Countering the biggest risk of all: attempting to govern uncertainty in healthcare management

Paul Moore
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Author: Paul Moore

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Foreword by Julian Hartley

I am delighted to have been asked to write this foreword for this important publication. Managing risk in healthcare settings is a complex and challenging task. My own experience as an NHS Chief Executive leading complex organisations, employing thousands of people engaged in thousands of different care interventions for patients has taught me that effective risk management must be embedded within and across the organisation. This is supported by a healthy culture which makes senior leaders and clinicians open to challenge and feedback and supports learning from mistakes at all levels. Difficult though it can be at times, Chief Executives and Boards should welcome and embrace difficult and inconvenient questions and constantly test the organisations’ openness to risk reporting and follow these up with effective action.

Paul Moore was our first Chief Risk Officer at the University Hospital of South Manchester NHS Foundation Trust. He reinvented and transformed the Trust’s approach to risk management in the wake of significant failures in MRSA, A&E and 18-week waiting time targets. Paul worked closely with the Board and myself to completely overhaul our risk management structure, reporting methods and processes. The contribution of this work to the rapid turnaround of the Trust was critical and it laid the foundations for a far more rigorous and reliable risk management approach across the whole organisation. This was validated for me when two Non-Executive Directors visited a ward and were able to hear the ward sister and her team describe their key risks, how they were assessed and what action was being taken to manage them. The embedding of risk management is central to its effectiveness and success.

Paul has set out a clear and compelling framework for risk management in this publication which combines his academic review with his real world experience of dealing with often seemingly intractable issues in a fast moving complex organisation, dedicated to the safe and effective treatment of patients. He poses some uncomfortable but essential questions for Boards and I would urge all Boards to embrace these as they improve and develop their management of risk in complex and challenging times.

Julian Hartley
Managing Director
NHS Improving Quality
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Introduction

Effective risk management is now the most pressing business issue of our time, but what can boards of NHS organisations do to govern risk effectively? From the Greek *kuberná* meaning ‘to steer’ (European Commission, n.d.), governance concerns the exercise of authority, direction, control and management (OED, 2002). It has been defined as the process by which “authority is conferred on rulers, by which they make the rules, and by which those rules are enforced and modified (World Bank, 2011: p1).” In this context governance concerns grip, and the term has a pervasive elasticity in so far as it is applied to almost everything that is subject to control: the organisation itself (corporate governance); research (research governance); or information (information governance) and so on. Clinical governance attempts to deal with uncertainty by managing risk and controlling outcomes, but it is conceptually ambiguous and thus far failed to halt serious service failure within the NHS following its inception.

I cite several examples of high-profile failures within the NHS because the risks that plagued them are emblematic of the challenges many healthcare providers increasingly face today. Research was undertaken to construct a conceptual framework for governing risk (Moore, 2012), part of which examined the practice of risk management in a selection of acute NHS providers subject to regulatory intervention. Moore (2012) identified features of organisational governance in common between cases; features from which boards can apply learning and enhance their capacity to keep risk under prudent control. The confluence of complexity, reduced visibility of risk and normalisation combine as conditions under which failure may flourish – conditions which can be readily found in most NHS organisations today. In those organisations subject to regulatory intervention Moore (2012) found a disassociation between corporate objectives and the operational reality at service level; these trusts struggled to identify their purpose and service level objectives and thus had difficulty identifying what risks could prevent the delivery of those critical goals.

I advance in this report a simple model for the governance of risk in healthcare settings, wherein it is proposed that effective assurance and resilience are dependent upon, or proportional to:

(i) clarity of organisational purpose and objectives;
(ii) effective treatment and monitoring of risk; and
(iii) robust accountability. Organisational culture and the behaviour of leaders also play a vital role in the development of good governance, as highlighted by Francis (2013a, 2013b, 2013c) and many others.

The Good Governance Institute (GGI) supports organisations to enhance their capacity to govern and control, but is increasingly asked what tools or techniques could be deployed to help boards protect their organisations against a broad set of high-consequence risks. This report enables the advancement of a new governance paradigm – a simplification, rationalisation and realignment of the basic elements of the clinical governance concept. Thus a new model is presented for countering the biggest risk of all – failing to make risk visible and failing to adapt to protect everything of value.

