

Risk and Public Services



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Risk and Public Services

In this special publication Christopher Hood (Oxford) and Peter Miller (LSE) ask what is new about public services risk and how risk in this area is different from other sorts of risk; Sally Lloyd-Bostock (LSE) and the late Ellie Scrivens (Keele) assess the management of risks in healthcare; Rod Morgan (Bristol) looks at risk management in custodial services; Tony Travers (LSE) writes on risks in education; and Sue White (Lancaster) and her co-authors explore how risks are managed in the high blame environment of children's social care.

The six pieces developed from a conference on Risk and Public Services convened jointly by the ESRC Public Services Programme and the LSE's Centre for Analysis of Risk and Regulation at the end of 2007. We hope this collection will help to promote continued discussion of a topic that is central to the provision of public services and likely to become more so in times of fiscal squeeze.

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Public Service Risks: What's Distinctive and New?

Christopher Hood and Peter Miller

What's Distinctive About Public Service Risks?

'Public services' are to politics what 'income' is to the Income Tax Acts – a term that's pervasive, but seldom defined, and then usually only in relation to specific disputes. In one sense, risk is central to public services however we define such services. For example, vaccination can save life in impressive numbers (some estimates of lives saved worldwide by MMR vaccinations between 1999 and 2005 put the numbers at 7.5 million or so), but in most cases there are also small risks of death or severe adverse effects. Likewise, given that obesity is conventionally claimed to reduce life expectancy by about nine years, school sports or measures designed to encourage children to walk or cycle to school can reduce the risks of early death in aggregate, but are also attended by low-probability high-consequence additional risks of death or serious injury. Many other examples can be given. But when we go beyond that general observation, the kinds of risks that are distinctive to public services depend on how we define public services, as the table below indicates.

	Definition of 'public service'	Example	Key risks
(a)	Services whose consumption is inherently collective in some way	Water supply	Systemic risk (of collective failure)
(b)	Services that involve use of the state's powers of compulsion over and above tort or contract law	Protection of children from parental abuse	Risks of sovereign failure
(c)	Services in which politics overrides markets	Publicly run banks	Political credit risks (of damage to political standing)

(a) Collective consumption and systemic risk

You might see public services as those services involving matters that have some or all of the qualities that economists conventionally associate with public goods or bads (non-excludability, unavoidable jointness of consumption, indivisibility of benefit or harm (see Ostrom and Ostrom 1991)). Standard examples include systems of defence or justice. Any public service so defined inevitably raises risk issues about how much protection is sufficient (as in the pieces that follow by Rod Morgan and Sue White and colleagues), and what measures will produce what results. All four services discussed in this Risk and Public Services publication have

some public good aspects of that type, with corresponding risk issues.

For public services in this sense, the salient risks involve not only those that any organization faces, but significant elements of 'systemic risk' too. Systemic risk denotes risks affecting a whole population or industry, such as military occupation, climate change, or the collapse of the underpinnings of a capitalist market system, such as robust identity or credit systems. Such risks are often ignored or given only a subordinate role in private-sector risk management, but they are fundamental to public services conceived as public-good provision.

(b) State Power and the Risks of Sovereign Failure: Deciding Who Runs What Risks

If you take a closely related but slightly different definition of public services as those services involving use of the state's special legal powers – its 'public power' to punish, permit, forbid and command – similar risk issues arise. Unlike private actors, the state has the legal power to determine the boundaries that define who runs what risks. Examples of

the use of such power in public services are military conscription, property requisitioning, removal of children from parents and other measures that compulsorily transfer risk from one group to another. In such cases, risk is not just an exogenous phenomenon to be managed, but the product of a legal power that can ultimately amount to deciding who lives and who dies. Each of the four services discussed in the pieces that follow involve some aspects of this type of the state's legal power. It is true that private individual or corporate acts can sometimes have the same effect, but the setting in which they take place is institutionally and legally different.

The distinctive risk associated with public services in this sense is that of 'sovereign failure'. By that is meant misallocation of risk through legal power, the reduction of welfare caused when powerful lobby groups capture the state's legal power to transfer risk from one party to another for their own gain, and other harms arising from the misuse of state-specific legal powers. To manage this kind of risk, corporate risk management frameworks will often be less important than legal and democratic process checks such as the classic principle *habeus corpus*.

(c) Politically-chosen Services and Political Credit Risks

Alternatively, you can think of public services empirically – simply whatever political leaders choose to provide, whether or not they involve 'public good' features or the public power. And we do not have to look far for examples of services of this type. Political leaders have often chosen to run services that could readily be provided by private markets, such as pubs or banks or car factories. There have even been state-run brothels in some times and places, with all their attendant risks.

For public services in this sense, the risks of provision and consumption will in one way not be distinguishable from other social and commercial activity. But public services so defined are dominated by a special kind of 'reputational risk', namely the risks to politicians and other high officeholders of political blame when services fail. They are necessarily linked to competition for votes among political parties in democracies. So the dominant currency in which risk is reckoned is that of political reputations and chances of securing or retaining political office, rather than that of financial cost. It is a world in which the assessment of political credit risks – traditionally the stock-in-trade of civil servants, at least before today's managerial age – is the central concern in practice.

What's New About Risk in Public Services?

So what, if anything, is new about risk in public services, in theory or practice? Despite all the 'risk society' hype, we might at first sight conclude that not much is new. After all, risk management has always been the central concern of the military and emergency services. And many of the most dramatic breakthroughs in social risk management have come from the state's activities, such as vaccination programmes as mentioned earlier. But at least three things seem to be fairly novel about risk in modern public services.

One is the emergence of a more high-pressure political-risk context for public services delivery, produced by a combination of information-age media and a post-cold-war style of politics that focuses heavily on public services provided to the swing voter.

A second is a more complex and internationalized world of public service provision, producing new forms of risk and new ways of dealing with them. Developments such as partnership arrangements, together with more complex regulation and more ostensibly arms-length delivery arrangements, increase the motive and opportunity for organizations to unload risk and blame onto one another. In combined military operations, the risks faced by one branch of the services can be inverse to those faced by other branches (for example, the risks faced by ground troops are likely to be greater, the further the navy or air force is from the combat zone, and vice-versa). That problem becomes pervasive in a 'partnering' world of public service provision. The danger of course is that each individual branch of the services managing its own risk can lead to overall failure in battle.

A third is the development – outside the traditional world of the state's management of risk, such as military operations, foreign affairs and emergency services – of a new language of risk and new formalized and bureaucratized risk assessment and management systems (such as risk committees, risk officers, risk maps and assurance frameworks, intended to make the future more manageable and calculable). This new world of generic risk management, which features in all of the five pieces that follow, comes from real or imagined private sector practice, and is spread by a new epistemic community of risk-management specialists (see Power 2007; Miller and Rose 2008).

Where Generic Risk Management Meets Distinctive Public Service Risks

We still have much to learn about the effects of that new risk management approach. Even for the private sector where such developments began in their modern form, there are questions about the efficacy of such systems, about the relationship between formal risk management and the 'real' management of risk in organizations, and about the returns relative to the costs of investing in formal risk assessment and management systems – a calculation rarely if ever made, even in the private sector.

But when private-sector-derived organizationally-based risk management frameworks are applied to public services in the three senses described here, they face extreme challenges. They do not transfer easily to the risks associated with the public goods provision, which rarely if ever involve single organizations or jurisdictions, and can lead to bizarre consequences if they are applied. Wherever public services are provided by multiple organizations, the classic combined-operations problem that we mentioned earlier will arise. No private-sector organizationally-focused risk management framework can handle this kind of problem.



For public services considered as activities involving the 'public power', the lack of market checks has key implications for risk management. In the private corporate sector, financial markets and analysts form some independent check on the robustness of a publicly listed corporation's risk management. But there is no equivalent check on public services' risk management. So the remedy has to lie outside the standard corporate risk-management framework, whether in democratic design, inter-jurisdictional competition or rating-agency activity.

Strange things can happen, too, when such risk management frameworks are applied to public services defined as services that politicians choose to provide. Given that the distinctive risks associated with public services in this sense are political risks – whether of loss of credit or office – there are strong incentives to use risk management frameworks for symbolic reassurance or blame-avoidance rather than 'real' risk management. Rigid and stylized protocols, committees and partnership arrangements that disperse rather than concentrate responsibilities, and defensive and standardised approaches to information provision can be the result, sometimes producing 'countervailing risk' problems of the kind much discussed in the literature on 'assurance' and 'avoidance activities' in defensive medicine (see Wiener 1998).

