Risk Management in the NHS– a Litigator's Perspective

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Promoting patient safety

The process by which an organisation makes patient care safer.

It should involve-:

- risk assessment
- identification and management of patient related risks
- reporting and analysis of incidents
- capacity to learn from and follow up on incidents
- Implementing solutions to minimise the risk of them recurring.

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Clinical Governance

"A framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish".

Scally v Donaldson 1998

3 most recognisable components

- Clinical effectiveness activities including audits and redesign
- Risk management including patient safety
- Patient focus and public involvement

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Clinical governance (cont)

- Having clear, robust national and local systems and structures that help identify, implement and report on quality improvement
- Involving healthcare staff, patients and the public
- Establishing a supportive, inclusive, learning culture

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A supportive, inclusive, learning culture

- The best way of reducing error rates is to target the underlying systems failures, rather than take action against individual members of staff.

- Dr Lucien Leape from the Harvard School of Public Health:

  - The perfection myth: if people try hard enough they will not make any errors

  - The punishment myth: if we punish people when they make errors they will make fewer of them.

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Patient focus

- What do patients want when things go wrong?
  - An apology and an explanation of what happened
  - A comprehensive and truthful incident investigation
  - An acknowledgement of the distress suffered
  - Assurances that steps have been taken to prevent a recurrence or harm to other patients
  - Support in coping with the emotional and physical consequences of the incident.
  - These factors were **more important** to them than pursuing financial compensation or disciplinary action against staff.

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Being open

- Clear and consistent advice
- Three circulars 1997, 2007 and 2009
- Section 2 of the Compensation Act 2006
- A factual explanation in good faith constitutes good clinical practice
- "Saying sorry is not an admission of liability and is the right thing to do"

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Section 2 Compensation Act 2006

'An apology, an offer of treatment or other redress shall not of itself amount to an admission or breach of statutory duty'.

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The NHS Litigation Authority

- Administers schemes under which NHS bodies can pool clinical negligence liabilities and promote high standards of risk management in the NHS.
- Objectives
- • • "…maximise the resources available for patient care, by defending unjustified actions robustly, settling justified actions efficiently
- • • "…ensure that, where liability has been established, patients have appropriate access to remedies including, where proper, financial compensation…"
- • • "…provide mechanisms for the proper, prompt and cost-effective resolution of disputes between NHS primary care organisations and the practitioners and organisations that provide or seek to provide services
- for patients…"

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Clinical Negligence Scheme for Trusts

- Voluntary membership scheme
- All NHS Trusts, Foundation Trusts and Primary Care Trusts in England currently belong
- Covers all clinical claims where the incident took place on or after 1 April 1995
- Costs of meeting claims paid via members' contributions on a "*pay as you go*" basis

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CNST Contributions

- CNST is a pay-as-you-go scheme. This means that sufficient money is collected from the members of the scheme each year to cover the claims and costs paid during that year. By operating on this basis, no reserves need to be held to cover either the claims that have been reported, but not yet settled or the claims that have been incurred but not reported. The fundamental benefit of this is that it keeps more money in patient care, rather than in reserves.

- For the 2010/11 year, £778m is being collected from the members of CNST to pay for settlements made on clinical negligence claims during that time. Having estimated the total payments that will be made during 2010/11, this amount is allocated between members of CNST in as fair and equitable a way as possible whilst keeping the process reasonably simple.

- This is done by estimating the clinical negligence risk that each member represents and allocating the £778m in proportion to that risk. Following this initial allocation of the £778m, a small loading is made to cover the expenses of running the scheme. Finally adjustments are made to reflect individual members' historic claims experience and risk management standards.

