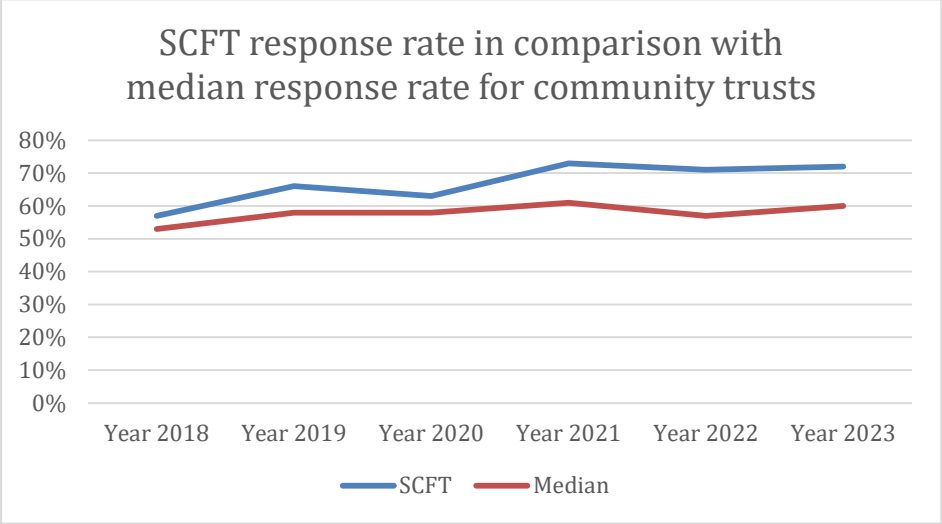


Figure 1: Trajectory of response rates

The high response rate for SCFT provides an indication of the extent to which services across the organisation have engaged with the National NHS Staff Survey and view it as essential data to be used locally. However, there are a sizeable number of staff who do not respond to the National NHS Staff Survey (28%). This was a point of discussion at the Voice of Our People Group and exploration of different ways of hearing from staff and those in 'outlier' teams is a focus for this group.

4.2 Overview of People Promise Elements and Themes

SCFT scores for 2023 show a statistically significant improvement from the 2022 results and SCFT is above average for all the People Promise Elements and Themes in comparison with other community trusts. When compared with the average for all the organisations in Sussex ICS, SCFT scores above average for all the People Promise Elements and Themes (Table 1).

People Promise Elements and Themes	SCFT	Average of all community trusts	Average across Sussex ICS
We are compassionate and inclusive	7.85*	7.75	7.32
We are recognised and rewarded	6.59	6.51	6.04
We each have a voice that counts	7.22	7.15	6.69
We are safe and healthy**			
We are always learning	6.20	6.04	5.68
We work flexibly	7.07	6.93	6.45
We are a team	7.29	7.20	6.83
Staff engagement	7.35	7.26	6.85
Morale	6.35	6.23	5.90

*Scores are out of 10
** This data is not available nationally due to an issue with the data

Table 1: People Promise Elements and Themes, comparison of SCFT scores with the average for all community trusts and across Sussex ICS.

The improvement in the Trust Engagement score (7.22 in 2022 and 7.35 in 2023) is particularly important as an increase in this score is linked to improvements in patient safety and health outcomes, staff health and wellbeing, and organisational performance.

5 Using the results

As identified above, we have lots to be proud of and have many areas where we do well. The highlights include:

- The People Promise element 'We are compassionate and inclusive' continues to be our highest scoring element, with all sub-scores remaining the same or showing improvement.
- The biggest improvement in score is for 'Morale' with all sub-scores also showing an improvement since 2022.
- 'We are always learning' and 'We work flexibly' were both areas of focus in 2022-23 and jointly have the second highest improvement in score between 2022 and 2023.

The work of improvement in staff experience is continuous and supports the strategic goal of SCFT as a great place to work. The areas of organisational focus for 2024-2025 will support this goal, have been informed by the overview of the results, and align with organisational priorities and the People Strategy. These areas are outlined below.

5.1 Reduce disparity of experience between staff groups

There has been some movement towards a reduction in disparity of experience between different staff groups, but this remains an ongoing priority for 2024-25.

The Belonging workstream in the People Strategy highlights the importance of healthy and diverse teams. It also includes a strategic goal to eradicate discrimination in our employment. The impact of this focus will be reflected in improvements in our WRES and WDES data and in the experience our staff report in the National NHS Staff Survey. Actions to support this area include:

- Launch of a refreshed Inclusion Training programme as part of the Leadership and Management Development offer
- Work with the EMBRACE Staff Network and the Recruitment Team to further develop and establish inclusive interview panels

5.2 Further develop systems and support to reduce incidence of musculoskeletal problems as a result of work activities

The National NHS Staff Survey results for 2023 show that the metric for staff who have 'experienced musculoskeletal (MSK) problems as a result of work activities' has improved since 2022. However, the workforce data shows that MSK problems have a significant

impact on the health and well being of our staff and is therefore an area for focus in 2024-25. Actions to support this area include:

- Workforce Health & Wellbeing service transformation.
- Development of MSK and mental health pathways for staff.

5.3 Develop resources, systems and support for Violence Prevention and Reduction agenda, reducing incidence and impact of violence experienced by our people

The People Promise element 'We are safe and healthy' includes the sub score for 'Negative experiences' which includes staff experience of violence, bullying and harassment. Our scores in this area have improved in 2023 but reducing this further is a priority for SCFT. Actions to support this area include:

- Continue the work alongside ICB partners to deliver the Violence Prevention and Reduction training programme.
- Develop the support for the pool of staff trained in 'workplace resolution' so they will be equipped to offer support to resolve conflict between staff and within teams.

6 Bank only workers survey

Conducting a survey of bank workers was mandated in 2023 for organisations with at least 200 eligible in-house bank workers on their staff list as of 1 September 2023. Workers in this group were surveyed using a tailored bank questionnaire.

This is the second year that SCFT has included bank only workers in the survey, providing some comparison data. However, the report from the National Co-ordination Centre where we are benchmarked with other organisations will not be published until April 2024.

This year we surveyed 590 eligible staff. Of these, 134 responded (23%), maintaining the same response rate as in the 2022 survey (23%).

These results are being reviewed by the Temporary Workforce Team who will explore the areas that require more investigation and identify actions required. The key findings will be shared with our bank workers via a series of newsletter/communications, each focusing on a different section, inviting feedback on how we may improve their experience. This will help to support engagement and ensure any actions identified are developed collaboratively.

7 Conclusion

Sussex Community NHS Foundation Trust National NHS Staff Survey results indicate that the organisation continues to maintain a positive position both in comparison with other community trusts and when measured against results from previous years.

The impact of the actions supporting the areas of focus show that we are making progress and these positive results, both the high level of response and the performance of SCFT, reflect the energy and engagement of our staff in giving and responding to feedback. There

is recognition at all levels of the organisation of the value of attending to this for our staff and the impact this has on the quality of care our service users experience.

We seek to build on the work of previous years and recognise that this is a continuous process. We need to remain attentive to feedback and measures of staff experience to continue to improve the quality of our services and in service of our objective of being a Great Place to work.

Sussex Community NHS Foundation Trust

Report to:	Trust Board		**Meeting date**:			28th March 2024	
Report title:	Annual Green Plan Progress Report 2023		**Agenda number**:			9	
Author(s):	Susie Vernon, Associate Director Sustainability		**Owner(s)**:			Mike Jennings, Chief Financial Officer and Deputy Chief Executive	
Purpose:	**Decision/Approval**	X	**Assurance**		**Briefing**		

Link to Trust Strategic Goals: *(If yes, please explain any links)*		
A Great Place to Work	X	Sustainable healthcare principle 'healthier lives' directly supporting staff wellbeing; sustainability important factor for staff recruitment and retention
Continually Improve	X	Sustainable healthcare principle 'streamlined processes and pathways' directly supporting Trust's continuous improvement goals.
Digital Leader	X	Strong links between digitisation of care and sustainability.
Reducing Service Inequities	X	Sustainable healthcare principle 'healthier lives' directly supporting staff wellbeing
Sustainability	X	Green Plan programme facilitating delivery of Trust's Net Zero goals.

Link to corporate objectives and BAF risks
Green Plan supports delivery of the Trust's strategic goals as described in previous section. It also supports mitigation of Trust's draft climate change thematic risk.

Link to Care Quality Commission (CQC) questions:		
Caring	X	Workforce wellbeing and enablement
Effective	X	Supporting people to live healthier lives
Responsive	X	Person-centred care, Listening to and involving people, Equity in experiences and outcomes, Planning for the future(?)
Safe	X	Learning culture, Involving people to manage risks, Infection prevention and control (waste operations primarily)

Well-Led	X	Environmental sustainability – sustainable development, Learning, improvement and innovation, Partnerships and communities, Governance, management and sustainability

Executive summary:

Our Trust Green Plan is now into its third year. We are building on progress in reducing our carbon emissions towards Net Zero, in line with NHS England targets.

Reduced emissions mean reduced admissions. Delivering on Net Zero improves patient care, the working life of our staff and reduces our impact on the environment, supporting the health of our communities.

This Annual Sustainability Progress Report sets out our final (independently verified) carbon footprint figures for 22/23 and summarises achievements over the past 12 months.

Our work this year has been focused on how we can reduce emissions within a clinical setting as well as maintaining our work to reduce emissions from travel and buildings. We have specifically worked to:

- Update and fine tune a 12-month delivery plan to ensure our focus is on the projects that bring most benefits within resources available.
- Complete delivery of our Net Zero Carbon Ready (NZC-R) Chailey project, continued electrification of the operational fleet and the development of our staff engagement programme.
- Support clinicians in identifying the sustainability gains of their projects for improvement to services.

This report reflects the ongoing partnership we are fostering with Sussex ICS to unify an approach to sustainable healthcare.

Finally, it provides a look at challenges going forward and key areas of focus for the next year.

Outcome/action requested:

The Board is asked to review and approve the Annual Green Plan Progress Report.

Equality, diversity and/or reducing inequities:

No adverse E&D implications.

Previously reviewed by:

Executive Management Group – 14th Feb 2023

care WITHOUT CARBON

NHS
Sussex Community
NHS Foundation Trust

Annual Green Plan Progress Report 2023

our health • our environment • our commitment

Contents

Foreword part one

This report sets out our progress in reducing the pollution from our care. We've made great progress to date but the hardest part of the journey to Net Zero perhaps lies ahead. Now more than ever before, in the NHS we are working under immense pressures with demand for our services increasing year on year against a backdrop of resourcing and budgetary challenges. And at the same time, we are seeing the impacts of our changing climate year on year in the southeast, and the knock-on effect that has on the health of the people who live here.

Delivering on our Green Plan is critical in helping us to manage the day-to-day pressures as a trust and as an NHS system – in both the short and longer term. Also to ensuring that we can continue to deliver excellent care for our communities in the context of climate change.

This report sets out our progress in reducing the pollution from our care - great progress to date but perhaps the hardest part of the journey to Net Zero ahead. With this in mind, I am pleased that we are shifting our focus to the ways we can deliver care differently and integrating sustainability principles into our core trust processes. The case studies in this report highlight the importance of our clinical projects in delivery of our Net Zero targets - alongside the work to reduce emissions from our travel and buildings.

Delivering on our Green Plan is not only the right thing to do for our shared environment, it is also the right thing to do for our patients, and wider community. I am confident that in working closely with our clinical teams, we will continue to find the innovative, new ways of working required to tackle the challenge of Net Zero. In doing so we are improving the care that our patients experience, and the working lives of all at our Trust.

Mike Jennings
Deputy Chief Executive Officer
Chief Financial Officer
Executive Lead for Sustainability

Foreword part two

As the Trust's first clinical sustainability lead, I oversee our work to embed sustainability thinking into clinical practices across the Trust.

As an Allied Health Professional (AHP), I've seen first-hand how our changing climate is already affecting the health of our communities, particularly the more vulnerable and often those already in need of care.

Between 2018 and 2022, there were around 1,900 heat related deaths in the southeast, one of the highest rates in the country. Air pollution, including carbon, is linked to an increase in conditions such as respiratory problems. A recent study in Brighton and Hove linked air pollution from transport to more than 170 deaths a year in the city. The risk of climate change to our health is obvious.

We're committed to delivering against our Net Zero targets through our Care Without Carbon programme. We're progressing well, with a focus on clinical sustainability and integration across the Trust this year.

We know Net Zero Carbon is important – but delivering on it is a challenge in the face of pressures across our services. This report shares how far we have come; it is also serves as a reminder that we still have a way to go. We must ensure that delivery of care does not add to the causes of climate change and to ill health in our communities. Integrating sustainability into our day-to-day decision making is critical. We're working hard on this through our Green Plan; I urge everyone to take the time to understand what is needed, why, and then to proactively find ways to contribute.

Together we can deliver a greener NHS – reducing carbon for healthier lives.

Jennie Bent
Associate Director AHPs

Delivering cleaner, greener healthcare

Sussex Community NHS Foundation Trust (SCFT) has led the way in delivering more sustainable healthcare for over a decade now. We've maintained momentum over this time through our Care Without Carbon programme, with a clear commitment to the national NHS target of Net Zero Carbon (NZC) by 2040.

The closer we get, the harder it gets, but Net Zero is possible.

We recognise the critical need to redouble our efforts now – in the face of incredibly challenging system pressures – in order to protect the health of our communities for the future. Without delivering on our Net Zero (NZ) commitment, we cannot deliver on our Trust vision to provide excellent care in the heart of the community.

Care Without Carbon Vision: Together we lead the way in Net Zero Carbon healthcare, protecting the environment on which our health depends.

Through our Green Plan, we are committed to addressing sustainability in three key areas:

1. **Mitigation:** Reaching Net Zero Carbon by 2040 for our direct emissions, and 2045 for our indirect emissions.
2. **Adaptation:** Adapting our services and infrastructure to current and predicted impacts of climate change in Sussex.
3. **Wider environmental impacts:** Reduce our impact on areas such as air pollution, biodiversity, water and waste in line with the requirements of the Environment Act 2021.

These reflect the requirements of both the Greener NHS climate change strategy and the Health and Social Care Act 2022.

Our key areas of focus

This Annual Green Plan Progress Report sets out our final (and independently verified) carbon footprint figures for 22/23 as well as a summary of key project highlights from our second year of Green Plan delivery (Sept 22 – Aug 23). Our focus over this year has been on four key areas:

- Delivering priority Net Zero Carbon projects including NZC-Ready Chailey Westfield, electrifying our operational fleet and launching our nitrous oxide reduction project;
- Integrating more deeply into clinical practice through our Evolving Care workstream, and with a new Trust lead for clinical sustainability;
- Setting up and embedding deeper programme governance; and
- Understanding the impact of climate change in Sussex through our Climate Impact Assessment.

Working together across the NHS

Net Zero Carbon is not something we can achieve alone; system-wide working is critical to delivering change at the pace required, with the limited resource available. We highlight within this report how we've benefitted from working with our partners both within Sussex and further afield.

This report shares how we've secured reductions to date, and sets out how we'll continue to deliver healthcare that protects our environment as well as our communities.

The pollution from our care: Taking stock from carbon to clinical care

An overview of our **carbon emissions**

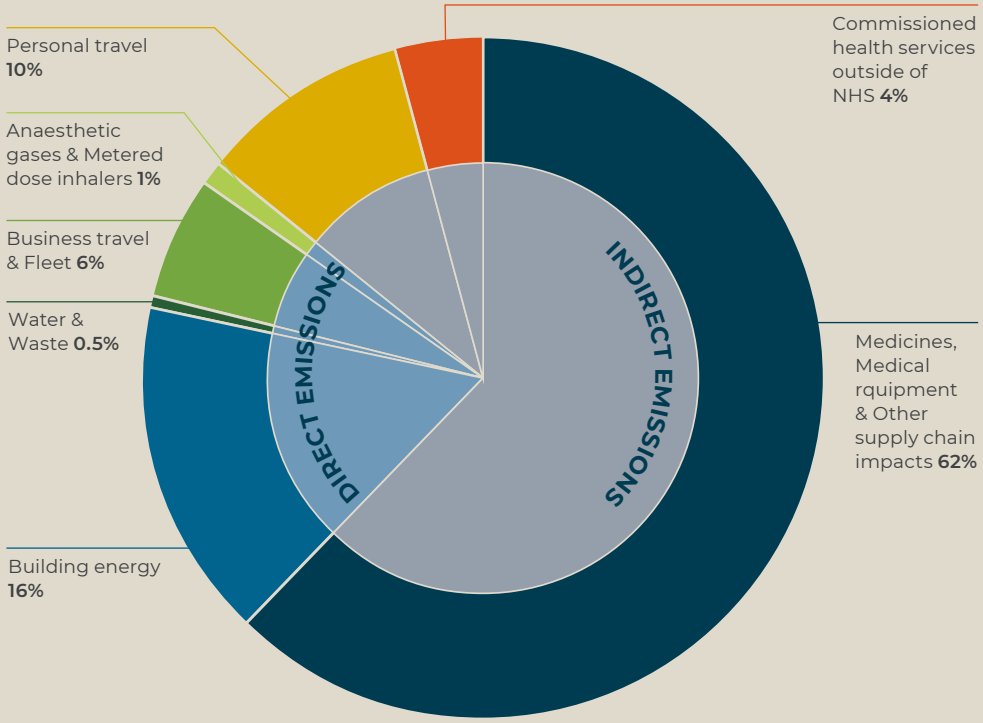


Figure 1: Sussex Community NHS Foundation Trust Carbon Footprint Plus 2022/23 – breakdown by source.

In order to effectively provide care at the heart of the community in Sussex – across nearly 80 sites and in patient homes – we use a significant amount of resources. From the energy used to heat our buildings to the medicines we provide and the travel to visit patients in their homes.

In 2022/23, the carbon footprint of our direct emissions – those within our control – was 5,207 tCO_2e. That is the equivalent to the electricity needed to power 1,000 homes for a year.

The majority of our emissions (around two thirds) comes from the electricity and gas used to heat and power our healthcare estate. The final third comes primarily from travel as we deliver care to patients in their homes and community settings across a large geographical area.

When combined with an estimate of our indirect emissions, our full NHS Carbon Footprint.

More detailed measurement and understanding of our indirect impacts is critical in our ability to reach our 2045 Net Zero target; this will be an important aspect of our Care Without Carbon Green Plan over the coming years. See page 13 to learn more about our approach with the Care Without Carbon framework, including our eight elements to define the actions we need to take.

What progress have we made **towards Net Zero Carbon?**

Since our 2010/11 baseline year, our carbon footprint has reduced by 46%, supported by the rapid decarbonisation of the national grid over the past decade alongside reductions made through our Care Without Carbon programme.

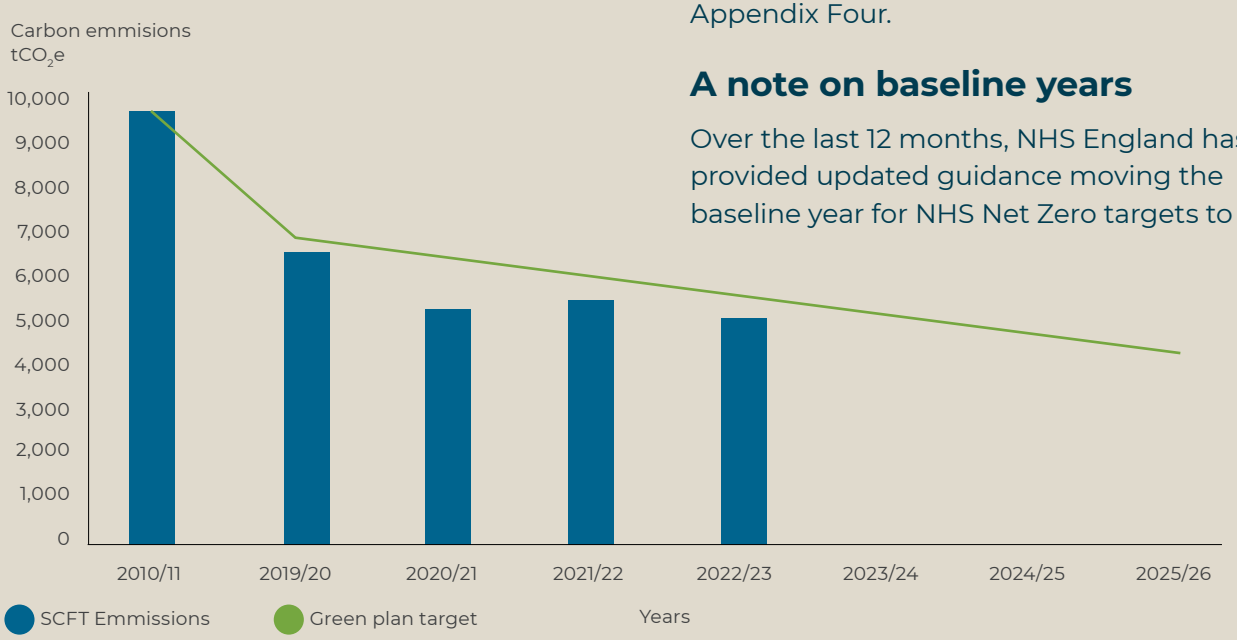


Figure 2: Sussex Community NHS Foundation Trust Carbon Footprint (direct emissions only) from current baseline year and target trajectory.

The Trust's emissions have consistently remained below the target line over this time, with emissions in 2022/23 dropping following a spike in emissions during 2021/22.

Since developing our Delivery Plan in 2022, we have been delivering against the high priority carbon reduction projects identified. Some of these projects are highlighted in the next chapter, with a full breakdown of progress in Appendix Four.

A note on baseline years

Over the last 12 months, NHS England has provided updated guidance moving the baseline year for NHS Net Zero targets to 2019/20. Although there are advantages to maintaining our existing baseline year of 2010/11, we have taken the decision to update our baseline year to 2019/20 from next financial year (2023/24) to allow for consistent reporting in line with other NHS trusts nationally.

Other environmental impacts

Although our carbon footprint is a critical measure of our impact on the environment, it does not encompass all of our environmental impacts as a Trust. We are working on measurement of these wider impacts, including biodiversity, as part of our continuous improvement around reporting.