So we need to think harder about what happens when the new language and practice of risk management is transferred from the business world to public services. While the costs and effectiveness of formal risk management systems remain to be demonstrated, such systems can too easily turn into a tool for blame avoidance and risk transfer. Unreflective use of private-sector-derived risk management practices presented as generic can easily either become distanced

from the real risk management processes or produce sub-optimal effects. And go-anywhere frameworks that aim to standardize and formalize organisational processes can obscure as well as clarify. In risk management, public and private services can sometimes be 'alike in all unimportant effects' (a phrase coined by Wallace Sayre and used by Graham Allison (1992)). For this reason, we need public-service-specific risk management frameworks that are more than convenient tools for blame avoidance or for avoiding difficult choices.

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Risk-based Approaches and Professional Regulation by the General Medical Council

Sally Lloyd-Bostock, CARR, LSE

Given the UK government's strong promotion of risk-based regulation and reducing regulatory burdens, it is perhaps not surprising to see the rhetoric of 'better regulation' and risk-based approaches in proposals for reform of the General Medical Council (GMC). It is evident, for example, in the 2007 White Paper, *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century*. But how workable are these approaches when it comes to regulation of the medical profession by the GMC? The GMC itself has expressed reservations, as has the Chief Medical Officer Sir Liam Donaldson. This piece explores some of the dilemmas and obstacles that arise.¹

Professional Self-regulation by the GMC

The GMC was originally created pursuant to the Medical Act 1858, primarily to enable the public to distinguish suitably qualified doctors from 'quacks'.² Today's GMC, still funded entirely by doctors' subscriptions, has statutory authority under the Medical Act 1983 as amended. Its duties include maintaining up-to-date registers of qualified doctors, dealing with doctors whose fitness-to-practise is in doubt and wider duties of fostering good medical practice and promoting high standards of medical education. The Council summarises its purpose as to 'protect, promote and maintain the health and safety of the community by ensuring proper standards in the practice of medicine'.³

The rise to prominence of risk-based regulation has coincided with a turbulent period for the GMC. By the 1990s, discontent with the 'old GMC' was coming from within the medical profession and within the Council itself, as well

as from academics and the public.⁴ Radical reform was already under way when a series of high profile failures in medical care brought the GMC under close scrutiny. The failures in paediatric cardiac surgery in Bristol⁵, together with several other 'bad cases' (*Ledward, Shipman and Neale*), presented a 'picture of a profession, a GMC and an NHS that had been casual about poor practice'.⁶ Most notably, the Inquiry into the Harold Shipman case was strongly critical of the GMC⁷. The Chief Medical Officer responded with a positive agenda for reform of the GMC, expressing support of risk-based approaches.⁸

The search for new approaches has also been encouraged by the growing global literature on medical error and 'adverse events', which has revealed healthcare as a source of risk on an alarming scale. Extrapolations from the data collected for the Harvard Medical Practice Study suggested that 100,000 Americans die each year from adverse healthcare events, almost 70 per cent of which were potentially preventable.⁹ A more recent study in the US¹⁰ estimated that at least a third of physicians will, at some time in their career, have a condition (most often a health or drug dependency problem) that impairs their ability to practise medicine safely.

Against a background of changing culture and uncertainty about its future, the GMC has expressed openness to risk-based regulatory approaches. However, ambivalence and sometimes serious reservations about risk-based regulation and better regulation principles are also found in GMC and Department of Health documents.¹¹ Some reservations relate to the acceptability of a risk-based approach in a professional context in which public trust and confidence is so central. Some relate to the practicalities of risk assessment and to the inherently moral nature of risk-based decisions. Some of the dilemmas the GMC confronts can also be seen as related to the definition of risks. This piece does not detail the debates, but draws out some of the issues, in three sections: defining risks, assessing risks, and weighting risks.

Defining Risks

Defining the risks that are properly the concern of the GMC is less straightforward than it



might seem. Black distinguishes between the regulation of risks to society and regulatory or institutional risk, concerned with risks to the regulatory agency itself¹² and the same point is made by Hood and Miller in the previous piece in this collection. Neither the societal nor the organisational risks the GMC must regulate and manage are easily defined. Its focus is individual doctors, but it must fulfil its duties in co-operation with a complex network of organisations. As Sir Donald Irvine (former President of the GMC) expressed it, 'The GMC sits uneasily at the interface between the medical profession, the public, Parliament and the National Health Service'.¹³ Organisational complexity is growing as new bodies concerned with standards and excellence in healthcare are created, and the GMC's remit alters as responsibilities are added, removed or redefined, obscuring where the work of the GMC begins and ends. Changing NHS work practices, changing conceptions of the causes of medical error which embrace organisational factors, and growing emphasis on supporting rather than sanctioning unsafe doctors, all have an impact on the definition of the GMC's role. The GMC endorses the 'four layer model' of professional regulation.¹⁴ 'Personal' and 'team-based' regulation are primarily concerned with the responsibility doctors take for their own and their colleagues' performance, guided by their duties as registered doctors. 'Workplace regulation' refers to NHS responsibilities, expressed through clinical governance and performance management systems. The work of the GMC is concentrated at the fourth level, 'professional regulation'. The hope is that each level will fulfil a distinct but complementary role.

Amongst the risks the GMC must manage are those associated with relying on other bodies, for example to provide reliable information about NHS employment environments, doctors' performance, and appropriate educational standards. Ambiguity over which risks various bodies ought to regulate gives rise to possibilities for blame transference and blame avoidance, creating further risks to the GMC. Organisational complexity in itself creates risk by creating room for error arising from ambiguities about responsibilities and accountability; and from failures in communication within hierarchies.

Assessing Risks

The heavy information demands of risk-based approaches are a serious impediment to their implementation in medical regulation.¹⁵ Information sources related to patient safety and the performance of doctors have proliferated in recent years, but information gathered for one purpose is often ill-fitted to serve other purposes. Reviewing the various data sources, Vincent writes of 'the problems of the existing abundance of poorly integrated systems'.¹⁶



In the case of professional regulation, complaints from members of the public are often a prime source. Complaints provide a rich source of risk-related information, but it is generated within reactive disciplinary systems. Any information is a function of the process whereby it was created. The GMC's own data on fitness-to-practise cases relies on matters being brought to its attention, which in turn depends on identification of a 'problem' to which the GMC is seen as the appropriate body to respond, and willingness to enter a possibly unpleasant complaints or referral process. Complaints and referrals are entangled with social processes of assigning responsibility. They are very unlikely to be representative of risks to patients, or even of patient dissatisfaction or employer concern. For example, research over the past 30 years indicates that most risks to patients are not recognized by them, let alone reported by them. The Harvard Study found little overlap between the incidence of malpractice suits and medical error identified from patient notes.¹⁷ Cranberg *et al* (2007) found a similar gap between patient perceptions and medical 'fact' in medical negligence claims against neurologists.¹⁸ When a patient or relative does decide to express dissatisfaction with the performance of doctors, there are several potential avenues, including the NHS complaints procedures, Patient Advice and Liaison Services, and a negligence claim. This further limits the extent to which data from any particular source is comprehensive. Similarly, information giving rise to fitness-to-practise cases come from several sources, including NHS employers, the police, and occasionally press reports, as well as members of the public. In addition, doctors are now under a professional obligation to report poorly performing colleagues.

Weighting Risks

Deciding on regulatory responses to risk involves deciding which risk factors to include and how to weight them. These are essentially normative and political decisions, and are riddled with difficulties. Difficult questions include: what weight should be given to risks of high impact events? Resources devoted to cases such as *Shipman* are productive: such cases prompt searching inquiry, expose poor practice and give impetus to reform. But should continuing resources be devoted to preventing another *Shipman*, or are they better used to tackle less spectacular risks that may collectively cause greater harm? The GMC has a high profile image to manage. Events that capture public attention naturally attract a high proportion of its effort. Moreover, the potential value for regulators of individual incidents, especially major incidents, should not be ignored, both in producing change and in highlighting previously unrecognized risks. Actual incidents can highlight previously unrecognized risks and attract the attention and resources needed to bring about change. Disasters have the power to change behaviour, at least in the short term, in ways that less vivid sources of information (such as risk statistics) cannot do. However, risk-based regulation attempts to take a neutral stance on the public impact of high profile individual incidents.

