

**Best practice benchmarking: risk
management and clinical
governance reorganisation
policies in the hospital setting**

Executive Summary



GOBIERNO
DE ESPAÑA

MINISTERIO
DE SANIDAD
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Plan de **Calidad**
para el Sistema Nacional
de Salud



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This study has been conducted by ANTARES Consulting through a contract with the Spanish Ministry of Health and Consumer Affairs.

This publication should be cited as: Best practice benchmarking: risk management and clinical governance reorganisation policies in the hospital setting. Executive summary. Madrid: Ministerio de Sanidad y Consumo; 2008.

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Ministerio de Sanidad y Consumo
Paseo del Prado, 18-20.
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January, 2008

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1 Introduction and background

Since the “To Err is Human” report was published in 1999, patient safety and risk management have been a central theme of healthcare policies worldwide. Publication of the number and severity of healthcare-related adverse events has attracted the attention of:

- The public, who demands greater transparency of the real risks.
- Healthcare providers, who are taking more and more steps (via protocols, regulations, etc.) to contain these risks, a development which, paradoxically, has facilitated the work of petitioning lawyers.
- Politicians around the world who draw up measures and objectives and conduct global campaigns (World Health Organization, European Health Committee, inter alia).

Against this background, hospital risk management structures and guidelines as well as a coherent reorganisation of the hospital governance structures should be understood not only as support measures but also as a means of ensuring that initiatives or solutions designed to optimise patient safety are launched and implemented.

In Spain, the high degree of variability of clinical healthcare and risk control quality, in light of the decentralised nature of the Spanish national health system, makes it difficult for best practice to be identified and initiatives shared.

For this reason, the SNS Quality Agency, in keeping with Strategy 8 of the SNS Quality Programme (improve safety for patients in Spanish healthcare institutions), has conducted a best practice benchmark study on risk management and clinical governance in the hospital setting and a workshop with key professionals in Spain’s hospitals and central organisations.

2 Objectives

The study is based on the analysis of the published experience of hospitals in the United States, the United Kingdom and France, aiming to identify and compare:

- Experience and best practice developed and specifically applied in the hospital setting designed to facilitate, promote and/or ensure appropriate implementation of risk management in day-to-day working.
- Singular features, differences, similarities and trends in clinical governance reorganisation systems and policies designed to optimise risk management in the hospital setting.

The SNS Quality Agency, aware of the importance of contrasting the results obtained with the real situation in Spain's hospitals, organised a workshop of key professionals from the main hospitals, with the following specific objectives:

- Present the first version of a study entitled "Best practice benchmarking: risk management and clinical governance reorganisation policies in the hospital setting".
- Identify the factors behind the development of risk management and clinical governance reorganisation policies in Spain's hospitals and identify the main barriers to implementation.
- Identify the initiatives to be developed to promote risk management and clinical governance reorganisation.

3 Methodology

3.1 Benchmarking

Benchmarking may be defined as a systematic process of identifying, comparing and learning from best practice in other organisations, whether or not in the same sector, with systematic breakdown of the set of factors that determine their success.

There are four types of benchmarking; this study will focus on “functional or industrial benchmarking”:

Type of benchmarking	Application
Strategic benchmarking	Focused on organisations in other sectors. Aims to diagnose potential changes and trends in order to keep ahead.
Functional or “industrial” benchmarking	Focused on organisations in the same sector but in a different geographical market. Helps to improve organisations’ key processes, taking on best practice of those organisations which, after indepth search, are considered to have achieved excellence.
Results benchmarking	Allows organisations to measure the results of their processes or services against those of other organisations.
Competitive benchmarking	Focused on direct competitors. Aims to make specific comparisons between organisations.

The project was based on the analysis of the published experience of hospitals in the United States, the United Kingdom and France, excluding policies, programmes, recommendations and other types of interventions not implemented in hospitals or whose specific results cannot be classed as “best practice”.

The countries selected for benchmarking have similar economic and social profiles to Spain. However, they also have features that differentiate them from Spain, for example:

- In the United States, the national health system is mainly privately funded and the healthcare sector is treated similarly to other private sector service providers.
- In France the national health system is mainly publicly funded and the healthcare sector is treated as a very specific sector in which profitability is not a key variable.