Progress against **Green Plan targets**

We use key metrics within our workstreams, set out in the Green Plan, to ensure we are progressing towards Net Zero year on year.

Places target

Impact for 2022/23

100% **renewable evergy**
purchased backed power from solar, wind and hydro.

Target for 2025/26

Completed
this target is under review for future years.

Journeys targets

Impact for 2022/23

3,701,644 **miles**
travelled by grey fleet (business miles).

79%
of our operational fleet are low emission vehicles.

Future targets

3,600,000 **miles**
targetted by 2025/26.

90% of our operational fleet upgraded to low emissions vehicles > 90% by end 24/25.

Evolving Care target

Impact for 2022/23

500kg **nitrous oxide** used in our dentistry and Minor Injuries Unit (MIU)/Urgent Treatment Centre (UTC).

Target for 2025/26

80kg this target to be updated following further data review and re-baselining.

Circular Economy targets

Impact for 2022/23

38% **non-healthcare waste** was recycled.

Target for 2025/26

65%

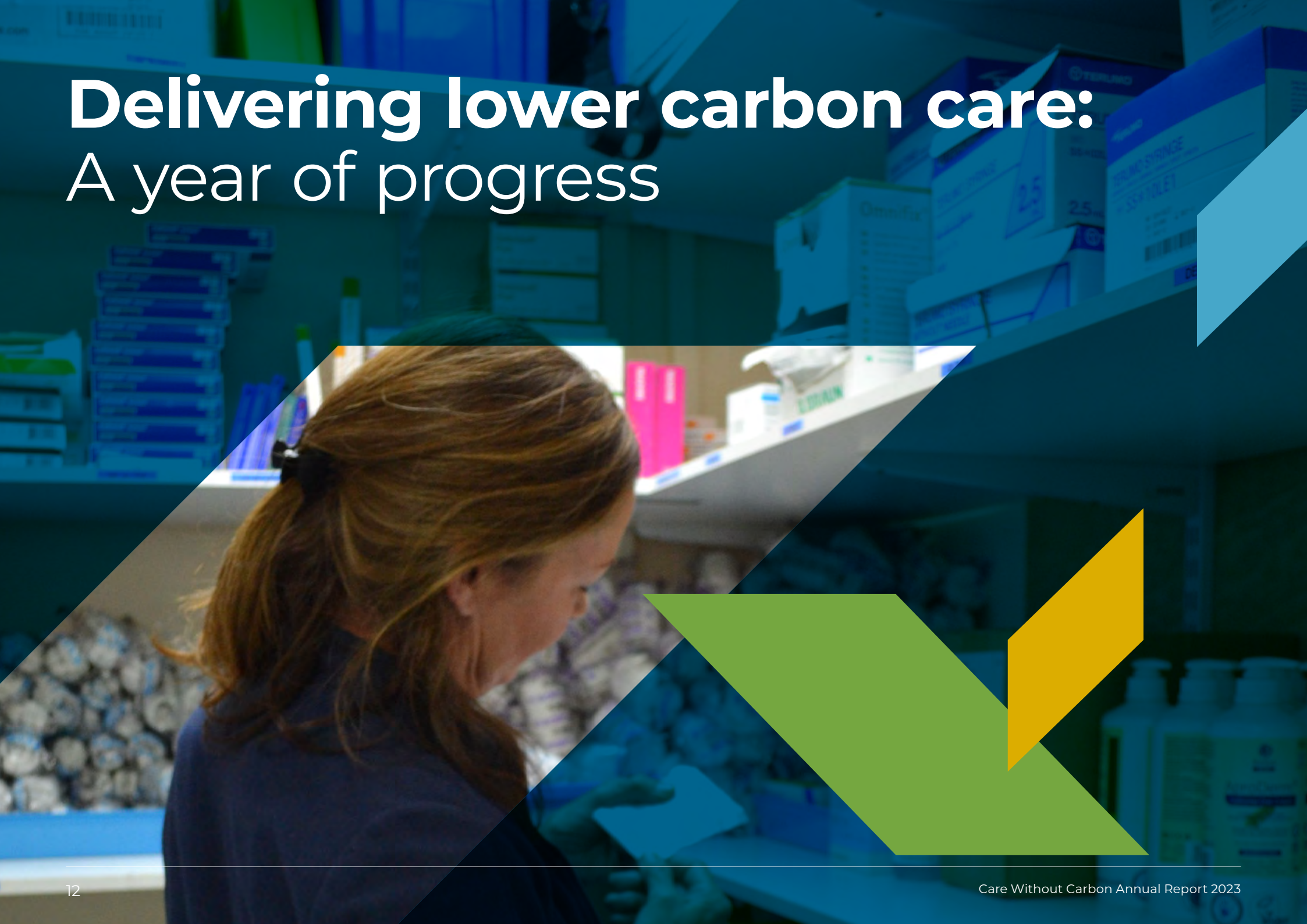
840 **tonnes of waste** was generated by the Trust this year.

725 **tonnes**

0 **tonnes of non-healthcare waste** was sent to landfill.

Completed

Delivering lower carbon care: A year of progress



Our approach:
Care Without Carbon

With 80% of our carbon footprint determined by clinical decisions, in order to hit Net Zero Carbon we must change the way we deliver care. Over the last 12 months we've focussed on developing our Green Plan programme governance and delivery to support a more integrated approach, delivered through our framework for sustainable healthcare, Care Without Carbon.

Our strategic goals at SCFT: A great place to work | Reducing service inequalities | Continuous improvement | Digital leader | Sustainability

Our three aims

01 Reducing environmental impact
Delivering care that is Net Zero carbon, minimising our impact on the environment and respecting natural resources.

02 Improving wellbeing
Supporting the health and wellbeing of our patients, staff and communities.

03 Investing in the future
Maintaining long term financial stability through sustainable decision making.

Our sustainable healthcare principles

Optimises activity

Healthier lives
Making use of every opportunity to help people to be well, to minimise preventable ill-health, health inequalities and unnecessary treatment, and to support independence and wellbeing.

Streamlined processes and pathways
Minimising waste and duplication within the Trust and wider health system to ensure delivery of safe and effective care.

Reduced intensity

Respecting resources
Where resources are required, prioritising use of treatments, products, technologies, processes and pathways with lower carbon, environmental and health impacts.

Green Plan governance and delivery

Sustainability and Net Zero lead: Mike Jennings, Deputy Chief Executive Officer, Chief Financial Officer.

Delivery through: Green Plan Oversight Group, bi-monthly.

Reporting to: Executive Management Group and Resources Committee, quarterly.

Healthier lives & streamlined processes: Primarily delivered through key clinical projects, Quality Improvement (QI) work or wider teams (digital, public health etc) with support from CWC team.

Respecting resources: Primarily delivered through Care Without Carbon (CWC) team with support from relevant Trust teams.

Our action plan is delivered through eight workstreams, we explain these in more detail on the following pages

Green Plan Year 2: Progress summary

Workstream	Evolving Care	Places	Journeys	Circular Economy
Element focus	Developing and enabling lower carbon, more sustainable models of community care.	Ensuring Trust places are low carbon and protect local biodiversity whilst supporting wellbeing for staff, patients and visitors.	Ensuring the transport and travel that links care and communities is low cost, low carbon and conducive to good health and wellbeing.	Respecting health and natural resources by creating an ethical and circular supply chain.
Progress to 2025	**Making progress >**	**Requires focus ~**	**Requires focus ~**	**Requires focus ~**
Spotlight	**Digital Sustainability:** Enhanced understanding of the link between digital healthcare and sustainability programs. Focus included integrating sustainability into the Trust's goal of digital leadership as a community trust, piloting with key digital healthcare projects, and seeking collaborations with the National Greener NHS team on digital initiatives.	**NZC-Ready Chailey (Public Sector Decarbonisation Scheme funding):** Completed the procurement of air source heat pumps at the Chailey Westfield. The project will replace the site's gas heating boilers with low carbon heat pumps and is due for completion in summer 2023/24. The project is being financed by a combination of Trust capital as well as grant funding awarded via the Public Sector Decarbonisation Scheme.	**Electrification of the Operational Fleet:** Progressed towards the 80% EV target by acquiring 13 fully electric cars, 51 hybrid electric vehicles (2 plug-in, 49 self-charging), and 9 electric bikes for business travel. Vehicle replacement continued despite supply challenges. Initial steps were taken to procure additional charging infrastructure across Trust sites, prioritising operational fleet vehicles.	**Net Zero and Social Value Criteria:** Criteria were drafted with input from various stakeholders and piloted in key Trust procurements. We aimed to implement 10% Net Zero and social value criteria into all procurements, adjusting proportions as needed.
What's needed to meet our 2025 targets?	● Clinical sustainability specialist in place. ● Reduce N2O emissions. ● Implement sustainable healthcare in high impact clinical areas.	● Reduce building emissions by 57%. ● Increase biodiversity across our estate.	● Achieve 90% of our operational fleet to be Low Emission by 2024/25. ● 80% of Trust operational fleet to be fully electric by 2025/26. ● Reduce business mileage emissions by 57% by 2025/26.	● 15% reduction of total waste by weight. ● Achieve 65% non-clinical waste recycling. ● Introduce sustainability criteria worth 10% into all Trust tenders.

● Current activity or resource sufficient.
● Additional activity or resource needed.
● Significant activity or resource needed.

Workstream	Culture	Wellbeing	Climate Adaptation	Partnerships & Collaboration
Element focus	Empowering and engaging people to create change to progress towards Net Zero.	Supporting people to make sustainable choices that enhance their wellbeing.	Building resilience to our changing climate in Sussex.	Enhancing impact by working with others.
Progress to 2025	**Making progress >**	**Making progress >**	**On track for 2025 +**	**On track for 2025 +**
Spotlight	**New Staff Engagement Approach and Website:** Collaborated with Trust communications and Integrated Care System to develop a new CWC website and 12 month campaign, "Together to Zero," to replace the previous "Dare to Care" campaign. Set to roll out in 2023/24, emphasising NHS 2040 Net Zero Carbon target and health-climate connections, supporting staff to integrate sustainability into their work.	**Cost of Living Crisis – Staff guide:** A guide to sustainable ways to save money on food, fuel and energy was created and shared with staff in both digital and hard copies as well as inclusion on the Trust wellbeing notice boards.	**Climate Impact Assessment:** A Climate Impact Assessment was undertaken at Integrated Care System level on behalf of NHS trusts in Sussex. This highlights the potential impacts of climate change in our area on our local population and our estate and sets out high level actions that can be undertaken across the Sussex system to further measure and mitigate these risks.	**Collaboration with other NHS Organisations:** Worked with Sussex Primary Care by helping GP practices to switch to better value energy contracts. ICS Sustainability: Advanced regionally funded projects including a new Green Plan, 'Together To Zero' staff engagement campaign, Sussex Climate Change Impact Assessment, Green Inhaler Project, and Staff & Patient Engagement research.
What's needed to meet our 2025 targets?	● 100% of staff aware of and understand the Sustainable Healthcare Principles. ● Develop and promote at least five Sustainable Healthcare case study projects.	● Sustainability impacts considered for all wellbeing projects. ● Climate impact assessment considered in wellbeing project planning. ● Measure the sustainability impact of all wellbeing projects.	● Become a leader in climate change adaptation in healthcare by 2025. ● Undertake a climate impact assessment and integrate findings into our business continuity procedures and long-term strategic health planning.	● Deliver a minimum of three projects up to 2025 in partnership with other organisations. ● To speak at a minimum of three events up to 2023 in support of collective action by healthcare organisations to address the environmental crisis.

● Current activity or resource sufficient.
● Additional activity or resource needed.
● Significant activity or resource needed.

Healthier lives

Making use of every opportunity to help people to be well, to minimise preventable ill-health, health inequalities and unnecessary treatment, and to support independence and wellbeing.

The changes we are seeing from extreme temperatures, to flooding and air pollution all negatively impact our health. Yet, the solutions within healthcare to reduce our emissions, can also improve health outcomes.

Of our three Sustainable Healthcare Principles, we lead with Healthier lives because this exemplifies why, as a healthcare provider, we must act on tackling the climate crisis. At a very basic level, the healthier people are, the fewer healthcare interventions are required – and the lower our environmental impact as a healthcare system.

Our focus within the 'Healthier lives' principle this year has been on beginning to highlight the environmental benefits that our clinical change projects and innovations are bringing alongside wider benefits to patient and staff health and wellbeing.

CASE STUDY

Community Link Workers

Working in partnership with Age UK, this project supports patients to remain well at home, reducing time spent in hospital, by introducing Community Link Workers (CLWs) into Immediate Care Units (ICUs) and Urgent Community Response teams within the Trust.

CLWs are non-clinical professionals who focus on the social, emotional, and practical needs that impact a person's health and well-being.

At Sussex Community NHS Foundation Trust, the team supports patients at risk of admission and/or in the early to mid-stages of hospital discharge.

They work with the patient to identify ways to support recovery and (where possible) self-management of health and social care needs; this could be anything from support with benefits to joining a community garden group.

Supporting patients with earlier discharge frees up hospital resources, and enables a speedier recovery so patients will need less care over the timeframe. With a single hospital admission estimated to produce around 500 $kgCO_2e$, each intervention makes a significant difference to our environmental impact as a Trust.

The team can also help with claiming grants for improving energy efficiency in patient homes, which keeps people warm and supports health, saves them money and reduces carbon emissions.

With a single hospital admission estimated to produce around 500 $kgCO_2e$, each intervention makes a significant difference to our environmental impact as a Trust.

177
frontline staff reached (target was 150)

143
frontline staff taught

29
organisations involved

CASE STUDY
Homeless Health

Brighton has the second highest number of people experiencing street homelessness after Westminster, and we know that homeless and vulnerably housed populations are one of the groups most impacted by climate change. Sussex Community NHS Foundation Trust's Homeless Health Inclusion Team supports homeless people who have tri-morbidity care needs e.g. psychological and mental health issues, substance use issues, social care needs, and palliative and/or long term chronic health conditions.

The Homeless Health Inclusion team realised that staff were not always identifying early enough when a patient had advanced ill health, which then delayed entry to care pathways.

For this project, the team is partnering with Martlets Hospice to ensure homeless and vulnerably housed people are supported with end-of-life care needs. They embarked on a series of palliative care training sessions led by Martlets:

- **29 organisations** involved
- **177 frontline staff** reached (target was 150)
- Live teaching delivered to **143 frontline staff** with **34** accessing through a webinar

Staff confidence rose from 11% to 78% in recognising when a client may be coming to the end of their life. This rise in confidence enabled more appropriate care referrals to be made. This improved awareness means patients may die with dignity, in their preferred location for care.

Following this successful project, further roll out is planned in 2024, with more training sessions and access to a webinar study session for all staff at SCFT.

Collaborative system working in this way ensures a better patient-centred experience of care. From an environmental perspective, earlier intervention helps avoid duplication and reduces the resource required. Projects like these are critical in supporting our Trust Net Zero and wider environmental targets.

CASE STUDY

Carers' Health Team

There are 84,395 carers in West Sussex. They are often caring for loved ones with little or no support and can experience their own physical and mental health issues as a result.

"I am able to refer carers with health problems, which may help reduce admissions"

CHT member of staff

The Sussex Community Carers' Health Team (CHT) delivers care and support to carers and those they care for. The service is in high demand and is seeing an increase in referrals every month.

The CHT is tasked with ensuring that carers have the knowledge they need about the patient's condition and likely care pathway. They work to support both patient and carer to achieve the best possible quality of life, relief from symptoms, and are ensure they are offered flexible and proactive choices alongside advanced care planning to assist them with the management and care of the patient.

"I am able to refer carers with health problems, which may help reduce admissions", CHT member of staff.

As well as ensuring a better patient experience, the team also bring carbon and cost savings, through reduced admissions and reduced need for clinical interventions.

Based on the average cost of mental health care per person, it is possible to estimate that, if all the carers in West Sussex were to be assisted by the CHT, potential savings of up to £271 million per year could be possible, with attendant waste and carbon savings

Streamlined processes and pathways

Minimising waste and duplication within the Trust and wider health system to ensure delivery of safe and effective care.

Delivering more sustainable healthcare has always been aligned with working more efficiently, reducing waste and enhancing opportunities to reduce costs while improving our care.

This year, our focus has been on integrating sustainability principles more deeply into existing Trust and Quality Improvement projects. By developing our tools and processes to achieve this, we're aiming to demonstrate the synergies between patient care and environmental sustainability and show the value of considering the two in tandem.

FOCUS ON

Green Impact Assessment Tool

We know that in order to deliver on our NZ targets, we need to fully embed sustainable thinking into how we work, so that it forms part of how we do things and is not viewed as an additional ‘to do’.

In partnership with the Trust’s Quality Improvement team and Project Management Office, our Care Without Carbon team has developed a Green Impact Assessment Tool to support this. It’s designed to evaluate the sustainability risks and benefits of projects, help teams understand the environmental impacts of a project and to integrate sustainability more explicitly into project outcomes.

The tool development was successfully funded by the Healthier Futures Action Fund from Greener NHS and has been piloted in several Trust transformation projects.

The next steps are to develop an online, more user-friendly version of the tool, where sustainability impacts can be visualised at a Trust-wide level and we are seeking funding opportunities to deliver this in 2023/24.

The tool development was successfully funded by the Healthier Futures Action Fund from Greener NHS and has been piloted in several Trust transformation projects.

CASE STUDY

Virtual Occupational Therapist

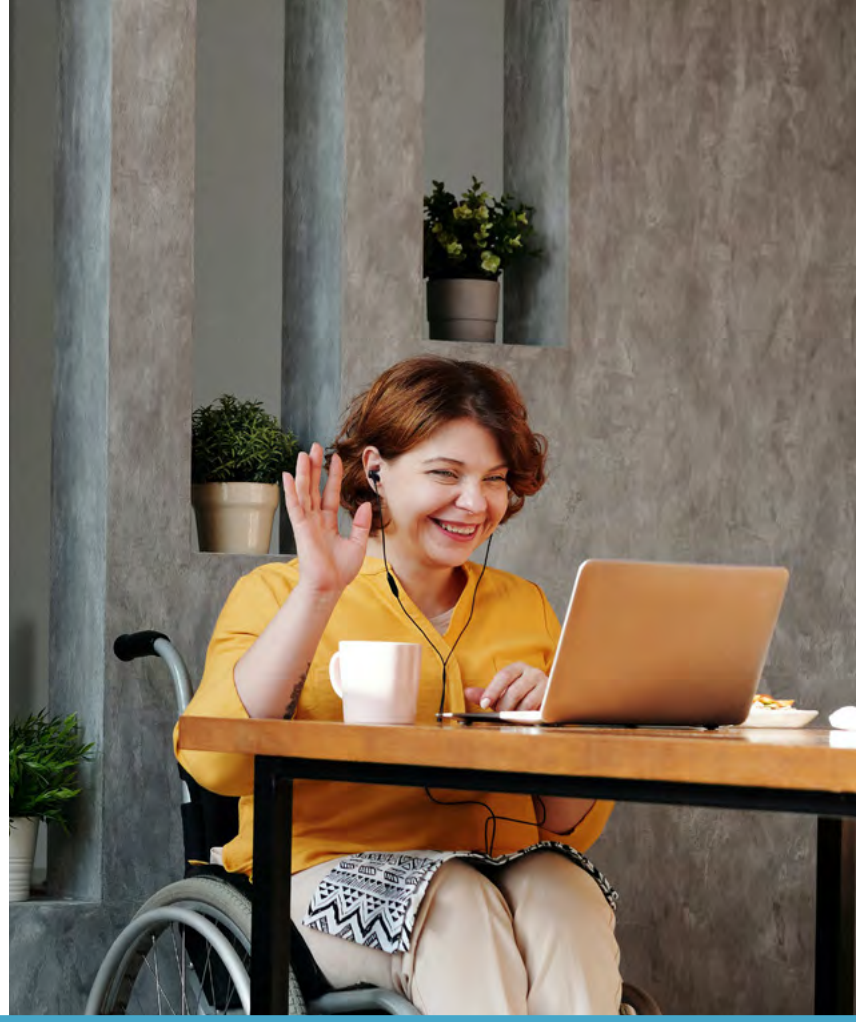
Virtual care is an important way of working for Sussex Community NHS Foundation Trust – helping us to support our patient care needs at the same time as reducing travel and our carbon footprint. However, it has to be used carefully – and in the right circumstances. This example in Occupational Therapy shows the value of this approach, with patient choice firmly in the centre of decision making.

The Community Neuro-Rehabilitation Team covering Horsham, Crawley and MidSussex added a virtual Occupational Therapist to the team in March 2022. Natasha provides all her occupational therapy patient consultations virtually, helping neurologically impaired patients with adjustments to manage their day-to-day tasks and activities. Patients are risk assessed for suitability and offered the choice of a virtual appointment, and either seen one-to-one or accompanied by a family member or Rehabilitation Support Worker.

Natasha said: *"Having a Virtual Therapist in the team has improved staff wellbeing and positively impacted on joint working, increasing autonomy and skills for the Rehabilitation Support Workers, and reduced the waiting lists which in turn reduced stress and pressure on staff members."*

"Virtual therapy can be beneficial to many services and impact patients positively who still gain good outcomes and improve their quality of life. In addition, it reduces the carbon footprint due to a significant reduction in travel, so it is much more environmentally friendly."

Between 2021/22 and 2022/23, by not needing to drive to patients' homes, the team saved 2,329 miles and 810 kg CO_2. That's roughly the same as a return flight from London to Lisbon, or driving from London to Edinburgh five times.



The team saved 2,329 miles and 810 kg CO_2. That's roughly the same as a return flight from London to Lisbon, or driving from London to Edinburgh five times.

We prevented potential instances of medicines-related harm for just under 1,200 patients and saved over 79,500 kg CO_2e.

CASE STUDY

Medicines optimisation in care homes

Medicines Optimisation in Care Homes (MOCH) teams are specialist teams of pharmacists and pharmacy technicians working within a Multi-Disciplinary Team model. At Sussex Community NHS Foundation Trust, our MOCH team has a unique focus on optimising medicines use for care home residents, ensuring people get the right choice of medicines, at the right time, and are engaged in the process.

Pharmacists and pharmacy technicians have ongoing discussions with patients, next-of-kin, and care home staff to review several aspects of their medicines. This might include whether patients can take the medicines effectively (inhaler technique for example), or discussing the risks and benefits of long-term medicines that may have changed since patients first started taking them.

