NHS
Sussex Community
NHS Foundation Trust

Quality Improvement Plan 2019/20 - Q2 update

Excellent care at the heart of the community

Table of Contents

Introduction

Quality is a top priority for Sussex Community NHS Foundation Trust. We have made good progress toward our mission of providing excellent care at the heart of communities through fostering a culture that embraces our values. Our values of compassionate care, working together, achieving ambitions, and delivering excellence provide the foundation for our quality improvement journey.

Our Quality Account Report 2018/19 celebrated our achievements, and outlined our quality priorities for 2019/20. This 2019/20 Quality Improvement Plan outlines the Trusts continued focus on improving our services for the benefit of the diverse communities we support.

The Trust's new 3 year strategy was published in June 2019 with an increased focus on joined up and coordinated care at individual and population levels. To enable delivery of new ways of working, there is a plan to develop a Quality Strategy to ensure that these strategic goals are supported through clinical delivery and this will replace the Trust's Clinical Care Strategy 2014-2019. This enables SCFT the opportunity to take a measured approach to drafting a new Quality Strategy, so ensuring appropriate, wide spread consultation can take place.

To ensure a continued focus on quality in the interim, this Quality Improvement Plan supports delivery and monitoring of the Trust's current Quality and Patient Safety goals. Our new 3 year strategy goal for quality is to foster a culture of continuous improvement, and Our Community Way will continue to empower local teams to have ownership and skill to make changes.

Our Three Year Strategy – Quality Improvement

The organisation's Three-Year Strategy mission is to continue to provide excellent care at the heart of the community. The Trust plans to achieve this mission through a set of five strategic goals:

- Quality Improvement
- Patient Experience
- Thriving Staff
- Value and Sustainability
- Population Health

Our strategic goal of quality improvement will foster a continuous culture of improvement by:

- using research and evidence to improve our care
- demonstrating the quality of our services and standardising our most effective pathways of care; and
- sustaining and embedding 'Our Community Way' to improve patient outcomes

SUCCESS WILL MEAN:

- Patients will report a noticeable improvement in the care that they receive from community services over the next three years
- Services will be able to demonstrate measurable improvements in the care that they provide as they implement new Quality Improvement initiatives and support innovation
- Staff report that they feel well supported and encouraged to undertake Quality Improvement projects
- Our research capability and capacity will continue to increase measured by an increase in the number of staff undertaking research activity and an increase in the number of patient participants in that research
- Staff and services will have ready access to data and information that enables them to improve the care that they provide for patients

WE WILL:

- Ensure that services deliver evidence based care to each patient
- Expand delivery of research and innovation
- Embed Quality Improvement through 'Our Community Way' in every staff member's daily work
- Empower people to identify areas of improvement for their service and enable them to make changes with support from 'Our Community Way'
- Provide a consistent offer of services across our geography, as appropriate
- Work positively with patients to improve each service
- Provide staff with relevant information and data which helps them to focus on areas that need to be improved
- Support teams to use information and data to enable them to provide effective services to our diverse communities

Please note, this report provides the progress of actions in Q2. Each quarter is rated according to the table below:

Key

Substantial Assurance	Action complete.
Reasonable Assurance	Progress adequate and likely to be completed on target.
Limited Assurance	Progress inadequate and unlikely to be completed on target.
No Assurance	No progress.
No Response	No response from Lead.

One year Quality Improvement Plan 2019-20

	Domain	Safe						
	Strategic Goal	Quality Improvement - Foster a continuous improvement culture						
	Origin / Linked to	Aim/Objective	Actions	Strategic Lead	Ops Lead	Governance	Progress	RAG
S1	CQC action plan Long Term Plan	Provide fair and equitable mental health support to SCFT intermediate care units.	Review provision of adult mental health support and expertise across SCFT, alongside Sussex Partnership NHS Foundation Trust (SPFT) in Intermediate Care Units, Minor Injuries Units and Urgent Treatment Centre (MIUs and UTC).	Medical Director (Med. Dir.) Dr S Lightowlers	Mental Health Lead D Brennan	TWGG	**Q1 Progress** Mental Health Programme Lead has completed his review into mental health needs assessment of Intermediate Care Units (ICUs).	Substantial Assurance
							Q2 Progress The review undertaken was presented at TWGG.	Substantial Assurance
							Q3 Progress	
							Q4 Progress	
S2	To continue from 18/19 review of QIP	To improve the recording & monitoring of inpatients fluid/oral intake to facilitate accurate NEWS scoring.	Reenergise the Nutrition and Hydration Group. Review the Group's Terms of Reference. Conduct an audit to gain baseline position. Evaluate actions arising from audit to ensure monitoring of inpatients' fluid/oral intake improves. Re-audit to evaluate actions taken.	Deputy Chief Nurse (West & Central) J Corser	Area Nurse (West) T Beck	TWGG	**Q1 Progress** Nutrition and Hydration group re-energised with amended ToR; priorities defined and delivery plan developed.	Limited Assurance
							Q2 Progress Nutrition and Hydration Group has scoped the national guidance and confirmed SCFT compliance. MUST re-audit devised and communicated. To be undertaken in Q2.	Reasonable Assurance
							Q3 Progress	
							Q4 Progress	

