Northern Lincolnshire and Goole Hospitals NHS Foundation Trust

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

A risk summit was held on 5 July 2013 to discuss the findings and actions of the Rapid Responsive Review (RRR) of Northern Lincolnshire and Goole Hospitals 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 discussed at the risk summit. 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 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:

  i. Whether existing action by these Trusts to improve quality is adequate and whether any additional steps should be taken.
  ii. Any additional external support that should be made available to these Trusts to help them improve.
  iii. 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.

- **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 three day announced RRR visit took place at the Trust's three sites (Diana, Princess of Wales Hospital in Grimsby, Scunthorpe General Hospital in Scunthorpe and Goole and District Hospital in Goole) on Wednesday 5, Thursday 6, and Friday 7 June 2013. The unannounced visit was held on the evening of Friday 14 June 2013 in Grimsby. 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 Northern Lincolnshire and Goole Hospitals NHS Foundation Trust. A full copy of the report was published 16 July 2013 and is available online: 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 ([lease 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 5 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 panel acknowledged that it had found a number of examples of good practice across the Trust, including in the diagnostics team, the midwifery service in Grimsby and the diabetes ward in Scunthorpe. However, there were also a number of key findings requiring urgent and high priority action which were summarised as follows:

- **Leadership and implementation** – clear issues were identified around clinical leadership and progress with implementation. For example, the National Early Warning System (NEWS) was not taken up or understood universally. An emphasis on finance and targets was felt to detract from quality at least at a staff level. It was not obvious to some staff that quality was the priority.

- **Flow of care** – the pathway at Grimsby requires particular consideration where issues were identified with regard to triage in Accident and Emergency (A&E) and handover from ambulances (observed at the unannounced visit), as well as the management of bed moves and outliers.

- **Acute stroke services** – out of hours stroke services are currently inadequate and improvements have not been implemented consistently across the Trust.

- **Staffing** – there are concerns over the staffing of key elements of acute care, including recruitment of staff and maintenance of adequate staffing levels and skill mix on the wards. Nurse staffing levels were found to be inadequate in places at the unannounced visit.

- **Poor care and patient experience in some areas** – a theme that emerged from patient stories was a lack of basic care. Patient stories also highlighted gaps in communication between professionals and between staff and patients.

The Trust responded positively to the findings and presented detailed actions to the risk summit addressing each of these five areas. The agreed actions are set out in section 3.

The Clinical Commissioning Groups referred to action plans developed in the past, challenged whether the Trust was focusing on the right things and asked for assurance that the action plans would be implemented successfully. Issues around patients not being listened to were part of a consistent theme and something which needed to be addressed. The review panel stated that the Trust needed to obtain evidence that patients were being heard.

Concerns over implementation were echoed by NHS England who questioned whether the plan was achievable and Monitor who stated that priorities within the detailed action plan would need to be considered. The review panel asked the Trust to ensure that priority actions were given focus and leadership. Monitor noted that there was a concern over quality governance and that they would be able to provide support, challenge and advice in this area. The Trust welcomed this statement and agreed that improvement was required. Monitor also offered to work with the Trust to help them to review the action plan monthly.

The Care Quality Commission (CQC) considered that the panel's report provided a strong framework for future improvement and that the findings were consistent with their own concerns about the Trust as reported following their last inspection earlier in the year. The CQC believed there was evidence of the Trust having a grip of the key issues,

with clear senior ownership of the improvement challenge and a holistic approach to action planning. NHS England also commented positively on the cohesiveness of the team which had presented the action plan and their readiness to address the challenges.

The Area Team highlighted that the system needs to work effectively to ensure that patients only end up in the A&E and Medical Assessment Unit (MAU) unless they absolutely need to be treated there, and that there needs to be an effective system to facilitate patients' exits from hospital.

It was concluded that the plan will only be successful if the system works around the Trust. Effective leadership, decision-making and momentum would also be required for the necessary change to happen.

Next steps

As the risk summit had focused on urgent and high priority actions, the Trust agreed to provide a detailed action plan to cover all outstanding concerns and recommended actions included in the RRR report by 15 July 2013. The Trust will also need to review priorities within the action plan, ensuring that it is achievable and that progress is measurable on a monthly basis.

