Risk Management in Public Service Delivery

Emily Rose Tangsgaard

Risk Management in Public Service Delivery

PhD Dissertation

Politica

ISBN: 978-87-7335-292-2

Cover: Svend Siune
Print: Fællestrykkeriet, Aarhus University
Layout: Annette Bruun Andersen

Submitted January 27, 2022
The public defense takes place April 8, 2022
Published April, 2022

Forlaget Politica
c/o Department of Political Science
Aarhus BSS, Aarhus University
Bartholins Allé 7
DK-8000 Aarhus C
Denmark

Table of Contents

Acknowledgements

To write a PhD is a fun, challenging, and rewarding solo expedition. You make the calls, take credit for them, and receive the critique. And then it is not a solo expedition at all. The clichés are all lined up, because I am indebted to several people for making this such a great time of my life.

I owe the biggest thank you of all to my supervisors Anne Mette Kjeldsen and Søren Serritzlew. You guys make an excellent team and complement each other in many ways. Thank you for helping me navigate academia. Thank you for numerous discussions on what risk is, what risky situations are, and how to conceptualise risk management. Thank you for your endless enthusiasm and curiosity, continuous encouragement, and willingness to discuss my definition of risk management once again, or the nth version of an argument. Your support, acknowledgement, and helpful comments over the last three years have been very motivating and ensured progress, whenever I felt I had reached a dead end. You are always generous, positive, and accommodating, and I appreciate the safe space you provided for testing ideas that were not fully developed, and drafts for papers and chapters at their early stages. Collecting data during a pandemic was not easy, and when my data collection more or less collapsed before it ever really took off, you were empathic and ready to provide supervision with short notice, and you made sure I quickly shifted focus to the more feasible parts of my project. With you guys, the glass is always half full, and I will continue to remind myself to frame arguments positively and emphasise how my choices solve the problem at hand. You are great role models and mentors – academically as well as personally. I only have praise for you.

Many public managers from the healthcare sector and social services have prioritised their own and their employees' scarce time to participate in my project. Without your willingness to do so, while also adjusting to the realities of COVID-19, I would have no project on risk management in public service delivery. Thank you does not cover the admiration and appreciation I have for you. I have learned so much from observing you and talking to you, and I look forward to presenting my findings to you and discussing their implications.

I have been surrounded by great colleagues in the public administration and leadership section. In particular, Lotte Bøgh Andersen must be highlighted. Thank you for always prioritising to put young researchers first in line, for pushing us forward in both subtle and obvious ways, and for providing excellent conditions for succeeding. Your work capacity is mind-blowing, and you somehow manage to always come forward as someone who has time to help or discuss something. The Leadership Center has provided me with great

opportunities to present and discuss my research with leaders at different levels, disseminate it to the right audiences, and excellent and helpful colleagues. Overall, the Political Science department is a great place to work. Thank you Ruth, Annette, Line, and Susanne for making my life so incredibly easy with all your administrative support, and thank you Njall for putting a smile on my face at the coffee machine. Former PhD coordinator Christoffer Green-Pedersen deserves recognition for taking such good care of the PhD group and tirelessly advancing our interests.

I also want to thank Gregg Van Ryzin from Rutgers University. From our first meeting, you took an active interest in my research and made me think in new ways that pushed my project forward in key areas. Thank you for inviting me to Rutgers and for all your helpful comments and suggestions along the way, even though I never made it to Rutgers.

Stefan Boye, you win the 'Office Mate and Meme-Master of the Year' Award. You taught me all the dos and don'ts at the department. It took me a few months to convince you of my winning personality, but once you were on board you never stopped interrupting me with your countless memes, (un)justified tantrums, and other very important departmental and political matters we had to discuss with the door closed. You made me laugh every single day (and sometimes even laughed at my jokes), and it was so much fun to share an office with you. Mads Pieter, we did not get to share an office for long, but it was a pleasure and honour to be your 'Kontorchef'. I hope you will invite me to your new house so I can see the fruit of all your hard labour, and that we one day get to do a course together on theory-building. You are very considerate, and I enjoyed sharing our tramping stories and discussing outdoor gear.

