MORPH

Management of Risks and Practices in Healthcare

MORPH Survey Report for the United Kingdom

Survey Date: February-May 2003

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1. Risk Management and Medico-Legal Protection Provision: Overview of current situation in the UK

1.1 Organisational structure

A key feature in the strategy employed to improve and establish good practice in risk management in England, Scotland and Wales involves the creation of Standards, covering all areas of identified risk, both clinical and non-clinical. The provision of these Standards is linked with accreditation schemes for Trust members, in which they are examined against the criteria set out in the Standards and, if found to be compliant, are awarded a level of competency which has significant financial benefits for the successful Trusts. Linked with the monitoring process is an ethos of help and the provision of training for those Trust bodies who either fail to reach a Standard or are in preparation for submission for accreditation.

The National Health Service Litigation Authority (NHSLA) is a Special Health Authority set up under section 11 of the NHS Act 1977 and established in 1995. The principal task of the NHSLA is to administer risk-pooling schemes for the NHS in England. There are three current schemes:

- Clinical Negligence Scheme for Trusts (CNST) covering liabilities for alleged clinical negligence where the original incident occurred on or after 1st April 1995.
- Liabilities to Third Parties Scheme (LTPS) covering non-clinical liabilities to any third party where the original incident occurred on or after 1st April 1999.
- Property Expenses Scheme (PES) covering expenses incurred as a result of loss or damage to NHS property where the original loss occurred on or after 1st April 1999.

All NHS Trusts and Primary Care Trusts (PCTs) in England are members of CNST and most belong to LTPS and PES too. Although the NHSLA has a small risk management team, many of its risk management services are outsourced to Willis Ltd, a specialist contractor.

Standards of risk management have been established under the CNST scheme and continue to be produced. Willis Ltd carry out performance monitoring of Trusts and accreditation of successful Trusts. The NHSLA provide education and training programmes in relation to the Standards themselves and the assessment process. Development of Standards take account of Controls Assurance and other risk management initiatives within the NHS. The NHSLA and Willis Ltd work closely with the Royal Colleges, other healthcare professionals, national bodies and other reviewing organisations regarding the Standards and the assessment process.

Compliance with the NHS Risk Management Standards is rewarded by a discount for the following two years from scheme contributions (10% = Level 1, 20% = Level 2 and 30% = Level 3) and the potential saving for some members is substantial. A very important budget consideration for Trusts is that the CNST assessment outcomes are reflected in the star rating performance indicators for Trusts.

In Scotland, Willis Ltd is contracted by the Scottish Executive Health Department to design, implement and manage the Clinical Negligence and Other Risks Indemnity Scheme (CNORIS). The Scheme:

- Incorporates a mandatory mutual funding mechanism that replaces a significant proportion of commercial insurance for NHS Scotland.
- A comprehensive set of Risk Management Standards is incorporated.
- An accreditation mechanism is set in place to promote good risk management practice in healthcare and to monitor outputs and outcomes.

- Accreditation of organisations for compliance with Standards is at basic Level one, Level Two and Level Three.

The accreditation process is linked with a guidance and training service to help both under performing Trusts and those about to be monitored for accreditation. As with the NHSLA in England, success in compliance with Standards leads to a reduction in fees for members and an improvement in the star ratings of the Trusts.

The Welsh Risk Pool (WRP) is a mutual self-insurance scheme designed to cover member NHS bodies in Wales. Membership to the WRP is voluntary, although every Trust and Local Health Board in Wales is currently a member. The pool is funded by premiums paid by members, dependent upon the size and claims history of the organisation. The pooling scheme covers both clinical and non-clinical risk issues such as staff injuries and physical assets. The two main aims of the WRP are to:

- Reimburse member organisations for claims made against them.
- Promote good risk management practices.

The Pool has a well-established set of Welsh Risk Management Standards, with which all members are expected to comply in pursuit of improving safety for patients, visitors and staff. The original seventeen Standards were converged with the Controls Assurance Standards in 2000 to uniquely provide one set of over thirty risk management Standards for Wales.

WRP staff carry out assessments of compliance with the Welsh Risk Management Standards annually. WRP provides training and guidance for targeted need with those Trusts striving to reach compliance with the WRP Standards.

It is important in describing the organisational structure in the UK to identify several other bodies who contribute substantially to the management of risk in the healthcare sector. These include the Controls Assurance Team (CAT) set up by the Dept. of Health in 1999 to help the NHS implement continuous risk management under the Controls Assurance Project (1995 to date). NHS boards are required to publish annual statements of assurance on the status of risk management and internal control. The annual assurances are linked to Controls Assurance Standards (3 core standards covering governance, risk management and financial management and 18 further organisational standards covering areas of specific risk) against which NHS bodies are required to self-assess risk and report to the Department of Health. The self-assessments are independently verified by internal and external auditors. On average across England, self-assessment scores against all the standards have risen year on year since 1999. In July 2003, NHS bodies in England reported 108,508 actions under way to mitigate identified risk. Further information is available at http://www.controlsassurance.gov.uk/ The Health and Safety Executive (HSE) set up under the Health and Safety at Work Act (1974) has responsibilities that extend throughout the UK. HSE seeks to establish that employers e.g. NHS Trusts and the self-employed e.g. General Practitioners, Dentists and Pharmacists, conduct their undertakings in a way that ensures that people other than patients are not exposed to risks to their health and safety. HSE does not, in general, seek to apply the Act to matters of clinical judgement.

In July 2001 the Dept. of Health established the National Patient Safety Agency (NPSA) with responsibilities for the whole of the UK. The Agency is trying to promote a blame-free culture in hospitals, encouraging doctors to report incidents without fear of personal reprimand. The Agency collects reports and initiates preventative measures with the aim of improving patient safety throughout the NHS and reducing costs of litigation.

There are three important organisations that provide a medico-legal protection service for, predominantly, self-employed members of the healthcare service including general practitioners of medicine and dentists. Not only do they provide insurance cover for members to reimburse costs of litigation, as mutual indemnity organisations but they also provide an extensive education, training and guidance service. They are the Medical & Dental Defence Union of Scotland (MDDUS), the Medical Protection Society (MPS) and the Medical Defence Union (MDU).

1.2 Sources of Information in relation to both clinical and non-clinical risks

a) Clinical Risks

The NHSLA quote the following information for England on their web site, at http://www.nhsla.com/

- 5025 claims were received by the NHSLA in 2000/01 in respect of clinical negligence.
- The NHS spent £386m in 1999/2000 for clinical negligence, including legal costs.
- The NHS have potential liabilities of £4.1 billion for clinical negligence.

Case studies of recent examples of litigation in connection with clinical negligence can be found on a number of web sits, including those of MPS (http://www.mps.org.uk/) MDU (http://www.the-mdu.com/ and MDDUS (http://www.mddus.com/html/). A web site of particular interest is that of David Evans, Solicitor, Health service Lawyer at http://www.davidevans-law.co.uk/ Notable cases that have been in the public eye in recent times, such as the Bristol enquiry, the Liverpool Alder Hay enquiry and the Ledward enquiry, are included at this site.

The Bristol Enquiry took place in 2000, reviewing a situation where children who had undergone open-heart surgery at Bristol Royal Infirmary received less than adequate care. More died than would have been expected in a typical paediatric cardiac surgery (PCS) unit. In the period between 1991 & 1995, between 30-35 more children under one year died after open-heart surgery in the Bristol Unit than would have been expected had the Unit been typical of other PCS units in England at the time. The Final Report of the Bristol Enquiry contained close to 200 recommendations.

