Review into the Quality of Care and Treatment provided by 14 Hospital Trusts in England

Key Findings and Action Plan following Risk Summit

July 2013
Contents

1. Overview

2. Summary of Review Findings and Trust Response

3. Risk Summit Action Plan

Appendices

Appendix I: Risk Summit Attendees
1. Overview

A risk summit was held on 1 July 2013 to discuss the findings and actions of the Rapid Responsive Review (RRR) of Tameside Hospital NHS Foundation Trust (“the Trust”). This report provides a summary of the risk summit including the Trust’s response to the findings and an action plan for the urgent priority actions from the RRR. The action plan includes any agreed support required from health organisations, including the regulatory bodies.

Overview of review process

On 6 February 2013 the Prime Minister asked Professor Sir Bruce Keogh, NHS England Medical Director, to review the quality of the care and treatment being provided by those hospital trusts in England that have been persistent outliers on mortality statistics. The 14 NHS trusts which fall within the scope of this review were selected on the basis that they have been outliers for the last two consecutive years on either the Summary Hospital-level Mortality Indicator (SHMI) or the Hospital Standardised Mortality Ratio (HSMR) 1.

These two measures are intended to be used in the context of this review as a ‘smoke alarm’ for identifying potential problems affecting the quality of patient care and treatment at the trusts which warrant further review. It was intended that these measures should not be reviewed in isolation and no judgements were made at the start of the review about the actual quality of care being provided to patients at the trusts.

Key principles of the review

The review process applied to all 14 NHS trusts was designed to embed the following principles:

1) Patient and public participation – these individuals have a key role and worked in partnership with clinicians on the reviewing panel. The panel sought the views of the patients in each of the hospitals, and this is reflected in the reports. The panel also considered independent feedback from stakeholders related to the Trust, received through the Keogh review website. These themes have been reflected in the reports.

2) Listening to the views of staff – staff were supported to provide frank and honest opinions about the quality of care provided to hospital patients.

3) Openness and transparency – all possible information and intelligence relating to the review and individual investigations will be publicly available.

4) Cooperation between organisations – each review was built around strong cooperation between different organisations that make up the health system, placing the interests of patients first at all times.

1 Definitions of SHMI and HSMR are included at Appendix I of the full Rapid Responsive Review report published here http://www.nhs.uk/NHSEngland/bruce-keogh-review/Pages/published-reports.aspx
Terms of reference of the review

The review process was designed by a team of clinicians and other key stakeholders identified by NHS England, based on the NHS National Quality Board guidance on rapid responsive reviews and risk summits. The process was designed to:

- Determine whether there are any sustained failings in the quality of care and treatment being provided to patients at these Trusts.
- Identify:
  1. Whether existing action by these Trusts to improve quality is adequate and whether any additional steps should be taken.
  2. Any additional external support that should be made available to these Trusts to help them improve.
  3. Any areas that may require regulatory action in order to protect patients.

The review followed a three stage process:

- **Stage 1 – Information gathering and analysis**
  
  This stage used information and data held across the NHS and other public bodies to prepare analysis in relation to clinical quality and outcomes as well as patient and staff views and feedback. The indicators for each trust were compared to appropriate benchmarks to identify any outliers for further investigation in the rapid responsive review stage as Key Lines of Enquiry (KLOEs). The data pack for the Trust is published at [http://www.nhs.uk/NHSEngland/bruce-keogh-review/Pages/published-reports.aspx](http://www.nhs.uk/NHSEngland/bruce-keogh-review/Pages/published-reports.aspx)

- **Stage 2 – Rapid Responsive Review (RRR)**
  
  A team of experienced clinicians, patients, managers and regulators, following training, visited each of the 14 hospitals and observed the hospital in action. This involved walking the wards and interviewing patients, trainees, staff and the senior executive team. This report contains a summary of the findings from this stage of the review in section 2.