Overview of clinical governance

Since its inception the NHS has worked with an implicit notion of quality (Halligan & Donaldson, 2001). In recognition that there needed to be a realignment of priorities within the NHS, the drivers behind clinical governance were recognised as: (i) intolerable failings in standards of care at the Bristol Royal Infirmary between 1984–95 (Kennedy, 2001); (ii) the need to rebalance financial control, externally driven performance targets and remove elements of the quasi-market which came into effect during the 1980s; and (iii) to put quality at the heart of decision making by increasing clinical leadership in healthcare management (Donaldson, 1998; Scally & Donaldson, 1998). Clinical governance was the
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keystone of Labour’s first NHS white paper (DH, 1997); and from 1999 onwards promoted quality to a statutory requirement (Great Britain. The Health Act 1999, Section 18). Thus proponents heralded clinical governance as a powerful driver for safety and quality, liberating a disenfranchised medical profession and restoring the profession’s relationship with the state on clinical terms (Flynn, 2002; Donaldson, 1998; Halligan & Donaldson, 2001).

Power and mistrust

Miles et al (2000) contest the underlying assumptions of clinical governance and view the discourse of continuous quality improvement as incompatible with the centralised assurance-focussed style of management and accountability. The discourse of clinical governance extolls the redistribution of power in the hands of clinicians in return for greater transparency, accountability and responsibility. However, to some this appears illusory. In contrast to the anticipation of greater professional autonomy, the focus on abstracted issues such as risk, safety and quality as discrete work streams fails to appreciate the way clinical care is delivered, and encourages clinicians to disengage as they view clinical governance as a divergent management exercise organised around central control and accountability (Degeling et al, 2004). Flynn (2002) observed that “complexity, fragmentation and uncertainty all place severe pressure on individuals’ and groups’ capacity to collaborate and their willingness to trust others (p162);” thereby amplifying the underlying conflict of mistrust within a principal-agent paradigm (Fama & Jensen, 1983) and against which rituals of verification (Power, 1997) create bureaucratic safe havens; necessary as an extrinsic motivator to satisfy a Principal’s need for information during failure. At issue here is the precise understanding of what healthcare governance is and what it is not and whether it is capable of controlling healthcare?

Conceptual ambiguity

Clinical governance is a very broad conceptually challenging subject, which is difficult to contextualise. It was originally defined within the Department of Health’s white paper (DH, 1997) as a process to reduce inequality and variations from good practice (Para. 1.1.2); a framework for accountability (Paras. 3.2, 3.14) applying to all healthcare workers (Para. 3.9); a programme of quality improvement (Para. 3.27); a state of mind (Para. 3.27); and based on responsibility for one’s practice (Para. 3.42). The policy context is centred on reducing inequalities in clinical practice and variation between services achieved through standardisation and application of clinical evidence. The emphasis of clinical governance was strongly associated with verification: “a process by which each part of the NHS quality assures its clinical decisions (DH, 1998; Para. 1.16).”

Viewed as a way of addressing concerns and responding to high-profile failings of increasing seriousness, Scally & Donaldson (1998) define clinical governance as “a system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish (p62).” Swage (2000) considered clinical governance as an overarching umbrella concept under which “all aspects of quality can be gathered and continuously monitored (p4)… it is multi-faceted and multidisciplinary (p230).” Whichever way you look at it the concept is ambiguously defined. What becomes clear is that the scope, scale and ambition of clinical governance is all-encompassing, complicated, and incorporates a highly diverse set of organisational and inter-organisational controls. Flynn (2002) recognised that the “proliferation of mixed metaphors indicates an inherent ambiguity about the precise nature of clinical governance (p158).” Maynard (1999) concluded that there is no satisfactory definition of clinical governance, but to what extent would a lack of clarity inhibit the utilisation of theory into practice?
The continuation of serious failure

