Sussex Community NHS Trust Action Plan in Response to Recommendations Made by CQC

England's chief inspector of hospitals has rated the overall quality of services provided by Sussex Community NHS Trust (SCT) as ***good***. The rating follows the inspection in December 2014 by Care Quality Commission (CQC) and offers evidence to the communities SCT serves that its services are safe, effective, caring, responsive and well-led.

The CQC rated SCT's end of life care as ***outstanding*** for how it responds to people's needs and said that some elements of SCT's inpatient care services in the safe domain ***requires improvement***, including medicines' management, training in the care of people with dementia, record keeping and care planning. In addition, the Trust must remain vigilant on staffing levels especially for inpatient units.

The inspectors looked at quality of care in four of SCT's main service areas: community health services for adults; community health services for children & young people; end of life care and community inpatient care.
In the process they found:

- Good practice to ensure safe and responsive care, and some exceptional and innovative practice.
- Caring staff who consistently provide good care.
- Clear leadership, a positive culture and good engagement.
- Partnership working that protects vulnerable people from abuse.
- Staff that feel valued and supported by their managers, supervisors and the trust Board.

The trust is committed to learning and improving based upon the Chief Inspector's feedback. The report made 10 recommendations and these are areas which the Trust recognises and is taking steps to improve. The recommendations have been collated into a CQC action plan with Executive Directors nominated as CQC action owners. The CQC action plan has been shared with our stakeholders to comment and contribute to its creation.

The recommendations and specific actions from the CQC action plan are embedded in the Trust's overarching Quality Improvement Plans (QIP) to ensure their detailed coordination, governance and delivery to agreed timelines. Action owners have assigned operational leads and progress will be monitored and reported through the Trust's formal clinical governance structures with assurance to the Board provided by the Quality Committee. Updates on QIP will also be provided to the Quality Review Meetings held with our Clinical Commissioning Groups.

There are detailed action plans underpinning each section of the overarching plan. These plans are summarised in a table on page 11 of this document.

Recommendation 1 Review recruitment policy to ensure that the vacancy levels in the trust reduce to ensure sustainability							
Ref	**Issue identified by SCT**	**Action**	**Responsibility**	**Date to be completed**	**Evidence/ assurance**	**Progress To Date**	**Success criteria**
R1.1	Review current recruitment plan including an exploration of new recruitment options e.g. working with other healthcare organisations around recruitment, PDSA cycles of new models, working with HEKSS re: commissioning training places, review of workforce plans and working with local universities to review training programmes	1. Revise recruitment plan 2. Evaluate current recruitment plan 3. Explore joint recruitment with other community Trusts 4. Meet with universities and other directors of nursing 5. Ensure workforce plans reflect new models of provision 6. Develop new model of community nursing 7. Provide quarterly updates to Quality Committee against the staffing and revised recruitment	1 HRD 2. CN 3. HRD with BSUH, SASH, WSHT, SPFT, WSCC, BHCC 4. CN with HEKSS and UoB 5. HRD with CCGs 6. CN 7. HRD	30/06/15	Revised recruitment plan reviewed through TWCGG (04/06/15) Assurance via Quality Committee (07/07/15)	1. Revised plan in draft 2. Evaluation of current plan underway 3. Initial meetings have taken place 4. HEKSS have held initial local discussions re: shared skillsets and an ongoing programme of expanding student placement is established 5. Initial work completed for transformation plan 6. New model for community nursing developed in draft for review and agreement 7. Next update due July 2015	Net increase in total number of healthcare staff in post to meet agreed safe staffing requirements and a decrease in the overall vacancy rates.

Recommendation 2

Executive team to give consideration to strengthening the role of middle management teams and in particular clarifying the role of the Clinical Director within the clinical teams.

