HOW TO:
Organise and Run a Risk Summit: 2012/13

National Quality Board

June 2012

This publication has been produced by the National Quality Team on behalf of the National Quality Board.

To find out more about The How To Guides please visit the NQB web site

http://www.dh.gov.uk/health/category/policy-areas/nhs/nqb/

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Contents

The purpose of ‘How to’ guides

Recent failings in the health and social care system have highlighted the need for greater clarity about who is responsible for identifying and responding to failures in quality. The National Quality Board has addressed this through the publication of two reports

1. Review of early warning systems in the NHS (24 February 2010):- www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113020
2. Maintaining and improving quality during the transition: safety, effectiveness, experience (March 2011) www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_125234

But if we are clearer about our roles and responsibilities, then we also need a more consistent approach to how these difficult judgements about quality are made and to provide the managers and clinicians who have to make them with more guidance and support. How should we judge whether a service is failing or not? What tools might be used to better understand the situation, and what action should be taken as a result?

As part of the SHA to SHA Cluster Handover Assurance Process run in 2011, we sought to understand from each region what the current ‘best practice’ operating model for key aspects of quality is in their area, with a view to encouraging adoption across the country. Rather than try and produce one overarching model, we have worked with the NHS and key stakeholders to produce a series of practical ‘How to’ guides that directly relate to the key issues that NHS staff have suggested that further guidance would be helpful. These documents and a range of other resources can be found on http://www.dh.gov.uk/health/category/policy-areas/nhs/nqb/. These guides are not set in stone: they represent our best understanding of the most effective way of responding to quality concerns, and we would welcome feedback and comment so that we can continue to incorporate any learning and experience into the operating model for quality.

Quality is complex. It is systemic: that is, the delivery of high quality care depends upon many different parts of the system working together. Therefore, the most important part of any operating model for quality in the NHS must be the culture and behaviours that our respective organisations adopt within and between ourselves.

Proposed Operating Principles

- The patient comes first – not the needs of any organisation or professional group
- Quality is everybody’s business – from the ward to the board; from the supervisory bodies to the Regulators, from the commissioners to primary care clinicians and managers
- If we have concerns, we speak out and raise questions without hesitation
- We listen in a systematic way to what our patients and our staff tell us about the quality of care
- If concerns are raised we listen and ‘go and look’
- We share our hard and soft intelligence on quality with others and actively look at the hard and soft intelligence on quality of others
- If we are not sure what to decide or do, then we seek advice from others
- Our behaviours and values will be consistent with the NHS Constitution

Summary

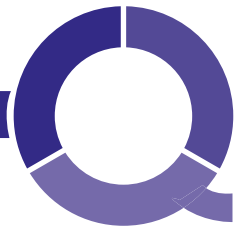
This is one of a number of 'How to' guides issued by the National Quality Board (NQB) which has been designed to provide guidance on the organisation and running of a risk summit when there are concerns about the quality of care being provided for patients. It offers practical advice and although prescriptive in parts, it does offer scope for local interpretation to match the demands of what can often be complex and difficult circumstances to manage.

The guide is specifically for use in the current healthcare system but the learning will be used as part of the design work underway to prepare for the changes to the NHS architecture and systems which are due to come into operation in April 2013. The guide also reflects the spirit of the NHS Early Warning Systems reports - Review of Early Warning Systems in the NHS - Acute and Community Services - February 2010 and Maintaining and improving quality during the transition; safety, effectiveness and maintaining and improving quality – part one 2011/12 (March 2011). Review of Early Warning Systems in the NHS stated that CQC would run "Triggered Risk Summits" to, "provide a responsive mechanism for a detailed discussion and assessment of risk in the event of a specific serious concern emerging about an organisation or group of organisations." This document uses the term 'risk summit' to refer instead to the SHA-led process once serious failure has been identified and hence does not supplant the authority of the CQC to call together stakeholders for discussions about risk to enable regulatory judgements to be made about a provider (see Chapter 2).