Working with patients to optimise their medicines has numerous sustainability benefits: better patient outcomes, avoiding harmful side-effects, and reducing wastage.

Over a 3 month period it was estimated that patients and carers, with support and supervision from MOCH specialists, chose to stop over 5,600 unnecessary prescriptions. This was estimated to prevent potential instances of medicines-related harm for just under 1,200 patients and saved over 79,500 kg CO_2e.

The information over this period was collected by the MOCH team, provided by Clare Knight, Kayt Blythin and Louise Nicholson principal clinical pharmacists, B&H, East and West MOCH as part of the Medicines Management Team.

CASE STUDY

Development of a Green Plan prioritisation methodology

Delivering on our Net Zero and wider environmental targets is critical to the health of our patient community in Sussex. We need to deliver high impact projects as quickly as possible within the limited resource that we have available. As such, it's vital that we prioritise this resource in the right place – delivering on those projects which will bring the greatest benefit to our communities.

In order to achieve this, we have developed a methodology for prioritising Green Plan actions in our Care Without Carbon framework. The qualitative assessment determines the action priority score by assessing the value of delivery of the action against a number of different criteria mirroring the Trust's Green Plan ambitions and wider Trust-level strategic goals and motivations.

We've applied this methodology across each of our eight workstreams to inform our our long- and short-term delivery planning. Priority actions are translated onto our annual action plan, which is overseen by the Green Plan Oversight Group, made up of stakeholders from across the Trust and reporting into Resources Committee.

In this way, we can ensure our resources are driving carbon reductions as quickly and efficiently as possible and focusing on actions with the greatest benefit to our staff and patient community.

We've applied this methodology across each of our eight workstreams to inform our our long- and short-term delivery planning.

Respecting Resources

Where resources are required, prioritising use of treatments, products, technologies, processes and pathways with lower carbon, environmental and health impacts.

For this area of work, 2022/23 was a year of focus on the development and delivery of the highest impact carbon reduction projects identified in our Delivery Plan – those critical to achieving our interim sustainability targets in 2025/26.

Key projects included the installation of heat pumps at Chailey – one of our flagship sites for sustainable healthcare buildings, transitioning our operational fleet to electric vehicles (EVs) and tackling food waste.

CASE STUDY
NZC-R Chailey

In 2021, the Trust applied for funding through the Public Sector Decarbonisation Scheme, a government led scheme to support public sector organisations switch from fossil fuel heating systems to low carbon alternatives. The grant is highly sought after, and the value of applications has always exceeded the amount of funding available.

The Trust has been successful with its bid to retrofit two old gas boilers with new Air Source Heat Pumps at its Chailey Westfield site in East Sussex. The project is due to deliver carbon savings and will provide the site with a new, future-proof heating system. Heat pumps are not always well suited to retrofits, but the Chailey Westfield building has an existing underfloor heating system installed throughout the site and this operates at a temperature that is well matched to the output temperatures from the proposed heat pumps.

The procurement phase of the project completed in spring 2023 with works on site completed in autumn 2023.

The Trust has been successful with its bid to retrofit two old gas boilers with new Air Source Heat Pumps at its Chailey Westfield site in East Sussex

CASE STUDY

Transitioning to electric vehicles

Key to our Delivery Plan was a commitment to switching our operational fleet to electric vehicles (EVs). This will save 48 tonnes of greenhouse gas pollution per year by 2025, that's the equivalent of the energy needed for powering six homes for one year.

We have improved our reporting to visualise on a team by team basis our business travel greenhouse gas pollution. Making this information more accessible to teams will help to highlight the benefits of switching to EVs.

Emission limits are now in place on lease car scheme vehicles, that set emissions to under 110 grams of carbon dioxide per km. This will encourage adoption of EVs.

Currently, we have 17% electric vehicles within our operational fleet of 65 vehicles.

Replacing our remaining and petrol diesel vehicles to electric is on schedule and we are on track to achieve our target of 80% electric vehicles by March 2026.

We have assessed our charging requirements to support our operational fleet switch to electric vehicles with a charging infrastructure rollout planned for 2024/25.

We are on track to achieve our target of 80% electric vehicles by March 2026.

CASE STUDY

Saving paper, reducing waste

Following the introduction of recycled paper in 2019/20 we have maintained our use of recycled paper at 93% saving the equivalent of 3,000 trees and 27 tonnes of greenhouse gas pollution each year.

In line with the waste hierarchy of reduce/reuse/recycle we must also focus on using less paper overall, not just a switch to recycled paper.

One measure of this is looking at paper waste. As staff have adopted more digital behaviours following the COVID-19 pandemic the Trust has reduced its paper waste. In 2022/23, we reduced our production of confidential paper waste by 13 tonnes from 2020/21 levels the equivalent of 2.6 million sheets of paper or 260 trees.

Now we are working to create a culture of printing less to embed these behaviours and keep our paper use low. This will help us achieve our total waste reduction target of 15% by 2025/26 from 2019/20 levels.

We have reduced our production of confidential paper waste by 13 tonnes from 20-21 levels the equivalent of 2.6 million sheets of paper or 260 trees.

CASE STUDY

Food waste segregation

In 2022/23, we continued to improve our food waste collections from our largest sites Crawley Hospital, Brighton General Hospital, Horsham Hospital and The Kleinwort Centre. Concern regarding pests and internal logistics of collecting the waste onsite were both significant challenges to overcome. By working with our contractor, we were able to establish a more reliable and frequent service whilst overcoming several barriers.

As a result we diverted an estimated nine tonnes of food waste from energy from waste incineration to anaerobic digestion, saving 111 kg CO_2e tonnes of greenhouse gas pollution and creating two useful products, biogas for energy and biofertilizer for food production.

In 2023/24 we will build on improvements to our processes and services with a planned rollout of food waste collections to our other sites. By April 2024 waste food from all of our inpatient catering services will be segregated and sent for anaerobic digestion.

By segregating our waste food, we can measure it, which means we can begin to take targeted action to significantly reduce waste. This will be our focus in 2024/25 alongside expanding our food waste collections to other sites.

We diverted an estimated nine tonnes of food waste from energy from waste incineration to anaerobic digestion, saving 111 kg CO_2e tonnes of greenhouse gas pollution.

CASE STUDY

Reducing pollution related to medical gases

Nitrous oxide is a common medicine used in hospitals in the form of Entonox, also known as ‘gas and air’. It is a safe and effective medicine, however it has a high environmental impact. At Sussex Community NHS Foundation Trust we use this gas mostly in our Urgent Treatment Centres, Minor Injuries Units and Dental Services.

Over the last few years, we have been streamlining our use and reducing any waste in our processes, resulting in a 15% reduction in greenhouse gas emissions in 2022/23, since our baseline year (2019/20).

During 2023/24, we are working with our pharmacy team to explore a trial of an alternative pain relief (Penthrox), which is equally effective but is a more sustainable option compared to nitrous oxide. It is used in several other healthcare settings in Sussex and across the country. This will ensure a considerable reduction in pollution related to medical gases and reduce our environmental impact.

Over the last few years, we have been streamlining our use and reducing any waste in our processes, resulting in a 15% reduction in greenhouse gas emissions.

Working across the system: Maximising impact

A collaborative approach

NHS
Sussex Community
NHS Foundation Trust

We are committed to achieving our Net Zero ambitions at Sussex Community NHS Foundation Trus, for the benefit of our patients and our staff.

That's why we place so much value on our work together with NHS partners within NHS Sussex and further afield. Collaborative projects across the system ensure we can have maximum impact for our patients at Sussex Community, NHS Foundation Trust with the ability to capitalise on economies of scale and efficient sharing of best practice.

care WITHOUT CARBON

Our partner work

Sussex Community NHS Foundation Trust has been working towards lower carbon care for over a decade now both within our own Trust but also supporting other trusts to do the same.

The Care Without Carbon team offers a range of skills from energy management to staff engagement to help these Trusts on their journey to Net Zero.

Working together as NHS organisations, enables us to realise greater benefits for our patients at Sussex Community NHS Foundation Trust as we:

- Share learning and specialist expertise – and avoid duplication.
- Deliver joint projects that bring impact and efficiencies of scale.
- Use our influence to effect greater change.
- Show strength and leadership in the sector by setting joint commitments – and delivering on them.
- Communicate as one voice on sustainability to our patient community.

Collaborative working within Sussex ICS

Over the last year, we have continued to develop our partnership working within NHS Sussex and the southeast to deliver a more cohesive and impactful approach to reducing emissions.

Collaborative projects across the system ensure we can have maximum impact for our patients at Sussex Community.

Over the next few pages we highlight three key areas of collaborative working within Sussex ICS from 2023.

As a healthcare system, we need to adapt to the immediate consequences our changing climate is bringing.

CASE STUDY

Sussex Climate Impact Assessment

As climate change accelerates, we are seeing direct and immediate consequences of heatwaves and extreme weather on our patients, the public and on our services. As a healthcare system, we need to adapt to the immediate consequences our changing climate is bringing.

Understanding the future impact of changes to our climate is essential to ensure that we can continue to deliver quality care for our patients through timely adaptation measures.

To help with this, we commissioned a Climate Impact Assessment for Sussex with investment from the Greener NHS team. The report focuses on understanding the climate impacts on our patients, NHS services and estates in Sussex over the period from 2030 to 2080.

Key findings

The impact assessment identifies 10 key areas of focus, including familiar examples such as high temperatures and heatwaves, flooding and air pollution. However, it also identifies other longer-term impacts that provider trusts will need to address including; increased risks of subsidence across the estate, vector bourne diseases and food security.

Next steps

The report has helped us understand broadly the potential risks to our healthcare system in Sussex. Conducting more localised climate impact risk assessments must come next; ensuring any high risks identified are added to our corporate risk registers; and developing action plans to deal with these. This will form a key aspect of our Green Plan programme over the coming years.

In spring 2023, CWC supported NHS Sussex in successfully applying for over £700k of funding through the government's Low Carbon Skills Fund.

CASE STUDY

Achieving a Net Zero NHS estate in Sussex: Our Heat Decarbonisation Plan (HDP) programme

Ensuring our NHS estate is both low carbon and resilient to the impacts of climate change is critical to the health of our communities in Sussex. Delivering on our Net Zero goals is a huge challenge – requiring upgrades to almost all of our sites across Sussex.

The first step is to understand what upgrades will be required to each of our buildings and how much the work will cost. This is where our HDP programme comes in.

The biggest NHS HDP programme in England

In spring 2023, Care Without Carbon supported NHS Sussex in successfully applying for over £700k of funding through the government's Low Carbon Skills Fund.

This funding is being used to develop 54 HDPs in Sussex including six of our sites at SCFT. These HDPs will provide detailed assessments of our NHS buildings, identifying potential projects (including costs) to support decarbonisation in line with the 2040 Net Zero target. Energy efficiency measures, low carbon heating solutions or on-site renewable energy could be included as part of these suggestions for further improvements.

How will this help?

Once completed, we'll be able to use the findings from these HDPs to develop accurate Net Zero Roadmaps focused on meeting our interim targets to 2025 and 2030. They will also inform our capital plans at Trust and ICS level, and provide the basis for external funding bids – both critical to ensuring deliverability of our ambitious, but critical, Net Zero objectives.

CASE STUDY

Engaging staff through Together to Zero: Reducing carbon for healthier lives

With 80% of our carbon footprint driven by clinical decisions, delivering Net Zero will require a big shift in how we deliver care. We require input from clinicians, care professionals and communities across the healthcare system. So finding ways to engage with staff on sustainable healthcare – in an increasingly pressured landscape – is vital.

Over 12 months during 2022/23, we worked with frontline NHS staff from across Sussex to develop a new staff engagement campaign, Together to Zero (TTZ).

Together to Zero

Our aim is to empower NHS staff in Sussex to support sustainable healthcare and make a positive difference to how their organisation delivers care.

The ask is simple: add your voice to a call for change in how we deliver care – because reducing emissions means reducing admissions.

Our new website – Care Without Carbon's sustainable healthcare hub for Sussex

The hub of the engagement campaign is the newly redeveloped Care Without Carbon website.

Staff can visit the website to add their voice for Net Zero – and to find out more about how they can support in reducing carbon for healthier lives.

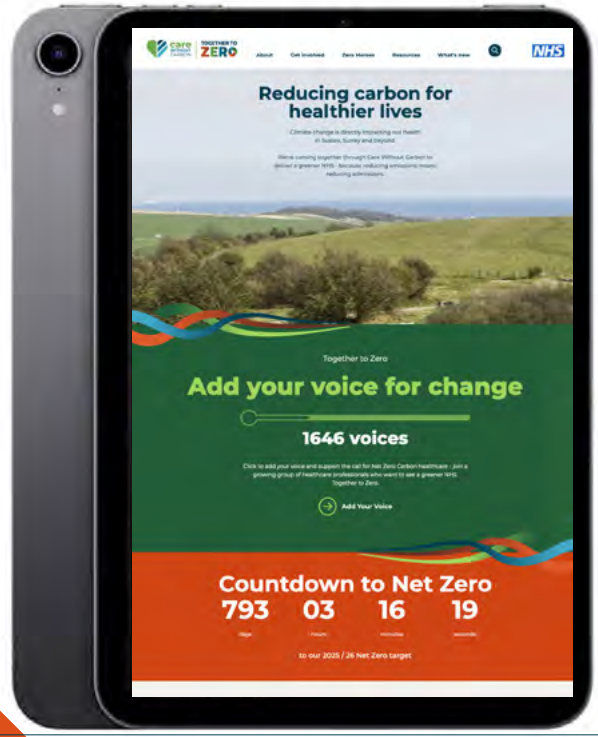
The hub hosts a wealth of sustainable healthcare guidance, inspiration from other Zero Heroes and case studies of shared best practice.

Your voice for Net Zero

Adding your voice for change is an important first step – join a growing group of healthcare professionals who want to see a greener NHS.

We hope to inspire staff across SCFT to support our Green Plan journey by joining this call for change.

Reducing carbon for healthier lives.



Looking ahead: The challenge of Net Zero

Challenges and opportunities

A system in flux

It's clear that climate change is directly impacting the health of our populations in Sussex. We need to act now to ensure we can continue to deliver excellent care at the heart of the community, in the context of climate change, because reducing emissions means reducing admissions.

We're working in the context of a healthcare system under huge pressure. Working from the base of an already stretched healthcare system, the NHS has had an immensely challenging time in the years since 2020 and the pandemic, with:

- ongoing backlogs from the pandemic adding to demand for services;
- growing demand generally, especially around winter;
- limited capital funding and an aging estate creating significant financial challenges and;
- the cost-of-living crisis impacting on staff and patient wellbeing.

A balanced approach

Healthcare demands action in the present; and as an NHS trust, our patient needs are paramount.

Our challenge is meeting the immediate needs of our patients while also creating the change needed to adapt to and mitigate against climate change, with its attendant impact on the health of our patients and communities.

Recognising these pressures on patients, staff, the Trust and the wider healthcare system, we need to approach and embed sustainable practice in a way that helps solve some of these system challenges rather than add to them.

How we will manage this to ensure we deliver on Net Zero

We know that if we are to hit Net Zero Carbon we must change the ways we deliver care, making sustainability part of our everyday thinking and decision making.

Key to delivery of our Green Plan in the context of these system challenges will be:

- **Always putting our patients and staff first**, promoting sustainable solutions that help support staff and manage demand on services from digital solutions to a focus on prevention.
- Focussing our activity on **delivering change that really matters** – taken a data driven approach, working to best practice strategies and rigorously prioritising.
- **Integrating sustainable healthcare principles into existing processes and projects** wherever possible – supported by the development of sustainability skills and tools not only within the Care Without Carbon team, but also for key teams across the Trust.
- **Explore new avenues for delivery** of Net Zero through improvement, innovation, research and development.
- **Continuing to share our learning across the system** in order to avoid duplication, drive value from collaboration and benefit from taking on bigger challenges together.
- **Celebrate the success of our staff and teams** as we progress, using the new Care Without Carbon website to feature case studies and shine a light on changemakers through Zero Heroes to inspire others to action and maintain momentum.

Next 12 months

Over the last year, the Care Without Carbon programme has undergone a transformative shift, with new governance and reporting structures, strong clinical representation and collaborative workstream groups enabling a much greater integration into core business than we have seen before.

Our focus for the next 12 months remains on continuing to develop this integration as well as focusing on delivery of key, high-impact sustainability projects. These projects will support our climate change mitigation goals, as well as bringing a new emphasis on climate adaptation.

01

Refocussing through the pandemic: Responding to the increase in personal protective equipment (PPE) and business mileage post pandemic.

Gloves off: Support our infection prevention and control team to promote safe, best practice and appropriate glove use with clinical colleagues and monitor the environmental benefits of reduced glove consumption as a result.

Agile working programme: Embedding a culture of agile working across the Trust, and accelerating and scaling clinical digital

02

Deeper clinical integration across the Trust: Meeting Net Zero by 2040 requires a big shift in delivery of care which cannot be achieved without input from clinicians.

Nitrous oxide: Using our detailed service-level NOx data, deliver a carbon reduction programme with MIU, dental and UTC clinicians in line with our 25/26 carbon reduction target.

Staff engagement: Deliver our Together to Zero engagement campaign and launch our deeper engagement programme at Sussex Community NHS Foundation Trust, Care Challenge, Share.

Key clinical projects: Work with project leads to integrate sustainable healthcare principles into key Trust projects including virtual consultations, UCR and community nursing.

03

Delivering against our NZC commitment: To keep us on track towards this challenging target

Owned estate: Finalise our NZ Roadmap project plan based on data from Heat Decarbonisation Plans and integrate into the capital plan and deliver for 2024/25 and 2025/26.

EV charging: Introduce EV charging infrastructure across key sites with a focus on operational fleet initially.

Sustainable procurement: Develop and enhance our use of Net Zero and Social Value criteria in all procurements to empower and motivate our suppliers to change their practices and join us on our journey to Net Zero.

Indirect emissions: Priority projects based on food/catering footprint – e.g. menu changes and link in to nutrition and hydration group.

04

Cimate adaptation: Buildinlg resilience to our changing climate in Sussex

Climate Impact Assessment: Using the Sussex CIA, identify the key risks of climate change to our patients, staff, services and estate at SCFT – and develop an adaptation plan to tackle this.

Health inequalities: Work with our public health consultant to identify which of our patient groups will be most vulnerable to the impacts of climate change.

05

Escalating our impact through partnership working: Leading on system wide approaches to tackling carbon emissions

Joined up approach to sustainability across NHS Sussex: Build on our current links to more formally drive value from collaboration and shared learning across our local healthcare system.

Research and Innovation: Explore new avenues for delivery of net zero through research and innovation projects.

Appendices

Appendix One
Our carbon footprint reporting boundary

The Greenhouse Gas (GHG) Protocol Corporate Accounting and Reporting Standard sets out two distinct approaches to setting accounting boundaries, as set out below.

Equity Share Approach – Where accounting for emissions is undertaken according to the share in the company in terms of economic interest.

Control Approach – Where an organisation accounts for 100% of emissions from operations over which it has control. Control is defined in either financial or operational terms. In addition, it introduces three scopes, as follows:-

- **Scope 1:** Direct emissions. These occur from sources owned or controlled by the reporting organisation.
- **Scope 2:** (Indirect) purchased energy emissions. These occur as a result of purchased energy consumed by the reporting organisation, but where the emissions occur from another organisation.
- **Scope 3:** Other indirect emissions. All other emissions that occur as a consequence of organisational activity, but which are not reportable in Scope 1 or 2.

The approach adopted by Sussex Community NHS Foundation Trust is to report on emissions from the activities over which it exerts operational control. In other words, the accounting boundary is drawn around the clinical services that the Trust is commissioned to deliver and which are therefore delivered in accordance with Trust policies and procedures.

This approach aligns the Trust's GHG reporting with other national NHS reporting processes and standards, notably the annual Estates Return Information Collection (ERIC).

In the case of the estate the Trust occupies (most of which is leased from third parties) this means that we account for emissions from energy we consume in the same way for both our owned and leased assets, ensuring only those emissions relating to the services provided by the Trust are reported.

The recent NHS England Improvement climate change strategy, "Delivering a Net Zero National Health Service", set out two clear targets for the NHS, as follows.

- Net Zero carbon by 2040 for the emissions we control directly (NHS Carbon Footprint).
- Net Zero carbon by 2045 for the emissions we can influence (NHS Carbon Footprint Plus).

Figure three shows emissions sources that fall within each of the NHS Carbon Footprint and NHS Carbon Footprint plus. Whilst there are no Scope 2 or 3 emissions reportable under the NHS Carbon Footprint Plus, the NHS Carbon Footprint does include emissions sources reportable under all three scopes.

At Sussex Community NHS Foundation Trust, we currently only measure the emissions that make up our NHS Carbon Footprint, but we are undertaking work to allow us to be able to confidently expand this to include emissions sources within our *NHS Carbon Footprint Plus* as soon as practicably possible. Whilst we are yet not in a position to fully measure and report the latter, in the main body of this report we do make reference to the contribution it makes to our total combined carbon footprint. This is an estimation based on the fact that, on average, the NHS Carbon Footprint makes up approximately 24% of the total combined carbon footprint. As we measure and report this component, we are then able to estimate the emissions that constitute our NHS Carbon Footprint Plus.

Appendix Two provides activity data and associated emissions for the emissions sources that constitute our NHS Carbon Footprint.

Our carbon footprint base year is currently 2010/11 but, in line with national NHS guidance, we are in the process of rebaselining to 2019/20 and so will report against this for the first time following 2023/24.

