

**National Quality Board**

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**Third Edition, July 2017**

**Risk Summits**

**National Guidance**

This document has been developed by NHS England on behalf of the National Quality Board (NQB), which provides coordinated clinical leadership for care quality across the NHS on behalf of the national bodies:

- NHS England
- Care Quality Commission
- NHS Improvement
- Health Education England
- Public Health England
- National Institute for Health and Care Excellence
- NHS Digital
- Department of Health

For further information about the NQB, please see:

<https://www.england.nhs.uk/ourwork/part-rel/nqb/>

This document was developed with the additional involvement of Healthwatch England, the General Medical Council, the Nursing and Midwifery Council, the Local Government Association and the Association of Directors of Adult Social Services (ADASS).

**This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact 0300 311 22 33 or email [england.contactus@nhs.net](mailto:england.contactus@nhs.net) stating that this document is owned by the Quality Strategy Team, Medical Directorate**

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# 1. Introduction

## Purpose of this document

1. This document is the third edition of National Quality Board (NQB) guidance on how to organise and run a Risk Summit. It describes:
  - the purpose of, and potential triggers for calling a Risk Summit;
  - the roles and responsibilities of the different participants;
  - governance arrangements for Risk Summits; and
  - practical advice on preparing for and conducting a Risk Summit.
2. The purpose of the document is to set out a clear and consistent framework for all NHS bodies across England to assist in the management of serious quality risks and failures. It offers best practice guidance with scope for local interpretation to meet the demands of what can often be complex and difficult situations.

## Context for the third edition, July 2017

3. Risk Summits were first proposed in the National Quality Board's 2010 report, [Review of early warning systems in the NHS](#). In July 2012, the first edition of this guidance (*How to organise and run a Risk Summit*) was published; it was updated with a second edition in December 2014.
4. The health and care system has evolved significantly over the period since the previous guidance was written. Relationships between organisations have matured and developed. This guidance is the culmination of a further review of Risk Summits undertaken by the NQB, to understand how they are operating across the country, to refresh their purpose and identify where they could be supported to be more effective.
5. The review found a clear consensus that it is useful to retain Risk Summits in their current form and with their current purpose i.e. to provide a mechanism to bring the system together very quickly when there is a serious, specific risk to quality. There was also consensus that Risk Summits should only be used very occasionally, and intelligently, in order to preserve their impact.
6. This guidance is published at a moment when further significant change has been signalled for the health and care system. [Next Steps on the Five Year Forward View](#) sets out a road map towards whole-system, place-based, integrated planning. Sustainability and Transformation Partnerships (STPs) are developing in every area of the country. In some places this will lead to the creation of Accountable Care Systems (ACSs). These will be systems in which NHS organisations (both commissioners and providers), often in partnership with local authorities, choose to take on clear collective responsibility for resources and population health.

7. This direction of travel has significant implications for the Risk Summit model. Currently, risks to quality are generally assessed at the level of single providers. As STPs develop and boundaries between providers and commissioners evolve, the way that local systems approach Risk Summits will need to be flexed pragmatically.
8. In any event, **it is important to be clear that, although risks to quality may *manifest* in one provider, both the causes and the solutions are usually system-wide. Risk Summits should be approached by all parties on this basis.** They are a mechanism for different parts of the health and care system to come together to find system solutions.

## What is a Risk Summit?

9. Risk Summits provide a mechanism for key stakeholders to come together to share and review information when a serious concern about the quality of care has been raised.
10. The distinct roles and responsibilities of different organisations in the NHS system mean that no one organisation will have a complete picture on the quality of care being provided. Routine and ongoing surveillance and quality assurance within a local health and care economy is provided by a range of mechanisms including safeguarding board arrangements and Quality Surveillance Groups (QSGs).<sup>1</sup> However, from time to time, concerns that there could be a serious quality failure may arise.
11. Risk Summits enable the organisations which make up a local health and care system to:
  - give specific, focused consideration to the concern raised, sharing information and intelligence, including with the service provider where a quality risk has been identified;
  - facilitate rapid, collective judgements to be taken about quality within the provider organisation in question; and
  - agree any actions needed as a result of the risks identified. As above, it should be emphasised that action is likely to be needed across the system, not only by the particular provider where the risk has manifested.
12. It is primarily for the Care Quality Commission (CQC) to determine and make recommendations to NHS Improvement or NHS England (depending on the sector) as to whether regulatory action is required as a result of a serious quality failing within a provider organisation. However, in the event of a serious quality failure (or where a quality problem has not yet become serious but risks becoming so) other parts of the system (commissioners, other regulators or supervisory bodies) may also need to take action to safeguard patients and improve quality of care. A Risk Summit provides these different parts of the system with an opportunity to align their actions with each

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<sup>1</sup> <https://www.england.nhs.uk/ourwork/part-rel/nqb/>

other so that they do not duplicate action, or fail to act on a misapprehension that others are acting. A list of the roles and responsibilities of commissioners, other regulators and supervisory bodies is provided at **Annex A**.