S3	Intercollegiate Document 2018	Increase numbers of staff with understanding of Level 3 Safeguarding to remain above the national trend of safeguarding in accordance with the intercollegiate document 2018. For all staff within roles identified within the intercollegiate document to have the appropriate level training and knowledge to safeguard patients from abuse and harm. During 2020/21 the national target of 85% minimum trained at level 3 will be achieved.	To ensure SCFT adult safeguarding level 3 training meets the intercollegiate document recommendations.Ensure milestone trajectories achieved.ESR catalogue online Level 3 training to be assessed and commencement of roll out from January 2020 with recommended options identified and added as training that meets compliance for this level. ESR Catalogue will include 3 online course options specifically for adults safeguarding level 3 training and 2 courses that will cover both adults and children's safeguarding at level 3 for those personnel specifically working with both patient demographics.Workbooks for all new starters on Mental Capacity Act to be included in starter packs to ensure all personnel are aware of the Mental Capacity Act and its principles.Existing paper based workbooks will continue to be in use to ensure staff have various methods of learning suited to their learning styles, work commitments and personal/ professional requirements including:Face to face level 3 training by subject experts;Online ESR E Learning programmes;Paper based workbooks.	Deputy Chief Nurse (West & Central) J Corser	Head of Safeguarding D Feakes	TWGG	**Q1 Progress** Level 3 Adult safeguarding training stretch target: 65% Q1 Level 3 adult safeguarding training data: 54.6% Target cohort: Adult Services: Bands 5-8A Nursing and Allied Health Professional (AHP) frontline clinical staff. Children, Dental and Wellbeing Services: B5-8A Time to Talk and Wellbeing Services frontline staff.	**Limited Assurance**
							Q2 Progress On target to achieve the trajectory stretch target of 65% by end of March 2020. Looking into ESR catalogue instead of e health for courses which will be automatically updated on people's profiles and overall compliance to mitigate problem reported re ESR/safeguarding training.	**Reasonable Assurance**
							Q3 Progress	
							Q4 Progress	
S4	QR priority 2019/20	To provide greater assurance in relation to evidence of implementation of NICE guidance in practise.	Scope how other NHS Trusts gain assurance of compliance with NICE guidance. Conduct a review of a selection of guidance which has previously been deemed compliant. Develop an audit tool for leads to assess guidance for continued compliance. Analyse data.	Safety & Risk Manager M Plows	Quality Effectiveness Lead G Cooper	Clinical Effectiveness Group	**Q1 Progress** A process has been set up to complete an annual audit. This has been completed and a report prepared. The review of guidance found that of the ten items, eight of which were previously assessed as compliant and two as partially compliant, six maintained the same status, one was assessed as now being not applicable and three were assessed as being for information only. Actions will be agreed through the Clinical Effectiveness Group, as per normal audit processes and a further audit to begin in Q4, 2019-20.	**Reasonable Assurance**
							Q2 Progress The Quality Effectiveness (QE) team liaised with two Trusts,	

			Report as per normal audit processes.				Birmingham Community NHS Foundation Trust & First Community Healthcare NHS Trust, to scope how they gain assurance of compliance with NICE guidance. They hold monthly Clinical Effectiveness Meetings, during which leads are allocated, NICE benchmarking tools are used and once completed are returned to Clinical Effectiveness (CE) meetings for oversight, more stringent time frames are in place and 1:1 support offered for advice on sources of evidence. The audit of historical NICE guidance found that overall SCFT continues to be compliant with guidance that is still relevant to services, but that applicability changes over time: one was assessed as being not applicable and two as now being for information only. A further audit is being considered, with specialist groups reviewing guidance assessed as compliant within the last year.	
							Q3 Progress	
							Q4 Progress	
S5	To continue from 18/19 review of QIP	To deliver 75% compliance for bank staff in relation to mandatory training to ensure competency.	Set monthly trajectory for delivery.Review process of activation and termination of bank staff.	Director of HR C Haynes	Head of Resourcing B Morris	Workforce Committee	**Q1 Progress** Compliance process changed to ensure routine inactivation and termination of non-compliant bank workers. Dual Patient Handling and Resus Courses are being held every 2 weeks for new starters and out of date workers to attend.Monthly meetings taking place to discuss compliance between Education and Training and Staff Direct.Monthly bespoke bank only statutory training sessions for other subjects will continue until we get assurance that the new changes in the induction increases bank compliance.Ensuring monthly reports of bank staff who do not attend training are followed up and a process followed.	**Limited Assurance**
							Q2 Progress Maintaining progress of process into Q2. Overall compliance rate increasing to 79.54%. Reviewing whether online e-learning mandate could incorporate bank workers. Joint working with education and training team to review follow up and payment process of both attendees and Did Not Attends (DNA's).	**Reasonable Assurance**
							Q3 Progress	