Donaldson (1998) anticipated that rigorous adoption of clinical governance would increase the resilience of the NHS and improve quality by preventing serious service failures. However, since the inception of clinical governance there has been a continuity of serious service failures transcending government administrations, often with catastrophic consequences for patients and antithetical to the notion of clinical governance. Some of the most notable events in the last decade have included:

- the trial, suicide and subsequent Public Inquiry into the murder of 15 patients by Hyde GP Harold Shipman (Smith, 2002);
- the failure to prevent a Consultant Gynaecologist struck off in Canada from practicing in the UK, who deliberately deceived his employers, cautioned over sexual misconduct and, by his own admission, over-reached himself in his clinical endeavours causing many women unnecessary trauma and suffering (DH, 2004);
- the conviction of Barbara Salisbury in 2004 on two counts of attempted murder after she tried to kill patients in order to free-up beds on the ward and achieve performance targets (Healthcare Commission, 2006);
- outbreaks of Clostridium difficile infection at the Maidstone and Tunbridge Wells NHS Trust (Healthcare Commission, 2007); and
- higher than expected inpatient mortality rates in non-elective admissions at the Mid Staffordshire NHS FT (Healthcare Commission, 2009; Francis, 2010; 2013a; 2013b; 2013c).

Despite Donaldson's (1998) aspiration, these events appear to demonstrate that clinical governance has been ineffectual at reducing the risk of serious failure. The key question here is whether serious service failure is a consequence of insufficient conceptual clarity underpinning clinical governance, or whether there is some other explanation such as the capacity to respond to uncertainty and control healthcare within the NHS? In my submission, even if the former were universally understood, it is unlikely, on its own, to prevent serious service failure. This is because simply understanding governance is not enough; as highlighted by CEO's in a recent Harvard Business Review study (Sonnenfeld, Kusin & Walton, 2013), boards need to understand the risk-reward envelope, refrain from rubber-stamp decision making and engage in energetic debate in the boardroom to promote understanding and adaptation. In other words, don’t shun risk or see it in personal terms; understand how to deal with uncertainty in order to protect everything of value.

Dealing with uncertainty

This leads us to consider how organisational risk is managed in the NHS, representing perhaps the single most important challenge of our time: how to address risks associated with the combined effects of a doubling of the population aged 80 or over in the UK by 2030 (ONS, 2009) with increasing capacity for medical intervention and the ability to maintain life; an increasing public expectation regarding service access and quality; rising healthcare costs; a rapidly decreasing financial resource to fund such interventions (Grint, 2010: p16); alongside a competitive and unstable operating environment promoted by the Government’s white paper (DH, 2010). Knowing exactly what healthcare governance is and how risk is utilised is therefore of paramount organisational importance.

Uncertainty has its origins in quantum theory. Quantum theory replaced certainty with probability (Obolensky, 2010), and proposed that the underlying reality of [almost] everything is uncertain. Uncertainty undermines deterministic properties of a governance paradigm. Risk is the effect of uncertainty on the entity’s objectives (BSI, 2008), and the approach to the management of risk is oligarchic. Donaldson’s (1998) application of clinical governance represents risk as a protectionist social construct, whose
properties seek to insulate the organisation and the patient from the harmful effects of uncertainty through standardisation and assurance. Within determinism risk management is a force which attempts to direct almost everything towards certainty; even if something is uncertain, the management response will be designed to minimise losses (Chapman, 2011) and convince others of the certainty of restoration and recovery. The plethora of standards, guidelines, policies, procedures and regulations (NHSLA, 2012a; CQC, 2010; DH, 2011a) all have deterministic properties and attempt to achieve a defined managed outcome by preventing an uncertain event from occurring.

We can deduce from the aforementioned NHS failings that failure appears to defeat control and it is therefore important for healthcare leaders to recognise that “disequilibrium and uncertainty are the essence of life itself (Obolensky, 2010: p99).” This suggests organisational survival is associated with the ability to anticipate the effect of uncertainty on objectives, and retain or develop the capacity to adapt in response to problems. Understanding the approach to risk management within organisations that have failed to govern effectively can assist in the development of a new theoretical framework for healthcare governance and organisational resilience.