A closely related question is: how much weight should be given to public opinion and the so-called 'risk appetite' of the public? Regulators are acutely aware of the importance of maintaining the trust and confidence of both the public and the regulated. The Council for Healthcare Regulatory Excellence came under criticism from within the medical profession for agreeing that maintenance of public confidence should be one of the criteria

for determining 'undue leniency' of decisions referred to the High Court under s29 of the 2002 Act.^{19 20} The GMC is long familiar with this delicate balancing act. Public trust and confidence is of central concern to the GMC and is prominent in current proposals for reform. At the same time, to be effective, and to retain its powers and remit, the GMC must command the confidence of the medical profession. Hood²¹ has suggested that risk models may be seen as a form of defensive risk management in the 'blame game', serving as a transparent and seemingly objective account of agency decisions. Risk-based regulation might therefore be a means of blame avoidance for regulators. However, it undoubtedly carries political risks where risks as perceived and weighted by regulators, politicians, the regulated and the public do not align.²²

Regulators sometimes fear that adopting risk-based regulation could damage public confidence because the approach explicitly accepts a certain level of risk. Human costs – including, in the medical arena, human lives – are assigned values, and winners and losers chosen. How can the regulator decide on a tolerable level of risk of medical error whilst maintaining public confidence? Indeed, the question arises whether a risk-based approach, apparently designed to target regulation and reduce regulatory burdens, is appropriate at all in a context in which the problem is often seen as under- rather than over-regulation of doctors. Sir Donald Irvine highlights the problem:

Why should the public be asked to accept a risk that is largely avoidable? After all it is patients, not doctors, who may be killed or injured by poor doctoring ... The risk-based strategy is not compatible with the concept of a guarantee to the public of a good doctor for all.²³

Risk-based regulation throws these problems into relief. It does not offer solutions to them.

Conclusion

The spread of risk-based approaches has changed the GMC's environment, but it is questionable how appropriate they are to the tasks and public sector values of the GMC itself. Risk-based tools can stimulate systematic thinking and expose questions about priorities, but they can also become instruments in blaming strategies.²⁴ Their use is often costly, limited by the information available, and involves inescapably normative decisions.

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Endnotes

- 1 This piece is based on a recent article, 'Reforming regulation of the medical profession: The risks of risk-based approaches', Lloyd-Bostock, Sally M. and Hutter, Bridget M. (2008), *Health, Risk & Society*, 10:1, 69-83. It relates to a research project currently being conducted by Sally Lloyd-Bostock within the ESRC Public Services Programme, 'An Analysis of Data on Registration and Fitness to Practise Cases Held by the General Medical Council in the Context of Risk-Based Approaches to Medical Regulation'.
- 2 It was originally established as the General Council of Medical Education and Registration of the United Kingdom. At the time, one in three doctors was thought to be practising without qualifications. See Walton, J. (1983), 'Foreword' in *General Medical Council Annual Report, 1982*, London: GMC, 5-6.
- 3 www.gmc-uk.org/about/
- 4 Eg, Smith, R. (1993), 'The end of the GMC? The government, not the GMC, is looking at underperforming doctors', *British Medical Journal* 307: 954; Kennedy, I. (1983) *The Unmasking of Medicine*, London: Granada; Stacey, M. (1992), *Regulating British Medicine: The General Medical Council*, Wiley, Chichester; Robinson, J. (1988), *A Patient Voice at the GMC: A lay member's view of the General Medical Council*, London: Health Rights.
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- 10 Leape, L., Fromson, J., 'Problem Doctors: Is there a system-level solution?', *The Annals of Internal Medicine*, 2006, 144:1-8.
- 11 The inherent looseness of definition of risk-based regulation and related terms is apparent throughout this debate.
- 12 Black, J. (2006), 'Managing Regulatory Risks and Defining the Parameters of Blame: A Focus on the Australian Prudential Regulation Authority', *Law & Policy*, 28, 1, 1-30.
- 13 Irvine, op cit, p 202.
- 14 See eg *The GMC's Proposals on Healthcare Professional Regulation*, GMC, 2006.
- 15 See, eg Sir Liam Donaldson, *Good Doctors, Safer Patients*, Department of Health, 2006, para 55-56.
- 16 Vincent, C. (2006), *Patient Safety*, London: Elsevier, p 58.
- 17 Brennan et al, (1991), *op cit*.
- 18 Cranberg, L.D., Glick, T.H., and Sato, L. (2007), 'Do the claims hold up? A study of medical negligence claims against neurologists', *Journal of Empirical Legal Studies*, 4, 1, 155-162.
- 19 National Health Services Reform and Health Care Professions Act 2002.
- 20 Editorial, *The Pharmaceutical Journal*, 2004.
- 21 Hood, C. (2002), 'The Risk Game and the Blame Game', *Government and Opposition*, 37 (1): 15-37.
- 22 Black, J. (2006), *op cit*.
- 23 Irvine, Sir Donald (2006), 'Good doctors, safer patients. The Chief Medical Officer's prescription for regulating doctors', *Journal of the Royal Society of Medicine*, 99,9: 430-432, p 431.
- 24 See: Hood, C. and Rothstein, H. (2000), 'Business Risk Management in Government: Pitfalls and Possibilities'; Appendix 2 in Report by the Controller and Auditor General, *Supporting Innovation: Managing Risk in Government Departments*, London: HMSO, pp 21-32.

The Risk of Risk-Preoccupation: Criminal Justice Policy in England

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Delivering domestic security is the inalienable, though not irreducible, duty of sovereign states. The late or post-modern era has arguably reduced the capacity of sovereign states to deliver security. Which arguably explains why, in recent times, 'law and order' has become the most hotly contested, party political policy sphere (Downes and Morgan 2007) with successive administrations flexing their vestigial muscles ever more vigorously whilst simultaneously seeking to deflect the

obloquy attached to failure. They have done this by *responsibilising* (Garland 2001) others whenever and wherever possible (making parents, for example, punishable for the behaviour of their children) or by contracting out services, thereby holding the quality of delivery at arm's length. One aspect of this trend is a growing formal preoccupation with risk, which now characterises all aspects of criminal justice policy from policing to sentencing.

Sample Form

Likelihood of Reoffending		
Static factors	Scoring	Score
Offence type ¹	<ul style="list-style-type: none"> • Motoring offences/vehicle theft/ unauthorised taking = 4 • Burglary (domestic and non-domestic) = 3 • Other offence = 0 	Click here
Age at first reprimand/caution/warning	<ul style="list-style-type: none"> • 10 to 12 = 4 • 13 to 17 = 2 • No previous reprimand/caution/warning = 0 	Click here
Age at first conviction	<ul style="list-style-type: none"> • 10 to 13 = 4 • 14 to 17 = 3 • No previous convictions = 0 	Click here
Number of previous convictions	<ul style="list-style-type: none"> • 4 or more = 4 • 1 to 3 = 3 • No previous convictions = 0 	Click here
Total static factors score (0-16)		0
Dynamic factors/Asset section		
Dynamic factors/Asset section	Scoring	Score
Living arrangements	0, 1, 2, 3, 4	Click here
Family and personal relationships	0, 1, 2, 3, 4	Click here
Education, training and employment	0, 1, 2, 3, 4	Click here
Neighbourhood	0, 1, 2, 3, 4	Click here
Lifestyle	0, 1, 2, 3, 4	Click here
Substance use	0, 1, 2, 3, 4	Click here
Physical health	0, 1, 2, 3, 4	Click here
Emotional and mental health	0, 1, 2, 3, 4	Click here
Perception of self and others	0, 1, 2, 3, 4	Click here
Thinking and behaviour	0, 1, 2, 3, 4	Click here
Attitudes to offending	0, 1, 2, 3, 4	Click here
Motivation to change	0, 1, 2, 3, 4	Click here
Total dynamic factors score (0-48)		0
TOTAL SCORE (0-64)		

The Focus on Risk

The history of the criminal justice system is conventionally divided into different historical periods. The present period, from roughly the turn of the millennium, has been variously labelled as 'public protection', 'new generation' or 'designer' (Merrington and Stanley 2007; Bottoms, Rex and Robinson 2004; Raynor 2007 and Gelsthorpe and Morgan 2007). Policing is increasingly informed by the granting of legal powers pressed for by practitioners in case they are needed (such as powers to detain terrorist suspects without charge for longer periods). Prosecution is more and more targeted on high risk, repeat offender groups. Sentencing now comprises creatively mixing penal 'interventions' tailored to the nature of offences and the characteristics of offenders. The latter decisions are in theory informed by assessments of both risk and effectiveness. Sentencers are guided, by means of pre-sentence reports prepared by the Probation Service or youth offending teams (YOTs) through use of risk assessments, as to which intervention will work best in terms of reducing risk of both further offending and harm.