  The two day announced RRR visit took place at Tameside Hospital on Thursday 23 and Friday 24 May 2013 and the unannounced visit was held on the evening of Sunday 2 June and morning of Monday 3 June 2013. A variety of methods were used to investigate the Key Lines of Enquiry (KLOEs) and enable the panel to analyse evidence from multiple sources and follow up on any trends identified in the Trust’s data pack. The KLOEs and methods of investigation are documented in the RRR report for Tameside Hospital NHS Foundation Trust. A full copy of the report was published on 16 July 2013 and is available online: [http://www.nhs.uk/NHSEngland/bruce-keogh-review/Pages/published-reports.aspx](http://www.nhs.uk/NHSEngland/bruce-keogh-review/Pages/published-reports.aspx)

- **Stage 3 – Risk summit**
  
  This stage brought together a separate group of experts from across health organisations, including the regulatory bodies (please see Appendix I for a list of attendees). The risk summit considered the report from the RRR, alongside other hard and soft intelligence, in order to make judgements about the quality of care being provided and agree any necessary actions, including offers of support to the hospital concerned.
The Risk Summit was held on 1 July 2013. The meeting was chaired by Richard Barker, NHS England Regional Director (North), and focused on supporting the Trust in addressing the urgent actions identified to improve the quality of care and treatment. The opening remarks of the Risk Summit Chair and presentation of the RRR key findings were recorded and are available online: http://www.nhs.uk/NHSEngland/bruce-keogh-review/Pages/published-reports.aspx

**Conclusions and priority actions**

The review panel found that patients generally had a good experience of care in the surgical pathway and identified good practice in this area. However, the experience of patients in the emergency and acute medical pathway was often poor and issues were identified which required urgent review and action to be taken. These included inadequate supervision by senior doctors, inappropriate use of escalation areas, insufficient nurse staffing levels and poor infection control practice for patients admitted with *Clostridium difficile*. Attendees at the risk summit acknowledged that whole system working on the emergency pathway would be required.

The panel also identified a failure by the Trust to learn from similar findings and to embed recommendations received in the past. The panel asked for assurance that recommended improvements in the emergency care pathway would be taken forward as a matter of urgency. It was considered that changes were required to Board and clinical leadership in order to ensure that effective learning takes place in the future.

Changes to clinical practice that had been made by the Director of Nursing, who was appointed in 2012, were acknowledged, but it was also noted that areas of on-going work had been identified during the review.

There were limitations in the information on quality being provided to the Board, including around on-going monitoring to provide assurance that cost improvement plans are not having a negative impact on quality. There was also a disconnect between some of the information reported at Board level and what the panel witnessed on the wards. The panel considered that quality is unlikely to improve until these issues are addressed.

The panel heard positive and negative stories from the more than 200 members of the public who attended the patient listening event, but many of the stories highlighted that the Trust was not being as candid and transparent with its answers to concerns as it should be. The quality strategy needed review and to take on board the voices of the patients and public.

The review identified a number of areas of outstanding concern across all eight KLOEs. Planned improvements were identified in most of the eight areas, but the panel included further recommended actions for each area. The panel summarised these recommendations at the risk summit as follows:

- Implement the required improvements in the emergency and acute medical care pathway.
- Ensure that there is true ward to Board assurance, rather than reassurance.
- Listen to, rather than just hear, the wishes of patients, and fully demonstrate a duty of care and candour.
- Ensure that it is clear to staff what the Trust's expectations are with regard to the quality of care.

The Trust responded positively to the RRR process and presented to the risk summit a number of actions in response to the feedback.
Next steps

The action plan presented by the Trust at the risk summit focused on urgent and high priority actions, and did not set out all necessary details, including measures and milestones. The Trust agreed to provide a specific and detailed ("SMART") action plan to respond to all outstanding concerns and recommended actions included in the RRR report by 15 July 2013. Recommended high-level timeframes have been included in the action plan set out in section 3. However, given the changes in management which took place shortly after the risk summit, it is acknowledged that the action plan may be reviewed by the incoming directors.

Monitor will play a lead role in overseeing the development of the action plan and will review progress against it as part of its usual regulatory duties. Follow up of the RRR and risk summit action plan will also be undertaken by other organisations within the system, including the Care Quality Commission (CQC) and General Medical Council (GMC) visits. A follow up visit was due to be undertaken by the Deanery the day following the risk summit on 2 July 2013. Given concerns over the capacity and capability of the Trust to deliver all the required changes, there was a commitment from the NHS England Area Team and Clinical Commissioning Group (CCG) to work together with the Trust to address some of the issues raised.