A conceptual framework for the governance of risk

The centrepiece of the findings is a new, simplified conceptual framework for the governance of risk. Constructed by triangulating evidence from substantive literature review, documentary analysis, semi-structured interviews, and drawing on personal experience, the conceptual framework for the governance of risk is illustrated in Figure 1 below.

The framework asserts that effective assurance and resilience is proportional to, or dependent upon: (i) the extent of clarity of organisational purpose and objectives; (ii) the extent of risk identification, treatment and monitoring of risk; and (iii) robust accountability. No values are placed against the concepts as would be expected in the expression of a mathematical statement; this would require further research and development by evaluating the relative importance of each concept in order to assign a value as part of a diagnostic tool. To assist the reader, each element of the conceptual framework is briefly summarised below.

Figure 1: a model for the governance of risk in healthcare

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Assurance

The literature espouses a strong focus on assurance within a governance paradigm, yet it is surprisingly silent on a definition. Seminal publications simply do not explain what is meant by ‘assurance’ (DH, 2002; Bullivant, 2009; DH, 2003). It is seen as: “mapping the connections linking organisational objectives and risk (DH, 2002: p3);” “evidence that risks are managed and opportunities realised (Bullivant, 2009); a framework to give boards of directors confidence (Bullivant, 2009; DH 2003); and evidence against which boards can justify declarations (Audit Commission, 2009). Assurance is defined as “something said to make someone feel confident about something (OED, 2002: p39);” or put more succinctly in the words of one participant:

“the avoidance of doubt.”

Therefore, within the context of healthcare governance, one can understand assurance as the evidence which provides confidence that the organisation will or will not achieve its stated objectives. It is the difference between guessing and knowing.

Assurance Questions for boards:

1. If assurance is the avoidance of doubt, what is your board relying on to demonstrate beyond doubt that is has capacity to handle risk?
2. How confident are you that a problem that could give rise to regulatory intervention or serious failure is visible in your Board Assurance Framework? What gives you confidence on this?
3. Would you say there are blind spots in your knowledge about safety, performance or quality?
4. How do you know that recommendations following serious incidents are implemented?

Resilience

As a conceptual property of this model, resilience was incorporated on the basis of the author’s experience and trawling specialist literature. It is notable that both the substantive reviews and interviews were silent on this concept. Organisational resilience is considered to be “the degree of flexibility of an organisation’s culture to recover from and respond to change (Chapman, 2012: p11).” It concerns the extent of adaptive capacity in so far as it represents the ability of the organisation to continue to achieve objectives when risks materialise. Bullivant (2009: p3) recognised that things go wrong but organisations will be judged by “how quickly we say sorry and act to put it right.” Resilient performance is dependent upon the extent to which disabling risks have been identified and prepared for (Lee, Preston & Green, 2012; Weick & Sutcliffe, 2007). This model assumes that assurance and resilience are proportional to or dependent upon the following concepts.

Resilience Questions for boards:

5. How adaptable is your organisation – what’s the next crisis to hit your trust and are you prepared to deal with it?
6. Can you describe the High-Impact Low-Probability events that could destabilise service delivery, and are these events managed within your appetite for taking risk?
Organisational purpose and objectives

The substantive reviews were relatively silent on organisational purpose and objectives, representing a gap in the literature, but their importance emerged from the interviews and specialist literature. The Audit Commission (2009) recognised that few NHS trusts had a manageable number of clear strategic objectives; this concurs with the Author’s experience and interview findings that corporate objectives are largely abstracted aspirations sometimes disassociated from operational reality. Organisational purpose “is what leads to an underlying meaning in day-to-day activities (Obolensky, 2010: p104).” Clarity of purpose and objectives connects people to the activities which manage risk thereby adding value by driving the achievement of stated goals and enabling resilient performance.

Foundation trusts are required to provide within the Annual Governance Statement a description of how risk appetites are determined (Monitor, 2012a). The substantive reviews and interviews were completely silent on the concepts of ‘risk appetite’ and ‘risk tolerance’. To understand this it was necessary to turn to the specialist literature. Risk appetite is the “amount of risk, on a broad level, an organisation is willing to accept in pursuit of value (Rittenberg & Martens, 2012; p1).” Risk tolerance, however, is subtly different in that it represents the application of risk appetite to specific objectives and refers to the “acceptable level of variation relative to achievement of a specific objective (COSO, 2004: p20).” In other words, risk appetite is how much risk you want, whilst risk tolerance is how much risk you can live with. There literature is agreed that risk appetite and tolerance are associated with organisational objectives (Rittenberg & Martens, 2012; COSO, 2004).

