Good Governance Institute

A simple guide to risk for members of boards and governing bodies

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The Good Governance Institute exists to help create a fairer, better world. Our part in this is to support those who run the organisations that will affect how humanity uses resources, cares for the sick, educates future generations, develops our professionals, creates wealth, nurtures sporting excellence, inspires through the arts, communicates the news, ensures all have decent homes, transports people and goods, administers justice and the law, designs and introduces new technologies, produces and sells the food we eat - in short, all aspects of being human.

We work to make sure that organisations are run by the most talented, skilled and ethical leaders possible and work to build fair systems that consider all, use evidence, are guided by ethics and thereby take the best decisions. Good governance of all organisations, from the smallest charity to the greatest public institution, benefits society as a whole. It enables organisations to play their part in building a sustainable, better future for all.

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This report is part of a growing series of reports developed by the Good Governance Institute (GGI) that consider issues contributing to the better governance of healthcare organisations. GGI is an independent organisation working to improve governance through both direct work with individual boards and governing bodies, and by promoting better practice through broader, national programmes and studies. We run board development programmes, undertake governance reviews and support organisations develop towards authorisation.

Other recent GGI reports and board development tools have considered board assurance, patient safety, clinical audit, quality and safety of telehealth services for people with long-term conditions, diabetes services, better practice in treatment decision-making, productive diversity, the board assurance framework, integrated governance, governance between organisations and of course good governance.

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A simple guide to risk for members of boards and governing bodies.

John Bullivant, Chairman, GGI
with support from Kevin Street and David Holden

The purpose of this guide is to assist members of boards and governing bodies, and those who support them, to better understand some simple rules of risk.

We strongly believe that risk is a fundamental currency of governance and can be both a hazard and an opportunity.

We have developed with colleagues a modern approach to risk appetite and see the idea of annually defining risk tolerance as a basic tool for clarifying the roles of management and committees, and also a way of containing ever-increasing agendas.

We recognise in this summary the work of Trevor Llanwerne, Professor David Spiegelhalter, Christopher Alberts, and Gerd Gigerenzer and his colleagues.

Contents

1. Why is a common understanding and treatment of risk important to boards?

All boards handle risk. Some avoid risk as if it is the enemy of performance and accountability. Others seek to identify risks that have plagued the institution in the past but fail to anticipate the risks of the future. Many have complex recording, reporting and monitoring systems but are bemused as to how to respond. We frequently note amongst complex systems the absence of the very risks that are really significant to outcomes.

This is not a good place for public bodies to be.

'Risk can be defined as the combination of the probability of an event and its consequences'

(ISO/IEC Guide 73).

Risk is handled throughout an organisation but one of the few places that risks can be considered comprehensively in the round is in the board room. To do this well the board must focus and align to avoid the distracting noise of detail. We would challenge a board that was overly focused on yesterday or today's operational detail at the expense of defining and seeking the realisation of its strategic vision.

The board's role is not always to minimise risk. Risk brings opportunity as well as loss. To be effective the board should be explicit in its risk appetite and clarify just what tolerances it has set in its delegation of roles to management, committees and partners and suppliers.

It is critical that boards have a common understanding of risk and their role in managing this.