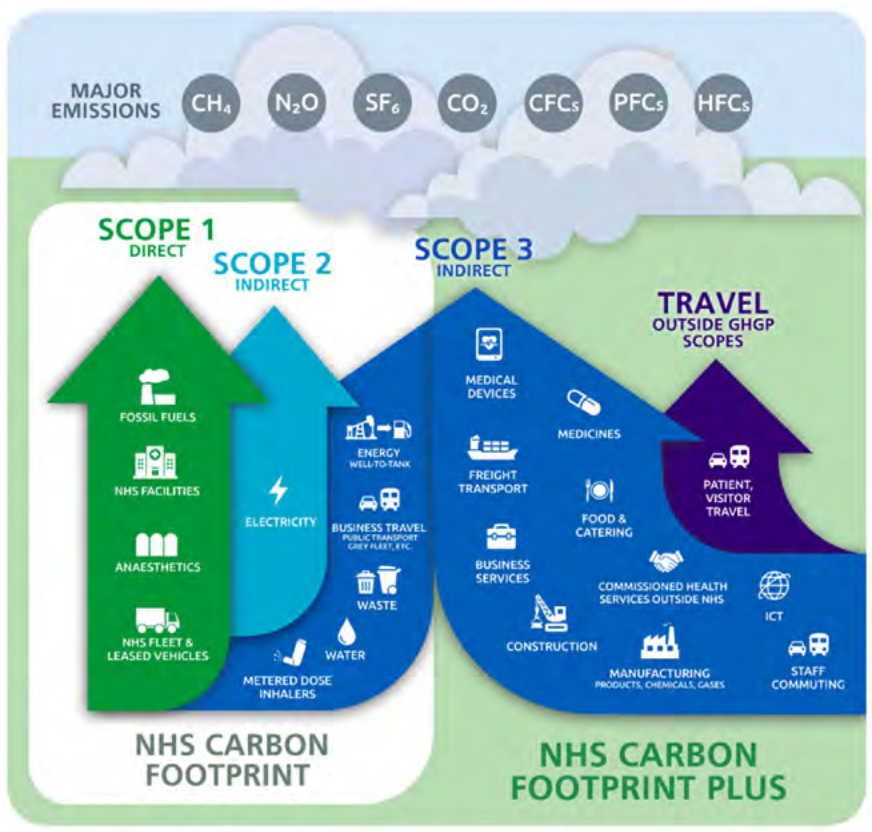


Figure 3: Emissions sources that fall within each of the NHS Carbon Footprint and NHS Carbon Footprint plus.

Appendix Two
Activity data and reported emissions by source

Table 1 below details all activity data associated with our NHS Carbon Footprint.

Scope	Emission Source	Units	2010/11	2019/20	2020/21	2021/22	2022/23
1	Fossil Fuels	kWh	15,772,544	12,349,499	11,546,529	11,551,367	10,864,309
1	NHS Facilities	N/A	Not reported	Not reported	Not reported	Not reported	Not reported
1	Anaesthetics	kg	231	486	318	463	500
1	NHS Fleet and leased vehicles	Miles	1,204,492	1,323,050	1,091,902	1,098,462	1,125,252
2	Purchased electricity	kWh	6,548,879	5,510,847	4,912,458	4,620,040	4,631,541
3	Business travel	Miles	5,053,738	4,061,009	3,130,509	3,555,885	3,494,913
3	Waste	Tonnes	817	826	781	874	840
3	Water	Meters^3	94,423	62,406	68,335	66,321	67,109
3	Metered dose inhalers	No. units	0	646	738	742	742

Explanatory notes

1. Metered dose inhaler data not currently available for 2010/11 reporting year so nil activity reported. As part of the re-baseline project, we will be able to include in the new 2019/20 baseline.
2. At this time, Business Travel only includes mileage claims made by staff in their own vehicles. We are looking to expand this to other forms of business travel, such as rail and bus.

Table 2 below below details all emissions reported based on the activity data provided on the previous page.

Scope	Emission Source	Units	2010/11	2019/20	2020/21	2021/22	2022/23
1	Fossil fuels	tCO_2e	2,921	2,273	2,125	2,120	1,987
1	NHS Facilities	N/A	Not reported	Not reported	Not reported	Not reported	Not reported
1	Anaesthetics	tCO_2e	72	145	95	138	149
1	NHS Fleet and leased vehicles	tCO_2e	294	228	183	187	189
2	Purchased electricity (location based)	tCO_2e	3,178	1,409	1,145	981	896
2	Purchased electricity (market based)	tCO_2e	3,178	998	1,409	1,122	1,182
3	Energy WTT	tCO_2e	1,018	774	547	729	655
3	Business travel	tCO_2e	1,583	1,157	864	981	960
3	Waste	tCO_2e	165	75	76	83	80
3	Water	tCO_2e	96	63	69	27	27
3	Metered dose inhalers	tCO_2e	0	13	11	10	10
3	Business travel WTT	tCO_2e	319	297	223	258	254

Explanatory notes

1. Metered dose inhaler data not currently available for 2010/11 reporting year so nil activity reported. As part of the re-baseline project, we will be able to include in the new 2019/20 baseline.
2. At this time, Business Travel only includes mileage claims made by staff in their own vehicles. We are looking to expand this to other forms of business travel, such as rail and bus.

Appendix Three
Carbon footprint verification

Statement of verification

Sussex Community NHS Foundation Trust
Environment and Logistics Arundel Building
Brighton General Hospital
Elm Grove,
Brighton
BN2 3EW

03 October 2023

Scope

Sussex Community NHS Foundation Trust (SCFT) engaged Carbon Footprint Ltd to verify its carbon footprint assessment and supporting evidence for the period **1st April 2022 to 31st March 2023**. SCFT is responsible for the information within the carbon footprint report. The responsibility of Carbon Footprint Ltd is to provide a conclusion as to whether the statements made are in accordance with the Greenhouse Gas Protocol Corporate Accounting and Reporting Standard.

Methodology

The verification was led by Zoe Rudge, Senior Environmental Consultant, Carbon Footprint Ltd. Carbon Footprint Ltd completed the review in accordance with the *'ISO 14064 Part 3 (2019): Greenhouse Gases: Specification with guidance for the verification and validation of greenhouse gas statements'*. The work was undertaken to provide a Limited level of assurance with respect to the GHG statements made. Carbon Footprint Ltd believes that the review of the assessment and associated evidence, coupled with this subsequent report, provides a reasonable and fair basis for our conclusion.

The following data was within the scope of the verification (below shows the post-audit results):

Scope	Source	Total	Unit
1	Company car travel (Trust milage), Natural gas consumption, Medical Gases, Liquid Fossil Fuels	2,325	tCO_2e
2	Electricity consumption	896 1,182	tCO_2e (location-based) tCO_2e (market-based)
3	Waste generated in operation, Use of Meter Dose Inhalers, Business travel (grey fleet), Water supply and wastewater, Well-To-Tank and Electricity Transmission and Distribution.	1,986	tCO_2e (location-based)
Subtotal (Scopes 1,2 and 3)		**5,207** **5,493**	**tCO_2e (location-based)** **tCO_2e (market-based)**

Assurance opinion

Based on the results of our verification process, Carbon Footprint Ltd provides limited assurance of the GHG emissions statement, **and found no evidence that the GHG emissions statement:**

- is not materially correct and is not a fair representation of the GHG emissions data and information.
- has not been prepared in accordance with the Greenhouse Gas Protocol Corporate Accounting and Reporting Standard.

It is our opinion that SCFT has established appropriate systems for the collection, aggregation and analysis of quantitative data for determination of GHG emissions for the stated period and boundaries.

Zoe Rudge, *BSc (Hons), MSc*
Senior Environmental Consultant
Carbon Footprint Ltd

Appendix Four
Our route to Net Zero: carbon reduction projects to 2025/26

At Sussex Community NHS Foundation Trust, our Delivery Plan sets out a detailed action plan and trajectory for reducing our direct emissions (primarily energy, business travel and medical gases) between now and our first interim target in 2025.

We have identified and started delivering on carbon reduction opportunities totalling a saving of 8,97tCO_2e to meet our 2025/26 carbon reduction target of 4,161tCO_2e. This leaves us with a gap of 92tCO_2e between our target and our modelled emissions by 2025/26 based on the position in November 2022. Our progress on these projects is set out below.

Note: this excludes the three sites recently transferred from NHS PS to the Trust. The Trust also plans to identify additional projects across these three new sites and others through the Heat Decarbonisation Plans funded through the government's Low Carbon Skills Fund.

Delivery Plan carbon reduction projects: estates

Action	Carbon savings to 25/26	Status
Chailey Westfield – Heating Electrification	53	● In progress
Chailey Westfield – DWHS Electrification	7	● Feasibility study required
Portslade HC – replacement glazing	2	● Business case to be developed
Portslade HC – LED lighting works	2	● Business case to be developed
Solar PV project	61	● Partly complete (Chailey)
Enhanced Energy Metering & Monitoring (automated reports and BMS interrogation)	7	● In progress – automated reporting under test
Non-specific projects where additional capital could be used to support carbon reduction	TBC	● Ongoing
Estates rationalisation	7	● Ongoing
Leased estate on target	187	● Ongoing

● Action likley to be delivered at current pace. ● Action likely to be delivered with some additional resource before 2025/26. ● Action unlikely to be delivered with current resource.

Delivery Plan carbon reduction projects: travel and medical gases

Action	Carbon savings to 25/26	Status
Digitilisation of services to reduce business travel – Patient visits, Community	113	● Project planning due to commence
Agile and remote working to reduce business travel – Meetings and Training	120	● Ongoing
Improve business mileage information for teams	14	● Performance team developing
Electrifying the Trust's owned fleet	48	● In progress but dependent on EV charging
Electrifying the Trust's leased fleet	41	● TBC
Electrifying grey fleet	114	● Requires plan
Increase active and public transport within business travel	TBC	● Requires plan
Reduce use of nitrous oxide or implement destruction kit	108	● Business case to be developed

● Action likley to be delivered at current pace. ● Action likely to be delivered with some additional resource before 2025/26. ● Action unlikely to be delivered with current resource.

For more information please contact:
Susie Vernon – Associate Director Sustainability

susie.vernon@nhs.net

Discover more at:
carewithoutcarbon.org

NHS
Sussex Community
NHS Foundation Trust

care WITHOUT CARBON

Sussex Community NHS Foundation Trust

Report to:	Trust Board	**Meeting date**:	28 March 2024
Report title:	Integrated Performance Report – Month 11 2023/4	**Agenda number**:	11
Author(s):	Ceri Davies, Deputy Director of Strategic Planning and Performance; Ed Rothery, Director of Finance and Performance; Phil Woolf, Head of Performance Analysis; Performance Team; Executive Directors for each section	**Owner(s)**:	Mike Jennings, Deputy Chief Executive and Chief Financial Officer

Purpose:	**Decision/Approval**		**Assurance**		**Briefing**	X

Link to Trust Strategic Goals:		
A Great Place to Work	X	
Continually Improve	X	
Digital Leader	X	
Reducing Service Inequities	X	
Sustainability	X	

Link to corporate objectives and BAF risks

The Integrated Performance Report is relevant to all Trust strategic goals and includes any operational and digital risks scored 15 or above.

Link to Care Quality Commission (CQC) questions:		
Caring	X	
Effective	X	
Responsive	X	
Safe	X	
Well-Led	X	

NHS
Sussex Community
NHS Foundation Trust

Executive summary:

Following feedback from the Trust's Board, the Integrated Performance Report (IPR) has been redesigned with a stronger focus on key areas of performance:

- Data is more timely. This IPR includes performance to the end of February.
- Performance exceptions are in a single dashboard at the start of the report.

Each section of the balanced scorecard – Quality, Operational Performance, Workforce and Finance – begins with an executive summary.

Outcome/action requested:

The Board is asked to:

Note and discuss current performance, including:

- Areas highlighted in each executive summary, covering success, strategy and delivery, and emerging risks and issues.
- Metrics showing performance exceptions.

An operational risk, scored at 16, in the Diabetes Care for You (DCFY) Podiatry team.

Trust goals, corporate objectives and strategic risks

The Integrated Performance Report is relevant to all Trust strategic goals and includes any operational and digital risks scored 15 or above.

Equality, diversity and/or reducing inequities:

An equality impact assessment has been carried out and no impacts identified.

Previously reviewed by:

Relevant Executive Directors

Sussex Community
NHS Foundation Trust

Integrated Performance Report

Month 11 February 2024
(reported 28th March 2024)

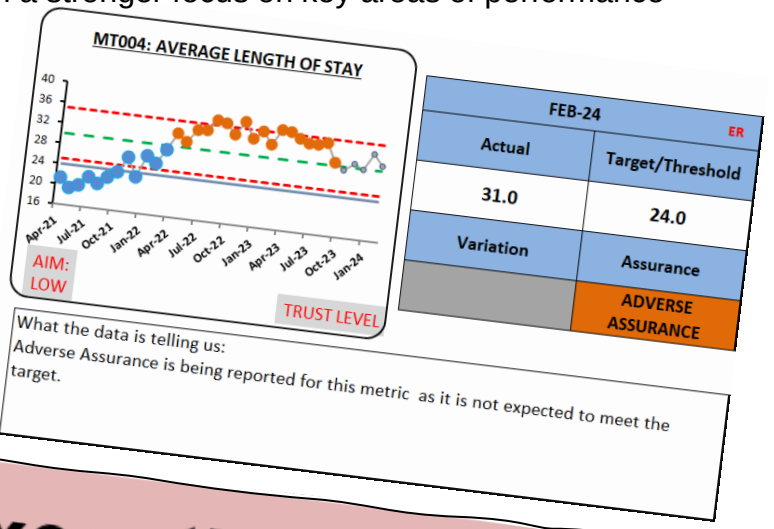
Mike Jennings
Deputy Chief Executive and Chief Financial Officer

Excellent care at the heart of the community

Changes to the Integrated Performance Report

Following feedback from Trust Board, the IPR has been redesigned with a stronger focus on key areas of performance

- Data is more timely.
  This IPR includes performance to end of February.
- Performance exceptions are in a single dashboard at the start of the report, with full dashboards at the end.
- Each section begins with an executive summary, covering success, strategy and delivery, and emerging risks and issues.
- A new design explains why metrics are being reported as exceptions and displays the key statistics.
  Commentary is focused on actions and timescales.



TRUST SCORE CARD - EXCEPTIONS

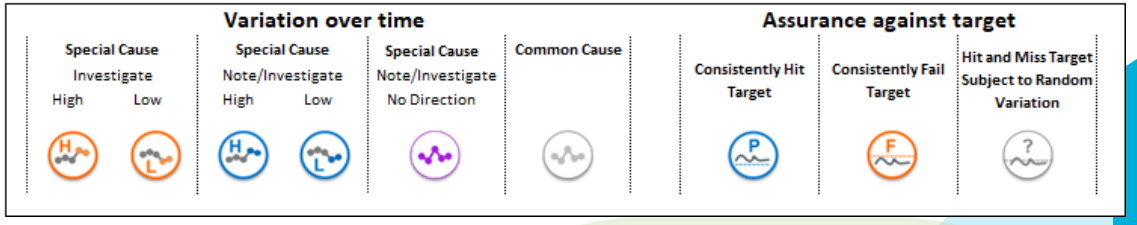
CATEGORY	METRIC		KEY POINTS	ACTUAL Variation	TARGET/ THRESHOLD Assurance	EXCEPTION
QUALITY	MT128	ALL HOSPITAL INFECTION OUTBREAKS DECLARED IN MONTH	February: Crawley ward flu outbreak. All patients recovered. Positive evidence of close teamworking to manage outbreak.	RAG	RAG	MONTH RAG (RED) YTD RAG (RED)

This month's exceptions

TRUST SCORE CARD - EXCEPTIONS

CATEGORY	METRIC		KEY POINTS	ACTUAL	TARGET/ THRESHOLD	EXCEPTION
				Variation	Assurance	
QUALITY	MT128	ALL HOSPITAL INFECTION OUTBREAKS DECLARED IN MONTH	February: Crawley ward flu outbreak. All patients recovered. Positive evidence of close teamworking to manage outbreak.	RAG	RAG	MONTH RAG (RED) YTD RAG (RED)
QUALITY	MT278	COMPLAINTS: RESPONDED TO IN TIME	Two complaints exceeded 45 day target (by 4 and 9 days respectively).	H	?	ADVERSE VARIATION
OPERATIONAL PERFORMANCE	MT004	AVERAGE LENGTH OF STAY	Established escalation processes in place to support timely inpatient discharges. Clinical harm reviews monitor impact of long hospital stays. Include incidents; patient's mobility or mental state deteriorating; and increased support needs (eg for washing and dressing) that could impact independence post-discharge.		F	ADVERSE ASSURANCE
OPERATIONAL PERFORMANCE	MT160	OCCUPIED BED DAY RATE		L	?	ADVERSE VARIATION
OPERATIONAL PERFORMANCE	MT029	PATS NOT MEETING CRITERIA TO RESIDE - % BED DAYS		L	F	ADVERSE VARIATION ADVERSE ASSURANCE
OPERATIONAL PERFORMANCE	MT022	NEURO DEVELOPMENT PATHWAY (NO. WAITING)	Internal SCFT capacity increased plus external provider being funded to deliver 300 assessments.	L	No Target	ADVERSE VARIATION
OPERATIONAL PERFORMANCE	MT270	UCR - 2 HOUR RESPONSE RATE	Response rate remains above target. Reduction coincides with increased demand on Urgent Community Response service.	H	P	ADVERSE VARIATION FAVOURABLE ASSURANCE
OPERATIONAL PERFORMANCE	MT103	COMM NURSING FACE TO FACE CONTS PER 10K POPULATION	National benchmarking and learning from Beds Optimisation informing Community Nursing Improvement Programme.		No Target	SPECIAL VARIATION
WORKFORCE	MT107	SICKNESS RATE	Range of activity addressing short and long term sickness, including piloting enhanced return-to-work interview tool.	L	F	ADVERSE VARIATION ADVERSE ASSURANCE
WORKFORCE	MT520	STAFF WITH EITHER APPRAISAL OR PDR WITHIN 12 MTHS	New and improved PDR process will better support learning requirements, talent management and career progression.	H	F	FAVOURABLE VARIATION ADVERSE ASSURANCE
FINANCE	MT512	I&E SURPLUS (£000)	Improved financial run rate over past two quarters. Confident plans are in place to meet the year end breakeven target.	H	F	FAVOURABLE VARIATION ADVERSE ASSURANCE
FINANCE	MT515	CAPITAL SPEND (£000)	Higher spend in final quarter expected as schemes move towards completion. On track to be close to plan at year end.			SPECIAL VARIATION

Reading the dashboards



Risks

This month's Integrated Performance Report (IPR) includes one Operational Performance risk currently scored at 15 or above.

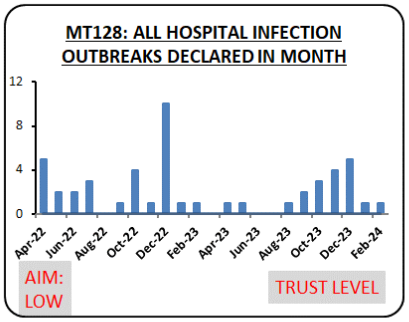
Quality Report

Quality Executive Summary

Success	• Findings recently released from NHS Impact's national baseline survey of improvement work. SCFT is one of 41% of NHS providers to include quality improvement (QI) training in staff induction and one of 95% with an agreed improvement methodology, although most are using either Quality, Service Improvement and Redesign (QSIR) or Lean. The results will be used to share and spread best practice. They will help embed strong and sustainable peer to peer learning and support networks. • Life Stage Framework self-assessment has been completed as part of the improvement programme, with 96% of services responding, 200 unique submissions and 9,500 data points. Engagement underway with operational teams to identify their top three improvement areas. General managers adding these to their portfolio of improvement activity and aligning with business planning. Initial results available and evaluation and data analysis in progress, the latter identifying characteristics of high performing teams. Aim is to drive improvement and deliver components of the Trust strategy.
Strategy and Delivery	• Delivery of the Trust allied health professional (AHP) strategy. Standardised clinical AHP competencies are being embedded within teams, moving into phase 2 (support workers and digitisation) for 2024/25. AHP community fed back a preference to focus on workforce commitments as a priority. Therefore focus for coming year will be around supported job planning and career development for AHPs, as well as promotion. Scoping of an AHP quality dashboard has started. In May Quality Improvement Committee will review implementation planning of the AHP strategy. • The Trust is working with the integrated care board (ICB) to redefine the quality improvement plan for rehabilitation, including a workstream relating to personalised care. The Personalised Care Network has been launched and is attended by clinicians and patients with lived experience.
Emerging Risks and Issues	• SCFT digital clinical governance structures have been strengthened with the introduction of CLOUD (clinical oversight for the use of digital). It allows us to respond quickly and with confidence to any incidents linked to our electronic patient record (EPR) IT system, enabling close partnership working between the digital clinical team and the patient safety team. • Recent engagement meeting with the Care Quality Commission (CQC) provided further information about the arrangements for the new inspection framework. CQC advised they will prioritise high risk organisations. While the new framework is being piloted this will be with social care providers initially. CQC were unable to provide further detail about the evidence to support Quality Statements and had no plans to be prescriptive about this, requiring providers to determine this themselves. They also advised they were not able to confirm the characteristics for an outstanding rating but that trusts could submit evidence they felt demonstrated outstanding care.

Quality Exception Report

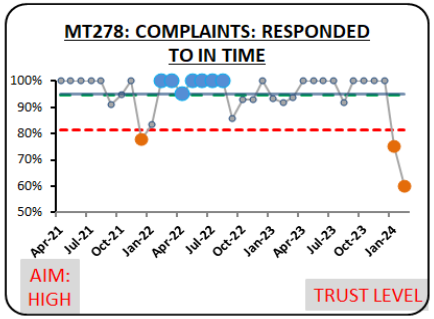
SAFE



FEB-24	
Actual	Target/Threshold
1	0
Variation	Assurance
MONTH RAG (RED)	YTD RAG (RED)

What the data is telling us:
This metric is reporting MONTH RAG (RED) as the current month actual (1) is above target (0)
This metric is reporting YTD RAG (RED) as the YTD actual (19) is above target (0)

Actions	**A flu outbreak** was declared during February on a ward at Crawley Hospital. Five patients were affected, all of whom recovered. No staff caught flu during the outbreak. As with all outbreaks, a lessons learned review was conducted. There was positive evidence of teams working closely together to manage the outbreak and there were no identified lapses in care.
Timescale	The System infection prevention and control winter surge plan was implemented on 1st February and remains in place. It reduced the isolation period for patients with Covid 19 and the respiratory human metapneumovirus (HMPV) from five days to three. This helps increase the number of community beds available. The plan has not led to more outbreaks. At the time of writing (mid-March), the cases reported here were the only outbreak since the escalation measure started.