The concepts of risk, control and monitoring that follow are expressed within parenthesis to represent a difference between corporate and operational management; corporate management providing leadership, guidance and driving accountability, whilst the operational management function is where specific actions are taken to actively manage risks involved in the delivery of healthcare. To assist understanding, it was considered important to make that distinction within the model.

Organisational Purpose and Objectives – Questions for boards:

7. Can you define the purpose of your organisation? What gives underlying meaning to healthcare activities in your organisation?
8. How do you know that there is clarity of purpose and objectives from board to ward?

Risk

Risk management was directly identified in four substantive reviews (Scally & Donaldson, 1998; Flynn, 2002; Som 2004; Freeman & Walshe, 2004). Understood as the effect of uncertainty on objectives (BSI, 2008), organisations need to recognise “what drives the creation of value and what destroys it (Chapman, 2011: p4).” Risk could be understood as what is or could stop an organisation from achieving its stated goals and expressed in those terms within risk registers. Reducing the harmful impact of risk or maximising opportunity is achieved through control (Chapman, 2011; COSO, 2004, BSI, 2008). Within the model the relationship between risk and control is shown as a dividing line to illustrate the assumed positive impact of control on the risk.
Critical Questions on Risk for boards:

9. Do you have a clear view on what will drive the creation of value at your trust over the next five years, and what could destroy it?

10. How do you make risk visible to your board, regulators and stakeholders – do board members understand your risk exposure?

11. How do you bring broad, relevant knowledge regarding risk to the boardroom table?

Control

Control refers to the “responses and specific action plans to address the risk and opportunities identified to secure the business objectives (Chapman, 2011: p223).” Occasionally referred to as ‘treatment’ (BSI, 2008), control was a dominant concept in all substantive reviews, but limited within interview data. Control takes many forms; however, triangulation of data reveals a propensity to rely on people, paper, education or training as the main controls for managing risk associated with healthcare delivery. Prominent controls cited included: (i) standardisation of clinical treatments through national standards or guidelines utilising clinical evidence (Som, 2004; 2009; Degeling et al, 2004; Flynn, 2002, Halligan & Donaldson, 2001; Scally & Donaldson, 1998); (ii) arrangements for tackling poor performance (Som, 2004; Halligan & Donaldson, 2001; Scally & Donaldson, 1998); (iii) policies, procedures and protocols (Som, 2004; Freeman & Walshe, 2004; Flynn, 2002; Halligan & Donaldson, 2001); (iv) clinical pathways or patient flow control (Degeling et al, 2004); (v) organisational structure (Freeman & Walshe, 2004); (vi) organisational culture (Marshall et al, 2002; Freeman & Walshe, 2004; Scally & Donaldson, 1998); and (vii) education or training (Som, 2004; 2009).

Critical Questions on Control for boards:

12. What are you relying on to control healthcare – are your controls sufficient to ensure care is safe and risk kept under prudent control?

13. What are you relying on to ensure essential standards are met?

14. How do you make sure colleagues know about these controls and apply them?

15. Do you know who is in control of all your undertakings (i.e. PFI partners, shared services)?

Monitoring the operation of controls

The measurement of performance or clinical indicators was a prominent consideration in the substantive reviews. However, the reviews suggested clinical outcomes rather than compliance with controls ought to be the focus of monitoring or audit. Chapman (2011) views monitoring as critical to successful risk management, referring the reader to the link between control and monitoring: there is a “need to ensure responses to identified risks are implemented and that implementation is proactively managed (p233).” There’s some debate however about the value of measurement: should we measure outcomes or compliance? Som (2004; 2009) and Flynn (2002) suggest measurement should focus on outcomes, either clinical or operational, whereas Freeman & Walshe (2004) found this was amongst the least important of factors. Monitoring outcomes alone is not sufficient for effective risk management, organisations need to monitor both outcomes and compliance with controls in order to rapidly understand which controls have delivered or failed, and how they have enabled success or failure.
Accountability