							Q4 Progress	
S6	To continue from 18/19 review of QIP	To support Our Community Way – QI Framework to exceed patient expectations, through excellence and commitment in the delivery of high quality services	Q1. Skill mix the Quality Improvement (QI) Team by creating B6 and B5 posts from 1 x B8a Whole Time Equivalent (WTE) post. This greater capacity will enable the QI Team to create capability through being able to offer more training sessions for example, whilst also ensuring that important improvement programmes are supported. In addition, we will have a rolling 3 month placement to develop QI Buddys (4 per year), which will ensure we build capability into our organisation.	Head of Commercial Development M White	Head of Quality Improvement Development & Partnerships J Olk	Quality Improvement Committee	**Q1 Progress** B5 and B6 positions have been recruited in Q1. QI Buddy role secondment ongoing and has proved to be a real success in developing QI Leads into confident QI specialists building our capability. QI have team have trained in excess of 2100 members of staff in some form of QI training which accounts for 42% of SCFT staff. From June 2019 we have replaced our SCFT Corporate induction offering with the full QI Crash Course training. In addition we now have trained 49 QI Leads. At the request of the Executive the QI Share and Learn event on the 12th June 2019 has been postponed to the Autumn '19.	**Substantial Assurance**
			Q2. QI Team to run the QI Crash Course once a week with a view that, accounting for staff turnover, at least 90% of staff within SCFT are trained within 18 months of the implementation of the new team structure. QI Team to run QI Lead every 4 months with a forecast of 100 members of staff going through the programme every 12 months. This means there will be at least 100 evidence building QI projects delivered each year.				**Q2 Progress** QI team have trained in excess of 2,800 members of staff in some form of QI training, which accounts for over 50% of SCFT staff. From June 2019 we have replaced our SCFT Corporate induction offering with the full QI Crash Course training. In addition we now have trained 49 QI Leads. Vacant B8a post recruited to with a B7 role which has enabled the QI Team to fund a 0.2FTE B3 administrator role. The QI Team programme (formally QI Lead) is being redeveloped with a view to run the first sessions towards the end of 2019. October update: At the request of the Executive the QI Share and Learn event on the 12th June 2019 has been postponed to allow more time to develop the event. The Team facilitated a QI seminar with SCFT Trust Board. The Board conducted an organisation checklist to assess what else is required to support QI within the trust - a plan is being formulated for any gaps that were identified. This was followed by a QI awareness session.	**Reasonable Assurance**
			Q3. Schedule a trust wide QI Share & Learn event on the 12th June 2019 showcasing quality improvement projects that have been successfully implemented across SCFT.				**Q3 Progress**	
							Q4 Progress	

S7	Planning & Dev Gateway group	To produce an Electronic Prescribing and Medicines Administration (EPMA) business case for intermediate care units and some outpatient areas which will be approved by SCFT. EMPA is where a digital system is used to enhance and facilitate communication of a prescription or medicines order, aiding the choice, administration and supply of a medicine through knowledge and decision support, providing a robust audit trail for the entire medicines process. EPMA will move the Trust away from a paper based system. To submit an application to NHS Improvement by 31 January 2020 for the central funding they have made available. NHSI will inform SCFT about the outcome in March 2020.	Register with NHSI regarding SCFT's intentions to submit a business case (Jan 2019). Assembling a small group to discuss the initial planning of the business case.Produce an EPMA business case that is approved by the SCFT. Complete the NHSI application form and submit by 31 January 2020. Receive outcome regarding success or not for receiving match funding from NHSI in March 2020.	Medical Director and Chief Digital and Technology Officer Dr S Lightowlers D Crean	Chief Pharmacist I Altman	Planning and Development Gateway Review Group, Medicines Safety & Governance Group and Digital Improvement Group	**Q1 Progress** 01/2019: (i) Project mandate agreed by Planning & Development Gateway Review Group regarding registering SCFT's intention to bid for central capital funding. (ii) Intention registered with NHS Improvement on 29 January 2019.	**Limited Assurance**
							Q2 Progress Monthly reports to planning and development group from Sep 2019. The writing of the business case has started Oct 2019. Escalated to the planning and development group in Sep and Oct 2019 and a process for the approval business case agreed. Timescale agreed with planning and development group. Business case to be submitted to planning and development group on 4 Nov 2019. The Planning and Development group has agreed a time-table for the business case for EPMA. The business case is due to go to the planning & development group on 4 Nov 2019. Provided they agree, the business case will be presented to the Executive Committee and Resource Committee in Nov 2019. (Have already asked for the agenda for each committee to include the EMPA BC). Chief Digital & Technology Officer has informed the EC that they can expect a business case in Nov 2019. The time scale is extremely tight. Currently still limited assurance but will reassess end of Nov 2019.	**Limited Assurance**

							Q3 Progress	
							Q4 Progress	
S8	Previous inspection's CQC action plan, relating to Pain and Holistic assessments	The Trust should have clear oversight to enhance the pace of change.	Improve audit program to ensure progress and developments made are reviewed and embedded.	Head of Governance C Edwards	Quality Effectiveness Lead G Cooper	TWGG	**Q1 Progress** Audit plan embedded.	**Limited Assurance**
							Q2 Progress The 2019- 20 audit plan is progressing according to scheduled, with additional audits undertaken as required. The Quality Effectiveness team continue to facilitate and monitor clinical audits and the resulting actions, through to completion.	**Substantial Assurance**
							Q3 Progress	
							Q4 Progress	

	Domain	Caring						
	Strategic Goal	Population Health - Improve health and care outcomes for our communities						
	Origin / Linked to	Aim/Objective	Actions	Strategic Lead	Ops Lead	Governance	Progress	RAG
C1	QR priority 2019/20	Improve shared learning to staff by reviewing the process of recording, monitoring and reporting actions plans arising from serious incident investigations. Review and revise the process of providing feedback from incidents to staff regarding the incidents they report.	Draft a structured process to ensure robust reporting and monitoring of local and trust-wide Serious Incident action plans. Draft a Standard Operating Procedure to ensure table tops follow an agreed framework, ensuring all expectations are met. Conduct a scoping exercise to examine the most effective method of providing feedback to reporters.	Head of Governance C Edwards	Safety & Risk Manager M Plows	TWGG	**Q1 Progress** A system for managing and monitoring SI action plans within Datix has been drafted. QIPSNs attend monthly Area Governance Groups to give feedback on SIs. A Patient Safety Newsletter containing details of SIs and actions taken will be produced on a quarterly basis and distributed to all staff.	Substantial Assurance
							Q2 Progress Changes to how action plans are managed within Datix have been made and an accompanying SOP drafted and will be presented to SIRG.	Substantial Assurance
							Q3 Progress	
							Q4 Progress	
C2	C/F from Quality Report 2018/19	To ensure all patients are holistically assessed at the beginning of their care pathway within SCFT.	This is an ongoing piece of work and supported by internal educational support such as the case management workshop. There are bespoke sessions being run and looked at across areas and improvements being monitored through harm free, complaints etc.	Deputy Chief Nurse (West & Central) J Corser Deputy Chief Nurse (CYP & Specialists and East) C Jones	Area Nurses	TWGG	**Q1 Progress** Holistic assessment audit actions from 2018/19 are monitored and communicated via the inpatient and community nursing task forces.	Reasonable Assurance
							Q2 Progress The work stream continues and is being monitored through area governance, SIs, RCAs and complaints. Bespoke training has taken place across areas and staff have attended the internal case management sessions. Action plan v3 embedded. Re-audit of community nursing holistic assessment currently underway.	
							Q3 Progress.	
							Q4 Progress	

