U.K. National Health Service: The Risk Manager's Dual Roles

by *Bill Stein**

Abstract

[This paper summarizes the results of a survey of United Kingdom National Health Service risk managers carried out in 1995. The survey sought to establish the extent to which a formal risk management structure existed within NHS Hospital Trusts. The resulting analysis revealed a limited response to the creation of specific Risk Manager posts or Risk Management Committees or Groups. It also highlighted the emergence of NHS managers from a wide variety of administrative and medical backgrounds being given the day to day responsibility for the implementation of risk management on a dual role basis. The paper concludes with a description of a development in 1996 in one area of the UK (Scotland) where managers from different health administration roles are looking for ways to help them respond effectively to their new responsibilities for the management of risk.]

Professionals engaged in the delivery of healthcare, whether face to face with patients, or as a medical support service, or in the provision or maintenance of a facility and its environment, all have a part to play in controlling the cost of risk. In addition, new technologies, new methods, and extended job roles, all create new risk factors and opportunities for accidents and losses which could be avoided.

No-one is suggesting that health professionals have not, as individuals, been motivated to protect the interests of their patients and their hospitals.

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However, the record of clearly avoidable losses does highlight the fact that there is some missing ingredient. For example, in a list of the top ten categories of radiology 'incidents' intimated by members of one of the medical defence organizations over a two year period, management and supervisory issues were clearly evident: inadequate supervision of patients resulting in falls from tables during examinations and treatments; wrong preparation of barium meal; failure to inform patients of abnormalities on radiological examination; and administrative errors occurring in the production of x-ray reports.

The National Health Service has a special place in the hearts of the British public. It also seems to have a special place reserved for it in the British newspapers. No week goes by without a clinical blunder or hospital management crisis being highlighted. It is a major consumer of public money and a major employer in the U.K. economy. Political considerations aside, it is clear that the well-being of the NHS is of importance to *all* members of British society. Whether an NHS employee, a patient, a supplier of goods or services to the NHS taxpayers or non-taxpayers, all should take an interest in the NHS as *potential patients.* Even if we can afford private health care we still rely on the emergency and acute services provided by the NHS, as well as for care into old age.

The influence of privatisation and market testing was introduced to state healthcare in the U.K. in 1991 by the creation of an internal market separating the purchaser (the large regional health boards) from the providers (individual hospitals or small groups of hospitals known as NHS Trusts). At the same time the responsibility for medical malpractice of NHS doctors and dentists was shifted from the individual clinicians (and their insurers, the medical defence organizations) and on to the shoulders of the NHS Trust by whom they were employed (known as NHS Indemnity). In a separate development, the special legal status of hospitals whereby, essentially, they were immune from prosecution (Crown Immunity), was removed.

The creation of NHS Trusts and Crown Indemnity, and the withdrawal of Crown Immunity have acted as catalysts for the introduction of a structured approach to Risk Management, with new pressures applied to Trust Boards and Management to survive within their new budgets. Before Crown Indemnity, patients had to sue the individual doctors and dentists who would in turn be covered by their personal professional indemnity cover (offered in the U.K. by three different medical defence organiza-

tions). The introduction of NHS or Crown Indemnity means that the bill for doctor's and dentist's medical negligence must be met by the Trusts. Such is the concern in Trusts over this new and uncertain liability that, in England, they now have the opportunity to join the Clinical Negligence Scheme for Trusts, a mutual fund designed to spread the cost of individual member Trusts experiencing a particularly bad year. The withdrawal of Crown Immunity put the NHS in the same position as any other business in terms of compliance with fire and health and safety legislation and the threat of prosecution.

Trusts face a wide range of risks which threaten their assets and their ability to deliver a high quality, safe service to their patients. Such risks are all steadily increasing due to a range of factors including greater capital investment at risk, increasingly complex technology and procedures, and changing and extended roles of staff.

Cost of Negligence

The cost of risk represents money wasted from finite resources which could otherwise have been spent on patients. One aspect of the cost of risk is growing faster than any other, namely the cost of medical negligence claims, reaching £ 150 million in 1994/95 on a U.K. wide basis (having grown from a figure of £ 53 million back in 1990/91). The steadily rising cost of medical negligence claims was a major factor behind the creation of Trusts, with the object of encouraging the focus of control and responsibility at the relatively local level offered by the Trusts, compared to the previous and much broader based Health Boards. To be fair, the £ 150 m has to be seen against the perspective of the multi-billion pound NHS budget. But NHS Risk Management needs to address risk from all hazards, not just clinical hazards. Thus security, fire, pollution, employee health and safety and other risks also need to be identified, costed and controlled. Unfortunately, there is a lack of hard information on costs of non-clinical risk.