In this context, some of the experience and best practice studied may have limited potential in the Spanish national health system.

Benchmarking is a very powerful tool but it has its limitations. In the context of this project, we focus on the experience and best practice that may be of interest in light of the characteristics of the Spanish national health system.

3.2 IDEF – *Integrated DEFinition*

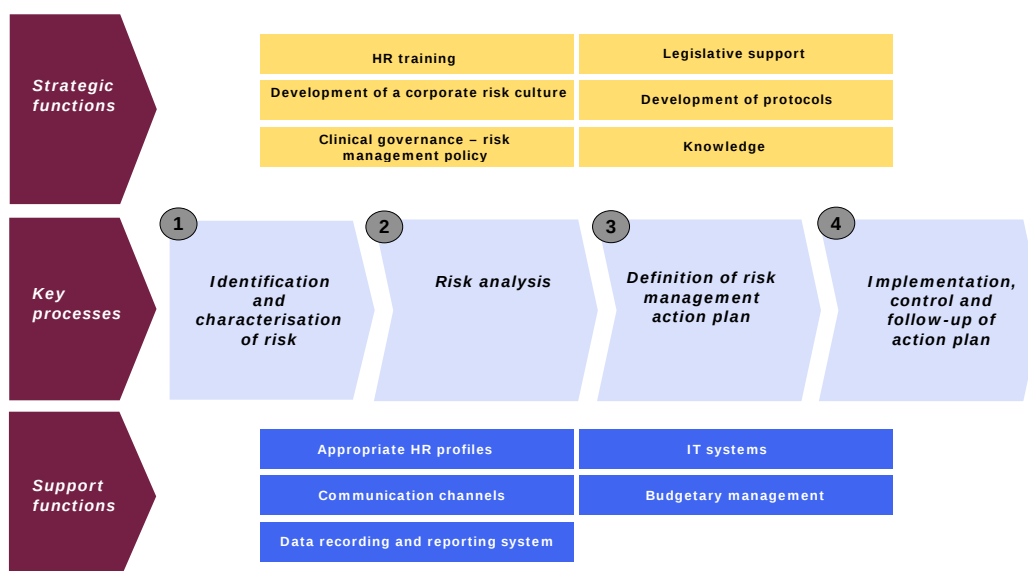
We base our benchmarking exercise on experience and best practice in the hospitals of the chosen countries on IDEF (*Integrated DEFinition*) methodology.

This methodology helps to integrate a company or organisation, via analysis, process simulation and modelling. It enables us to:

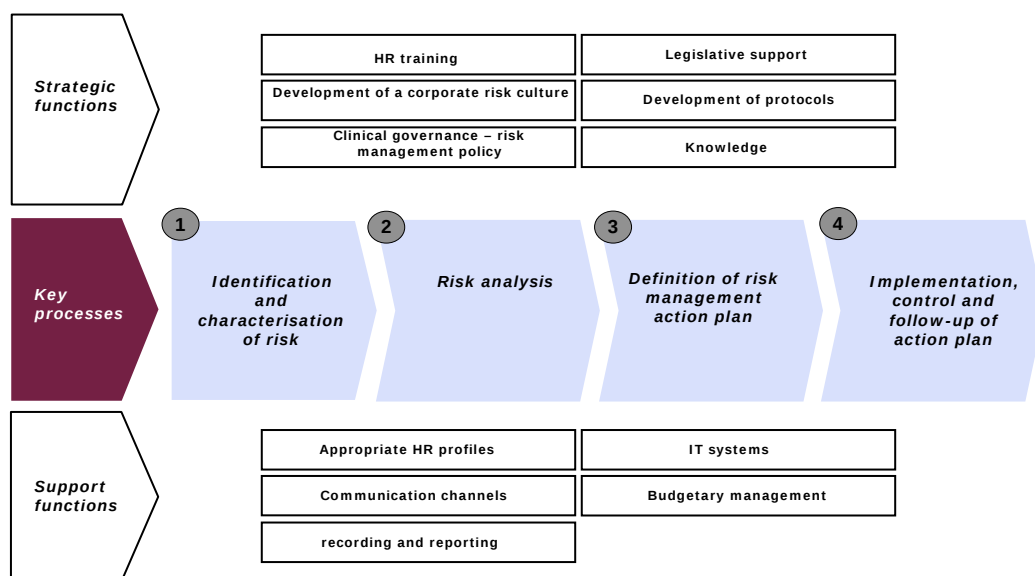
- Represent and analyse the activities of a company or organisation. Each process (key, strategic or support process) has a different magnitude and different problems, and should therefore be treated differently.
- Distinguish an organisation's value chain via reflection on its mission.
- Design (new or existing) processes, incorporating a comprehensive view of the entire process or activity.
- Diagnose the level of development of an organisation, including all its functions or activities, via representation on ideal and existing process maps.