FEB-24	
Actual	Target/Threshold
60.0%	95.0%
Variation	Assurance
ADVERSE VARIATION	

What the data is telling us:
This metric is reporting Adverse Variation as performance is below the expected range.

Actions	The **timeframe for responding to a complaint** depends on the complexity of investigation and response it requires. Of the five complaints closed in February, two breached their target time for response. For both, the target was 45 working days. For one, the Area Head of Nursing requested an extension to enable further information to be gathered. The complainant was notified that the investigation would take longer and the case was closed after 54 days. For the other, the deadline for replying was calculated incorrectly and the investigation went slightly beyond 45 days. The case was closed after 49 days, although the target date that had been communicated to the complainant was achieved.
Timescale	Both complaints have now been closed.

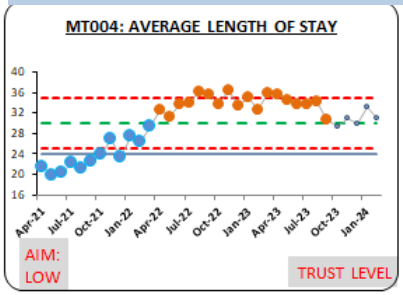
Operational Performance Report

Operational Performance Executive Summary

Success	• The Trust now has access to a SECAmb web portal that shows patients currently waiting for an ambulance. It enables Urgent Community Response and UCR Plus teams to identify and visit suitable patients, reducing demand on the ambulance service. SCFT is the first provider in the region to go live with this approach. It builds on an already-established daily SCFT-SECAmb meeting, which on average was identifying nine additional referrals a week for the UCR service. That has already more than doubled since the portal was introduced.
Strategy and Delivery	• Transformation of SCFT's virtual wards service is underway, building on experience since its launch and recent national reviews of the Sussex provision. The service is being remodelled to focus more on admission avoidance. It is part of a wider Sussex move towards 'virtual health', including using remote monitoring to identify when patients with long term conditions are at risk of deteriorating. • February's Sussexwide Discharge Summit agreed to pursue a 'discharge to recover' model. This would increase the proportion of acute inpatients discharged to their usual place of residence instead of a community hospital or temporary stay in a care home. As part of this, a greater percentage of assessments about patients' ongoing care needs would happen after discharge as opposed to in hospital. A demand and capacity plan will be developed, including identifying how funding would move to support the increased use of community services such as Urgent Community Response.
Emerging Risks and Issues	• There continues to be a risk to patient care in the Diabetes Care for You service, caused by capacity in its podiatry team. A detailed update is provided at the end of the Operational Performance section of the IPR.

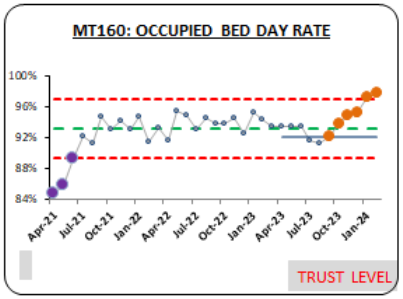
Operational Performance Exception Report

INTERMEDIATE CARE



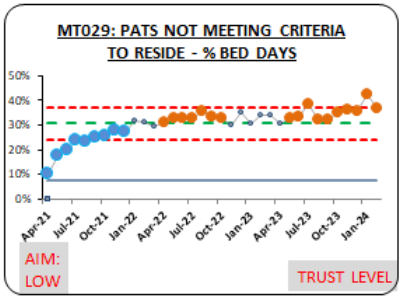
FEB-24	
Actual	Target/Threshold
31.0	24.0
Variation	Assurance
	ADVERSE ASSURANCE

What the data is telling us:
Adverse Assurance is being reported for this metric as it is not expected to meet the target.



FEB-24	
Actual	Target/Threshold
97.9%	92.0%
Variation	Assurance
ADVERSE VARIATION	

What the data is telling us:
This metric is reporting Adverse Variation as performance is above the expected range.

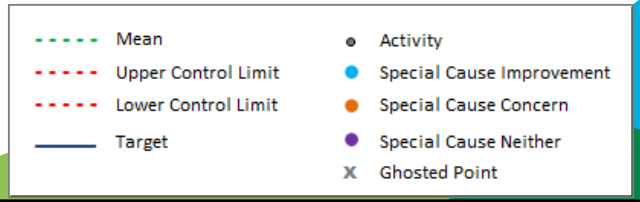


FEB-24	
Actual	Target/Threshold
37.1%	7.5%
Variation	Assurance
ADVERSE VARIATION	ADVERSE ASSURANCE

What the data is telling us:
This metric is reporting Adverse Variation as performance has been above the mean for 7 or more months.
Adverse Assurance is being reported for this metric as it is not expected to meet the target.

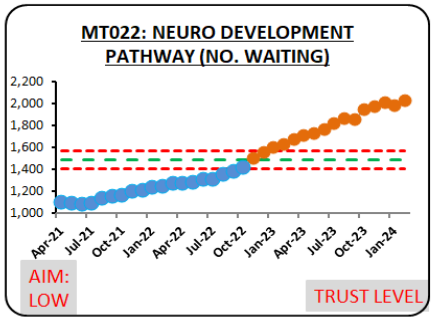
Actions	**Supporting flow.** Established escalation processes are in place to support timely inpatient discharges. These include Area senior leadership teams and clear routes to colleagues at System level and within adult social care. **Clinical harm reviews** monitor the impact of long hospital stays on patient experience and outcomes. The scoring considers incidents, for example pressure ulcers and falls, and also factors such as a deterioration in someone's mobility or mental state, or them needing increasing support with activities such as washing and dressing – something that could impact on their independence post-discharge. The fourth phase of the Trust's **Beds Optimisation Programme** will include delivering training on the new enhanced support policy. This focuses on consistently assessing, and safely delivering, levels of support and observation for inpatients requiring enhanced care.
Timescale	The end date of the Community Beds programme final phase has been extended to September 2024. This is to allow time to embed changes and establish robust arrangements to monitor these changes and to oversee ongoing improvements.

Statistical process control (SPC) charts key



Operational Performance Exception Report

CHILDREN



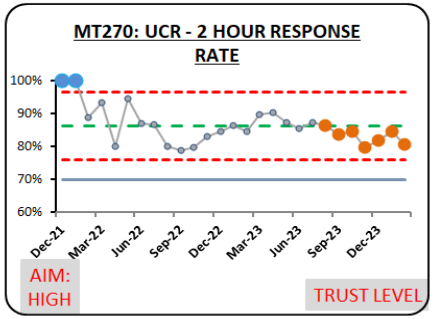
FEB-24	
Actual	Target/Threshold
2028	No Target
Variation	Assurance
ADVERSE VARIATION	

What the data is telling us:
This metric is reporting Adverse Variation as performance is above the expected range.

Actions	**Internal capacity.** The Trust has increased its capacity; training more staff for aspects of the neuro developmental assessment; increasing resource in key roles; providing weekend clinics and using locums. **External provider.** SCFT is funding an external provider to deliver 300 assessments for children. By the end of May, this is projected to reduce the total number of children on the pathway to the mid-September 2023 level. The clinics started on 6th January, with an assurance process in place to ensure the quality of the externally-delivered assessments. Children are counted in this performance metric until their assessment is completed, so it does not yet reflect the impact of the new provision.
Timescale	The external provider is on schedule to complete the first 160 assessments by the end of April. A further 140 families are now being contacted.

Operational Performance Exception Report

WELLBEING



FEB-24	ER
Actual	Target/Threshold
80.8%	70.0%
Variation	Assurance
ADVERSE VARIATION	FAVOURABLE ASSURANCE

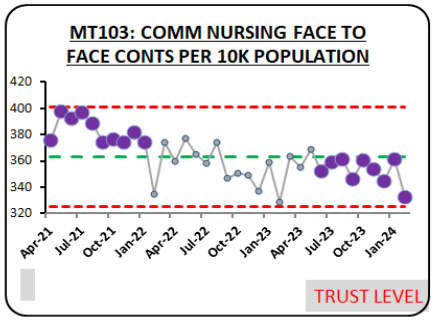
What the data is telling us:
This metric is reporting Adverse Variation as performance has been below the mean for 7 or more months.
Favourable Assurance is being reported for this metric as the target is expected to be met.

ER means externally reported:
published nationally or included in the NHS Oversight Framework

Actions	**Increased activity.** The reduction in response rate coincides with an increase in demand on SCFT's Urgent Community Response (UCR) service. It had more than 3,300 referrals requiring a two hour response in the first 11 months of 2023/24, reaching three quarters of them within the target time. This metric includes two hour performance for the UCR and overnight services, and has remained above the 70% national target throughout the year. In December, the latest month for which confirmed national performance is available, SCFT's response rate was 2% points under the national average and in the middle of providers across England. The number of two hour referrals was the tenth highest among 113 providers nationally.
Timescale	Performance continues to be monitored through the UCR performance workstream and Finance, Performance and Quality (FPQ) meetings.

Operational Performance Exception Report

COMMUNITY & OUTPATIENTS



FEB-24	
Actual	Target/Threshold
332.4	-
Variation	Assurance
SPECIAL VARIATION	

What the data is telling us:
This metric is reporting Special Variation as performance has been below the mean for 7 or more months.

Actions	The **Community Nursing Improvement Programme** is applying learning from SCFT's Beds Optimisation Programme, with five workstreams now established: • **Right patient** including referral triage, patient assessment and self management. • **Right caseload/workload** including reviewing and optimising the size of caseloads and number of patient visits; rostering and multi disciplinary team (MDT) working. • **Right intervention** including wound care and patient centred and individualised care. • **Right staff** including safe staffing, skill mix and continuous professional development (CPD). • **Right digital** including setup of the SystmOne electronic patient record and performance data. **Benchmarking data** for community nursing has been used to identify areas where SCFT may be an outlier. Levels of patient contacts are lower than the national average. However further work is needed to understand if more contacts would equate to more effective and efficient care. **SCFT ran a safer staffing audit** across all community nursing teams in February following a successful pilot. It uses a nationally developed methodology to assess the complexity of care being delivered to each patient and the resources needed to do so safely.
Timescale	The newly established programme board met for the first time in February. Phase one of delivery due to start in June.

Operational risks scoring 15 or above

Title	**Insufficient capacity for clinical demands in the Diabetes Care for You (DCFY) Podiatry team**
Description	There is a risk to patient care and safety in DCFY where the vacancy and turnover of podiatry staff has meant prioritisation of clinical need. The podiatry staff vacancy rate has improved, but the service has been unable to recruit to the correct skill mix so there will be a reduction in capacity to see patients in an appropriate, personalised follow-up timeframe. Ongoing vacancies at Band 7 and some planned short term sickness mean there will also be a risk of patients not seeing a clinician with the appropriate knowledge and skills to provide them with the necessary care. Possible future turnover, upcoming planned long term sickness, short term sickness and the skill mix of staff left in the team have also contributed to the risk. The service is currently prioritising those with active foot ulceration but this means increasing waits for foot protection clinics. When the risk was raised, 56% of the patients who were waiting had breached their follow up appointment date with a median wait beyond their appointment due date of 10 weeks. Currently 30% of patients who are waiting have breached their follow up appointment date with a median wait beyond their appointment due date of five weeks. The potential impact of current delays may be indicated by learning from the pandemic, when podiatry patients also experienced increased waits. A clinical harm review of Covid-related delays showed a harm rate of 6% in the community podiatry caseload.
Control Measures	**Workforce** Newly recruited 0.8 whole time equivalent (WTE) Band 7 has joined the team. Anticipating risk score can be reduced mid April once new starter inducted and long term sickness resolved. 46% vacancy at Band 6, being re-advertised. Recruited to fixed term Healthcare Assistant role to support podiatry clinics. Locum in place. Having an apprentice within the team for longer term recruitment strategy. **Caseload** Risk stratifying caseload. Prioritising high risk patients and evaluating potential for clinical harm. Following communications to primary care, the Trust has written to patients assessed as lower risk. The letter explains the likely delay in their care, describes risk signs associated with deterioration and provides contacts back into the service for those who rapidly decline. **Assurance and oversight** Daily touch point calls to ascertain risk and priorities each day and alternate weekly senior management meeting. Using risk assessment matrix for situation report (sitrep)/reviews.
Further actions to reach target score	Recruitment to funded establishment with appropriately skilled staff. Establish a robust development plan for junior staff and competence sign off. Longer term resource for professional development support. Agreement about next steps on new referrals and the existing patients with low podiatric need.
Current Risk Score	Consequence: 4 (major) Likelihood: 4 (likely) Current risk score = 16

Workforce Report

Workforce Executive Summary

Success

- Workforce metrics show a strong performance across the board. Sickness is seasonal and continues to be impacted by elevated levels of short-term sickness caused by coughs, colds, flu and respiratory symptoms.
- NHS Staff Survey results released on 8th March. Exceptional level of staff engagement with the survey. SCFT's 72% response rate was highest among community trusts (national community average 60%) and top amongst provider trusts in Sussex (average response rate 51% excluding SCFT). SCFT also significantly outperforms the national response rate of 48%. Our highlights:

	2022	2023	Average*
Recommend organisation as place to work	69%	74%	68%
Recommend as place to receive treatment	78%	80%	77%
Care of patients/service users is organisation's top priority	81%	82%	82%

Appendix B: Significance testing – 2022 vs 2023

Survey Coordination Centre NHS

Statistical significance helps quantify whether a result is likely due to chance or to some factor of interest. The table below presents the results of significance testing conducted on the theme scores calculated in both 2022 and 2023*. For more details please see the technical document.

** Statistical significance is tested using a two-tailed t-test with a 95% level of confidence.*

People Promise elements	2022 score	2022 respondents	2023 score	2023 respondents	Statistically significant change?
We are compassionate and inclusive	7.78	3692	7.85	3968	Significantly higher
We are recognised and rewarded	6.38	3691	6.59	3974	Significantly higher
We each have a voice that counts	7.14	3662	7.22	3930	Significantly higher
We are safe and healthy	6.29	3665	6.53	3926	Significantly higher
We are always learning	5.93	3576	6.20	3753	Significantly higher
We work flexibly	6.83	3679	7.07	3952	Significantly higher
We are a team	7.16	3681	7.29	3968	Significantly higher
Themes					
Staff Engagement	7.22	3692	7.35	3969	Significantly higher
Morale	6.05	3693	6.35	3975	Significantly higher

Strategy and Delivery

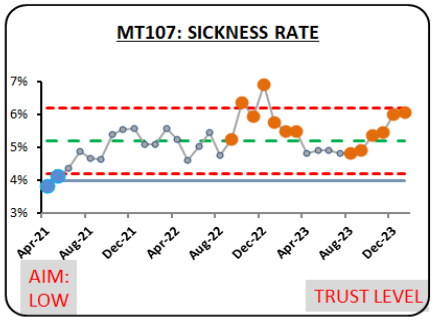
- The latest iteration of the Strategic Workforce Plan (SWP) was presented at Workforce Group. It was well-received, with progress on its development noted. Discussion focussed on the approach required for the next stage of development, including ensuring stakeholder engagement and alignment with the wider People Strategy Delivery Plan (PSDP).

Emerging Risks and Issues

- A future reduction has been proposed for SCFT's thematic workforce risk score in light of the positive developments and progress evidenced in the SWP.

Workforce Exception Report

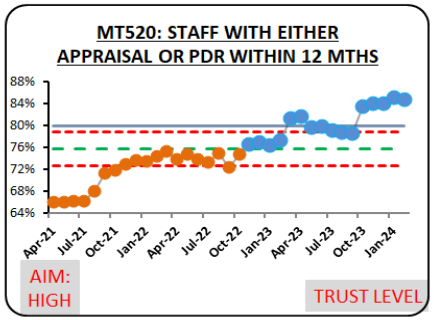
PERFORMANCE



JAN-24	ER
Actual	Target/Threshold
6.1%	4.0%
Variation	Assurance
ADVERSE VARIATION	ADVERSE ASSURANCE

What the data is telling us:
This metric is reporting Adverse Variation as performance has been showing an upward trend for over 6 months.
Adverse Assurance is being reported for this metric as it is not expected to meet the target.

Actions	A range of activity is **addressing both short and long term sickness**. An enhanced **return-to-work interview** tool has been developed for use by managers meeting with returning staff members. It is being piloted. A number of teams have been chosen to participate in **team-level sickness deep dives**. A mix of quantitative and qualitative information will inform the development of specific, tailored local approaches to sickness absence management. The **health and wellbeing passport** is being promoted to encourage use by managers and staff. **'Supporting attendance' training sessions** run to improve sickness management in the Trust. **Individual case management plans** are developed for all long-term absentees. Reporting includes **analysis of outliers and high impact teams,** helping inform strategy and approach.
Timescale	A refreshed sickness deep dive report is to be presented at May's People Committee.



FEB-24	ER
Actual	Target/Threshold
84.9%	80.0%
Variation	Assurance
FAVOURABLE VARIATION	ADVERSE ASSURANCE

What the data is telling us:
This metric is reporting Favourable Variation as performance is above the expected range.
Adverse Assurance is being reported for this metric as it is not expected to meet the target.

Actions	**Internal and external engagement** on Performance Development Reviews (PDRs) now complete. It is anticipated that the resulting new and improved PDR process will better support learning requirements, talent management and career progression. HR business partners are regularly conducting **data quality audits** on PDRs. Recent checks show correct recording on the ESR staff record computer system, an improvement on previous audits. PDRs are **reviewed and monitored monthly at FPQ**. HR business partners offer support to teams. Guidance and associated literature is available on the Trust's intranet The Pulse.
Timescale	Development of revised PDRs, including work on adding them to the Trust's new learning management IT system, to continue in quarter one of 2024/25.

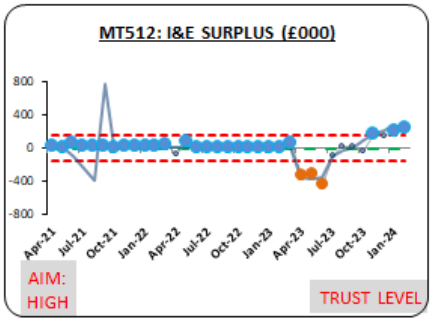
Finance Report

Finance Executive Summary

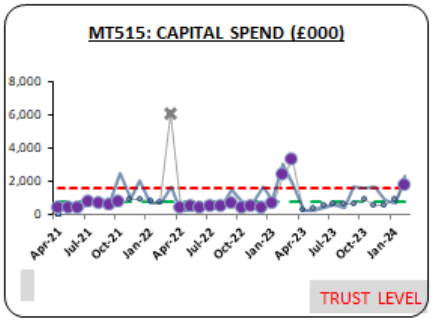
Success	• At the end of February, SCFT remains on track to deliver a breakeven financial position for 2023/24. This is a significant achievement in the context of challenging financial and operational conditions. • Performance on a number other key metrics remains favourable to plan, including on BPPC performance. Cash balances are slightly below plan at the end of February but we expect that the position improves by the end of March.
Strategy and Delivery	• The Trust is developing financial plans for the 2024/25 financial year. It is working alongside system partners to develop plans that are sustainable financially and continue to focus on best value for our patients and populations. • We continue to explore opportunities to increase capacity for out-of-hospital services where they can provide better care for patients and better value in terms of the use of scarce financial resources. • Final plans will be agreed with NHS England for the Sussex ICS. SCFT's draft plan, developed collaboratively with ICS partners, has a breakeven position in 2024/25. That includes the need to achieve £14.9m of efficiency programmes. Delivering the plan and efficiencies will require support from the ICB and our system partners.
Emerging Risks and Issues	• Medium term planning still shows a sustainability risk for the Sussex system with further mitigations to be developed. For SCFT, medium term financial sustainability remains a key strategic risk and is kept under review through our Executive team and Resources Committee. • Although we believe we have mitigated the most significant risks to delivery of the financial targets in the current year, risks to delivery in the 2024/25 financial year are recognised as being in excess of £11m, £7m after mitigations.

Finance Exception Report

FINANCE



FEB-24	ER
Actual	Target/Threshold
225	213
Variation	Assurance
FAVOURABLE VARIATION	ADVERSE ASSURANCE



FEB-24	
Actual	Target/Threshold
1684	2300
Variation	Assurance
SPECIAL VARIATION	

What the data is telling us:
This metric is reporting Special Variation as performance is above the expected range.