Structured Approach

The NHS Management Executive advocate the implementation of a structured approach to Risk Management to help achieve the Trust objective of a high quality service to patients. However, they do not seek to impose a blueprint on Trusts as to how they should implement it. This, coupled with the fact that Trusts were created over three years in four separate 'waves', means that the structure of Risk Management has developed in different ways through the many separate units which comprise the NHS.

A Questionnaire

In 1995 I sent a Questionnaire to all Trust Chief Executives. The questionnaire asked a range of questions including:-

Who (by job title and grade) in the Trust has day to day responsibility for:

1. Risk Management
2. Health and Safety
3. Fire Safety Management
4. Security

(respondents were then asked to indicate if one individual employee held more than one post)

What is the professional background and training of the individuals listed above? (e.g. finance, nursing, security, safety etc.)

Do you have a Risk Management Committee or Group?

(Respondents were then asked to list members of such groups by Job Title and Grade)

Do you have a formalised written Risk Management Policy or Mission Statement?

The questionnaire also asked for examples of risk control initiatives and for an indication of priority of concern currently attaching to specific area of risk. For this purpose I used the descriptions of areas of risk used in the publication 'Risk Management in the NHS' a manual commissioned by the NHS Management Executive and issued to all Trusts.

The Response

Out of the 450 questionnaires issued 115 completed forms were returned. By most standards this was a very good response rate but it was disappointing to note that a number of Trust Chief Executives wrote to say that they were either too busy or could see no value to themselves in arranging for the questionnaire to be completed.

I found that the largest single group (29%) of those charged with day to day responsibility for Risk Management had a background in NHS Management, including general administration and also estates management. The next largest (21%) had a Nursing background. There was significant representation from Finance (11%) but a lower than anticipated proportion from Health & Safety (10%). 76% of respondents had established a Risk Management Group or Committee. One third of the Risk Management Groups reported the involvement of outside consultants with a legal or insurance background in attendance at their meetings. Only 3% of respondents were Risk Managers with a

legal or insurance background.

Concern Areas

The area of risk which the respondents indicated as currently causing most concern was Fire (64% expressing High Concern), followed by Personal Security of Staff (63% expressing High Concern) and next communication between Staff (60% expressing High Concern). I had anticipated that Communication would be high on the list because of its relevance to the Clinical Risk problem but was surprised at the concern shown for Fire as we did anticipate that fire prevention activity would be regarded as a well established strength in the NHS. At the other end of the list of 17 separate areas of risk I found Information Systems and Information Technology (34% expressing High Concern) and Crisis Recovery Planning (32% expressing High Concern). Further enquiry will be necessary to establish the reasons for the greater levels of comfort with those areas. One Trust Risk Manager has suggested that in the case of Crisis Recovery Planning this could be attributed to the generally regular testing of some emergency plan, but that in the case of Information Systems and Information Technology it might be due to a failure to grasp the potential for loss from this rapidly developing area.

It would not be correct to infer that failure to return the questionnaire in any way implied that there was little in the way of formalised Risk Management structure in place. I was certainly impressed by the high level of interest and general willingness to talk as evidenced by the number of telephone calls made to discuss aspects of the survey.

Follow-up

Follow up visits to selected hospitals have confirmed the view that there is an immense range of risk management structures. Some now have embryo risk management groups but compete, with no special priority, against many other special projects. Some concede, with a little embarrassment, that in practical terms their risk management horizon does not extend beyond employee health and safety legislation and fire and security risks. On the other hand, one major teaching hospital aims to carry its reputation as a centre of excellence in the medical field into its approach to the recognition and management of risk. This is evidenced by the appointment of the Medical Director as the Lead Director, the appointment of a Risk Manager and formation of a cohesive risk management group.

Special Interest Group

While all NHS Trusts are different and the risk management strategy will grow in different Trusts in different ways, there are clearly benefits to be had by sharing the information and expertise which is gradually developing. In Scotland, NHS Trust risk managers have taken the first steps to set up a special interest group. Although still at the development stage, the aims of the group include:

- The exchange of information and ideas
- Cooperation in the development of documentation
- To advise the Trust Chief Officers Group and the NHS Management Executive on risk issues
- To identify best practice and share standards
- To identify training needs and stimulate or provide training and continued education.

I am convinced that as more information on risk and risk management is developed in the NHS it will lead naturally to an understanding that, particularly in such large organizations, the bottom line cost of risk centrally be identified and then controlled. Groups such as that being established in Scotland are part of that movement.

Why is it called a "building" when it is already built?

x——— x———x

Why do they call them "apartments" when they are all stuck together?

x——— x———x

Why is there an expiration date on SOUR cream?

x——— x———x

If you keep trying to prove Murphy's Law, will something keep going wrong?

x——— x———x

Why do flammable and inflammable mean the same thing?

x——— x———x

How can someone "draw a blank?

x——— x———x

Shouldn't there be a shorter word for "monosyllabic"/

x——— x———x

Why is the word " abbreviate" so long?

x——— x———x