C3	Clinical audit action plan	To ensure all patients admitted to an SCFT intermediate care unit are assessed as per SCFT's Thromboprophylaxis Policy and Treatment Guideline for the Prevention and Management of Venous Thromboembolism (VTE) for Adult In-Patients).	Review outcome of previously undertaken clinical audit to determine QI target. Increase the number of initial assessments of VTE on admission. Snap audit to be completed by Deputy Medical Director in Q 1 / 2019. To increase the number of weekly reviews.	Deputy Medical Director Dr V Patil	Clinical Director Dr Shahid Azziz	Clinical Effectiveness group	**Q1 Progress** Audit commenced July 19 and data collection and analysis expected to be completed by the end of August 19.	**Limited Assurance**
							Q2 Progress Audit results show reasonable assurance with first review and limited assurance with 1 week assessment. Need to highlight that almost 30% of patients are on anticoagulation which skews the figures a bit.	**Reasonable Assurance**
							Q3 Progress	
							Q4 Progress	

C4	KLOE Dashboard	Improve overall compliance with resuscitation training and therefore competency.	Plan trajectory for delivering target. Consolidate training around the Moving and Handling training locations to enable staff who need to requalify their moving and handling can achieve this in a single training day. Supply specific resuscitation and moving and handling training sessions for the new joiners, allowing both sessions to be achieved in a single training day. Monitor compliance monthly.Continue to liaise with stake holders.Develop further targeting strategies in-line with the compliance status.	Safety & Risk Manager M Plows	Resus Officer I Hubbard	Resus Group/TWGG	**Q1 Progress** There are a number of on-going initiatives, including: 1 Monthly conference calls between the Area Nurses and Matrons, discussing specific compliance figures and their local issues in this regard. 2 A report is generated and forwarded to the managers of staff who withdraw or fail to attend a booked session. On withdrawal staff are asked to state why they need to withdraw (from drop down menu and free text), this data is being collated by education and training in order to gain insight on trends. 3 Resuscitation training has been consolidated around the now shared Moving and Handling training locations, this has enabled staff to requalify both their resuscitation and moving and handling in a single training day. 4 Since April 2019 there is the opportunity for new staff to gain compliance with their mandatory moving and handling and resuscitation training. Unfortunately the numbers attending the designated new joiner sessions has thus far proved disappointing. This situation is being monitored by Moving and Handling lead, Staff Direct Bank Administrator and Resuscitation Lead specifically looking at the fundamental mechanisms that place the new staff onto this training; ideally this should be part of their joining routine. The current waiting time for staff training through the ESR for either course is 2-4 months. 5 Planned audits of staff actions at mock arrest is also in the planning phase, the audit tool has been developed and the proposed details of the audit will be forwarded to TWGG in the near future.	**Reasonable Assurance**

							Q2 Progress Compliance remains stubbornly around 80% to 85%, despite the stated interventions over the last 3 quarters. Training provision remains on track. Collection of data around staff withdrawals needs to be rigorously collected if it is to prove actionable. The new joiners' specific resuscitation and manual handling training hasn't proved as popular as hoped. Currently the bank staffing organisation does not place new staff onto this training. HR/TRAC are booking staff onto the training, however, numbers rarely exceed 10. Audit of night staff mock arrest has been conducted and will be discussed in the next deteriorating patient and resuscitation committee meeting in October. Staff compliance data for the deteriorating patient is not reported on scholar, and currently data only available in terms of training figures e.g. Completed, DNA and withdrawals, this doesn't allow for Trust compliance data to be generated.	**Substantial Assurance**
							Q3 Progress	
							Q4 Progress	
C5	KLOE Dashboard and Safety Thermometer	Sustain reduction of the number of patients with pressure ulcers causing harm under SCFT care and try to reduce even more.	Review data from Datix monthly to monitor trends.	Deputy Chief Nurse (West & Central) J Corser Deputy Chief Nurse (CYP & Specialists and East) C Jones	Quality & Patient Safety Improvement Nurse (QPSIN) L Fowler	TWGG	**Q1 Progress** Working with Tissue Viability Nurse (TVN) to agree whether it's a reduction in lapses in care or the number of all Pressure Ulcers (PU) reported under SCFT. Ensure this is agreed at the next Pressure Ulcers Steering Group.	**Limited Assurance**