Once designed, we used the theoretical “ideal” hospital risk management IDEF to analyse and compare experience and best practice in the countries chosen for benchmarking, identifying best practice and experience for each IDEF (key, strategic or support) process.

Hospital risk management: theoretical “ideal” IDEF

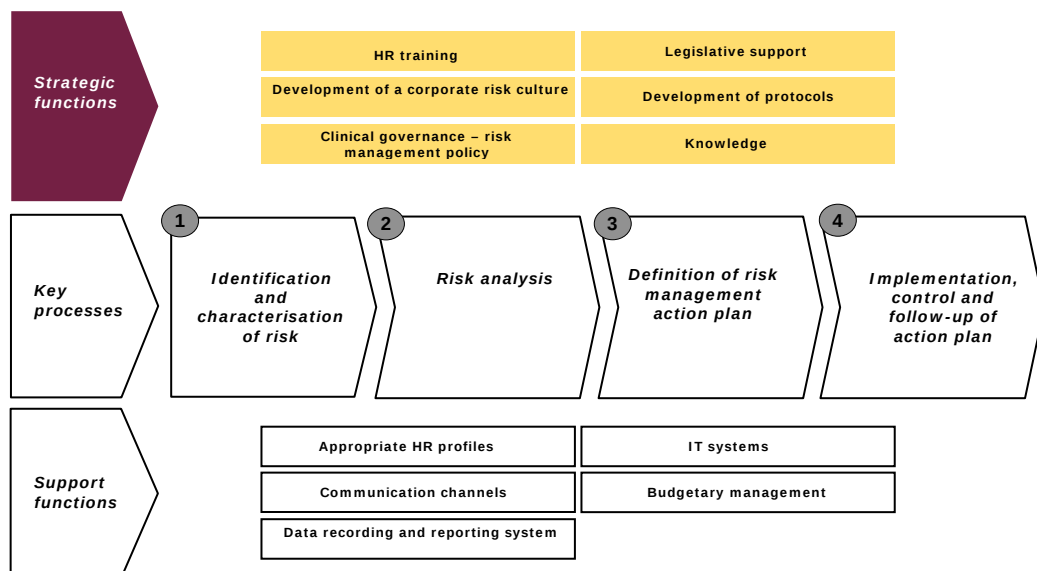


Hospital risk management: definition of key processes of theoretical “ideal” IDEF



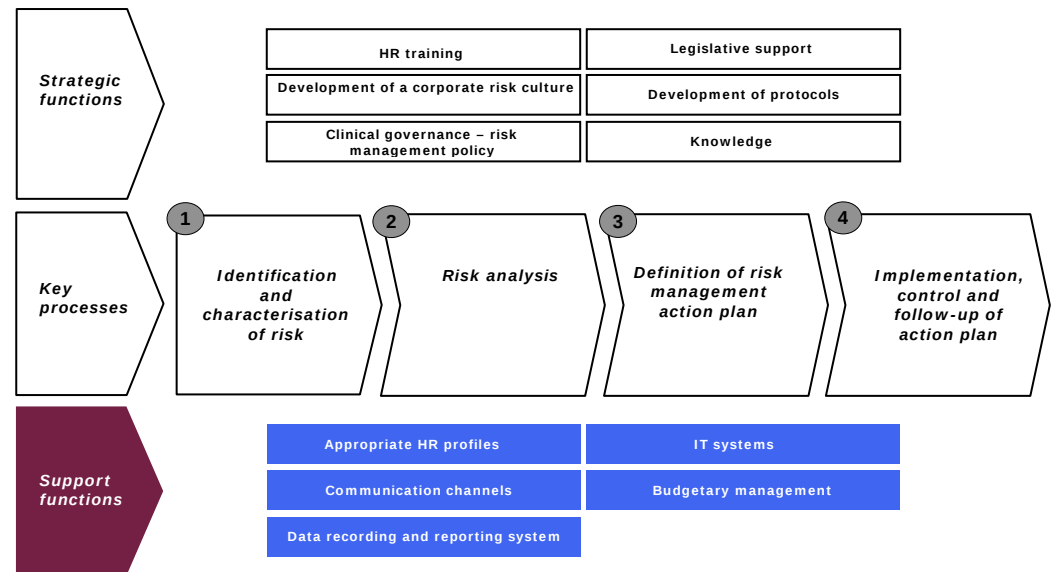
Key processes	Definition
Identification and characterisation of risk	Precise identification and characterisation of hospital risks: type (care- or environment-related), location (department, unit, building, etc.), severity (low, medium or high), etc.
Risk analysis	Detailed analysis of hospital risks, to identify their causes, assess their potential impact and establish an order of priority by impact.
Definition of risk management action plan	Definition of a detailed action plan to eliminate or at least reduce hospital risks. To contain: specific objectives, specific actions, timetable, responsibilities of persons involved, etc.
Implementation and follow-up of action plan	Implementation of action plan defined and follow-up of achievement of objectives defined via use of indicators.

