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'Benign invigilation': Using appreciative inquiry to reposition clinical risk in multi-disciplinary CAMH teams

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Abstract
In response to a spate of serious untoward incident enquiries, CAMHS team leaders in East London, UK, embarked on a series of clinical risk workshops with staff teams. Complementary to what might be called *retrospective* organisational responses to high risk events, these *prospective* workshops were predicated on the idea that risk reduction is increased when individuals in teams are responsive to one another, when teams are *positively* risk-aware and when risk awareness is seen as having the capacity to predict what may go wrong in the future.

Keywords
Risk, clinical risk, appreciative inquiry, prospective, multi-disciplinary

Introduction

Risk reduction for organisations has come to centre stage within world-wide public discourse since the financial crash of 2008; indeed, a number of papers published since then have argued for both traditional and new ways of approaching risk (Buchanan, 2011; Choudhry, 2011; Taleb, 2011). Within the UK's children's social care and adult mental health services a similar process has been ongoing; a long tradition of enquiries following critical incidents, going back to the Maria Colwell and Clunis reports (HMSO, 1974; HMSO, 1994), have made numerous and often similar exhortations to agencies, backed by legislation, to improve their protocols and interagency communication pathways. The Care Programme Approach in adult mental health service and the Common Assessment Framework in children's services are examples of these (Department for Education, 2011a; Department of Health, 2011). Recently, commentators have suggested that these approaches may themselves inadvertently heighten risk and that such approaches need to be complemented by other approaches which enhance professional responsiveness and values as well as bureaucratic oversight (Department for Education, 2011b; Williams & Fulford, 2007). Recent UK Department

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of Health guidance (2007b) advocates a collaborative approach to risk management and delineates the differences between collaborative risk management and defensive risk management, highlighting the risks in 'tick box' approaches. Similar points were made in a report by the UK's Royal College of Psychiatrists in 2008. Indeed, the emergent fields of probability, chaos and complexity theory in mathematics (Markov, 1971) and similar developments in organisational theory (Morgan, 1997) might point to prospective ways of raising risk awareness and reducing risk probabilities within teams and agencies.

Child and adolescent specialist mental health services in London's east end experienced a spate of serious untoward incidents (SUIs) throughout 2007 and 2008. These involved suicide, serious suicide attempts and one homicide. The newly formed East London NHS Foundation Trust, covering three socially deprived London boroughs, initiated three separate enquiries, leading to a series of significant recommendations, including clearer care pathways, organisational restructuring and greater clarity around accountability and leadership. The incidents and their sequelae had a depressing effect on morale in some teams in the organisation. The East London NHS Foundation Trust covers Hackney, Tower Hamlets and Newham, three London boroughs very high on all the indices of social deprivation, with large youth populations, higher than average incidences of mental health problems and higher than average referral volumes.

As a group of senior leaders, we were concerned to improve service quality, minimise poor outcomes, and address the impact of the spate of SUIs on staff morale. We wondered if a complementary whole-service approach could be tried, with threefold aims:

1. To raise intra-personal and team responsiveness about clinical risk;
2. To reframe risk awareness as a positive attribute of the organisation;
3. To create a context where risks might be predicted.

Development

The authors were struck by the organisational discourses prevalent around risk, particularly compared with clinical audit, which was positively discoursed within the agency. After a long period of development within the organisation, audit was well understood and delineated. Like research, audit was seen as a responsibility of all and was positively connoted. Clinical risk, on the other hand, was often embedded in negative local and public discourse – discussed after a serious event and in the context of scrutiny. Although the management style of the organisation had been to create a post-event, non-blaming, 'learning' culture (Birleson, 1999), the spate of SUIs coming together injected a good deal of fear into some teams. As one clinician said: 'I don't lie awake at night worrying about audit, but I do worry about risk!' The senior clinical team were keen that the new organisational protocols and pathways take root in positive soil. As team leaders discussed the effect on the organisation of these events and our responses, a number of questions arose:

1. A number of organisations both nationally and worldwide run 'what if' sessions – particularly businesses engaged in high-risk areas. Oil companies, for example, regularly run scenario planning sessions for whole staff groups. Could focusing on the future, as well as the past, help re-position risk as something to be actively embraced and welcomed?
2. Like clinical audit, could clinical risk be re-contextualised as something to be welcomed?
3. Could an Appreciative Inquiry model (Cooperider & Srivastva, 1987) increase responsiveness between clinicians so that risk management is enhanced? Appreciative Inquiry (abbreviated to AI in the literature) is a method for conducting organisational reviews which,

rather than using a traditional problem solving approach, focuses on what is already working well and enlarging that; and, in particular, creating a dialogue within the organisation which attempts to envision what might usefully happen in the future.