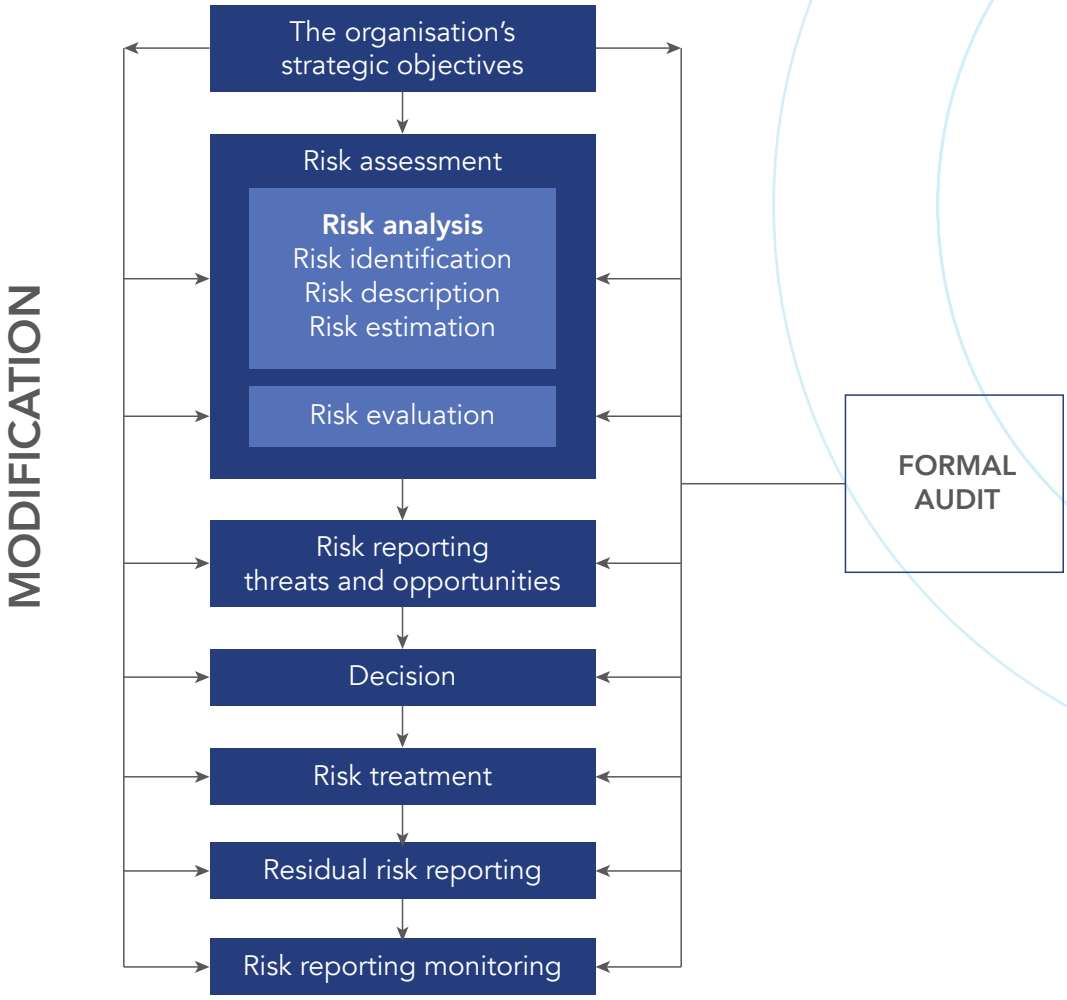
Principle One	An engaged board focuses the business on managing the things that matter
Principle Two	The response to risk is most proportionate when the tolerance of risk is clearly defined and articulated
Principle Three	Risk management is most effective when ownership of and accountability for risks is clear
Principle Four	Effective decision-making is underpinned by good quality information
Principle Five	Decision-making is informed by a considered and rigorous evaluation and costing of risk
Principle Six	Future outcomes are improved by implementing lessons learnt

(National Audit Office, 2011)

2. Which risks should the board focus on?

Not all risks are equal. Ideally, an organisation should develop a board assurance framework which is comprehensive in its treatment of risk at all levels (GGI and 360 Assurance, 2014). This should not be confused with the document often presented to the board as the BAF. Staff at the coalface face risks which they must assess and treat. Managers must consider the risks under their control, evaluate and act, recording and escalating as appropriate. The board's role here is to seek assurance that the risk management system is working and that escalation is coming to their attention in a timely manner and consistent with their delegated risk tolerances. We can see that if we have sought to establish our risk appetite and tolerances, this is itself a control problem.

The board should be focused on its strategic objectives and the risks that might compromise their achievement. This presupposes that strategic objectives are defined and time limited and that our board reporting systems not only predict progress along the forward trajectory required, but seek to highlight risks that might stop, slow, or accelerate progress in one or more of the objectives.



3. Challenges to understanding the context of the risk?

1. What is the source of the risk; is it external or internal?
2. What is the nature of the risk; is it operational or strategic?
3. Is our assessment reliable, valid, and timely?
4. What are we being asked to do; treat, tolerate, transfer, terminate or take on the risk?
5. Is the risk framed correctly; cause and effect, 5X5 matrix; consistent use of statistics?
6. Is this risk 'ours' or 'theirs', or is it truly shared: is control ours to implement?
7. How do our 'partnership' risks impact on our risk profile and business?
8. What 'intelligence' have we to support this risk; papers, assurance, audit?
9. Does our BAF truly relate to strategic risks; should this risk be on the BAF summary?
10. How do the board sub-committees provide assurance to the board about the risks delegated to them?
11. Have we taken the 'jargon' out of risk terminology; is it practical rather than technical?
12. What is our overall risk profile; is it manageable?
13. Are we confident who is accountable for each risk?
14. What governance arrangements do we have to share, respond, escalate, or de-escalate risk?