My greatest concern going into academia was that it would be lonely. Luckily, there is an excellent PhD group at the department who made that concern redundant. Infinite trips to the coffee machines, pre- and post-pandemic parties, and mid-pandemic online music quizzes, conferences, summer and winter methods schools, and countless laughs attest to this. Clara Siboni Lund, Mathilde Winsløw, Karoline Kolstad, Sarah Yde Junge, Amalie Trangbæk, and Matilde Jeppesen: You made settling into Aarhus so much easier. Thanks a million for letting me tag along when I knew no one in the beginning, for going on walks with me during lockdowns, and for becoming great friends. Further, Mathias Rask Østergaard-Nielsen, Rebecca Nørgaard, Trine Høj Fjendbo, Mr. Anders Grøn, Aske Halling, Niels Nyholt, Anne Kirstine Rønn, Mette Østergaard, Rikke Overvad Kolding, Laurits Florang, Anne-Sofie Greisen Højlund, Jens Tyssedal, and Steffen Selmer Andersen made going to work so much fun. Finally, thank you Fabio Wolkenstein, Tobias Risse, and Valentin

Daur for inviting me to your Frederiksbjerg Beer Club, even though my German is somewhat poor. Overall, I count myself lucky to have so many new Aarhus friends.

My PhD did not only take me to Aarhus, but also to my second home country of Aotearoa New Zealand. Thank you to the School of Government at Victoria University of Wellington for opening your doors to me in 2021. I look back on many great talks with Karl Löfgren, Lola Toppin-Casserly, Michael Macauley, Julia Talbot-Jones, Wonhyuk Cho, and Barbara Allen. My research stay provided good conditions for me to discuss my research, and my project developed considerably during my stay. Together with former Government Statistician Len Cook, Rob Teppett from Oranga Tamariki, and Scott Taylor and Sue O'Shea from the Public Service Association, I had several fruitful discussions on how my research is relevant in a New Zealand context. And to Bryn. Falling in love with you was by all means inconvenient and not part of my plan going to Wellington. At the same time, it was very much appreciated, and our time together is one I would not have gone without. You showed me colours I did not know I could see, and for that I am grateful.

Last, but definitely not least, thank you friends and family. Sarah, Sidsel, Koch, Johanne, Camilla, Ida x 2, Sofie, Juste, Nico, Malene, Laura, Louise, Kamilla, Alberte, Peder, Anders, Astrid, Karoline, Roland, Mette-Mary, sisters Sarah and Maja (and your kiddies), moster Trine, mormor, mum and Søren, and the New Zealand whānau of Debra, Paul, Marion, Rod, Hugh, Jane, and Gael. I am repeatedly overwhelmed by your love and support. Thank you for always providing me with a couch or (bunk) bed when I came to visit you in Copenhagen for the first two years of the PhD. Thank you for not making me feel left out when I went weeks and months without seeing you. Thank you for sharing yours, mine, and our highs and lows, and for listening to me when the going got tough. And thank you for essentially not caring that much about my project and indirectly reminding me what really matters. Your unwavering support and ability to discuss other things than work mean the world to me. To you, I'm the one who accidentally let out my apartment 47 times on Airbnb and got a fine and lifetime ban from cancelling all reservations, the one who cannot clap in time with the music at concerts, the one who estimated the unit price per shower over a ten-year period when deciding whether to renovate my bathroom, and the one who has a Taylor Swift or boyband song for every occasion. I appreciate having a worth to you that is not tied to my academic achievements. Since high school, you have said that I am '*klog i teori, men dum i praksis*'. Completing this PhD is testament that you were right all along.

Emily Rose Tangsgaard
March 2022

Chapter 1. Introduction

'It is hard to go back and pick a new way out of the roundabout. […] Which rotten egg should I choose? We know that both can have negative consequences for the service recipient' (Frontline manager)

Risks to service recipients are a basic condition faced by frontline managers and their employees in public service delivery. There are rarely right and wrong answers to the challenges they face, so frontline workers rely on discretion in their decision-making (Lipsky 2010; Tummers 2013). The purpose of this PhD dissertation is to position the concept of risk management in the public administration and public management fields, and to provide empirical evidence of how risk management is exercised and how it affects frontline workers who face situations where there are risks to service recipients.

Consider the jobs of a doctor and a social worker. Doctors diagnose patients and make treatment plans that can entail surgery, medication, rehabilitation, and the like. Doctors make these decisions on the grounds of blood tests, scans, biopsies, and explanations of perceived symptoms from patients – some of which are at times contradictory. Likewise, social workers make decisions in relation to service recipients who are in vulnerable positions. This could include a case of suspected child abuse, where the social worker has to make a recommendation regarding what, if any, precautionary measures should be taken. On the one hand, removing a child from their potentially abusive parents could radically improve the child's life. On the other hand, removing a child who turns out not to have been suffering from abuse is a significant intervention with negative consequences for the child and the family.