A further risk summit will be held in September 2013 so that stakeholders can agree whether the action plan and progress to-date are adequate. A formal follow up will take place thereafter, consisting of a desktop review and a targeted unannounced site visit to the Trust, set for November or December 2013, to review key areas and understand the improvements that have taken place. The review panel will be invited to take part in the follow up review. A report of the follow up findings will be issued to the risk summit attendees and if there are significant remaining concerns, consideration will be given for the need to convene a further risk summit.
2. Summary of Review Findings and Trust Response

Introduction

The following section provides a summary of the RRR panel’s findings and recommendations, and the Trust’s response presented at the risk summit. The detailed findings are contained in the Trust’s RRR report, and the findings and action plan in this report should be read in conjunction with the RRR report. An action plan in response to the urgent and high priorities is included in the following section.

The Trust’s response was presented by Christine Green, Chief Executive, supported by John Goodenough, Director of Nursing; Tariq Mahmood, Medical Director and Paul Connellan, Chairman.

Overview of Trust’s response

The Trust stated that the review process was a challenging experience, but it recognised its weaknesses and accepted the review panel's findings in full. A formal apology for care failings was made by the Director of Nursing.

The Board committed to implementing the recommendations in full and to being held publically to account for delivery. The Trust stated that it wanted to address the challenges and lead on improvements, and do so in an open, honest and transparent way. It stated that it would be important to work together with its stakeholders and partners.

The Trust described actions in response to the panel’s findings about care risks, Board leadership, the quality strategy, organisational culture and patient and public engagement. The Medical Director also described a multidisciplinary leadership programme that was being implemented and highlighted that clearer job plans and increased powers through revalidation would help to ensure adequate performance of doctors. The Director of Nursing highlighted the many changes being made, particularly following the recruitment of two deputies, and development support which will be provided to nurses going forward.

The Trust recognised that it needed help and highlighted external support that it expected to require, including continued work with the Urgent and Emergency Care Intensive Support Team (ECIST), a more in-depth third party review of governance, support from the NHS Confederation on external communications and public affairs, working with the Deanery on medical education challenges and working with the CCG which includes consideration of key quality metrics.
Summary of Review Findings

1. Care risks associated with the emergency and medical pathway

The panel considered that external recommendations to review and improve the acute medical pathway had not been sufficiently progressed by management. A number of issues requiring urgent action had been identified by the panel. These included inadequate consultant supervision of junior doctors and patients (particularly at night), a resulting lack of timely investigations in some areas, inappropriate use of escalation areas, insufficient nurse staffing levels and the use of nurses in escalation wards who are not regular staff on the wards, and poor infection control practice for patients admitted with *Clostridium difficile*.

The panel described to the risk summit a number of examples of observations made during the site visits to the hospital which illustrated these concerns.

Recommendations

- The Board should assure itself immediately that no patients are at immediate risk of unsafe care due to the issues raised in the RRR report and improve key safety processes, including management of deteriorating patients.
- The Trust should review operational planning in the emergency and medical pathway to support appropriate care, including improving clinical cover and leadership, particularly at night. The Trust should agree a plan of action for improving the acute medical pathway including the management of escalation areas and bed management protocols immediately.
- The Trust should agree a plan of action for improving the acute medical pathway in line with the recommendations from the reports already commissioned by the Board.
- The Trust should develop a workforce strategy to support the clinical strategy and as part of this undertake a medical and nurse staffing review to ensure safe standards of care and dignified patient experience is achieved. The review should focus on reducing locum spend, vacancy rates and staff moves and ensure that the e-roster templates reflect staffing standards, guidance and effective deployment practice.

Trust response

The Trust immediately increased the frequency of safety thermometer point prevalence audits to weekly.

The Medical Director described a multidisciplinary leadership programme that was being implemented and highlighted that clearer job plans and increased powers through revalidation would help to ensure adequate performance of doctors. In response to challenge from the GMC and Deanery over ensuring adequate leadership and oversight from senior medical staff, the Medical Director described personally checking all appraisals and that training and support that was offered to the group of appraisers. He stated that disciplinary action would be taken in future if necessary, that trainees had been encouraged to escalate to the on-call manager and Medical Director if a consultant does not turn up and that feedback would be sought from trainees weekly.