Effective communication between stakeholders is essential in making sure that everyone stays alert to the potential for failings in patient care. Sharing information willingly and in a timely fashion is crucial to ensuring that material intelligence about trusts and other providers is not overlooked. No one player in the system holds all the available intelligence about NHS funded services. This is why collaboration, communication and co-operation between commissioners, Monitor, the Care Quality Commission and other stakeholders is so important in protecting patients and staff.

Although primarily focussed on the role of chief executives as accountable officers this guide is also relevant to medical and nurse directors across all levels of the NHS. It promotes the value of clinical leadership in helping non – clinicians navigate and understand complex patient safety issues. In this context, we believe, medical and nurse directors have key roles to play in making sure risk summits remain focussed on patients and that the actions required to safeguard them are both sensible and appropriate.

Chapter one: Context



These are challenging times for the NHS and indeed for any provider of care and there can be no doubt that the public spotlight is on both individual organisations and staff to make sure that they are working together to protect patients. At times this attention can be penetrating and all-consuming leading to organisations and those responsible for them, being held to account publically.

Moreover, failings in standards of care found at Mid Staffordshire NHS Foundation Trust and the associated concerns expressed at the Robert Francis Public Inquiry on the degree to which stakeholders failed to share information with each other has compounded the situation and served to reduce public confidence.

Following the first report from Robert Francis, a sub-committee of the National Quality Board came together to agree how the system would work together to identify and respond to early warning signs of failure in NHS care. A report was produced in February 2010, and updated in March 2011, setting out the respective roles and responsibilities, recommending the use of risk summits as a way to ensure that information was shared, (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_113021.pdf). This report provides further guidance on how and when to call a risk summit.

It is important that stakeholders work collaboratively to share soft and hard intelligence about providers in a timely and sincere manner. Indeed when individual or systematic quality failures first emerge then it is the duty and statutory responsibility for all supervisory and regulatory bodies to act in a co-ordinated manner to restore a quality service.

Routine business apart, there is a role for a risk summit as a vehicle to focus attention on what matters, secure collective ownership of the issues at hand, challenge perspectives about providers and offer a level of transparency which bolsters confidence that the right things are being done to uphold standards of patient care and to support staff.

That said no system can ever be completely failsafe, which makes it is critical that there be absolute clarity about how the system will respond if a specific service failure or more serious systemic quality failure is suspected or indeed identified. Holding a risk summit is a significant step towards providing that clarity but it is not a catch all and should only be considered part of the solution.

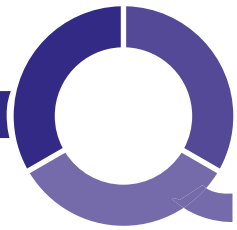
What is a risk summit?

For the purposes of this guide the following definition has been used;

"A meeting of high-level leaders called to shape a programme of action which is focussed on sharing information willingly to help achieve a consensus about the situation under scrutiny and the actions required to mitigate the identified risks."

Normally the risk summit process will need to continue over several days or even weeks before the SHA and stakeholders can be satisfied that matters under review can be safely handed over to routine operational management systems, which is the ultimate goal.

Chapter two: When to call a risk summit



If any part of the local, regional or national system has concerns that there may be a serious quality failure within a provider organisation and which cannot be addressed through established and routine operational systems, they should in the first instance contact CQC, and also notify the SHA. The SHA has a responsibility to 'hold the ring', which is highlighted in the NQB publication, February 2010[1] and more recently in the March 2011 publication[2]. The two quotes set out below are taken from the March 2011 document - Maintaining and improving quality during the transition; safety, effectiveness and maintaining and improving quality – part one 2011/12. The first highlights the role of the SHAs and the second makes clear the role of the Regulators.

"In the event of a serious failure, the SHA is responsible for holding the ring and ensuring that the management and regulatory responses remain aligned and coordinated at all times."

"The CQC aims to work closely with SHAs as the performance managers of PCTs and NHS trusts (not NHS foundation trusts), and with Monitor as the independent regulator of NHS foundation trusts, so that there is agreement on who is best placed to take any action in response to specific concerns."