13. Participants of Risk Summits should routinely consider whether information and / or intelligence shared at the Risk Summit may be relevant to the roles and functions of Safeguarding Boards, Health and Wellbeing Boards and Local Authority Overview and Scrutiny Committees. In particular, most Safeguarding Boards will have established mechanisms for sharing intelligence about care quality which should both inform and be informed by Risk Summits. Further information on safeguarding can be found on page 17.
14. The term “Risk Summit” is often used to refer to both an event (the initial meeting between stakeholders) and subsequent process (any agreed actions following that meeting until the quality failure has been addressed or the risk adequately mitigated).

## Operating principles

15. The following operating principles were developed by the NQB, and underpin this guidance and the governance arrangements for all Risk Summits:

<b>The person comes first</b> – not the needs of any organisation or professional group.
<b>Quality is everybody's business</b> – from the ward to the board, from the supervisory bodies to the regulators, from the commissioners to primary care clinicians and managers. The board of each NHS organisation is ultimately accountable for the quality of the services it commissions or provides.
If we have concerns, we <b>speak out and raise questions</b> without hesitation.
We <b>listen</b> in a systematic way to what our patients and staff tell us about the quality of care.
If concerns are raised we listen and <b>'go and look'</b> .
We <b>share</b> our hard data and emerging intelligence on quality with others and actively consider that of others.
If we are not sure what to decide or do, then we <b>seek advice</b> from others.
Our behaviours and values will be <b>consistent with the NHS Constitution</b> .

## 2. Deciding whether to call a Risk Summit

16. A Risk Summit is a significant event that requires statutory organisations across the health and care system to come together to give specific, focussed consideration to the concerns raised. This should facilitate rapid, collective judgements to be taken about the specific risk to quality. A Risk Summit should be considered when:
- i) serious quality failings are identified by any organisation or part of the system; and
  - ii) the organisation or part of the system believes that there is a need to act rapidly to protect patients and / or staff.
17. Serious quality concerns may be identified through a range of routes, for example:
- individual organisations' routine quality and operational performance monitoring systems;
  - Quality Surveillance Groups;
  - completion of a Quality Risk Profile Tool;
  - CQC Chief Inspectors;
  - Safeguarding Boards;
  - information sharing meetings; or
  - a single, material event.
18. A Risk Summit should normally be triggered if there are significant and serious concerns that there are, or could be, quality failings in a provider or system. However, NHS leaders must exercise professional judgement when considering whether or not to call a Risk Summit, and should do so only as a **last** resort, i.e. where there are no other mechanisms that are more appropriate for dealing with the issue at hand (for example, local safeguarding mechanisms, professional regulatory routes, or breach of contract proceedings).
19. Section 10 of the Quality Surveillance Groups National Guidance ("Assessing and responding to risks to quality") sets out the range of actions available to QSGs, and may be helpful in deciding whether a Risk Summit is required, or whether another mechanism is more appropriate. It should be recognised that overuse risks their impact becoming diluted.
20. The following case studies are intended to help local health economies exercise their judgement in determining whether a Risk Summit is appropriate in a given situation.

### **Case Study 1**

At a Local QSG, a number of stakeholders raised quality and governance concerns about a particular provider. The QSG considered whether a Risk Summit should be requested and concluded that the most appropriate first step was to convene a meeting with the provider, regulators and commissioners to share the concerns and agree appropriate next steps/actions.

The reason that the QSG considered that a Risk Summit was not appropriate at this stage was because some of the information shared about the provider at the QSG was very recent soft intelligence and the QSG concluded that the provider may not be aware of all of the concerns that had been raised.

### **Case Study 2**

A Risk Summit was convened regarding a provider which had recently taken over responsibility for mental health and learning disability services in a neighbouring county. A CQC inspection had found failings in the part of the service newly taken over and the Risk Summit was set up to bring together the multiple stakeholders in order to agree a shared approach.

Participants included a large number of CCGs and local authorities, two NHS England DCO Teams, a specialised commissioning team, NHS Improvement, CQC, General Medical Council (GMC), Nursing and Midwifery Council (NMC) and Healthwatch, as well as the NHS England Regional Team. The Risk Summit was successful in bringing about a shared and agreed action plan, although with so many stakeholders around the table it was difficult to manage the meeting and to allow all players to contribute.

Since the quality failings were only in one part of the geographical area served by the provider, it might perhaps have been possible for a smaller number of commissioners and local authorities to agree a way forward, without involvement at a regional level. However, the regionally-led Risk Summit approach was appropriate in this instance and was successful.

## **Intelligence sharing teleconference**

21. Any statutory organisation – local, regional or national – that has concerns about the quality of care within a provider should alert relevant QSG members to their concerns and can raise concerns which trigger the Risk Summit process.
22. The organisation raising the concern should immediately arrange an intelligence-sharing teleconference with relevant parts of the system, to determine whether a Risk Summit should be held. Usually this should be within 24 hours of the concern being identified. Discussion should not be left until the next QSG meeting (unless the QSG meeting falls within 24 hours of the concern being identified).