The Trust agreed to take the following actions:

- Ensure the identification and appropriate management of deteriorating patients.
1. Care risks associated with the emergency and medical pathway

- Enhance and increase clinical walk rounds including Executive Directors, Non Executive Directors and Clinical Leads. The Trust stated that it had increased visibility at nights and on week-ends.
- Work with junior doctors to establish a weekly safety barometer reported via the Medical Director to the Board.
- Progress urgent elements of the workforce strategy. The Board has agreed to a thorough review of medical staffing to ensure adequate supervision of junior doctors, including a review of out of hours cover. Also, it will provide additional middle grade cover, particularly at week-ends, to stabilise cover, by September.
- Continue implementation of the Emergency Care Intensive Support Team (ECIST) action plan.

2. Board not effectively leading quality improvement and governance and leadership has not delivered required improvements in quality of care

The Board needs to improve its focus on quality improvement in the organisation. It was recognised that the Board has received limited performance information to enable it to obtain assurance on the quality of care and treatment and has not sought to effectively use all available information in the Trust. This includes limited evidence of taking on board fully the views of its patients and staff.

The panel noted that a number of recommendations previously made by other agencies – all relating to the acute medical pathway and many relating to senior medical involvement – did not appear to have been implemented by the Trust. The panel considered that changes were required to Board and clinical leadership in order to ensure that effective learning takes place in the future.

The Clinical Commissioning Group also highlighted that action plans had been in place before and asked how the Trust would assure them that things would be different this time. It was suggested that a further risk summit be held later in the year to review progress.

Recommendations

- Urgently review the Board’s leadership style and optimise the effectiveness of this on organisational culture and quality improvement, including enhancing the visibility of all of the Directors.
- The Board should consider how it can introduce more challenge to the “assurance process” including seeking independent corroboration of statements on outcomes and processes which are reported to them.
- The Trust should accelerate the ward and senior leadership development programme and focus on improving clinical leadership (both medical and nursing) in the organisation.
- Enhance staff communication, including ward performance, audit results, incident reporting and learning from reviews. This may be more effective through better use of directorate and ward level meetings and direct email newsletters.
2. Board not effectively leading quality improvement and governance and leadership has not delivered required improvements in quality of care

Trust response

The Trust acknowledged that although progress had already been made in addressing some issues, the review had identified that the incremental approach was not sufficient. The Trust had to go a step further to radically transform the face of Tameside Hospital.

The Trust agreed to take the following actions:

- Obtain an external assessment of the skills and capability of the Non Executive Directors and Executive Directors with a view to strengthening the challenge and mentorship role in the organisation.
- Invest in and accelerate Board and personal development. Utilise expert external support and mentoring to facilitate Board development, identifying skill gaps.
- Make a significant investment and improvement in staff and stakeholder engagement and communication.

3. Quality strategy and performance management information needs significant improvement

The Trust’s quality strategy needed to be reviewed and refreshed. Staff were unable to state what the priorities for improvement were or the progress that was being made in achieving these. The panel argued that the Trust was not doing enough to understand and make improvements to address the high SHMI.

The Board does not receive on a monthly basis a comprehensive quality dashboard including performance information relating to CQUIN and quality account objectives. This would limit opportunities for the Board to address deviations in performance. Although the Trust has quality impact assessments of CIPs, these do not include selection of quality indicators for monitoring improvement or deterioration in care quality. The Board is also not receiving adequate information on mortality.

At the risk summit the panel provided an example of where there was a disconnect between information reported to the Board and performance witnessed by the panel on the wards. The North West Care Indicators were “green” across the board. However, at the unannounced visit the panel did not see such high performance in practice, for example around record-keeping and patient assessments.

Recommendations

- Develop an updated, single, cohesive quality strategy that takes account of external reports, mortality concerns, feedback from patients and staff, clinical audit recommendations, current identified risks and current Trust performance. As part of this, agree quantifiable and measurable improvements.
- Develop a single improvement plan relating to quality and outcomes as set out in the quality strategy. Undertake a Safety Culture Audit to inform this and prioritise actions that link to a reduction in mortality and improvement in quality and patient experience.
- Review reporting to the Board to ensure that performance against the quality strategy and action plan can be monitored and challenged effectively. Reporting should be more responsive and comprehensive, including improvements identified in Board level review of quality accounts, mortality data and the ongoing quality...
3. Quality strategy and performance management information needs significant improvement

- Impact of CIPs. Assess performance against the upper quartile of national care.
  - Review the governance of mortality improvement to bring rigour and pace to a comprehensive and coherent programme of work such that mortality reviews are of adequate depth to produce recommendations.
  - Ensure that there are clear lead responsibilities in particular with regard to any joint health economy strategies and actions. In addition, the Trust should consider external scrutiny to care audits and mortality reviews.