Normally a risk summit would be triggered either as a result of routine monitoring and surveillance, possibly through regular clinical quality review meetings between commissioners and providers or as a result of reviews undertaken by the commissioners, professional regulators, CQC or Monitor or peer review. It may also be triggered by new information and intelligence from an unexpected source, for example, from a whistleblower, a patient, an undercover reporter or dramatic local or national media exposure.

Irrespective of the source the SHA must take stock of the situation using all available data and intelligence and make a judgement as to the appropriateness or not of convening a risk summit. The SHA must inform the CQC at an early stage and in the case of a FT must also inform Monitor. The over use of risk summits could bypass and / or devalue established performance systems which could result in a breakdown of those very systems.

Care has to be taken to ensure that the reason(s) for calling a risk summit are valid and evidence based. The potential triggers for calling a risk summit are set out in table one overleaf. The list is not exhaustive and will require sound and proportionate judgement on the part of the SHA in interpreting the particular situation it faces. The complex nature of health and social care means that the triggers outlined in table one can only be a guide.

1. Review of Early Warning Systems in the NHS - Acute and Community Services. February 2010.

2. Maintaining and improving quality during the transition; safety, effectiveness and maintaining and improving quality – part one 2011/12.

Chapter three: Potential triggers to calling a risk summit

NHS leaders must always exercise their professional judgement when considering whether or not to call a risk summit. The checklist set out below is not meant to provide a definitive list of potential triggers but can be used to inform the application of judgement. When making a decision to call a risk summit, it might be useful to consider whether or not you would feel able to publicly account for your decision to either call, or not call, a risk summit.

Triggering a risk summit should be considered when;

(i) serious failings about a provider are raised by the CQC;

(ii) the SHA must act rapidly to safeguard patients and/or staff and there may not be time for CQC to act;

(iii) the CQC is unable to act.

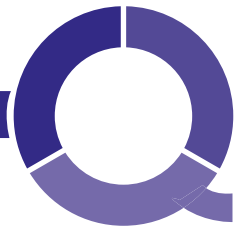
In any case, CQC must be consulted on the appropriateness of calling a risk summit.

Table one: Potential Triggers to calling a Risk Summit

- Care Quality Commission issues a warning notice(s), applies material conditions on a provider or serves notice to withdraw registration
- Serious failings in the provision of care such that patients are at imminent or immediate risk. For example;
  - ✓ Quality, patient safety / experience metrics causing alarm
  - ✓ Clinical services poorly performing, missing targets and the serious incidents / never event profile suggests / confirms there to be an unsafe or failing service
  - ✓ Serious and sustained safety breaches indicative of a more systemic quality failure within a single provider or across a health and social care system
  - ✓ Death of a patient(s) which is unexpected and avoidable and which raises specific alarms about clinical practice
  - ✓ Significant safeguarding breaches and breakdown in systems which compromise the protection of vulnerable adults and children (statutory and other formal processes apply)
- Soft intelligence, which when triangulated against the quantitative data, including trend analysis, clearly identifies a serious problem
- Patients / carers speak out at a level beyond that which would be expected to be addressed by the provider and local commissioners
- Monitor raises serious concerns about the governance and/or leadership of an FT
- One or more of the professional regulators raises concerns about the appropriateness of trainees / students remaining on clinical placements in a provider and are considering / intend withdrawing them
- An independent report, such as a Royal College report, raises serious concerns about patient safety which cannot be managed locally through routine service improvement

- Validated staff / staff side concerns which make clear that patients are at risk
- Repeated and sustained failure to deliver agreed remedial action plans such that little or no progress is made and patients are exposed to sustained and increasing levels of risk
- Significant and damaging loss of public confidence in a provider / alarming media profiles
- When clinical staffing levels / clinical leadership is inadequate to support safe service delivery
- Major public health failing
- Breakdown in confidence in the senior leadership of the provider, including clinical leadership such that clinical services are compromised placing patients and staff at risk
- An unusual or novel situation which is judged to require action beyond routine intervention
- A significant commissioning failure which leave patients / services at risk
- Significant shortfalls in patient safety identified through education and training reviews /trainee feedback

Chapter four: Roles and responsibilities



When facing challenging concerns about quality or when a crisis is about to hit it is important to know who will represent the organisations involved. The obvious option is the chief executive but it may be that a lead director is more appropriate. The organisation should plan ahead as far as possible to identify its representative for this type of crisis management as part its general contingency planning. This will help avoid delays when a risk summit is called at short notice.