							Q2 Progress Agreed to undertake as a deeper dive into the data available. Data from Datix, National safety thermometer and National benchmarking reviewed and plan to present this to PUP in September to agree a percentage or number that we are aiming to achieve regarding either lapses or numbers being reported. This QIP action may need to be extended to two years to get a real sense that we are meeting the planned objective and that it is maintained. Assurance will be reasonable once we have an agreed a target.	**Reasonable Assurance**
							Q3 Progress	
							Q4 Progress	
C6		To improve the quality of data being recorded using the Safety Thermometer.	Ensure staff involved in collecting and recording Safety Thermometer data are fully aware of correct methods and processes.	Head of Governance H Pescott		TWGG	**Q1 Progress** Meeting with performance has been completed and the following agreed:The National Safety Thermometer (NST) will be added to the Key Lines of Enquiry (KLOE) dashboard with national benchmark provided as a comparable;NST will have a relaunch and review of the guidance;Reports will be created to show trends and those teams not reporting will be part of the Area Management Team (AMT) slides;Safety thermometer data will be discussed at area governance meetings.	**Limited Assurance**

							Q2 Progress The safety thermometer is now on the KLOE and a recent report was sent to the areas highlighting SCFT remaining an outlier with a request to areas that assurance is gained regarding staffs knowledge and ability to effectively collate the data and export to NST. All steps predicted for the first and second quarter were completed, but the expected results have shown minimal improvement. Further work is planned including a review of the guide for staff and NST data will be presented via the AMT slides, to continue raising the profile of NST and its importance.	**Reasonable Assurance**
							Q3 Progress	
							Q4 Progress	
C7	QR priority 2019/20	Introduce Safety Thermometer for Children and Young People.	SCFT will register and submit data aligned to the 2019/20 submission timetable. Identify harms associated with Children & Young People (CYP) deterioration through a focused review of pain, extravasation and skin integrity with quality improvements and shared learning events to reduce harm healthcare incidents in children and young people.	Deputy Area Director T Ward	Head of Specialist & Community Nursing Jane Mulcahy	TWGG	**Q1 Progress** Planning meetings with performance team. Communications with staff – Matrons, Team Leads and administrators orientating staff to what the CYP Safety Thermometer is.	**Substantial Assurance**
							Q2 Progress Reporting commenced 31st July. 2 periods of reporting complete. Awaiting pull through to KLOE Dashboard.	**Substantial Assurance**
							Q3 Progress	
							Q4 Progress	

C8	C/F from QIP Y5	Enhance the training offered to staff regarding the prevention and reduction of falls and pressure damage causing harm to patients.	Please note - this action has been superseded by the introduction of e-learning. Utilise the skills of the Trust's Communications team and specialist clinical leads to produce a training video for staff on Pressure damage and Falls.					

	Domain	Effective						
	Strategic Goal	Value & Sustainability - Improve efficiency and reduce waste						
	Origin / Linked to	Aim/Objective	Actions	Strategic Lead	Ops Lead	Governance	Progress	RAG
E1	NHSI	To further develop the investigation process to include the national Just Culture guide.	Incorporate Just Culture guide into investigation policy and put in place training to embed principles. Proactive work alongside NHSI regarding SCFT implementing the use of the Just Culture guide. Incorporate the guide into the Incident Reporting Policy. Develop training sessions to include Just Culture. Use Just Culture guide when necessary as part of Serious Incident (SI) investigation. Scope methods to measure use of the guide.	Head of Governance	Patient Safety & Clinical Effectiveness Manager	TWGG	**Q1 Progress** Just Culture is in use with all investigations and is promoted by the QPSINs, training via Power Point presentation to all area governance meetings is in progress. HR advised that they do not have any historic data of staff involved in SI's who have been taken through a HR process. QPSINs will need to keep a log on when the JC guide is being used and when staff are taken through HR as part of the SI.	Limited Assurance
							Q2 Progress Anecdotal evidence that Just Culture being used by QPSINs with mixed results. The Incident Reporting policy has been updated to reflect SCFT's commitment to embed learning. Plan to add something to Datix, or SI report template to indicate Just Culture used so use can be measured.	Reasonable Assurance
							Q3 Progress	
							Q4 Progress	

E2	QR priority 2019/20 NHSI	For all clinical areas to use evidenced based safety trigger tools (NEWs) as part of assessment processes.	Embedment of National Early Warning (NEWs2) trigger tool trust wide. Draft a robust plan of action to ensure we have staff prepared for the implementation of NEWs 2 in March 2019; to include interactive and on-line training. Reaudit the use of NEWS2 in Q1 2019/20, following the NEWs audit in Q3 2018/19. Use audit results to provide a base of the staff knowledge and the correct use of the tool. Act accordingly on audit results and the percentage of staff trained.	Deputy Chief Nurse (West & Central) J Corser Deputy Chief Nurse (CYP & Specialists and East) C Jones	QPSIN Debbie Johnson	TWGG	**Q1 Progress** Audit planned for this month. Data indicates a good take up of the E learning training, but this is not held by education and training (E&T). Staff need to ensure they send their certificates to E&T so attendance can be recorded on ESR.	**Limited Assurance**
							Q2 Progress All the results showed a positive improvement and further targeted work is required regarding escalation. NEWS 2 on SystmOne has been reviewed based on staff feedback. A request to Clinical Operations is planned regarding staff having access to the Royal Society of Physicians app for NEWS2. The Simbulence continues to visit clinical areas across the organisation to assist staff with life like deteriorating patient scenarios. Collaborative working with national numeracy, QI and NEWS 2 audit results is planned.	**Reasonable Assurance**
							Q3 Progress	
							Q4 Progress	