Follow up of the RRR and monitoring of the risk summit action plan will be undertaken by other organisations within the system, including Monitor who will work with the Trust on a monthly basis to review progress, the Care Quality Commission (CQC) and General Medical Council (GMC).

The GMC stated that they were willing to provide support to the Trust in terms of medical leadership improvements. A further offer of support was made to the Trust in terms of helping them to overcome their recruitment challenges. The Trust welcomed this and agreed to follow up.

A formal follow up of the review and risk summit will consist of a desktop review and a targeted unannounced site visit to the Trust, tentatively set for October or November 2013, to review key areas in order to understand the improvements that have taken place. Panel members will be invited to attend. A report of the follow up findings will be issued to the risk summit attendees and will consider, if there are significant remaining concerns, if there is a 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 the Trust's response presented at the risk summit. The detailed findings are contained in the Trust's RRR report. The Trust's response was presented by Karen Jackson (Chief Executive), supported by Wendy Booth (Director of Clinical and Quality Assurance / Trust Secretary), Karen Dunderdale (Chief Nurse) and Carrock Sewell (Consultant and medical representative for the Trust at the risk summit). The agreed action plan in response to the urgent priorities is included in the following section.

Overview of Trust's response

The Trust welcomed the review and stated it had tried to be very open and honest because of the culture it is driving for. The Trust accepted the findings and stressed that the report reflects a position which is not where the Trust wants or aspires to be. Structures had been developed to support quality governance, but it accepted that there is a need for pace, consistency and demonstrable improvement. The Trust stated that the review had allowed them to test the plans in place, to tighten them and inject pace.

The Trust confirmed its commitment to a patient safety culture, acknowledging that a big change was required from where they had started from. The culture had started to turn, but it needed to turn more quickly. An example of the Trust's commitment which was provided was the "back to basics" campaign led by the Chief Nurse which had started in March 2013 and aimed to ensure compassionate care.

The Trust stated that it would need the support of the health and social care economy around it to help drive improvements, as care does not start at the hospital front door and end after the hospital visit. It highlighted that it has three sites over 62 miles and that the communities are isolated. The Director of Operations had been released to perform a sustainable services review, but this will require discussion as a community. The Trust agreed to continue to build an open and transparent relationship with relevant external stakeholders, for example the CQC and MPs, and to continue to actively seek external scrutiny of the Trust's quality and quality governance arrangements. This includes obtaining agreement of a joint working protocol with Healthwatch during July 2013.

The panel highlighted that Healthwatch and other stakeholders should be involved sooner, rather than later, in future service planning.

Summary of Review Findings

1. Inadequate progress being made to improve the quality of services with pace utilising effective clinical leadership

The panel observed a lack of sufficient implementation of clinical strategies. Data reporting and governance processes are in place, but there was little evidence of widespread clinical change. There needs to be effective clinical leadership and adequate involvement of senior medical staff in redesigning services. The systems in place need to be thoroughly tested.

The panel was particularly concerned that the Trust is not yet offering thrombolysis treatment for stroke patients after hours and there are inconsistencies in stroke care across the sites. The National Early Warning System (NEWS) had not yet been used or understood consistently.

Whilst there was some evidence of a shift from a financial to quality orientation, the Board needs to ensure a greater focus on the quality agenda throughout the organisation. An emphasis on finance and targets was felt to detract from quality at least at a staff level.

Recommendations

- The Board needs to prioritise actions to improve quality, urgently addressing key areas of high mortality (including the treatment of stroke, respiratory diseases, pneumonia and septicaemia) and other concerns.
- The Trust must continue to embed the learnings from stroke care improvements in Scunthorpe across the Trust, and facilitate thrombolysis for all stroke patients.
- The Trust needs to work with the CCG to urgently address the provision of stroke services out of hours. It is recommended that the Trust conduct an urgent review of the out of hours stroke services at Diana, Princess of Wales Hospital and implement recommendations, agreed with the CCG, by the end of July 2013.
- Improve clinical leadership to ensure implementation of clinical strategies.