**Trust response**

The Trust agreed to take the following actions:

- Invest in improving and enhancing the information reporting and capability.
- Develop a single, outcome focused quality dashboard in conjunction with the CCG covering the entire patient pathway.
- Produce publicly available joint performance reports to the Trust Board, the Governing Body of the CCG and the Health and Wellbeing Board.

4. Need to develop organisational culture to remove tolerance of sub-optimal care and engage more effectively with staff at all levels to improve quality

The Trust needs to review how it can improve its organisational culture to focus more on quality and patient experience. The panel did consider that the staff that were interviewed and observed were committed and loyal to the Trust and genuinely believed that they were providing good care, though they could not easily describe what good looked like or how they knew that care compared well to other providers.

The panel observed acceptance of sub-optimal standards of care across the organisation, including low care bundle compliance, acceptance of bed moves for non-clinical reasons (for example, a patient will undergo four bed moves before an incident is reported and investigated), poor quality mortality reviews and clinical audits with limited evidence of lessons learnt, and a complaints process which was slow and not as transparent and candid as it should be.

**Recommendations**

- Develop a clinical effectiveness programme to improve the staff knowledge of evidence based care including infection control, clinical audit, leading and managing quality improvement change.
- Agree a programme of development support such that there can be effective cultural change where patients and staff, including trainees, feel heard, valued and cared for.

**Trust response**

The Trust agreed to take the following actions:

- Pilot the use of a Cultural Barometer.
- Undertake and implement the findings of a Safety Culture Audit.
- Implement an improvement programme based on staff and patient surveys.
- Designate and charge a specific Non Executive Director to ensure the implementation of the improvements.
## 5. Patient and public engagement

The Panel did not see clear evidence that the Board is hearing the voice of patients and families to learn what needs to be done to improve the quality of patients’ experience. This is essential to set a cultural tone for staff that is in line with the stated objectives of initiatives such as Everyone Matters, and provide development to ensure staff are sensitive to patients’ needs and learn from complaints. At the risk summit the panel highlighted that many attendees at the public listening event had described how their complaints had not been handled satisfactorily.

### Recommendations

- Develop a programme to improve listening to patients including training staff to respond to concerns in line with the Trust’s vision of “Everybody Matters” and “treat you and your family as partners in care”.
- Review the complaints management ethos and process to ensure that public expectations and the required duty of candour and standards are met.
- The impact of changes to the complaints process will need to be evidenced so that the Trust Board can be assured that full and proper learning takes place.

### Trust response

The Trust agreed to take the following actions:

- Significantly invest in and improve staff and stakeholder engagement.
- Review the internal complaints processes, training and expectations.
- Continue to rapidly build upon the foundations with Healthwatch.
3. Risk Summit Action Plan

Introduction

The Trust accepted the findings of the panel and presented an action plan based on the high priority recommendations from the RRR report. No information in addition to the RRR report was presented at the risk summit. This section provides an overview of the issues discussed at the risk summit together with the action plan developed containing high-level actions, owners, recommended high-level timescales and external support required. The action plan should be read in conjunction with the RRR report.

As mentioned in a previous section, the Trust must still submit a detailed action plan which is specific and measurable. It is acknowledged that the action plan may be reviewed by incoming directors. Monitor will play a lead role in overseeing the development of the action plan and a further risk summit will be held in September 2013 so that stakeholders can agree whether the action plan and progress to-date are adequate. CQC will also monitor delivery of the action plan through its regulatory processes.