4. Could an AI model create better conversational styles between clinicians in teams, such that the quality of risk management is increased? If so, would this enhance clinical decision-making?
5. If we were to encourage staff members to think about their present work from the perspective of a future point in time-what would they consider risky now?
6. Are there risky events brewing in the organisation at present that are giving off very faint but noticeable fumes?
7. What kind of positive organisational culture supports good risk management, and can that culture be modelled and described?

Two risk discourses

As the planning progressed, we delineated two agency discourses around clinical risk: one having to do with protocol/regulation/policy and procedure, which *looks back*, and the other to do with personal and team responsiveness, clinical judgement making and team acculturation perspectives, which *looks forward*. Both are important perspectives (Kessels-Habraken, Van der Schaaf, De Jonge, Rutte, & Kerkvliet, 2009).

Two Discourses in Risk Awareness

Retrospective Model	**Prospective Model**
handed down from above	coming from below
external regulation of risk	internal regulation of risk
systematised	unpredictable
objective	subjective
clear	obscured patterns
explicative	intuitive
dominant voices	quiet voices
past	present/future
rational/scientific knowing	professional experience
outer conversation	inner conversation
reductionist	complex
reactive	active
risk of fear	possibility of hope
protocol	clinical judgement
assessment	decision-taking

We conjectured that while both are helpful, the retrospective model has become the dominant model over the past 40 years in health and social care. In what we began to call the prospective-responsive model, staff groups meet and are mobilised to predict what is likely to occur, as well as

taking part in routine post-SUI protocols and briefings. In this respect AI (Cooperider & Srivastva, 1987; Oliver, 2005) seemed a good place to start, as in AI the focus is to identify the organisational processes that work well and to envision and prioritise processes that would work well in the future. We were also influenced by constructionist, systemic and dialogic approaches to knowledge, learning and organisational change which view new knowledge and change as arising from interaction and dialogue between persons (Campbell, 2000; Shotter & Katz, 1998). In the retrospective model, systems determine the actions of individuals; in the prospective/responsiveness model, persons in interaction have a determining effect on systems. We looked at the value of both approaches. The retrospective model has value in that it outlines frameworks for action, but it may have less utility in the day-to-day unpredictability of real-life clinical work: we were aware that clinicians engage in many discussions about risk on a daily basis and very often *it isn't clear what to do*.

A case example: members of a family therapy team were discussing a family that had been assessed in the CAMHS assessment team and had then been referred to the family therapy team. The case was that of a 12 year old West African girl who had been living with an auntie for 14 months since arriving from Africa. When the family failed to turn up for their appointment and failed to respond to letters and phone calls, there was a discussion in the team whether to close the case or not. On the surface, the original CAMHS assessment team had identified only moderate risk factors; the request for family therapy had concerned the girl's emotional adjustment to her new situation after the school had reported her tearfulness in lessons. A vigorous debate ensued in the team about whether to close or not. Some colleagues argued that the case should be closed as the family had already been assessed, had exhibited only moderate risk, and in any case, there was a waiting list with other more urgent cases waiting. Others argued that there had been reports in the national press about children being placed with people who were in fact not relatives and had not had vetting of any kind. In some of these cases abuse and neglect had occurred. The conversation in the team went on for some time and the team leader eventually brought the conversation to a close by advising that the case should be closed. The allocated therapist said that she was not happy with this decision and said that she would like to check with the referrer before closing. The referrer (the school's Special Educational Needs Coordinator, or SENCO) said that the child had not returned to school in the autumn term and they had received a telephone message from the auntie to say that the girl had returned to her homeland during the summer holidays. The SENCO said that she had very little information to offer and did not know the auntie well at all. The therapist reported back to her supervisor: 'I don't know… something isn't right.… I just have a feeling that I ought to check this out. There have been news reports locally of the prevalence of trafficked children in our Borough. This girl has just disappeared!' Consequently, the therapist, following further discussion with supervisors, decided to refer the matter for investigation by children's safeguarding services. A social worker visited and made enquiries about what had happened. The auntie had in fact moved to a different address, which explained the non-response to letters and phone calls. Eventually children's services reported that they had been able to trace the person concerned, who was indeed an aunt, and were able to verify that the girl had in fact returned to West Africa and was safe. The case was closed at CAMHS. This case illustrates was is not captured in the retrospective risk model; clinicians in daily practice make decisions in complex, unique situations for which there is no standardised protocol and for which a range of responses are required-ethical, conversational, professional- drawing on a range of emotions and knowledge (Gigerenzer, 2003; Gigerenzer, 2007). At any point in this sequence of events there were a number of different decisions that could have been taken. Indeed, there was no consensus about what should happen and certainly no protocol to guide actions. The sequence of events is marked by a kind of moral