A common denominator between these examples is that they represent risky situations, where there is a high degree of uncertainty and potential negative consequences to service recipients. Frontline workers in these situations must consider a range of factors: What is at stake here? How can the different options be assessed? What are the potential outcomes? What is the right decision? These risky situations require leadership, because the frontline workers facing the risky situations rely on the (limited) information available to them and their professional knowledge, experience, and discretion (Lipsky 2010; Evans 2011; Harrits 2019). This may lead to decision-making on insufficient grounds, and it is the responsibility of the frontline managers to ensure that risky situations are handled the best way possible to mitigate negative conse-

quences to service recipients. Further, these are situations of high political salience because public service delivery is a question of political priority and is something on which politicians are assessed by the electorate (Hjortskov 2019; James 2011; Van Ryzin 2004; Larsen 2021). Many actors beyond politicians, such as the media and interest groups, also take an active part in what happens at the frontlines in order to keep public service delivery organisations accountable (Binderkrantz, Christiansen, and Pedersen 2015). In this way, frontline workers' decision-making receives great attention from those with little tolerance for negative consequences to service recipients, which makes frontline managers crucial in helping improve the grounds for decision-making and supporting frontline workers as they make their decisions.

1.1 Research Question

The point of departure for this dissertation is thus that public service delivery organisations face complex decision-making in which risks to service recipients are a basic condition, and they navigate in a complex environment with many stakeholders. The question is how frontline managers can support frontline workers' decision-making to enable them to handle risky situations as competently as possible and avoid service recipients experiencing negative outcomes from their encounters with public service delivery. This dissertation studies risk management in public service delivery as a way of improving decision-making grounds in risky situations and, ultimately, mitigating negative consequences to service recipients. To achieve this, the dissertation poses the research question:

What is risk management, how is risk management exercised, and how does a managerial focus on risk matter to the risk perception of frontline workers?

This research question is important for theoretical and empirical reasons. What happens at the frontlines of public service delivery is of high salience. To many service recipients, their encounters with, for instance, hospitals, schools, employment agencies, kindergartens, the police, or the social services represent their experiences with the welfare state and its politically prioritised services. Their experience of these encounters shapes their perceptions of the welfare state and of politicians' performance. If too many service recipients experience negative outcomes from risky situations in public service delivery, it becomes an issue that the responsible politicians must respond to. Several empirical examples attest to this. In Aotearoa New Zealand, internal and external reviews recently documented that many newborn Māori babies were removed from their families on insufficient grounds, which led to significant

policy changes (Boshier 2020; Commissioner 2020a; Reid 2019). In Denmark, strong political reactions were triggered and clinical guidelines changed when three teenage boys – independent of each other – died of meningitis at three different hospitals following inadequate professional assessments and decision-making (Gertsen and Frandsen 2020; Rømeling, Stemann, and Deiborg 2017).

However, it is very important to keep in mind that negative outcomes following risky situations also occur when all guidelines are followed and no mistakes are made in the decision-making process. This could include, for instance, a cancer patient experiencing side effects from their treatment, a service recipient suffering from substance abuse who is not entitled to receive help and subsequently overdoses, or a patient who has been bitten by a tick and has symptoms of Lyme disease, but has no evidence of it in blood tests. Regardless, risk management in public service delivery touches upon themes of accountability and responsibility, and ultimately upon trust in the organisations that deliver politically prioritised public services. This is the reason we need more knowledge regarding how frontline managers can support and improve the grounds for decision-making in risky situations to avoid negative outcomes to service recipients in public service delivery.

1.2 Theoretical and Empirical Point of Departure

The research question is somewhat explorative because there is limited theoretical and empirical knowledge to build on. The concept of risk management is in its infancy in the public administration and public management literatures (Bullock, Greer, and O'Toole 2019). So far, studies have primarily focused on formal risk management systems as governance tools, especially related to preventing financial loss (Bracci et al. 2021; Carlsson-Wall et al. 2019; Palermo 2014). We therefore need a theoretical point of departure that enables a structured and systematic approach to the study of how frontline managers handle what happens at the frontlines, where frontline workers make decisions in risky situations based on their specialised theoretical knowledge, their experience, and their discretion.

Theoretically, the dissertation builds on different strands of literature. To conceptualise risk management, theory on leadership is combined with insights from the broader literature on risk and the psychological literature on decision-making under risk. To understand how risk management is exercised, the dissertation investigates the hypothesis that risk management practices are exercised more when distribution of responsibility is collectivised than when it is individualised. The hypothesis draws on blame avoidance theory.