Hospital risk management: definition of strategic functions of theoretical “ideal” IDEF



Strategic functions	Definition
HR training	Initial training (for medical students) and continued training for the organisation's healthcare providers, in addition to training of hospital risk management experts.
Development of corporate risk culture	Development within the hospital of a strong corporate risk management culture, defined by good acceptance of change, firm commitment and error acceptance by healthcare professionals. This kind of risk culture is found, for example, in the air traffic and nuclear power industries.
Clinical governance: risk management policy	Development of a hospital risk management policy (which may be included within the framework of Clinical Governance) including: corporate objectives, management bodies and managers, levels of confidentiality, communication policies, disciplinary measures and psychological handling of errors, incentives, etc.
Legislative support	The backing of an internal or external body to handle legislative issues relating to hospital risks: handling of patient complaints and claims, evaluation of plans of action, etc.
Development of protocols	Development of protocols to improve healthcare quality and thus eliminate or at least reduce hospital risks.
Knowledge	Development of a knowledge base to enable healthcare professionals to acquire knowledge and improve the quality of their work. Information on best practice in healthcare, new medical techniques, etc.

Hospital risk management: definition of support functions of theoretical “ideal” IDEF



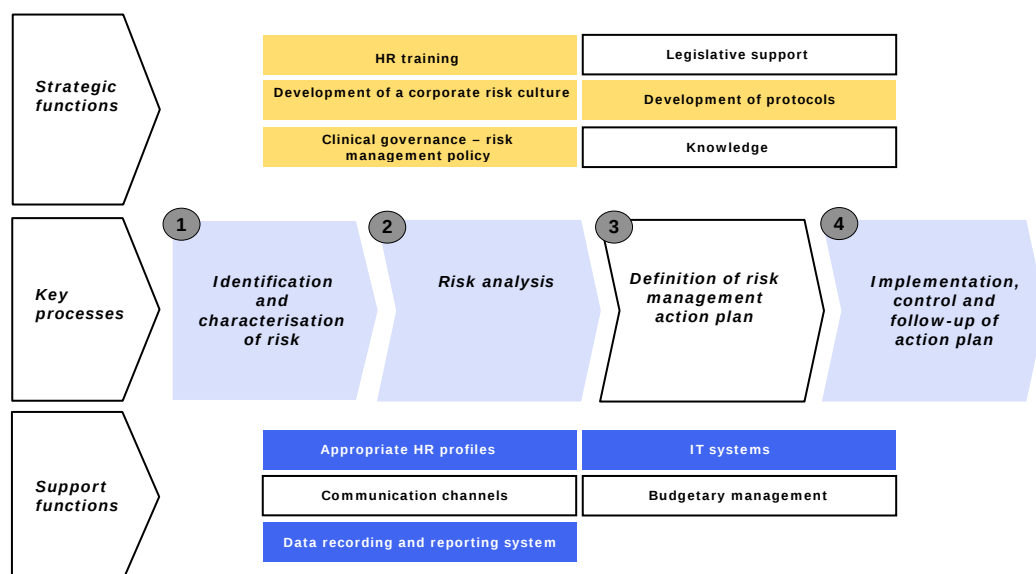
Support functions	Definition
Data recording and reporting system	Definition of a reporting system that will record all the relevant data and pass it on to the persons responsible for hospital risk management, to enable them to correctly implement and follow up all action plans.
Communication channels	Handling of hospital risk management related communication: internal communication with healthcare professionals (measures taken, objectives, areas for improvement, etc.), and external communication with patients, the public and the media (transparency of results, improvements, etc.).
IT systems	Implementation of an IT system that ensures that hospital risk management data are stored and are accessible and that constitutes a basis for identification and analysis of hospital risks.
Appropriate HR profiles	Definition of an appropriate profile for each position, to ensure that the capabilities and experience of each healthcare professional match their responsibilities in the organisation.
Budgetary management	Management of necessary budget for hospital risk management. Funding of necessary structures to ensure that risk management is performed and action plans undertaken.