Trust response

There are structures in place to support quality governance, including a new directorate for clinical and quality assurance established in September 2012 and a Mortality Performance Committee (MPC). However, the Trust accepted that there is a need for more pace, consistency in the implementation of pathways and improvement plans, and demonstrable improvement. One of the key issues the Trust is working on is clinical leadership. The MPC will hold clinical leads to account and test the changes which are made. Clinical leadership will also be reviewed.

The Trust accepted that an effective and safe solution to stroke care is needed which takes account of the geography of the area.

The Trust has agreed to take the following actions:

- Review stroke services to ensure the delivery of 7 day stroke care, including interaction with tertiary institutions. An options appraisal for the provision of stroke services will be delivered by mid-July 2013.

1. Inadequate progress being made to improve the quality of services with pace utilising effective clinical leadership

- Undertake a review of clinical leadership (to include Clinical Directors and Mortality Pathway Leads) across the organisation to include clear expectations of the role and the agreement of appropriate development and mentoring support. Roles will be cross-site. To be completed by 31 August 2013.
- Deliver priority clinical work streams within agreed timescales. The MPC will 'sign off' clear action plans for each work stream including the process for wider clinical engagement and utilising SMART principles by the end of July 2013. Non-delivery of milestones and work streams is to be escalated to the Trust Board via the MPC 'Highlight' reports.
- Strengthen the performance management framework including implementation of the revised 'Commitment to Improve Quality and Safety ('Zero Tolerance') Framework' during July 2013. The framework will be reviewed to ensure the inclusion of compliance with pathways, as appropriate.
- Directorates / Groups will be held to account for delivery of agreed objectives / work streams via the performance review process led by the Chief Executive.
- Embed the use of the Health Assure system (quality and patient experience dashboard) by September 2013.
- Undertake a gap analysis against Monitor's updated quality governance framework and agree and implement any required additional actions arising from that process (by August 2013).
- Formalise the programme of unannounced out of hours Director Visits and dissemination of good practice from that process by July 2013.
- As part of the Ward Review assessment process, introduce an 'accreditation' process for compliance with relevant ward standards including recognition and reward of good practice by September 2013.

2. Poor patient flow management, lack of early triage, multiple bed moves and poor management of outliers, particularly at the Diana, Princess of Wales Hospital

The panel observed effects of inadequate capacity and poor patient flow management throughout the emergency and acute pathway, as well as in theatres and on surgical wards, most acutely at the Grimsby site. A number of concerns require urgent attention, including:

- Lack of adequate early triage in A&E,
- Patients being cared for by ambulance staff in A&E, and
- The management of bed moves and outliers including improvement of the consistency of the medical team allocated.

2. Poor patient flow management, lack of early triage, multiple bed moves and poor management of outliers, particularly at the Diana, Princess of Wales Hospital

Recommendations

- Urgently implement adequate triaging at the A&E interface.
- Ensure that prompt hand-over can be made by ambulance staff.
- Develop a clinically led approach to managing the acute medical pathway in conjunction with stakeholders.
- Minimise patient transfers. A move needs to be discussed with clinicians to agree the impact that it would have on clinical care.

Trust response

The Trust has agreed to take the following actions:

- Undertake an immediate independent review of the Triage arrangements across the Trust. This will also take account of recommendations of the Urgent and Emergency Care Intensive Support Team (ECIST) visit to Scunthorpe General Hospital. Ensure that there is only triage in A&E unless absolutely necessary (immediately).
- Continue joint work with EMAS to support better monitoring and management of handover times; continue to work on managing multiple arrivals (immediately).
- Pathways to be reviewed to ensure that the requirement to minimise patient transfers, and for clinicians to agree the impact a move would have on clinical care before it takes place, is included and reinforced by 31 August 2013.
- Reinforce responsibilities and accountabilities of wider consultant body with respect to the discharge policy as part of the planned review of pathways and the planned review of clinical leadership and link to work on the performance review process, organisational development and culture (by 31 August 2013). The Trust stated that developing the use of technology via the WebV Clinical Portal will support improved discharge planning.
- Implement fully the recommendations arising from the visit from the Urgent and Emergency Care Intensive Support Team (ECIST) by September 2013.