Given that quality is the primary focus of a risk summit it is expected that the medical and nurse directors of the respective organisations be involved at the outset and that their involvement is maintained throughout the risk summit.

These arrangements may need to be supplemented depending on the circumstances presented. For example, the director of public health would have a prominent role if the issues at hand were associated with a major public health event.

With regard to chairing and co-ordinating the risk summit, as outlined above, this responsibility lies with the SHA. In the *Review of Early Warning Systems in the NHS*, the lead role is ascribed to Strategic Health Authorities;

1. Because of their responsibility for the patients being cared for at the failing provider as well for meeting the ongoing healthcare needs of the wider local population
2. Because they have the capacity to take on the role, including the liaison with other parts of the national system including the CQC and Monitor

The SHA chief executive has responsibility for briefing the Department of Health.

Chapter five: Governance

As outlined above under the current arrangements the SHA has the lead responsibility for convening and leading a risk summit and it is important that the decision to carry out a risk summit is taken by the chief executive. This responsibility can be formally delegated to a relevant board director usually the medical or nurse director. In effect the decision to convene a risk summit must be taken at 'the top of the office'.

The rationale for the decision to hold a risk summit should be well documented and shared among the stakeholders, notably the CQC and Monitor (when an FT is involved) and include the relevant provider chief executive(s). Only in exceptional circumstances, judged by the SHA chief executive or his / her nominated lead director, should the provider chief executive be excluded from proceedings. If this course of action is taken the SHA chief executive must keep the matter under constant review and be prepared to justify the decision to exclude the provider chief executive.

Apart from detailed documentation setting out the rationale for the summit the process should be underpinned by transparent governance arrangements which confirm lines of accountability through to the SHA Board. The arrangements should also be aligned to the principles set out in the *NHS Early Warning Systems and Maintaining and improving quality during the transition: safety, effectiveness, experience, Part One 2011-12*, particularly the sections relating to roles and responsibilities throughout the system and enhancing resilience for quality.

A time log of conversations held, decisions taken by whom and when, together with formal document control should be maintained by the SHA. This information will be needed for future reference.

Chapter six: Preparing for a risk summit

A risk summit should be convened quickly, usually within 24 hours, but may need to be arranged earlier. Interruptions associated with week-ends, Bank Holidays and other such out of hours diary commitments must not limit the planning or execution of the risk summit. If the SHA chief executive feels that calling a risk summit can wait for days then it may be an indication that the trigger for calling the risk summit is in fact insufficient and matters should perhaps be transacted through routine systems. This is a judgement call for the SHA chief executive.

The risk summit should seek to;

Take decisive action rapidly to safeguard patients. Establish quickly whether concerns are of real substance and require action over and above the normal escalation of any one organisation (the 'is it safe?' question).

- Demonstrate leadership and operational grip
- Ensure alignment of actions across a range of organisations
- Promote / maintain public confidence
- Ensure the continued provision of services to the population
- Begin the process of securing improvements
- Ensure provider staff, including both front line workers and board members have support
- Not compromise routine performance management processes
- Ensure all members of the risk summit are content that appropriate and proportionate action is being taken to protect patient safety

Papers should be well prepared and a briefing pack circulated in advance of the summit, or at least tabled at the meeting if time does not allow pre-distribution. The briefing should include as a minimum;

- A letter or briefing note from the SHA chief executive setting out the reason for calling the summit
- Quality, patient safety / experience dashboard populated with the latest intelligence together with a high level analysis to highlight key issues
- Integrated performance data
- Any risk or impact assessment(s) carried out of current situation
- Any additional information which would usefully inform the risk summit such as CQC, HSE, NHSLA, CNST, counter fraud and security management, deanery reports, Quality and Risk Profiles or service specific reviews carried out by an independent body such as a Royal College

Essential Membership of a Risk Summit

The exact composition of the summit is for local determination but must include as a minimum the following core participants;