Recommendation 6

Review and strengthen the role of Clinical Directors within services ensuring clarity of responsibilities

Ref	Issue identified by SCT	Action	Responsibility	Date to be completed	Evidence/ assurance	Progress to Date	Success criteria
R2.1 / 6.1	Review and redesign the operational structure to clarify roles and responsibilities and provide middle managers and Clinical Directors with consistency across localities	1. Establish a corporate objective to deliver review 2. Develop a consultation document based on the outcome of review	1. COO 2. COO	31/08/15	Objective reviewed and monitored at ELT meeting	1. Corporate objective included in 15/16 annual plan	Improved clarity of role and consistent working evidenced through individual appraisal and group evaluation
R2.2 / 6.2	Review, as part of the redesign process, job descriptions at middle management and Clinical Director level to include a new competency framework.	1. Extend rollout of current competency framework to middle managers and Clinical Directors	1. COO	31/08/15	Objective reviewed at Quality Committee	1. Review process underway	Recommendations from review in place by the end of March 2016

Recommendation 3 Review how to achieve consistency of standards within services across the three localities to minimise variation							
Ref	**Issue identified by SCT**	**Action**	**Responsibility**	**Date to be completed**	**Evidence/ assurance**	**Progress to Date**	**Success criteria**
R3.1	Variation in standards across the organisation	1. Identify those services which are demonstrating outstanding practice in their field 2. Develop a timed action plan for moving all teams to best practice	1. MD	30/09/15	Reported to TWCGG and assurance via the Quality Committee	1. First new quarterly shared learning event held with front line staff.	Timed action plan in place
R3.2	Improve sharing of best practice through technology, communication and a culture of continuous improvement	1. Develop shared learning portal to include appreciative inquiry 2. Refresh transformation ideas area on Pulse 3. Include improvement science in leadership development programme	1. DoT 2. DoT 3. DoT	31/08/15	Evidence is reported to the Transformation Board	1. Portal established for all SCT staff, 3. New transformation development training package designed	Transformation Facilitators in place, who have been trained in a consistent way, to lead transformation based on best practice
R3.3	Develop shared commissioning for quality and innovations (CQUINs) by commissioners across the 3 localities to ensure consistency	1. Work with commissioners across the 3 localities to ensure consistency through developing shared CQUINs	1. CN and CCGs	31/08/15	Review CQUINs through the TWCGG and Quality Review Meetings	1. Initial meetings held and draft CQUINs agreed	Shared CQUINs for 15/16 in place
R3.4	Ensure the operational structure supports consistency of standards	1. Review and implement necessary changes to the operational	1. COO	31/03/16	Review and report through Executive Leadership	1. Initial planning undertaken with PAG and discussed with	Recommendations from review implemented

Recommendation 3 Review how to achieve consistency of standards within services across the three localities to minimise variation							
Ref	**Issue identified by SCT**	**Action**	**Responsibility**	**Date to be completed**	**Evidence/ assurance**	**Progress to Date**	**Success criteria**
		structure following review in line with recommendations 2 & 6 to develop consistency.			Team.	ELT	
R3.5	A plan for peer review to be developed by senior clinical leads to enhance the sharing and embedding of best practice	1. Develop action plan for peer review process	1. CN	30/09/15	Action plan progress reported through TWCGG. Assurance provided to Quality Committee	1. Initial discussions held via PAG workshop (29/04/15)	Peer review reports in place

Recommendation 4 **Ensure delivery of estates strategy to address some of the concerns during the inspection e.g. Crawley Urgent Treatment Centre room for people experiencing mental health issues**							
Ref	**Issue identified by SCT**	**Action**	**Responsibility**	**Date to be completed**	**Evidence/ assurance**	**Progress to Date**	**Success criteria**
R4.1	Review the suitability of the Crawley Urgent Treatment Centre room for use by people with mental health issues.	1. Undertake review and identify issues.	1. COO	31/07/15	Progress reported to FT programme board	1. A review and risk assessment for ligature points has been undertaken and actions implemented in response to identified risks	Crawley UTC compliant with patient usage

