Elizabeth Haxby
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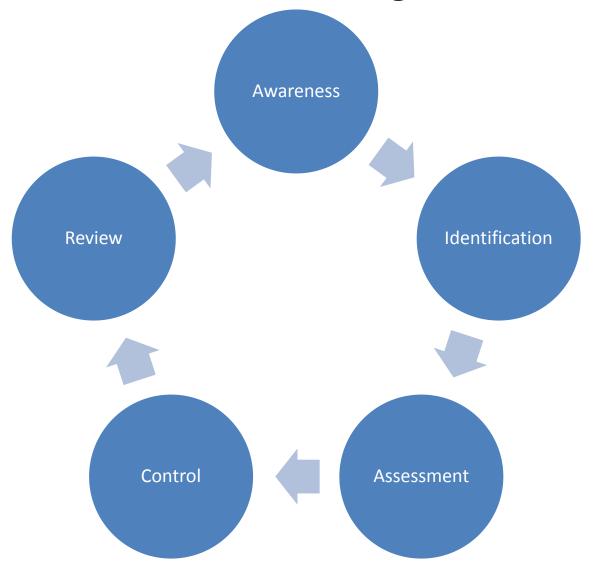
Health Authority Convention 2013
Hong Kong

# Francis Inquiry



A systematic process for the identification, analysis and control of actual and potential risks and their resource implications.

This will include risks to people, structure, reputation and any other issues which could impact upon or compromise the ability of the organisation to carry out its normal activities in a safe and effective manner



## Safety Culture

'A culture where staff have a constant and active awareness of the potential for things to go wrong. It is open and fair and encourages people to speak up about mistakes. In organisations with a safety culture people are able to learn about what is going wrong and put things right. It influences the overall vision, mission and goals of an organisation'

### Clinical Risk Identification

- Mortality
- Morbidity
- Incidents / SIs
- Complaints / Claims / Compliments
- EBM / reliability
- Competence
- Quality Indicators
  - Process
  - Outcome
- Staff wellbeing
- PROMs / PREMs
- Regulatory compliance
- Evidence based practice
- Risk assessments



### Clinical Risk Assessment



	Likelihood				
Consequence	1	2	3	4	5
	Rare	Unlikely	Possible	Likely	Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

Note: the above table can to be adapted to meet the needs of the individual trust.

For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

1–3 Low risk
4–6 Moderate risk
8–12 High risk
15–25 Extreme risk

# **Risk Scoring Matrix**

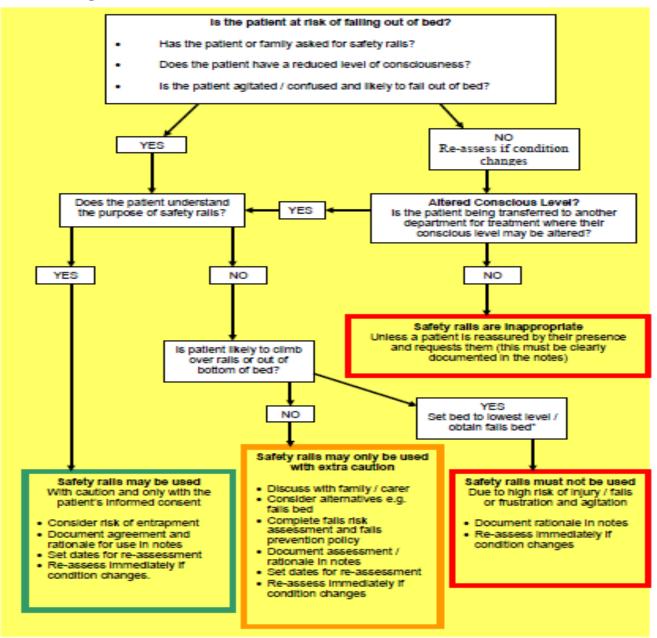
Catastrophic = 5					
	5	10	15	20	25
Major = 4	4	8	12	16	20
Moderate = 3	3	6	9	12	15
Minor = 2	2	4	6	8	10
None = 1	1	2	3	4	5
Severity	Rare = 1	Unlikely =2	Possible =3	Likely = 4	Certain = 5
	Likelihood -				-

Risk Rating Score	Level	Action Level
1-3	Very Low Risk	Accept Risk. To be managed by local management.
4-10	Low Risk	Address Risk: To be managed by local management.
11 - 16	Medium Risk	Management action required to reduce risk level to low risk level.
17 -25	High risk	Significant Risk. Board Level Action/Awareness required