Accountability was identified in all papers selected for substantive review, although none defined the concept explicitly. Accountability itself tended to be viewed as a process discharged through an accountable officer or from clinicians to management (Scally & Donaldson, 1998; Som, 2004); from management to the public (Halligan & Donaldson, 2001); from the board to the public, regulators or government (Flynn, 2002); or was viewed as a structural construct delivered via committee oversight (Freeman & Walshe, 2004). Some commentators noted the negative connotations associated with accountability viewing accountability as disciplinary, a form of institutional control eroding clinical freedoms (Degeling et al., 2004; Flynn, 2002). Degeling et al. (2004) viewed clinical autonomy a prerequisite to effective accountability.

Accountability was largely recognised by participants’ as a reactive process, usually initiated after a negative outcome. It was strongly associated with an appearance before one's peers and leaders. However, Participants’ didn’t appear to recognise that accountability is increasingly discharged proactively through assured declarations or self-certifications (Audit Commission, 2009; Monitor, 2012b), reflecting a trend towards high-trust light-touch risk-based approach to regulation common in banking prior to the 2008 global financial crisis (Lanchester, 2010).

I see accountability as an essential component of effective governance. Accountability disrupts normalisation, can help express expectations and play an important role in developing organisational culture.

Features of organisational governance in common in failing NHS trusts

To consider what features of organisational governance were in common between cases, data were triangulated to reveal any similarities. Triangulation highlighted many more differences than similarities, reflecting local geography, organisational culture, local or regional patient needs and priorities. However, there were some important similarities between cases as follows:

Critical Questions on Accountability for boards:

19. How are people being held to account for safety, quality and control?
20. Are clinical teams asked to explain and justify their clinical results – how do you know?
21. How do you ensure accountability drives improvement in safety, quality and patient experience?
22. How do you disrupt normalisation?

Critical Questions on Monitoring Control for boards:

16. How does your board know that controls are effective?
17. How are gaps in control brought to the attention of your board?
18. How do you ensure your trust has capacity to monitor the operation of priority controls?
• Risk Registers and BAFs did not reveal the issue ahead of regulatory intervention;
• Risk Registers and BAF’s were viewed as bureaucratic, complex, overwhelming, non-value-added and difficult for boards to utilise effectively. Consequently the visibility of risk within the BAF was reduced, and boards did not prioritise sufficient time to review Risk Registers and BAFs;
• the relationship between risk and the impact on objectives was unclear, and controls were ambiguous, poorly specified or confused with future actions within Risk Registers;
• risk management operated in a corporate vacuum, remote and disconnected from operational teams;
• the approach to risk appeared reactive with no obvious recognition or documented analysis of High-Impact Low Probability events;
• assurance tended to focus on sources of assurance rather than outcomes of assurance, and was not directly focussed on the operation of controls;
• the Head of Internal Audit opinion on the BAF provided significant assurance prior to regulatory intervention;
• there was a gap in understanding between the board and operational teams in respect of organisational purpose and objectives prior to regulatory intervention; and
• the majority of staff employed by the index organisations [range: 76%–81%] did not report good communication between senior management and staff within the annual staff survey.

Complexity, blindness and normalisation

The confluence of complexity, organisational blindness and normalisation appears to create the conditions for governance failure. The complexity associated with the development and utilisation of BAFs was a dominant finding from documentary and interview data. Cases in this study struggled to comprehend and deal with a BAF in a productive way. If we accept the suggestion in the literature that the purpose of the BAF is to provide confidence by setting out assurances on the operation of controls, the sheer complexity involved in articulating and verifying the effectiveness of all relevant controls in a multi-million pound, highly-diverse, human orientated business appeared to produce voluminous documents lacking clarity and credibility. BAFs appeared to provide little or no value to the board’s endeavours and rather than providing assurance or reveal gaps, the opposite was found in that BAFs were insufficiently prepared, inadequately scrutinised and tended to accentuate positive assurances. This was considered an opportunity missed. Insufficient identification of risk, and assurance on the effectiveness of the operation of controls, resulted in the boards being completely unaware of risk, and unclear whether failure was consequential to insufficient control design or inadequate and unreliable implementation. Boards were not aware of the nature or extent of failure until the Regulator intervened and alerted them to it.

