Clinical risk management in obstetric practice

Roger Smith

Abstract

This review aims to describe why risk management is of particular importance in obstetrics and to describe the practical functioning of the maternity risk management process in a tertiary care teaching hospital maternity service. In addition recent developments such as Duty of Candour, the NHS England Serious Incident Framework, and the Early Notification Scheme for severe new-born brain injury are also covered. This topic is especially relevant given the number of maternity unit scandals over recent years.

Keywords Duty of Candour; early notification scheme; maternity risk management; risk management; root cause analysis; serious incident framework

Introduction

Risk management as a concept is a process that is not confined to healthcare but can be applied in any situation where there is the possibility of harm occurring. In a generic sense it can be defined as the identification, assessment, and prioritization of risks followed by coordinated and economical application of resources to minimize, monitor, and control the probability and/or impact of unfortunate events.

Informal risk management is something good clinicians have been doing for many years. At its most basic this has entailed recognizing when something "has gone wrong", investigating events in a reflective manner, and trying to learn from the incident. This is the basis to the morbidity and mortality meetings that most departments have run. However, over the past decade or more the NHS has adopted a more formal approach to risk management. This has been in response to: well publicised failures in care such as the "Bristol heart babies scandal"; a recognition that the application of good practice in regard to risk was patchy; research findings that errors in care were much more prevalent than generally recognized with as many as 1 in 10 hospital in-patients suffering avoidable harm; and a desire to reduce the harm and financial cost associated with medical error. Although the landscape of risk management in the NHS today can appear complex, it is important to recognize that the principles are straight forward: the primary aim of risk management is to improve the quality of care and to achieve better outcomes for our patients, and in order to do that we must look with openness and objectivity at what is happening within the services that we deliver.

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Risk management is of particular relevance to maternity care because the consequences of error, such as maternal death or a handicapped baby are so catastrophic. Indeed it is for this reason that many would argue that the labour ward is the area of highest risk within the entire health service. According to the NHS Litigation Authority (NHSLA) in 2015/16, although obstetrics took 3rd place in the ranking of the number of medico-legal claims received by speciality, it took 1st place when specialities are ranked according to the financial value of such claims, accounting for 42% of the total value of all claims received (Figures 1 and 2). Not all claims are successful, but nonetheless an increasing amount of money is being paid out by the NHS via the NHSLA in legal costs and claims settlement (Figure 3). In 2015/16 such expenditure amounted to £1488.5 million, approximately 1.28% of the total NHS budget for England, and the figure is progressively rising. At a time of unprecedented financial pressure on clinical services this is a very considerable sum to be spent outside of the clinical environment.

Unfortunately the human cost of maternity claims can be devastating. One of the most tragic outcomes is catastrophic brain damage occurring in a baby who entered the labour or delivery process healthy and undamaged. Such children may require intensive lifelong supportive care, and the impact upon the individual and their family is huge. Not surprisingly the courts tend to award significant damages to fund such care, and awards in such cases now often exceed £10 million. Box 1 summarizes an article from the *Daily Mail* in 2015 reporting such a case, and captures both the human and financial consequences of such a case. Over the past decade the number of such cases has remained constant at approximately 200 per year, whilst their financial value has increased progressively (Figure 4).

Although there is much national guidance, in practice the management of incidents which do not result in severe harm, will be determined by local trust policy, however the management of incidents graded as severe is subject to reporting to commissioners and NHS England, and specific national guidance. The aim of this review is to describe the functioning of the risk management process from the perspective of the front-line maternity department itself.

Types of risk

Clinical risk management predominantly deals with risk to our patients. The other risks listed in Box 2 all flow from the occurrence of harm to patients. Other risks may be considerable, for example the reputational harm to the Mid Staffordshire NHS Trust arising from the recognition that there had been preventable harm to patients resulted in the dissolution of the organization on 1st November 2014. Specifically what we are interested in is potentially preventable harm to, or death of, patients arising in the context of the delivery of healthcare. The key words in this sentence are *potentially preventable*; healthcare deals with human beings who are unwell, and as not all conditions are preventable or treatable, unfortunately there will be an expected incidence of death and morbidity within this population of unwell people. For example a woman who presents to labour ward with a massive placental abruption, in whom death of the baby in utero is diagnosed at presentation,

Please cite this article in press as: Smith R, Clinical risk management in obstetric practice, Obstetrics, Gynaecology and Reproductive Medicine (2017), http://dx.doi.org/10.1016/j.ogrm.2017.06.011