Audit reports of inspections carried out under the CNST scheme are to be found under the CNST Call In documents on the NHSLA site at http://www.nhsla.com/asp/docs.ap The Medico-Legal Journal sponsors a web site called Medical Claims at http://www.medicalclaims.co.uk/

Comprehensive legislation is in place in the UK in relation to patient rights and to promote good healthcare risk management. Within the area of competence assurance, the initial competence of medical professionals, dentists and nurses is verified by success in final examinations set by centres of learning registered to teach these professionals, followed by further periods of practical training. The General Medical Council will register individuals as doctors after achieving success in examinations followed by a further year of training on the wards. The General Dental Council carries out the same task for dentists' registration and the Royal College of Nursing for nurses. Revalidation procedures for doctors and dentists have recently been introduced. These are based on a five-year cycle, utilising continuing professional development (CPD) and maintenance of skills through a series of portfolios.

A variety of guidelines have been published in the UK pertaining to or relevant to patient rights/healthcare risk management. Significant amongst these are the Controls Assurance

Standards and the Guidelines for Medical Directors to be found at the Controls Assurance Team web site http://tap.ccta.gov.uk/doh/rm5.nsf The Dept. of Health has also produced a CD-ROM for hospitals entitled "Corporate Governance and Controls Assurance 2001" in collaboration with Standards Australia

Guidelines relating to the implementation of risk management standards in Scotland, in connection with the CNORIS scheme, can be obtained via http://www.cnoris.com/ A review of risk management in NHS bodies in England & Wales has been published by the Dept. of Health and is located on http://www.casu.org.uk/

The Scottish Intercollegiate Guidelines Network (SIGN) was formed in 1993. A programme of 60 evidence-based clinical guidelines has been developed. Information can be found on the SIGN web site at http://www.sign.ac.uk

A landmark litigation case in England was reported in March 2002, (In the matter of Ms B and an NHS Trust Hospital" (2002) by the Times at http://www.timesonline.co.uk/article/0,,1-244302,00.html The case involved a competent adult woman who had requested the hospital not to treat her by way of assisted ventilation. The hospital did not respect her written request and thought it their duty to continue treatment. The woman sought a court declaration that her treatment was unlawful and was an unlawful trespass. The Court upheld her claim. Important guidelines where produced based on this case.

Several other reports have been published in recent times. These can be found at the David Evans site mentioned earlier. They include "The Removal, Retention and Use of Human Organs" post Alder Hay Hospital case, "The Prevention of Intrathecal Medication Errors" post the vincristine event at Queen's Centre Nottingham, "The Human Rights Act 1998, Implications for Health Providers" and "A New National Reporting System for Clinical Errors".

b) Non-clinical Risks

The National Authority for the UK is the Health and Safety Executive. An important document for the healthcare sector is to be found on the HSE web site at http://www.hse.gov.uk/ The document is the Health Services Sheet No. 1 entitled "The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995: Guidance for employers in the Healthcare sector. The regulations quoted are known widely as RIDDOR and require employers and others to report accidents and some diseases that arise out of or in connection with work. There is a clear link between RIDDOR and possible claims for non-clinical negligence.

The NHSLA quotes at their web site http://www.nhsla.com/ that 2445 claims were made in England in 2000/01 in respect of the LTPS/PES schemes associated with non-clinical risk. The NHS indicated potential liabilities for non-clinical risks of £50 million.

A general source regarding the structure and functioning of the NHS in the UK is to be found in the document "The NHS explained – How the NHS works", located at http://www.nhs.uk/thenhsexplained/HowTheNHSWorks.asp

1.3 Implications of Current Status of Risk Management and the future Developments in the UK

A very significant development in the UK within the last eight years has been the establishment of devolved government in Scotland and Wales, with separate budgets to be applied to healthcare. This has led to the establishment of agencies that act in England, Wales and Scotland exclusively. However, these agencies are seen to carry out similar functions in the three countries and the development of risk management Standards is likely to continue down this path of compatibility even though Scots Law is significantly different from that practiced in England and Wales. The other factor in relation to devolution is that the Scottish Executive has it's own tax raising powers, which could be extended over the next few years. This could result in larger sums being provided to reduce clinical and non-clinical negligence, over and above what is provided from Westminster.

Several bodies, including the NPSA the HSE and the mutual indemnity societies, MDDUS, MPS and MDU have members throughout the UK. Many of the other organisations discussed in this chapter have jurisdiction only in England, Scotland or Wales. This pattern is likely to be maintained if and when new bodies are set up, especially in Scotland.

A crucial area of future development is the provision of education and training in risk management for employees working in the healthcare sector. At present, a significant amount of training is available through the accreditations bodies such as the NHSLA and with the mutual indemnity organisations such as the MDDUS. This training provision is likely to be extended in the future as more Trusts aspire to higher levels of compliance with established Standards.

The number of established courses in risk management, leading to a recognised qualification for those such as risk managers working fulltime in the field, is more patchy. A unit is established at University of Keele, headed by Prof. Scrivens and entitled Controls Assurance. Two-day courses for risk managers in the NHS are offered from time to time but do not lead to a formal certificate. Other recognised centres for postgraduate training in risk management include University College, London and the University of Leeds. A multi-level accredited course is being developed by the Welsh Risk Pool and the University of Wales for both clinical and non-clinical staff who have responsibilities for risk and claims management. Some tuition is provided in risk management within postgraduate management courses offered by Glasgow Caledonian University.

A learning needs matrix for controls assurance is available on the Controls Assurance Website http://www.controlsassurance.gov.uk/trainingmatrix/ However there is a need for good training materials to be available for risk management courses. Access to readily downloadable up-to-date files, coupled with DVDs and interactive CD-ROMs will find a ready place in the training armoury. The deliverables produced from the current MORPH Project will go some way to satisfy this demand and may stimulate extra internal training within the Trusts.

1.4 Conclusions

The NHS is under government scrutiny as never before. The ever-increasing cost of providing healthcare that reaches the expectations of the public is forcing government ministers and healthcare senior managers to look at new ways of funding healthcare and of reducing the rate of the upward spiral of costs. In the light of this scrutiny, the climate could not be better than at present in the UK for promoting implementation of risk management Standards, coupled with a drive to reduce litigation claims and costs in both the clinical and non-clinical areas of the healthcare sector.

Hence a UK-wide survey of the kind described in this Report, carried out for the MORPH Project during 2003, may provide an extra stimulus in the development of good practices in risk management. The international Survey allows comparisons of the current situation in four countries, Bulgaria, Ireland, Poland and the United Kingdom, either current members of the EU or soon to be joining. Such an exchange of information can only be of value in the ongoing development of risk management procedures and the improvement of standards.

2. Profile of Survey

2.1 Methodology/Data Collection Techniques

The MORPH Survey questionnaire was printed after extensive consultation with experts in the field. It was a two colour bound document containing 67 questions.

The questionnaire, with accompanying letter of explanation and Freepost reply envelope, was sent out either by direct mailing or through the mailing of an organisation in the field of risk management. A version for completion on line was posted on the MORPH Project web site. Links to this were provided from our own web site.

Approximately 1,650 copies of the bound questionnaire were distributed between early January and the end of April 2003. These were either distributed through the various routes outlined below, in the period before the end of February or by direct mailings resulting from requests identified through follow-up phone calls. 200 calls to Acute, Ambulance and Primary Care Trusts were made between mid-March and the end of April. Distribution was carried out via:

- 850 copies to self-employed medical & dental practitioners through a periodic mailing of MDDUS.
- 350 copies to named risk managers, corporate governance managers etc by direct mailing using a list of England supplied by NHSLA.
- 100 copies to risk managers and directors with responsibility for risk management in fifteen NHS Trusts in Wales, distributed through mailings by the Welsh Risk Pool. The questionnaire was also placed on the WRP website.
- 134 copies mailed directly to CNORIS members in Scotland.
- Approximately 80 copies mailed to risk managers, corporate governance managers etc in Scotland from a list provided by the Tayside Risk Management Co-ordinator.
- Approximately 120 copies sent out to NHS Trusts in England, Scotland and Wales in response to follow-up phoning activities.