Action plan

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<thead>
<tr>
<th>Key issue</th>
<th>Agreed action and support required</th>
<th>Owner</th>
<th>Timescale</th>
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<tbody>
<tr>
<td>1. Care risks associated with the emergency and medical pathway</td>
<td>▪ Ensure the identification and appropriate management of deteriorating patients.</td>
<td>Trust</td>
<td>Immediate</td>
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<td></td>
<td>▪ Review operational planning in the emergency and medical pathway to support appropriate care. Agree a plan of action for improving the acute medical pathway including the management of escalation areas and bed management protocols immediately.</td>
<td>Trust</td>
<td>By end July 2013</td>
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<td></td>
<td>▪ Complete development of, and implement, the ECIST action plan. Report on outcomes to be submitted to relevant organisations.</td>
<td>Trust</td>
<td>By end July 2013</td>
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<td></td>
<td>▪ Work with junior doctors to establish a weekly safety barometer reported via the Medical Director to the Board.</td>
<td>Trust</td>
<td>By end August 2013</td>
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<td></td>
<td>▪ Perform a thorough review of medical staffing to ensure adequate supervision of junior doctors and patients, including a review of out of hours cover. Provide additional middle grade cover.</td>
<td>Trust</td>
<td>By end July 2013</td>
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<td></td>
<td>▪ Enhance and increase clinical walk rounds including Executive Directors, Non Executive Directors and Clinical Leads. Increase visibility at nights and on week-ends.</td>
<td>Trust</td>
<td>By end September 2013</td>
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<td></td>
<td>▪ Develop workforce strategy with urgent elements progressed immediately.</td>
<td>Trust</td>
<td>By end September 2013</td>
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<tr>
<td>Key issue</td>
<td>Agreed action and support required</td>
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| 2. Board not effectively leading quality improvement and governance and leadership has not delivered required improvements in quality of care | • Obtain an external assessment of the skills and capability of the Non Executive Directors and Executive Directors with a view to strengthening the challenge and mentorship role in the organisation.  
• Invest in and accelerate Board and personal development. Utilise expert external support and mentoring to facilitate Board development, identifying skill gaps. Engage the North West Leadership Academy in this regard.  
• Make a significant investment and improvement in staff and stakeholder engagement and communication. Engagement needs to cover ward performance, audit results, incident reporting and learning from reviews to enable performance management to take place effectively.  
• Accelerate the ward and senior leadership development programme.  
• Provide support for governors in developing their roles, including networking opportunities. | Trust, Trust | Trust | By end August 2013, Implementation by beginning September 2013, Trust 2013 (actions and timing to be clarified in detailed plan), Trust 2013 (actions and timing to be clarified in detailed plan) |
| 3. Quality strategy and performance management information needs significant improvement | • Develop an updated, single, cohesive quality strategy that takes account of external reports, mortality concerns, feedback from patients and staff, clinical audit recommendations, current identified risks and current Trust performance. As part of this, agree quantifiable and measurable improvements and a single improvement plan relating to quality and outcomes as set out in the quality strategy.  
• Invest in improving and enhancing the information reporting and capability.  
• Develop a single, outcome focused quality dashboard in conjunction with the CCG covering the entire patient pathway. Ensure that performance against the quality strategy and action plan can be monitored and challenged effectively.  
• Commission a more comprehensive review of governance arrangements, including both Board and clinical leadership and governance.  
• Produce publically available joint performance reports to the Trust Board, the Governing Body of the CCG and the Health and Wellbeing Board.  
• Review the governance of mortality improvement to bring rigour and pace to a comprehensive and coherent programme of work such that mortality reviews are of adequate depth to produce recommendations. | Trust, input from CCG and Area Team, Trust, Trust, Trust, Monitor | Trust, CCG, Trust, Monitor, Trust, CCG, Health and Wellbeing Board | By end September 2013, By end September 2013, By end July 2013, By end 2013, By end August 2013 |
<table>
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<tr>
<th>Key issue</th>
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| 4. Need to develop organisational culture to remove tolerance of sub-optimal care and engage more effectively with staff at all levels to improve quality | ▪ Ensure that there are clear lead responsibilities in particular with regard to any joint health economy strategies and actions.  
▪ Pilot the use of a Cultural Barometer.  
▪ Undertake and implement the findings of a Safety Culture Audit.  
▪ Develop a clinical effectiveness programme to improve the staff knowledge of evidence based care including infection control, clinical audit, leading and managing quality improvement change.  
▪ Implement an improvement programme based on staff and patient surveys. Use a "you said, we did" approach to patient and staff feedback.  
▪ Designate and charge a specific Non Executive Director to ensure the implementation and outcomes of improvements including effective cultural change where patients and staff, including trainees, feel heard, valued and cared for.  
▪ Significantly invest in and improve staff and stakeholder engagement.  
▪ Review the internal complaints processes, training and expectations. As part of this, review the complaints management ethos and ensure that public expectations and the required duty of candour and standards are met.  
▪ Continue to rapidly build upon the foundations with Healthwatch. | Trust, CCG, Health and Wellbeing Board Trust Trust Trust Trust Trust Trust | By end August 2013 September 2013 Identify leads, agree methods, commission work programmes by end of August and start implementation by beginning of September 2013 Link into quality strategy workstream and clarify as part of detailed action plan On-going 2013 (actions and timing to be clarified in detailed plan) Review completed by end September 2013, with implementation by end October 2013 2013 (actions and timing to be clarified in detailed plan) By end February 2014 |
| 5. Need to improve patient and public engagement                         | ▪ Evidence and review the impact of changes to the complaints process so that the Trust Board can be assured that full and proper learning takes place.                                                                                                                                       | Trust                                      |                                                                                                      |
Appendices
# Appendix I: Risk Summit Attendees