Objective analysis of board minutes indicated that boards set aside little time for dealing with the BAF. The desire to provide positive assurance, especially under external scrutiny, appeared to create the conditions for organisational blindness; these are blind spots that make it difficult to see and respond to risk. Blind spots were created by:

• producing documents so voluminous and detailed, yet at the same time lacking clarity, that boards could not visualize the material issues;
• failing to reveal the issues which eventually led to regulatory intervention; and
• the desire for positive assurance appeared to distort the profile of risk exposure as viewed from the board. The BAF’s appeared isomorphic and repetitive, conforming to an externally determined format and potentially giving rise to a lack of ownership or the risk of normalisation.
Normalisation refers to conditioning wherein repeated exposure to the same stimulus makes it less visible, as was the case of the management failure in the Challenger shuttle accident in 1986 (Vaughan, 1996). Normalisation is a powerful yet often underestimated influence on healthcare safety. Repeated exposure to inadequate or silent management responses to incident reports can become normalised and discourage reporting because ‘nothing ever changes’. Normalisation can also increase risk appetite without you realising. For example, if you experience consecutive near misses for the same type of event, such as failure to carry out safer surgery checks, this can become normalised to such an extent that people expect the next failure to be a near miss too; thus, consequential to becoming normalised, people may stop looking for a solution because they don’t expect an adverse impact to occur. Normalisation therefore leads to organisational blindness; these blind spots must be discovered and made visible in order to protect patients from failure.

**Objective disassociation**

The absence of consensus or clarity of organisational purpose and objectives beneath the board was a common feature of this study, creating the conditions wherein it was difficult to identify and make risk visible. If risk is understood as the effect of uncertainty on objectives (BSI, 2008), it is difficult to see how one could evaluate the impact of risk if the objective was ambiguous or not known? Objectives make intentions explicit.

**Culture**

The findings demonstrate that the properties of the model of governance (Figure 1) underestimate the importance of culture and leadership. As an anthropological concept, organisational culture is difficult to define precisely, but is understood as “how things are done around here (Mullins, 2010: p739) when nobody is looking (Hart, 2013)”; it reflects the underlying attitudes, beliefs and behaviours about the execution of work (Atkinson, 1990). Culture is an extremely important dimension linking success to effective leadership and common values.

The culture in those cases studied could be characterised as looking upwards towards a hierarchy of authority – waiting for instruction from the top and, in a post-intervention context, gave emphasis to the design and planning of assurance through structures and definition of individual duties and responsibilities. GGI believes errors are normal and everyone, no matter how accomplished or experienced, will be involved in errors from time to time. Where safety is concerned, GGI strongly encourage boards to give permission to their colleagues to fix it.
Critical Questions for boards:

23. GGI believes all trusts should adopt an ‘open and learning culture’ and that it’s OK to speak up. I use the phrase *If you see something, say something, make it safe and tell everyone about it.* What steps have your board taken to encourage people to speak up and talk about unsafe practices? When was the last time you publicly thanked someone for telling you something important about safety at your trust? Are there any barriers to communicating safety critical information at your trust?

24. How do you publicise and tell others what you have learned?

25. How do you trust people to make the right decisions?

26. How does your board avoid being too insular or remote?

27. **You will achieve the level of safety you demonstrate you want.** How does your board convey the level of safety it wants?