exegesis underpinned by continual, open and respectful dialogue. The daily life of risk management is more chaotic and variant than that suggested by the retrospective model and resultant statutory frameworks.

A second example arose from a clinical team discussion in which a course of action was decided at the behest of the senior leader in the team; a few weeks later, new information came to light which supported a different course of action. In the course of the team discussion, one of the team members said: 'I wanted to say so at the time but didn't want to give offence'. It emerged that the team member had wanted to question the decision, and felt she had grounds to do so, but didn't feel able to challenge the senior leader. This led us to hypothesise that in well-functioning teams risk is continually and openly discussed, in ways which enhance rather than restrain relationships (Sainsbury Centre for Mental Health, 2001). This raised for us the importance of leaders of clinical meetings creating the kind of dialogue that engages everyone's attention and allows informed speaking to occur. Atul Gawande (2010), a surgeon who has written eloquently about risk reduction in teams, advocates the use of checklists to orientate clinicians to risk areas. The checklists include measures aimed at shifting the organisational climate (for example, requiring operating teams to introduce themselves to one another before commencing an operation). In the case above, the senior leader could have asked: '… and are there any different perspectives about this?' It might be that Gawande's advocacy of checklists offers a bridge between retrospective and prospective risk management models, functioning to orientate clinicians towards the future in a systematic manner.

We hypothesised an organisational value which we termed *benign invigilation*, in which team members can raise potentially sensitive issues about the practices and judgement of others without giving offence. We speculated that the role of management is to create such a conversational climate. Indeed, the disaster enquiry literature would point to the need for just such an approach. In both the Piper Alpha and the Columbia space shuttle disasters, employees later said that they had wanted to say or do something but held back. Official enquiries into these disasters found that ground-level workers had been warning that the systems might fail, but these warnings were not heeded. The many child protection and mental health enquiries are littered with similar stories. The management literature has underscored the role of fear in restraining performance, particularly the fear of healthy ground-level conflict and challenge (Gelink, 2012). Our proposition was that risk is reduced *all the time but we don't notice it,* particularly in agencies where there is good, responsive, open and sometimes passionate communication between staff and their teams and supervisors. We surmised that the proposed clinical risk workshops could be framed as mobilising and enhancing this process, and enhancing positive professional cultures where people are sensitive to risk, talk about risk, engage with the issue and act on their inter-professional dialogue in real time. We theorised that the concept of *benign invigilation* might offer a bridge between the two discourses outlined above.

The risk seminars

The three authors are currently heads of discipline and senior leaders in the three CAMH services across east London. At the time of the spate of SUIs we became concerned about their effect on staff morale and wondered whether a prospective-responsive approach to clinical risk might help our staff become more motivated, hopeful and creative around the issues of risk. Following discussion in our different locality teams we took the workshop proposal to a senior management group, who welcomed the idea, then went to the local management groups to agree the project plan. One borough agreed to the inclusion of a two-hour slot in their service away-day, another agreed to a

three-quarter-day event and the other to a half-day event, and the programme was adapted to fit the available time. (Two specialist teams also asked us to arrange a tailor-made workshop for them.) We then circulated a letter of invitation to staff within the three boroughs.