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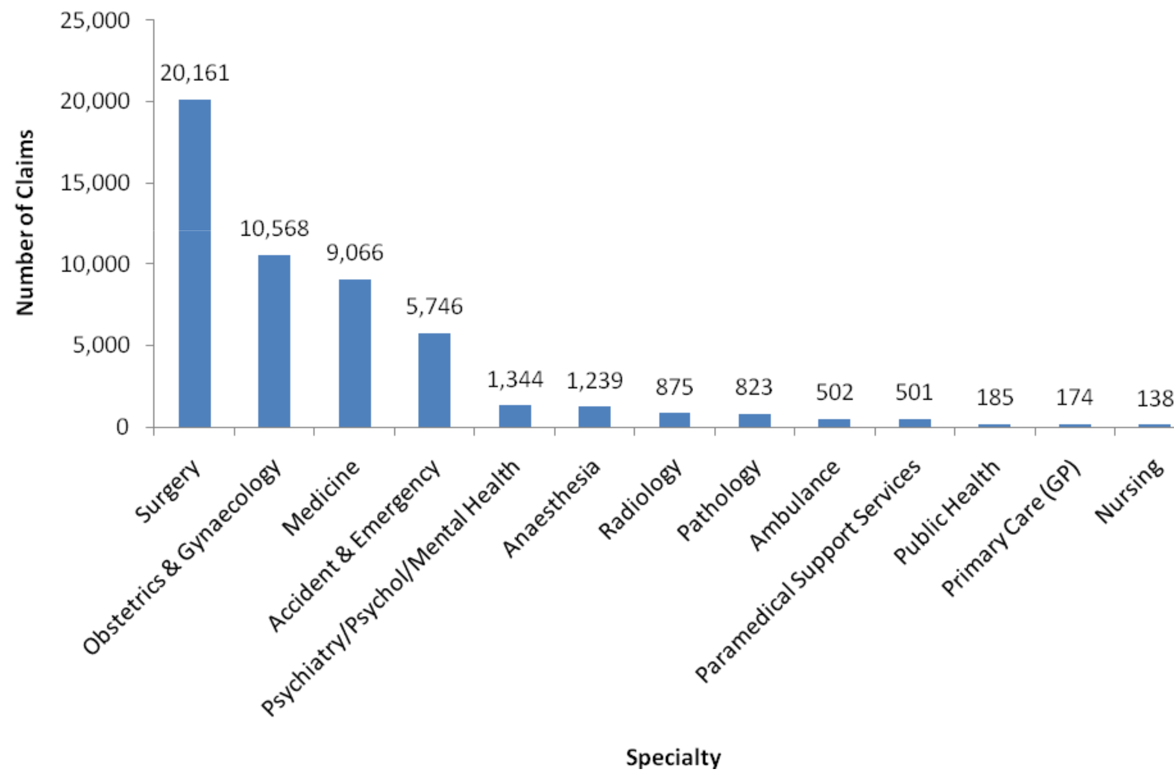
Total Number of Reported CNST Claims by Speciality as at 31/03/09

(since the scheme began in April 1995)



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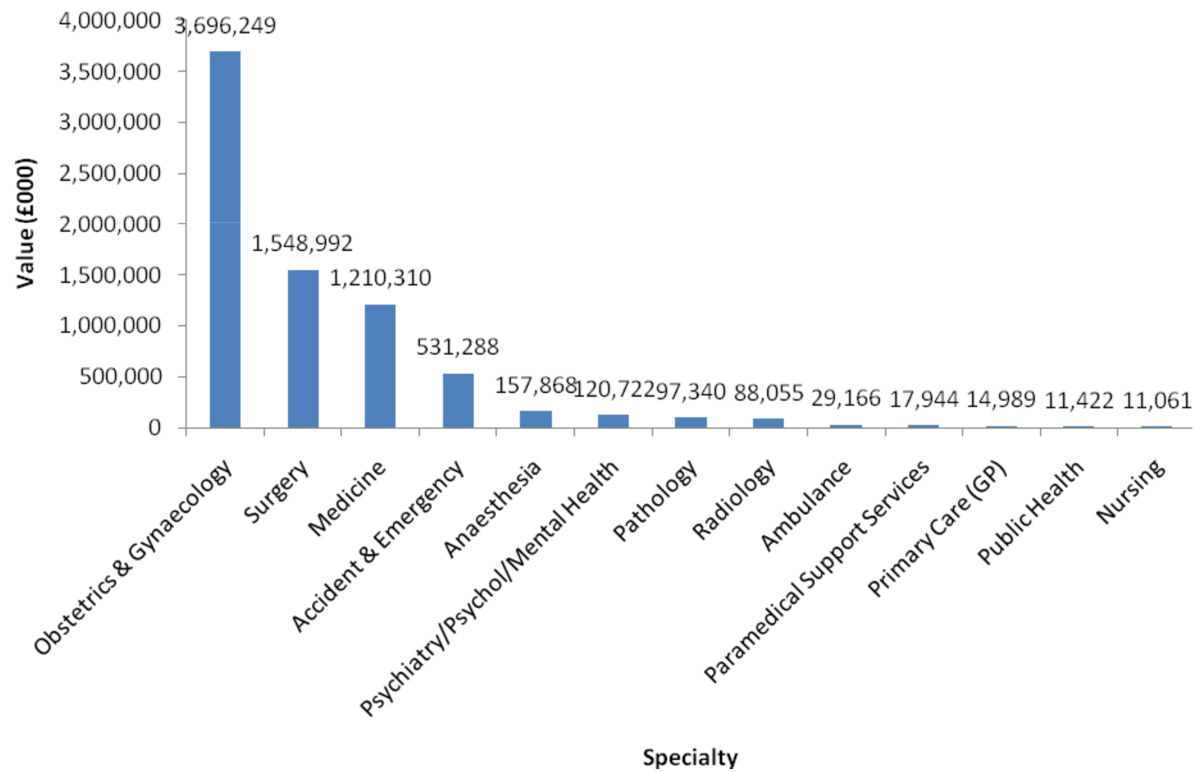
Total value of Reported CNST Claims by Speciality as at 31/03/09

(since the scheme began in April 1995)