The theoretical “ideal” IDEF serves as a basis for benchmarking of experience and best practice in the hospitals of the countries chosen. However, reliable publications on experience or best practice are not available for each of the four key processes, six strategic functions and five support functions.

Accordingly, we concentrated on the following:

- Three key processes, four strategic functions and three support functions on which reliable published information is available in the chosen countries.

- The “Clinical governance: risk management policy” strategic function which is the central theme of the benchmarking project.



4 Results

Benchmarking of best practice in risk management in the hospitals studied enabled us to identify three key variables in the development and implementation of risk management policies:

- 1. Cause:** in many cases, development of a genuine risk management policy or culture in the hospitals studied was connected with a specific event, i.e. an incident or accident, new hospital management, increase in average length of stay, increase in demand, etc.
- 2. Barriers** found in the hospitals studied: acceptance of change (reporting, supervision, multidisciplinary work, protocols, etc.) by healthcare professionals (doctors, nurses, etc.), cost of measures implemented, inter alia.
- 3. Lessons** learned in the hospitals studied: setting of short-term objectives and celebration of their achievement, etc.

4.1 Causes

In almost all the hospitals studied, risk management policies were developed in connection with specific events.

International publication of the US report entitled “To Err is Human: Building a Safer Health System” was the key driving force behind the development of risk management policies in the hospitals studied. This report contained evidence demonstrating the high number of medical errors that occur in hospitals and the consequences of these errors; the report had a decisive impact on quality perceptions of both patients and healthcare professionals.

Four other key events behind the development of risk management policies in the hospitals studied were also identified:

- Medical errors resulting in death, reported in the local, regional and national press.
- Appointment of a new manager highly committed to risk management.
- A negative trend in certain quality indicators, chiefly average length of stay and readmission.
- Decrease in a hospital's market share and level of activity.

Development and implementation of an efficient hospital risk management policy cannot be based solely on political will; it also requires a combination of internal and/or external factors to motivate healthcare professionals in this respect.

4.2 Barriers

At the implementation stage, hospitals may face many kinds of barriers to risk management policies, but there are three types of “universal” barriers that the great majority of hospitals face:

1. Rejection of change by doctors and nursing staff

Doctors generally believe that new protocols are too “mechanical” and that they do not allow them to use their experience and personal judgment. In their view, this compromises patient safety. However, in all the hospitals studied, the new protocols introduced led to an improvement in quality- and safety-related results. The most common complaint expressed by nursing staff in connection with the introduction of new protocols is the increase in administrative work and bureaucracy.

To overcome both these barriers, hospitals can:

- o Designate lead doctors and nurses to motivate their colleagues.
- o Organise meetings/conferences to give healthcare professionals an opportunity to express their opinions.
- o Create new processes that form part of (rather than add to) existing practices.

2. Shortage of resources

Structural and organisational changes demand significant resources in terms of hirings, training sessions, IT acquisitions, etc.

These investments may seem reasonable when organisations are running a profit, but when they cease to do so or when activity levels decline, cost-cutting policies seem much more reasonable and much more essential than investment in structural and organisational changes.

Moreover, the results of investment in risk management are seen in the medium to long term and it is difficult to translate these results into financial terms. This generally makes these investments difficult to justify before administrative teams.