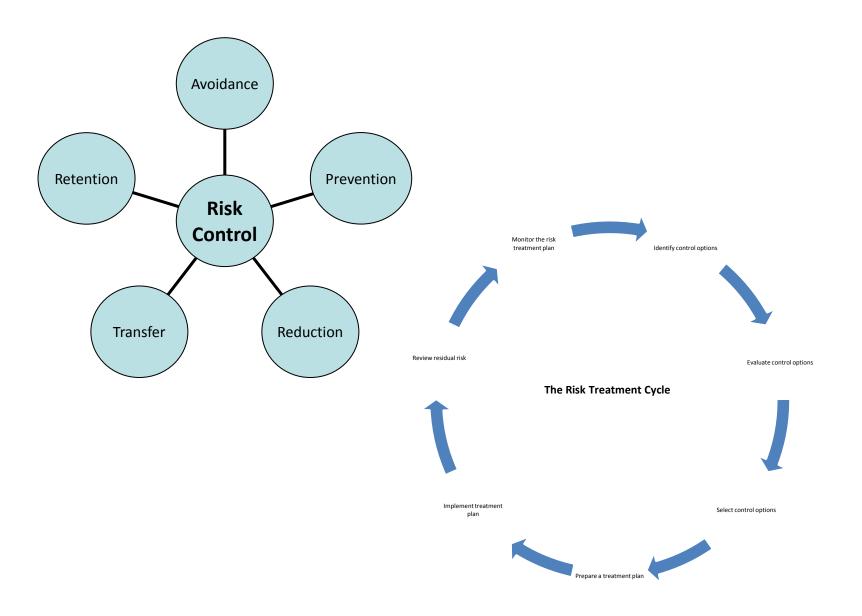
Likelihood	Description
Almost Certain	Will undoubtedly recur, possibly frequently
Likely	Will probably recur but is not a persistent issue
Possible	May recur occasionally
Unlikely	Do not expect it to happen again but is possible
Rare	Can't believe that this will ever happen again

For description of severity grading for differing types of risk, please see Appendix B, overleaf

### Safety rails flowchart – Assessment of immediate risk



### **Risk Control**



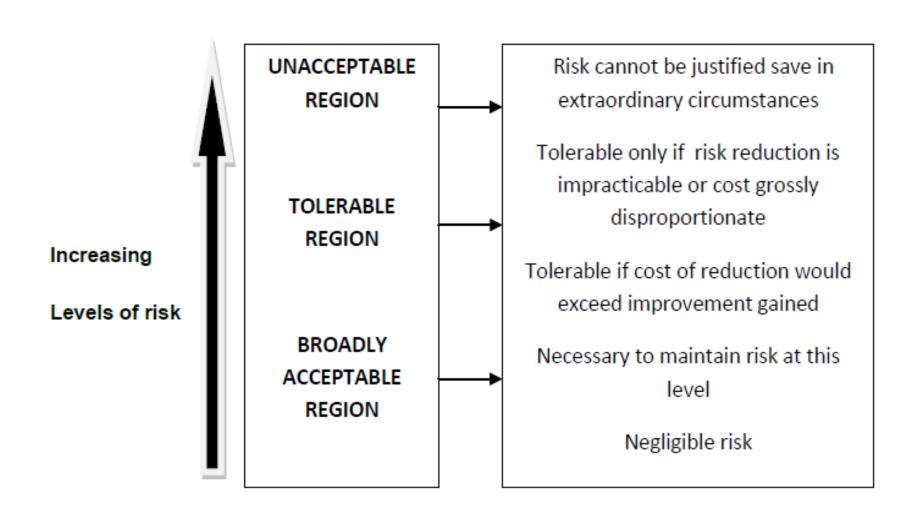
Hierarchy of controls



## Risk Review

Objectives	The link between strategic objectives and key risks for more major risks		
Description of specific risk	This may be a simple phrase to describe the risk or a more detailed and complete description		
Location	Where in the organisation this particular risk is an issue		
Risk rating ( likelihood x consequence)	Colour coding is used to group risks into general categories of risk and then within these risks may be ranked by number to allow more specific focus (see chapter 4 risk assessment) on significant risks		
Lead individual / department	Risk must be assigned to a lead individual or department who 'owns' the risk and is responsible for ensuring that the risk is monitored and mitigated or controlled		
Existing Controls	This describes what is currently in place to reduce the risk		
Action / treatment plans	This describes what resources are required to mitigate the risk to an acceptable level. IT may include a target risk rating which is the overall aim and level which would be considered acceptable		
Sources of assurance	How the organisation will be assured that the controls / treatments in place are effective		
Dates	The timeframes for implementation of any new controls and for review of the existing levels of risk		
Cost-benefit analysis	To demonstrate that the controls are cost effective . This may guide the approach taken if more than one solution is possible		
Acceptance / Completion	Necessary to show which risks are still active or have been accepted at the current level or closed		
Comments	For supplementary information such as relevant policies or dates of meetings at which a particular risk was discussed.		