Bureaucracy

Bureaucracy is a form of control, but it can also provide a safe haven (Cloke & Goldsmith, 2002). The proliferation of assurance frameworks within the NHS, such as those used for authorisation as a NHS foundation trust or clinical commissioning group, need to be approached with great care and an inquisitive mind-set if they are not to create an illusion of order and control. It is a relatively small investment to make to do this well compared to the disruption associated with failure and regulatory intervention. Assurance frameworks must reflect reality however challenging this may be. Bureaucracy might create a safe haven for the board, a regulator, commissioner or government department, but it could equally propagate insecurity if complexity within your BAF is over-simplified and not understood or sufficiently challenged by an inquisitive board. Regulatory intervention is extremely disruptive and can distract leadership from achieving their goals; thus allowing competitors or other stakeholders to exploit the situation to their advantage. Proactive and effective risk management is therefore an essential tool for avoiding regulatory intervention or investigation that could prove so costly to the enterprise as a whole.

Bureaucracy can only add value if it usefully supports boardroom decisions that maximise opportunity and mitigate failure. GGI recognise that an assurance framework can be a powerful tool in promoting confidence, but further development is needed so that these frameworks are capable of picking up on the entity’s informal intelligence, effectiveness of communications, and the extent of adaptive capacity to respond effectively to problems.

Dealing with the unexpected

The absence of resilience from the substantive reviews and interviews is an incredible finding. It implies in practice there is no link between governance and resilience. What is the purpose of governance if it is not to promote the interests of the organisation? Would understanding the risks and dealing with them in a way that facilitates the achievement of objectives, no matter what goes wrong, not promote business interests by protecting what is most valuable to the organisation? This finding suggests risk management was approached as a bureaucratic process; poorly executed and not regarded as proactive nor a value-adding business tool. This is not to say continuity planning wasn’t happening, rather business continuity and rapid adaptation to changing circumstances appeared discrete and intuitive activities, allowing risk to become disassociated from objectives and resilience viewed in isolation from effective governance.
Uncertainty in healthcare management: how GGI can help you

The Good Governance Institute is well placed to assist healthcare providers to understand their risk exposure, advance simple tools and techniques to help achieve greater control, and build stakeholder confidence in services. As an illustration, the Good Governance Institute use Moore’s (2012) framework to help organisations:

- **scan the horizon** for emergent opportunities and threats;
- develop and apply **risk appetite** to business activities;
- undertake or facilitate **Causal Factor Analysis** and **Failure Mode Analysis** to unearth underlying weakness in control of activities;
- undertake or facilitate the **independent investigation** into serious incidents;
- develop and test the robustness of **Board Assurance** and **Quality Governance Frameworks**;
- enhance an organisations **capacity to handle risk**;
- **restore confidence** in the event of regulatory intervention; and
- develop and apply best practices in **Safety Management**.

Next steps by Andrew Corbett-Nolan

Paul Moore’s report is an impressive and thoughtful resource. All members of NHS boards should read this report carefully and think through how they can apply its findings in their own organisations. I first met Mr. Moore a little more than a decade ago at one of the first NHS workshops on Root Cause Analysis, where I was presenting about the Joint Commissions RCA process and how we should be using this to help better understand clinical risks and incidents. His thoughts on patient safety and risk were impressive then, but as this report shows he has spent a decade reflecting, innovating and continually developing his credo around this key issue for the NHS. His work as the first Chief Risk Officer in the NHS provided him with the opportunity to test many of the theoretical concepts he describes in this report and to work up a practical approach to using these to improve organisations.

More recently, Mr. Moore has been able to take his ideas forward and test these with an increasing range of other healthcare organisations through is work as an associate with GGI and independently. This has included working with stable, high-quality organisations as well as others with specific and significant quality and risk problems that their boards are needing to address. His model holds good in either setting.

Now a full time and leading member of the GGI team, Mr. Moore is able to move his ideas forward again using the resources and work programme of GGI to further test, refine and promote the better use of the discipline of risk with the board of healthcare organisations. GGI will be taking these ideas forward with healthcare boards throughout the UK. The title of his report is itself a call to arms, and we are delighted to be able to provide the next platform for Mr. Moore’s contribution to improving the NHS.
References


NHSLA (2012a) *NHSLA Risk Management Standards for Acute, Primary Care Trusts and Independent Sector Providers of NHS Funded Care*. London. National Health Service Litigation Authority


Countering the biggest risk of all: attempting to govern uncertainty in healthcare management

Paul Moore
May 2013

www.good-governance.org.uk