Take-up was in the region of 90% and at each event there were upwards of 45 people from the whole range of CAMHS clinical professions, including administrative staff. Given the size of the workshop, there were four convenors, with two leading on the presentations and two observing the group and individual processes. The workshop commenced with a brief introduction about the ideas that we were drawing from and our intentions in running the workshop, outlined above. In addition, we posited that we wanted to hear the ‘inner conversations’ of those involved in the workshop (Rober, 1999). We theorised that risk may be reduced when clinicians in daily interaction are able to give voice to what they are thinking and feeling; we suggested that clinicians may be experiencing self-talk containing a number of dilemmas and we wanted to warm the context of the enquiry by suggesting so. Such dilemmas included:

1. How long do I go on with a case/when do I cut off?
2. Do I sit within the boundaries of conversation or move outside?
3. Do I follow head or heart?
4. Do I hold on to a case or pass on?
5. Do I write long or brief notes?
6. Do I offer myself in a care co-ordinating role or hang back?
7. Can I find a voice and challenge poor practice without giving offence?
8. Do I hold risk or pass it on?

The rationale for AI was also outlined. Then participants were invited to form pairs, and to interview one another as follows, taking 20 minutes for each partner:

- Tell a story about a case that you have worked with or a team discussion you have taken part in, one in which there were complex risks, a lack of clarity, perhaps network confusion and a decision to be taken, yet despite these constraints you feel you and/or the team made the best decision you could and risk was reduced.
- Whilst you are telling this story, the other person should note down what the story-teller did that was helpful in addressing the risk dilemmas thrown up by the case. For example, perhaps consider:
  - How did the story-teller conceptualise risk?
  - How did they manage their feelings?
  - What different constraints/ideas/concerns/values/beliefs were affecting and driving their judgement?
- Then, can you tell us one thing that you do, or a practice that you admire in others, that helps reduce risk for you/client/agency?

Where administrative staff members were also present, an equivalent set of questions were used to guide their discussions:

- Can you think of two or three things you do that help reduce risk for the client/for the clinicians/for the agency [for example, re-reading an address to make sure it is correct or reminding a clinician to phone back a client who has left a message – that kind of thing]?

- Can you talk about something you do that helps to reduce risk – that you feel hasn't been noticed and it would be good for others to know about and do as well?
- You might just want to tell a story about when you did something or raised an issue or pointed something out, and about how what you did, looking back, helped to reduce risk.
- Make sure you get someone or a group of people to feed back these successes to the whole group.

We then asked each pair to feed back the practices which were helpful in reducing risk, making sure that every pair had the opportunity to share their experiences and demonstrating our commitment to valuing the perspective of each and every staff member. Because of the number of people in the room, we found it a struggle to limit the feedback to 'key points' rather than lots of content. The use of a handheld cordless microphone assisted in helping all the participants hear the feedback. The convenors walked around the room so that the participants engaged with the feedback process. As the feedback accumulated, we attempted to group the feedback into themes.

In one of the boroughs a team working with some more risky cases had already developed a more 'positive' approach to risk management, involving regular meetings to highlight practices which served to reduce risk, and two members of that team presented their experiences.

Towards the end of the session we asked staff to divide into the multi-disciplinary teams they belonged to in order to carry out a further task, drawing upon the practices described during the first exercise to consider how they could take these forward as a team in practical ways. Teams then fed back on their proposals, which were also carefully noted down, then typed up and re-circulated to the separate teams following the workshops. By the time of the second workshop, in the last exercise, we invited teams to set a specific target that they wished to achieve within the next six months.

A detailed feedback form was used to establish whether the workshops had been experienced as helpful by the participants. The feedback from both exercises was circulated to the whole group afterwards. We carefully transcribed the feedback and emailed it to the local leaders in the form of action points.

Results

General points:

Some of the feedback from pairs doing the first exercise is listed below:

1. 'There is a real tension between managing risk with adolescents and allowing adolescents to take risks';
2. 'Our own histories/stories in relation to risk affect our risk assessments and vary with context';
3. 'There are sometimes waves of high levels of anxiety when things are critical with clients, which constrain us';
4. 'Open-plan office and the way anxiety circulates quickly … anxiety can spread like wild-fire';
5. 'When there is a lot of anxiety we are apt to forget resilience factors, particularly in parents';
6. 'Responsibility being given or offered to a young person serves to reduce risk';
7. 'We need to identify strengths/protective factors when the attention of the system is focused on risk and concern';

8. 'We need to create contexts where we can really hear each other's differing views and create more freedom for creative solutions';
9. 'We need to recognise that different professions will see different risks; we need to build relationships and improve communication between disciplines'.