206 completed copies and 4 spoiled copies were returned by the closing date of the 10th May. Of these, 21 were completed on line and 185 returned in the Freepost envelopes.

2.2 Profile of respondents

The identity of the organisations responding is outlined in Table 2.1

Table 2.1: Institution nature (n=204)

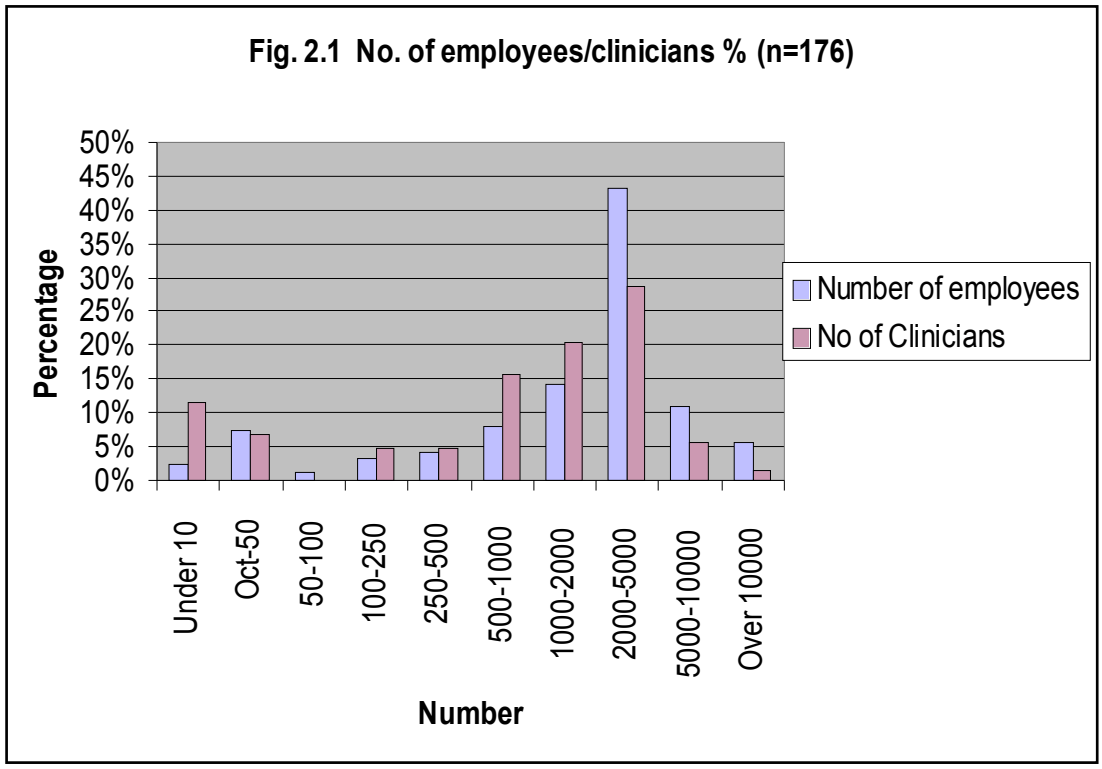
Institution	Percentage
Public Hospital	60.8
Private Hospital	2.0
General Practice	9.8
Cooperative	0.5
Acute& Primary Care Trust/Health Board	23.5
Ambulance Trust	3.4

The highest response was from NHS hospitals with a significant smaller group indicating responsibility throughout a Trust or Health Board. Individuals completing the questionnaire, Table 2.2, were predominantly risk managers/risk co-ordinators/health & safety managers. Of the rest, many held posts in senior management within the hospital. It was encouraging to note that almost 13% of respondents were clinical consultants and 9% were general practitioners.

The histogram of data outlined in Fig 2.1 indicates that the response to the questionnaire has come, in a little above half the cases, from organisations having between 1,000 and 5,000 employees of which a high proportion are clinical staff.

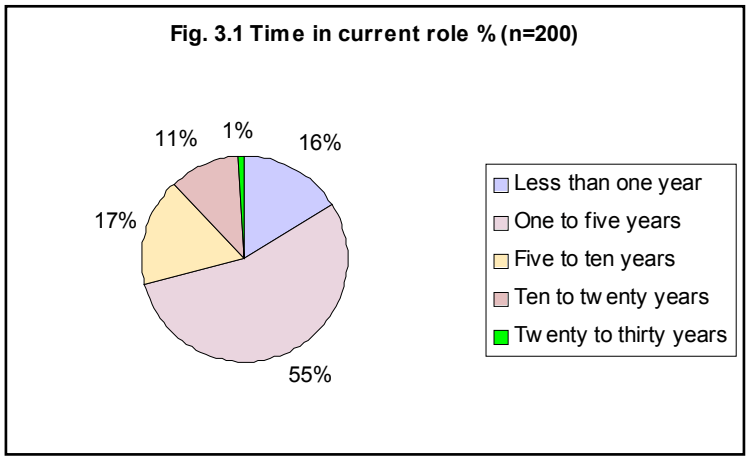
Table 2.2: Job title (n=199)

Title	Percentage
Chief Executive	0.5
Executive Director	10.1
General/Governance Manager	4.5
Risk Manager/Health&Safety Manager	36.2
Head of Department	1.5
Consultant	12.6
General Practitioner	8.5
Senior Administration	13.1
Administration	0.5
Nurse	0.5
Risk Coordinator	8.5
Professor/Lecturer	0.5
Medical Director	3.0



3. The role of the individual respondent in the risk management process

Most respondents had been in their current role for up to five years, fig 3.1. This agrees with later data, Table 4.0, which indicates that more than three quarters of the risk management policies and strategies have been introduced since 1998. Those responding that they have served in their current role for more than five years may reflect clinicians and senior administrators who have been employed by the Trust for a number of years but who have taken on extra risk management duties since the introduction of the Policy.



Most of those indicating that they are responsible for the risk management process in their institution, share the responsibility with one or more other staff, Table 3.1. Only 12 % of those responding stated that they have sole responsibility for the process. This figure is still surprisingly high, considering that risk management has important implications from the CEO down. The job titles of those who share in the risk management process are identified in Table 3.2. Senior management, including the CEO, figure in the decision-making process in 36% of the organisations responding.

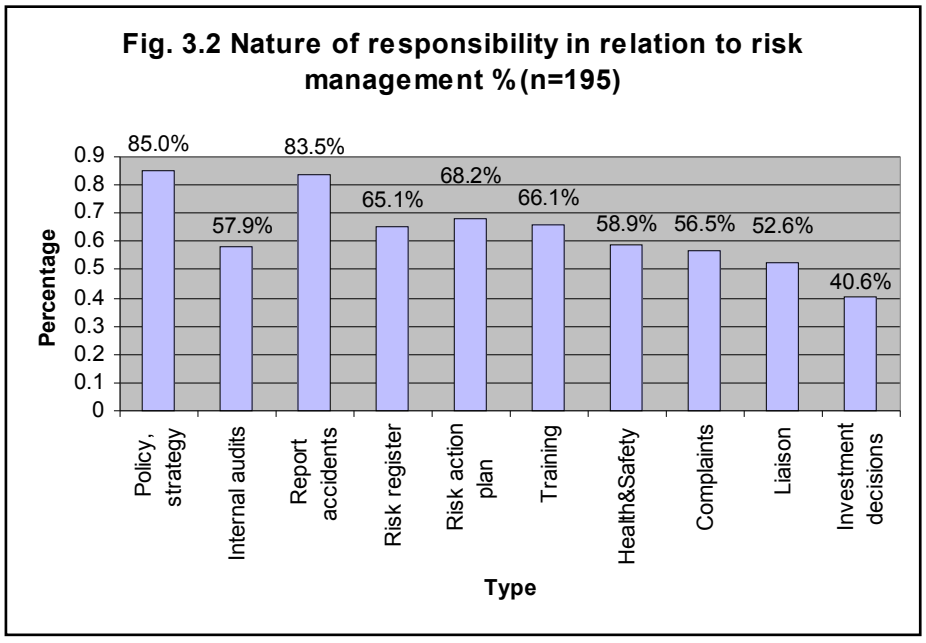
Table 3.1: Number responsible (n=153)