3. Difficulty of combining concentration on improvement initiatives with maintenance of high everyday quality levels

Introducing improvement initiatives in the field of risk management demands a high level of involvement by healthcare professionals; each time a new protocol is assessed and introduced a new problem arises that must be solved. But these same professionals must also maintain their quality standards in their everyday duties.

Accordingly, in practical terms it is difficult for healthcare professionals to commit to new initiatives whilst continuing to concentrate on other issues.

4.3 Lessons

Implementing a risk management policy is a complicated process, especially in cases in which there is no risk management culture. In the hospitals studied, five “universal” lessons were identified:

1. Set easy-to-achieve short-term objectives and celebrate their achievement

When a new improvement initiative is introduced, healthcare professionals should be able to see the results fast, to ensure that they remain motivated and committed to the initiatives.

- o Signposting, events, awards, newsletters, etc., can be used to communicate the efforts made to introduce the risk management related initiatives and the results obtained.
- o Doctors are generally motivated by peer result comparisons.

2. Involve healthcare professionals in identification of risk and determination of improvement initiatives

In order to commit to the process, healthcare professionals need to know that their opinions count insofar as identification of risks and determination of improvement initiatives are concerned.

For this purpose, value must be afforded to their personal experience and all healthcare professionals involved, whatever their position, must be made to feel that they are playing an important part in the risk management improvement process.

3. Identify and support leaders and “champions”

Change requires the involvement not only of the persons responsible for managing change but also of “natural” leaders.

In this respect, a culture must be created in which all healthcare professionals are made to feel involved and in which any one of them may become a champion of quality improvements, thus permitting “natural” leaders to emerge.

4. Be patient

Once the necessary structures have been created and the necessary investment made, the end results will be some time in coming; risk management policies yield results in the medium to long term.

Accordingly, in addition to evaluation of the end results, mid-term evaluations of the improvements achieved should be made.

5. Establish a balance between quality objectives and financial objectives

Quality improvements require investment, but they will not necessarily result in cost cuts in the short term. For this reason, quality initiatives should not be assessed using financial models (business case models), but a balance should be established between quality improvements, cost improvements and corporate objectives.

Long term, quality improvements will result in higher market share, higher activity levels and enhanced profitability.

5 Conclusions

To compare the results obtained in the benchmarking study with the real situation in Spanish hospitals, and thus establish the direction for future measures, the SNS Quality Agency organised a workshop with key professionals from the main Spanish hospitals.

The workshop had two chief objectives which were successfully achieved thanks to specific facilitator techniques that ensured that all those attending played an active part. These objectives were:

- to identify the factors behind the development of risk management policies and clinical governance reorganisation in Spanish hospitals, as well as the key barriers to their introduction; and
- to identify the initiatives needed to promote risk management and clinical governance reorganisation.

The workshop was first divided into two groups, each of which was presented with a specific question. For one hour the groups reflected on their questions and noted down their responses on cards which were then used by the group spokespersons to present these reflections.

Reflections Group 1:

What are the key factors behind implementation of risk management policies in Spanish hospitals?	
Clinical governance factors	▪ Quality management responsible for risk management. ▪ Risk management assigned management functions. ▪ Communication of management commitment to clinical safety. ▪ Guidelines determined by clinical management units.
Development factors	▪ R&D strategies targeting patient safety. ▪ Introduction and dissemination of safety indicators. ▪ Safety guidelines targeting modifications or creation of structures. ▪ Promotion of self-assessment and comparison tools for hospital accreditation. ▪ Training in clinical safety tools.
Environment factors	▪ External recognition (society): safety commitment. ▪ Incentives via central organisation guidelines (management contracts).