E3	SCFT Disability Network	Review the Communication Access UK (CAUK) project, which aims to increase communication accessibility in businesses and organisations throughout the UK, to assess suitability for roll-out across the Trust .	Scope pilot at Chailey Clinical Services -an early adopter of the symbol whose Speech and Language Therapists (SLTs) have completed webinar training.Review the impact /outcome/ evaluation of the Communication Access UK (CAUK) pilot with Chailey (once completed).Review suitability of project for roll out across the Trust.	Director of Finance & Estates	Chair of Disability Staff Network	E&D steering group	**Q1 Progress** The Disability Network receives the evaluation of the Communication Access UK (CAUK) pilot with Chailey first (once completed) and reviews the impact/outcome before any decision is made about whether this should be rolled out across the Trust, and in particular with patient communication e.g. letters/appointments sent from services, patient leaflets etc. The trust Equality and Diversity Lead will become involved and should it be implemented Trust-wide would need engagement and sign off at Executive Level.This will be reviewed at the next Disability network as part of the review for the objectives for 2019/20.	**Limited Assurance**
							Q2 Progress Progressing well, particularly regarding letters and appointments. All leaflets are being reviewed by Clinical Effectiveness Group, who are data cleansing storage on the Pulse, for completion by the end of October 2019. The Equality and Diversity Lead is played into the project and reporting through the EDIG work plan.	**Reasonable Assurance**
							Q3 Progress	
							Q4 Progress	
	Domain	**Responsive**						
	Strategic Goal	**Patient Experience - Use patient experience to improve what we do**						
	Origin / Linked to	**Aim/Objective**	**Actions**	**Strategic Lead**	**Ops Lead**	**Governance**	**Progress**	**RAG**

R1a	Patient Experience strategy	To facilitate better understanding of peoples experience of care and what matters to them.	Establish PALS Clinics within SCFT's bedded units. Plan for regular PALS clinics for Intermediate Care Units in place and will involve 6 – weekly visits to each service.	Head of Governance	Patient Experience & Assurance Manager M Hammerton	Patient Experience Group	**Q1 Progress** A programme of PALS and 'What matters to you' clinics are planned for Q2.	**Limited Assurance**
							Q2 Progress PALS have continued to visit services and public events and patient groups throughout Q2, although this work has not been regular. Work has commenced with the Voluntary services lead to train volunteers to support the work of the patient experience team by collecting feedback. A programme of community hospital visits will recommence in Q3.	**Reasonable Assurance**
							Q3 Progress	
							Q4 Progress	
R1b	Complaints Data	For relatives and users to gain an understanding of their treatment on an on-going basis (and measure this through audit). To reduce the number of complaints received related to poor communication.	Refresh the matron's role and identify key objectives in relation to patient experience. Refresh ward welcome booklet. Support ward managers to undertake ward welcome meetings.	Deputy Chief Nurse (West & Central) J Corser Deputy Chief Nurse (CYP & Specialists and East) C Jones	ICUs Matrons		**Q1 Progress** Revised Ward Welcome book for printing Allotted time for relatives to meet with ANPs and DRs developed in some ICUs, for roll out.	**Reasonable Assurance**
							Q2 Progress The matrons are supporting the ward managers with ward welcome meetings (on patient arrival) and family meetings when required. They are also reinforcing the importance of liaison with patients and their families during the course of any patient stay. ward Welcome meeting metrics in place	**Reasonable Assurance**

							Q3 Progress	
							Q4 Progress	
R2	QR priority 2019/20	Promote shared learning to staff by reviewing and revising the process of providing feedback from incidents.	Develop standardised agenda for Area Governance meetings. Ensure reporting through area FPQ meetings. Develop a Patient Safety Newsletter.	Head of Governance	Patient Safety & Clinical Effectiveness Manager T Allan	Serious Incident Review group TWGG	**Q1 Progress** To ensure shared learning from SIs the QPSINs will as part of their role attend the area governance meetings to discuss recent SIs and the learning. A spread sheet is being drafted for this process. Patient safety newsletter devised and the plan is to send this out with Quality Governance monthly slides, initially with a longer term plan to have the newsletters on the Pulse page.	**Reasonable Assurance**
							Q2 Progress Briefing paper on using Datix to track action progress, together with an accompanying standard operating procedure (SOP) drafted. Area Governance meetings provided with a monthly SI report from recent investigations highlighting the learning. Furthermore September will see the publication of the 2nd patient safety newsletter which is available on the Pulse.	
							Q3 Progress	
							Q4 Progress	

R2a	QR priority 2019/20	Translating research into improved care.	Frailty Pathway	Deputy Chief Nurse (CYP & Specialists and East)C Jones	Head Of Research Development And InnovationC Evans	Research & Innovation Group	**Q1 Progress** Year 1 objectives:1. Establishment of a SCFT multi-disciplinary working group and identification of local partners and collaborators - completed. Frailty Steering Group meeting established and first meeting held 26th May 2019. Terms of Reference drafted and ratified by Trust wide Governance Group (TWGG) July 2019. Steering group members comprises SCFT staff with representation from adult community and inpatient services, speciality and professional leads, and senior management trust wide and for respective geographical areas. The group is multi-disciplinary with representation from nursing and AHPs. We are seeking a medical doctor to join the group. Local partners identified, and regional groups on frailty. Our intention is for the steering group members to act as a conduit between existing regional frailty groups and national acute frailty network with reporting and reciprocating between the respective groups and network. We will seek to co-opt identified partners at strategic points in the work to enable delivery. 2. Development of the frailty pathway building on clinical initiatives, national guidance and research to detail local protocols and pathways. Mapping of clinical initiatives/ quality improvement projects on frailty in SCFT commenced. Steering group members requested to update and review mapping. Next Steering group meeting 20th August 2019 will focus on frailty services/QI projects activities in SCFT with presentations from the respective leads.	**Substantial Assurance**
							Q2 Progress 1. Develop and incorporate training on frailty recognition for all staff (tier 1). Training to include understanding of frailty as a long-term condition and recognition from emergence (e.g. frailty syndromes) to end of life. Training needs analysis for senior clinical staff (tier 2 and 3) on holistic and comprehensive assessment of frailty. Progress - Incorporation of training frailty recognition within planned training activities. This will include the Training Needs Analysis (TNA) in the Community	**Reasonable Assurance**