The panel highlighted that the Trust should not over-rely on technical solutions, such as Web-V, when issues are also related to attitudes and behaviours.

3. Inadequate staffing levels, quality and skill mix in a number of areas

The Trust had recently identified that the nursing establishments were low, but considered that they generally still met the minimum determined from national guidance (for example RCN standards). However, the Trust identified four high risk areas and took immediate action.

At the unannounced visit in Grimsby, the panel observed inadequate nurse staffing levels and leadership to cope with clinical demand in A&E, MAU and the medical wards (which are different to the wards mentioned above) and this needed to be addressed urgently. Staff and patients also raised concerns over staffing levels.

The panel also observed gaps in handover and in middle grade and senior medical involvement out-of-hours which would result in lower standards of care. Some local medical staff reported multiple use of short and long term locum junior doctors resulting in variable quality and experience of non-consultant grade medical staff. A recruitment deficit at this grade was acknowledged by management.

Recommendations

- Continue to review nurse staffing levels and skill mix and address areas with inadequate staffing. Ensure staffing and skill mix are appropriate to provide safe patient care in all areas 24/7.
- Close monitoring of acuity / dependence in all areas, with prompt escalation when appropriate, needs to be put into place urgently until longer term solutions are approved by the Board.
- Develop a recruitment strategy which focuses on known and impending areas of weakness. Work with the area team, other trusts, regional team and LETB to address wider issues regarding recruitment.
- Fast track discussions with commissioners, and the wider health economy regarding plans to implement a seven day service.
- Review medical cover out of hours and provide more senior cover to ensure safe standards.
- Handover procedures should be strengthened so that they are safe.

Trust response

The Trust agreed with the panel's findings that nurse staffing was inadequate on the evening of the unannounced visit in the areas specified by the panel. A redeployment of staff had failed and the Trust took immediate action to review the process.

The Trust presented information to the risk summit on the safety of nurse staffing levels and skill mix across its wards. The information showed the four high risk areas with regard to staffing levels where the Board had already agreed to fund additional staffing. However, risk summit attendees challenged the general level and mix of staffing across the wards as numerous other wards were on the border between safe and unsafe care levels.

The Trust has agreed to take the following actions:

3. Inadequate staffing levels, quality and skill mix in a number of areas

- Agree next steps in relation to safe nursing establishments at the Trust Board during July 2013, following the confirm & challenge and impact assessment process.
- Implement changes to senior medical staff cover in the AMU at Diana, Princess of Wales Hospital that were implemented in the MAU at Scunthorpe General Hospital (immediately).
- Fully embed the new handovers process across the Trust (immediately).
- Develop a formal medical staffing recruitment strategy building on recruitment initiatives already agreed and utilising external support as required (during July 2013).

The Trust asked for advice in developing a more outward looking recruitment strategy and this was noted by the panel. The panel also highlighted areas closer to home that the Trust should address to make working near the hospitals more attractive, including accommodation. The Trust confirmed that it was reviewing accommodation available for its staff.

The Trust also requested help with an external review of A&E doctor rotas.

4. Evidence of poor care and patient experience in some areas

The Trust is using interpretations of the single sex accommodation standards in certain areas of the Trust which are no longer deemed acceptable. The Trust needs to review the application of the national definitions urgently to ensure that patients' dignity is maintained.

Patient stories highlighted significant weaknesses in communication with patients and families and many instances of patients not receiving basic care. In some cases, patients were not provided with adequate hydration and nutrition, including food that met medical needs. Urgent review of hydration and feeding practices is required.

The panel observed variations in the standard of case notes and clinical documentation and best practice needs to be reinforced urgently across the Trust.

Recommendation

- Perform a Trust wide review of the application of the national definitions and reporting of mixed sex accommodation breaches.
- Training should be provided to all staff to ensure that they are familiar with the national guidelines and definitions.
- Review hydration and feeding practices across the Trust. Identify best practice, share information and implement necessary reforms.
- Review processes governing the completion of clinical documentation and establish safe standards of practice.
- Implement improvements to the complaints procedures before September 2013.