23. The organisations that need to be involved will vary from case to case, but will usually include:
- Care Quality Commission;
  - NHS Improvement;
  - NHS England Directors of Commissioning Operations (DCO) Team (the Regional Medical Director and Regional Chief Nurse should be made aware of the cause for concern and invited to join the teleconference if they wish);
  - Clinical Commissioning Groups (CCGs) that commission services from the provider;
  - The local authority (where services are commissioned jointly, or where safeguarding concerns are raised);
  - Health Education England (where there are healthcare students or doctors in training in the clinical environment);
  - PHE (where the incident concerns a public health service (screening, immunisation, sexual health or drug treatment etc.) or a health protection issue such as healthcare associated infections); and
  - Relevant professional regulators (where appropriate).
24. The provider in question should usually also be invited to join the discussion, although there may be some occasional cases where it is not appropriate to involve the provider at this stage.
25. Local Healthwatch should be involved as appropriate, ensuring that Local Healthwatch branches which may have relevant intelligence have the opportunity to contribute this.
26. The purpose of the teleconference is to establish the key quality concerns and whether or not there is confidence these will be resolved without a Risk Summit. Participants should therefore have their organisation's latest available assessment of the particular service in question, and should be willing to share both emerging intelligence and hard data. All intelligence should be triangulated so that there is a clear view of the issues and whether they can be resolved through established and routine operational systems.
27. The teleconference should usually be chaired by the organisation raising the concern, unless there is a clear rationale for another organisation to carry out this role. The Chair will conclude whether, on the basis of the evidence heard, to formally recommend a Risk Summit. Each instance of actual or potential serious failure will be different and dependent on the type and size of the provider(s) in question. If a decision is made to recommend a Risk Summit, there must be certainty that there is a serious quality failure that cannot be resolved through established and routine operational systems.

## Decision not to recommend a Risk Summit

28. If the decision is not to recommend a Risk Summit, all participants on the teleconference must be clear on what actions are to be taken, by whom, to ensure the quality of services.

## Decision to recommend a Risk Summit

29. If there is a recommendation to hold a Risk Summit, QSG members on the information-sharing teleconference must agree which organisation will chair. It is important that one party is recognised as 'holding the ring' (the 'chair' organisation) to ensure an aligned and coordinated system-wide response, in what may be a fast-moving situation of high pressure. This will usually be NHS England or NHS Improvement. A formal request setting out the concern and reasons for recommending the Risk Summit should immediately be made in writing to the nominated representative from the chair organisation (this is likely to be someone at a more senior level within the nominated chair organisation than those who were involved in the information sharing teleconference).

### 3. Calling a Risk Summit – roles and responsibilities

30. The nominated chair of the Risk Summit should decide quickly whether to agree with the recommendation to convene the Risk Summit (usually within 24 hours). This decision should be communicated to those who attended the information sharing teleconference and, if a Risk Summit is going ahead, to Risk Summit attendees (see membership list below).

#### Role of the chair organisation

31. The chair organisation will have responsibility for:

- ensuring the decision to hold a Risk Summit is communicated to the provider(s), attendees and other key stakeholders;
- determining the time and location of the Risk Summit meeting;
- chairing and supporting the meeting(s); and
- providing a record of discussion and agreed actions.

32. Throughout this process, the chair organisation will need to recognise other parties' roles and statutory responsibilities, i.e. that one party cannot direct any other party in the exercise of their statutory functions.

#### Essential membership of a Risk Summit

33. Each organisation / part of the system should identify the roles within their teams that will participate in a Risk Summit when required. QSGs should agree a list of all potential participants that may be invited to a Risk Summit in their areas. The nature of Risk Summits requires participants to be responsive and of sufficient seniority to contribute to the Risk Summit and represent their organisation.

34. The exact composition of the Risk Summit is for local determination but should include as a minimum the following essential participants:

- NHS England DCO Team (Director, Medical and Nurse Directors);
- NHS Improvement (Delivery and Improvement Director and a clinical lead, who could be the Senior Clinical Lead for the region and/or the Regional Nurse or Medical Director);
- Care Quality Commission;
- Relevant CCG (Accountable Officer or a nominated Director-level representative);
- The local authority (where services are jointly commissioned);
- Relevant provider (Chief Executive and any provider board representatives appropriate to the Risk Summit (see 'Involving the provider organisation' below));
- General Medical Council;

- Nursing and Midwifery Council;
  - Health Education England (where there are learners in the organisation concerned);
  - Secretariat (to be provided by a senior manager within the 'chair' organisation);
  - Communications support from the chair organisation, if necessary (see page 19).
35. Local Healthwatch should be involved as appropriate, ensuring that Local Healthwatch branches which may have relevant intelligence have the opportunity to contribute this.
36. Depending on the nature of the issues to be discussed, there may be a need to involve other parties in the Risk Summit, for example:
- other commissioners with an interest;
  - other local government agencies;
  - Public Health England;
  - the Local Supervising Authority Midwifery officer;
  - the Police;
  - Safeguarding Boards;
  - expert witnesses; and
  - other professional regulators.
37. Each instance of potential or actual quality failure will be different, and so involvement of each of these other parties should be determined locally according to the circumstances.