Actions	**The Trust is reporting a year to date deficit of £450k against a plan of £244k**, an adverse variance of £206k. For February the Trust reported a £225k surplus against a plan of £213k, a favourable variance of £12k. **Our financial run rate has improved over the past two quarters** with reductions in agency costs, contractual agreements that have reduced non pay spend and increased income receipts. We continue to review financial risks and opportunities to the end of the current financial year and we are confident that plans are in place to meet the year end breakeven target.
Timescale	End March 2024

Actions	**The profile of spend** on the Trust's capital programme for 2024/25 is based upon forecast assumptions that there will be an increase in costs over the final quarter of the financial year as a number of investment schemes move towards completion. This is the case in February where capital spend increased to £1,684k in the month, the highest spend in a single month since March 2023. The high spend in **February** was driven by a number of investment schemes, including at the Brighton General site, in Hove, Arundel and Bognor. Despite this we are reporting spend of £7,464k for the year to date which is £2,876k behind plan. However plans are kept under review and on track to be close to plan by the end of March 2024.
Timescale	March 2024

Performance Dashboards

Quality Dashboard

CATEGORY	METRIC		ACTUAL			TARGET/THRESHOLD				EXCEPTION	REPORTING MONTH	MONTHLY / QUARTERLY
			Variation	Month	YTD	Assurance	Month	YTD	Annual Target / Threshold			
SAFE	MT170	PATIENT SAFETY INCIDENT INVESTIGATIONS DECLARED	-	0	3	No Target	-	-	-		FEB-24	M
	MT175	PATIENT LEARNING RESPONSES (AAR,SEIPS,TR) DECLARED	-	13	19	No Target	-	-	-		FEB-24	M
	MT072	NEVER EVENTS	RAG	0	0	RAG	0	0	0		FEB-24	M
	MT280	ALL HCAIS:SCFT LAPSE IN CARE IN THE PAST 12 MONTHS	RAG	0		RAG	0		0		FEB-24	M
	MT128	ALL HOSPITAL INFECTION OUTBREAKS DECLARED IN MONTH	RAG	1	19	RAG	0	0	0	MONTH RAG (RED) YTD RAG (RED)	FEB-24	M
	MT066	MIXED SEX ACCOMMODATION BREACHES	RAG	0	0	RAG	0	0	0		FEB-24	M
	MT266	PATIENT SAFETY INCIDENTS CAUSING HARM (MODERATE+)		0.9%	0.9%		1.3%	1.3%	1.3%		FEB-24	M
	MT267	PRESSURE ULCERS: CAT3&4 SCFT LAPSE	RAG	0.0	1.0	RAG	0.8	9.2	10.0		FEB-24	M
	MT129	MEDICATION INCIDENTS: TOTAL MODERATE OR ABOVE	RAG	0	0	RAG	0	0	0		FEB-24	M
	MT043	FALLS: TOTAL MODERATE OR ABOVE	RAG	1.0	16.0	RAG	1.5	16.5	18.0		FEB-24	M
	MT117	VTE: RISK ASSESSMENT		98.0%	97.7%		95.0%	95.0%	95.0%		FEB-24	M
	MT527	% HAND HYGIENE OBSERVATIONS COMPLIANT(ICU/UTC/MIU)		98.4%	98.4%		90.0%	90.0%	90.0%	FAVOURABLE VARIATION FAVOURABLE ASSURANCE	FEB-24	M
	MT528	% HAND HYGIENE OBSERVATIONS COMPLIANT(COMM TEAMS)		97.9%	98.0%		90.0%	90.0%	90.0%	FAVOURABLE ASSURANCE	FEB-24	M
CARING	MT522	PATIENT FFT: SERVICE EXPERIENCE VERY GOOD/GOOD		96.3%	96.5%		93.0%	93.0%	93.0%	FAVOURABLE ASSURANCE	FEB-24	M
RESPONSIVE	MT278	COMPLAINTS: RESPONDED TO IN TIME		100.0%	95.3%		95.0%	95.0%	95.0%		DEC-23	M
	MT495	CAS ALERTS CLOSED IN TIME	RAG	100.0%	100.0%	RAG	100.0%	100.0%	100.0%		FEB-24	M

Operational Performance Dashboard

CATEGORY	METRIC		ACTUAL			TARGET/THRESHOLD				EXCEPTION	REPORTING MONTH	MONTHLY / QUARTERLY
			Variation	Month	YTD	Assurance	Month	YTD	Annual Target / Threshold			
INTERMEDIATE CARE	MT004	AVERAGE LENGTH OF STAY		31.0	32.4	F	24.0	24.0	24.0	ADVERSE ASSURANCE	FEB-24	M
	MT160	OCCUPIED BED DAY RATE	L	97.9%	93.9%	?	92.0%	92.0%	92.0%	ADVERSE VARIATION	FEB-24	M
	MT029	PATS NOT MEETING CRITERIA TO RESIDE - % BED DAYS	L	37.1%	35.1%	F	7.5%	7.5%	7.5%	ADVERSE VARIATION ADVERSE ASSURANCE	FEB-24	M
CHILDREN	MT022	NEURO DEVELOPMENT PATHWAY (NO. WAITING)	L	2028		Target TBC				ADVERSE VARIATION	FEB-24	M
	MT033	CYP COMMUNITY HEALTH SERVICES - TOTAL WAITING		3857		Target TBC					FEB-24	M
WELLBEING	MT112	TALKING THERAPIES: PATIENTS MOVED TO RECOVERY		58.5%	54.8%	P	50.0%	50.0%	50.0%	FAVOURABLE ASSURANCE	FEB-24	M
URGENT CARE	MT088	PATIENTS IN MIU/UTC <4 HOURS	H	98.9%	98.6%	P	95.0%	95.0%	95.0%	FAVOURABLE VARIATION FAVOURABLE ASSURANCE	FEB-24	M
	MT270	UCR - 2 HOUR RESPONSE RATE	H	80.8%	84.5%	P	70.0%	70.0%	70.0%	ADVERSE VARIATION FAVOURABLE ASSURANCE	FEB-24	M
	MT020	UCR - % PATIENTS NOT MEETING CRITERIA TO RESIDE		40.8%	39.2%	Target TBC					FEB-24	M
	MT130	VIRTUAL WARD OCCUPANCY RATE		80.6%	69.1%	?	80.0%	80.0%	80.0%		FEB-24	M
	MT131	NUMBER OF VIRTUAL WARD BEDS (AT MONTH END)	H	118		?	100		100	FAVOURABLE VARIATION	FEB-24	M
COMMUNITY & OUTPATIENTS	MT031	DIAGNOSTIC WAITS <6 WEEKS		96.8%	94.0%	?	95.0%	95.0%	95.0%		FEB-24	M
	MT115	RTT WAITING TIME INCOMPLETE PATHWAYS: >65 WEEKS	L	0		?	0		0	FAVOURABLE VARIATION	FEB-24	M
	MT007	COMMUNITY HEALTH SERVICES - TOTAL WAITING	L	17347		Target TBC				FAVOURABLE VARIATION	FEB-24	M
	MT150	DNA RATE		8.6%	7.9%	Target TBC					FEB-24	M
	MT073	AVG DAYS FROM REF TO DISCH FOR COMM NURSING PATS		91	93	?	90	90	90		FEB-24	M
	MT103	COMM NURSING FACE TO FACE CONTS PER 10K POPULATION		332.4	354.2	Target TBC				SPECIAL VARIATION	FEB-24	M
	MTxxx	*POP HEALTH: LIKELIHOOD OF DEPRIVED PATIENTS WAITING LONGER (IN DEVELOPMENT)*										

Workforce Dashboard

CATEGORY	METRIC		ACTUAL			TARGET/THRESHOLD				EXCEPTION	REPORTING MONTH	MONTHLY / QUARTERLY
			Variation	Month	YTD	Assurance	Month	YTD	Annual Target / Threshold			
PERFORMANCE	MT116	VACANCY RATE	L	4.5%		?	9.5%		9.5%	FAVOURABLE VARIATION	FEB-24	M
	MT139	MONTHLY TURNOVER RATE		0.72%		?	1.43%		1.43%		FEB-24	M
	MT107	SICKNESS RATE	L	6.1%		F	4.0%		4.0%	ADVERSE VARIATION ADVERSE ASSURANCE	JAN-24	M
	MT520	STAFF WITH EITHER APPRAISAL OR PDR WITHIN 12 MTHS	H	84.9%		F	80.0%		80.0%	FAVOURABLE VARIATION ADVERSE ASSURANCE	FEB-24	M
	MT025	TRAINING: ALL STATUTORY COURSES - SUBSTANTIVE	H	96.2%		P	85.0%		85.0%	FAVOURABLE VARIATION FAVOURABLE ASSURANCE	FEB-24	M

Finance Dashboard

CATEGORY	METRIC		ACTUAL			TARGET/THRESHOLD				EXCEPTION	REPORTING MONTH	MONTHLY / QUARTERLY
			Variation	Month	YTD	Assurance	Month	YTD	Annual Target / Threshold			
FINANCE	MT512	I&E SURPLUS (£000)	H	225	-450	F	213	-244	0	FAVOURABLE VARIATION ADVERSE ASSURANCE	FEB-24	M
	MT513	CASH (£000)		30128		?	30958		26852		FEB-24	M
	MT514	BPPC (%)		95.0%	95.1%	?	95.0%	95.0%	95.0%		FEB-24	M
	MT515	CAPITAL SPEND (£000)		1684	7464		2300	10340	11904	SPECIAL VARIATION	FEB-24	M
	MT002	AGENCY ONLY COSTS AS % PAYBILL		3.4%	3.5%	?	3.7%	3.7%	3.7%		FEB-24	M
	MT519	CIP DELIVERY (£000)	H	1713	14795	?	1491	15162	16700	FAVOURABLE VARIATION	FEB-24	M

Sussex Community NHS Foundation Trust

COMMITTEE CHAIR'S REPORT TO BOARD

Committee name:	**People Committee**
Name of Chair:	**Mandy Chapman**
Date of meeting:	**5th March 2024**

Main items on agenda:	• Workforce Group & H&S Chairs Reports
	• Trust Workforce Performance Report
	• People Strategy Delivery Report
	• Workforce Systems Programme Report
	• Deep dives
	  ○ Flexible working
	  ○ Retention
	  ○ Voice of our people
	  ○ Violence Prevention and Reduction
	• Workforce Thematic Risk Review

Points for Board to note (if any):	• **Trust Workforce Performance Report –**
	  ○ **Sickness absence** increased to 6% against a target of 4% but this is broadly in line with the seasonal trend and lower than this time last year. Short term absence accounts for 59% and is mainly due to coughs, colds and flu. The main cause of long-term sickness is to MSK and Mental Health. There is an ongoing focus on sickness management and improving the use of return-to-work interviews. There will be a deep dive at the next meeting to better understand, regional and national sickness trends.
	  ○ **Retention performance** is at 81.7% showing an improving trend across all regions, we are getting close to our 82.5% target.
	  ○ **Recruitment –** median time to recruit continues to improve for both internal and external candidates. The committee was assured that the impact of new standard operating procedures and training are having a positive impact. We hope to see further improvement as digital solutions (digital ID checks and digital recruitment forms) are implemented over 24/25.
	  ○ **Ratio of white appointments vs BAME** is still above target and an ongoing focus for improvement. Recruitment training for managers is being developed and further work continues to support recruitment from abroad through all channels.
	• **People Strategy Delivery** – We looked at progress this year against the 3-year People Strategy and received some assurance that we are on track, as 37% of actions have already been completed and 39% partially completed. We reviewed the long list of completed actions and progress against each strategy pillar and were assured that they are directionally delivering the outcomes intended.
	• **Workforce Systems Programme Report** – There will be more detail to follow once the tendering process for the e-rostering system provider is completed in April.
	• **Flexible Working** – We were updated on the diagnostic phase of a project to look at how effectively we are using flexible working across the trust and to identify areas where we could improve. While we already receive quite positive feedback from staff in the survey on this, there are new areas where we could add flexibility to make as a more attractive place to work (flexible retirement, flexible team rostering and flexible job design) which will be explored further.

	• **Retention** – We were updated on recent work to understand retention issues across the Trust looking at retention of new starters after a year. While we have seen improvement in overall retention, the reasons for staff leaving are complex. The metrics appear to be consistent across all teams and across gender and ethnicity. However, retention is lower in younger staff and in pay bands 2 and 3. A list of proposed actions was shared, and we will continue to track this metric at People Committee. • **Voice of our People Group** – We discussed this innovative group which allows open discussions on staff experience within the Trust. • **Violence Prevention and Reduction Update** – we received a report on the implementation of the national NHS Violence Prevention and Reduction Standard which was launched in April 2023 highlighting the risks challenges and priorities for SCFT. Of particular note, we heard that most incidents continue to happen in Urgent Community Response. Actions are being taken to improve incident reporting, provide a communication toolkit to support staff to feel more empowered to handle any incidents and at a Trust-level to engage more effectively with Sussex Police. • **Workforce Thematic Risk Review –** ○ **Workforce Risk Score 16 –** We agreed that the risk should stay at 16 until some of the new systems developments are completed and adding value and the SCFT long-term workforce plan is more clearly defined.
Items for escalation to the Board (if any):	• None

Sussex Community
NHS Foundation Trust

COMMITTEE CHAIR'S REPORT TO BOARD

Committee name:	**Resources Committee**
Name of Chair:	Mark Swyny
Date of meeting:	26th March 2024
Main items on agenda:	• Month 11 Financial performance • 2024/25 Business plan • ERIC (estates return information collection) report • BGH F block additional works • Service Line review • Improvement programme portfolio
Points for Board to note (if any):	<u>Financial performance</u> • Month 11 ytd position shows a £450k deficit (vs planned £244k deficit) and an in-month surplus of £224k. • Assurance received that we remain on track to deliver full year outturn of breakeven after £321k income reduction to support Sussex outturn is applied by ICB. • Cost Improvement Plan has achieved £14,795k savings against stretch target of £15,162k. Expectation that full year target (£16.7m 5.4%) will be achieved although work ongoing to ensure appropriate classification of cost savings. • Capital spend is £7,464k, £2,876k behind plan. Spend is being closely monitored and expectation is delivery in line with plan at year end. • Cash position has reduced to £30.1m due mainly to payments to NHSPS. • Current Sussex system position shows year end forecast of £31m deficit. <u>2024/25 Business plan</u> • Update provided following March extraordinary board meeting and ongoing discussions with NHS Sussex. • Plan submission will show breakeven position (previously £2m deficit) and an increase in the efficiency programme ask of £0.9m to £14.9m. • Support for 'route to breakeven' has been received from ICB. • Financial risk has increased to £5.3m after mitigating actions and committee highlighted additional risk from MSK tender outcome and SPC which should be considered. <u>ERIC report</u> • Insights provided on nationally submitted data on estates and benchmarking position. • Whilst no specific actions were highlighted, there is a need to improve data quality and data controls, and a plan to do so has been set for the coming year. • Discussed importance of confidence in estates data given desire to produce a more holistic view encompassing multiple stakeholder perspectives.

	<u>Fletching Building (Block F) external works</u> • Business case discussed proposing additional capital expenditure to support structural and cosmetic works, to utilise existing scaffolding in situ. • Noted that this had not yet been to EMG and agreed support subject to confirmation by EMG that this was an appropriate use of funds given broader constraints. • Noted the need to continue to undertake remedial works on BGH site until broader development plans crystalised. <u>Service Line reporting and Patient Level costing update</u> • Noted continued development of insights and opportunities for usage internally and within system. • Intent to use service data to reset ICB contract to better reflect the true costs of service delivery, providing greater transparency of cost. • Opportunity to also highlight system costs of different patient pathways with observation that out of hospital care is 1/5 cost of acute care. • Data is now also being shared with services to provide insights and initiate discussion. Work will continue with understanding that patient outcomes need to be considered alongside financial information. <u>Improvement Programme delivery report</u> • Update provided on progress against improvement activities aligned to strategic priorities. • Recognised importance of clarity on outputs and benefits to patients / staff, particularly in demonstrating progress to strategic goals. • Suggested need to finalise what information is considered at board, committee and executive fora to ensure appropriate granularity and focus.
Items for escalation to the Board :	• Note proposed balanced budget for 2024/25 in line with recent communications • Note that MSK ITT2 was submitted in line with tender timeline. Contract award expected June 2024

Sussex Community NHS Foundation Trust

COMMITTEE CHAIR'S REPORT TO BOARD

Committee name:	**Resources Committee**
Name of Chair:	Mark Swyny
Date of meeting:	27th February 2024
Main items on agenda:	• Month 10 Financial performance • Business planning • Community data set and performance metrics • Digital strategy and dashboard • Virtual consultations update • Mobile technology contract evaluation • UCR in HWLS evaluation • Brighton & Hove overnight nursing business case • MSK - Draft ITT bid update
Points for Board to note (if any):	<u>Financial performance</u> • Month 10 ytd position shows a £675k deficit (£216k worse than plan) with in-month surplus of £200k delivered to close gap to breakeven. • Year-end target position remains breakeven after £321k income reduction applied by ICB. Assurance provided that we are on track to deliver this system ask • Cost Improvement Plan delivery is £13,081k vs stretch target of £13,671k and confidence we will achieve year-end target, with some utilisation of non-recurrent opportunities. • Capital spend is £5,780k, £2,260k behind plan due to lower digital and estates spending. Achievement of year-end target is forecast, with close ongoing monitoring of estate schemes. Further work on Zachary Merton has been deferred while full cost of addressing on-site issues is assessed. • Cash position has reduced slightly to £35.7m with continued reduction anticipated to year end as creditor balances reduce. • Current Sussex system position shows £55.4m deficit (vs £6.7m deficit plan). • Impacts on future year funding discussed, with non-recurrent and slipped activities creating headwinds. <u>Business planning</u> • National planning guidance for 24/25 has still not yet been received, although some assumptions have been provided by NHSE and are being used. • Current view shows a deficit with some opportunities identified to close gap. However, these will require systems support and need further discussion and commitment. • Noted that SCFT draft budget includes c£3m income reduction due to convergence to allocation and repayment of system deficits. Concern expressed by committee that we are being asked to cover deficits despite consistently achieving breakeven and supporting system targets.

	Community Services Data Set (CSDS) • Insights provided on CSDS and its use in Model Health System for benchmarking purposes. • Noted ongoing issues with data quality, consistency and collection, which need to be addressed. • Recognised BAF risk around data and discussed areas of improvement including data production (via SystmOne), submission using Faster Data Flows and data completeness (e.g. patient ethnicity). • NHSE plans indicate increased focus with intent to develop Community Currency model over next 2 years. Digital strategy • Noted progress in a number of areas, including approval in principle of EPR FBC by NHSE. • Delivery and embedding of innovation and Apps discussed. Agreed need for further insights to obtain assurance that initiatives are embedded in line with corporate objective. • Discussed challenges with Robotic Process Automation (RPA) performance and planned changes to improve return on investment. Recognised that current year objective won't be achieved but agreed robustness in approach and focus on RoI will support wider aspirations. Virtual consultations • Update on progress received. Acknowledged that progress is behind track. • Working with 5 services to set targets, although this remains outstanding. • Good learnings around barriers identified and need to be addressed through communications and training. • Stressed value of patient perspective and choice in developing service offer. • Executives recognised need for additional focus and plan board discussion. Mobile technology contract evaluation • Insights provided on benefits from contract implemented in May 2023. • Noted financial benefits through reduced unit costs and greater control on specification. • Non-financial benefits highlighted including improved value through service and support from supplier and simplified procurement process. UCR in HWLH evaluation • Insights provided into positive benefits of new UCR provision. • Recognised additional care capacity, positive impacts on patient health and improved staff retention. • Good performance against targets and positive patient feedback provide assurance that service is operating well. Brighton & Hove Overnight Nursing service

	• Service currently provided by SCFT in West Sussex, with request from ICB to expand service to run B&H service at end of current contract. • Discussed benefits around improved service, workforce resilience and development of a trust-wide model supporting high quality patient care. • Service is fully funded and contract approved with service start date of 1 May 2024. <u>MSK Draft ITT update</u>. • Discussed current status with expectation of submission by mid March. • Discussed transformational opportunities and importance of highlighting value of SCFT capability and experience. • Good progress made on internal governance and clarity on partner roles • Agreed benefits of update to board in mid March.
Items for escalation to the Board :	• Need to review / agree budget submission for 2024/25. Scheduled for 13 March • Proposal to share key elements of MSK ITT with board prior to submission. Possibly also on 13 March.

Sussex Community NHS Foundation Trust

Report to:	Trust Board	**Meeting date**:	28 March 2024
Report title:	Freedom to Speak Up Q1 and Q2 report including summary report of self-reflection tool	**Agenda number**:	14
Author(s):	Mary Bell – FTSU Guardian	**Owner(s)**:	Donna Lamb - Chief Nurse

Purpose:	**Decision/Approval**		**Assurance**	x	**Briefing**		

Link to Trust Strategic Goals: *(If yes, please explain any links)*

A Great Place to Work	x	Supports organisational culture and delivery of the People promise
Continually Improve	x	Supports a culture of improvement
Digital Leader		
Reducing Service Inequities		
Sustainability		

Link to corporate objective and BAF risks

Overall link to organisational values and being a great place to work through supporting a safe and open culture of speaking up.

This report includes a summary of the national self-reflection tool, which is improvement focused.

Link to Care Quality Commission (CQC) questions:

Caring	X	Workforce well-being and enablement
Effective		
Responsive		
Safe	X	Learning culture
Well-Led	X	Shared direction and culture, capable, compassionate and inclusive leaders, freedom to speak up, workforce equality, diversity and inclusion, learning, improvement and innovation

Executive summary:
This report summarises themes of concerns and learning raised by staff to the Freedom to Speak Up (FTSU) Guardian in Q1& Q2, 2023-24. It also reports activity undertaken by the guardian during this period to continue to develop the culture of Speak Up, Listen Up and Follow Up. In Q1 and Q2 there were 36 cases. There were no significant risks identified and most cases were supported and signposted back to local management actions. During this period the FTSU Ambassadors increased to 22 across the trust, and were active in promoting FTSU month in October 2023 across the Trust. The ambassadors continue to receive regular restorative supervision sessions from a Professional Nurse Advocate (PNA), and quarterly support meetings from the FTSU Guardian. The FTSU Guardian continues to raise awareness of Speak Up and Listen Up across teams and services and support a range of workstreams within the organisation. Coaching on the ASPIRE leadership programme also continues, with active contributions to the SE guardian Network and the support of new guardians in the SE region. Appendix A is a summary of the national guardian's office self-reflection and planning tool, which trusts are encouraged to repeat every two years. Learning and areas for improvement have been identified.
Outcome/action requested:
The Board is asked to note this report, including the summary report of the self-reflection tool and endorse the recommendations.
Equality, diversity and/or reducing inequities:
No EIA has been completed but the principles of equality are fundamental to the FTSU function.
Previously reviewed by:
Quality Improvement Committee

Raising Concerns FTSU Report (Q1 & Q2 2023-24)

1. Introduction

This report presents concerns raised by staff to the Freedom to Speak Up (FTSU) Guardian in Q1 & Q2, 2023-24. The data presented in this report reflects the National Guardian's Office (NGO) criteria and includes the concerns raised month by month, in Q1 & Q2, (Fig.1), the staff groups or services (Fig.2) and the thematic trends (Fig.3).

2. New Concerns raised to Freedom to Speak Up Guardian

Figure 1: Number of concerns raised month by month:

Month	Q1 23-24	Q1 22-23	Q2 23-24	Q2 23-24
Total	**16**	**20**	**14**	**16**

Source: FTSU database as of 7th August 2023

- The figures for Q1& Q2 2023-24, have remained comparable to the monthly average of 15-20 cases.
- Most concerns continue to be managed through close working between the FTSU Guardian and local management for resolution and shared learning.
- There were 9 cases in Q1 and 5 cases in Q2 with an element of inappropriate attitudes or behaviours, this includes types of discrimination as defined by the National Guardian's Office (NGO) reporting categories.

    - In Q1, 1 case related to race, but all 9 cases had a relational or behavioural aspect.
    - In Q2, 1 case related to a member of staff with a protected characteristic (disability), and all 5 cases had a relational or behavioural aspect with a person in a leadership position.