Thus, for example, YOTs, following recent advice from the Youth Justice Board (YJB), are pressed to adopt what is termed a 'Scaled Approach' (YJB 2008) when advising the youth court and determining how intensively to supervise sentenced offenders. This mirrors the approach already in place in the Probation Service for adults where the risk assessment tool is OASys – the Offender Assessment System – (see NOMS 2005), and there are also obvious parallels with the risk assessment scoring system for local authority child protection services discussed in Sue White and her colleagues' piece.

On the basis of an actuarial risk assessment tool, the Asset – Core Profile (used to assess



Possible Sentence Structures by Intervention Level			
Intervention level	Function	Typical case management approach	Possible sentence requirement/component (not exclusive)
LOW	Enabling compliance and Repairing harm	<ul style="list-style-type: none"> Organising interventions to meet basic requirements of order Engaging parents in interventions and/or to support young person Monitoring compliance Enforcement 	<ul style="list-style-type: none"> Reparation Stand-alone unpaid work Supervision Stand-alone attendance centre
MEDIUM	Enabling compliance and Repairing harm and Enabling help/change	<ul style="list-style-type: none"> Brokering access to external interventions Co-ordinating interventions with specialists in YOT Providing supervision Engaging parents in interventions and/or supporting young person Providing motivation to encourage compliance Proactively addressing reasons for non-compliance Enforcement 	<ul style="list-style-type: none"> Supervision Reparation Requirement/component to help young person or change behaviour, eg, drug treatment offending behaviour programme, education programme Combination of the above
HIGH	Enabling compliance and Repairing harm and Enabling help/change and Ensuring control	<ul style="list-style-type: none"> Extensive ² Help/change function plus additional controls, restrictions and monitoring 	<ul style="list-style-type: none"> Supervision Reparation <i>plus</i> Requirement/component to help young person or change behaviour Requirement/component to monitor or restrict movement, eg, prohibited activity, curfew, exclusion or electronic monitoring Combination of the above

Overall assessed likelihood of reoffending	
Rating	
Low (score 1-24)	
Medium (score 25-41)	
High (score 42-64)	

the risk of re-offending and supplemented where necessary by Asset – Risk of Serious Harm, which is used to assess risk of serious harm to others), an aggregate score is recorded. From this assessment recommendations are made to the court and the level of subsequent supervision, if a court order results, is determined. Four static and 12 dynamic factors relating to offending are assessed, each scaled 0-4 thereby providing an aggregate score of 0-64. This results in a young offender and an indicative supervision level.

The Downside of Risk-preoccupation

This managerially rational approach comprises, for practitioners, what supervisors term 'defensible decision making'. Risk cannot be eliminated. So it must be managed defensibly. If practitioners tick all the assessment boxes and provide risk-proportionate levels of intervention then, if harm arises, they cannot be blamed. They have done their reasonable best. Over time, however, the evidence suggests that there is a downside to this rationalist orthodoxy. The intensifying emphasis on risk, including high profile publicity given to supervision cases that have gone wrong and resulted in significant harm (see for example, the report on the *Rice* case – HMIProbation 2006),

has prompted progressive risk aversion which calls into question the sustainability of the system and will likely prove counter productive for effectiveness, in terms both of re-offending and of harm prevention.

Consider the following. Since 2003 (Criminal Justice Act s.142) all sentencing supposedly strikes 'the right balance' (Home Office 2002) among five different sentencing purposes, of which 'protection of the public' is one. That is, sentencers must, in addition to the purposes of punishment, deterrence, rehabilitation, and reparation to victims, have regard to the *incapacitative* impact of their decisions so as to safeguard the public from possible future harm. The problem is that the five purposes are in important ways conflicting and the framework is based on weak evidence. That is, it is not at all clear how sentencers can rationally strike the right balance among conflicting purposes. The result is that risk aversion is winning out, not least with regard to the extensive, unforeseen use of indeterminate sentences for public protection (IPPs) introduced by the Criminal Justice Act 2003 (Prison Reform Trust 2007). This sentencing trend has been backed up by a parole system originally introduced to maximize prisoners' rehabilitation, but now has been 'refocused entirely on risk and risk assessment' (Shute 2007). The result is a dramatic build up within the prison system of IPP prisoners, many of them with quite short sentence tariffs (representing the just punishment which the seriousness of their offences is judged to merit), not being released because they have not taken part in offending behaviour programmes that might demonstrate to the Parole Board a reduced risk of re-offending. For this reason IPP prisoners, with tariffs as short as 2-3 years, become indistinguishable from life sentence prisoners.

The IPP saga is only the latest manifestation of a longer-term trend. The record high prison population – over 84,000 at the time of writing – is the consequence of the courts imposing longer sentences in like-for-like cases and resorting to custody in a higher proportion of cases than previously (Hough, Jacobson and Millie 2003).

This more intensive intervention is not confined to custody. It applies also to community-based sentences, where more 'requirements' – proportionate to risk, though there is no evidence that increasing the dosage of punishment or supervision is associated with reduced re-offending – are being imposed by the courts, generally on the recommendation of the probation and youth services. The proportion of offenders subject to probation orders, or their contemporary equivalent, with no additional requirements declined from 85 to 50 per cent between 1985 and 2006 (Home Office 2007, para 6.6). This was not because the offenders were more serious in nature. The proportions of the probation caseload comprising first time, non-indictable or non-violent offenders have all steadily risen

(Morgan 2003). That is, as the system becomes more risk averse, the probation caseload is silting up with minor offenders, with the increased requirements made of them being more strictly enforced, and with the result that growing numbers of offenders initially subject to community orders are being committed to prison for breach.

Conclusion

The evidence suggests that all the political parties are currently wrestling with a fundamental policy dilemma: How to ratchet back the expanding remit of the criminal justice system without appearing to be 'soft on crime' and increasing the public risk of victimisation? To the extent that they succeed, the risk they run can be argued to be more apparent than real. For if more parsimonious criminalisation and intervention policies were adopted, the best available evidence suggests that the risks of re-offending would in fact be reduced, not increased (see McAra and McVie and Morgan and Newburn 2007).

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The Mismatch Between Quality Assurance and Risk Regulation: Will the Real Risk Please Stand Up?

Ellie Scrivens

Better regulation doctrines assume a risk-based approach to regulation is feasible. But in healthcare, as no doubt in other fields, there are major difficulties in determining what 'risk based' actually means, and how it could work. Processes such as corporate governance, systems control, and quality improvement are typically felt to be central to identifying risk in healthcare. But, these elements are difficult to disentangle and manage.

Take as an example a 2007 official report into the conditions at Maidstone and Tunbridge Wells NHS Trust in England, where 90 patients are estimated to have died of *Clostridium difficile* between 2004 and 2006. The report highlighted several similarities between this case and that of Stoke Mandeville hospital, where 30 patients were estimated to have died from the same cause in an earlier investigation. In both cases

'...there were many complaints from patients and relatives about the quality of nursing care. These primarily related to patients not being fed, call bells not being answered, patients left in soiled bedding, medication not administered, charts not completed, poor hygiene practices and general disregard for privacy and dignity.' (Healthcare Commission 2007b)

Such findings have led to much discussion about how regulation can be improved to reduce or remove such risks. While medical regulation of the kind discussed in Sally Lloyd-Bostock's piece focuses on reducing risks created by the failings of individuals, other health regulators operate from the presumption that harm is system driven (Department of Health 2006). But even from this 'organizational' perspective on risk regulation in healthcare, there are two very different views of how the risks arise, and how they should be managed and regulated.