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Risk Management Levels

- Level 1 – Policy

  Effective risk management systems and processes have been documented

- Level 2 – Practice

  The systems described at Level 1 have been implemented

- Level 3 – Performance

  The organisation is monitoring its compliance with systems and acting on the findings

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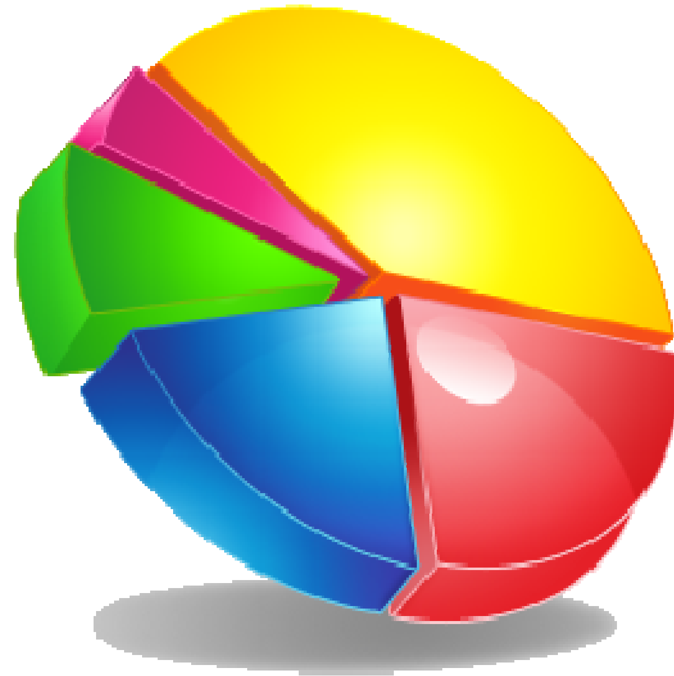
CNST Discounts

- Level 1 = 10%
- Level 2 = 20%
- Level 3 = 30%



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Contributions in Context

- 2008/2009

Gross premium (before 10% discount)	£8,157,135
Obstetric aspect	£5,340,000
10% discount	£815,714
Potential discount	**£2,447,140**

- 2009/10

Gross premium (before 10% discount)	£13,502,630
Obstetric aspect	£7,978,000
10% discount	£1,350,263
Potential discount	**£4,050,789**

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Claims data

- As at 31.03.2008 NHSLA had 17,899 live claims

- Wealth of information on database
  - Adverse incident reports
  - Investigation reports
  - Witness statements
  - Expert reports (Claimant and Defendant)

- Extensive Risk Management Programme
  - Assessments
  - Solicitors' risk management reports

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Learning from Litigation

- Litigation – a very visible manifestation of adverse outcomes of care.
- Many injuries judged in retrospect to have been potentially avoidable.
- Data from litigation represents a potentially rich source of learning from failure.
- Very small proportion of claims are pursued through to Court– a tremendous amount of unutilised data which provides a further potential source for learning.

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Learning from Litigation cont…

- The processes of dealing with adverse events which lead to litigation are often themselves perceived by patients as a further element of poor care.
- Lessons to be learned and improvements to be made to procedures for dealing with the aftermath of adverse events.
- A move away from automatic denial towards an approach which is much more open. NHS is much better at admitting mistakes and offering apologies.

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Focus for the future

- Need to

  - Ensure organisations are **actually** learning from mistakes and taking appropriate action.

  - Ensure lessons learned from individual claims are shared widely.

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How will risk management data be used to promote patient safety?

- RM team may contact Chief Executive on receipt of new report
- Report sent to Chief Executive each financial year outlining claims & seeking details of action taken
- Poor responses followed up with Chief Executive
- Ultimate sanction
  - Full CNST reassessment against standards
  - Refer to CQC

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Information from other sources

- No single comprehensive system of gathering data
- Consider also–:
  - NHS Complaints procedure
  - Coroner’s cases
  - Cases referred to HCC (now CQC)
  - Confidential enquiries– eg peri infant mortality
  - Medical Devices Agency alerts
  - Professional Regulatory Bodies– eg GMC
  - Royal College Visits and publications
  - National Patient Safety Agency – National Reporting & Learning Service
  - NICE Guidelines
  - “Whistleblowing”

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Conclusions

- Awareness of the nature, causes and incidence of failures is a vital component of prevention – ("*you can't know what you don't know*")
- Analysis of failures needs to look at root causes, not just proximal events. Human errors cannot sensibly be considered in isolation of wider processes and systems.
- Organisational learning is a cyclical process. Distilling appropriate lessons from failures is not enough: there is a need to embed this learning in practice, and it is at this stage that the "*learning loop*" often fails.
- Culture is a crucial component in learning effectively from failures.
- Good safety information systems are a pre condition for avoiding systematic learning failures. They need to take account of the fact that low level incidents or "*near misses*" can provide a useful barometer of more serious risks, and can allow lessons to be learned before a major incident occurs.

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Thank You

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