Number	Percentage
1	9.2
2	13.7
3-5	28.1
5-10	7.2
Many-Unspecified	39.9
6	0.7
7	1.3

Table 3.2: Responsibility for Process (n=161)

Title	Percentage
Chief Executive	13.7
Executive Directors	19.9
General Manager	1.2
Risk Manager/Health&Safety Manager	10.6
Consultants	1.2
General Practitioners	6.8
Senior Administration	1.2
Administration	1.2
Nurse	1.2
Risk Steering Group	13.0
Staff at various levels	25.5
Managerial Staff	4.3

The ranges in responsibilities for those who completed the questionnaire are outlined in the histogram, Fig 3.2. Whilst the vast majority are concerned with formulation of policy/strategy and the reporting of adverse incidents, only 40% make decisions in relation to further investment in the risk management process.



When the data in Table 3.3 is considered in relation to that displayed earlier in Table 2.1, whilst 63% indicate a responsibility for one or more hospitals, as against 61% in Table 2.1, it might have been expected that respondents who reported responsibilities for a number of hospitals would also have reported a responsibility for risk management in the whole Trust. The fact that the latter figure is around 21-24 % in both tables suggests that there may be some confusion in the responses here.

Table 3.3: Organisations (n=191)

Organisations	Percentage
1 Hospital	22.0
2-5 Hospitals	30.9
6-15 Hospitals	9.9
General Practice	7.9
Cooperative	1.0
Trust/Health Board	20.9
Department	4.2
Ambulance Trust	3.1

Only 26% had formal qualifications in risk management and of these, almost two thirds gained this qualification through a university course. The data in Table 3.4 indicates, as expected, that such a qualification is not mandatory for carrying out the role of risk management manager, or being involved in the risk management process. However, almost two thirds report that such a qualification is desirable.

Table 3.4: Importance (n=80)

Importance	Percentage
Mandatory requirement	6.3
Not mandatory but desirable	63.8
Not important, wanted to further knowledge of risk management	30.0

The vast majority of the organisations responding have a health & safety officer. Regular interaction between those involved in risk management and the individual appointed as health & safety officer occurs in almost 80 % of the organisations responding, Table 3.5

Table 3.5: Specific Health & Safety Person (n=198)

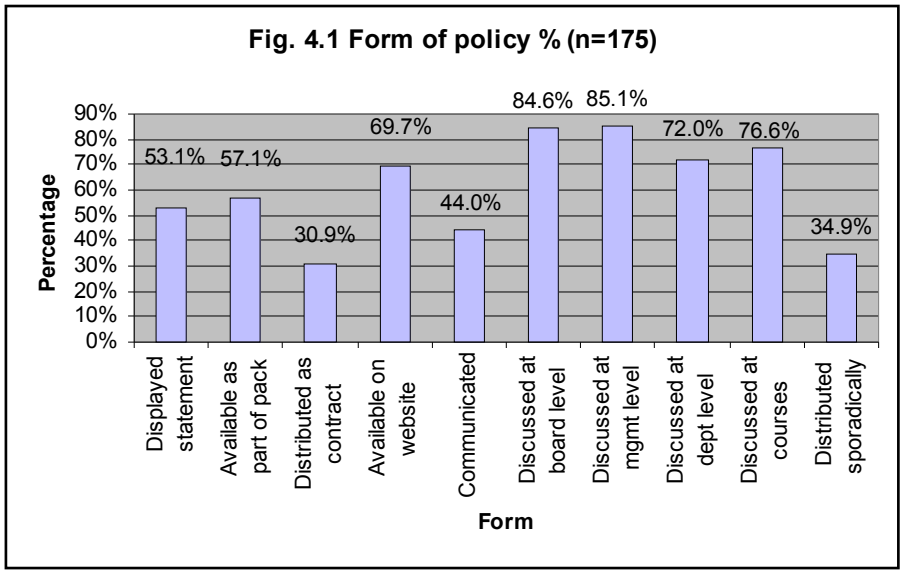
Specific Person	Percentage
Yes*	90.4
Regular interaction	78.3
Not regular	13.0
On occurrence of an adverse incident	7.5
No interaction	1.2

*Yes = there is a specific Health & Safety person

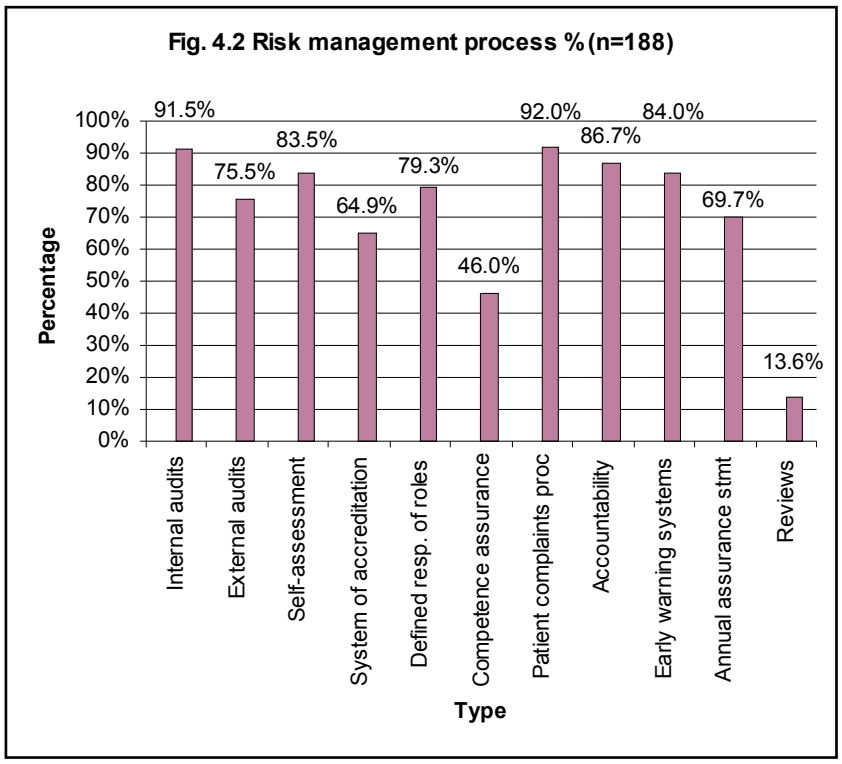
4. Risk Management at the Institutional/Organisational Level

Ninety two percent of respondents reported the existence of a specific risk management policy in their institution. In view of the financial penalties that exist for Trusts if they are shown to be negligent, and the requirement of mutual indemnity organisations for their members to have such a policy, it is not surprising that the figure is so high in the UK. Indeed, under controls assurance, it is inter alia a requirement to have a risk management policy in place to comply with the core standards.

The data displayed in Fig 4.1 supply useful information on the individual risk management processes. Most of the means of communicating the important details to staff are used in many institutions. It is a little surprising that less than 50% of institutions interact with staff as part of an overall communications strategy. However, the topic may be regarded in many organisations as too important to disseminate in that way, although it would add to the likelihood of everyone seeing it if it was included in Trust newsletters.