							Nursing Review, and annual TNA for the inpatient clinical units. Reviewing incorporation of frailty recognition within the core clinical competencies work. 2. Developing the frailty pathway to improve consistency across the trust in frailty assessment and management and outcomes of care. Intention is to develop approach of 'person-centred frailty management'. Completed initial mapping of services and initiatives to identify, assess and manage frailty in SCFT, and intentions/initiatives from partner organisations and collaboratives. Most commonly used tool to assess frailty is the Clinical Frailty Scale (Rockwood) (CFS). This is incorporated in System one for community services and the Individual Patient Document (IPD) in ICUs. However, there is less clarity on how the CFS is used in clinical practice or the extent that incorporated within a comprehensive assessment to inform clinical decision making. Use in the IPD to be reviewed in the planned records audit of the ICUs. Presentations from key initiatives and commissioned services including managing swallow for older people with frailty in care homes by empowering care home staff, Brighton and Hove area (Theresa Samms, SALT); and evaluation of frailty nurse activities against KPI HWLH. Key activity widening patient access to advance care planning (ACP) with ACP completed for 183 patients in 6 months delivered by small team of 4 frailty nurses. 3. Multi-disciplinary Frailty Steering Group established with representation across services, disciplines and levels of seniority from senior clinical staff to Heads of service. Agenda items aligned to milestones to deliver Frailty QIP.	
							Q3 Progress	
							Q4 Progress	

R3	QR priority 2019/20	Improve patient feedback by increasing the FFT response rates at MIUs and UTC in the Trust's four areas; Central, Children's & Well-Being, East and West.	Targeted work with areas on response rates. Number of responses required for each MIU and UTC will be identified and shared with Areas (basing on the average number of contacts within these services). New formats for collection to be agreed by the Patient Experience Group. Meet with Communications to bring these plans to fruition. Set trajectory for 2019/20 once targeted work is complete to increase FFT response in all areas .	Deputy Area Director	Patient Experience & Assurance Manager M Hammerton	TWGG/Patient Experience Group	**Q1 Progress** Target work has been undertaken within the Central Area and improvements in response rates has been noted. Work continues to install real time digital Friends & Family Test (FFT) devices. SCFT are aiming to be a front runner in implementing the new FFT guidance, when this is published in Q2.	**Limited Assurance**
							Q2 Progress Response rates in two pilot MIUs have improved since the onset of the S1 process of collecting email addresses and emailing those who give permission, to invite them to complete the FFT online survey. The Patient Experience Team is currently working on a pilot site (Crawley UTC) to use a plinthed tablet to gain real-time feedback. Staff are primed and we are currently awaiting the arrival of the plinth as there are no volunteers available to keep the device secure. The success of the pilot will be assessed in Q3 and the roll out of tablets to all MIU's/UTCs will commence with appropriate training to staff and volunteers, so that response rates can increase. Currently all area nurses receive monthly reports to highlight those services that are, or are not completing FFT in their areas. The feedback from these are they are beneficial in tracking participation. Targeted work has happened since Q1 in services to continue to raise the profile of the FFT and encourage participation in the core services who are not submitting completed FFT surveys. The new FFT guidance has been published and there are plans in place to discuss the requirements of operational services and commissioners when designing the SCFT new FFT.	**Limited Assurance**
							Q3 Progress	
							Q4 Progress	

R4	To continue from 18/19 review of QIP	Improve and encourage the recording of compliments made to staff.	Agree process of collection with Area teams via area nurses who will be asked for views from teams about how compliments could be collected to simplify the process.Design of a new format for recording will commence once agreed by Areas.	Patient Experience & Assurance Manager	Area Nurses	Patient Experience Group/TWGG	**Q1 Progress** Work is planned with the SCFT Volunteer lead to engage volunteers in the collection and recording of compliments.	**Limited Assurance**
							Q2 Progress An application has been submitted to obtain a volunteer to work with the patient experience team to support services to input and report on compliments.	**Reasonable Assurance**
							Q3 Progress	
							Q4 Progress	
R5	Carried forward from 18/19 review of previous QIP	Meeting patients and their families' expectations of individual cultural/religious needs at the end of their life.	Caring across cultures resource to be published on intranet. Plans across Equality & Diversity (E&D) group for further cultural competence work across the trust. Undertake End of Life Care (EOLC) post bereavement survey. Develop Care Plan for the Dying Patient audit. Undertake audit. Use results of audit to inform future actions. Review results of bereavement survey.	Chief Nurse S Marshall	EOLC Lead L Smith	EOLC Steering Group	**Q1 Progress** EoLC steering group have reviewed this. On-going with some slippage but confident for year-end.	**Limited Assurance**
							Q2 Progress There has been little progress made on the online cultural resource due to sickness. To review extra resource to support.	**Limited Assurance**
							Q3 Progress	
							Q4 Progress	