4. Good ideas for board members

4.1 Align strategic and sustainability objectives with board agendas

The board should focus on its strategic objectives and the risks which might prevent delivery to time and outcome. For this reason, the agendas of boards which are often cluttered with other people's business must be refocused around objectives, outcomes, delivery trajectories, identification and successful mitigation of risk, and support the re-prioritisation of objectives, their resourcing and timescales. As Trevor Llanwarne puts it, 'If you do things on an outcome basis, in practical terms there will only be a small number of risks on the risk register' (Llanwarne).

Example: All NHS boards have strategic objectives, but in our experience not all are measurable (SMART). However, most do have strategies that can be used as enablers even when strategic objectives are vaguely constructed. A strategic objective 'to improve quality' for example could be enabled by an organisational Quality Strategy complete with key performance indicators; likewise, an unmeasurable strategic aspiration such as 'to be excellent' could be reflected in an Organisational Development Strategy.

Challenge: Enablers must be outcome focused, the notion of key strategic risks being linked to planned outcome, and to the BAF is fundamental. Boards should recognise the value a well-constructed BAF provides as a useful story book, a journey of organisational intent, of performance and trajectory.

Board members should challenge what is on the board's agenda and what is missing. Why are we discussing this?

4.2 On an annual basis define risk tolerance for management and all sub committees to clarify delegation authority and when issues need to be escalated

Boards can help to clear and focus agendas by delegating tolerance; this means giving committees of the board and management clarity on the board's risk appetite and the tolerance levels within which committees and management are empowered to act. When delivery falls outside these tolerances then the matter should be escalated back to the board with an indication of how to ameliorate. The Audit Committee can use its auditors to check this is working as intended.

Example: Risk appetite can be a complex and is easily misunderstood. Logic determines that we all have a 'low' risk appetite for safety. High risk clinical interventions can lead to potentially poor safety outcomes on the one hand, and on the other remarkable success. Risk and reward, perception, acceptability, and ultimately risk culture determine 'how much risk to take on', and how much and when to escalate.

Challenge: The board's risk appetite should place a grip on risk management, not a strangle hold on creation and innovation. Board clarity in setting expectations with robust, timely, and valid escalation processes should be supported by annual risk appetite statements set against each strategic objective. Assurance committee roles should be recalibrated annually and should themselves be active in ensuring risks abide by set parameters.

Board members should challenge whether committees and management have clear delegated tolerance and are escalating matters which breach the agreed tolerance.

4.3 Clarify where ethical decisions will compromise legal, audit or regulatory constraints

Governance is about fairness and boards should uphold high standards of fairness to users, staff and partners even when to do so would compromise legal, audit or regulatory requirements. This follows Professor Mervyn King's mantra of act and explain rather than narrow compliance. To act otherwise is a reputational risk. Members of boards if unsure about conflicts of interest should seek advice but generally follow the 'Daily Mail test'.

"Before choosing a course of action, directors should ask themselves 'How would this look in the Daily Mail?'"

(Sir Nigel Rudd, chairman of Kidde and a director of Barclays, Boots and Pilkington, while addressing the CBI conference in Manchester, 2002)

Guidance on fiduciary duty in the NHS is weak and overemphasises business models of protecting the institution rather than those the enterprise serves. Board members considering an investment decision should use a wider set of criteria than the narrowly economic guidance of the Treasury Five Case model to include a sixth: The Sustainability Case: to show the "preferred option" successfully supports the sustainability of the service to patients.

Example: Members of the board should direct the organisation in such a way that it does not adversely affect the natural environment, society, or future generations (King, 2016).

Challenge: Have we weighed up the reputational risks of acting in the best interests of the public and users over compliance with regulation? Whatever we decide, can we and will we explain our actions?

Board members should challenge whether they or their organisation and partners have acted fairly.

4.4 Develop a framework for risk appetite that allows the board to use a common language in deliberation of complex reputational / financial / outcomes / regulatory risks

Not to define risk appetite in relation to strategic objectives and significant changes to service delivery and access is itself a control problem as staff will not know what resources or priority to assign to different matters. The board should adopt a framework and common language for deliberating risk appetite and delegated tolerance. This should cover reputational / financial / outcomes / regulatory risks.