The important question of what is included in the process is explored with the data described in the histogram in Fig 4.2. Most items in question 19, Fig 4.2, appear in the process of the institutions responding. However the absence of competence assurance in more than 50% of the responses is surprising.



The years when the idea for the development of the risk management process evolved and its eventual introduction took place are displayed in Table 4.0. Clearly, the important period for development and implementation is from 1998 onwards.

Table 4.0: Year of idea of process/year introduced (n=160)

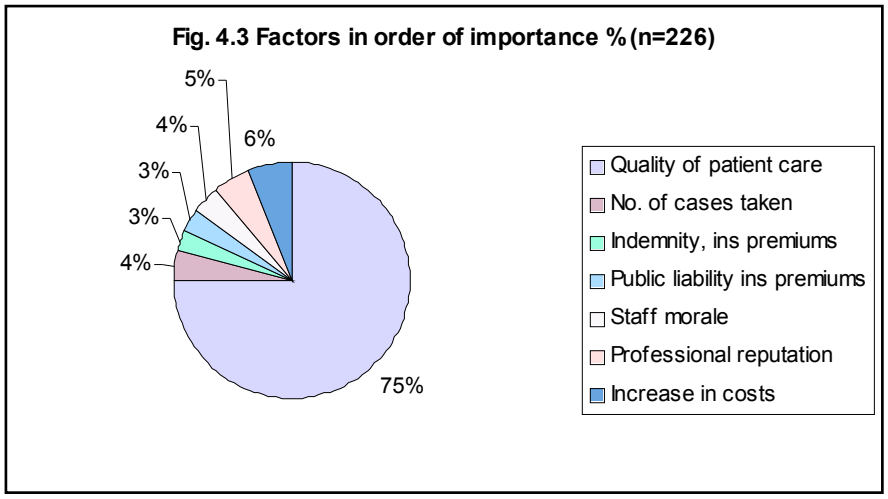
Year of Idea of Process	Percentage
2003	1.3
Year introduced – 2003	3.1
2002	6.4
Year introduced – 2002	15.0
2001	12.8
Year introduced – 2001	23.1
Year 2000	20.5
Year introduced – 2000	16.3
1999	17.3
Year introduced – 1999	11.9
1998	12.2
Year introduced – 1998	8.1
1997	7.1
Year introduced – 1997	6.3
1996	7.7
Year introduced – 1996	7.5
1995	5.8
Year introduced – 1995	5.0
Before 1995	9.0
Introduced before 1995	3.8

The responses to the question of who was involved in drawing up the Policy, outlined in Table 4.1 reveal that approximately one third have appointed a Risk Steering Group.

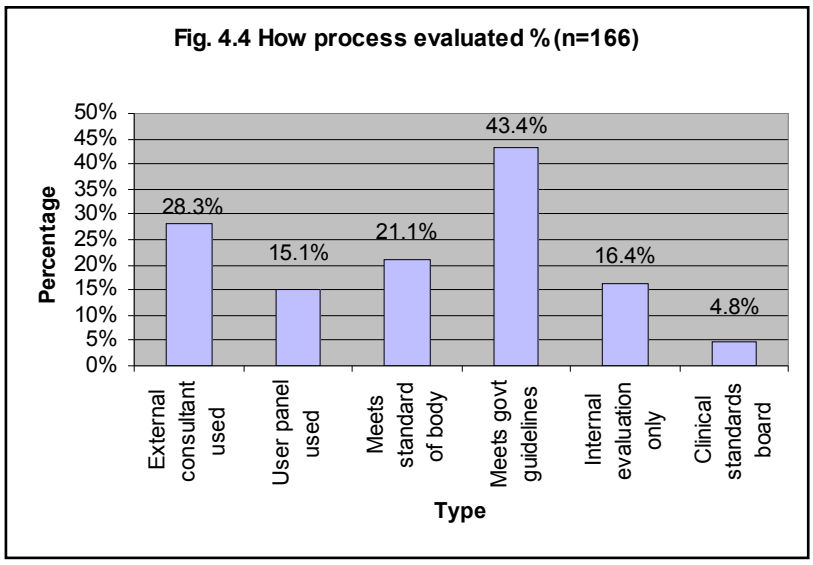
Table 4.1: Who drew up process (n=168)

Title	Percentage
Chief Executive	11.9
Executive Directors	13.1
General Manager	1.2
Risk Manager/Health&Safety Manager	11.9
Heads of Department	0.6
General Practitioner	2.4
Senior Administration	0.6
Nurse	0.6
Risk Steering Group	29.2
Staff at various levels	13.7
Audit Committee	12.5
Board	2.4

The ranking of factors important to institutions in producing a risk management policy is described in the chart in Fig 4.3. The overwhelming response for one most important factor shows that the quality of patient care is the major driving force.



Only 17% of risk management policies had been evaluated after completion, a staggeringly small percentage, considering the importance to both patient care and finance. Of those that had been evaluated, Fig 4.4, the most usual by far was that of meeting government guidelines. For NHS Trusts, the accreditation process described in Chapter 1 and the formal assessment of compliance, after training, suggests that the process was probably evaluated informally by the accrediting body.



In view of the fact that over 90% of respondents reported the existence of a specific policy for improving risk management in their institutions, it was surprising that only 27% could report the existence of a specific budget for the policy, despite the need for clear trails of expenditure to be identified within the NHS. As might be expected, in those cases where such financial provision was identifiable and in place, more than 60% reported that the percentage of total annual budget of the institution allocated to risk management was < 1%. Two thirds of those respondents with budgets reported that the budget allocation had not been increased within the last three years. Interestingly, in these days of financial accountability, only 25% reported an official costing procedure for the risk management process. Without this rigour, it is hardly surprising that budget allocations have not been increased.

The question of the responsibility of management to the risk management process was asked and the responses reported in Table 4.2. Strong support was registered for the various areas of responsibility identified. Interestingly, in view of what is said about finance above, the least popular responsibility was that of varying budgets for risk management, when required.

Table 4.2: Selected responses to management (n=171)

Responses to Management	Percentage
Lessons learnt from past	83.6
Vary budgets/investment	60.2
Define responsibilities of staff	80.7
Communicate process	83.6
Ensure commitment	73.1

Not surprisingly, 83% reported that management were accountable for the risk management process. It could be argued that the figure should have been 100%. However of the 17% who responded that management were not accountable for the process, 50%, reasonably, linked this accountability to all staff, revealing confusion of the exact meaning of the term "accountability".

The results from the important question regarding how clinical staff where made aware of the risk management process are revealed in Table 4.3. All obvious routes have been used, although it would have been expected that more than the 52% of those responding would have reported the efficient use of the organisation's web site for use in training and updating on the process. Overall, 60% of respondents believed that the risk management process was satisfactory in their institution. However, with 40% having a negative view, it may suggest that the concept of being satisfactory, could, for some, mean not requiring further change and improvement.

Table 4.3: Selected responses as to how made aware of process (n=155)

How made aware of process	Percentage
Through documentation	75.5
Staff/dept meetings	81.9
Training/lectures internal	85.2
Training/lectures external	23.2
Organisation's website	52.3
Lessons learnt from past	9.7

5. Education, Training and Protocols

The significant proportion of risk managers amongst the respondents, 36%, the low percentage of these, 26%, who have qualifications in risk management and the high proportion of institutions replying to the MORPH Survey, which have a specific risk management policy, 92%, prompts questions on education and training provision of good practice in risk management for staff in NHS institutions. Less than one third, 29%, of those, responding reported a mandatory system of continuing education in place for risk managers. When such a system is in place, the methods used in the process of continuing professional development (CPD) are listed in Table 5.1 Traditional methods of teaching, involving lectures and workshops are used in the majority of cases, whilst the provision of interactive electronic training tools is only found in 24% of the positive responses.