Risk Management in Healthcare Organizations: Two Presumptions

One such view, which can be called the 'systems approach' or 'governance approach', assumes risks of the kind highlighted by the

Maidstone and Tunbridge Wells case are caused by healthcare systems failure rather than individual failures, and that many of these systems failures can be prevented.

Such failures are held to include 'infections, falls and other injuries, and medication and medical device problems, some of which are preventable' (Australian Institute of Health and Welfare, 2004: 292). Systems approaches are based on the assumption that it is necessary to improve reporting, analysis and action to move 'beyond blame' to develop 'a culture of safety' (Braithwaite Healy and Dwan 2005). This view is associated with the assumption that systems that deliver healthcare are directly controllable by management, meaning those who run healthcare organizations can be held responsible for managing the risks of harm to their organizations' patients. Governing bodies and senior managers must therefore show they are aware of the risks particular to their own organization, and that they are continually addressing those risks. They must manage known causes of harm, monitor other unanticipated harms, and be seen to deal with those harms rapidly.

A second and contrasting view, the 'design approach' or 'quality management approach', assumes that external assessors can and should take the lead in identifying systems weaknesses that lead to adverse outcomes. In healthcare such external review often uses standards involving specified practices, intended to manage risks of error. Some models seek compliance with minimum standards of care and require minima to be achieved to ensure safety and quality of provision. Organizational licensing of the kind found in the United States is often based on this approach. Organizational accreditation systems are typically based on standards thought to reflect the best practice to which providers can aspire in their internal systems management, and thus to identify where providers need to improve their systems and processes. Accreditation does not in and of itself necessarily alert providers to risks of harm to patients but in some regulatory systems the achievement of accreditation

is taken as evidence that at least minimum standards have been met.

What is the task of the regulator?

Put simply, the difference between those two approaches lies in where the risk is to be addressed. If risk management is the task of the board or the managers (as in the first view), the regulator needs to confirm that those actors are identifying and managing risks properly, and that they are identifying and managing the *right* risks. The systems approach generally assumes that healthcare organizations will act to minimize risks to their corporate objectives and that those objectives will include good patient care. Associated with John Braithwaite (2001) and his colleagues, this approach assumes that regulators have to find ways to encourage the regulated to seek out and destroy the ever-present possibility of systems failure, and to assess whether such risk identification is being properly conducted.

However, the key criticism of the systems approach is that there may be acknowledged weaknesses inherent in the design of healthcare systems, raising the question of how those weaknesses are to be identified. So in contrast, the design approach – a standards-based view of risk regulation – assumes there is a set of operational practices that must be adhered to, and that adverse outcomes are the product of failure to adhere to practices based on good systems design. That means the task of the risk regulator is to assess compliance against the standards.

The English Dimension

Recent government policy in England has stressed the need to devolve management in public services, including the NHS. This policy approach has tended to go with an emphasis on lighter touch regulation, to reduce bureaucratic compliance burdens. In healthcare the stress has been placed on reducing 'red tape' inspection, in the sense of a high degree of regulatory control, combined with low emphasis on support and facilitation to help organizations improve. The desire to reduce inspection has gone hand in hand with a desire to reduce the prescriptiveness of standards used in inspections. It has been suggested elsewhere that prescriptive standards can lead to '...too much emphasis on measurable outputs and too many rules for workers to keep up with, at the expense of client or user outcomes' (New Zealand Literature Review 2006).

In an attempt to deal with that familiar bureaucratic problem, there have been many attempts to write standards in the language of outcomes. For instance, some two decades ago the US Institute of Medicine (1986) strongly promoted the introduction of standards which would focus on the health and welfare of patients, arguing that 'residents who receive good personalized care and opportunities for choice have higher morale, greater life

satisfaction and better adjustment' (*ibid*: chapter 3) and called for both process and outcome standards to be rewritten to reflect that objective. But such care standards are still highly prescriptive, and in England the attempt to put even more emphasis on outcomes led to the centralized setting of high level standards rather than detailed operational standards, aiming to ensure equity for patients across the country and guarantee basic requirements for quality and safety while permitting local service innovation (Department of Health 2004). The main 'organizational' regulator, the Healthcare Commission, was required to take those high-level standards 'into account' in its assessments of individual organizations. The driving idea behind the high level standard was to provide a common focus for regulators and regulatees and allow a combination of local management with common standards.

The Regulatory Solution in England and Wales

Against that policy background, the Healthcare Commission for England and Wales (created in 2004 and abolished in 2009 on the creation of a new Care Quality Commission) faced a difficult task in risk regulation. It had to work within the requirements placed upon regulators, which effectively mandated a reduction in inspection and a policy of devolved management which emphasized the responsibilities of organizational boards for providing services and assessing the attainment of national standards. To deal with the different demands being placed on it, the Commission opted for a hybrid system based on principles of 'good governance', at the centre of which was an obligation laid on boards to conduct and report on self assessments of their own organizations. Boards had to report whether there had been compliance, or instances of what were termed 'significant lapses' in compliance, with the standards during the previous twelve months, or more seriously in the view of the regulator, insufficient assurance to know whether there had been a significant lapse. That system involved retrospective reporting of each board's perception of its ability to comply with the standards, and the Commission adopted the role of an assurance auditor, attempting to assess the veracity and the validity of boards' claims to have achieved compliance. Failures in compliance with national standards would trigger inspections, although unsurprisingly these did not capture all instances of failures in the delivery of care. Later inspections by the Healthcare Commission, initiated not by self assessment reports but by patient complaints about the quality of care, demonstrated serious failings in the provision of care (Healthcare Commission 2007a, 2007b).

Conclusion

The two approaches discussed above, the systems-based or governance approach (based on the board or managers' ability to identify and manage risks) and the design or quality

management approach (based on defining and monitoring detailed standards), offer rather different ways to address risk regulation in public services. Ideally the two systems should be at least compatible or, better still, mutually reinforcing, but experience suggests it is not so easy to relate the one to the other in practice.

Under pressure from government to reduce the burden of inspections, the organizational regulator in England has turned to broader corporate governance approaches to regulation, because such approaches have risk as their central theme and because healthcare is a complex activity with many risks. Moreover, the concept of risk in clinical practice is about managing the uncertainty of clinical outcome to achieve safety, which is defined as the prevention of harm that could feasibly have been prevented. The concept of clinical risk therefore tends to be tied closely to the idea that good management of risk is something that cannot be externally controlled, but which managers need to be encouraged or cajoled to develop and nurture. Such an approach is compatible with the doctrine of corporate, organization-wide or enterprise risk management that holds that all risks should be subject to 'good' internal risk management processes. The problem with that approach in healthcare is that the process has to encompass a vast number of very differently formulated risks and the sheer number may undermine the assumption that organization-wide risk management is readily feasible.

Indeed, critics think this focus on management systems is inadequate to ensure that patients receive high-quality care. As one senior manager in social care pithily put it, 'There is no performance indicator that can ever be designed that will pick up the smell of urine.' Such critics think there is no substitute for on-the-ground inspection of the conditions in which patients are treated, using so-called 'command and control' models that emphasize compliance with centrally determined requirements and that have been found to be successful in occupational health and safety.

In the search for balance between the two views, the most common solution is for regulators to use a corporate governance model to underpin their regulatory approach but also to use findings from more detailed standards-based assessments in their reviews. However, that system does not lead to a reduction in the level of 'bureaucracy' imposed on regulatees and may indeed increase it. It may also mean that regulators have to depend upon assessments of failure coming from other review or audit bodies, which may lead to legal or other difficulties when it comes to exercising enforcement powers.

The organizational regulation of healthcare worldwide (and not just in England and Wales) is therefore caught between very different models of quality assurance monitoring and

how risks are to be identified and managed. Outcomes and processes compete for position as the best indicators of quality. The way forward is still unclear.

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Managing Risk in a High Blame Environment: Tales from the 'Front Door' in Contemporary Children's Social Care

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Following a number of high profile inquiries into non-accidental child deaths, children's social care services in the UK have been widely blamed for deficiencies in their policies, procedures and practices. As a result, children's services departments have been subject to numerous measures designed to manage risks, including systems of regulation, proceduralization and metrics, all justified using the rhetoric of child welfare. These developments share obvious features with the broader New Labour modernization agenda for reforms in public services.