## Involving providers

38. As set out above, the relevant provider should usually be involved in discussions as soon as quality concerns are raised. The Chief Executive of the provider organisation and members of their executive team should normally be invited to participate in Risk Summits relating to their organisation, and it is important that the chair organisation notifies the provider Chief Executive of the rationale for calling the Risk Summit.
39. In the event of an exceptional circumstance where the chair of a Risk Summit considers that it would be inappropriate for the provider to be present for all of the meeting, the rationale for this must be documented and shared between all stakeholders. These situations would be rare and would involve the Risk Summit chair agreeing the action with NHS Improvement or NHS England as appropriate. The Risk Summit chair would be responsible for communicating the decision and rationale to the provider Chief Executive as soon as reasonably practicable.

## 4. Preparing for a Risk Summit

40. Given the seriousness of the concerns that might trigger a Risk Summit, the Risk Summit meeting itself must follow the decision within a matter of days. Interruptions associated with weekends, bank holidays and other such out of hours diary commitments must not limit the planning or execution of the Risk Summit.
41. Where stakeholders consider that it is acceptable to convene a meeting to a longer timeframe following the initial concerns being raised, this may indicate that the concerns raised do not reach the threshold for a Risk Summit. Before extending the time frame, all parties should reconsider alternative processes.
42. 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 process of any one organisation (the 'is it safe?' question);
  - ensure alignment of actions across a range of organisations
  - promote / maintain public confidence;
  - ensure the continued provision of services to the population and manage the impact of any actions across the wider health and care economy;
  - begin the process of securing improvements;
  - ensure provider staff, including both front line workers and board members have adequate support;
  - not compromise routine performance management processes; and
  - ensure all members of the Risk Summit are content that appropriate and proportionate action is being taken to protect patient safety.

### Meeting preparation

43. The chair organisation is responsible for co-ordinating the Risk Summit (initial meeting and ensuing process) on behalf of all stakeholders. This will include:
- **the invitation letter / email** from the chair organisation to stakeholders (see further below and suggested template at **Annex C**).
  - **arranging the Risk Summit** meeting and confirming the date, venue and attendees via email and electronic calendar invitation;
  - **collating, compiling and circulating a briefing pack**, giving members sufficient time to read prior to the meeting. If the risk is high and timescales do not allow the pack to be circulated in advance of the meeting, the pack should at least be tabled at the meeting (see further below);
  - **chairing and supporting the meeting(s)** (beyond the initial Risk Summit meeting if required), including providing a record of the discussion and agreed actions; and

- **ensuring Risk Summit members meet** at regular and appropriate intervals until action has been taken.

## The invitation letter

44. The invitation letter should be circulated as soon as reasonably practicable following the formal decision to convene a Risk Summit meeting.

### Key points to note:

- The invitation letter should include a clear statement as to why the Risk Summit is being held.
- Invitees should be reminded that risks raised need to be specific and current, and presentation concise to support identification of issues and focussed discussion on immediate and current risks. The Risk Summit is not an opportunity to raise every concern linked with the provider, or historic concerns.
- The invitation letter should set out clear deadlines for the submission of any information for the briefing pack as material that is submitted late will be of limited use to the Risk Summit.

## The briefing pack

45. The briefing pack should focus on those issues that gave rise to the Risk Summit.

46. The Chair of the Risk Summit should discuss and agree the agenda, data pack requirements and the requirements and deadlines for submissions from participants. Submissions should provide a clear assessment of the identified failure or risk. The deadline for submissions should allow sufficient time for review and circulation to attendees prior to the Risk Summit meeting.

47. The chair organisation will collate submissions and ensure the overall pack includes:

- an agenda (template at **Annex B**), briefing materials (including data pack) and full meeting invitee and participant list;
- the reason for calling the Risk Summit (as agreed at the information sharing teleconference) and an assessment of the current risk to patients - this will allow the focus of the meeting to be on agreeing mitigating actions rather than the clarification of concerns;

- clear assessments of the quality risk by the organisation(s) providing the brief, with individual assessments, including whether the provider/system is addressing the concerns, and any differences in views (making clear whether this is data driven or emerging intelligence);
- a quality dashboard populated with the latest intelligence together with a high level analysis to highlight key issues / risks; and
- any additional information from stakeholders which would usefully inform the Risk Summit. This might include for example, CQC inspection reports, NHS Improvement reports, independent reports, outcomes of educational visits, and any risk or impact assessments of the current issue.

48. The chair organisation should distribute the above as a comprehensive pack in a timely manner and at least 24 hours before the meeting. The Chair of the Risk Summit meeting should limit the tabling of any new papers at the Risk Summit meeting.

49. Good practice is for the chair organisation to prepare the integrated briefing pack in collaboration with CQC, CCGs, and any other stakeholders as appropriate. The provider organisation should independently submit its own briefing on the quality and safety concerns and the steps they have taken to address them. This should also be circulated to participants at least 24 hours before the meeting.

**Key points to consider when preparing briefing papers:**

- Papers should be clear, honest, factual and succinct focusing on the quality concerns for discussion at the Risk Summit.
- It should be clear where there is consensus between parties, and where there are divergent views.
- Consideration should be given to how easily the reader can navigate the information. Multiple documents, appendices or embedded documents should be avoided where possible as this can make papers difficult to send and receive.

