Risk governance within an NHS Foundation Trust: a case study

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MSc dissertation

I, Melanie Kate Reid, hereby declare (a) that this Dissertation is my own original work and that all source material used is acknowledged therein; (b) that it has been specially prepared for a degree of the University of London; and (c) that it does not contain any material that has been or will be submitted to the Examiners of this or any other university, or any material that has been or will be submitted for any other examination.

This Dissertation is 11,997 words.

Signed: ...........................................................................

Date: .............................................................................
Abstract
The concept of risk has become a central governance principle across the NHS with organisational risk management structures established as a way of visibly attempting to reduce patient harm and meet external regulatory requirements. However, there is little published evidence demonstrating their effectiveness, or of the social and cultural contexts in which these systems operate. This case study examined a single NHS organisation in detail through observing risk governance meetings and interviewing staff to understand how and why risks are identified, assessed and escalated. The goals for risk analysis were found to be ambiguous, affecting how and why risks were identified and allowing politicisation of the system. The primary risk assessment tool (a 5x5 matrix) was analysed in detail and shown to have significant shortcomings. The systems were seen by staff to be bureaucratic with emphasis on meeting external requirements. Further research is suggested to balance regulatory expectation with organisational functionality.
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## Abbreviations

<table>
<thead>
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<th>Acronym</th>
<th>Full Form</th>
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<tr>
<td>AC</td>
<td>Audit Committee</td>
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<td>AS/NZS</td>
<td>Australian and New Zealand Standard</td>
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<td>BAF</td>
<td>Board Assurance Framework</td>
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<td>CGC</td>
<td>Clinical Governance Committee</td>
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<td>CNST</td>
<td>Clinical Negligence Scheme for Trusts</td>
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<td>CQC</td>
<td>Care Quality Commission</td>
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<tr>
<td>DH</td>
<td>Department of Health</td>
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<tr>
<td>ED</td>
<td>Executive Director</td>
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<td>ISO</td>
<td>International Standards Organisation</td>
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<td>NASA</td>
<td>National Aeronautics and Space Administration</td>
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<td>NED</td>
<td>Non-Executive Director</td>
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<td>NHS</td>
<td>National Health Service</td>
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<td>NHSLA</td>
<td>NHS Litigation Authority</td>
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<td>NPSA</td>
<td>National Patient Safety Agency</td>
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<td>OWAM</td>
<td>Organisation With a Memory</td>
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<td>RACG</td>
<td>Risk Assurance and Compliance Group</td>
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<td>RAG</td>
<td>Risk Action Group</td>
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Acknowledgements & dedications

My sincere thanks to each and every person who contributed to this study, in particular to those who freely gave up their time to participate in the interviews. I am so grateful to everyone for sharing their views with me so willingly and in such an open manner.

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Introduction

Risk is difficult to define; elusive, contested and inherently controversial, it is characterised by diversity of opinion around principles for its identification, measurement and regulation (Fischhoff et al., 1984; Pidgeon, et al., 1992). This controversy has not, however, prevented risk from emerging as a key organising principle for public and private sector organisations alike (Power, 2007). Power (2007) describes an “explosion” of risk discourses since the mid-1990s, accelerating as services become transformed by risk thinking (Heyman & Titterton, 2010). Public healthcare was no different; the introduction of clinical governance in 1999 placed risk firmly at the heart of NHS management and comprehensive enterprise-wide risk management structures have since been established in an attempt to forecast and prevent patient harm.

Fifteen years on, the NHS faces great uncertainty given the UK’s ageing population, increasing co-morbidities and spiralling treatment costs yet ever-reducing budgets and multi-layered regulatory requirements competing for organisational attention. Combined with pressure from an adverse media, public scandals and top-down governmental reorganisation, the need for visible and effective risk management is greater than ever.

Despite the ubiquity of organisational risk management systems and the enormous amounts of resource required in their operation, there is little empirical evidence available on their effectiveness (Heyman, 2010a), and an increasing body of literature questioning the tools and techniques popular in the NHS. Tellingly, the expressed desire of regulators and the public for robust risk management underpinned by a low-blame reporting culture has not been met (Francis, 2013). To change, we must first understand why this may be the case; yet there is limited research into how understandings of risk are shaped by social, organisational and politico-regulatory pressures, and how risk can be used by individuals and groups to achieve their own aims and objectives (Alaszewski & Coxon, 2008).

This case study aimed to fill this gap in part by focussing on a single NHS organisation and using risk literature from outside the NHS to understand how and why risks are assessed, identified and escalated within the organisation, and factors influencing these processes.
Author

The author is a Risk Manager currently employed in the Clinical Governance & Safety Team of the Trust being studied. In previous roles the author worked in regulation, including inspection of NHS risk management systems, and within the NHS, establishing risk and compliance governance systems. The topic of research for this study arose from the author’s interest in balancing the needs of regulatory compliance against genuinely effective risk management.
Background

History of risk management in the NHS

A reference timeline of key events in the development of NHS risk management is at Appendix B.

Risk management was formally introduced into the NHS in the early 1990s in response to spiralling litigation costs and loss of Crown immunity against prosecution for clinical negligence. The first formal guidance was published in 1993 by the NHS Management Executive, recognising that managing risk was no longer an optional extra but was now the responsibility of NHS managers. It provided practical suggestions to look beyond the traditional remit of health and safety to consider risks to, for example, patient care and service provision. It did not prescribe tools to use, noting that “an educated guess may be just as valid [as a sophisticated analysis technique]” (p. 5). The 130-page guide focussed primarily on risk identification, with four pages describing how risks should be assessed for prioritisation purposes. The guide suggested “construct[ion] of a simple numerical matrix using as a base 1=low, 3=medium, 5=high” (p. 119) to score both frequency and severity of a risk, before multiplying together to produce a risk exposure score. The guide did not contain any references evidencing how this approach had been evaluated or validated.

In 1995, formal standards for risk management were developed by the NHS Litigation Authority (NHSLA), established to administer the Clinical Negligence Scheme for Trusts (CNST), a method of insurance for clinical liability. NHSLA considered good risk management would reduce patient harm and therefore the number of negligence claims received (NHSLA, 2013), and financial incentives were given for compliance with standards in the form of reduced membership fees.

Growth of risk management continued under the Health Act 1999, which ushered in a new statutory requirement for quality and accountability through ‘clinical governance’. Defined as a “framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish,” (Scally & Donaldson, 1998) clinical governance explicitly promoted risk management as a response to the growing
public expectation for prevention of incidents, crises and service failures in the NHS (DH, 1999). This was particularly desirable at a time where the Bristol Royal Infirmary, retained organs and Harold Shipman scandals threatened public confidence. Clinical governance and formal risk management would help NHS Boards stay informed; a comprehensive risk profile would be available through a “risk register”, a central repository for all risk information (CASU, 2002), with each organisation expected to identify between 75-200 key risks, with 6-12 regularly discussed by the Board (DH, 2003).

Around the same time, the patient safety agenda began to gain momentum following publication of two seminal reports: To Err is Human (IOM, 1999) and Organisation with a Memory (OWAM) (Donaldson, 2000). Both reports raised awareness of levels of harm associated with healthcare, emphasising the need for low-blame cultures and incident reporting systems to allow analysis of errors to prevent future harm. OWAM stated the new emphasis on clinical governance would provide impetus for further development of local risk governance systems. In response, the Department of Health (DH, 2001) created the National Patient Safety Agency (NPSA), an arms-length body tasked with improving quality of healthcare by ensuring effective risk management systems through reporting and learning from incidents and near-misses (Alaszewski & Coxon, 2008). For the next decade, NPSA (2004; 2006) and NHSLA promoted the need for integrated risk management within NHS organisations, including NPSA’s endorsement of risk matrices to improve consistency in risk assessment (NPSA, 2008) based on the Australian/New Zealand risk management standard (AS/NZS, 2004). The patient safety and risk management agendas became intertwined across the NHS, with safe healthcare becoming recognised as a feature of organisations with robust risk management.

Notwithstanding the importance that is placed on risk management in healthcare and the complex systems involved in its development and inspection, the last three years have seen significant changes in the external environment surrounding the oversight and regulation of risk in the NHS. In particular, the Mid-Staffordshire NHS Foundation Trust scandal threatened public confidence in the NHS and its regulators. The Care Quality Commission (CQC), the arms-length body which regulates healthcare across England, had inspected the Trust and identified failures to meet standards but did not take appropriate action to
address the failings. This called into question the ability of both the trust and the CQC to identify, assess and act on risk. In 2012, DH initiated a strategic review of the CQC; coupled with the conclusion that the regulator was not fit for purpose (Francis, 2013; DH, 2012; DH, 2013), the DH and CQC developed a new regulatory approach for NHS acute trusts from September 2013. The 2012 NHS restructure saw NPSA abolished with its patient safety functions transferred to the newly-created NHS England. Around the same time, NHSLA realised that compliance with their standards did not correlate with effective risk management or reduced claims; as a result they actively moved away from assessments to establish an innovative programme supporting organisations in proactive risk identification and management (NHSLA, 2014).

Whilst this external environment was not directly examined as part of this study, these changes will no doubt impact the internal governance of risk within NHS organisations and are an important part of the context for this research.

**Background and context of the Trust**

This case study focusses on an NHS Foundation Trust (“the Trust”) based in central London, providing specialist paediatric healthcare across more than 50 clinical specialties; a relatively ‘risky’ organisation combining healthcare, complex patients and cutting-edge treatments.