The reconfiguration of professional work into formalized 'business processes' and a talismanic faith in the power of information and communication technology (ICT) to enable radical organisational change are mutually reinforcing themes of that modernization agenda (Peckover *et al*, 2008a; 2008b). Translating professional practice into standardised procedures, protocols, templates and timescales, all mediated by ICT, aims both to produce an audit trail against which key performance targets may be measured, and to reduce variability and hence 'error' in human performance. Figure 1 gives an illustrative example.

The formal, geometric orderliness of the process model is immediately obvious. But is the real work as formalizable as the model suggests and by what logic will greater formality reduce risks? Standardisation may be the key to improving quality in manufacturing but does it fit the lock of safety in child welfare?

Taking Referrals and Assessing Risk at 'The Front Door'

To investigate these issues, we studied five UK children's services directorates in England and Wales in 2007-8: a London borough, a large county council, a metropolitan borough, a unitary authority ('Seaton') and a Welsh rural authority ('Valleytown'). We studied management and practice (in decision-making loci such as the duty desk and strategy and review meetings) and explored how practitioners and managers responded to referrals and made decisions about priorities and interventions. We will focus here on the early stages of categorization at the so-called 'front door' – the point at which cases enter the bureaucratic system.

Social workers at the front door (in 'referral and assessment teams') faced acute challenges arising from the often competing imperatives to safeguard children while minimising the possibilities of error and blame for failing to meet performance targets. Practices at the front door were reconfigured in England and Wales in the early 2000s following the Department of Health's Framework for the Assessment of Children in Need and their Families (2000). This framework introduced rigorous performance timescales: for instance, within one day of a referral being received, a decision about what response was required had to be made and within seven days an initial assessment had to be complete. Moreover the range of possible 'disposals' was rigorously circumscribed at every stage, with enforcement of deadlines and the sequencing of work built into the ICT systems that social workers had to use. For instance when an assessment or decision became 'overdue' the task would appear in red on the worker's screen and could only be removed once it had been 'workflowed' to the next stage. Such procedures designed to require social workers to prioritize risks and provide a timely response may seem perfectly sensible, but may be inappropriate for the complexity and variety of the cases referred to children's social care. For example, we know as information processors, human beings tend to deviate little from their initial classifications and hypotheses, seeking out evidence that confirms, rather than destabilizes them. Thus, we may expect a system which forces precipitous decision making also to increase error, particularly in situations where minimal information is available.

How did initial assessment teams manage and respond to the 300 or so referrals¹ they faced on average each month (DCSF, 2007)? Table 1 illustrates the problem they faced by listing the referrals waiting for a team manager in 'Valleytown' one Monday morning.

Figure 1. Workflow model of the initial referral and assessment process (CIN – Child in Need; CLA – Child Looked After; CP – Child Protection)

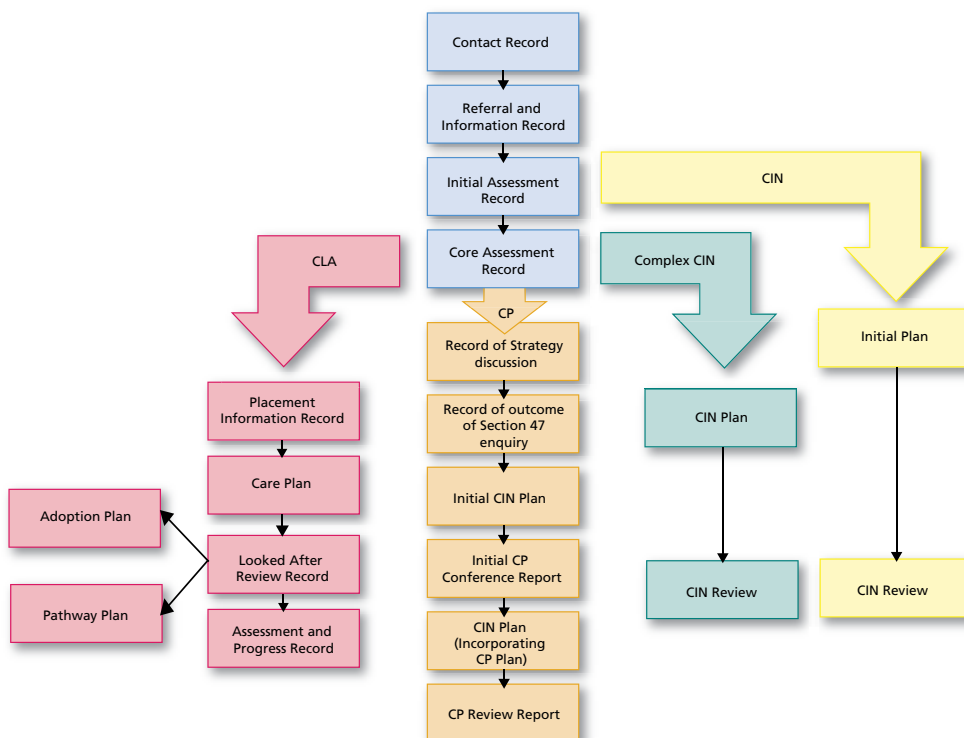


Table 1. 'Monday Morning': Cases Referred to 'VALLEYTOWN' Office

1	Police referral following w/e call out. Three children witnessed domestic violence. Mother taken to hospital with fractured nose. Father arrested.
2	Sexual abuse, and child assaulted by mother.
3	Information that child is having contact with offender who has convictions for sexual assault.
4	Young child (3) shot himself with airgun whilst in care of father over weekend. Parents separated. Child in hospital.
5	Extra-familial assault.
6	Referral from police following domestic violence call out. Children in household.
7	Fight between step-father and young person.
8	Behaviour issues with a teenager. Police called by parents.
9	Out of area child placed in 'Erewhon' area. Older half-brother has alleged that he was assaulted by this foster carer when he was living there.
10	Police referral. Called to argument between a mother and her sibling. Baby present. No assaults or damage reported. Baby not involved.
11	Referral from police following call-out to a domestic violence incident. Ex-partner attacked a woman who has young children.
12	Father with alcohol and mental health issues. Police referral.
13	Catering worker at school hit a child in the dinner queue.
14	Child with severe head lice. Non-engagement with services.
15	Referral from probation. Substance misuser in relationship with woman with three young children.
16	Allegation of physical assault by father to 14 year old son.
17	Notification from police they need to interview a minor who witnessed an extra familial assault.
18	14 year old boy with learning difficulties and past history of abuse from his father. Now concerns about his mothers parenting.
19	Children in care of their mother. Father has a Residence Order but children and mother have moved away. Allegations from father about their care and role of new boyfriend (using alcohol, abusive attitude).
20	Telephone call from mother saying she needed help with the baby as she couldn't cope.

The pressures are obvious, and in all but one of the initial assessment teams studied, far more contacts or referrals were received than they could accept². Rapid decisions were required to distinguish the relevant from the non-relevant, the high from the low priority, all within immutable timescales. And this high pressure decision making took place in a context where there had been a considerable retrenchment of services so that social services could offer a service only to children and families that met strict 'eligibility criteria'³. So various forms of improvisation were used to translate *enforced delay* ('there is nobody to see this case') into the institutionally legitimate rationality of *strategic deferment* (for example, 'I will seek more information'). For instance, in 'Erewhon', the rationing inherent in the initial assessment process was managed by a numerical risk assessment process built into the 'workflowing' software that was used to progress cases. A quantitative score of the estimated severity of the risk posed by each case was arrived at by the following scoring process:

[The likelihood of the 'danger' occurring, scored as 1, 2, or 3]

multiplied by

[The consequences of the 'danger' occurring, scored as 1, 2, or 3]

equals:

Risk Assessment Score.