Reflections Group 2:

What are the key barriers to implementation of risk management policies in Spanish hospitals?	
Culture barriers	▪ Error reporting associated with “guilt”. ▪ Punitive error culture. ▪ Poorly trained healthcare professionals (care providers and managers). ▪ “Bureaucracy” in risk identification and reporting. ▪ Concern regarding natural incorporation of patient safety into care process. ▪ Rejection of change.
Leadership barriers	▪ Action plans are proposed but not implemented. ▪ Pace of development differs between healthcare centres and Regional Health Authorities. ▪ Lack of management commitment. ▪ Total lack of receptiveness on part of healthcare professionals of any plans / programmes coming from management.
Process barriers	▪ Lack of global view of patient-oriented care process. ▪ Lack of risk prevention processes. ▪ Mapping of safety-oriented processes.
Tool kit barriers	▪ Lack of management tools to drive change (target-based management and variable remuneration systems). ▪ Lack of flexibility and confidentiality in reporting channels. ▪ Deficient communication channels: limited dissemination of strategic objectives. ▪ Few barriers to errors / adverse events.
Resource barriers	▪ Lack of human, material and economic resources. ▪ Medium-term investment. ▪ Economic problem not assuming “cost-effectiveness”.
Management / follow-up barriers	▪ Lack of information and/or communication.

Finally a plenary session was held at which initiatives to be developed for promotion of risk management and clinical governance reorganisation were identified.

The plenary session was organised as follows:

1. Each participant was given a card on which to note one initiative to be developed for promotion of risk management and clinical governance reorganisation.
2. All the initiatives proposed were presented to all the participants by the facilitator, with opportunity for discussion.
3. The initiatives were grouped into eight main themes.
4. Each participant voted the three groups of initiatives that they considered most important, thus prioritising the results and establishing a degree of consensus.

The following initiatives to be developed for promotion of risk management and clinical governance reorganisation were identified:

Evaluation / comparison (14 votes):

- ✓ Hospital recognition via risk management indicators.
- ✓ Self-assessment and comparison tools.
- ✓ Self-assessment and creation of safety benchmark standards.

Training / knowledge (10 votes):

- ✓ Training for healthcare professionals.
- ✓ Safety training.
- ✓ Dissemination of contrasted and comparable data.

Culture (8 votes):

- ✓ Raising awareness among healthcare professionals.
- ✓ Dissemination of clinical safety culture (from management down to patients).
- ✓ Conferences with associations.

Strategic programme (6 votes):

- ✓ Development of a strategic programme with specific objectives and follow-up indicators.
- ✓ Clinical safety indicators within a strategic programme.

Management tools (6 votes):

- ✓ Use of risk evaluation tools.
- ✓ Creation of a multidisciplinary working party to define, establish consensus on, disseminate, implement and evaluate the risk management process.

Regulatory issues (4 votes):

- ✓ Decriminalisation of adverse event reporting.
- ✓ Creation / pilot of “comprehensive management” programme.

Advisory services (2 votes):

- ✓ Hiring of advisory services for Primary Care management teams.

IT systems (1 vote):

- ✓ Electronic prescription.

6 Expert workshop participants

Participants in the expert workshop held on 26 November 2007:

- Cantero González, David. Technical Officer, Quality Subdirector, Central Organisation, Basque Regional Health Service (OSAKIDETZA).
- Caramés Bouzan, Jesús. Manager, Santiago Teaching Hospital Complex.
- Carreras Viñas, Mercedes. Quality Subdirector, Santiago Teaching Hospital Complex.
- de Miguel Montoya, Isabel. Quality Directorate General. Regional Health Authority.
- del Pozo Herranz, Purificación. Nursing Manager, Fuenlabrada Hospital.
- Delgado Ochando, Jesús. Nursing Manager, La Fe Teaching Hospital.
- Garí Parera, Jaume. Medical Director. Manacor Foundation Hospital.
- Gómez, Oscar. Area 6, Madrid Regional Government.
- Gómez Suárez, Ana. Preventive Medicine and Clinical Analysis, Albacete Teaching Hospital.
- Jurado, Juan José. Area 6, Madrid Regional Government.
- Lucas Imbernon, Javier. Quality Coordinator, Albacete Teaching Hospital.
- Martín Martínez, Jesús. Chairman Mortality Commission, Miguel Servet Hospital.
- Mata, Félix. Subdirector, Programme, Planning & Innovation Office, Balearic Islands Regional Health Authority.
- Morís, Cesar. Heart Clinical Management Area Director, Asturias Central Teaching Hospital.
- Morís, Joaquín. Cabueñas Hospital.
- Serrano Balazote, Pablo. Medical Director, Fuenlabrada Hospital.
- Torralba, Luís. Catalonia Regional Government.
- Valentín Delgado, José Julio. Nursing Manager, Virgen del Puerto Hospital, Plasencia.



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