Example: A common failure seen across the sector is the misuse of risk registers and the BAF. Managers and staff have a tendency to use these instruments to over or under exaggerate true risk positions. Managers will downgrade or remove risks to prevent scrutiny in a particular area. We have seen the misuse of risk to prevent 'change' in working practice. Both management and staff see the risk registers as a 'black hole', a place for organisational problems or a form of 'I told you so' when risk are realised. Escalation of risk simply by the risk score is unhelpful, rather escalation of risk should facilitate decision-taking that cannot be taken at the risk source. It is acceptable for high risks to be retained and contained within a department.

Challenge: Risk culture is critically important in understanding and developing risk perception; behaviour determines outcome. Training for all levels of staff within an organisation should be mandatory and consistent, and the use of a jargon free lexicon is essential. All must be able to recognise that ownership of risk remains with the risk identifier, but decision-taking for control or mitigation can be escalated for others to action.

Have we a risk appetite framework? Do the board, committees and management / clinical leaders understand risk appetite and risk tolerance, and use these terms consistently?

4.5 Develop with partners a framework for risk appetite that allows all to use a common language in deliberation of risk sharing.

We need to understand the risk appetite of our partners and suppliers as they need to understand our position. Not to do so will cause misalignment of priorities and resourcing. Developing a common understanding will help us to agree sustainable risk sharing arrangements and what to do when things go awry especially in relation to funding and progress.

Example: Section 75 of the 2006 Act gives powers to local authorities and clinical commissioning groups to establish and maintain pooled funds out of which payment may be made towards expenditure incurred in the exercise of prescribed local authority functions and prescribed NHS functions. Bevan Brittan in their revisions to the NHS England framework partnership agreement relating to the commissioning of health and social care services point out:

'We have made changes to the risk share arrangements to make it clearer that the partners need to have agreed at the start what happens in the case of overspends and underspends. We have seen instances where particular schemes within the local plan have not progressed, and issues have arisen over what happens to the money allocated for those purposes.' (Bevan Brittan, 2016)

Challenge: Parent bodies should be clear on their own and their partners risk appetite for change to allow for informed risk sharing of costs and reputation. Agreed tolerances will help those representing the organisation at partnership meetings to know when variations in expected performance need to be referred back to the parent bodies for additional effort, prioritisation, or resources.

4.6 Challenge managers and the board secretary to prevent disinformation in board papers

Lessons from medical journals suggest a rule devised for editors that could apply to board secretaries who should enforce transparent reporting in board papers with 'no mismatched framing,' i.e. do not use relative risks without also including baseline risks, and always give absolute numbers such as number needed to treat (NNT). The NNT offers a measurement of the impact of a medicine or therapy by estimating the number of patients that need to be treated in order to have an impact on one person. The concept is statistical, but intuitive, for we know that not everyone is helped by a medicine or intervention — some benefit, some are harmed, and some are unaffected. The NNT tells us how many of each.

Briefings that include graphs should ensure that part-to-whole relationships are available. Visual aids may help people attend to the relationship between the numerator (the number of people affected by a hazard) and the denominator (the entire population at risk), whereas graphs that show only the numerator appear to inflate the perceived risk and may induce risk-averse behavior. Communicators should not assume that all graphics are more intuitive than text; many studies have found that patients' interpretations of graphics were dependent upon expertise or instruction.

Examples: There have been 50% more hate crimes as a result of Brexit. This is bad but if it means an increase from 2 to 3 that is less significant than an increase from 800 to 1200.

Liverpool Women's NHS Foundation Trust: the neonatal unit employed an effective system to benchmark practice and outcomes against other similar units in the UK and the USA. There was also benchmarking against similar units for mortality and morbidity rates (CQC, 2015). The trust was Commended by Chief Inspector of Hospitals in his report.

The chart below is good but would benefit from including absolute numbers to quantify that fourfold higher risk for black mothers' mortality in childbirth.

"Know what to measure, and manage the numbers; don't let the numbers do the managing for you"

(Williams)

Maternal mortality rate by ethnic group

	Rate per 100,000 maternities	95% CI	Relative risk (RR)	95% CI
Ethnic group (England only)				
White	7.42	6.12 to 8.9	1 (Ref)	
Asian	10.1	6.25 to 15.43	1.36	0.81 to 2.18
Black	31.13	20.8 to 44.7	4.19	2.69 to 6.35
Chinese/others	4.11	0.84 to 12.01	0.55	0.11 to 1.66
Mixed	3.32	0.08 to 18.49	0.44	0.01 to 2.54

Challenge: Board secretaries should be empowered to reject briefing papers that use misleading framing.