Recommendation 5 **Review the timescales in relation to the roll-out of electronic systems that support and record care to ensure that there is assurance that risks are always identified assessed or monitored using an effective system and there is consistency across localities.**							
Ref	**Issue identified by SCT**	**Action**	**Responsibility**	**Date to be completed**	**Evidence/ assurance**	**Progress to Date**	**Success criteria**
R5.1	Delays in the rollout of SystmOne Programme	1. First wave - Review the timeliness of the rollout of SystmOne programme 2. Second wave - 70% of roll out to be completed by December 2015 (adults community, in-patients and healthy child programme) 3. Third wave - 100% of roll out completed	1. DoF 2. DoF 3. DoF	30/06/15 31/12/15 30/06/16	This will be tested by internal audit in Q3/Q4 2015/16 and reported to the SystmOne programme board and ELT	1. SystmOne roll out programme agreed and the risks identified 2. Second wave on track for delivery 3. Initial prioritisation for third wave completion	SystmOne delivered against agreed plan.
Recommendation 6 is included with recommendation 2							

Recommendation 6 **Review and strengthen the role of Clinical Directors within services ensuring clarity of responsibilities**
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Recommendation 7 **Take action to review record keeping and that all records are up to date and personalised to meet patients' needs**							
Ref	**Issue identified by SCT**	**Action**	**Responsibility**	**Date to be completed**	**Evidence/ assurance**	**Progress to Date**	**Success criteria**
R7.1	Develop an action plan on patient records improvements to include personalisation of care and consistency of content across the trust	1. Develop action plan for improvement 2. Develop guidelines for record keeping 3. Develop and pilot standardised documentation for inpatient services 4. Rollout of standardised care plan	1. CN 2. CN 3. CN 4. CN	30/11/15	Progress against plan reported to TWCGG and assurance given to the Quality Committee	1. Action plan developed 2. Guidelines for record keeping developed 3. Standard inpatient documentation being piloted 4. Plan developed for rollout of care plan	Audit and re-audit results
R7.2	Ensure do not attempt cardiopulmonary resuscitation' (DNACPR) decisions are completed consistently in inpatient units	1. Produce action plan on DNACPR decision making 2. Identify future training requirements 3. Audit compliance	1. MD	31/10/15	Progress reported through Resuscitation Committee and TWCGG	1. Approved DNACPR policy in place 2. Training plan in place for DNACPR which includes a review of training 3. Audit tool in development	Audit demonstrates 95% policy compliance
R7.3	Review patient record storage policy and compliance	1. Review the Terms of Reference for the health records group 2. Identify new ways of recording and storage 3. Audit compliance	1. DoF	30/09/15	Progress against plan reported to the health records group	1. Terms of Reference for the health records group reviewed	Mock CQC inspections demonstrates improved record storage

Recommendation 7 Take action to review record keeping and that all records are up to date and personalised to meet patients' needs							
Ref	**Issue identified by SCT**	**Action**	**Responsibility**	**Date to be completed**	**Evidence/ assurance**	**Progress to Date**	**Success criteria**
R7.4	Work with partners in Western Sussex Hospitals to ensure the safe transfer of records.	1. Meet with WSHT 2. Develop a plan for safe transfer of records	1. COO 2. COO	30/09/15	Progress against plan reported to the health records group	1. Initial meeting with WSHT has taken place 2. Draft plan developed	Audit and re-audit

Recommendation 8 Undertake an audit of medicines administration and documents relating to this to ensure that patients receive the correct medication at the correct time							
Ref	**Issue identified by SCT**	**Action**	**Responsibility**	**Date to be completed**	**Evidence/ assurance**	**Progress to Date**	**Success criteria**
R8.1	Undertake regular audit of medicine administration and documentation	1. Review Documentation 2. Develop Trust wide adult prescription and administration chart and evaluate 3. Provide training on use of chart 4. Medicines Management to conduct regular annual missed doses audits and develop associated action plans 5. Rollout the Productive Wards medicines modules to all wards	1. MD 2. MD 3. MD 4. MD 5. GB	30/09/15	Reported to medicines safety and governance group and TWCGG. Assurance to the Quality Committee	1. Documentation reviewed 2. Trust wide adults inpatients prescription and administration chart developed and evaluated 3. Training commenced 4. Audits scheduled 5. Gap analysis being completed	Reduction in incidents due to omitted doses