## 5. Conducting a Risk Summit meeting

The Risk Summit meeting is conducted in private so that confidential and sensitive business can be discussed. Risk Summit meetings should be routinely conducted face to face with all participants. On occasion, it may be necessary to arrange a telephone or video conference to avoid delays where face to face participation is not possible.

### Considerations when conducting a Risk Summit meeting:

- It is a formal process, which will be open to scrutiny and as such should provide a reliable audit trail for future reference.
- All participants have a stake in the successful outcome of the Risk Summit and all perspectives are relevant.
- Open and constructive challenge should be encouraged in order to identify key issues and remedial actions.
- The statutory position of stakeholders must be respected and acknowledged.
- The debate should be focused on the analysis of comparative information and trends to create an informed picture based on facts and appropriate judgment, including consideration of emerging intelligence.
- As far as possible a consensus position should be reached. If all participants cannot reach a consensus and the disagreement(s) are material, the Chair of the Risk Summit will consider the most appropriate way forward, taking into account the statutory responsibilities of the Risk Summit participants. In particular, care should be taken to ensure that if an organisation has statutory responsibility for a decision or service, the views of that organisation are not overridden if it is in the minority.
- Actions to resolve the key issues identified should be clear for all organisations – providers, commissioners and others.

### Outcome and follow-up actions

50. The expectation of the Risk Summit is that it results in:

- clearly stated and understood conclusions;
- the identification of appropriate actions with a stated lead person/organisation for each and agreed timescales for completion; and
- once these have been completed, de-escalation of the QSG level of surveillance to routine.



51. As part of the conclusions from a Risk Summit, the next steps must be set out, including a package of actions taken forward to respond to an actual or potential serious quality failure. Actions should:

- be clearly linked to the issues being raised;
- be aligned with a view to protecting the interests of patients and minimising regulatory burdens on providers;
- rapidly safeguard patients;
- ensure the continued provision of services to the population; and
- begin the process of securing improvements at the provider organisation, including supporting staff as necessary.

**When setting follow-up actions:**

- Consideration should be given as to what focused attention is required by different parts of the system, and as a matter of routine, as to whether any professional standards issues have arisen and if so whether a referral needs to be made to the professional regulator.
- The impact on patients, services and staff of any decisions taken by the Risk Summit must be discussed and documented, particularly where a decision is taken that, despite known risks, a service should be maintained because it would present a greater risk if services were transferred to an alternative provider. Where there is a need for a formal impact assessment to support this type of judgement, the Chair should commission an assessment to be completed within a few days of the Risk Summit.
- Risk Summit meeting attendees should make a judgement about whether there needs to be a follow up Risk Summit meeting, or a return to normal operations and oversight. If there is to be no further Risk Summit meeting, there should be agreement as to how actions from the Risk Summit will be monitored and taken forward within defined timeframes. Again it is important that one organisation is recognised as the 'chair' in these collective discussions to ensure an aligned and coordinated system-wide response within tight deadlines.

## Safeguarding issues

52. It is recognised that where poor quality is found, there is the potential for individuals to suffer harm as a result of neglect or abuse. Where abuse or neglect is suspected or identified, it is essential that these concerns are reported into the relevant multi-agency safeguarding process, for either children or adults, so that appropriate action can be taken.

53. Local Safeguarding Children Boards (LSCBs) and Safeguarding Adults Boards (SABs) are the key mechanisms for agreeing how the relevant organisations within a local authority

footprint co-operate to safeguard and promote the welfare of children and adults in their locality, and for ensuring the effectiveness of the safeguarding arrangements within these organisations.

54. LSCBs were established under section 13 of the Children Act (2004).<sup>2</sup> Each LSCB has a range of statutory functions that are set out in the Local Safeguarding Children Board Regulations (2006). In order to fulfil their statutory functions, an LSCB is required to:

- assess the effectiveness of help being provided to children and families;
- assess whether LSCB partners are fulfilling their statutory obligations set out in [Working Together to Safeguard Children \(2015\)](#);
- quality assure practice; and
- monitor and evaluate the effectiveness of training to safeguard and promote the welfare of children.

55. Although Safeguarding Adults Boards (SABs) had been in existence in most areas for some time, the Care Act 2014 made it a statutory requirement for local authorities to establish these. SABs are required to meet their objectives by co-ordinating and ensuring the effectiveness of what each of its members does. LSCBs and SABs do not have the power to direct other organisations and each Board partner retains their own existing line of accountability.

56. The Chair of a Risk Summit must ensure that appropriate mechanisms are in place to share information and intelligence to support safeguarding boards in the discharge of their duties and functions. Risk Summit participants should routinely and collectively consider whether information or intelligence shared at the Risk Summit may be relevant to the roles and functions of safeguarding boards. Equally, Risk Summits may be convened as a result of intelligence from safeguarding boards.

57. To facilitate appropriate decision making and communication from a Risk Summit to a safeguarding board, the Chair should usually have an agenda item that prompts the group to consider any issues that need to be communicated and the responsible member (see *Sample Agenda* at Annex B). This action can be agreed and minuted in the Risk Summit meeting (see *Recording a Risk Summit* at Annex D).

