Best Practice & Research Clinical Obstetrics and Gynaecology
Vol. 21, No. 4, pp. 593–607, 2007
doi:10.1016/j.bpobgyn.2007.02.005
available online at http://www.sciencedirect.com

6

Embedding quality improvement and patient safety at Liverpool Women's NHS Foundation Trust

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The provision of safe high-quality care in obstetrics and gynaecology is a key target in the UK National Health Service (NHS), in part because of the high cost of litigation in this area. Good risk management processes should improve safety and reduce the cost of litigation to the NHS. This chapter looks at structures and processes for improving quality and patient safety, using the stepwise approach described by the National Patient Safety Authority (NPSA). This encompasses building a safety culture, leading and supporting staff, integrating risk management activity, promoting reporting, involving and communicating with patients and the public, learning and sharing safety lessons, and implementing solutions to prevent harm. Examples from the Liverpool Women's NHS Foundation Trust are used to illustrate these steps, including how they were developed, what obstacles had to be overcome, ongoing challenges, and whether good risk management has translated into better, safer health care.

Key words: risk management; medical errors; risk assessment; benchmarking; clinical audit; quality assurance; health care.

Liverpool Women's NHS Foundation Trust (LWH) is one of the largest providers of women's and neonatal services in mainland Britain. Following the centralization of in-patient obstetric services in 2004, around 8000 babies have been delivered each year on one site. The provision of safe high-quality care is a key aim of the Trust, and it prides itself on being one of only three Trusts in England to have achieved the highest level in the Clinical Negligence Scheme for Trusts (CNST) Risk Management Standards in both the Maternity and General Standards.[1,2] There are three CNST levels. Level one represents the basic elements of a clinical risk management framework. Level

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two is more demanding, and is concerned with the implementation and integration into practice of policies. Level three requires audit of the effectiveness of the clinical risk management systems. Achieving these national standards should lead to improved patient safety and reductions in contributions made to fund clinical negligence costs (£1.7 million a year), allowing us to provide high-quality services. We have achieved this by embedding quality improvement and patient safety into the day-to-day activities of the organization at all levels.

This case study will use examples from LWH of structures and processes for managing risk and show how these were developed, what obstacles had to be overcome, ongoing challenges, and whether good risk management has translated to better, safer care. These examples will be based on the seven steps to patient safety[3], which is a guide on good practice in patient safety published by the National Patient Safety Agency (NPSA) in the United Kingdom. The steps provide a simple checklist for organizations to plan their activities and measure performance.

BUILDING A SAFETY CULTURE

The key to patient safety is a culture where staff understand that safety is everybody's responsibility, and not that of a few individuals within the organization. This is possible only if there is an embedded fair blame culture and the priority given to safety is explicit in all of the activities of the organization.

This has to be visible to staff on the shop floor, and it is important that senior staff from the Chief Executive (CE) downwards demonstrate this in their working. There must be an open and non-punitive environment in which it is safe to report incidents.[4] Staff are more likely to report incidents if they have an understanding of the nature of human error and the inevitability that mistakes will occur, and that these mistakes are usually as a result of system rather than individual failures. Errors fall into recurrent patterns regardless of the people involved.[5] This understanding also enables staff dealing with incident reports do this in a systematic and fair way. It is also important that staff can see that appropriate learning and action occur as a result of their reporting, that they will not be punished, and that the underlying causes will not be ignored.

The above needs to be underpinned by policies that state what staff should do following an incident, how it should be investigated, and what support should be given to patients, families and staff. These must describe individual roles and accountability for when things go wrong. These policies must be living documents.

Tools such as the NPSA's interactive web-based Incident Decision Tree[6] are extremely useful in dealing with staff involved in serious incidents by providing a systematic, transparent and fair approach to decision-making. At LWH this has been achieved through adhering to the principles described above. A trust-wide risk management strategy and supporting policies covering incident reporting and review (major incidents) have been developed and are regularly reviewed.

LEADING AND SUPPORTING STAFF

It is vital that safety and quality are high on the agenda of organizations. To facilitate this, an executive board member should have responsibility for them.[3] LWH includes safety and quality in its corporate objectives and service plans, striving to give the best possible facilities to patients and staff. Patient quality, operational services, estate management, risk management and clinical governance are the responsibility of the