As with other NHS organisations, the Trust is complex, having a fragmented hierarchical structure with varying degrees of tight and loose coupling. It exists in a highly regulated environment where risk management is of interest to a range of groups including Trust Board, the Board of Governors, regulators, commissioners and auditors; all demand accountability in their own way, putting pressure on risk governance frameworks.

The Trust’s Risk Management Strategy (“the Strategy”) sets out the integrated processes governing the flow of information and responsibility, requiring risk information to be recorded via two key mechanisms in line with best practice as described by Haxby (2010):

- a top-down Board Assurance Framework (BAF), capturing risks identified by Executive Directors to the organisation’s strategic aims; and
bottom-up Divisional risk registers, capturing risks identified by staff within the operational Divisions.

This case study focusses primarily on the Divisional processes.

**Risk governance structures**

The four key Trust-wide committees formally tasked with risk governance (figure 1) are:

- **Trust Board** (“the Board”), responsible for effective functioning of the Trust, including risk management across the organisation;
- **Audit Committee (AC)**, who review the establishment and maintenance of effective governance, control and risk management systems, focussing on finance and business;
- **Clinical Governance Committee (CGC)**, who review the establishment and maintenance of effective clinical governance risk management systems; and
- **Risk Assurance and Compliance Group (RACG)**, responsible for detailed monitoring of the organisation’s risk management systems. RACG is the only Trust-wide committee where Divisional risk registers are formally reviewed, as AC and CGC focus on the BAF.

![Trust-wide risk governance structure](image)

*Figure 1. Trust-wide risk governance structure.* Divisional Boards and Corporate Departmental Boards (not shown) feed into RACG where Divisional, Departmental and BAF risks are
considered in detail. Strategic risks feed via the BAF into the CGC or AC. The statutorily-required AC is the overarching organisational risk committee, illustrated by its slightly higher position towards the Board when compared to CGC. Whilst other meetings/committees may use risk information (e.g. Senior Management Team), this diagram illustrates only those groups tasked with identification, assessment and escalation of risk information within the formal governance structures.

Below the Trust-wide committees, the Trust hierarchy is made up of clinical Divisions and corporate Departments; this study focusses on the former. Divisions each comprise a number of clinical specialties, for example the Division of Surgery encompasses specialties such as Orthopaedics and Anaesthetics. Each Division has at least one risk register, although many choose to have multiple registers at specialty level. Each register is owned and maintained through a Risk Action Group (RAG), a dedicated multi-disciplinary committee tasked with risk identification, assessment and escalation to Trust-wide committees as appropriate (figure 2). A Risk Manager from the Clinical Governance & Safety Team attends each RAG to support Divisional staff in risk analysis and assist in Trust-wide information sharing.

![Figure 2. Divisional risk governance structure.](image)

Under the Trust-wide committees sit seven clinical Divisions, each comprising multiple clinical specialties. Using three Divisions as an example, this diagram illustrates that each Division has one Board but a variable number of RAGs, which may be situated at specialty or Divisional level, depending on local preferences.

Throughout this report, a distinction is been made between:

- Divisional/local committees (e.g. RAGs, Divisional Boards), referred to as “Divisional” and members as “Divisional staff”; and
- higher-level, Trust-wide committees (e.g. RACG, CGC and Trust Board), referred to as “Trust-level” committees and their members as “Executive Directors” and “Non-Executive Directors”, or collectively as “senior managers”.

**Risk registers**

A risk register is a grouping of risks to facilitate their review and prioritisation. The BAF can be considered a self-contained register of strategic risks; at the time of this study, the BAF contained approximately 40 risks.

Divisional risks, however, are grouped at a variety of levels to create specialty, Divisional and Trust risk registers (figure 3):

![Diagram: Risk registers and Board Assurance Framework]

**Figure 3a. Divisional risk registers.** Divisional registers (purple) can either be standalone (i.e. Divisions with a single RAG) or a consolidation of multiple specialty registers (green). Trust-wide risks are logged on a separate Trust-wide risk register (orange), managed by RACG. Risks can move between Divisional and Trust-wide risk registers with RACG agreement. The Trust risk register (blue) is the totality of risks identified at Specialty, Divisional and Trust level.

**Figure 3b. The Board Assurance Framework.** The BAF (red) is a standalone risk register of risks to the organisation’s strategic objectives. Risks from the Divisional risk registers can shift to the BAF at the discretion of RACG.

For Divisional risk registers, the Trust uses a commercial database with a user-customised interface. Divisional risks can be identified by any staff member; to record the risk in the database, the risk form (Appendix C) is completed, including use of two semi-quantitative,
semi-qualitative 5x5 three-colour risk matrices. These matrices display initial and current risk to demonstrate how the level has changed over time. Risks are scored for “likelihood” and “consequence”, combined on the matrix to give (a) an overall score between 1-25, (b) a grading of high, medium or low, and (c) a colour. The Strategy states that matrices are used to provide consistency, assist in risk prioritisation and determine where management responsibility lies regarding frequency and ownership for risks reviewed. High or red risks are those scoring 12 or above. There are pre-defined risk escalation steps linked to the risk score; for example, Divisional Boards and RACG review all high risks monthly. Risks may also be escalated to RACG on an ad-hoc basis where agreed by an Executive Director.

Risks can be open, closed (where the risk has been removed) or accepted (where all steps to reduce the risk have been taken but residual risk remains); across the registers reviewed in this study, there were 803 closed risks and 157 open risks, of which 12 were accepted.

Across the clinical Divisions and Trust-wide committees, around 40 hours are dedicated a month to risk governance meetings, and many meetings involve in excess of a dozen attendees. It is estimated that this equates to over 400 staff hours per month in risk governance meetings alone, indicating the depth of resource required in maintenance of the system.
Literature review

In this report, the term “risk analysis” is used to denote the overall package of risk-related activities used to understand and deal with risk, encompassing individual components of risk identification, assessment and escalation. “Risk governance” refers to the framework of information-sharing between individuals and groups which underpins risk analysis.

Risk perception

Regardless of the inherent difficulties in its definition, the term “risk” is used ubiquitously (Heyman, 2010a); problems can arise when it is not clear what definition is meant (Titterton, 2005). For example, risk can refer to risk generally, or an item in a risk register (Leitch, 2010); it can be both the object of governance and a threat to the governing institution (Rothstein, 2006), or ‘uncertainty quantified’ (Gigerenzer, 2002). Heyman & Titterton (2010) also distinguish between the study of “risks” and the study of “risk”, both of which are reviewed in this research. The use of any one definition is therefore a political choice and should be chosen with care as it will impact on subsequent discussion (Fischhoff, Watson & Hope, 1984). The key consistency between definitions is that risk involves some element of uncertainty.

The perception of something as a “risk” is a process relative to an individual’s own experience and knowledge. As humans, our biases, beliefs, feelings, attitudes, experiences, values and understandings cannot help but influence our perception of information (Bradbury, 1989). Likewise, the groups we belong to - social, cultural and political - influence our attitudes and perceptions. Risks, and what is chosen to be risky, are therefore socially constructed ideas, influenced by a range of variables (Pidgeon, et al., 1992). Whilst social theories of risk perception (e.g. Slovic, 1992; Douglas, 1992) explicitly recognise that individuals have differing views of risk, caution must be exercised when using the term “perceived risk” as it can imply that “absolute risks” exist, which they do not (Kaplan & Garrick, 1981). Likewise, anything can be framed as a risk depending on how it is analysed (Ewald, 1991).

Individual understandings of the purpose of organisational risk analysis can also affect risk perception. Risk analysis was established as a discipline to inform rational decision-making
under conditions of uncertainty (NRC, 2009), but how this is understood and interpreted by individuals and organisations varies. The social nature of risk means its analysis cannot be completely objective, and whatever goals and methods are chosen will inevitably include a range of underlying value-laden assumptions (Fischhoff, et al., 1983). Any choice of method for analysing risk is a political decision emphasising what matters within the organisation (Douglas & Wildavsky, 1982), in turn influencing how individuals within that organisation identify and conceptualise risk (Huber & Rothstein, 2013). For example, in their studies of UK regulators, Huber & Rothstein (2013) found conceptual ambiguities around what constituted a ‘risk’ gave individuals scope to selectively identify risks fitting with their own preferences. Douglas & Wildavsky (1982) consider it key to analyse social structures within organisations and their underlying value systems to understand how differing views of risk arise.

**Risk assessment**

Humans are not adept at estimating risks (Heimer, 1988) and risk assessment models are required (Wilson & Crouch, 1987). Whatever approach is used, it is recognised that humans simplify complex judgments needed in assessing risks and rely on heuristic principles (Slovic, Fischhoff & Lichtenstein, 1980), which introduce elements of subjectivity. Of particular relevance are the *availability heuristic*, where frequency is assessed according to the ease by which occurrences of an event can be brought to mind; and the *anchoring & adjustment heuristic*, where an initial value is adjusted to yield the final answer (Tversky & Kahnehan, 1974).

The approaches popular in the NHS are based on standards including ISO 31000:2009 and AS/NZS 4360:2004, promoting tools such as probability-impact matrices and risk registers. Despite their ubiquity across the UK public sector, these models often conflict with theoretical approaches to risk. For example, key risk concepts such as *uncertainty* – the central feature of risk thinking (Heyman 2010b) – are underutilised in the NHS. Whilst risks are theoretically understood to be socially constructed, ISO 31000:2009 describes risks as if they are naturally occurring phenomena which simply need to be identified and can be described in finite numbers. This gives rise to the assumption it is possible to maintain a register providing the organisation with a current, correct and comprehensive
understanding of all risks it faces; yet this expectation is impossible to meet in practice (Leitch, 2010).