    The themes have been discussed with the Chief Operating Officer, the Chief Nurse and the quarterly workforce sharing meeting, as well as Organisation and Development (OD), and Human Resources Business Partners (HRBP), where appropriate.

- Where cases have been raised alongside an HR process or external investigation the FTSU process has remained pastoral until completion and then reviewed for outstanding FTSU concerns.

Figure 2: Total number of cases brought in Q1 and Q2 2023-24:

PROFESSIONAL GROUP	TOTAL NUMBER OF CASES	
	Q1	Q2
Allied Health Professionals	1	2
Medical and Dental	0	1

Additional professional scientific and technical	0	1
Registered Nurses and Midwives	9	6
Additional Clinical (includes HCAs)	5	3
Administrative/Clerical	0	0
Estates and Ancillary	0	1
Students	0	0
Other (including Not disclosed)	1	0

Source: FTSU database

- Most cases in Q1 and Q2 were resolved through supporting back to local management.
  In Q1, the remaining included: 1 case for Step 2, (HR formal process), and 8 cases were advice and signposting only.
  In Q2, the remaining included: 3 cases already in Step 2, (HR formal process), 1 case had sought additional advice from HR, and 5 cases were advice and signposting only from the FTSUG.

- Registered Nurses continue to be the largest group reporting concerns, with distribution as follows:
  Q1: Primary Care Network teams / Hospital at Home: East 2, Central 3. Intermediate Care Units (ICUs): East 1, Central 1. Children's and Specialist services: Central 1, and 1 other Registered Nurse (area not disclosed).
  Q2: Primary Care Network teams / Hospital at Home: East 1, Central 1. Intermediate Care Units (ICUs): Central 1, West 1. Children's and Specialist services: Central 1, West 1.

- An anonymous survey is typically sent to all staff who raised concerns when their case is closed. Verbal and written feedback is also invited. Nineteen cases from Q1 & Q2 are closed, fifteen have reported they would speak up again and 4 did not respond.

- FTSU Ambassador data is requested quarterly, guidance was revised by the NGO regarding the recording of FTSU Ambassador/Champion data in April 2022.
  In Q1, ambassadors reported 6 informal Speak Up discussions, HCA (West 1) and Estates/ Maintenance (Central 5).
  In Q2, ambassadors reported 3 informal Speak Up discussions, which all transferred to the FTSUG as formal concerns and have been included in Q2 data reporting.

Figure 3. Themes raised of which there was an element of: (some concerns had more than one element)

THEMES RAISED	Q1 NUMBER in CATEGORY	Q2 NUMBER in CATEGORY
Number of cases raised anonymously	3 cases were raised on behalf of other staff either individuals or teams) for advice and	2 cases raised where staff member wished to remain anonymous although identity known to FTSUG.

	signposting (2 cases have progressed to FTSU guardian for support).	(1 advice and signposting only, 1 raised to managers as an anonymous concern)
Number of cases with an element of patient safety/quality	0	2 (1 related to staffing template reported anon) 1 related to Medical caseload -not progressed)
Number of cases with an element of worker safety or wellbeing	12	8
Number of cases with an element of bullying or harassment	2 (*See Actual detriment category below)	4 (*See Actual detriment category below)
Number of cases with an element of other inappropriate attitudes or behaviours (This includes types of discrimination)	8 in total: Disability cited as a factor (1 East)	6 in total: Disability cited as a factor (1 East)
Number of cases where disadvantageous and/or demeaning treatment because of speaking up (often referred to as 'detriment') is indicated **** NB: Some cases cited both a perception they were already being treated differently AND a sense of Futility that nothing would change because of Speaking Up.**	10 1 Actual (witnessed by others or evidenced in correspondence: (Grievance procedure commenced) 8 Perception of being treated differently after speaking Up: 1 (requested redeployment) 6 (Resolving through manager intervention) 1 withdrew from FTSU process. Fear will be treated differently after speaking Up: 9 cases cited sense of Futility/Fear of raising open concern, however, 6 progressed to manager intervention with support.	7 in total: Perception of being treated differently before or after speaking Up: 1 (requested redeployment but has now resigned, Exit interview completed but withheld) 2 resigned (one submitted an Exit interview) 3 involved long term sickness but are still in employ of SCFT 2 resolved through FTSU guidance and manager intervention

Source: FTSU database

4. Detriment

There has been no change to the main group raising concerns, registered nurses, (RNs), with an emphasis on staff experiences of leadership and behavioural / relationship issues between individuals or teams as a main theme.

There were 8 cases of perceived detriment in Q1, and 7 cases in Q2. How to respond to perceived detriment or fear of detriment is currently under discussion with the Learning and Organisational Development Lead. There was 1 case of actual detriment in Q1, this member of staff remains in the trust and is going through a Step 2 process (formal grievance procedure), with Executive oversight. Themes varied across this same group in Q2, and 4 were resolved with FTSUG support and line manager intervention, 1 case was raised anonymously and 1 case was advice and signposting only.

5. Combined themes across Q1 and Q2 include:

- Complaint about the mishandling of a grievance including perceived inaccuracies and impact on member of staff; investigated with HR and Executive oversight.
- Communication and leadership: Poor or inconsistent communication style, staff reporting being ‘closed down’ in a meeting, ‘not being heard’. Complaints about attitude, behaviour or approach from managers or leaders generating a lack of confidence from staff.
  However, there were also examples of good outcomes in Q2, where miscommunications had been raised early at the staff member / line manager level.
- Inconsistent approach to staff development perceived as unfair or preferential to others.
- Inconsistent approach to staff health and wellbeing: Lack of follow up and attention to individual wellbeing needs, both on returning to work after absence or illness, and as part of routine supervision or line management practice.
- Inconsistent approach to application of systems/process/policy by managers: included poorly executed work rosters, frequent last-minute changes. Payroll issues taking too long to resolve, causing significant impact or in one case, financial hardship.
- Inflexibility around agile/ flexible working: compared to similar teams/services, or an inconsistent approach applied within teams, and/or no consideration given to discussion.
- Relationship difficulties within teams or between individuals not addressed early enough or at all. Perception that microaggressions experienced by team members can be ‘minimised or glossed over’ to avoid challenging conversations.
- Other:

- Concern about a lack of professional nursing background where managers are leading nursing teams i.e. nurses being led by an allied health professional (AHP).
- Issues about role clarity: inconsistencies around staff responsibilities and/or individual capability, including one example of a Band 5 Nurse being told after 18months of work that she had 'not been here long enough to apply for a Band 6 promotion opportunity'.
- Anonymous concern raised about the staffing template in an ICU, including adequate cover for breaks and response time for patients requiring assistance. Concern raised to Matron of unit. No immediate patient safety risks identified. Themes to be addressed in an all-staff team meeting.
- Concern raised about retiring and process to return onto the Bank. Temporary workforce team addressing concerns; follow up pending.
- Concern raised about size of caseload and lack of time to review cases properly, inadequate quiet environment to review notes/update records and a concern about the competency of a registered nurse. No immediate safety issues identified. Themes drafted as a Speak up concern. Case pending as staff member has had recent sick leave followed by annual leave.

6. Summary of learning points in Q1 and Q2:

- Issues of discrimination fall into several categories and require ongoing monitoring. The issues raised in Q1 are being addressed via the OD team, the Connect team and in current workstreams.
- Staff psychological health and wellness remains a priority in 2023-24. The need for staff to be given time 'to be heard' appears to be increasing but is not facilitated often enough, meaning opportunities for early intervention are frequently missed.
- Supporting leaders to tackle perceived poor behaviours in teams. Lack of knowledge about the basic principles of Speak Up/Listen Up training which gives a blueprint for how to approach concerns.
- Career progression: some of the concerns raised about lack of opportunity have come from international recruits, who are keen to progress quickly during their UK tenure. Fair recruitment processes being essential to avoid discrimination.
- Leadership and communication: This has a bearing on how willing staff feel to approach leaders and on their sense of affirmation/value within teams. Visibility of leaders as a form of psychological safety is a theme that has been raised before. Staff going through formal HR processes particularly investigations where they have been the one to raise the concern, may require a revised approach to support whilst waiting for final outcomes. Staff report being left 'not knowing' as very stressful, often moving them prematurely towards resignation.
- Lack of confidence in responding to Speak Up concerns: there remains a lack of knowledge about the basic principles of Speak Up/Listen Up training which gives a blueprint for how to approach concerns, including being an Upstander, and knowledge of civility in the workplace. The FTSUG has

responded to all invitations to speak to teams about the speak up service but recognises there is still much work to be done.

7.Training

- Raising concerns training (Speak Up for all staff) compliance data in Q1 2023-24 compliance was at 89.36%, the target being 70%. In Q2, data was not accessible due to reports not yet being available from the new LMS system.
- Tackling fear of Speaking Up and futility, is a focus for 2023-24. Priorities will continue to focus on raising awareness and encourage the Speak Up/Listen Up training. To support and enable managers with how they listen and follow up, is vital to a positive open and transparent culture. It is also an individual and collective organisational responsibility across all grades and job roles.

8. FTSU Guardian / Other development:

- The guardian has completed all NGO training and is part of the SE regional FTSU Guardian network. The revised annual Guardian refresher training is up to date.
- The guardian is supporting 2 coachees annually through the ASPIRE coaching programme and is an active partner in the Professional Nurse Advocate (PNA) network.
- The guardian has regular meetings with the Non-Exec Director for FTSU, bi - monthly meetings with the Chief Nurse and the Chief Operating Officer as well as regular meetings with the Chief Executive.
- The guardian actively contributes to a variety of workstreams at SCFT including Violence Aggression and Prevention, Blending Our Data, (BOD), FTSU Ambassador supervision, Connect team, the PNA and SE Guardian networks and will be contributing to Voice of our People workshop later this month.
- Contributions have also taken place with Patient Safety Day, the Annual Members (Marketplace) meeting, Healthcare Support Worker celebration and the NGO Primary Care Roundtable. The FTSUG has also linked with local partners including the EDI/FTSU lead at ICB, Worthing.

9. Feedback

- An anonymous survey is typically sent to all staff who raised concerns when their case is closed. No responses have been received in Q1 or Q2, 2023-24, although verbal and written feedback has been received from the majority. This is reported to board as part of the annual FTSU report and is contributing to the Staff Voice workstream through Learning and Organisational Development.
- Restorative supervision sessions for all ambassadors are continuing with a dedicated Professional Nurse Advocate. Feedback has been positive particularly from non-clinical ambassadors.

11. Next steps

- The strategy Implementation plan is being completed and an update on its implementation was provided in the annual report.
- A new approach of triangulating quality and safety themes (including FTSU) across the Trust is in development utilising thematic analysis – “Blending Our Data (BOD). Voice of the People workshop looking at the qualitative data from a variety of sources will commence in November 2023.
- Discussions are planned on how to present FTSU data in a different way once the new dedicated FTSU InPhase platform is established.
- In February/March 2024, the NGO self reflection and improvement tool was completed, in consultation with the executive team and other key stakeholder. The report has been shared in full with the Quality Improvement Committee and a summary, including recommendations, is included at appendix A.

12. Recommendation

Members are asked to note the contents of this report.

Appendix A

Freedom to Speak Up – A Self Reflection and Planning Tool Report

Introduction:
NHS England published its new and updated national Freedom to Speak Up policy in June 2022, applicable to primary care, secondary care and integrated care systems.

Together with NHS England, the National Guardian's Office has also published new and updated Freedom to Speak Up guidance and a Freedom to Speak Up reflection and planning tool with an expectation that this is completed every two years.

Each will help organisations deliver the People Promise for workers, by ensuring they have a voice that counts, and by developing a speaking up culture in which leaders and managers value the voice of their staff as a vital driver of learning and improvement.

NHSE asked all trust boards to be able to evidence by the end of January 2024:

- An update to their local Freedom to Speak Up policy to reflect the new national policy template (SCFT adopted this in its entirety in 2022).
- Results of their organisation's assessment of its Freedom to Speak Up arrangements against the revised guidance
- Assurance that it is on track implementing its latest Freedom to Speak Up improvement plan (reported to board as an update in January 2024 prior to this report).

This presents an opportunity for SCFT to refresh Freedom to Speak Up arrangements and will help executive leaders reflect on and achieve a healthy and supportive Speak Up, Listen Up, Follow Up culture."

Comparison with previous year; 2022:
In 2022 the National Guardian's Office required that Boards use a self-review tool to reflect on its current position and the improvements needed to meet the expectations of NHS England, NHS Improvement and the National Guardian's Office.

The exercise at that time was a self-review approach, completed by the FTSU executive lead (Chief Nurse), the FTSU guardian and the FTSU non-executive lead, with the findings being shared with the Board for discussion and challenge.

As a result of the self-assessment in 2022 the following actions were agreed and implemented:

- Review of FTSU Ambassador roles and responsibilities including recruitment process to increase diversity and reach across the trust.
- Focus on wider dissemination of lessons learned and recommendations from speaking up.
- Board development workshop for NEDs in Feb 2022.

- Freedom to Speak Up policy (adopted from the national policy) ratified by Dec 2022
- Develop inclusion of FTSU question into Quality Impact Assessment process
- Further work in relation to sharing learning across trust, including analysis of exit interviews and grievances.
- FTSU guardian to link with Patient Safety Newsletter in 2022.

Summary review of the 2023 Self-reflection and Planning tool:
The review exercise was repeated in early 2024, using a revised tool which is based on self-reflection and supports planning for improvement. The self reflection has been carried out by the FTSU Guardian, Chief Nurse, Non-Executive Director lead for FTSU, the executive team and the trust lead for organisational development.

The self-reflection has demonstrated many areas of strength across eight principles with a recommendation that high level actions are focused on areas that still require development. The full reflection tool has been discussed at the Quality Improvement Committee.

It was identified that SCFT is particularly strong in the following areas:
- Having a robust FTSU guardian recruitment process with continued support for the guardian to fulfil the role in a way that meets workers' needs and National Guardian's Office requirements
- Providing continued support and supervision facilitated by the knowledge and commitment of the executive and non-executive leads
- Valuing Speaking Up across the trust, ensuring workers know how to Speak Up and feel safe and encouraged to do so
- Using Speaking Up as an opportunity to learn and continually improve our organisational culture

The tool encourages the identification of high level developmental actions. These have been agreed as:
- To focus on detriment using an evidence-based tool to tackle inequality and disadvantage.
- Increase recognition of the FTSU ambassador role through revised intranet profiles and extend their reach to include awareness raising/presentations to teams to support the guardian role.
- Use outputs from the 'Voice of our People' workstreams to contribute to improvement measures for the Speak Up service.
- Develop a process for an After-Action review model approach, following Speak Up cases that have involved multiple strands of support across the trust, including how cases were approached, supported and followed up for wider organisational learning.
- Review of reporting to ensure trends and analysis over time are visible and to strengthen how we triangulate Speak Up information with other quality information.
- Agree a communication and engagement plan which supports delivery of the Speak Up strategy

The actions will be monitored through regular reporting to both the Executive Management Group and the Quality Improvement Committee.

Recommendation:
The board is asked to:

- Note the self review findings and areas for improvement identified
- Take assurance from this exercise that FTSU arrangements are good and that they role model the organisations culture of continuous improvement

NHS
Sussex Community
NHS Foundation Trust

Report to:	Trust Board	**Meeting date**:	28 March 2024
Report title:	Patient Safety Incidents Report Q3 2023/2024	**Agenda number**:	15
Author(s):	Deborah Fron, Patient Safety Manager	**Owner(s)**:	Karen Eastman, Chief Medical Officer

Purpose:	**Decision/Approval**		**Assurance**	X	**Briefing**		

Link to Trust Strategic Goals: *(If yes, please explain any links)*

A Great Place to Work		
Continually Improve	X	
Digital Leader		
Reducing Service Inequities		
Sustainability		

Link to corporate objectives and BAF risks

This supports our strategic goals and specifically to continually improve by meeting the following success criteria:

- We will learn through an open approach when things go well and when things go wrong; we will drive safety through learning which will have, at its heart, the voice of our patients.

Link to Care Quality Commission (CQC) questions:

Caring		
Effective		
Responsive		
Safe	X	<u>Freedom to speak up</u> We foster a positive culture where people feel that they can speak up and that their voice will be heard. <u>Learning, improvement and innovation</u> We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research.
Well-Led		

Executive summary:
These quarterly reports have previously been presented in two parts, with only Part B presented to Board outlining incidents resulting in significant harm and a summary of claims and inquests data. We have now transitioned from the previous Serious Incident Framework to the new Patient Safety Incident Response Framework. Therefore, this report presents a summary of key patient safety information including reviews of our patient safety priorities according to our patient safety profile. These have been previously presented as our Patient Safety Incident Response Plan, which outlines how we will manage and respond to patient safety events (incidents). There was one incident that was escalated for an in-depth investigation in Quarter 3. This related to the care of a patient with learning disabilities and remains under investigation. This incident did not meet the criteria for declaration under the previous framework.
Outcome/action requested:
The board to be assured that the Trust has implemented the Patient Safety Incident Response Framework and to note the report.
Equality, diversity and/or reducing inequities:
Patient safety processes support reducing service inequities and seek to identify underlying inequalities.
Previously reviewed by:
Trust Wide Governance Group Quality Improvement Committee

Sussex Community
NHS Foundation Trust

2023-2024 Q3: Patient Safety Report

Deborah Fron, Patient Safety Manager

Excellent care at the heart of the community

Contents

Introduction

The Trust operated under the NHS Serious Incident framework 2015 until full transition to The Patient Safety Incident Response Framework (PSIRF) on 1st January 2024. PSIRF introduces fundamental changes to incident management, investigation, and oversight.

PSIRF advocates a data driven approach to determine our incident profile with proportionate responses to incidents and patient safety priorities. We now use a range learning responses (investigations) which reflect human factors. A focus previously was on the level of harm when deciding the learning response, whilst the new framework emphasises the level of risk and potential for learning.

However, an in-depth investigation will always be undertaken in the event of a patient being permanently or fatally harmed because of their health care delivery. The duty of candour remains applicable to all incidents resulting in significant harm to a patient.

We have developed our Trust incident response plan from our incident profile. The plan describes how we intend to respond to patient safety incidents and outlines key areas for improvement. In previous quarters, this Quarterly report was presented in two parts; Part A with detail presented at Trust Wide Governance Group (TWGG) and Quality Improvement Committee (QIC) and Part B, was presented to Trust Board. Part

B contained incidents meeting SI criteria declared under the former SI framework with a summary of claims and inquests data.

Following a thorough review through TWGG and QIC, the below now presents a summary report of the key information for the Trust Board. In this way, the Board can be assured that the finer details have been reviewed by the Executive Lead and that they are being provided with the key information they require.

Section 1: Patient Safety Incidents.

SCFT staff reported 2735 patient safety incidents in Quarter 3 2023/24, including events occurring to patients whilst under SCFT care and events outside of SCFT care and control. December 2023 saw 767 incidents reported compared to 1145 in December 2022. This drop in incident reporting was anticipated as staff got used to the new local system (InPhase) and a new style of incident report incorporating the nationally mandated fields.

SCFT has a historically good reporting culture and reporting levels are rising again, although are not entirely restored to previous levels, with 949 patient safety incidents reported throughout January 2024.

This report focuses on the SCFT patient safety priorities and improvement work related to those priorities. As we progress, the report will shift focus onto learning and outcomes to align with the goal of the Patient Safety Strategy to be continuously improving patient safety.

1.1 Pressure Ulcers:

Pressure ulcers place a high care burden across SCFT and we have developed a specific reporting form for assessment of these against expectations and best practice for the risk assessment and prevention of pressure ulceration.

In Quarter 3, there were 344 incidents and 14 (4%) of those were considered to have missed opportunities or delays in SCFT care processes that contributed to the development or deterioration of the pressure ulcer. This percentage is consistent with previous quarters. Therefore, 96% of pressure ulcers reported for patients under SCFT care, were due to factors and influences outside of SCFT control. Examples of these factors include patient choice, carers not following advised skin care, episodes of acute illness, skin changes at life's end.

Where missed opportunities or delays on behalf of SCFT care processes were identified, these were all due to known factors, that align with current improvement work identified. The Trust's Tissue Viability Group steers that improvement work.

Risk 1030, which relates to significant delays in the delivery of equipment, since the change of community equipment provider at the beginning of April 2023, remains at a risk score of 12. Incidents are triaged daily and escalated through the established process.

We completed a learning response to explore how a patient who was being cared for at Horizon ICU had developed a pressure ulcer. The report was presented in October 2023. The panel found that the patient received good care with no missed opportunities or care delivery factors that contributed to the wound development and deterioration. Their family were engaged and supportive in the patient's care needs and had no concerns in relation to the care provision. Incidental findings indicated some local learning around wound photography.

In conclusion, whilst pressure ulcers remain the highest number of reported incidents for SCFT, only 4% can truly be attributed to patient harm due to SCFT provided healthcare.

1.2 Slips, Trips and Falls.

We have included the national learning response template for falls within our incident reporting.

All reported patient falls are triaged by the Patient Safety Leads and the Trust's Falls Lead. There were 189 patient falls reported in Quarter 3 across inpatient and community settings. Of those falls, 4 resulted in bony injuries / fractures with one requiring an escalated learning response led by the Falls Lead. The report was presented in November 2023. Key issues identified were:

- Staff knowledge about when to use the Hoverjack to safely move patients from the floor.
- Enhanced patient support and observation processes.

These issues are already incorporated into ongoing improvement work. Therefore, there was no new learning identified.

A thematic review is being undertaken exploring the use of bed rails in the ICUs. This links with the actions undertaken to ensure Trust compliance with the National Patient Safety Alert 2023.010.MHRA. This alert relates to reducing risks to patients of entrapment in bed rails. This work will be presented in the next Quarterly report.

The Trust has a Falls Lead and Falls Steering Group that lead improvements in Falls Prevention and post falls management. Inpatient falls reduction is improvement work identified in the 2023/24 Quality Account Priorities. In addition, there is a commitment to improve falls prevention and management in community settings.

1.3 Medication

The Trust's Medication Safety Officer oversees all medication incidents and publishes a monthly Learning from Incidents Newsletter.