Table 5.1: Selected responses to education and training (n=60)

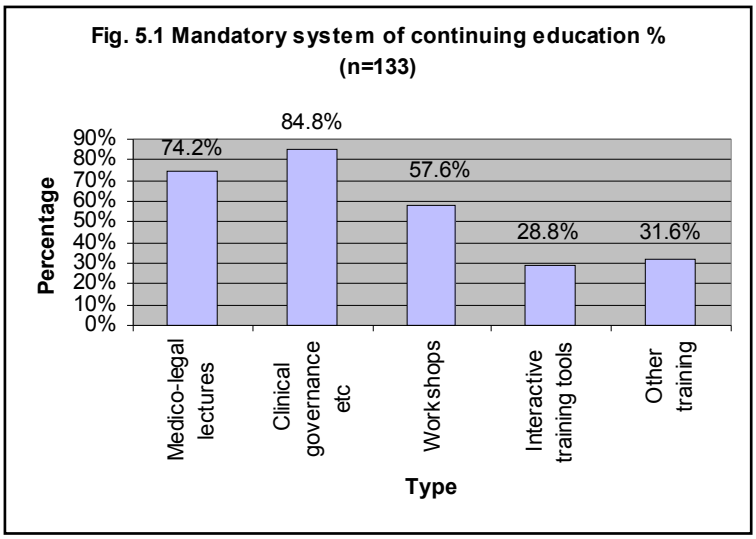
Education and Training	Percentage
Medico-Legal Lectures	76.7
Clinical Governance etc	91.5
Workshops	59.3
Interactive Training Tools	23.7
Other Training	39.7

The frequency of provision of the training for risk managers is outlined in Table 5.2. Clearly, training based on an annual cycle of lectures etc. is the most favoured timetable.

Table 5.2: Training – how often for risk managers (n=61)

How often	Percentage
Every month	6.6
Every four months	11.5
Annually	44.3
Bi-annually	8.2
Other – through meetings/conferences	4.9
Other – variable	24.6

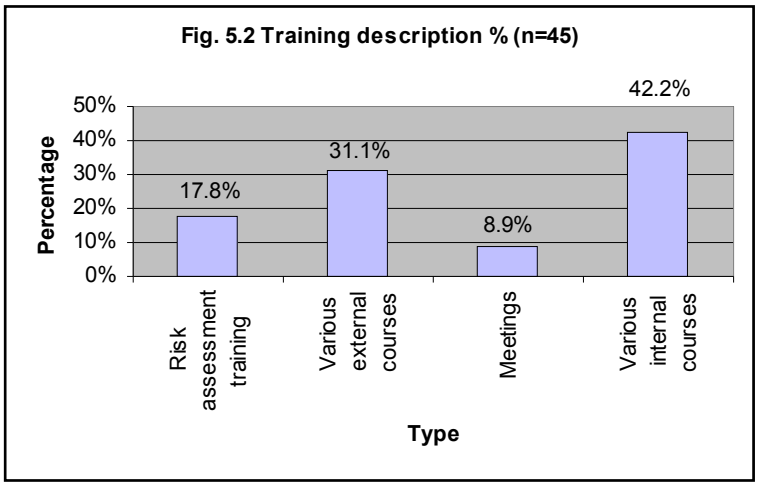
Interestingly, in view of the response reported earlier indicating only 29% of risk managers receiving mandatory CPD, respondents reported that in three quarters of their institutions, CPD for clinical personnel is mandatory. This question may have been interpreted by some to mean CPD on all topics relevant to clinical staff. It could also reflect the fact that risk managers and health & safety managers can provide CPD on these topics to clinical staff but who provides the CPD for risk managers? The histogram in Fig 5.1 indicates again the use of traditional teaching techniques and the lack of use of interactive training tools. Almost certainly, in both cases highlighted above, this reflects the lack of availability of good electronic training tools.



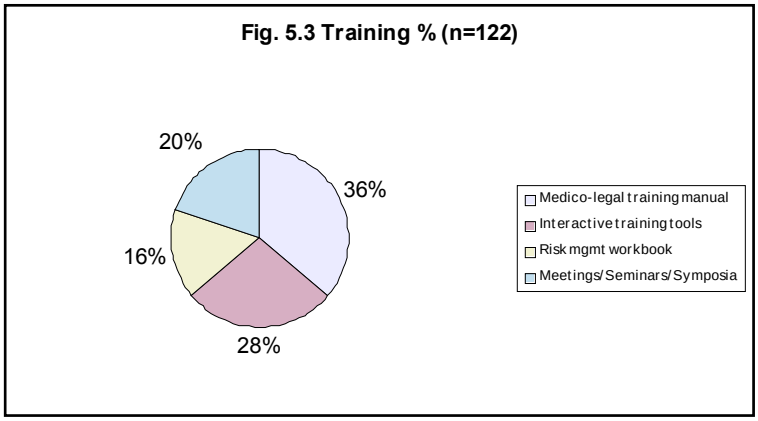
It can be seen from Table 5.3 that training carried out on an annual basis is the most popular timetable for CPD provision. Where mandatory systems for provision of CPD to clinical personnel are not in place, 82% reported the existence of voluntary systems. Of these, Fig 5.2, three quarters of the training was received on internal & external courses, with only 18% described as being risk assessment training. Where clinical audits were carried out the results were fed back to clinical staff through the CPD training process in over 82% of the institutions reporting.

Table 5.3: Training – how often for clinical personnel (n=134)

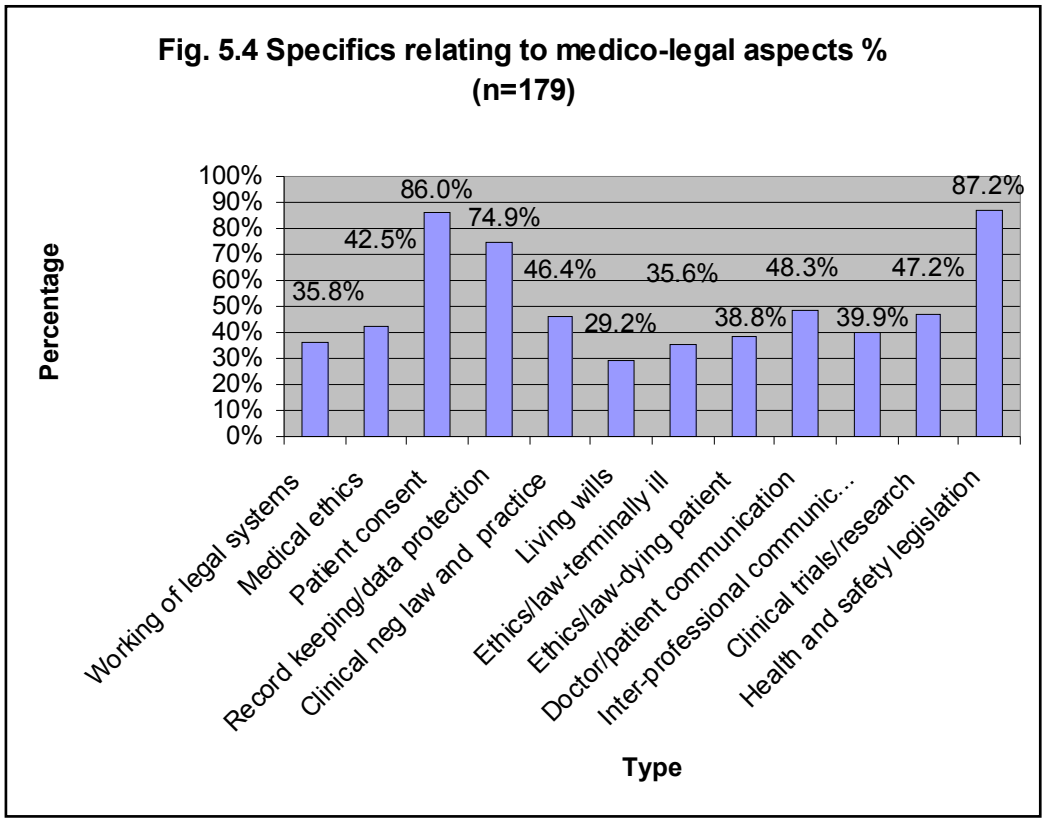
How often	Percentage
Every month	9.7
Every four months	6.7
Annually	47.8
Bi-annually	11.9
Other – through meetings/conferences	3.0
Variable	20.9