Probability-impact matrices are praised as simple, intuitive and effective tools improving consistency in risk assessment (Cox, 2008). Their underlying principle is reduction of the continua of “likelihood” and “consequence” into a small number of discrete categories. For each risk, values chosen for likelihood and consequence are combined to give a risk score, used for: prioritisation; articulation as high, medium or low risk; justification of action; and to enable reassessment to show effectiveness of control measures (Pickering & Cowley, 2010). They are considered best practice in the NHS, endorsed by the NPSA (2008) with handbooks referencing their use as “evidence-based” (Lovatt & Johnson, 2010).

Despite this, there is limited published research demonstrating effectiveness of matrices in improving risk management decisions; on the contrary, recent research has questioned the theory, logic and assumptions underlying their use (e.g. Cox, 2008; Pickering & Cowley, 2010; Hubbard, 2009). Cox’s (2008) review highlighted significant issues: multiplication of likelihood and consequence scores magnify errors in categorisation; “range compression”, the condensation of risk continua into discrete categories, leads to very different risks having identical scores; and inability to deal effectively with negatively correlated (e.g. high-impact/low-probability) values, leading to worse-than-random decisions. Kaplan & Garrick (1981) acknowledge that, whilst both likelihood and consequence require consideration, their multiplication illogically equates high-probability/low-impact and low-probability/high-impact events. The subjective judgments (including heuristics) and arbitrary decisions required to use the matrix imply they cannot be objectively completed or interpreted, and the resulting score is subject to biases which may be influenced by experience, proximity to perceived benefits, voluntariness and social, cultural and ethical factors (Cox, 2008; Pickering & Cowley, 2010). Matrices are prone to political modification, whether amplification to secure resource or attenuation to avoid scrutiny (Pickering & Cowley, 2010). Whilst advocates consider they are ‘better than nothing’, critics such as Hubbard (2009) disagree, believing the false sense of precision and objectivity given by the process makes use of matrices worse than judgment alone. Research within the NHS itself has not
dismissed matrices, although some approach them with caution, finding them open to interpretation (McIlwain, 2006) or useful merely a conversation starter (Hollman, 2010).

A key outcome of the matrix is a risk score, but this is also contested; numbers portray objectivity which may not exist (Porter, 1995) and, as Pidgeon et al. (1992) succinctly stated, “risk perception cannot be reduced to a single subjective correlate of a particular mathematical model of risk, such as the product of probabilities and consequences, because this imposes unduly restrictive assumptions about what is an essentially human and social phenomenon” (p.89).

**Social and cultural context**

Due to the inherently social nature of risk, there are convincing arguments to shift focus from probabilities to the risk perceiver, and to the social and cultural context in which risk assessment and management is undertaken (Bradbury, 1989; Otway & Thomas, 1982; Douglas & Wildavsky, 1982). An example of how social context affects risk perception is illustrated through studies comparing NASA and commercial aviation (Vaughan, 2005); whilst the two institutions had similar goals (safe launch and landing of aircraft), NASA’s view of problems as normal, expected and inconsequential led to toleration and eventually normalisation of deviance. In commercial air traffic control however, errors were not tolerated and were systematically investigated in a completely different cultural setting.

Turner (and Pidgeon, 1997) was the first to systematically examine the social and cultural context in which non-natural disasters occurred, demonstrating patterns of management failures relating to communication, information handling, and coordination, incubating disaster as important signals were overlooked or misinterpreted. These pre-conditions are more likely to be prevalent in complex organisations as they give rise to more opportunities for communication failure, particularly where units and subunits are involved; these groups develop subcultures, with group members reflecting attitudes, beliefs and behaviours shaped by membership of the group (Pidgeon, et al., 1992). Groups are important to bring together collective wisdom and overcome limits of bounded rationality, but they can also contribute to collective blindness (Turner & Pidgeon, 1997).
Whilst Turner, Pidgeon and Vaughan have examined how social and cultural factors influenced single disaster events, others have examined how these factors shape organisational understandings of risk before disaster has occurred. Some theorists (e.g. Beck, 1992) consider the ever-increasing risk focus reflects the increased riskiness of late modernity. Others, such as Power (2007) and Rothstein (2006) disagree, arguing the primary driver in the UK is a dramatic increase in regulatory and governance requirements, underpinned by a culture of defensiveness as both regulators and organisations seek to defend their legitimacy in the face of public crises, desire for greater economic rationality and increased pressure for accountability (Rothstein, Borraz & Huber, 2012). The concept of risk appeals in this context as, by explicitly including the possibility of failure, it rationalises the limits of what governance can achieve (Luhmann, 1993). Whilst risk management was historically promoted as a prioritisation method for choosing between risks to be managed (Kaplan & Garrick, 1981), the growing popularity of risk as an organising concept has evolved to become an entire rationality for governance (Power, 2007).

Broader organisational studies have shown that organisations increase legitimacy and survival prospects by adopting practices and procedures prevailing in society, regardless of whether those practices actually help (Meyer & Rowan, 1977). The process by which organisations become matched with their environments, isomorphism, is important for earning legitimacy: coercive isomorphism results from societal expectations e.g. regulation; and mimetic isomorphism, where uncertainty leads organisations to model themselves on those they perceive to be successful (DiMaggio & Powell, 1983). These studies consider the ubiquity of certain structures to be credited more to mimetic processes than evidence of enhanced efficiency.

Building on these ideas, Power (2004; 2007) describes the rise of an ‘Audit Society’ where increased emphasis on scrutiny and accountability, a growing blame culture fuelled by regulatory failures and organisational scandals, and widespread expectation that organisations must be seen to act as if risks can be managed, causes organisations to respond by producing information to maintain the appearance of legitimacy and protect against blameability. To allow external evaluation by regulators, this information must be auditable, however risk management itself cannot be - for who can tell if the lack of an
adverse outcome is due to good management or chance? As a result, the systems and processes for risk management have become the auditable proxy, shifting focus away from *analysing* and *understanding* risks towards ritualistic production and maintenance of systems for risk *governance*. He argues that risk analysis has evolved into something it did not set out to become – an unnecessarily elaborate and distracting internal accountability system focussing on process rather than outcome, requiring massive investment, persistence, time and effort yet with disputable functionality.

Within this model, issues historically managed through conventional organisational structures become explicitly recorded, communicated and rationalised through risk governance frameworks, reframing problems not previously associated with risk as ‘risk problems’ (Huber & Rothstein, 2013), potentially burying relevant information in a sea of data (Turner & Pidgeon, 1997). Risk analysis becomes prone to type III errors (i.e. right solution to an incorrectly identified problem), as complex problems and informal information are not easily captured by simple auditable governance processes. Form filling becomes a ritual designed to protect the organisation when things go wrong (Alaszewski & Coxon, 2008). Information is collected because it is collectable rather than relevant, and management attention is diverted from important but difficult-to-quantify problems and towards the easily managed and describable (Power, 2004; Huber & Rothstein, 2013). Driven by the fear of responsibility and accountability, Power (2004; 2007) envisages a potentially catastrophic spiral of expert judgment shrinking to an empty form of defendable compliance, focussing on loss aversion and defence against blame.

**Blame**

Blame is central to risk (Hood, 2002) as the discipline necessarily deals with adverse outcomes. A high-blame approach focusses on adoption of incentive structures imposing liabilities on individuals best placed to manage the risk. At the opposite end, low-blame approaches consider that complex systems can only function if incentives to hide information about errors are removed in order to allow reporting and analysis of incidents and near-misses (Hood et al., 1992). An expressed preference for a low-blame culture has arisen in the NHS, highlighted in OWAM (Donaldson, 2000) and the Francis report (2013), which pointed out the desired low-blame culture has still not been achieved.
Situated within the Audit Society thesis are concerns about how the desire to deflect blame contributes to a culture of risk aversion. Concepts of blame and risk perception are intertwined; individuals identify certain risks as worthy of attention in accordance with their own preferences and to shift blame onto others (Douglas, 1992). In particular, blame-shifting becomes significant when reputation is at stake (Hood, 2002), and attempts to deflect blame are exhibited not only in explicit attempts to ‘pass the buck’ to other individuals or organisations, but also in articulation of due process in an attempt to defend legitimacy (Power, 2007). It is essential for organisations to understand how this impacts risk analysis; fear of blame can lead to risk aversion (Gigerenzer, 2014) and blame avoidance can create strong incentives for manipulation of risk assessments (Huber & Rothstein 2013).

However, the feasibility of establishing an organisational low-blame culture is dependent not just on the socio-cultural attitudes within the organisation, but also the external legal and regulatory framework; factors such as decreasing trust and public scandals increase the salience of blame (Wells, 1996; Horlick-Jones, 1996). Accordingly, regardless of expressed preference, the NHS is unable to generate a low-blame culture by itself.
Methodology

Scope

This research used a case study design to focus on a single organisation, taking an idiographic approach to intensively examine internal processes for risk identification, assessment and escalation. The Trust being studied is an exemplifying case (Bryman, 2012), epitomising a broader category of which it is a member; although the specific features of this organisation (i.e. tertiary care, paediatrics) mean it may not be fully representative of other NHS organisations. An inductive approach was used to derive theory from the analysis of data.