4. Evidence of poor care and patient experience in some areas

- Patient voice to be heard at Board level to improve engagement with patients.

Trust response

The Trust immediately undertook a mixed sex review in all areas following the review. It was clear that the policy had not been applied in some areas. Some staff were not aware of the policy and many struggled with the intricacies of it. The Trust stated that it would welcome an external review of the policy.

The Trust acknowledged issues around nursing documentation, catering delivery and the temperature of food (the service was being redesigned), and fluid management. It stated that it was in the process of moving to a MUST tool, implementing a fluid management bundle and piloting the use of volunteers at mealtimes, as well as working with families to support patients. Charts are being reviewed for accuracy every month on every ward.

The Trust stated that it had undertaken a review of the complaints process, but would ensure that the resulting action plan was clear, timely and responsive. The Trust aims to get more patients in to discuss their concerns and will embed the existing framework around patient stories.

The panel highlighted that the Trust will need to produce evidence that patients are being heard.

The Trust has agreed to take the following actions:

- Develop a policy on a page to improve awareness and understanding of the policy on mixed sex accommodation by September 2013.
- Review and standardisation of nursing documentation to be completed by September 2013. Bedside documentation to be fully electronic by December 2013 (on Web-V). Trust wide Electronic Patient Records (EPR) to be implemented by June 2014.
- Complete ward service pilots by September 2013.
- Implement MUST screening tool by September 2013.
- Complete fluid management project by September 2013.
- Implement the revised Nutrition and Hydration Care Pathway by September 2013.
- Implement a Nursing Dashboard / Quality Wall on wards so that everyone can understand and see the performance on the ward (by September 2013).
- Implement the actions arising from the formal review of the complaints process by September 2013. Review the availability and prominence of information on the complaints process in wards & departments and training provided to staff (to start in September 2013).

The Trust also stated that it would continue to strengthen mechanisms for sharing lessons learnt and good practice following incidents / SUIs and ‘never events’, but asked for advice on how to ensure adequate learning across the Trust.

3. Risk Summit Action Plan

Introduction

The risk summit development of an outline plan focused on the urgent and high priority actions from the RRR report. No information in addition to the RRR report was presented at the risk summit. The following section provides an overview of the issues discussed at the risk summit with the developed action plan containing the agreed actions, owners, timescales and external support required.

In line with challenge provided at the risk summit, the Trust will need to review the action plan before implementation commences, to ensure that it is specific, achievable and measurable.

Action plan

Key issue	Agreed action and support required	Owner	Timescale
1. Inadequate progress being made to improve the quality of services with pace utilising effective clinical leadership	Review stroke services to ensure the delivery of 7 day stroke care, including interaction with tertiary institutions.	Trust working with CCG's	Review completed by mid-July
	Undertake a review of clinical leadership across the organisation.	Trust	Completed by end August 2013
	MPC to 'sign off' clear action plans for each work stream including the process for wider clinical engagement and utilising SMART principles.	Trust	By end July 2013
	Implement the revised 'Commitment to Improve Quality and Safety ('Zero Tolerance') Framework'. Framework to be reviewed to ensure the inclusion of compliance with pathways, as appropriate.	Trust	By end July 2013
	Embed the use of the Health Assure system (quality and patient experience dashboard).	Trust	By end September 2013
	Undertake a gap analysis against Monitor's updated quality governance framework and agree and implement any required additional actions arising from that process.	Trust	Completed by end August 2013
	Formalise the programme of unannounced out of hours Director Visits and dissemination of good practice from that process.	Trust	By end July 2013
	Introduce a ward 'accreditation' process for compliance with relevant ward standards including recognition and reward of good practice.	Trust	By end September 2013