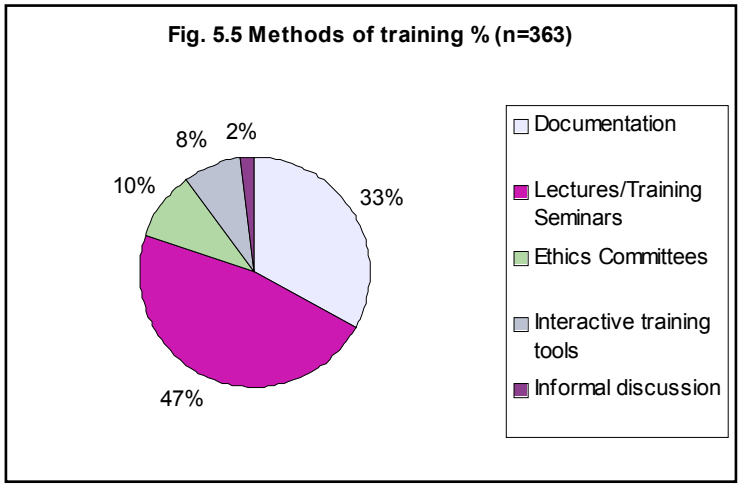
The data displayed in Fig 5.3 illustrates that the provision of a risk management training manual, interactive training devices or other educational tools are only available in around 20% or less of the institutions responding.



A range of medico-legal issues in relation to the management of both clinical and non-clinical risks was explored in the Survey. Information of training provision on a number of these is outlined in the histogram described in Fig 5.4 Large variation in the frequency of when certain topics appear in the curriculum is observed. As might be expected, training in health and safety legislation and procedures takes top spot, with patient consent and record keeping/data protection following closely behind.



The responses reveal that if training is given in the variety of areas reported in Fig 5.4, these can be divided up into the various methods of communication described in Fig 5.5. Again traditional methods of teaching are used in the vast majority of cases.

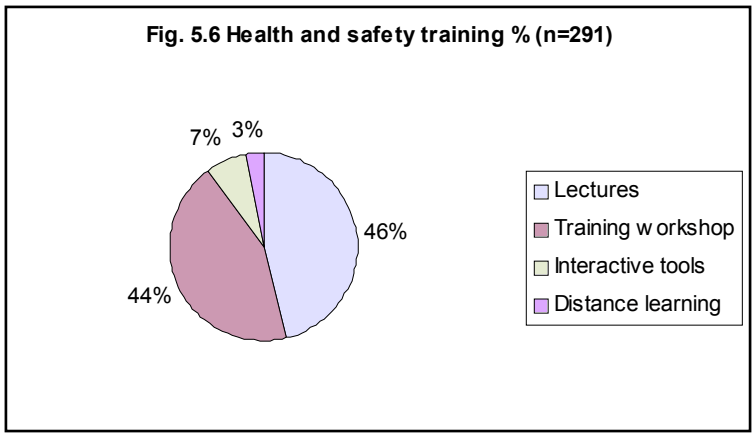


The existence of protocols and procedures for dealing with a number of health and safety issues in institutions is considered in Table 5.4. It is clear that training and guidance is provided to staff in these topics in the vast majority of institutions responding to the Survey. The existence of a health and safety statement was in place in 90% of cases. In these cases, 77% have in place a procedure for transmitting the statement to every employee, both clinical and non-clinical. Over 60% of institutions review the health and safety statement annually whilst a further 26% carry out the procedure when considered necessary.

94% of those responding reported that all personnel receive health and safety training, with traditional means of getting the information across reflected in Fig 5.6 There is no evidence to suggest that interactive electronic training tools are used any more in health and safety training than was found for risk management, even though it would be thought that they may be more easily available in the former discipline.

Table 5.4: Selected responses – procedures in relation to health and safety (n=highest 191, lowest 138)

Health and Safety	Percentage
Sharp injuries	97.9
Chemical agents	85.9
Manual handling	91.6
Sterilisation equipment	86.4
Slips and falls	64.9
Waste management	86.3
Stress management	68.4
Violence at work	90.0
Security in workplace	82.2
Infection control	93.2
Fire emergency	92.0
Drugs and alcohol	53.5
Computer use	50.7



When asked if the National Agency with responsibility over health and safety visited the institution/organisation, 84 % responded positively. The 16 % who seem not to get visits is surprising and may reflect very small organisations. The frequency of these visits by the National Agency to those institutions who responded positively, is reported in Table 5.5, with irregular intervals being reported as the most common experience of the timetable for these spot checks.

Table5.5: Health and safety statement – how often reviewed (n=129)

Health and Safety Statement Reviewed	Percentage
Every four months	2.3
Annually	19.4
Bi-annually	5.4
Every two years	29.5
At irregular intervals	42.6
Not known	0.8

The question of clinical negligence is considered in Table 5.6 The experience of institutions in this area is considered over the last three years. Of those institutions giving a definite answer, a significant number, 44%, reported an increase in litigation claims, with only 15% being able to report a decrease. Many institutions did not know the percentage of their total annual budget used on such litigation, Table 5.7. Of those that did know, the range 0.76-1.0% was the figure most chosen. It is interesting to note that around 5% replied that they were covered by insurance and hence, perhaps, the actual figure was of less interest to them, even though claims will have a significant effect on the level of future premiums. 77% of those responding reported that their institution incorporated the findings of court decisions into their training protocols in order to improve the risk management process.

Table 5.6: Negligence litigation (n=161)

Negligence	Percentage
Increase	43.5
Decrease	14.9
No change	41.6

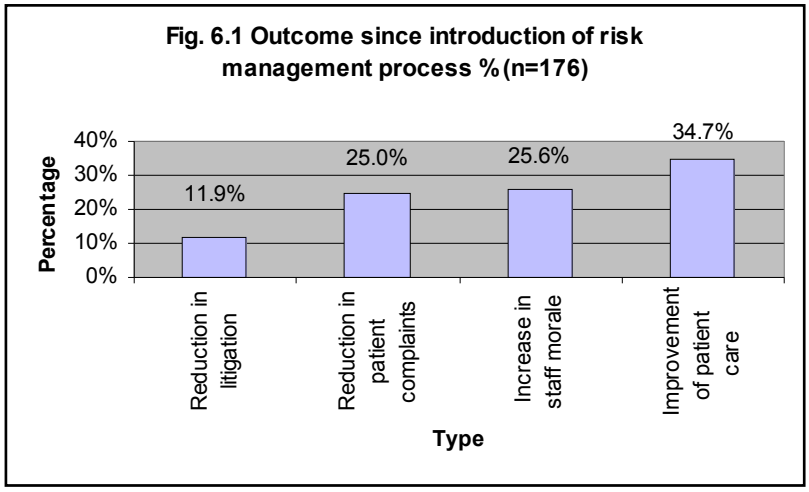
Table 5.7: Budget % for litigation (n=114)

Budget %	Percentage
Not known	54.4
None	7.9
0-0.25%	5.3
0.26-0.5%	1.8
0.51-0.75%	0.9
0.76-1%	10.5
1-3%	8.8
3-5%	2.6
5-10%	0.9
10.1-20	1.8
Covered by insurance	5.3

6. Perceived Benefits and Outcomes

Any management programme must result in definable benefits to sustain funding. These benefits, ideally, should be identifiable as tangible outcomes of the management programme, leading to future improvements and benefits to both the individual and the institution. The results of the risk management programmes put in place over the last few years, were investigated in the MORPH Survey.