58. Organisations that are members of safeguarding boards and who participate in Risk Summits should routinely consider whether any information or intelligence shared at the safeguarding boards may justify a Risk Summit being called. Where the Risk Summit representative and safeguarding board representative is not the same person, organisations should have mechanisms in place to ensure that the Risk Summit representative is briefed appropriately.

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<sup>2</sup> Local arrangements for safeguarding children will be changing over the coming 18 months, following legislative changes in the Children and Social Work Act 2017. Risk Summit Chairs should ensure that they continue to have appropriate mechanisms in place to work with safeguarding partners under the new arrangements.

59. Where it is agreed that a matter warrants a Risk Summit being called by a local safeguarding board, this should be done by the Chair of the safeguarding board.
60. NHS England DCO Teams, CCGs and Local Authorities are key partners at safeguarding boards and Risk Summits.

### Documenting and minuting a Risk Summit meeting

61. The Risk Summit Chair will be responsible for ensuring that experienced administrative support is provided to the Risk Summit meeting to enable a high quality, contemporaneous record to be made of the discussion, conclusions and agreed actions.
62. It is good practice for the Chair to email all core participants within 48 hours following the meeting, summarising the discussion and setting out a table showing actions agreed, lead responsibility and timescales for delivery.
63. Formal minutes should be sent to the Risk Summit Chair for approval within two working days and circulated to participants, by or on behalf of the Risk Summit Chair, within five working days of the Risk Summit, to confirm the key points of the discussion and the agreed actions.

#### **Risk Summit meeting minutes should:**

- follow a standard format (reflecting the agenda) and include a table that captures the actions, their owners and deadlines for completion (a suggested template is at **Annex D**);
- be frank, explicit and unambiguous - recording of information should not be precluded by the Freedom of Information Act (FOI), which makes provision for rejecting requests for confidential or sensitive material where disclosure is not in the public interest. If an FOI request is received for any information collated and held through the Risk Summit process, the FOI processes as agreed by the QSG should be followed (see *Quality Surveillance Groups – National Guidance*)<sup>3</sup>; and
- include the date of any follow-up meeting.

### Communications

64. The Risk Summit Chair should decide whether it is necessary for communications involvement. If it is deemed necessary, it is important that the Chair discusses and agrees a communications plan with meeting participants. The plan should include internal and external communications.

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<sup>3</sup> <https://www.england.nhs.uk/ourwork/part-rel/nqb/>

# Annexes

Use of the Annexes below is not mandatory and the templates should be adapted according to local circumstances and purposes:

A: Roles and responsibilities of commissioners, regulators and supervisory bodies

B: Suggested Risk Summit agenda

C: Standard letter to alert and invite participants to a Risk Summit

D: Template for recording a Risk Summit

E: Risk Summit checklist

## **Annex A – Roles and responsibilities of commissioners, regulators and supervisory bodies**

### **NHS England**

NHS England as a commissioner of primary care, specialised services, health and justice and military health and veterans' services has a role in supporting and enabling CCGs to commission high quality, safe and effective services for local populations.

If NHS England has concerns about quality, it should raise them with the relevant commissioners, with the CQC and within QSGs and Risk Summits. The NHS England Director of Commissioning Operations, and DCO Medical and Nurse Directors are core members of Risk Summits. Where the concern is about a specialised service, the DCO Team responsible for commissioning the service will be invited.

### **Clinical Commissioning Groups**

Clinical Commissioning Groups (CCGs) commission the majority of NHS funded health services: planned hospital care, rehabilitative care, urgent and emergency care (including out of hours services), most community health services, and maternity, mental health and learning disability services. In commissioning these services, CCGs are responsible for securing a comprehensive service within available resources, to meet the needs of their local population. They are a vital member of Risk Summits.

CCG Accountable Officers / Clinical Leads attend Risk Summit meetings to share information and intelligence about quality within provider organisations. If they have concerns about whether providers are meeting the essential standards of quality and safety, they should raise this with the CQC and with any other parts of the system with an interest through the QSG and / or Risk Summit as appropriate. This should include concerns they have about providers from whom they do not commission services, such as primary care providers, but with whom they interact.

The CCG Accountable Officer or a nominated Director-level representative will attend Risk Summits as core members.

### **Care Quality Commission**

The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England. The CQC makes authoritative judgements on the quality and safety of health and care services, according to whether they are safe, effective, caring, responsive and well-led. The Chief Inspectors rate the quality of providers' accordingly and clearly identify where failures need to be addressed. CQC also uses its regulatory powers to require improvement where care does not meet regulatory standards.

CQC is a core member within Risk Summit meetings, where it will share information and intelligence about providers with other parts of the system, and use information and intelligence from others to inform their judgements on quality.

## **NHS Improvement**

NHS Improvement is responsible for overseeing NHS foundation trusts, NHS trusts and independent providers. It provides strategic leadership, oversight and practical support for the trust sector, and supports NHS trusts and NHS foundation trusts to give patients consistently safe, effective, compassionate care within local health systems that are financially and clinically sustainable. It works alongside providers, building deep and lasting relationships, harnessing and spreading good practice, connecting people, and enabling sector-led improvement and innovation. As such, NHS Improvement is a core member of Risk Summits, exchanging information and intelligence about providers with other parts of the system.