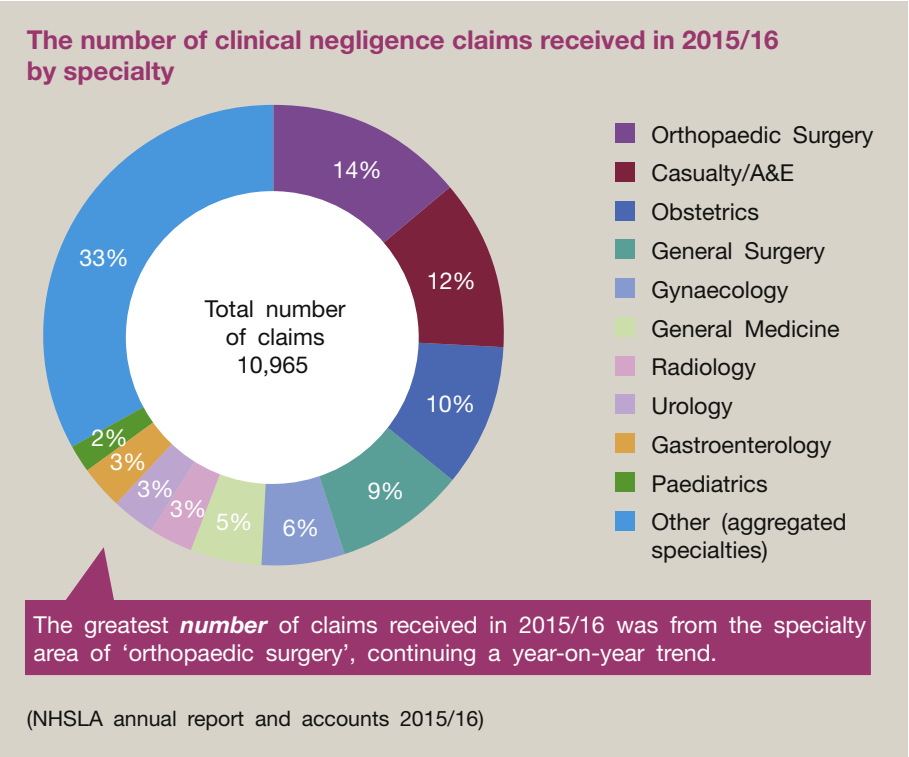

Figure 1

and who requires a hysterectomy to manage a massive obstetric haemorrhage, followed by a stay in intensive care, prior to her eventual recovery and discharge home, will be judged to have had a distressing and poor outcome to her pregnancy. However, if the sequence of events was appropriately managed to a good standard, then it may be concluded that there was no *potentially preventable* harm present in the case. The risk management process is primarily concerned with those cases

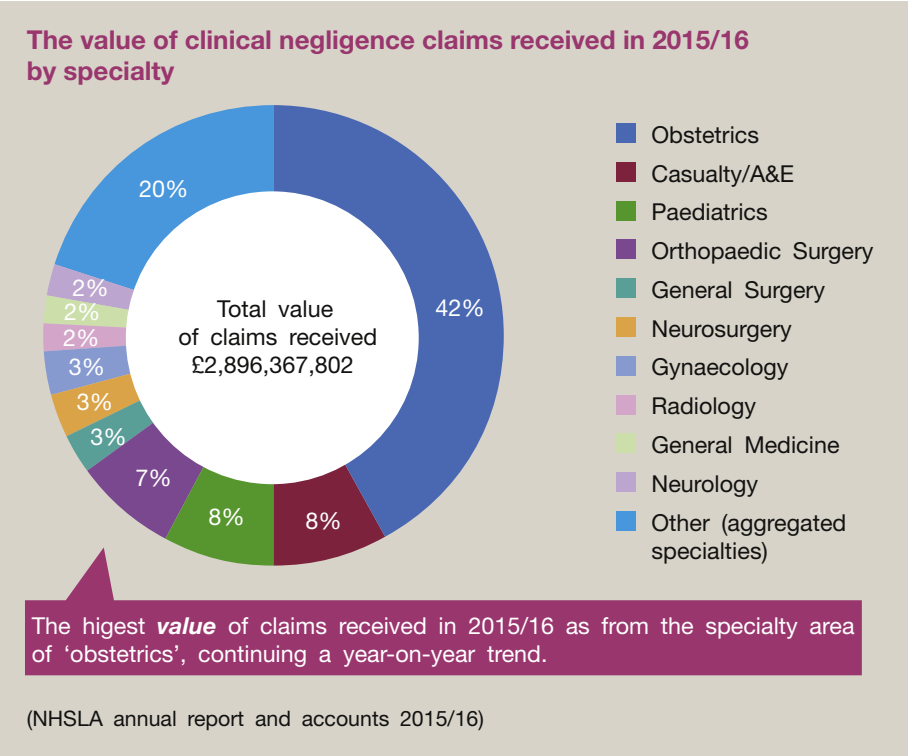

Figure 2

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