Recommendation 8 **Undertake an audit of medicines administration and documents relating to this to ensure that patients receive the correct medication at the correct time**							
Ref	**Issue identified by SCT**	**Action**	**Responsibility**	**Date to be completed**	**Evidence/ assurance**	**Progress to Date**	**Success criteria**
R8.2	Develop a detailed action plan to include independent observation of medicines administration, development of local medication action groups, identification of common themes, regular review and reporting of missed dose audits	1. Medicines Management Team to undertake independent observations of medicines administration of selected wards and provide feedback. 2. Gap analysis on ward action groups 3. Identify common themes from wards and monitor actions through the inpatient task force 4. Identify local lead to produce a local action plan for addressing missed doses or review and update current action plan	1. MD 2. MD 3. CN 4. MD	30/09/15	Report to medicines safety & governance group (MS&GG) and TWCGG. Assurance to Quality Committee.	1. Gap analysis complete. Some wards already have Medication Action Groups	Medication action groups in all wards Zero tolerance to avoidable missed doses
R8.3	Conduct recurring annual audit on missed doses	1. Medicines Management Team to undertake missed doses audit	1. MD	28/02/16	Report to (MS&GG) and TWCGG. Assurance to Quality Committee.	1. This is a recurring annual audit with next audit data collection due October to December 2015.	Annual audits undertaken and improvements made compared to previous audit.

Recommendation 9 Review processes for pain management and evaluation							
Ref	**Issue identified by SCT**	**Action**	**Responsibility**	**Date to be completed**	**Evidence/ assurance**	**Progress to Date**	**Success criteria**
R9.1	Identify, develop and rollout best practice for pain assessment	1. Review pain assessment tools used in acute trusts and identify best practice for use in SCT 2. Develop standardised pain assessment tool and documentation. 3. Develop a roll out plan of standardised tool, to include appropriate training.	1. CN with BSUH, SASH and WSHT 2. CN with BSUH, SASH and WSHT 3. CN	30/09/15	Through TWCGG. Assurance to Quality Committee.	1. Collation of tools used has commenced 2. Work has started at documentation group to develop tool 3. Tool development in progress	Standardised tool developed and implemented across inpatient units

Glossary	
BSUH	Brighton and Sussex University Hospitals NHS Trust
CCGs	Clinical Commissioning Groups
CN	Chief Nurse (Susan Marshall)
COO	Chief Operating Officer (Richard Curtin)
DoF	Director of Finance (Jonathan Reid)
DOT	Director of Transformation (Gareth Baker)
ELT	Executive Leadership Team
HEKSS	Health Education, Kent, Surrey and Sussex
HRD	Human Resource Director (Carol Beardall)
MD	Medical Director (Dr Richard Quirk)
UoB	University of Brighton
PAG	Professional Advisory Group
PDSA	Plan Do Study Act
SASH	Surrey & Sussex Hospitals
SPFT	Sussex Partnership Foundation Trust
TDA	Trust Development Authority
TWCGG	Trust-wide Clinical Governance Group
WSHT	Western Sussex Hospitals NHS Foundation Trust

Each recommendation has a detailed underpinning action plan as follows:	
1	Recruitment plan
2 and 6	Review plan in line with corporate objective
3	Plan for moving all teams to best practice
4	Risk assessment action plan
5	SystmOne Programme plan
7	Health Records Improvement Plan
8	Medicines Management action plan
9	Pain assessment tool rollout plan