## **Healthwatch**

Healthwatch exists to ensure that people's needs are at the heart of health and social care. It listens to what people like about services, and what could be improved, and shares it with those with the power to make change happen.

There is a local Healthwatch in every area of England. They listen to the views of local people and share them with those with the power to make local services better. They also share them with Healthwatch England, the national body, to help improve the quality of services across the country. Relevant local Healthwatch should be invited to attend risk summits.

## **Public Health England**

The role of Public Health England (PHE) is to protect and improve the nation's health and to address inequalities.

Directors of Public Health in local authorities and public health system leaders in PHE will work together to contribute to Risk Summits where appropriate, providing information on the quality of public health services provided by NHS and independent sector providers and on health protection issues in these sectors. PHE's role is particularly key in its relationship with local authorities and in relation to PHE staff who are embedded in NHS services, ensuring that there are effective liaison arrangements between and within organisations to ensure that areas of concern can be highlighted through Risk Summits.

## **Health Education England**

Health Education England (HEE) supports the delivery of excellent healthcare and health improvement to the patients and public of England by ensuring that the workforce of today and tomorrow has the right numbers, skills, values and behaviours at the right time and in the right place.

HEE is represented by its local offices in Risk Summits. Local Offices are core members of Risk Summits if there are learners in the organisation concerned. As part of monitoring the quality of education and training, HEE may have information and intelligence about the quality of care being provided within provider organisations, any concerns about which should be shared at Risk Summits.

## **Local Government**

Local authorities are increasingly jointly commissioning services with health and have an interest in collaborating with health partners around key areas, such as: nursing, care homes and home-based services, safeguarding and overview and scrutiny arrangements. In addition, local authorities have a wealth of knowledge about the health and wellbeing of their local communities and, through their interactions with health commissioners, providers and the public, will hold information and intelligence about health services which could be of value to other Risk Summit members.

Local authorities are the local leaders of public health and so will commission public health services from NHS providers and from third and independent sector providers.

Local authorities have statutory responsibilities with regard to the overview and scrutiny of local health services and services which impact on health and wellbeing (including social care). They may have useful intelligence on the quality of local health services and may also wish to conduct scrutiny reviews of services and care pathways where quality concerns have been raised. Safeguarding Boards are likely to have considerable intelligence about the quality of local services.

It is recommended that the Risk Summit representative(s) from local government remains constant in order to aid the development of trusting relationships. It is at the discretion of authorities locally to determine which Senior Officer(s) has the most comprehensive oversight of the health and care system locally and is therefore best placed to participate in the Risk Summit.

Local government should also be represented in some capacity in Risk Summits to ensure there is a local government input into and involvement with decisions affecting provision at local level. Regional involvement could also help to ensure that decisions taken to address quality concerns take into account the Overview and Scrutiny functions of local authorities.

## **The General Medical Council**

The General Medical Council (GMC), the independent regulator of the medical profession and all postgraduate medical education training environments, is a core member of a Risk Summit and is represented by its Employer Liaison Service. The GMC sets the standards for the profession, medical schools and postgraduate education and training, uses information from the Risk Summits to inform regulatory action, and works closely with HEE, CQC, NHS England, NHS Improvement and others to address shared concerns.

## **The Nursing and Midwifery Council**

The Nursing and Midwifery Council (NMC) is the regulator for nursing and midwifery professions in the UK. It sets standards of education, training, conduct and performance so that nurses and midwives can deliver high quality healthcare consistently throughout their careers. The NMC is a core member of a Risk Summit, represented by its Regulation Advisers.



## Annex B – Suggested Risk Summit Agenda

Risk Summit for [organisation or service]

[venue]

[venue address]

[date]

[time]

### Agenda

ITEM		
1	Welcome and introductions	Chair
2	Scene setting/confirmation of rationale for Risk Summit	Chair
3	Review of briefing materials	All
4	Provider perspective	Provider CEO
5	CCG perspective	CCG
6	NHS England Regional/DCO Team perspective	NHS England
7	Care Quality Commission perspective	CQC
8	NHS Improvement perspective (as relevant)	NHS Improvement
9	Professional regulators' perspective	GMC/NMC
10	Perspectives from local Healthwatch and other invited stakeholders (list accordingly)	
11	Discussion and reflections on perspectives	All
12	Conclusions drawn on risks identified and actions to be taken	All
13	Consideration of any safeguarding issues and agreement as to which representative should liaise with the relevant safeguarding	All
14	Agree arrangements for reporting back to organisations	Chair/All
15	Follow up arrangements including any further Risk Summit meetings	Chair/All
16	Agree communications plan	All
17	Summing up	Chair

## Annex C: Standard letter to alert and invite participants to a Risk Summit

Dear colleagues,

Re: RISK SUMMIT [date] [organisation/ service] – REQUIRES RESPONSE

I am writing to advise you that following a number of concerns raised by [insert name(s) of organisation(s) raising concerns] it has been agreed to hold a Risk Summit on [insert name of organisation or system]. The key areas that have triggered the Risk Summit are:

- [bullet list of areas of concern that have triggered the Risk Summit]

This meeting is intended to facilitate an open discussion to clarify and agree the risks and agree mitigating actions.