Key issue	Agreed action and support required	Owner	Timescale
2. Poor patient flow management, lack of early triage, multiple bed moves and poor management of outliers, particularly at the Diana, Princess of Wales Hospital	Undertake an immediate independent review of the triage arrangements across the Trust.	Trust	Immediate
	Continue joint work with EMAS to support better monitoring and management of handover times; continue to work on managing multiple arrivals.	Trust, EMAS	Immediate
	Review pathways to ensure that the requirement to minimise patient transfers, and for clinicians to agree the impact a move would have on clinical care before it takes place, is included and reinforced.	Trust	Completed by end August 2013
	Reinforce responsibilities and accountabilities of wider consultant body with respect to the discharge policy as part of the planned review of pathways and the planned review of clinical leadership and link to work on the performance review process, organisational development and culture.	Trust	Completed by end August 2013
	Implement fully the recommendations arising from the visit from the Urgent and Emergency Care Intensive Support Team (ECIST) by September 2013.	Trust	By end September 2013
3. Inadequate staffing levels, quality and skill mix in a number of areas	Agree next steps in relation to safe nursing establishments at the Trust Board during July 2013.	Trust	By end July 2013
	Implement changes to senior medical staff cover in the AMU at Diana, Princess of Wales Hospital that were implemented in the MAU at Scunthorpe General Hospital.	Trust	Immediate
	Fully embed the new handovers process across the Trust.	Trust	Immediate
	Develop a formal medical staffing recruitment strategy building on recruitment initiatives already agreed and utilising external support as required.	Trust	By end July 2013
4. Evidence of poor care and patient experience in some areas	Develop a policy on a page to improve awareness and understanding of the policy on mixed sex accommodation.	Trust	By end September 2013
	Review and standardisation of nursing documentation to be completed by September 2013. Bedside documentation to be fully electronic by December 2013 (on Web-V). Trust wide Electronic Patient Records (EPR) to be implemented by June 2014.	Trust	September – June 2014
	In relation to nutrition and hydration: ▪ Complete ward service pilots ▪ Implement MUST screening tool	Trust	By end September 2013

Key issue	Agreed action and support required	Owner	Timescale
	▪ Complete fluid management project ▪ Implement the revised Nutrition and Hydration Care Pathway		
	Implement a Nursing Dashboard / Quality Wall on wards so that everyone can understand and see the performance on the ward.	Trust	By end September 2013
	Implement the actions arising from the formal review of the complaints process. Review the availability and prominence of information on the complaints process in wards & departments and training provided to staff (to start in September 2013).	Trust	By end September 2013

Appendices

Appendix I: Risk Summit Attendees

Risk summit role	Name
Risk Summit Chair NHS England, Regional Director (North)	Richard Barker
RRR Panel Chair NHS England, Deputy Medical Director and Regional Medical Director (North)	Mike Bewick
NHS England, Regional Chief Nurse (North)	Gill Harris
RRR Panel Representative NHS England, Regional Deputy Medical Director	Jane Dunning
RRR Panel Representative (patient / public (lay) representative)	Madeleine Wang
RRR Panel Representative	Bill Cunliffe
RRR Panel Representative	Bethan Graf
RRR Panel Representative CQC	Nick Allen
Trust Chief Executive	Karen Jackson
Trust Director of Clinical and Quality Governance / Trust Secretary	Wendy Booth
Trust Director of Nursing	Karen Dunderdale
Trust Medical Representative	Carrock Sewell
NHS England, Communications (North)	Caroline Radford
Area Team (North Yorkshire and Humber) Director	Chris Long
Area Team (North Yorkshire and Humber) Medical Director	Paul Twomey
Area Team (North Yorkshire and Humber) Director of Nursing and Quality	Jo Coombs
CCG	Lynn Poucher

Risk summit role	Name
Deputy Chief Executive CCG, North East Lincolnshire CCG	Helen Kenyon
Deputy Chief Executive / Chief Financial Officer, North East Lincolnshire CCG	Cathy Kennedy
Chair, North Lincolnshire CCG	Margaret Sanderson
Health Education England	Sharon Oliver
Health Education England	Jon Hessain
CQC Regional Director (North)	Malcolm Bower-Brown
Monitor, Regional Director (North)	Yvonne Mowlds
General Medical Council, Employer Liaison Advisor	Blake Dobson
Independent Moderator	Colin Pollock Carolyn Clark
Project Management Support	Peter Norriss
Recorder	Lawrence Shotliff