According to the research aims, processes for risk identification, assessment and escalation were examined. A qualitative strategy was used for data collection, specifically:

- observation of risk governance meetings to understand how members conceptualised and spoke about risk; and
- interviews with members of risk governance meetings to explore their personal risk understandings.

The primary focus was risk governance, that is, the systems and processes for sharing risk information, of which identification, assessment and escalation are key. Risk management was specifically excluded from the scope as, whilst important, it is an outcome of risk governance rather than part of the governance process itself.

Sampling

From the seven clinical Divisions, three were excluded due to conflicts with the researcher’s main role in the organisation; the remaining four Divisions allowed a balance between breadth and depth of analysis. The Clinical Governance & Safety Team, whilst central to organisational risk governance, were also excluded due to conflicts with the researcher’s role. A generic purposive sampling approach (Bryman, 2012) was used to select (a) committees/meetings to observe and (b) interviewees. Data were collected between January and April 2014.
**Sampling meetings**

The high number of risk governance meetings (figure 4) meant not all could be observed, so a representative sample size of at least 50% of RAGs and one Board per Division was set. Trust-level committees were observed as often as the research schedule allowed, noting that the Audit Committee was not included as the Strategy specifies it focusses on non-clinical risks.

![Governance structure for observed Divisional meetings](image-url)
Table I. Risk governance meetings observed. Percentage of RAGs observed per Division is given in brackets

<table>
<thead>
<tr>
<th></th>
<th>Division 1</th>
<th>Division 2</th>
<th>Division 3</th>
<th>Division 4</th>
<th>Trust-wide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk Action Groups</td>
<td>3 (75%)</td>
<td>2 (67%)</td>
<td>6 (60%)</td>
<td>2 (100%)</td>
<td></td>
</tr>
<tr>
<td>Divisional or specialty Board</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Risk Assurance and Compliance Group</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Governance Committee</td>
<td></td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trust Board</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>

**Sampling Divisional interviewees**

Interviewees were mostly self-selected by nominating themselves during the meeting observed via a nomination form. This approach ensured interviewees were willing and able to reflect on risk governance processes, and allow triangulation of meeting observations. A quota was established for three interviewees per Division: a clinician (i.e. either a doctor or nurse), a manager, and an allied health professional.

In two cases, the quota was exceeded; the researcher selected an interviewee based on dissimilarity to others in the quota e.g. selection of a junior staff member if other interviewees were relatively senior.

In three cases, the quota was unmet and three RAG members were approached directly with an invitation to interview; all accepted, with one subsequently unable to attend.

Overall, the quota was met for all but one Division (table 2).

**Sampling other interviewees**

Senior managers were also self-selected, either at meetings or via email correspondence. No specific quotas were established for senior managers.

Additionally, five individuals outside the Trust were approached for interview; two as representatives of relevant stakeholder organisations, and three relating to their involvement in historic NHS risk governance work. Three agreed to be interviewed.

The sample size of 19 (table 2) was felt sufficient to give a broad horizontal and vertical view of risk governance across the Trust. Towards the end of the interview schedule, responses
from Divisional interviewees stopped producing new information, indicating saturation was being achieved and the sample size was appropriate for this study.

Table II. Number of interviews conducted by interviewee role/background

<table>
<thead>
<tr>
<th>Interviewee Role/Background</th>
<th>Division 1</th>
<th>Division 2</th>
<th>Division 3</th>
<th>Division 4</th>
<th>Trust-wide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinician (C)</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Manager (M)</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Allied Health Professional (AHP)</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Executive Director (ED)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Non-Executive Director (NED)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>External organisation (Ext)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3</td>
</tr>
</tbody>
</table>

Data collection & analysis

The researcher was a minimally-participant observer at meetings, to obtain first-hand information about how risk was conceptualised by staff in as authentic a setting as possible. Interviews were semi-structured, with standard questions (Appendix D) used to guide discussions with internal staff, although the order and wording of questions shifted depending on the conversation. In six cases, interviews were not transcribed: five were conducted over the telephone/Skype and in one case, permission for transcription was declined. Typed records of meetings and interviews were coded using QSR NVivo to assist with thematic analysis (Braun & Clarke, 2006).

Limitations of study design

The case study design of this research means findings are unable to be generalised (Bryman, 2012). There are also multiple selection biases, in particular purposive sampling. This method was needed to obtain an overview of risk governance across the organisation within the resource limits of the researcher, however it is recognised that attending committees set up to discuss risk and allowing individuals to self-select for interview will bias results. The Divisional quotas may have contributed to operator bias (Rice, 2010) as on occasion the researcher needed to consciously choose staff to approach or remove from the interview list.
That the researcher is a member of staff may have impacted on how information was provided by colleagues by introducing a power dynamic (Valentine, 2005). Additionally, the researcher’s role may have also affected their interpretation of results, by subconsciously overlaying personal experience into the analysis. Finally, exclusion of the Clinical Governance and Safety Team due to conflict with the researcher’s main role has resulted in a key part of risk governance being unable to be analysed in this research.
Findings

Risk identification

Individuals in the Trust are faced with an almost limitless expanse of issues, problems and concepts which can be framed as “risks”; clinical risks to patients, strategic risks to organisational priorities, operational risks associated with processes – the list goes on. From this expanse, individuals must first identify those issues they believe worthy of attention as risks, before refining to pick out the few for recording on the register. As predicted, this refinement process was observed to be inherently subjective, with individuals unavoidable influenced by their own experience and biases in constructing a personal perception of a particular risk. This subjectivity appeared further exacerbated by the broad scope of the Strategy, implicitly encouraging individuals to raise whatever they feel could pose a risk across a range of domains, including but not limited to patient safety. Whilst this scope might be deliberately vague in response to genuine concerns about unintended consequences of attempting to limit risk identification, the range of issues recorded on the register and the variation in understandings of risk identification between groups demonstrate the breadth may be too wide to be practical.

Purpose of Divisional registers

Observations of RAGs and follow-up interviews revealed a view that many risks on the Divisional registers are active problems requiring resolution, where action should be able to be taken reasonably quickly:

C2: It’s supposed to be an active document, as far as I’m concerned, the risk register, so why leave things dormant on it?...[it’s] something that actually has to be physically worked on, week in, week out to get rid of and sort and resolve.

***

ED1: if [a risk] has been there for more than a month I get really agitated if it’s red, you know, I’m phoning up people. I like to see red risks being addressed – that bothers me.
For example, the Divisional registers included risks of “extractor fan not functioning”, “clinical guidelines need reviewing” and “clinic letters not being completed in a timely manner”. These types of issues raise a question about whether they should indeed be considered to be risks in the academic sense, where it is agreed that ‘risk’ must include an element of uncertainty. In these cases, the issue has occurred (removing uncertainty) and the risk being referred to is the risk of recurrence, or of not addressing the issue. Whilst it can be argued these issues pose a risk of harm if not addressed, they are fundamentally different to the types of risks analysed through the Board Assurance Framework (BAF) (figure 3), such as “risk that all patients at all times don’t receive safe medical cover” and “failure to deliver an excellent experience for patients and families”. The BAF risks also pose a risk of harm but are not necessarily active problems and certainly not issues which could be ‘got rid of and resolved’.

Of course, the Divisional risk registers are operational and the BAF, strategic; however it illustrates that even within a single organisation, different purposes for analysing risks impact on what is initially identified as a ‘risk’. Whilst the BAF has been explicitly defined in the Strategy as the “record of principal strategic risks to the Trust achieving its objectives”, what is not clear is whether the use of Divisional risk registers to record ‘active problems’ was an explicit organisational choice, or has arisen through assumptions and interpretations shared via isomorphic processes.

This is not to say that recording active problems as risks is necessarily wrong, but unintended consequences must be considered and questions asked about the expected benefit from putting such a problem onto a register. Issues such as “clinical guidelines need reviewing” are not new, but historically would have been resolved through normal management processes. By re-framing them as “risks”, dealing with the problem now requires compliance with a formal bureaucratic process, which may be disproportionate to resolving the issue. The numbers of problems which can be re-framed in this way may threaten to overwhelm the capacity of the system and the register can become a dumping ground for recording issues which are not immediately solvable.
Identifying risks for recording

Within the wide scope of risk identification, individuals and groups were observed to apply an intuitive set of rules in deciding which risks to record: during RAGs, members could often quickly decide if a particular issue would be considered a risk to be placed on the register; yet in interviews, could not specify the general principles for these decisions:

Interviewer: What qualities does a risk have to have before you think, ah, that needs to go on to the Register?

M4: Mmm. Sometimes it’s...ah, it’s a good question. I’m not sure I can answer that.

***

AHP2: It’s very difficult to put anything concrete on that...I’d want to have a pile of minutes in front of me and say, well, I can discuss this one exactly and that one exactly.

In delving deeper, staff expressed reliance on attributes like whether change was proving difficult, and the perceived significance of the risk:

AHP1: ...we’ve spoken about them or raised them informally, and there’s been no action to change them.

***

M3: ...the risks that are perceived as quite serious risks tend to go on to the risk register, because actually a lot of, if you like, less serious risks you tend to attempt to deal with them and move on.