- SHA chief executive (chair*) or nominated director, usually the medical or nurse director
- SHA medical and nurse directors
- Monitor
- CQC
- PCT/PCT cluster chief executive, medical and nurse directors
- Provider chief executive, medical and nurse directors
- Secretariat

***Chairing should be consistent in the event the risk summit continues beyond a single meeting.**

It is recommended that the provider chief executive and relevant directors should be invited to all or part of the risk summit. There is distinct value in including the provider perspective but depending on the nature of the issues under discussion, this will require consideration by the SHA chief executive before a decision is made. Whatever decision is taken by the SHA chief executive the exchange of information between stakeholders, including the provider, must not be compromised because the situation is deemed to be too delicate or sensitive.

Depending on the nature of the issues to be discussed consideration should be given to inviting;

- Local Authority
- Public Health
- Independent sector
- Post Graduate Medical Dean (Medical /Dental or GP)
- Local Supervising Authority Midwifery Officer
- Professional Regulator(s)
- Expert witness(es)
- Police

Irrespective of the final cast list it is crucial that the attendees are drawn from the relevant chief executive or director pool. Attendance should only be delegated to sub-board level staff in exceptional circumstances and approved by the SHA chief executive, since the presence and commitment of directors will aid proportionate and fair decision-making. Moreover, risk management involving patients must be managed and led by senior people who can make things happen quickly if necessary, are comfortable with taking tough decisions and who can readily accept responsibility for leading difficult and complex situations.

A checklist is provided at Appendix A.

Chapter seven: Conducting a risk summit

The importance of face to face debate rather than a simple reliance on virtual data exchange cannot be over stated. The opportunity to listen carefully to soft intelligence in the context of hard data is invaluable and needs to be given weight in the overall process of planning for, and conducting, a risk summit. If necessary a telephone or video conference should be adopted rather than incur delays in arranging a face to face meeting.

The summit should be conducted with the following points in mind;

- It is a formal process which will be open to scrutiny and as such should provide a reliable audit trail for future reference
- The statutory position of stakeholders must be respected and acknowledged
- Quality is everyone's business and responsibility therefore, all contributions should be valued
- The process should be clinically focussed but not unduly dominated by clinicians
- The opportunity for peer review and critique which supports open and constructive challenge must exist. There is no room for hesitation of thought or enquiry
- The debate should be focussed on the comparative analysis of information and trends to create an informed picture based on facts and appropriate judgement, including consideration of soft intelligence
- The summit works to identify lines of enquiry, cues for action or prompts for intervention
- The risk summit should be conducted in private given the confidential and sensitive nature of the business to be transacted
- As far as possible a consensus position should be reached
- The SHA must provide experienced administrative support to enable the smooth running of the summit and to facilitate reliable record keeping which will be of prime importance in the future, especially in the event of any enquiry which might follow

If a consensus is not forthcoming and the disagreement(s) material, the SHA chief executive should take stock and decide whether to go with the majority view or not. This of course cannot overrule the statutory responsibilites of Regulators. Dialogue should be maintained and efforts to secure a consensus continue unremittingly. The overriding priority however, must be that of decisive action for the protection of patients and the integrity of health and social care provision, which will include the delivery of any remedial measures found necessary.

Appropriate administrative support to ensure reliable record keeping and the generation of reports should be identified at the outset. The records will need to be explicit and unambiguous and fear of Freedom of Information (FOI) requests should not inhibit frankness since there are provisions within FOI to reject unreasonable requests for confidential and sensitive material.

Having reliable information management systems and associated document control processes in place will also improve the overall validity of the risk summit. The chance that working documents will be accessed in the future or be subject to audit is fairly likely, particularly in the event of an adverse incident or deterioration in the provider's safety profile arising once the risk summit has agreed a plan.

For medical and nurse directors this will be particularly important given their professional accountability to, and registration with, the General Medical Council and Nursing and Midwifery Council.