4.7 Routinely challenge management and clinical staff on sins of omission

We tend to focus on risks to what we are currently doing but failing to take up opportunities is itself a risk to our success.

Example: Sins of omission such as the hospice comfortable with a traditional number of beds oblivious to the demand in the community, or the clinical team unwilling or slow to adopt evidence based practice from elsewhere.

According to Amdahl's law, usually applied to computing, 'transformation of an entire system occurs only at the pace of the slowest part to change.'

Challenge: Have we ever had a report on major clinical innovations and cost improvements commonplace elsewhere that we don't do? If so, were they implemented? Was the delay or resistance justified by independent observers?

4.8 Seek to disentangle process, operational outcome and strategic risks

The board's focus must be on risks to their strategic objectives but they will be held to account for operational failures that they might reasonably have been expected to address. It is important to disentangle risks of process i.e. a failed process or a process which goes wrong (e.g. an operation, a major procurement etc.); and an operational outcome where the processes might be working but the desired outcome is not achieved, possibly by factors outside institutional control e.g. the patient returned to hospital because they had no adequate care arranged or failing an access target because demand increased dramatically.

The board must expect management to manage; they cannot know everything but they should expect staff and partners to be held to account by the CEO and executive team.

Failures to achieve strategic aims must lie with the board as they own these and the assurances that they are on target. A common failing when under pressure on one objective is to fail to revisit the other objectives to readjust resource allocation, timescales and expected outcomes.

Example: The three lines of defence model illuminates a structured systematic approach that allows vertical and horizontal risk communication across the operational and strategic risk portfolio of the organisation (IIA, 2013).

Challenge: To build structures that define role, responsibilities and accountability. To have in place a risk culture and a process that allows the journey of a risk from ward (operational risk) to board (strategic risk) to be appropriately communicated and acted upon.

4.9 Seek to integrate financial, clinical and workforce risks

Mid Staffordshire NHS Foundation Trust was the classic case of financial concerns being allowed to outweigh safe clinical delivery. Boards must learn to see their services in the round combining all elements such as money, quality, workforce etc. It is unhelpful to receive a financial report unaligned to rising demand and shortage of staff. Executives teams must get used to collaborating on reports to give boards the opportunity to add value by weighing up priorities and timescales for change.

Example: The board has a responsibility for ensuring that it has sight of strategic risks that are appropriately framed (cause and effect) and linked. All risks identified on the BAF should be seen as having interdependency e.g. Finance-Quality-HR-Compliance-Safety. When the right thing to do is contrary to central compliance the board should still act, but should explain why they have taken the decision to do so.

Challenge: The concept of Enterprise Risk Management or the more familiarly termed integrated risk is for the NHS a relatively a new initiative; practiced well, the model provides a well-rounded approach to understanding and supporting sound decision making.

4.10 Invite the risk elephants into the room

Too often we ask board members for their most significant risks. They know what they are, but they are not included in risk registers or the BAF and are therefore not tackled. These are the real risks - the unmentioned elephants in the room and we need to devise ways to ensure they are addressed.

Examples:

- Lack of clinical commitment to change
- Organisation is neither clinically nor financially viable
- Weak commissioners or providers
- Managers have no capacity (or competence) to deliver what is promised
- There is no political will for the necessary changes...by MPs, Assembly Members, Councilors, Ministers etc.
- Partners who will not share risks
- Knowledge of abuse to patients or staff that has gone unreported
- Disdain for whistleblowers
- Compliance trumps doing the right thing

Look at any BAF and see if any of the above are quoted as impediments to achieving outcomes. Oxford University Hospitals NHS Foundation Trust is one of the better trusts in being prepared to include the following items. Recognising the problem means it can be tackled.

Challenge: Is the discussion of what is going wrong getting incorporated into risk registers, plans and action?

4.11 Develop a disinvestment protocol to avoid critical judicial reviews

Organisations undertaking significant change are held to account for not following due process rather than for the outcomes they seek. Boards must develop an appropriate protocol for service delivery changes, closures etc. and then follow the process or expect sanction.

Example: What are the lessons for leading and managing during difficult times? Boards will need to be explicit in their decision making if they are to avoid reputational risk and judicial review. In 2009 Tayside Health Board considered the following Principles for Disinvestment:

1. The organisation is committed to improving the health of the community and the quality, responsiveness and effectiveness of services.
2. The organisation has limited budgets but will work with others to lever resources from within and outside the community.
3. The organisation will always seek to do the right thing first, and then take resourcing decisions.
4. We will regularly assess our organisation's position in terms of financial management, service delivery and strategic change.
5. We will seek to speed up system reform and re-engineering.
6. We will scenario plan for the future, exploring the impact of decreasing amounts of growth.
7. We will critically review our organisation's priorities and develop plan Bs for those we cannot put off.
8. We will engage with our stakeholders and communities in decision- making and share our decisions taken.
9. We will be positive and optimistic.