## Risk Tolerability



## High Reliability Organisation

- Systems that recognise the cost of failure and benefits of reliability
- Actively seek to know what they don't know
- Make knowledge related to a problem available to all staff
- Learn quickly and efficiently
- Train staff to respond to abnormalities
- Empower staff to act



HRO expects its organisation and its sub-systems to fail and works hard to avoid failure while preparing for the inevitable in order to minimise the impact of failure

## Reliability

- Current improvement methods are highly dependent on vigilance and hard work
- Permissive clinical autonomy creates and allows wide performance margins
- The use of deliberate designs to achieve articulated reliability goals seldom occurs

NAME OF THE OWNER, AND DESCRIPTION OF THE OWNER, WHERE DODGE HE

### SPECIAL ARTICLE

### The Quality of Health Care Delivered to Adults in the United States

Elkabeth A. McGlyan, Ph.D., Steven M. Aach, M.D., M.P.H., John Adams, Ph.D., Joan Keesey, B.A., Jenn Fer Hidde, M.P.H., Ph.D., Allson DeCristofaro, M.P.H., and Eve A. Kers, M.D., M.P.H.

### ARSTRACT

We have little systematic information about the estent to which standard processes insolved in health care — a keyelement of quality — are delivered in the United States.

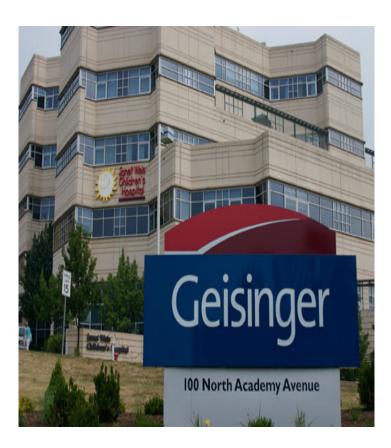
Wetelsphoned a random sample of adults living in 12 metropolitan areas in the United States and asked them about selected health care experiences. We also received written consent to copy their medical records for the most recentive o-year period and used this information to evaluate performance on 419 indicators of quality of care for 30 acute and chronic conditions as well as preventive care. We then constructed aggregates cores.

Participants received \$49 persent (95 persent confidence interval, \$4.3 to \$5.5) of recommended care. We found little difference among the proportion of recommended pro- Nilog | Net 2003 50 505 60. windse care provided (\$4.9 percent), the proportion of new mineraled acute care prosided (\$3.5 per cent), and the proportion of recommended care provided for chronic conditions (56.1 percent). Among different medical functions, adherence to the processas involved in care ranged from \$2.2 percent for screening to \$85 percent for follow-up care. Quality varied substantially according to the particular medical condition, ranging from 70.7 percent of recommended curve(95 percent confidence interval, 73, 3 to 84.2) for amile cutarast to 10.5 per cent of recommended care(95 percent confidence interval, 6.8 to 14.6) for also hel dependence.

The deficits we have identified in adherence to recommended processes for basic care pose serious through to the health of the American public. Strategies to reduce these defkits in caream warran ind.

Michigan, AnniArbor (E.A.K.). Address i print requests to Dr. McClerin at SAND, 17th Walin St., P.O. Scott 15th, Santa Wan

# Geisinger Healthcare



### PROVENCARE BY THE NUMBERS

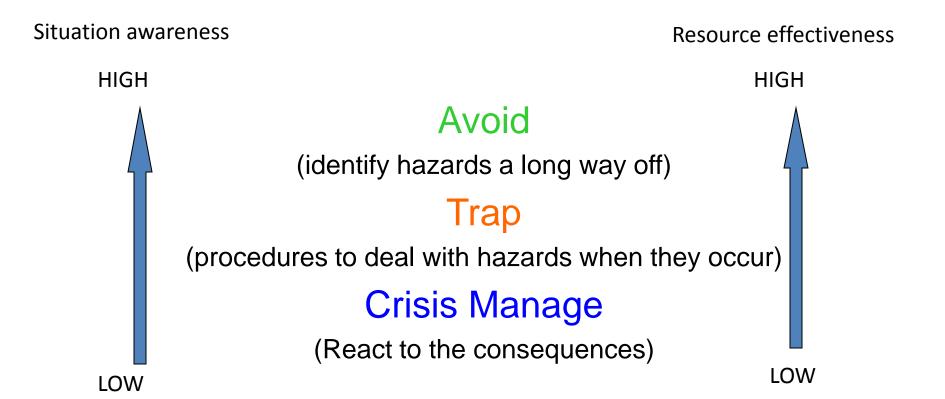
### ELECTIVE CORONARY ARTERY BYPASS GRAFT

Program went live: February 2006 Number of procedures in first year: 151

Percentage of patients eligible to participate: 34% (under Geisinger Health Plan)

Proven Care by the Numbers (16 months)	Before Proven Care	With Proven Care	% Improvement/ Reduction
Average total length of stay	6.2	5.7	
30-day readmission rate	6.9%	3.8%	44%
Patients w/ any complication	38%	30%	21%
Patients w/less than 1 complication	7.6%	5.5%	20%
Incidence of strial fibrillation	23%	19%	17%
Neurological complication	1.5%	0.6%	60%
Any pulmonary complication	7%	4%	43%
Blood products used	23%	18%	22%
Re-operation for bleeding	3.0%	1.7%	55%
Deep sternal wound infection	0.0%	0.6%	25%

# Plan for Safety



'Its fine to celebrate success but it is more important to heed to lessons of failure'

