LUISS BUSINESS SCHOOL
DIVISIONE DI LUISS GUIDO CARLI

Speaker series

***Il 'Mondo' della Sanità*:**
Esperienze Internazionali di Eccellenza

Organizzare il Risk Management in Sanità

Roma, 14 novembre 2007

Briefing Paper for the Presentation by Susan Burnett

Organisational Issues in Risk Management in the NHS in England

Structure of Presentation:

- The NHS in England: the policy context
- The drivers for improved risk management
- Standards for Better Health
- Governance and Assurance in the NHS
- Risk Management and Patient Safety
- Organisational issues: discussion

The NHS in England: policy context

Health services in England are funded through general taxation and are free at the point of delivery. They are organised broadly into primary care, acute care, mental-health and ambulance service organisations, called NHS Trusts, each with a Board made up of executive and non-executive directors. Primary care organisations also commission services. There are ten strategic health authorities relating directly to the Department of Health, responsible for public health and for developing and delivering strategies to ensure government targets are met locally and for driving improvements in the quality and safety of health care. The Board of each NHS Trust is responsible for delivering financial balance and for achieving government targets including improving access to services (lower waiting times) and also reductions in hospital acquired infections.

Until recently the NHS was run from the centre but government policy is now creating a shift to a more locally accountable service. The challenge now is for the NHS to move from a highly centralised system, to one which is able to meet local needs, whilst at the same time maintaining equity of access and common standards of quality in clinical care. Government policy is focussed on:

- NHS treatment remaining free at the point of delivery, wherever you are treated
- More choice and a much stronger voice for patients
- Money following the patients, rewarding the best and most efficient providers, giving others the incentive to improve

- More diverse providers with freedom to innovate and improve services – more involvement of the private sector and new models for NHS organisations to give them more freedoms from government
- National standards and a framework for regulation of healthcare organisations

In order to deliver this, local NHS organisations, through their Boards, require good governance, strong risk management and sound assurance frameworks.

Drivers for change in risk management

There have been a number of drivers for improved risk management in the NHS; these include the rising costs of litigation, the increase in hospital acquired infections, and the demand from the public for improved cleanliness and a number of high profile cases where patients have died unnecessarily. These include deaths of children following heart surgery at the Bristol Royal infirmary (1) and the murder by one GP, Harold Shipman, of over 200 of his patients (2).

Only recently, the regulator of health services in England, the Healthcare Commission, has investigated a large number of deaths in a hospital in the south of England from a hospital acquired infection. The report, which was published recently (3) highlighted a lack of information at board level and their drive to achieve financial and waiting times targets at the expense of patient safety and service quality.

Standards for Better Health

As more providers, other than traditional NHS hospitals, have been commissioned to provide services for NHS patients, the Government realised that there was a need to develop a set of national standards. Standard for Better Health (4) were introduced in 2004 to set the foundation for a common level of high quality of health care throughout England. The standards cover: patient safety; clinical and cost effectiveness; patient focus; access and response; environment; and public health.

Governance and Assurance in NHS Organisations

Given the complexity of running an NHS organisation, it is important to have good systems of governance and assurance. In 1999, NHS organisations were given a corporate responsibility for quality through an act of Parliament. This new duty was called clinical governance. Organisations are now considered mature, when clinical governance is seen as the core and prime accountability issue for the board. This has been termed 'integrated governance' (5). The challenge for an NHS organisation is to integrate into one framework all areas of risk management, including: financial; health and safety; clinical quality; patient safety; research; and information.

<u>Assurance</u>

In 2003 the Department of Health issued a document entitled 'Building the Assurance Framework' (6). The assurance framework is a document that provides evidence to the

Board in a relevant and coherent way to show how and why they can be assured that they are managing the risks in meeting their objectives.

Risk Management and Patient Safety

Risk Management

Within the NHS, 'risk management' is the term applied to the use of a logical and systematic method of identifying, analysing, evaluating, controlling, monitoring and communicating risks associated with any activity, process or function necessary to the achievement of the organisation's objectives. It can also be described as a method of minimising loss and maximising opportunity. Risk management is a continuous process which aims to influence behaviour and develop an organisational culture within which risks are recognised and addressed. It is a fundamental part of the governance and assurance framework of any NHS organisation.

Each NHS organisation will have a risk management committee and a risk manager. To give a sense of the many and varied risks within a typical NHS organisation, the following is a list of sub committees of the risk management committee which look at specific areas of risk. The risks identified here are incorporated into the Trust's overall risk register: drug incident group; decontamination committee; medical devices committee; complaints and claims group; infection control committee; sharps committee; radiation safety group; environment & waste committee; security group.

The risk manager will also have a role in: risk assessments; reporting; and investigating incidents.

Patient Safety

Systematic data collection of the hazards of health care can be traced back at least to publications in the 1860s (7). Now all healthcare organisations have embraced patient safety and have some form of reporting systems for adverse events. There is also a considerable body of knowledge on how to improve patient safety, learning from other safety conscious industries and the evidence from research and practice in the health service. Patient safety is now a priority for the NHS in England (8, 9, 10).

Organisational issues: discussion

- Complexity of integrating all aspects of risk management into one overarching framework
- Prioritisation of risks when finances are tight
- Financial risk management: longer history and more developed
- Resources for clinical risk low in comparison
- Scale of patient safety and the cultural changes are complex

References

1. Learning from Bristol: the Department of Health's response to the report of the public enquiry into children's heart surgery at the Bristol Royal infirmary. 1984 to 1995 Command Paper: CM 5207, 2001
2. Sixth Report - Shipman: The Final Report, Published 27 January 2005 www.the-shipman-inquiry.org.uk/finalreport.asp5
3. Investigation into outbreaks of Clostridium difficile at Maidstone & Tunbridge Wells NHS Trust, October 2007, Healthcare Commission
4. Standards for Better Health, Department of Health 2004
5. The Integrated Governance Handbook, 2006. The Department of Health p 11 Gateway Reference 5947
6. Building the Assurance Framework:, the Department of Health 2003
7. Vincent C. Patient Safety. Edinburgh, Scotland: Churchill Livingstone; 2006.
8. Department of Health. An Organisation with a Memory: Report of an Expert Group on Learning from Adverse Events in the NHS Chaired by the Chief Medical Officer. London, England: The Stationery Office; 2000.
9. Department of Health. Safety First: A Report for Patients, Clinicians and Healthcare Managers. London, England: The Stationery Office; 2006.
10. Burnett S. Vincent C. Patient Safety in the United Kingdom: Evolution and Progress: Agency for Healthcare Research and Quality http://www.webmm.ahrq.gov/perspective.aspx?perspectiveID=41; 2007.