R6	QR priority 2019/20	To develop and roll out the ReSPECT programme.	Develop training programme. Roll out training. Set clear trajectories for delivery. Evaluate.	Chief Nurse S Marshall	EOLC Lead L Smith	EOLC Steering Group TWGG	**Q1 Progress** The Trust agreed to an alternative implementation 'go-live' plan with training to be delivered from April 2019 to March 2020 and the benefit measure to be amended to achieve 95% compliance by March 2020. Training compliance is monitored at each Area governance meeting and the monthly Project Board. A review of the ReSPECT processes is expected to be undertaken within the annual Health Record keeping audit. The timeline to engage with patients/public will be reviewed at the Patient Experience Group.	**Limited Assurance**
							Q2 Progress Training of both level 1 & 2 training continues, training compliance remains a challenge and is being monitored through the ReSPECT project board. Audit of ReSPECT forms to begin Oct/Nov SCFT. Patient engagement events for Respect delivered in HWLH & B&H CCGs.	**Reasonable Assurance**
							Q3 Progress	
							Q4 Progress	
R8	To continue from 18/19 review of QIP	For staff in ICUs to be able to consistently identify adults who are malnourished, at risk of malnutrition (undernutrition), or obese - enabling them to develop appropriate care plans.	Gap analysis of MUST training in all Intermediate Care Units.Develop training programme.Roll out training.Set clear trajectories for delivery.Evaluate.	Chair of Nutrition & Hydration Group T Beck (NSG)	ICU Matrons/TVNs	Nutrition & Hydration Group	**Q1 Progress** Group reinvigorated work commenced on the gap analysis in East and West.	**Limited Assurance**
							Q2 Progress NSG has reviewed and audit planned in Sept 19. Gap analysis will then be discussed and further actions put in place. Problem reported regarding MUST training/ESR. Escalated appropriately.	**Reasonable Assurance**
							Q3 Progress	
							Q4 Progress	

R9	CQC Action Plan	Referral pathways and processes to be established to ensure patients receive appropriate support with pain management.	Reinstate the working group with the accountable matrons. Further review of results to consider consistent trust wide approach to pain reviews and documentation within the inpatient setting. Review pain in line with other documentation, e.g. the comfort round. Discuss the option of reviewing the current drug chart to incorporate a review of analgesia linked to pain scale with SCFT's medicines management team. Harm Free meetings within each area will monitor and agenda organisation discussions regarding consistency and progress through the in-patient taskforce.	Deputy Chief Nurse (CYP & Specialists and East) C Jones	Area Nurses	TWGG	**Q1 Progress** Pain charts now on SystmOne and in end of bed folders. Matrons have highlighted the importance of completion and checking on drug rounds analgesia given and its effect. Discussed in safety huddles on each unit. Unable to review or change drug chart, but will be discussed at medicines management. Last audit shared with teams re audit in September to include bedside folders to triangulate the data set.	**Reasonable Assurance**
							Q2 Progress Ready for a reaudit in quarter 3. Matrons are keeping and monitoring the work stream. Pain formulates part of handover conversation. Matrons completing snap shot sporadic checks on the ward. Pain captured on comfort rounds as well as drug rounds.	**Reasonable Assurance**
							Q3 Progress	
							Q4 Progress	
R10	Trust Strategy	To improve the diversity of our patient representatives to ensure as many groups as possible are represented.	Please note - Removed from QIP as falls under the remit of the Workforce Steering Group					

	Domain	Well-Led						
	Strategic Goal	Thriving Staff - Provide rewarding working lives and careers						
	Origin / Linked to	Aim/Objective	Actions	Strategic Lead	Ops Lead	Governance	Progress	RAG
W1	To continue from 18/19 review of QIP	Reduce the level of stress induced sick leave for SCFT staff.	Improving the support to the workforce around mental health and wellbeing, including workplace stress, form a central part of the Workforce Health and Wellbeing Group Action Plan. The introduction of Mental Health First Aid (MHFA), flexible working and additional resources to support managers in having conversations with staff are being actioned.	Director of HR C Haynes	Consultant in Public Health C Turner	Health & Well Being Group	These objectives and actions form part of the Workforce plan and will be reported on through the Workforce Committee.	
W2	QR priority 2019/20	Improve/streamline process for recruiting staff to the bank.	To promote and bring greater visibility to the bank, the following changes will be implemented from 1st March:	Director of HR C Haynes	Head of Resourcing B Morris	Workforce Committee		

			A new calendar and approach to recruitment to the bank will be devised. Information regarding temporary work will be made available on the Trust website and all bank vacancies will be live on our Trust recruitment website. A focused advertising campaign encouraging people to join the bank in general and for particular roles will take place via love local jobs and social media. All Bank vacancies will have links on the 'individualasyou' site. Print and online advertising campaign for joining the bank, for Nursing and Health Care Assistant (HCA) roles. Open days about joining the bank will be held Trust-wide.					
W3	To continue from 18/19 review of QIP	To ensure the procedures in place for managing cases that go to Coroners are effective and supportive for staff.	Review of the current coronial process by an experienced Medico-legal Services Manager. Review the coroners and inquest policy to ensure staff are fully supported throughout the process and are aware of their responsibilities. Produce an action plan to ensure completion.	Head of Governance C Edwards	Patient Experience & Assurance Manager M Hammerton	TWGG Executive Committee	**Q1 Progress** The Coroners process has been reviewed and the policy amended. The guidance for staff is being updated and will be presented to the TWGG for approval in September 2019.	**Reasonable Assurance**
							Q2 Progress The new process was presented to TWGG in September 2019 and approved pending changes in reporting and communication lines. The amendments are being redrafted and will be implemented once agreed.	**Reasonable Assurance**
							Q3 Progress	
							Q4 Progress	