The scores were taken seriously as an accurate reflection of the risk involved. They shaped decisions about allocation of cases, and speed with which children and families were visited. They were also used to demonstrate to senior managers the extent and seriousness of unallocated cases arising from resource limitations. So the scores had moral and rhetorical force, showing that a rational, judicious process had been followed and that teams were managing under difficult circumstances. In practice only cases scored 6 or 9 would routinely be accepted as referrals in 'Valleytown', with the latter triggering an immediate response. For example, a child aged 3 injured by an airgun while in the care of his father over the weekend was given a 9 and immediately visited (despite that fact that the child was by then in hospital and no longer in immediate danger). A referral from a probation officer about a substance misuser in



a relationship with a woman with three young children, and a police referral about a father with alcohol and mental health issues were typical of the cases receiving a risk score of 6. While those risk scores served as a justification for the rationing of scarce resources in difficult circumstances, the rapid time scales required for response meant the tacit criteria behind the award of the scores were not questioned. In one case a child of 8 who was routinely talking about hanging himself and was found wandering late at night did not receive a high enough risk score to warrant a response. Moreover, as the threshold scores that prompted action depended on the referral rate, the severity of cases that received a score of 6 or 9 shifted from one week to another and even one day to another.

Assessment Team Managers were thus in a precarious position as their role was to manage cases coming to the front door, ensuring that children's circumstances were properly assessed and that steps were taken to protect children 'at risk of significant harm'. That involved deciding the timing and urgency of visits and how heavily to intervene to protect children at risk, up to the point of compulsorily removing children from their homes. Scarce social work resources had to be carefully deployed to ensure the most urgent or 'risky' cases were prioritised, but at that time little information about the child's circumstances was available. Gathering further information through home visits, writing reports, drawing up plans, and completing assessments was intensely time consuming, but had to be completed within strict time limits, with the activities and the time taken measured for the organization's performance indicators. The requirement for audit trails and the pervasiveness of ICT systems means that all these data had to be electronically recorded. The social work office took on more and more the appearance of the back office at a bank; and needless to say, while social workers were inputting data, they could not be out visiting families.

Conclusion

The few illustrations given in this short piece demonstrate the profound and pernicious way that the performance management culture has changed the face of UK social work. More and more (up to 80 per cent) of social workers' time was spent servicing ICTs, entering data and mechanically following bureaucratic procedures. Such preoccupations inevitably reduced the time available for careful investigation of individual family circumstances and engaging directly with real people and their lives.

It is hard to see how such practices can reduce the risk to children, and such evidence as there is gives little indication that micro-management of this type has had any real impact on child deaths and non-accidental injuries. Figures for Serious Case Reviews (undertaken when a

child is harmed or dies and abuse or neglect is believed to be a factor) in England and Wales over the years 2003-2005 were not greatly different from the comparable figures for the 1990s. There were 161 Serious Case Reviews between April 2003 and March 2005, involving deaths (including suicide) in two-thirds of those cases and serious injuries in the other third. Twelve per cent of the children involved were on the child protection register and 55 per cent of them were known to social services departments at the time of the incident (Brandon et al 2008).

At the very least, there are grounds to question whether this kind of risk management has had any effect in reducing risks of death or serious harm to children. And there may even be grounds for concern that performance management has produced a dystopia in which the very reverse will be the case. All good design begins with systematic research; the work ecology must be thoroughly understood and users must be involved (Kawalek and Wastell, 2005). Instead, the systems now in place to manage risk in child welfare have been imposed from the top down, seemingly designed on no more than dogma and an all-pervading enchantment with numbers, paying little heed to Einstein's simple dictum:

Everything that can be counted does not necessarily count; everything that counts cannot necessarily be counted.

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Next Risk Please: Metrics and Risk Management in Schools in England

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Nowadays schools need to think about many questions that, in the past, would not have concerned them. Changes in society and escalating demands from the core of central government have generated significantly greater risks than in the past. This short piece attempts to provide a framework for analysing the extent of the risk-based demands now facing individual institutions.

Schools in England are currently part of a wider sphere of government attention that includes social services, youth justice and other aspects of childcare. The government has responded to earlier failures within childcare, notably the 2003 Laming Report¹ by creating 'children's services' departments within local government, removing the previous divide between 'education' and 'social services'. The risk of failure within social care and education services for children has become a major driver of institutional reform and professional behaviour. This piece considers the consequences of 'risk' for schools in the wider context of policy towards children.

The provision of public services for children is now seen as sufficiently important to justify the creation, in 2007, of the Department for Children, Schools and Families. This department explicitly brought together schools, social services and elements of the youth justice system insofar as they related to children and families. The implication of the pages in the new department's first annual report² devoted to safety and the duty of care owed by public bodies to young people was that there are many risks faced by schools and other institutions.

In a section of the report entitled, *Role of schools in safeguarding children*, it was stated that:

'Schools are legally bound by a duty to carry out their work with a view to safeguarding and promoting the welfare of children [...] People working in schools should be able to identify any concerns about children's safety and be willing to act on them. All staff working in schools should have training on protecting children, and every school should have a person designated to deal with child protection issues'³.

This and other parts of the report strongly imply that schools now have a wide-ranging responsibility to ensure children are protected from risks not only within the school itself, but also at home, in care, in hospital and in all other circumstances. The use of the term 'legally bound' is extremely powerful and suggests schools now face far greater risks than in the past. Any act of abuse, cruelty or neglect affecting a child could, if undetected by a school, result in its staff being held to account for matters that had taken place beyond the school gates.

Risk in Schools

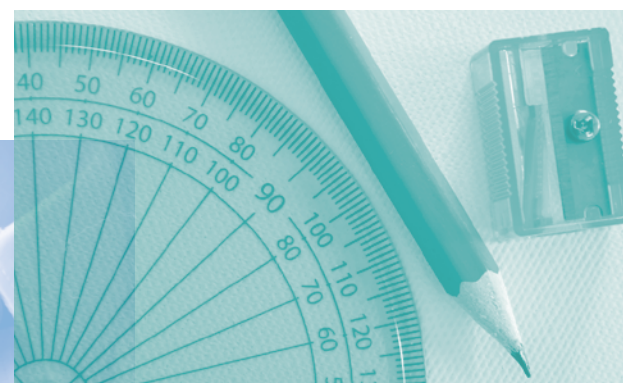
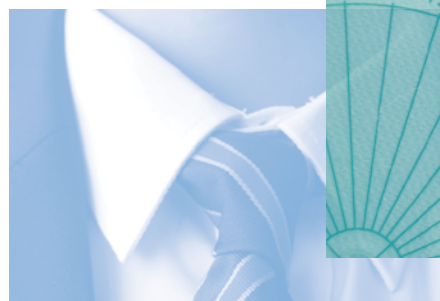
Schools now find themselves in a position where the state and the public expect them to protect and develop children in ways that imply significant risks to institutions and those who work in them. Moreover, the development of complex measures of performance and the need for institutions to protect themselves against the risks of failure to deliver against

government targets has also become a subject of concern to regulators, commentators, head teachers and the public.

In the 'social services' part of children's services, there has been a sharp move towards formal efforts to reduce risk, including software systems that prompt social workers to check 'at risk' children as described by Sue White and her colleagues in the previous piece. Schools, as autonomous institutions subject to national regulatory oversight, are in a complex position, when dealing with pupils with and without special educational needs. Risk management is located in various places, including head teachers, governing bodies, local authorities, Ofsted and the Department for Children, Schools and Families.

Concerns of various kinds evolve within central government (and its agencies), leading to the setting of objectives and targets. Schools must then decide how to respond to government initiatives and demands for delivery. The government is often willing to penalise – or to threaten to penalise – institutions that do not deliver. Head teachers and governors, inevitably, feel the need to develop defensive strategies to cope with new demands. For example, schools have responded to the risk of financial difficulty by creating cash balances, only to then find themselves faced with a new problem – the risk the government will penalise them for excessive prudence. This is by no means the only risk that heads and governors must juggle in providing education at the institutional level. Schools face risks such as a decline in examination performance, litigation by disaffected parents, changes in central government policy and, most emotively, the possibility that one or more children within their care will suffer an accident.

As a result of the particular model of target-setting, regulation, performance measurement and public protection that has evolved, head teachers need to respond with strategies to manage risks. It will not always be easy to differentiate between short-term government concerns and those that will last for several years. Moreover, the demands of 'joined up government' imply that schools must now take an interest in many spheres of public policy that in the past would have been outside their direct concerns.





Schools must now accept responsibility not only for educating children, but also for assisting parents in the wider job of bringing up those children. Thus, for example, schools will now have to take a role in helping parents to monitor and control their children's weight and/or exercise patterns. Schools must also watch out for signs of ill-treatment at home. They must also accept responsibility for their pupils' behaviour in local shops and on public transport.