Whilst this seems practical, these responses illustrate that staff operate to an internal rule-set which may not match up with organisational aims. For example, the Strategy does not specify risks should only be recorded when a threshold is reached – on the contrary, assuming the level of risk without assessment could actually undermine the process and can lead to high-impact/low-probability risks being overlooked. Mimetic isomorphism can reinforce intuitive rule-sets between RAG members, embedding a subculture of common understanding within the group; subcultures within organisations can be a pre-condition to
disaster where information handling across the organisation is compromised (Turner & Pidgeon, 1997). The reinforced understandings impact not only on the risks each group identifies (or not), but contributes to inconsistency between groups, undermining the comparability desired from the overall Trust risk register.

Most Divisional staff felt the register should be used to record risks they were unable to resolve themselves:

M2: ...if we can fix it, then clearly it’s not going to be necessary on the risk register, because you can just deal with it at the time, job done, but if we think it’s a recurring issue...that’s usually the primary reason why it will go on the risk register.

***

AHP3: The only things that should go on the risk register are things we can't do anything about.

Interviewer: Why do you say that?

AHP3: Because if we can do something about them, then we should do it.

However, this creates a circular argument around Divisional risk identification; that is, if the risk is within the ability of Divisional staff to resolve, they do so; if not, they place it on the register. By definition, this means a significant proportion of risks on a Divisional register cannot be addressed by those responsible for its review. There are a number of undesirable consequences which can arise from stagnation of risks on the register, including staff frustration, disillusionment with the process and gradual acceptance of the risk over time as staff become more familiar with seeing it on the register (Slovic, 1992), particularly where no associated incidents arise.

The view of risk registers as a record of active problems which are unable to be easily fixed may also influence the RAG to become a bureaucratic process to routinely remind staff of the things they need to sort out. This was reflected in interview:

M2: ...I think it is a good aide-memoire...it’s actually putting something out there, putting some action in place...otherwise we would just trundle along, and you forget
half the stuff, because you've got so much on your plate...then the RAG will come along and you think, oh yes....

**Identifying risks which should not be recorded**

Interviewees also talked about identified risks which were not on the registers; Divisional and senior managers agreed this was acceptable when risks related to staff behaviour or interaction, as highlighting these in a written register could be detrimental to working relationships. Even so, significant concern was expressed in interview over these risks given their potential to impact on service, patient/staff experience, and reputation. In particular, two interviewees (C3 and ED1) each considered the most significant risks facing the organisation to be social, yet both felt these issues were not best managed through formal risk governance. ED1 considers there to be a “parallel universe in problem-solving going on [in addition to] the risk register”, expressing concern that in attempting to manage social issues through formal risk governance, “people spend a lot of time trying to find forms of words for the risk register which explain [social problems] which then neuter it...you lose the benefit of granularity at the same time as finding a politically correct way of stating what the problem is”. C3 seemed less concerned about managing issues outside of the frameworks, stating that “I'm dealing with it, it's in hand, [General Manager] knows about it, [Executive] knows about it, but I don't feel it is something that should be on the risk register”. These understandings further illustrate the set of intuitive, unwritten rules which individuals use to determine what risks do and do not get placed onto the risk register, and some of the practical limitations of the risk governance processes.

**Risk assessment**

In practice, risk assessment was observed to mean completion of the risk form *(Appendix C)*, including generation of a risk score and grade through use of the risk matrix tool.

Given the criticisms of matrices in the literature, it was not surprising to observe staff making assumptions and subjective judgments when using the matrix. What was more unexpected was the tendency for staff to use the tool in ‘reverse’. The correct procedure requires the risk perceiver to objectively identify the most appropriate “likelihood” and
“consequence” categories according to the stated definitions, before moving inwards across the grid to identify where the two planes meet (“outside-in” approach). The meeting point provides both score (between 1-25) and grading (high, medium, low). However, this sequence of steps was often not followed in practice; of the 13 RAGs observed, only five used the risk matrix tool; the remaining eight talked about risks purely as grades. For the five groups using the matrix, RAG members showed a preference for working “inside-out”, i.e. deciding subjectively whether the risk was high, medium or low, and then identifying the most appropriate corresponding box on the grid. For example, one RAG Chair said words to the effect of “put it in the orange box, it’s not a high risk…that’s me aiming for medium all the time” (RAG2). In RAG4, even though group members discussed the likelihood and consequence category definitions and where the risk would fit, the Chair said the risk would “have to go on as high” before deciding it was “definitely medium” without calculation. Discussion at a third RAG included comment from a member that “[I’m] OK with medium, definitely not high, you don’t hear anywhere near as much about this issue [as before]” (RAG6).

This seemingly subtle shift from outside-in to inside-out has significant implications, the most concerning being it turns an assessment process into a documentation of perception. To illustrate this point, take the example risk of wrong site surgery. Using the outside-in approach, the consequence is identified (e.g. unexpected death, a score of 5) and the likelihood of occurrence estimated, requiring analysis of how many surgeries are undertaken annually, historic rates of wrong site surgeries, and effectiveness of controls. Once estimated (e.g. “we can expect one wrong site surgery approximately every 40,000 surgeries”), the relevant likelihood category can be selected – according to the Trust’s matrix (Appendix C), 1:40,000 is an “unlikely sequence of events”, or a score of 2. The likelihood (2) is combined with consequence (5) to reveal, through calculation against the categories pre-defined by the organisation, the risk score/grade in accordance with the Trust’s appetite – in this case, medium (10). As this process involves a calculation, the answer may or may not correlate with the assessor’s perception. In this way, the tool both challenges the risk assessor’s intuitive understanding and situates the risk within the organisational appetite.
In contrast, the inside-out process removes the calculation step and any challenge the tool can provide, rendering it ineffective as a risk assessment aid. As a result, the risk record effectively becomes a documentation of intuition; the same result would be obtained from simply asking people to specify whether they thought a risk was low, medium or high.

Interviewees were open about reliance on intuition when assessing risks:

   Interviewer: So if you... looked at your likelihood, you looked at your impact, you got a score at the end, but your intuitive feeling about it didn’t match up, which one would you rely on?

   M3: Well, my intuitive feeling.

   ***

   AHP1: I do it instinctively by how worried I feel about this risk... I feel “three out of five” worried about it.

The inside-out process was also used in reviewing existing risks. Using the above example, if a new control reduced likelihood of wrong site surgery from one in 40,000 to one in 80,000, the likelihood score (2) should remain unchanged due to range compression, even though the actual likelihood has halved. However, the observed practice of RAGs indicates a strong desire to downgrade likelihood when any kind of mitigating action has been taken, without taking the category definitions into account. For example, one RAG member commented “we should put it to medium, my perception is that it has decreased, it’s not very scientific but it’s all we’ve got to go on” (RAG4). This concept was expanded on in interview by a different staff member:

   M2: ...was it any better than it was last week or when we first put it on the risk register, have we moved any way forward... have we done anything in between then and now? Loads has happened, it is better, it isn’t as it should be necessarily but it is workable and we feel that patient care is better. Therefore, it’s a risk, but it is not where it was, so we felt it was appropriate to downgrade it to medium.
Whilst this study did not examine in detail how the preference for the inside-out process has arisen, possible factors include:

1. lack of understanding about the correct process or implications for misuse. Only one interviewee (ED1) had received formal training in risk assessment at the Trust;

2. mimetic isomorphism reinforcing and embedding this approach as accepted practice;

3. problems in calculating likelihood, such as:
   a. lack of data with which to make robust estimations. Of all RAGs attended, there were no observed instances of attempting to calculate likelihood by using real data, and such data are not always available even if desired;
   b. observed preference of individuals to rely on interpretation of the qualitative frequency statement (e.g. “foreseeable under unusual circumstances”) rather than attempt to calculate the quantitative frequency (e.g. “1:1,000 to 1:10,000”);
   c. lack of time, as often 10–20 risks require review during the RAG;
   d. reliance on memory of recently reported incidents to determine frequency, leaving the assessor open to the availability heuristic;

4. conscious or subconscious attempts to politicise the assessment; or

5. the correct process is not perceived as helpful so it is simply not used.

However, even if the process is correctly followed, the underlying issues with risk matrices discussed in the literature review warrant consideration. The Trust tool has some immediately obvious practical issues; for example, the likelihood category ranges overlap (e.g. 1:1,000 could be scored as either 2 or 3), and the frequency statement “1:100 chance in any one year” is mathematically illogical (except for those events which occur precisely 100 times per year). These problems could be quickly resolved by a thoughtful review of the Trust tool.
Of greater significance are the assumptions underlying risk matrices in general which make their use problematic. The findings from this study support the questions now being asked by critics of risk matrices (e.g. Cox, 2008), such as:

- matrices have been promoted as “permit[ting] comparison of totally unlike risks, such as a fire in a tower block, or patient slips and falls” (NHS Management Executive, 1993, p.119). On reflection, this seems questionable - it is right, desirable or even truly achievable to compare ‘totally unlike risks’? Can risks to patient safety, estates, finance and reputation be equated?

- matrices reduce the continua of consequence and likelihood into compressed categories, rendering an almost infinite expanse of fluid information into discrete chunks for comparison. The ranges captured by each category are arbitrarily delineated and result in illogical outcomes, e.g. likelihoods of 1:101 and 1:999 have the same score, yet 1:999 and 1:1001 do not. These boundaries appear precise but in reality, due to this logic and the difficulties in calculating likelihood, must be treated as if they are vague;

- consequence ranges are also illogically compressed so that a single unexpected death and an explosion killing multiple patients would both be described as “catastrophic”, when these events are of clearly different magnitudes;

- following the matrix process gives a single risk score. In addition to the issues raised in the literature review, this proved problematic in RAGs as there were instances where a single risk would be better expressed using multiple consequence/likelihood pairs, which the matrix does not allow; and

- regardless of the general acceptance of interviewees and RAG members that risk assessments and scores are subjective, there are inbuilt mechanisms relying on scoring, e.g. escalation of risks scored over 12, and frequency of review determined by risk score. Thus, the output of the matrix was said to be subjective, but treated as if it were objective.
Risk escalation

A minority of RAG members interviewed expressed a view that their risk register was for Divisional use only, and escalation was non-existent or unnecessary. For example, during one RAG staffing levels were raised as a concern, however the Chair declined to record it saying “there is no point in escalating this as it’s an issue right across the Trust” (RAG13). One staff member interviewed (C3) indicated that as RAG staff were responsible for risk register actions, senior oversight was unnecessary.