Ways forward:

Some of the specific ways forward and action plans generated by individual teams during the second task are listed here:

1. 'We need to create safer reflecting meetings, where we can critique our own practice';
2. '[There should be] more discussion about inviting families themselves to drive risk assessment';
3. 'We are good at immediate risk, less good at chronic risk; we could focus more on long-term cases';
4. 'We need to document risk discussions with schools';
5. 'We need to give ourselves permission to use our own anxiety as a marker';
6. 'We could do with more discussion of cases where risk is managed successfully';
7. 'We need to focus on how the team talks about risk; we need to establish ground rules for team talk';
8. 'We need a chance to reflect on the impact on ourselves';
9. 'We need to use more appreciative questions when workers are bringing back cases for discussion in the team'.

Participant feedback:

Feedback on the workshops *on the day* was overwhelmingly positive. On the first event 25/28 agreed or strongly agreed that the workshop had been useful and relevant to practice, and 24/27 agreed or strongly agreed that they had developed their understanding of the key elements of good practice as a result of the workshops.

After one year, the following feedback was obtained from one of the teams, where 25% of the team (n=40) were able to respond to a brief 5-point Likert scale ranging from *strongly agree* to *strongly disagree*:

1. 70% of respondents agreed with the statement 'the quality of team discussion about clinical risk has improved since the workshop', whilst 20% were uncertain and 10% disagreed;
2. 70% of respondents agreed with the statement 'the quality of discussion between individuals about clinical risk has improved since the workshop', whilst 20% were uncertain and 10% disagreed;
3. 30% of respondents agreed with the statement 'the quality of clinical decision making has improved since the workshop', whilst 60% were uncertain and 10% disagreed;
4. 20% of respondents agreed with the statement that 'the markers for improving clinical risk management agreed at the workshop have been achieved', whilst 70% were uncertain and 10% disagreed;
5. 50% agreed with the statement 'I think there has been an improvement in the organisational/agency culture around risk management', whilst 40% were uncertain, and 10% disagreed;

6. 30% strongly agreed with the statement that 'clinical risk workshops should take place annually', whilst 50% agreed, 10% were uncertain and 10% disagreed.

Conclusion

Although the sample of respondents at one-year follow-up was small, it is interesting that whilst the majority thought that the quality of individual and team discussion had improved, far fewer thought that the more pragmatic measures for improvement had been achieved. This may have resulted from the agendas for change developed at the seminars having become submerged during a year of major organisational change across the service.

There was a lot of interest and positive feedback about the idea of prospective-responsive models of risk management and the majority of respondents agreed that the sort of workshops described are useful for the management of risk.

In retrospect, we could have monitored the impact of the workshops more comprehensively and helped to keep the agreed agenda for change more in the forefront of team thinking by setting up regular feedback loops with the other senior leaders in the multidisciplinary teams. We could have, for example, explained to workshop members that we would be assessing the outcome of the workshops at six months and a year, and that we would be tracking whether the teams' markers for improving clinical risk management had been achieved. However, our busy schedules and other organisational changes during this period did not allow us time to do this.

There is a burgeoning literature, from both psychology and nursing, linking team performance, risk and health outcomes (Heinemann & Zeiss, 2002), and in retrospect we might have drawn from this to inform our construction of the feedback tools we developed.

The authors also learnt a lot about running whole service seminars, and the participant feedback improved as the workshops were rolled out across the organisation. Feedback points to both retrospective and prospective scenario planning and modelling as useful tools in the organisational management of risk (Kessels-Habraken et al., 2009). Clearly further work in this area is needed, particularly whether 'benign invigilation' holds up as a unifying value in the organisational management of clinical risk. Following our experience of running the seminars, we would advocate the use of AI in enhancing organisational learning, particularly when developing learning around themes which are central to the work of the organisation, and for which 'bottom up' rather than 'top-down' approaches are called for. More recently, for example, two of the authors (PA and JS) have been involved in running a series of seminars using a similar model on another key area of service development, that of clinicians being able to come to well-informed and confident case formulations.

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