Risk management in obstetrics

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Abstract

Risk management is an integral part of clinical care in the UK. It is vital that all clinicians, mangers and commissioners understand the underlying principles and how it works in practice. It is a useful tool in driving forward the quality of patient care combining as it does evidence based medicine (pro-active risk management) and response to incidence and complaints (re-active risk management).

The risk management team will be responsible for ensuring that guidelines are up to date, national reports are responded to, training of all staff is in line with national recommendations and there is a good system for responding to, investigating and learning from all incidents, complaints and claims.

This review will describe some of the principles of risk management and the role of the National Health Service Litigation Authority (NHSLA). We have also outlined two case reports to illustrate how risk management works in practice.

Keywords CNST; duty of candor; incident reporting; never event; NHSLA; risk management; risk register; serious incident

> "Those who do not remember the past are condemned to repeat it."
>
> George Santayana (1863—1952)

Introduction

Risk management is the systematic identification, assessment and evaluation of risk. Done well it to improves the quality of care and develops safe systems of care that in turn minimise adverse events both for the patient and the staff. Risk management can be reactive (for example, in response to a serious incident or a complaint, Figure 1), pro-active (for example, in the establishment of a risk register or an assessment of the national guideline or report) or preventative (for example, ensuring adequate training and staffing levels). It is an opportunity to improve patient care.

What is risk management?

All healthcare professionals should have an understanding of the principles of risk management. Risk management is not only a tool to reduce litigation or a process to report incidents; it mainly exists to improve the quality of care. Risk management encompasses many aspects of clinical governance from risk reporting (and response to complaints) to audit, guidelines, risk assessments (in the form of a risk register) and training. Raising awareness at all levels of the workforce is essential from senior consultants to trainees, midwifery managers to all the ancillary staff including the cleaners and the porters. It has been a common misunderstanding that risk management is the concern of service managers and little to do with clinicians and the rest of the staff, however, clinicians play an invaluable role in all aspects of risk management.

Increasing emphasis has been placed on the topic of risk management and clinical governance, with clinicians' knowledge of these subjects being assessed in job interviews and included in postgraduate training and examinations.

The application of risk management is seen at all levels within an NHS hospital trust. For example, senior management may be concerned with the local strategy for infection control in a department, and the possible impact in terms unit closure if an epidemic arose (e.g. avian flu epidemic). A multidisciplinary team may look after a young, pregnant, unsupported teenager with social problems; assessing and treating the risks flagged up during the course of her care. A clinician will identify a clinical risk and plan the management to minimise harm. For example, she may organise an ultrasound scan to identify a placenta accreta in a woman with a placenta praevia and two previous caesarean sections. She will then organise suitable support from the interventional radiologists at the time of delivery (possibly including a transferring care to a tertiary centre) to prevent massive post partum haemorrhage. After the event, there may be a meeting to reflect on the care, and consider changes to guidelines to maximise care in the future and ensure learning from the case.

How big is the problem?

The impact of risk on the patient can range from minor effects to severe disability or even death. There are also the unquantifiable effects such as the sequelae of psychological impact and loss of both faith and trust in the healthcare system. Such effects may be long-lasting and influence how the individual uses the healthcare system in the future. Healthcare professionals are also inevitably affected by risk.

Staff can become disillusioned with their careers, demotivated in the workplace, become demoralised and at higher risk of making an error or more likely to leave the health service to find other jobs with less risk exposure leading to recruitment problems and understaffing. Morale is often severely affected and the effect on an individual's personal reputation is not to be underestimated. Over a third of doctors who are sued suffer from clinical depression. The impact of risk on a country needs to be recognised.

The media avidly reports risk events and this is a powerful channel with the capacity to influence a nation. Reports may not be constructed accurately and generate unfounded negative opinions and even fear amongst members of the public, thus imposing additional burdens on the healthcare system.