In contrast, the majority of RAG members felt escalation was part of the process, although few knew who they were escalating to:

AHP1: I think it’s [General Manager] has to escalate it further if it’s really serious...and that is a world I don’t know about.

***

Interviewer: Would we still have the same amount of change if we didn’t have the register and/or the escalation process?

C2: Have we got escalation processes then?

Interviewer: We do.

C2: I haven’t had any feedback from anywhere, in relation to our register, apart from ages back, a couple of years back...maybe that’s good, maybe that’s because we’re managing them, I have no idea.

***

AHP2: ...there can be some sense that it’s sort of shouting into outer space. You’ve got to have a degree of faith that what you’re submitting is actually seen by someone and processed and recorded in some way.

In practice, Divisional risk registers are overseen by RACG who review (1) all high risks and (2) full risk registers for 2-4 Divisions/specialties, and feedback is given when their reviews indicate it is warranted. A relatively high number of risks are scheduled for review each
meeting: for example, in March 2014, the agenda included 57 high risks, >95 Divisional/specialty risks and approximately 40 BAF risks. These numbers illustrate the importance of effective mechanisms for prioritising risks for Executive attention. Senior managers rely on accurate risk assessments through RAGs to support prioritisation, however:

- setting an arbitrarily determined number (12) as the escalation factor implicitly assumes that risks are consistently and objectively scored, which this and other studies (e.g. Hollman, 2010) call into question;
- the number of Divisional risks graded “high” indicate that risk scoring may not be the most effective way of delineating risks warranting executive attention. Most senior staff interviewed expressed concern about the number of risks they needed to review, with one reflecting there simply wasn’t enough time to go through these in detail at RACG (ED3);
- there is an underlying assumption that senior managers need to know about everything scored 12 or above, and local areas can manage everything else themselves. This impacts on what information is shared with whom and when, and can additionally contribute to risk politicisation; and
- low-probability, high-impact events can be overlooked for escalation, a concern expressed by both Non-Executive Directors interviewed.

The twice-yearly RACG review of each full Divisional/specialty risk register is designed to mitigate some of these flaws, although the volume of information to be examined is still concerning.

**Risk governance**

Reflecting on the overall risk governance processes, a significant proportion of RAG time was observed to be used in staff providing and recording progress updates against individual risks, a process with strong emphasis on meeting governance requirements e.g. ensuring high risks are reviewed monthly in accordance with the Strategy. When asked about the purpose of risk analysis, interviewees felt that regulatory requirements were key, expressing that risk governance was disproportionately burdensome; one Non-Executive Director
(NED2) felt the focus had become ‘terribly misplaced’ onto the listing of risks, rather than taking action to resolve the identified issues. Others stated:

M4: …the pressure to actually keep [the risk register] updated and, you know, make sure it’s been recently reviewed, and trying to make sure every high risk is looked at every month. So, there’s an administrative pressure that you have to look at it. And sometimes it does feel a bit like lip-service, actually. You just go in every month, you make sure you write something in, that it’s been updated.

***

ED1: I think it’s very bureaucratic and it creates a compliance assurance framework which in itself becomes a piece of work… it comes around unremittingly frequently so that I actually lose the will to live when I’m asked to review a risk…I just don’t have time to do that because it’s another month’s gone by, or another quarter, and you have to look at this risk and think, well, what have I done in-between times because I’ve been so busy I haven’t had time to really focus on that risk…so I have to go away, find somebody, check, rewrite it, write it down, make some guesswork about risk appetite, make some guesswork about the scoring system, and in the end it becomes quite subjectively done in a hurry….I think your energy gets subsumed into some of this work so instead of concentrating on solving the problem you’re concentrating on feeding the beast – doing the risk compliance framework.
Discussion

Through analysing the individual components of risk identification, assessment and escalation, four cross-cutting themes will be explored in more detail: goal ambiguity; politicisation; the appearance of objectivity, and bureaucracy. This section will conclude with some suggestions for further research.

Goal ambiguity

Whilst staff are clear the overall goal for risk analysis in this context is reduction of harm to patients and staff, this study found that individuals - whilst sure about their own understandings and interpretations of how risks should be identified, assessed and escalated - were inconsistent when compared to other individuals and groups. This is considered to be, at least in part, a result of goal ambiguity arising from the wide scope of the Strategy where expectations for the specific elements of risk governance have not been unambiguously defined, and where it is not clear whether risk analysis within the Trust aims to support decision making, act as an information sharing framework or house a ‘to-do’ list.

To illustrate that goal ambiguity shapes risk identification and escalation, consider the aforementioned example of the RAG Chair who declined to record a staffing risk because ‘it is an issue right across the Trust’. If a goal of risk governance is to escalate information for Executive attention and/or action, the staffing risk should have been recorded even if RAG members could not address it themselves simply so that senior managers were aware of the concern. Alternatively, if a goal for the register is to act as a reminder and record of issues being dealt with locally, the risk may not need to be recorded if the Chair felt this could not be addressed.

The Trust has been proactive to ensure each Division retains ownership of their register, and there is a sense that if non-Divisional management were to attempt to restrict how staff identify or deal with risks, this ownership would be compromised; there seems to be a preference for a wider-than-necessary scope around what is conceptualised as a risk, rather than potentially alienating front-line staff with restrictive definitions. Whilst these are valid concerns, in reality a risk governance framework without boundaries can easily become overwhelming and the focus misplaced. The sheer number of risks involved in this review –
over 200 just in the Divisions analysed as part of this study – illustrate that this may already be the case.

It must be accepted that individuals are already using a framework to filter risks for analysis, relying on factors such as perceived severity or inability to deliver change, because - given the expanse of issues which could be considered risks - limitations are required for practical purposes. However, where these mental frameworks arise from intuitive and unspoken assumptions rather than strategic decisions, they can become silently reflected and embedded within the subculture of individual RAGs through isomorphism. The development of subcultures allows different understandings of goals to emerge and undermines the desired consistency of approach; it also makes it difficult to challenge inconsistency when it arises. Whilst there are distinct benefits from having a group-based approach to risk assessment, such as consideration of multiple viewpoints, goals must be clear to reduce the risk of subculture evolution as this can contribute to failures of communication and information handling, key pre-conditions to disaster (Turner & Pidgeon, 1997). Goal ambiguity can also contribute to risk reviews becoming seen as cursory, if those involved in the process do not understand the benefits to be gained; in this situation, governance or regulatory targets can become the assumed goal, and the threat of the “empty defendable compliance” described by Power (2007) starts to appear as a possibility.

The view of risks as active problems warrants particular consideration, as it could potentially contribute to risk aversion by implying that risks are not to be borne by the organisation but instead should be reduced and resolved. Whilst the Trust does have a policy for accepting risks where actions have been taken but residual risk remains, only a small proportion (1% of the risks reviewed in this study) are accepted, perhaps indicating a potential conflict between the organisational understanding of risks as problems to be fixed and the concept of accepting residual risk. It seems logical that for staff to be comfortable with taking considered risks, they must be familiar with the concept that not all risks can, or should, be reduced to zero; whilst this is stated within the organisation the evidence suggests that this may not yet be fully embraced.
Politicisation

In this context, politicisation is considered to be manipulation of the risk governance system to support a desired outcome.

There was general acceptance from interviewees that risk governance is open to active politicisation, usually over-scoring to secure additional resource. One interviewee (ED1) reflected on a high risk they recognised as artificially inflated to secure funding for a staff post. Interviewees also recognised that risks may be under-scored to keep issues off the register as staff may feel it is an “admission of fault” (M4) or because RAG members simply don’t want others to know what is being dealt with:

   ED1: I think people use the risk registers as a political tool quite often – it’s not really a risk, it’s what they want, and so they change the colour of it based on what they want, or to manipulate the politics of the organisation because they know it can be escalated quite quickly, and vice versa, if they don’t want something they keep its colour low.

A kind of passive politicisation was also observed. Sometimes, this was the result of system ambiguities previously discussed, whereby individuals recorded their perceptions which are influenced by range of biases, including political biases and personally desired outcomes. In this sense, individuals may not be aware that they are passively manipulating the processes for their own purposes if, for example, they intuitively determine that a risk should be “high” without scoring it.