Documenting the summit

The taking of risk summit minutes is a formal business action and should be carried out with the same degree of accuracy and formality as, for example, board meetings. In addition the SHA chief executive should write to all core participants immediately following the summit summarising the discussion and setting out the actions agreed with timelines citing those accountable for delivery. The SHA chief executive should also agree with core participants the information to be placed in the public domain i.e. the information to be taken to open board meetings of the participating organisations. This should form part of the communications plan.

Subsequent meetings following the original risk summit should adhere to the same standard of documentation and record keeping.

Suggested risk summit agenda

A suggested outline agenda is provided below.

Suggested risk summit agenda

1. Welcome and introductions
   SHA CEO
2. Scene setting: confirmation of why the risk summit has been called
   SHA CEO
3. Review of the briefing material to confirm acceptance by all core participants that the information is accurate and complete
   Core Participants
4. Overview of the Provider by each core participant to confirm individual assessments of the provider(s);
   - Care Quality Commission • PCT cluster • Monitor (FTs) • SHA
   - Others depending on the circumstances / issues. For Example, post graduate medical dean or local authority
5. Provider overview of the situation
   Provider CEO
6. Reflection and summary of the information known to, and shared with, the Risk Summit
   SHA CEO
7. Agree key risks and discuss action required
   Core Participants
8. Confirm consensus on risks identified and the actions to be taken noting the lead organisation(s) / staff. Agree time frames
   Core Participants
9. Agree reporting arrangements to individual boards
   Core Participants
10. Agree handling / communications plan
    SHA CEO
11. Summing up, agree actions and timescales, and confirm whether or not any participant thinks further actions are required to protect patients
    SHA CEO / Core Participants
12. Decide whether or not a further risk summit is required or if alternative processes should dominate
    SHA CEO / Core Participants

Chapter eight: Impact assessment and communications

Impact Assessment

Thought should be given to the impact on patients, services and staff of any decisions taken by the risk summit. For example, if a decision is taken that despite known risks, a service should be maintained because it would present a greater risk to patients if services were transferred to an alternative provider(s). The rationale for this type of decision should be presented as a formal impact assessment. This will enable due consideration of the facts and provide formal justification for the decision(s) taken by the risk summit.

Such a formal impact assessment may not be available to the risk summit at its initial meeting. However, the SHA chief executive / chair of the risk summit should commission the assessment within a tight timeframe of a matter of days. Work to refine the submission can continue but it is important that arguments placed for a particular course of action are based on facts and sound judgment since it is highly likely that decisions taken by the risk summit will be open to challenge, ongoing scrutiny or audit.

Communications

It is important that the SHA creates and agrees a communication handling plan with core participants. This should include aspects of both internal and external communication. Deciding how information is to be made public is best agreed at the outset and possibly modified as greater clarity is gained on the issues put before the risk summit.

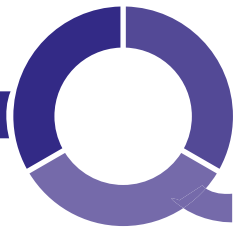
Chapter nine: Conclusion

The risk summit is a mechanism to enable the sharing of information and intelligence across the different organisations and sectors, reflecting the holistic nature of the patient journey and the systemic nature of quality. Applying this guidance and adopting a robust, systematic and inclusive approach to the sharing of information should ensure the effectiveness of the risk summit.

That said this guidance is not a catch-all and must be applied by board level leaders across the care system who can recognise, respond and adapt to the complex and dynamic nature of the challenges facing them.

The National Quality Team, on behalf of the National Quality Board, is currently working with the NHS, social care and other stakeholders to identify the appropriate roles and responsibilities for quality in the new system, and will produce further guidance and support in the summer.

Appendix A: Checklist



Action	Comment	Update
Rationale for calling the risk summit is clear, agreed with core participants and documented		
Any immediate action to protect patients has been taken/initiated and is documented		
Nurse and medical directors fully engaged and committed to the risk summit		
Board(s) and DH briefed		
Action log commenced and being maintained		
Administrative support identified and in place		
Core participants aware of their responsibilities and suitably briefed on what is required of them		
Briefing pack in place / being prepared		
Impact assessment completed or commissioned		
Communications plan being constructed / in place		
Staff support in place as necessary