Possible benefits are explored in Fig 6.1. More than a third reported improvements in patient care since the introduction of the programme. This was identified as the most desirable outcome of such a programme earlier in this report. 12% reported a reduction of litigation. This figure is disappointingly low but the lead-time between the introduction of a risk management process, the adoption of the culture of good practice and reduced risk and a lowering of litigation cases could be quite long. 15% identified a reduction of medical indemnity costs and 16 % a reduction in public liability insurance costs. These figures agree well and it is gratifying to see the reduction of insurance costs in line with reduction of litigation, even if only a modest start has been made.



In line with the findings described above, more than 40% believe that improvements in the risk management process will lead directly to reduction in costs of litigation. This caution may reflect the response that showed only 12% could report a decrease in litigation cases to date. More than 82% believe that reduction of litigation costs will further enable the institution to improve the delivery of healthcare. The impact of the introduction of the risk management process in the institution of the respondent is reported in Table 6.1. The majority believe the process has had some impact whilst 25% believe this impact to be considerable. This is gratifying if it is recalled that only about one third of the respondents to the Survey are risk managers, whose progress in their career may make them be slightly more optimistic in answering this question than others, from other areas of responsibility in the institutions, that responded.

Table 6.1: Impact of risk management on patient care (n=181)

Impact	Percentage
No impact	1.1
Very little impact	5.5
Some impact	51.4
Considerable impact	25.4
Difficult to say	16.6

7. Opinions for the Future

63% of those responding believed that the Government should have a role in the regulation of the risk management process, with only 21% believing that Government should not get involved. Various questions were asked regarding the role of the legal system and the role of courts in clinical negligence cases. The results are reported in Table 7.1 The most important role of a court of law, by far, was seen in providing a medium for a fair hearing of the case.

Table 7.1: Selected responses to role court of law should play in clinical negligence cases (n=191)

Role	Percentage
Setting standards	22.5
Compensating for loss	13.2
Medium for fair hearing	69.8

Two thirds of respondents believed that clinical negligence litigation should remain within the court system and be improved. The ratings of issues that may be involved in this striving for improvement are displayed in Table 7.2. The overwhelming favourite is the introduction of specialised medical courts that only deal with cases of clinical negligence. Whether such a move would drive up the costs of the litigation process is open to question.

Table 7.2: Selected responses to improvements within the court system for clinical negligence/litigation (n=153)

Improvements	Percentage
Payment of damages	10.5
Speed up process	32.7
Specialised medical courts	64.7

Strong support was shown for Alternative Dispute Resolution (AD) systems in relation to matters of clinical negligence. 87% supported such a strategy. The popularity of certain factors associated with AD was explored and the results reported in Table 7.3. No strong favourites emerged to be implemented in utilising ADR systems.

Table 7.3: Selected responses to ADR systems being utilised in relation to matters of clinical negligence (n=150)

ADR Systems	Percentage
Arbitration	15.0
Mediation	29.9
Patient complaints system	33.1
No fault liability	32.7
Medical injuries compensation boards	11.6

8. Conclusions

The responses received and incorporated in this MORPH Survey report for the UK were drawn overwhelmingly from the public sector acute and primary care Trusts. Very few were from private hospitals and only 10% from general practice clinics. Whilst a wide range of individuals with different jobs titles responded, more than one third, 36%, came from risk managers or health and safety managers. Hence the information presented will strongly reflect their views. The next two jobs sectors to respond were senior administrators, 13% and clinical consultants, 12.6%. 55% of respondents had been in their current post less than five years, in many cases probably reflecting when the post of risk manager was first created. The information in Fig 2.1 indicates that the development of the specific risk management policy began between 1998 and 2001 and was introduced between 1999 and 2002. This profile of a recently appointed risk manager being involved with the development and introduction of the specific policy is important to consider when trying to evaluate the data presented.

Whilst it would have been expected that the primary motivation for introducing and risk management policy would be to improve the quality of patient care, the relatively low ranking of litigation cases and the cost of insurance as a result of litigation payouts is a little surprising, especially with the current emphasis on reducing costs of the NHS. It can been seen from Table 5.7 that approximately 20% of respondents reported litigation's costs of between 0.76 and 3% of the total annual budget of the institution, a substantial figure when the budget may be many millions per annum. 50% of those responding did not know what part of the budget was being taken up by litigation costs. It is tempting to suggest that if the respondents were better informed on this matter then reducing litigation costs might have figured more highly in the factors evaluated in Fig 4.3

It has been commented on earlier in this report that there is a greater emphasis on providing continuing professional development for clinical personnel than for risk managers. In view of the relatively low number of risk managers with qualifications in the discipline, this may be regarded as surprising. Having made this comment, the impression from the Survey is that there is now a reasonably comprehensive system for provision of CPD in place for all staff, both on risk management and on the more general health and safety issues. It is clear that traditional teaching methods of lectures and workshops are favoured for imparting CPD, with little evidence of use of interactive tools. However, this almost certainly results, in part, from the current lack of availability of suitable material in the UK.

The importance of accreditation bodies providing Standards for risk management and described in chapter one, is seen as a key factor in the development of good practice in risk management in the healthcare sector of the UK. The fact that this is linked with the provision of training and advice to institutions to enhance their chances of reaching compliance is an excellent model for others to follow. It is clear from Fig 4.4 that the evaluation of the newly developed risk management process by institutions was evaluated by the accrediting body in that part of the UK and shown to comply with government guidelines.

If risk management processes have been introduced and extensive training of personnel is being provided then it is logical to look at perceived benefits and outcomes, especially since many processes have been in place for more than two years. However, as can be seen in Fig 6.1, evaluation of the success of the process in tangible outcomes is difficult to define. Even when patient care is considered, only one third of respondents could point to improvements and other factors such as increased staff morale and reduced cases of litigation received 25% or less of positive responses. A similar story is found for reduction in medical indemnity and public liability insurance costs. It is tempting to conclude that the processes, leading to improved practices in the management of risk, have been in place for too short a time for many to make proper assessments of their value to both patients and the institution. However,

there is optimism that the process will deliver reduced litigation costs and the money saved will lead to improved delivery of healthcare for the patients.

This optimism for the value of installing good management practices to identify and control risk is tempered by concerns for the future, expressed by approximately 30% of those who responded. Lack of funding is clearly a major concern as is the increased pressure on the time available for all personnel to consider and implement better practices. Concern is also expressed regarding the increasingly compensation-oriented culture and the bureaucracy that may come with plans to implement changes in the risk management process. Some fear that it will be difficult to bring all to the same level of clinical governance and practice. However, as more Standards are produced by the accrediting bodies and more institutions reach higher levels of compliance then the tangible benefits will become more obvious. Patient care will improve, litigation costs will be reduced, channelling more funds back to improve patient care. These improvements will raise staff morale, which, in turn, makes further improvements possible. Hence a cyclic self-reinforcing process is set up. Great care will be required to ensure that lack of funds, too bureaucratic a process and the increasing demands on personnel time, do not interfere or even sabotage this self-reinforcing process.

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