Another source of passive politicisation seems more closely aligned to blame and responsibility shifting as a defence mechanism. Senior managers seemed to share a view that Divisional staff perceived recording a risk to be the end goal, with the act of logging the risk on the register equating to taking action and in particular, shifting of responsibility onto ‘someone else’ (even if it was not known whom this would be). At least two interviewees expressed frustration with staff perceiving the recording of risks on the register as a self-protection mechanism so that if something went wrong, they could say the issue had been flagged up and responsibility had been escalated (C3 & ED2). ED3 expressed frustration that recording a risk was sometimes more effort than just resolving it, with ED1 feeling as though
the Trust had become somewhere where “problems are pushed upwards instead of solved locally”. This perceived need for self-protection, and use of risk governance systems to facilitate blame- and responsibility-shifting, is reminiscent of the Audit Society thesis where risk governance is reduced to a form of defence. What is not clear from this study is whether this responsibility-shifting is purposeful (i.e. staff want to shift responsibility for self-protection) or a misinterpretation of the escalation mechanisms within risk governance (e.g. staff believe that responsibility should be shifted if they cannot deal with something easily); more research is warranted in this area to inform an understanding of the underlying organisational assumptions.

The appearance of objectivity

The subjectivity involved in risk analysis was routinely reiterated to staff during RAGs, discussed at interview and explicitly stated in various risk assessment guidance documents (e.g. NPSA, 2008). Regardless, the outputs of risk assessment – grades and numbers given to assessed risks – were treated as objective by virtue of the automatic mechanisms relying on those numbers to determine how often risks should be reviewed and by whom. The very existence of these mechanisms assumes that risks are correctly scored.

The use of risk scores to automatically determine actions is not new and certainly not unique to the Trust, however the logic of this process is worth reflecting on. If it is acknowledged that every step of risk analysis is subjective, it seems illogical for the overarching system to assume consistent scoring and treat the outputs of the assessment as objective. This finding is consistent with Bradbury (1989) who considered that subjective decisions made during risk analysis are often overlooked and risk is treated as an objective fact once assessed. This can be visualised as a kind of “laundering” process whereby subjective information is entered into a subjective classification framework and assessed using subjective judgements, yet comes out with the sheen of objectivity under which action is taken.

Treating risks as objectively assessed can contribute to politicisation by commanding automatic escalation or invisibility of information to senior managers. It also calls into question the underlying assumption that all risks over a given number require Executive
attention and those below do not; given the inherent ambiguities in how risks are conceptualised, and the catastrophic potential of high-impact/low-probability risks which may not make the threshold score, it seems implausible to expect that numbers and grades assigned to every risk will correctly determine how it should be managed and who needs to know about it.

**Bureaucracy**

There was a clear sense of belief at all levels in the concept of proactive risk management – no debate that the Trust, as an organisation, should be aiming to resolve issues to both reduce and prevent harm. What individuals found difficult to reconcile, however, was the burden of the process: Divisional staff feeling frustrated about diverting finite energy and resources towards a never-ending cycle of risk register updates; and senior managers concerned that governance processes have become a way of shifting responsibility rather than resolving issues.

Whilst the dark picture painted by Power (2007) may not be reality for the Trust, the processes examined in this study do echo the Audit Society in parts: that interviewees were readily able to express the need for risk analysis to comply with regulation; the defensive desire for individuals to protect themselves by recording information on the register; even simply reflection on the significant amount of resource required to maintain the system. It is telling that staff interviewed do not always feel the systems add value to the desired aim of reducing harm.

The problems alluded to in the literature about the difficulty of fitting socially-constructed information into an auditable framework became clearer during this study; whilst the framework described in the Strategy meets the needs of auditors and regulators, it was not always straightforward to use in practice. People need to rely on intuition to consider risks but intuition is not a socially acceptable form of information (Gigerenzer, 2014). Information about risk is by its nature often vague, imprecise, uncertain and fuzzy, reliant on expertise which may not always be easily articulated (Vaughan, 2005). The process of shoehorning complex and intuitive information into an auditable framework can undermine risk analysis as in the search for simplicity, the richness which adds value and understanding can be lost.
Further research

Risk analysis within NHS organisations

Given the ongoing uncertainty in the literature about what risk is and how it should be managed, there can be no right or wrong way to approach risk analysis; surely then each organisation should be empowered to determine its own goals for what it wants risk analysis to achieve and set structures accordingly. Yet the multiple overlapping regulatory requirements which cover risk analysis, and the ubiquity of certain approaches, call into question whether NHS organisations are genuinely empowered in this way. Whilst it is true that regulatory standards need to be met, it is worth asking the question, is it better to have risk management frameworks instantly recognisable to a regulator as “best practice”, or to employ a risk management system which focusses on adding value in line with organisational goals? Of course, this is not to say that upon reflection the “best practice” methods will not be found to be best for the organisation; but that the selection of any method should be an active choice based on evidence and a clear understanding of desired outcomes. There needs to be due caution in adopting methodologies and practices simply because they have become widespread; prominence does not equal suitability (Leitch, 2010) and concern about quality, however genuine, is not the same as methodical assessment based on reliable evidence (Maxwell, 1984).

The CQC and NHSLA are currently transforming their approaches in an understanding that rote compliance with standards does not always achieve the desired outcome as too often the goal becomes misplaced towards tick-box compliance to pass inspections. In the same spirit, it is timely for NHS organisations to also review their internal systems, as they have a responsibility to themselves and their patients to ensure that whatever approach they choose to invest in is chosen because it adds value and contributes to risk reduction, rather than because ‘this is what risk management looks like in the NHS’.

Politico-regulatory environment

A sobering consideration from the Audit Society thesis is that countering the spiral towards empty compliance is not solely within the gift of a single NHS organisation – external pressures have caused risk management to evolve in a particular direction, so changing this
direction demands a change in the regulatory and political environment. There are conflicts in external messages about risk management in the NHS, such the expressed preference for a low-blame culture (Francis, 2013) but concurrent implementation of legalistic approaches which incentivise hiding of errors such as the Duty of Candour regulations, and rating Trusts based on incident reporting rates (Campbell & Wintour, 2014). These conflicting messages could create uncertainty, causing organisations to seek legitimacy as a form of self-protection. Whilst examination of these external pressures is outside the scope of this study, it is clearly an area where further research could have significant benefit.
Conclusion

This study has examined specific processes of risk identification, assessment and escalation in a single NHS organisation to attempt to understand what factors influence these processes and how they impact on organisational risk analysis. Whilst the findings are not able to be extrapolated beyond the Trust under review, they raise questions which other NHS organisations may find useful to consider.

For the organisation in question, this research has shown that ambiguity in organisational goals has impacted the processes of risk perception and identification, with a wide range of issues processed through the risk governance frameworks. Whilst there are advantages for this in terms of capturing information, there are adverse consequences as well, including inconsistency and increased bureaucracy as the information to be processed through the system grows. Isomorphic processes can lead to group subcultures developing, compromising the Trust-wide consistency desired for risk analysis; and the limitations of the tools used for risk assessment suggest that review is at least required and if they continue to be used, systems established to correct for their shortcomings.

For this and other NHS organisations, the wider questions to be asked are around finding a balance between regulatory expectation and organisational functionality. The recent decisions by the CQC and NHSLA to review their methods should act as a signal to NHS organisations that now is the time for approaches to risk to be examined and where they are found to be lacking, for change to occur. The Audit Society thesis paints a picture of risk governance becoming more about defensiveness than understanding risks; to ensure this does not eventuate, organisations must actively decide what approaches will work best for them, rather than passively adopting mechanisms which meet regulatory requirements but don’t meet organisational needs. This will require more research, more resource and challenge both internally and externally, but too much is at stake to let risk analysis become rote compliance for regulatory purposes. It is hoped that this study can at least start a conversation which will allow NHS organisations, their regulators and other stakeholders to engage in finding solutions which benefit all – especially our patients.
Appendix A – ethics and risk assessment forms

Note: the forms provided have been anonymised with regards to the organisation being studied, but details can be provided upon request
Research ethics screening form

Email confirmation that the form will be signed by Henry Rothstein and submitted to the Geography Office on my behalf. The signed form is available from the Geography Office – this was confirmed in a telephone conversation with Maria Halas Lisoy on 26 August 2014.

---

From: Rothstein, Henry  
Sent: 29 October 2013 11:45  
To: Reid, Melanie  
Subject: RE: Next attempt

All looks fine to me. I would maybe include a note in 9.4 to the effect that you have got agreement that this is service evaluation and therefore out of the purview of NHS ethics. I’ll sign the ethics screening form for you.

Henry

---

From: Reid, Melanie  
Sent: 26 October 2013 16:30  
To: Rothstein, Henry  
Subject: RE: Next attempt

Henry

Thanks for this very helpful clarification

I’ve attached my low risk ethics form, consent form and information leaflet for you to review and submit if you are happy with them - let me know if not and I will amend.

With regards to NHS permission, I have confirmation that the Trust considers the project to be service evaluation rather than research so it will be registered with our Clinical Audit department (rather than the Research Office) - I will complete the registration form shortly, so let me know if you need confirmation of registration before the ethics application is submitted.

I’ve also attached the screening form which I need your signature on - is it OK to do this by email or do I need to bring a physically signed copy into the Geography office? If you/KCL are happy to accept my email as my signature, could you please sign and pass on to the Geography office? If not, I will need to organise a time to get your signature for submission on Friday.

Many thanks,

Melanie
Confirmation from R&D Office regarding ethical approval

From: Lunny, Marice
Sent: 01 November 2013 09:51
To: Reid, Melanie
Cc: Butcher, Daniel
Subject: RE: MSc Dissertation

Dear Melanie,

Apologies for my delayed response on this.

We are in agreement with the R&D Office that this is service evaluation and therefore doesn’t require ethical approval from the College either. Therefore there is no requirement for you submit an application through the low risk system as this system only reviews research. From a College perspective you are free to commence this work.

Let me know if you have any further questions.