The Risk Summit is not an opportunity to raise an exhaustive list of concerns in relation to [insert name of provider or system]. Contributions should focus on key current risks. Please contact me ahead of the Risk Summit if you intend to raise any other substantive risks at the meeting.

In order to make best use of the time at the Risk Summit, please could each participant organisation come prepared with three short, clear bullet points that set out their key concerns. Please also consider ways to mitigate the risks identified in advance of the meeting.

The Risk Summit is scheduled as follows:

Date: [insert date]

Time: [insert time]

Venue: [insert venue]

The Risk Summit will be chaired by: [insert chair]

A draft agenda is attached. We will circulate the final agenda, data pack and other support information on [insert date].

If you would like to present data or other information, the deadline for submission is [insert date]. Please provide this information to [insert name] at [insert email address]. Papers and other written information can only be tabled at the Risk Summit by prior agreement with the Chair. This will only be permitted under exceptional circumstances.

Please confirm your attendance by email to [insert name] at [insert email address] by [insert date].

If you are unable to attend, please inform us which of your executive colleagues will be taking your place. We would like to see full attendance from all key stakeholders.

Yours sincerely

[Risk Summit chair]

## Annex D: Recording a Risk Summit

**Risk Summit** – [insert provider or system name]

**Held:** [insert date, time and venue]

**Attendees:** [insert names and organisations]

**Apologies:** [insert names and organisations]

**Specific reason(s) for calling a Risk Summit**

[Insert reasons identified, including risk to patient care]

**Request for the Risk Summit was made by:** [insert name of organisation]

**Risks and comments for each participating organisation**

[Insert risks highlighted and comments provided by each participating organisation]

**Agreed risks**

[Record the risks agreed at the Risk Summit]

**Key mitigating actions agreed**

[Record the actions to be taken to mitigate the risks identified above, who owns each action and the deadline for delivery of the action in the table below]

Risk	Mitigating action	Owner	Deadline

**On-going surveillance and monitoring**

[Insert agreed process for on-going surveillance and monitoring and ownership of this process]

**Future Risk Summit**

[Insert date of future Risk Summit if it has been agreed that a further Risk Summit is required]

**Agreed matters for the attention of local safeguarding board(s) and responsible representative**

[Insert details of safeguarding concern, agreed actions for notifying safeguarding board including name of representative ]

## Annex E – Risk Summit checklists

### Preparing for a Risk Summit – actions for the Chair organisation

	Action
1	Arrange Risk Summit: <ul style="list-style-type: none"> <li>• determine date;</li> <li>• identify venue; and</li> <li>• agree briefing requirements with the Chair</li> </ul>
2	Send invitation letter/email to key stakeholders and provider(s) (unless agreed with NHS Improvement/NHS England that it would not be appropriate for the provider to attend) communicating: <ul style="list-style-type: none"> <li>• the reasons for calling a Risk Summit;</li> <li>• the date, time and venue, briefing requirements and deadlines or submission (confirming date, venue and time via electronic calendar invitation); and</li> <li>• that attendees should only raise specific and current risks, in a concise format.</li> </ul>
3	Collate and compile briefing pack in collaboration with other stakeholders, ensuring the pack clearly includes: <ul style="list-style-type: none"> <li>• agenda;</li> <li>• full participant list;</li> <li>• the current risk to patients; and</li> <li>• briefing materials - clear assessments of quality risks by the organisation(s) providing the brief (with distinctions made between hard data and emerging intelligence, and differences in opinion highlighted), quality dashboard with a high level analysis to highlight key issues / risks and further information of use to the Risk Summit.</li> </ul>
4	Distribute comprehensive briefing pack in timely manner.

## The Risk Summit and follow-up actions

	Action	Who
1	Provision of minute taking and administrative support	Chair organisation
2	At end of meeting: <ul style="list-style-type: none"> <li>• agree conclusion of the discussion;</li> <li>• agree actions linked to the issues raised and organisation responsible for each action (discussing and documenting the impact on patients services and staff, and commissioning a formal assessment if required).</li> <li>• determine whether any professional standards issues have arisen and whether to refer to professional regulator;</li> <li>• determine whether a follow-up Risk Summit meeting is required or a return to normal operations and oversight;</li> <li>• if no further Risk Summit meetings, agree how actions will be monitored;</li> <li>• agree communications handling plan, if necessary.</li> </ul>	Risk Summit Chair
3	Email all core participants within 48 hours of the Risk Summit, summarising the discussion and setting out a table of actions agreed, lead responsibility and timescales for delivery.	Risk Summit Chair / Secretariat
4	Share information and intelligence with Safeguarding board(s), if required.	Risk Summit Chair
5	Formal minutes to Chair within 2 working days for agreement and circulation to Risk Summit members within 5 working days, including table of actions, owners, deadlines, and dates of follow-up meetings.	Risk Summit Secretariat
6	If impact assessment undertaken, ensure this is discussed with relevant organisations and documented.	Risk Summit Chair / Secretariat
7	Where required, organise further Risk Summit meetings	Risk Summit Secretariat