

NHS Risk Summits

Risk Summits are a reactive mechanism to bring together commissioners, regulators and often the provider, where a potential or actual serious quality failure has come to light.

All relevant parties share information, intelligence and their particular concerns about the provider in question to enable informed judgements to be made, particularly by the regulators.

Risk Summits allow for an aligned response between commissioners and regulators in support of the provider as far as possible to make the necessary improvements to provide a high quality, sustainable service to patients.

Serious incidents may sometimes trigger risk summits, but not all serious incidents will warrant a risk summit.

Commissioners

Commissioning is the process of arranging continuously improving services which deliver the best possible quality and outcomes for patients.

Commissioners are responsible for ensuring there is timely reporting of serious incidents by the providers they commission services from and for quality assuring the robustness of the serious incident investigation, learning and action plan implementation undertaken by their providers. They do this by evaluating the investigation and gaining assurance that the process and outcomes of the investigation including identification and implementation of improvements are consistent with principles outlined in this Serious Incident.

Framework

Commissioners should use the details of serious incident investigation reports, together with other information and intelligence achieved via day to day interactions with providers, to inform actions that continuously improve services. Commissioners must establish mechanisms for sharing intelligence with relevant regulatory and partner organisation.

Integrated Care Board

Each ICB is responsible for holding to account the providers of care they commission for the providers' responses to serious incidents that occur in care commissioned by that ICB.

This means ICB are responsible for managing providers' responses to serious incidents in the majority of acute, community, mental health and ambulance services.

ICB must also encourage and facilitate the sharing of learning as appropriate across the health community. ICB also have a central role in supporting quality and safety development within local providers, including primary care services.

It is important that affected patients, victims, perpetrators, families and carers are involved and supported from the onset of an incident. An early meeting (which should not take place at the site of the incident) must be held to explain what action is being taken how they can be informed and what support processes have been put in place.

All staff involved in liaising with and supporting bereaved and distressed families must have the necessary skills, expertise, and knowledge of the incident in order to explain what went wrong promptly, fully and compassionately. The appropriate person must be identified for each case. Expert support must be sought to help facilitate such discussions where required.

Victims and families will want to know:

- What happened?
- Why it happened?
- How it happened?

What can be done to stop it happening again to someone else?

The victims, families and carer must have access to the necessary information and should:

- be made aware, orally and in writing, as soon as possible of the process of the investigation to be held, the rationale for the investigation and the purpose of the investigation (that is, to establish facts);
- have the opportunity to express any concerns.