Kind Regards

Marice

From: Reid, Melanie
Sent: 20 October 2013 16:55
To: Butcher, Daniel
Subject: MSc Dissertation

Dear Daniel,

I am a PT student of Henry Rothstein's, entering my second year of a MSc in Risk Analysis. I am not 100% sure of the ethical approval requirements for my dissertation study and Henry has suggested that I get in touch with you for advice.

Essentially, the work that I am proposing to do is low risk according to the Low Risk Ethics Application Guidance, but it will be using NHS data which has made us consider whether the study needs further review. I will be undertaking a case study of how risks are identified and escalated at [redacted], where I work as a risk manager. I will be undertaking secondary analysis of data I already have access to by virtue of my job, and conducting interviews with staff (selected due to their role in assessing risks) about how they assess risks. There is nothing patient identifiable in the risk registers. Staff involved in interviews will need to provide informed consent and can withdraw at any time.

I have spoken to our R&D office who have advised that under NRES criteria this would be service evaluation rather than research, so NHS REC approval is not required.

Could you please let me know your thoughts on whether or not this research can go through the low risk ethics pathway? If you require further information, please let me know - if it would be easier, you can contact me on [redacted].

Many thanks,
Melanie
Page left intentionally blank – see bound copy for NHS organisation confirmation of registration of project
Page left intentionally blank – see bound copy for signed risk assessment form
<table>
<thead>
<tr>
<th>Year</th>
<th>Event(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1989</td>
<td>First formal risk management programme in NHS piloted at Brighton Health Authority</td>
</tr>
<tr>
<td>1990</td>
<td>NHS and Community Care Act establishes an internal market system and requires NHS organisations to become provider Trusts from whom healthcare will be purchased</td>
</tr>
</tbody>
</table>
| 1991 | - Crown immunity removed from NHS, making NHS organisations liable to prosecution for offences, including clinical negligence  
- The first NHS Trusts established as self-governing bodies, responsible for their own risk management |
| 1992 | Cadbury Code published bringing principles of corporate governance into the private sector |
| 1993 | First formal guidance on risk management in the NHS published by NHS Management Executive, explicitly making risk management the responsibility of NHS managers rather than risk management professionals |
| 1995 | Establishment of the Clinical Negligence Scheme for Trusts and the NHS Litigation Authority as its administrator |
| 1997 | - White paper “The New NHS, Modern, Dependable” published to address issues of quality and effectiveness. Includes proposals for establishment of the National Institute for Clinical Excellence (NICE) and the Commission for Health Improvement (CHI)  
- Nolan report published, introducing the term ‘clinical governance’ to the NHS |
| 1998 | - Consultation document “A First Class Service: Quality in the New NHS” outlined the government’s strategy for quality management, with clinical governance anticipated to be implemented in all Trusts by early 1999 |
| 1999 | - Health Act introduced a statutory duty of quality and introduction of systems for continuous improvement in the NHS via clinical governance  
- NICE and CHI established  
- “Clinical Governance in the New NHS” provided practical guidance to Trusts on implementation of clinical governance  
- Requirements introduced for NHS Boards to sign off on assurances for internal controls and risk management as well as finance  
- “To Err is Human” report published by the Institute of Medicine in the US, highlighting high rates of patient harm during healthcare |
| 2000 | - “An Organisation with a Memory” published in the UK, a report of an expert group on learning from adverse events in the NHS identifying that incident reporting and learning systems need significant development  
- The Department of Health announces the creation of the National Patient Safety Agency (NPSA) and the National Reporting and Learning System (NRLS) to centrally drive the patient safety agenda across the NHS |
| 2001 | - Kennedy Report of the Bristol Royal Infirmary Inquiry published, identifying key failures around teamwork, leadership and environment where problems were not adequately identified or addressed  
- Redfern Report of the Royal Liverpool Children’s Inquiry investigated retention and disposal of human organs and tissues removed at post mortem, finding inadequate consent and communication procedures  
- Establishment of the NPSA and NRLS |
<table>
<thead>
<tr>
<th>Year</th>
<th>Event(s)</th>
</tr>
</thead>
</table>
| 2002 | “Assurance: the Board Agenda” sets out responsibilities of NHS Boards, including an understanding of risks facing the organisation  
- CHAI formed from the amalgamation of CHI and National Care Standards Commission  
- Risk Register Working Group guidance published |
| 2003 | Health and Social Care Act establishes Monitor as the regulator for Foundation Trusts |
| 2004 |  
- First Foundation Trusts established  
- AS/NZS published the first formal generic standard on risk management, promoting the use of matrices in risk assessment  
- CHI subsumed by the Commission for Healthcare Audit and Inspection, later renamed the Healthcare Commission (HCC)  
- “Seven steps to patient safety” published by NPSA, including the need for integrated risk management across the organisation |
| 2006 |  
- Results of the Harold Shipman Inquiry published, recommending introduction of regular assessment and appraisals of doctors  
- “Risk assessment programme” published by NPSA |
| 2007 | “Health risk assessment made easy” published by NPSA |
| 2008 |  
- Health and Social Care Act establishes the Care Quality Commission, replacing the HCC and two other regulators  
- “A risk matrix for risk managers” published by NPSA, first formal NPSA endorsement for use of a 5x5 risk matrix tool |
| 2009 |  
- CQC introduced  
- ISO publishes first international standard of risk management, drawing heavily on AS/NZS  
- First Inquiry report into failings of care at Mid-Staffordshire NHS Foundation Trust published |
| 2010 |  
- White paper “Equity and Excellence – Liberating the NHS” published, proposing radical NHS reforms  
- Second Inquiry report into failings of care at Mid-Staffordshire NHS Foundation Trust published |
| 2012 |  
- Significant NHS reform under the new Health and Social Care Act, including establishment of NHS England  
- NHSLA commences review of strategic aims and approach to risk management and harm reduction  
- CQC commences strategic review of its inspection and regulation services  
- NPSA disbanded; patient safety functions transferred to NHS England and NRLS transferred to Imperial College Healthcare NHS Trust |
| 2013 |  
- Third (public) Inquiry report (Francis report) into failings of care at Mid-Staffordshire NHS Foundation Trust published, including a recommendation for a statutory duty of candour  
- Berwick report “A promise to learn – a commitment to act: improving the safety of patients in England” published, to distil the lessons learned through the Mid-Staffordshire scandal and reviews for NHS and government and to specify the required changes. The report disagrees with an automatic duty of candour  
- Keogh report published of an investigation into 14 hospitals with high mortality indicators  
- NHSLA decision to move away from the use of standards and assessments |
| 2014 |  
- Duty of candour consultation led by the Department of Health  
- NHSLA introduced Safety and Learning function to achieve its strategic aims |

This table has been compiled with thanks to Walshe (2001); Hammond (2010), NHSLA (2012; 2014)
Appendix C – risk form in use at the Trust

The risk form includes the following fields for completion:
- Risk title
- Description of risk
- Risk lead
- Date the risk was identified
- Date the risk was last reviewed
- Date of next planned review
- Risk location – Division, physical location
- How was the risk identified?
- Type of risk
- Controls in place
- Are the controls adequate to control the risk?
- Progress notepad
- Risk grading – initial (matrix #1) – details overleaf
- Risk grading – current (matrix #2) – details overleaf
- Closed date
The matrix:

<table>
<thead>
<tr>
<th>Likelihood</th>
<th>1 No injury, no treatment, no financial loss</th>
<th>2 Short term injury, 1st aid treatment, minor financial loss</th>
<th>3 Semi permanent injury, medical treatment, moderate financial loss</th>
<th>4 Permanent injury, long term harm/sickness, fire, major financial loss</th>
<th>5 Unexpected death, catastrophic financial loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 Common occurrence – 1:100 chance in any one year</td>
<td>5</td>
<td>10</td>
<td>15</td>
<td>20</td>
<td>25</td>
</tr>
<tr>
<td>4 Easily foreseeable ((1:1000\text{ to }1:100))</td>
<td>4</td>
<td>8</td>
<td>12</td>
<td>16</td>
<td>20</td>
</tr>
<tr>
<td>3 Foreseeable under unusual circumstances ((1:10,000\text{ to }1:1,000))</td>
<td>3</td>
<td>6</td>
<td>9</td>
<td>12</td>
<td>15</td>
</tr>
<tr>
<td>2 Unlikely sequence of events ((1:100,000\text{ to }1:10,000))</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>1 Freak event – no known history ((1:100,000\text{ or less}))</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
Appendix D – interview questions

Background
1. Job title, length of time in role
2. Involvement in RAG, any training?
3. What does risk mean to you? Why do we identify and assess risks?

Risk identification
4. How are risks identified?
5. What qualities does a risk have to be logged on the risk register?
7. Anything you are worried about which isn’t on?
8. Cross-divisional sharing – how does this work?
9. Who owns risks on the register?

Risk assessment and scoring
10. How do you assess a risk?
11. What’s most important - the score, the rating or the narrative?
12. Who decides on the assessment?
13. How do you deal with disagreement with assessment?
14. How does RAG assessment compare to clinical risk assessment?
15. Do you refer to the risk register outside of the RAG process?

Risk escalation
16. How is risk information escalated? To whom?
17. Does register and escalation make change happen?
18. Do you get feedback from escalated risks?
19. How would you escalate risks you are really worried about?

Follow up questions
20. Overall, what is the purpose for the systems we have in place –RAGs, risk registers etc.?
21. Anything you’d like to add or anything you expected me to cover which we did not?
Reference list