There were 171 no or low (minimal) harm medication incidents reported in Quarter 3. An incident on Piper ward highlighted that caution is required when administering liquid medications prescribed through the EPMA system. EPMA allows only for prescribing

in milligrams (mgs) rather than millilitres (mls). In this incident, the nurse mistakenly gave 25mls of medication instead of 25mgs. In response to this an observation exercise was undertaken by the Patient Safety Team and a Patient Safety Partner. This explored if any other unknown challenges for staff administering medicines using EPMA would benefit from identifying and shared learning. The outcome will be shared in the next quarterly report.

Most medication incidents across the Trust continue to relate to insulin administration to diabetic patients in their own homes. This is currently being scoped for improvement work and will include the input from one of our valued Patient Safety Partners, who is an expert through experience. Progress will be reported on in future Quarterly reports.

1.4 Deteriorating Patient Events.

Under Trust policy all deteriorating patient events are incident reported to enable us to monitor and measure the effectiveness of the early detection and management of deteriorating patients. This helps us to monitor and measure the effectiveness and success in implementing the National Early Warning Score 2 (NEWS2). Therefore, this patient safety priority collects and compares both positive and negative data. Similarly, cardiac arrests and resuscitation attempts are also collected with this data. The data is reviewed at the Resuscitation and Deteriorating Patient Steering Group which reports into the Trust Wide Governance Group.

A review of all 163 deteriorating patient events and 5 cardiac arrests and resuscitation events reported for Quarter 3 identified that these were predominantly well managed.

A thematic review is being undertaken and is due to be presented in April. This will be reviewed with other learning responses to inform an improvement project.

A learning response into a deteriorating patient event at Uckfield ICU was presented in November. This identified that the Trust needed a clear chest pain protocol for ICU staff to support them to act confidently when managing patients with chest pain and handing over to paramedics. This has since been developed, presented and approved at the Resuscitation and Deteriorating Patient Group.

2. Learning Response Improvement outcomes.

There was one incident in Quarter 3 that triggered the commissioning of an in-depth investigation. The incident relates to the care of a patient with learning disabilities. The incident was reported in retrospect on discovering that, following discharge from an SCFT ICU, this patient had been readmitted to an acute hospital and later died. The initial incident review identified that this incident did not meet the previous Serious Incident framework criteria for declaration. This is because there was no causal link between the care provided by SCFT and the patient's re-admission and death.

To ensure that we are identifying appropriate actions and linking with wider projects to drive improvement we are now reviewing these across Quality and Safety, and Quality Improvement.

2.1 Patient Safety Partners:

The Trust has four Patient Safety Partners (PSPs) recruited since April 2023 and who are valued members of the Patient Safety Team. A strategy day was held with our PSPs on 29th January 2024 to discuss the development of this role. The following actions were agreed:

- To ensure that we can achieve attendance of two PSPs at QIC, all four PSPs will be developed so that they can provide cross cover.
- Each PSP will be linked with a Patient Safety Lead (PSL) for supervision and development.
- The PSPs will be supported to provide insight into learning responses and Patient Safety Incident Investigations (PSIIs). This will include attending Trust sites and completing SEIPS observation exercises with PSLs, Sit and See exercises and joining relevant task and finish groups leading improvement work.

2.2. Reporting Good Care.

We are now able to report examples of good care. The purpose of this reporting is to enable positive learning to be acknowledged, shared and the good care replicated.

This concept is new to staff across healthcare and the NHS and the Patient Safety Team plan to work more with staff to drive understanding of what is a good care event and when to report it.

3. Claims and Inquests.

There were two new clinical negligence claims initiated against the Trust in Quarter 3 2023/24.

There were 5 inquest referrals from the coroner's office in Quarter 3. These are being managed within the agreed process and where required, staff are being fully supported to provide statements and/or attend as witnesses.

Figure Three:

	Claim	Inquest	Total
Q4 2022/23	1	7	8
Q1 2023/24	4	10	14

Q2 2023/24	0	4	4
Q3 2023/24	2	5	7

Conclusion and Recommendations

The Trust's transition to PSIRF, InPhase and LFPSE has changed the format and categorisation of patient safety events. The next quarterly report will include more information about the range of learning responses, learning outcomes, emerging themes and updates on improvement work.

Sussex Community NHS Foundation Trust

Report to:	Trust Board		**Meeting date**:		28 March 2024		
Report title:	Mortality Review Report.		**Agenda number**:		16		
Author(s):	Dr Vivek Patil, Deputy Chief Medical Officer.		**Owner(s)**:		Dr Karen Eastman, Chief Medical Officer.		
Purpose:	**Decision/Approval**		**Assurance**	X	**Briefing**		

Link to Trust Strategic Goals:		
A Great Place to Work		
Continually Improve	X	We focus on continuous learning, innovation, and improvement across our organisation so that we can provide best quality End of Life care in our intermediate care units. We actively contribute to safe and effective practice.
Digital Leader		
Reducing Service Inequities		
Sustainability		

Link to corporate objectives and BAF risks
None specifically.

Link to Care Quality Commission (CQC) questions:		
Caring	X	
Effective	X	
Responsive	X	
Safe	X	
Well-Led	X	

Executive summary:

This is the summary of our Intermediate Care Unit mortality reviews using structured judgment forms. The aim is to identify if the trust could have improved the quality of care leading up to the death, identify any trends that would indicate that poor care had led to the death, identify if any of our Intermediate Care Units had higher than expected mortality rates and take the necessary actions as need be. Since the introduction of the Medical Examiner system, our review process supports wider learning and dissemination of best practices around the ICB area.

Outcome/action requested:
The Board is asked to note the content of the report.
Equality, diversity and/or reducing inequities:
N/A.
Previously reviewed by:
Mortality Review Board, Trust Wide Governance Group and Quality Improvement Committee

NHS
Sussex Community
NHS Foundation Trust

Mortality Review Report Q3

Dr Vivek Patil
Deputy Chief Medical Officer.

Excellent care at the heart of the community

Reader Box	
Description	This is the summary of all structured judgment reviews of deaths in our intermediate care units. Any learning from how we cared for the patient pre and post death is shared across the Trust through mortality review meetings and Trust Wide Governance Group (TWGG).
Date published	
Date due for review	None
Executive Lead	Dr Karen Eastman Chief Medical Officer
Author	Dr Vivek Patil Deputy Chief Medical Officer
Contact details	vivekanandpatil@nhs.net
Primary audience	Mortality Review Group , TWGG and QIC.
Secondary audience(s)	Executive Team, Trust Board, Quality Committee and others.
Notes	This is the summary of mortality reviews done in our intermediate care units using structured judgment forms. The aim is to identify if the trust could have improved the quality of care leading up to the death, identify any trends that would indicate that poor care had led to the death and to identify if there are any intermediate care units where mortality is higher than expected and to take the necessary actions as need be.

Table of Contents

1. Introduction

Sussex Community NHS Foundation Trust (SCFT) has been using structured judgment forms to review the care in the period before a patient has died. Reviewing deaths in this way will identify any trends that would indicate that a particular unit has higher deaths than average which would lead to a more in-depth review of the care provided within that unit.

2. Results for Q3 and analysis.

2.1 Overall deaths during the reporting period.

From 1st Oct 2023 to 31st Dec 2023 there were 3 reported deaths in our intermediate care units. All deaths have been reviewed using the structured judgement review forms. Due to low number of deaths and risk of patient identification, name of intermediate care units has been withheld.

2.2 Deaths that have been reviewed using SJR process.

Age range was from 76 to 87 with mean age range of 83.3 years. All deaths were reviewed using structured judgement (SJR) forms.
SJR forms were completed by ward doctors and advanced nurse practitioners.
All patients were admitted before 20.00 hours and time of admission did not have any relation to outcome of death in any of the reviews.
Main cause of death were cancer and infected wound secondary to frailty.
Increasing comorbidity is seen in the form of cardiovascular, respiratory and metabolic pathology.

2.3 Involvement of Coroner

There was no hospital postmortem examination for any of the deaths. All deaths were reported through Medical Examiner system and one death was discussed with Coroner.

2.4 Medical oversight of patients who have died.

The first clinical review of patients took place within hours to one working day in line with the standard operating procedure for our intermediate care units.

It has been recorded that in all reviews there was evidence of clear management plans within one working day and there were no omissions in the initial management plans.

2.5 Transfer between wards and hospitals.

There were no patient transfers to the acute trusts for terminally ill patients. One patient was transferred to acute trust for suspected neutropenic sepsis and was transferred back after treatment.

2.6 Medical staff reviews.

It has been documented that patients were seen on a regular basis in accordance with the standard operating procedure and documentation was noted to be of a good medical standard.

2.7 Care preceding death.

There were no documented falls in any patients nearing end of life care. One patient developed pressure ulcers at end stage of their life. Nursing notes indicate that appropriate measures such as regular turning and pressure relieving materials were used.

Fluid balance has been documented as adequate in all cases. Nutritional assessment was addressed appropriately for those nearing end of life.

National Early Warning Score (NEWS) was recorded as appropriate in all cases and in all cases this was discontinued as patients approached the end of life.

None of the patients had abrupt drops in haemoglobin (indicating blood loss), hypoglycemia (low blood sugar level) or raised international normalized ratio (INR) (indicating a likelihood of bleeding) or raised Troponin T (indicating a likelihood of a heart attack)

Two patients had a urinary catheter inserted.

There is no documentation of never events in patients who have died under our care in intermediate care units.

Resuscitation status was documented in all cases. All patients had an escalation plan written up in case of an emergency. All patients were seen before the death by a clinician.

From review two of the patients needed syringe drivers for symptoms control. There was no delay in setting up the syringe driver from the time the clinical decision was made.

From the review it is felt that patients received optimal care in the patient's preferred place except for one case.

All patients' relatives and carers were involved in discussion about the preferred place of death using either face to face or e consultation.

In overall review, it is felt that there was no delay in making a diagnosis and there was good communication between teams. There was no delay in delivering care and no recorded suboptimal care provision. It is felt from the review that different care would have made no difference to the outcome of the patients**. All deaths were explainable**. From the review it is felt that there were **no avoidable deaths**. There was no evidence of poor communication, organisational failure or delivery of suboptimal care provided.

2.8 Evidence of Good Standard of Care.

Highlights of good care were communication, teams, documentation, keeping families and carers involved in discussion regarding treatment plans and the care given by the staff themselves.

The standard of documentation is noted to be good.

3 Learning

Members discussed the transfer of care from acute trusts, patient transfer clinical information was not always available to all clinicians. Also, there were concerns about the extent to which a patient and family had been informed about their diagnosis and management plans by the acute trust. This was discussed and agreed that actions that were needed will be taken through the Community Hospital Transformation Project Board.

Sussex Community
NHS Foundation Trust

COMMITTEE CHAIR'S REPORT TO BOARD

Committee name:	**Quality Improvement Committee**
Name of Chair:	**Lesley Strong**
Date of meeting:	**21st March 2024**
Main items on agenda:	• Trust Wide Governance Group (TWGG) Chair's report and Key Lines of Enquiry (KLoE) quality report • Clinical Advisory Group (CAG) Chair's report • Infection Prevention & Control Chair's report • Mortality review Q3 • Patient Experience Report Q3 • Patient Safety Report Q3 • Quality Impact Assessment report • Safeguarding Committee Chair's report • Safer Staffing 6-month update • Hearing the Patient Voice • Quality Improvement Plan (QIP) Q3 • Quality Account Priorities • Quality Improvement Report • End of Life Care Annual Report • Review of BAF risk • Evaluation of Electronic Prescribing and Medicines Administration (EPMA) • FTSU self-assessment
Points for Board to note (if any):	• <u>Quality Metrics</u>: QIC reviewed the quality KLoE metrics and feedback from TWGG gave assurance that SCFT continued to provide safe care. Assurance was received that systems and processes are in place which meant that any issues are raised promptly. Key areas highlighted: ○ A review of the risks related to NICE guidance has been completed and the risk reduced. ○ Reports of patients and staff safety measures by Intermediate Care Units (ICU) and key metrics by teams with the highest vacancies show no concerns. ○ Correlation of data from complaints and incidents within Kleinwort has led to an After-Action Review (AAR) being completed. The Safety and Quality Improvement Review of Evidence (SQUIRE) group will monitor the action plan. • <u>CAG Chair's report</u>: ○ Clinical oversight of digital (CLOUD) new group to link digital developments with clinical safety. ○ Support for staff when caring for patients with complex mental health needs. Further collaborative work with SPFT being taken forward by the CMO and Head of Safeguarding • <u>Infection Prevention and Control</u> ○ The Trust's MRSA policy has been updated. New standards included around antimicrobial reviews. Audit showed further work needed to support improved prescribing. ○ Hand hygiene audit monthly completion improving for community teams to 72%. ICU audits show difference between link nurse audit and validation audits by IPC team.

- The IPC Board assurance framework was presented to QIC, and the improvement actions noted.

- Mortality Review
  - In Q3 there were three deaths reviewed using structured judgment forms. All were expected and none were avoidable. There was evidence of good practice.
- Patient Experience Report Q3:
  - Feedback from the Patient Experience Group (PEG) and agreed that the purpose of the group will be expanded to include all patient experience, engagement, and involvement work across the Trust.
  - 55 complaints received which is an increase on the same period last year (48). Represents 0.01% of patient contacts.
  - Outline plan for the implementation of the new Parliamentary Health Service Ombudsman Standards (PHSO) including training.
  - QIC noted the plan for the development of the new patient experience strategy.
  - Friends and Family Test (FFT) 24% increase on last year. February figures are the highest ever.
  - QIC and audit committee have noted the increase in requests for financial remedy. A review is being undertaken to ensure equity of access.
- Patient Safety Incident Report Q3
  - The Trust has transitioned to incident management under the Patient Safety Incident Response Framework (PSIRF) from the Serious Incident Framework. There is now a proportionate response to patient incidents with a focus on learning.
  - Incident reporting was less in Q3 with the reduction in numbers in December due to the introduction of the InPhase system. QIC received assurance that reporting has now increased.
  - QIC received assurance of appropriate levels of incident reviews from local review, hot debrief, after action reviews and patient safety incident investigation (PSII).
  - One PSII investigation started in Q3.
- Quality Impact Assessment Report
  - Assurance of robust process received from TIAA audit. Good practice noted in the review 6 months after the change has taken place.
  - QIC noted that some requests have been challenged or rejected.
- Safeguarding Q3 report
  - ICB completed a quality assurance inspection visit with positive outcomes.
  - Safeguarding strategy has been updated.
- Safer Staffing 6 monthly update

  Review of nursing establishments in adult ICUs July 23 to Feb 24
  - The review used the full Shelford acuity tool as per NHSE recommendations.
  - Proposal to increase the number of registered nurses on some units and reduce the number of registered nursing associate posts needs further discussion within the executive team.
  - QIC noted further work on CHPPD.

	• Hearing the Patient Voice.
	  ○ QIC received a report of a patient story which demonstrated the application of the new incident investigation process under PSIRF using After Action Review (AAR) methodology. The patient had developed a category 3 pressure ulcer whilst an inpatient in an ICU. The conclusion gave evidence of good care and identified areas for learning.
	• Quality Improvement Plan Q3:
	  ○ Evidence of good progress in all areas
	  ○ CQC new framework. QIC noted that there is still lack of information about the new single assessment framework but the Trust is completing a review of fundamental standards
	• Quality Account Priorities 24/25
	  ○ QIC were assured of the process in developing the draft priories using a blending of data approach.
	  ○ QIC endorsed the proposed priorities:
	  ▪ We will improve how we share the actions and learning from feedback and incidents.
	  ▪ We will enhance skills in delivering personalised care across all the services.
	  ▪ We will improve in supporting our patients to communicate about heir needs as part of Mental Capacity Assessment
	  ○ QIC recommended further work to strengthen measurable actions.
	  ○ Discussion around carrying over any uncompleted priorities from the current plan.
	• Quality Improvement Report
	  ○ QIC noted the increase in demand and uptake for training.
	  ○ Plans to increase the number of coaches via the quality coach development programme.
	• Freedom To Speak Up
	  ○ Trust Boards are expected to undertake a self-assessment every 2 years. SCFT last completed the tool in February 2022.
	  ○ QIC noted that the assessment in February 2024 demonstrated progress has been made in developing our FTSU arrangements.
	  ○ Some high-level areas for action were noted including:
	  ▪ a focus on detriment using an evidence-based tool to tackle inequality and disadvantage.
	  ▪ Developing a process for an After-action review
	  ▪ Review of report to ensure trends and analysis over time are visible.

Items for escalation to the Board (if any):	For the Board to note: The Safter Staffing review and the requirement for further discussion of proposed staff changes with the Executive Team The draft Quality Account Priorities for 24/25 prior to the full quality account coming to a future board meeting. The FTSU self-assessment and the proposed actions.

Sussex Community
NHS Foundation Trust

COMMITTEE CHAIR'S REPORT TO BOARD

Committee name:	**Charitable Funds Committee**
Name of Chair:	**Mandy Chapman**
Date of meeting:	**12th March 2024**
Main items on agenda:	• Charitable Funds Balances • Administration and fundraising costs • Dormant Funds Review • General Fund Grant Making Review • Charity Update • Charity Lottery Marketing Proposal • Corporate Sponsorship Policy • Partnership Update and new Corporate Partnership Pack • Charity Risk Register
Points for Board to note (if any):	• **Finance Update** o Overall balances (£1,1m) have not changed very much over the last period. We have spent some of the Midhurst funds and gained grant funding from NHS Charities Together in the period which have balanced each other out. o We agreed the need to be more joined up in our grant funding with local LoF organisations to maximise the benefits of grant funding. o We have limited balances in the general fund and need to proactively drive general fundraising while focusing on spending the other funds that we have in place. • **Administration and fundraising costs** o Following successful grant making last year, our costs are disproportionately high compared to our fund size. The Annual Management Fee from the Trust has been reduced which is a very positive step forward. However, we still have fundraising costs to cover. We have already proposed a bold fundraising strategy to the Board as Trustee and are using this year to prove that the investment in fundraising staffing is a viable and positive way forward for the charity. o A new proposal will be developed for apportioning our costs across the different funds, as we have committed grants against most of the Midhurst balances which means the pro-rata apportionment used in previous years is no longer possible. • **Dormant Funds** o We currently have over 30 dormant funds which are being reviewed to agree what should happen to the funds to ensure the money can be spent in line with the charities aims. • **General Fund Grant Making Review** We discussed a model used in other NHS charities to grant money in the year after it is raised. We agreed to look at potentially considering a 6 monthly cycle given that our General fund is quite low and we don't want to stop all General grant funding completely. • **Charity Lottery Marketing**

	○ We reviewed the marketing/comms plan for the new Lottery which will be shared with EMG and the Board as Trustee. We will build in clear messaging around safeguarding our staff and be very clear about the chances of winning. • **Corporate Sponsorship** ○ We reviewed the Sponsorship Policy and were assured that we have strong safeguards in place to ensure that we scrutinise and filter the appropriate commercial organisations who might want to support us. • **Charity Risk Register** ○ We reviewed our risks and the committee asked for regular review of income versus target to provide further assurance on the trajectory of the charity's finances.
Items for escalation to the Board (if any):	• Marketing Plan for Lottery • Sponsorship Policy

Sussex Community
NHS Foundation Trust

COMMITTEE CHAIR'S REPORT TO BOARD

Committee name:	**AUDIT COMMITTEE**
Name of Chair:	Gill Galliano
Date of meeting:	20th March 2024
Main items on agenda:	• Annual self-assessment and terms of reference • Internal Audit progress report and review the Internal Audit recommendations tracker. • Deep dive – Assurance review of Quality Impact Assessments (QIA) • Internal Audit draft plan 24/25 • Draft Head of Internal Audit Opinion 23/24 • Counter Fraud progress report and tracker. • Counter Fraud annual plan 24/25 • External Audit plan and fees • Going concern and accounting policies • Fit and proper persons test policy. • Trust registers • Losses and Compensation and waiver reports up to February 2024
	• The committee reviewed the draft assessment report which will be presented to the June Trust Board. This year the checklists had been circulated to all committee members and Internal Audit and Counter Fraud so their views could be captured. Minor changes to the terms of reference will also be submitted to the Board for agreement. • Internal audit had issued four reports in the period with two reports at the draft stage. One report issued provided substantial assurance, the other two reports issued provided reasonable assurance and one was advisory. There was one proposed change to the 23/24 audit plan with a new audit of utilities management agreed. • The deep dive into the assurance review of Quality Impact Assessments (QIA) provided the committee with further assurance on the audit process undertaken. Internal Audit reported that the Clinical and Executive QIA panel meetings were well run with good input and supportive challenge. • The internal audit recommendation tracker reported that five recommendations have been implemented and marked for closure. This was supported by internal audit and the Committee agreed. There were two overdue actions and fifteen not yet due. A date extension for three recommendations had been approved by the Executive team. • Internal audit presented the Internal Audit plan for 24/25. This had been prepared through discussions with the Executive team and had been informed by review of the Trust Board Assurance Framework (BAF). Following discussion, the committee approved the plan.

	• The committee noted the draft Head of Internal Audit opinion for 23/24 as 'reasonable assurance'. This opinion assigns a level of assurance on the Trusts system of internal control based on the internal audit work completed. • Counter Fraud shared the progress report for 23/24 and provided an overview of all investigations. The tracker showed the progress made in reducing outstanding actions, there were still a number that remained in progress/overdue. There is a plan in place to reduce these. The meeting noted that a Counter Fraud agency engagement visit was taking place on the afternoon of 20th March and any recommendations would report to the July audit committee. • The draft Counter Fraud Annual plan for 24/25 was approved. • External audit presented their plan and timings for 2023/24 audit . This was approved by the committee. • The audit committee considered and approved the going concern basis of preparation for the 23/24 accounts and considered the draft accounting policies. • The audit committee ratified the Fit and Proper Persons Test (FPPT) policy. It was noted that enhanced DBS checks would now be required. • The audit committee received assurance and noted all Trust registers and Governor's declarations. • The committee noted the actual losses payments for the period were in total £121032.46, the net total of losses and compensation charges reflected in the Trust accounts at the end of the period (29th February 2024) is £(72274.58) • There were no waivers in the period.
Items for escalation to the Board (if any):	There are, at this time, no issues to be escalated to the Board.