<table>
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<tr>
<th>Risk summit role</th>
<th>Name</th>
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</table>
| Risk Summit Chair  
NHS England, Regional Director (North)                                              | Richard Barker                            |
| RRR Panel Chair  
NHS England, Regional Chief Nurse (North)                                              | Gill Harris                               |
<p>| NHS England, Regional Deputy Medical Director (North) and RRR Panel Representative  | Damian Riley                              |
| NHS England, Deputy Medical Director and Regional Medical Director (North)          | Mike Bewick                               |
| RRR Panel Representative (patient / public (lay) representative)                   | Margaret Hughes                           |
| RRR Panel Representative                                                          | Mike Wright                               |
| RRR Panel Representative                                                          | Gavin Nicol                               |
| RRR Panel Representative                                                          | Helen Carter                              |
| RRR Panel Representative                                                          | Tom Foley                                 |
| Trust Chief Executive                                                            | Christine Green                           |
| Trust Chairman                                                                   | Paul Connellan                            |
| Trust Director of Nursing                                                         | John Goodenough                           |
| Trust Medical Director                                                            | Tariq Mahmood                             |
| NHS England, Communications (North)                                                | Caroline Radford                          |
| Area Team (Greater Manchester) Director                                           | Mike Burrows                              |
| Area Team (Greater Manchester) Medical Director                                    | Raj Patel                                 |
| Area Team (Greater Manchester) Director of Nursing and Quality                     | Trish Bennett                             |
| Area Team (Greater Manchester) Deputy Director of Nursing and Quality              | Helen Barlow                              |
| Area Team (Greater Manchester) AD Clinical Strategy                               | Karen O’Brien                             |</p>
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<th>Risk summit role</th>
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<tr>
<td>CCG (Tameside and Glossop) Chair</td>
<td>Alan Dow</td>
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<td>CCG (Tameside and Glossop) Chief Operating Officer</td>
<td>Steve Allinson</td>
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<tr>
<td>CCG (Tameside and Glossop) Chief Finance Officer</td>
<td>Kathy Roe</td>
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<tr>
<td>CCG (Tameside and Glossop) Director of Quality and Nursing</td>
<td>Nikki Leach</td>
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<tr>
<td>CQC Regional Director (North)</td>
<td>Malcolm Bower-Brown</td>
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<tr>
<td>CQC Head of Regional Compliance (North West)</td>
<td>Ann Ford</td>
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<tr>
<td>CQC Compliance Manager</td>
<td>Steven Bennett</td>
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<td>CQC Compliance Inspector</td>
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<td>Tameside MBC, Director of Public Health</td>
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<tr>
<td>Dean of Postgraduate Medical Studies and head of the Deanery (North West Deanery)</td>
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<td>Monitor, Senior Regional Manager</td>
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<td>General Medical Council, Employer Liaison Advisor</td>
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<td>Quality Governance Support</td>
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<td>Independent Moderator</td>
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