Challenge: Have we created a robust protocol for disinvestment?

'In order to achieve the transformation required, we need to focus on how we share risk across the system and re-balance the risk between providers and commissioners responsibilities…it is vital that NHS organisations do not respond by just trying to transfer risk to another organisation. We will not succeed if we have islands of success in a sea of failure. We have to recognise that we have a zero-sum game. If risk is transferred elsewhere in the system, it doesn't take the risk away. The people who pay are patients. They don't recognise organisational boundaries. What they recognise are services that are joined- up across the system.

David Nicholson's Foreword to the operating framework for the NHS in England 2010/11, DH gateway 13232, Dec 2009 (now archived)

4.12 Manage cross-boundary risks

Maintaining grip across organisational boundaries without mergers is a formidable challenge. Holding partners to account requires a sophisticated approach to challenge and an understanding of the partners' approach to accountability. David Nicholson set this out in 2009 (see box) but it is even more apparent today. Local government has traditionally used the term scrutiny but it is becoming more prevalent in health. Scrutiny itself is evolving both in legislation and in practice. In 2014, the Department of Health offered guidance to health and local government on the changing context in light of the 2012 Act and the advent of new players such as Healthwatch.

This affirmed that the primary aim of health scrutiny is to act as a lever to improve the health of local people, ensuring their needs are considered as an integral part of the commissioning, delivery and development of health services.

Health scrutiny also has a strategic role in taking an overview of how well integration of health, public health and social care is working – relevant to this might be how well health and wellbeing boards are carrying out their duty to promote integration – and in making recommendations about how it could be improved. At the same time, health scrutiny has a legitimate role in proactively seeking information about the performance of local health services and institutions; in challenging the information provided by commissioners and providers of services for the health service and in testing this information by drawing on different sources of intelligence.

In the light of the Francis Report, health scrutiny will need to consider ways of independently verifying information provided by relevant NHS bodies and relevant health service providers – for example, by seeking the views of local Healthwatch.

Example: GGI have developed an etiquette checklist for Cross boundary scrutiny: see box.

Challenge: In the light of the Francis Report, health scrutiny will need to consider ways of independently verifying information provided by relevant NHS bodies and relevant health service providers – for example, by seeking the views of local Healthwatch.

Multi-agency scrutiny etiquette card

1. Agree common outcomes, values and metrics

2. Ensure separation of executive delivery and scrutiny review roles

3. Re-establish and share engagement principles

4. Allow stakeholders to engage early enough to influence strategy and plans

5. Ensure attendees have delegated authority to take decisions

6. Log, share and track agreed decisions inviting each sovereign body to provide assurance of delivery trajectories

7. Understand each other's risk appetite to allow for shared costs and risks

8. Delegate to partners and suppliers within agreed risk tolerance

9. In scrutinizing papers focus on improvement rather than dismissing

10. Aim for 'what goes around comes around rather than win win

11. Recognise that our Boards and stakeholders must police regulation before regulators

12. Seek alignment of scrutiny, audit, inspection and regulation within and between different agencies to provide mutually reinforcing systems

13. Be prepared to explain variance rather than simple complying with regulation or norms

14. Appoint arbitrator to handle disputes before they arise

5. Footnote: collective decision-taking

Finally, some advice from another sector. Aon Hewitt developed a checklist to help reduce bias in investment decision-making for defined benefit pension trustees. We hope some of these ideas resonate:

1. Authority

Do not allowing a person's experience from a different domain to unduly influence you in this domain.

2. Herding and groupthink

Listen to your 'gut', and speak without censoring yourself. If you agree with others, it is because you have consciously and effortfully made that choice.

3. Loss aversion

Evaluate loss and gain by using calculations and logic – your feelings about either are not important.

4. Status quo

Should you wish to leave an option as it is, make an active choice to do so – nothing you do is 'by default'.

5. Endowment

Make this decision 'as if' you were not involved previously, 'as if' you were giving advice on someone else's problem.

6. Reputation and responsibility

Make a choice in favour of the best outcome, irrespective of what others may think of you.

Aon Trustee Checklist - Investment decision making in defined benefit trustee meetings, 2016

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