Head teachers now face media attention if there is an incident involving children from their school. In the light of recent public health concerns about obesity and the demand that schools monitor children's weight, it is surely likely that there will soon be demands for national league tables of schools with different numbers of overweight children. In order to mitigate the risk of being found to be a 'fat school', heads will have to take precautions to recalibrate their efforts towards the issue of exercise and diet.

Conditions That Increase Risk

The recent political development of Britain (mostly England) suggests small institutions such as schools and hospitals will face serious threats from risks of various kinds, for five main reasons:

- Centralised control of policy-making for schools, supported by...
- numerous 'national' regulators reporting into a heavily nationally-oriented media which have...
- aggressively stated concerns about educational standards and an array of other 'risks' and which use...
- evidence of failures within a minority of schools as a measure of the government's performance/failure...
- which are used by the opposition to attack the government and its policy.

Thus, falling standards, changes in pupils' health, behaviour problems or other difficulties in a minority of schools are a major risk to their heads and governors because there is a chance such matters will be used as a way of attacking the government more generally. The risk at the school level becomes magnified by the possibility that a failure (or a minor difficulty) will become a far bigger concern. For heads and governors, such risks may be faced personally if, as is often the case, there are demands for an individual to blame. TeacherNet, the schools' information website explicitly addresses the issue of risks facing schools.

The evolution of risk in schools has, inevitably, produced efforts to blame-shift and to share responsibility. Regulators wish to ensure their regimes appear effective, but also want to ensure that final responsibility lies with the government and/or institutions. Heads and governors need the certificate of approval

offered by Ofsted or the Audit Commission, even if they do not want to spend too much time form-filling. Whitehall needs to be able to be distant enough from schools to avoid blame for serious failures, yet be seen to have set a framework for oversight that can be defended to the press. Teachers and other professionals need to be sure their decisions conform to standards and procedures that, if adhered to, protect them from personal responsibility (or witch-hunts) if there is a failure.

The Reform of School Governance Since the 1980s

A radical reform of the governance of schools in England has occurred during the past 20 or so years. As recently as the late 1980s, maintained schools were subject to significant local government control over their budgets, staffing and management. This system had evolved over a century, making the Local Education Authority (LEA) an essential element in the 'national system locally administered' that constituted education.

The Thatcher government shifted power away from local government to schools by introducing Local management of schools (LMS)⁴, which allowed schools to have their own governing bodies and funding allocations. This meant they would become increasingly autonomous from local authorities. During the mid-1990s, a minority of institutions were offered the option of becoming 'grant-maintained (GM) schools', receiving their funding from central government, via the newly created Funding Agency for Schools, rather than the LEA.

After Labour took office in 1997, GM schools were re-integrated into the LMS system. The government has since created academies and other schools intended to create greater distance between themselves and traditional LEA-controlled institutions. Academies receive their funding directly from Whitehall.

As schools have become increasingly self-governing and have seen their links to local government reduced, new mechanisms have been created (or previous ones reformed) to provide improved oversight of the large number of fairly small schools that now operate with relative independence. In effect, regulation has had to be strengthened to cope with an increasingly deregulated set of institutions.

As a result of the institutional reform outlined above, risk has been transferred downwards from LEAs and their officials to schools, governors and managers. Risk has also moved upwards through the system to Ofsted. Local government is, to an important degree, less exposed to risk than it used to be. Overall, risk has been expanded and spread.

Regulation and Regulatory Reform

Maintained schools had traditionally been run by LEAs. Oversight and inspection had



been provided by Her Majesty's Inspector of Schools (HMI), local inspectors and the officials in LEAs. The creation of LMS and GM schools changed everything. There was now a need for new forms of regulation, including a much-developed inspection regime within the reformed HMI, renamed the Office of Standards in Education (Ofsted)⁵. LMS and GM schools were to be the object of enhanced inspections. The Audit Commission also expanded its programme of financial and 'value for money' work to include the oversight of schools.

Thus, a relatively formal and externally imposed form of regulation replaced an internal, bureaucratic one. Ofsted published tell-all reports on individual schools. The Audit Commission and (occasionally the National Audit Office) reported on the overall performance of the school sector. Schools had to demonstrate their fitness for purpose in a way that would have been unthinkable – and unnecessary – before the late 1980s. The government threatened to close poorly performing institutions. Decentralisation of control to schools was accompanied by a significant increase in the use of performance measures and, after 1997, targets.

Performance Indicators and Targets

In the 1990s, the Major government began a process of demanding performance measures from public institutions. Schools found themselves expected to report on achievements in public examinations and also against key stages of educational outcomes. Measures such as truancy rates also had to be reported. Increasingly, league tables were published showing the performance of every school in the country.

The government's rationale for the publication of so many school-by-school measures was that information of this kind would allow parents to decide which were the best (and worst) schools. Market choice could then operate: good schools could grow, while poor ones would shrink. The loss of 'market share' would provide an incentive – backed up by Ofsted reports – for schools to improve. Failing schools would eventually close.

Labour accepted many of the elements of the Conservative government's approach to performance indicators and league tables. But under Blair the Treasury set a series of targets designed to demand faster improvement from departments and their sponsored bodies. Schools found themselves required to improve performance in line with a number of targets⁶. Failure to hit targets has led to pressure on schools to improve. Each departmental report annually charts the success or failure of its services to achieve targets set in previous years. If schools did not contribute towards hitting the targets, pressure was applied from the centre.

Targets increased the need for risk-handling. Schools and their overseers were put under

greater explicit risk than previously. Of course there had long been demands from bureaucrats and politicians, but these had been largely internalised and were not made public. Targetry and associated performance indicator-type measures made the process of accountability more explicit and, directly, increased the risks of failure. A glance at the annual league tables – covering every school in the country – provides evidence of the difference between the 'implicit' and 'explicit' forms of school accountability. During the early weeks of 2009, Children's Secretary Ed Balls called on (new) academies that had failed to deliver good results to improve or be penalised. Exam results were the origin of his criticism.

Framework for Analysing 'Risk' in Schools

Any framework for the analysis of risk within the school sector would have to make it possible for heads and governors to assess the scale of the risk in the short, medium and longer term. Schools would need to analyse individual threats following a set of logical steps such as those outlined here:

- 1) identify the full range of predictable risks facing the school and list them;
- 2) score each risk factor in terms of its likelihood to occur;
- 3) assess whether the threat posed is immediate, medium-term or longer-term; and
- 4) score each risk as 'minor', 'moderate', 'major' or 'catastrophic'.

A task of this kind would be unique to each institution, though some risks would be common to most or all schools. High-scoring risks could then attract the greatest attention and, possibly resources.

Using a framework of the kind outlined above would undoubtedly see examination performance scoring highly. By contrast, the risk that the school might nurture terrorism would, in virtually all cases, be very small. Child abuse risks might be calculated as a medium threat, as might the problem of obesity. But in some institutions, child abuse and/or obesity might score higher than examination performance risks.

Most heads and their governors are likely to undertake an analysis of the above kind informally, even if they do not produce formal risk assessments. But as the scale of risk facing schools, hospitals and other smaller public bodies grows, there may well need to be a move towards formality.

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Endnotes

- 1 The Victoria Climbié Inquiry Report of an Inquiry by Lord Laming, Cm 5730, January 2003, London: TSO.
- 2 Departmental Report 2008, Department for Children, School and Families, Cm7391, London: TSO, Chapter 2.
- 3 Departmental Report 2008, Department for Children, School and Families, Cm7391, London: TSO, pp 23.
- 4 See Sofer, A. in Education in a Global City, 'Global city school systems', London: Bedford Way Papers, 2007, pp 44-45. Explains how English schools are autonomous by international standards.
- 5 For a full discussion of this issue see Hood, C.C., Scott, C.D., Jones, G.W. and Travers, T., Regulation inside Government: Waste Watchers, Quality Police and Sleazebusters, Oxford: Oxford University Press, 1999.
- 6 Indeed, large numbers of targets were set for services across Whitehall. For a systematic examination of targets and government policy, see: House of Commons Public Administration Committee, On Target? Government by Measurement, Fifth Report of Session 2002-03, Volume 1, HC 62-I, London: TSO.

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