From a financial perspective, the problem of risk in obstetrics is huge. Data from the NHSLA shows that Maternity claims

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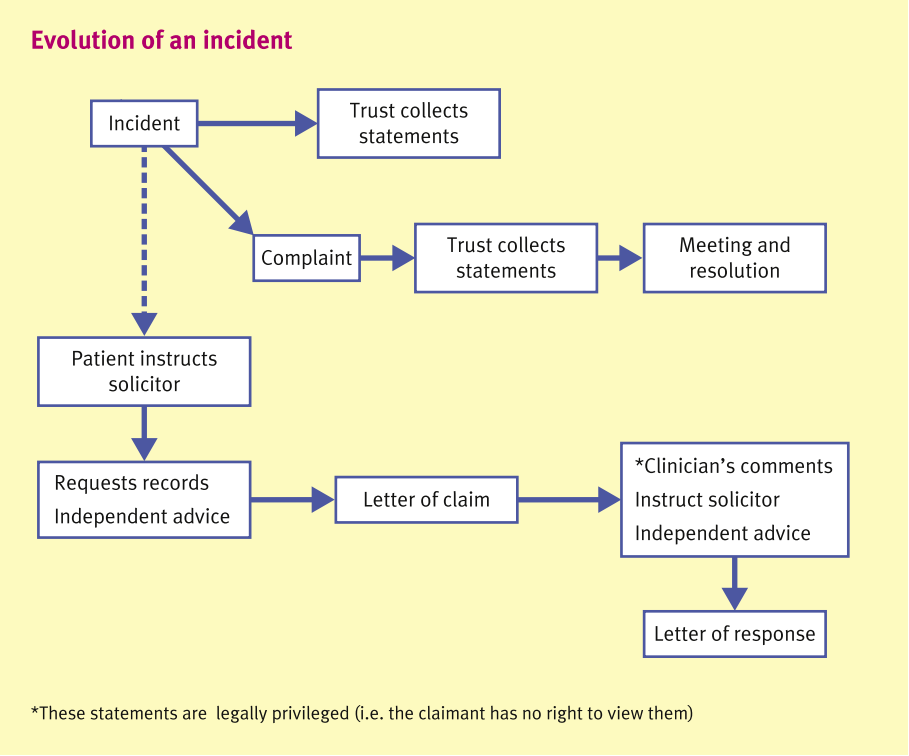

Figure 1

represent the highest value and second highest number of clinical negligence claims reported. In the NHSLA report of 'Ten years of Maternity claims' there were 5087 maternity claims with a total value of £3.1 billion. During a similar time there were 5.5 million births in England. The report also found the three most frequent categories of claim were those relating to management of labour (14.05%), caesarean section (13.24%) and cerebral palsy (10.65%).

Two of these categories, namely cerebral palsy and management of labour, along with CTG interpretation, were also the most expensive and together accounted for 70% of the total value of all the maternity claims. In total, 41% of claims are abandoned, 41% will be settled out of court and of those that go to court about 29% are settled in favour of the claimant. This money (including legal fees) all comes out of the NHS budget.

It is known that approximately 10.8% of hospital patients in the UK experience an adverse event of which 1% can lead to severe harm or death. The number of events appears to be rising (though that may be due to higher awareness) with under 1000 per quarter reported to the National Patient Safety Authority (NPSA) in 2003 and over 350,000 in 2013; the percentage of trusts reporting increased from under 5% to over 60%. Of those incidents, approximately 25% are due to patient accidents (falling out of bed and tripping in hospital) and 60% are due to clinical events (medication, treatments, communication etc).

The evolution of risk management

Over the last decade, several published reports have been instrumental in developing risk management. In 2001 "An organisation with a memory" highlighted the need to learn from clinical error. The National Patient Safety Agency (NPSA) was established in 2001. Its remit was to develop a national approach towards reporting incidents and learning from them. This included development of a national database for reporting patient safety incidents, distribution of safety alerts, formulating solutions to identified risks and internet training for root cause analysis. The NPSA analysis concentrates on a systems approach rather than focusing on individuals.

What is CNST and NHSLA?

After Crown indemnity was removed (whereby the NHS funded centrally all claims), it became clear that in some financial years a few trusts (and in turn their patient population) may suffer severe financial embarrassment if there were several high paying claims (often obstetric in origin).

NHSLA is a not-for-profit part of the NHS. It manages negligence and other claims against the NHS in England on behalf of their member organisations. There are equivalent schemes in Wales and Scotland. (The Welsh Risk Pool and the Clinical Negligence and Other Risks Indemnity Scheme (CNORIS), respectively).

The Clinical Negligence Scheme for Trusts (CNST) was set up to allow trusts to pool their claims/risks, with each trust paying a proportion of its turnover into a common pot; the high and low claims were balanced out so that no single trust would have to suffer if one year they had a number of huge claims (usually for birth hypoxia).

From the outset, a trust had to show a basic level of Risk Management to enter the scheme; maternity (as the area of