Empirically, the research question is studied comparatively between the Danish healthcare sector (hospitals) and social services. Both are sectors with high stakes for the service recipient in question, visible risks, and frontline workers with specialised theoretical knowledge, considerable discretion, and decision-making autonomy. One way in which the two sectors differ is in how responsibility is formally distributed. In hospitals, healthcare workers are authorised professionals who are individually responsible for the decisions they make, while in the social services, the municipal state agency as a collective unit is formally responsible for the decisions made in cases concerning service recipients. This difference makes the two sectors suitable cases for studying the hypothesis that risk management is exercised more when responsibility is collectivised than when it is individualised. A mixed methods approach employing observations, interviews, scale development, and survey experiments is utilised to answer the different research questions.

1.3 Structure of the Dissertation

The dissertation consists of this monograph and three single-authored articles. The monograph can be read as an independent body of work, as it is focused on answering the questions of what risk management is and how it is exercised. When the articles are incorporated, for instance to discuss findings, they are briefly introduced to provide context and a frame of reference. Table 1.1 provides an overview of the three research questions, how they are approached, and in which parts of the dissertation they are addressed. The three manuscripts in the dissertation are:

A. Tangsgaard, E. R. (2021). How Do Public Service Professionals Behave in Risky Situations? The Importance of Organizational Culture. *The American Review of Public Administration*, 51 (7), https://doi.org/10.1177/02750740211010348
B. Tangsgaard, E. R. (2022). Risk Management in Public Service Delivery: Multi-Dimensional Scale Development and Validation. *International Public Management Journal,* https://doi.org/10.1080/10967494.2021.2004270
C. Tangsgaard, E. R. (n.d.). Does a Managerial Focus on Risk Affect Frontline Workers' Risk Perception? Evidence from Three Survey Experiments. *Working paper*

Article A is a qualitative study of how organisational culture matters to the behaviour of frontline workers in risky situations. This is studied at five Danish hospital wards, building on 35 hours of observation, 15 interviews with doctors, and 15 interviews with nurses. The findings show that organisational

culture can be a driver of both risk-seeking and risk-reducing behaviours among frontline workers. The implications of the findings are, among other things, that it is a managerial responsibility to promote and support an organisational culture where risky situations are handled appropriately, which underlines the relevance of risk management.

Article B is a scale development article. The article presents a theoretical framework of risk management in public service delivery and tests and validates a standardised, individual-level scale. This is achieved by employing insights from qualitative interviews with 16 public service managers and data from a survey of 187 public service managers and 698 of their employees. The factor structure was tested and validated using exploratory and confirmatory factor analysis, which provided satisfactory results regarding criterion validity, convergent validity, and discriminant validity.

Article C is a study of how a managerial focus on risk affects the risk perception of frontline workers in public service delivery. Utilising survey experiments with 659 Danish junior hospital doctors, 365 nursing students, and 114 social work students, the article finds that a managerial focus on risk in the shape of discussing professional issues significantly reduces risk perceptions among frontline workers, and that the effect diminishes as level of professionalisation increases.

Table 1.1 Overview Research Design, Applied Methods, and Data

Theme	Method	Data	Product
What is risk management?	Theoretical conceptualisation		Chapter 2: Conceptualising Risk Management in Public Service Delivery Chapter 3: Is Risk Management Contingent on Distribution of Responsibility?
	Scale development using structural equation modelling	Survey data: - 187 head nurses, and - 698 of their nurse employees	Article B Tangsgaard, E.R. (2022). Measuring Risk Management as a Leadership Behavior in Public Service Delivery: Multi-Dimensional Scale Development and Validation. *International Public Management Journal*. https://doi.org/10.1080/10967494.2021.2004270
How is risk management exercised?	Semi-structured interviews with 62 frontline managers	Interview data: - 12 focus group interviews with social service frontline managers - 8 individual interviews with clinical directors - 9 focus group interviews with head and ward nurses	Chapter 5: Risk Management as a Leadership Behaviour Chapter 6: Risk Management and Distribution of Responsibility Chapter 7: Conditioning Factors of Risk Management
Managerial focus on risk, risk perception, and behaviour of frontline workers	Survey experiment	Survey experimental data: - 660 junior hospital doctors - 365 nursing students - 114 social work students	Article C Tangsgaard, E.R. (Working paper). Does a Managerial Focus on Risk Affect Frontline Workers' Risk Perception? Evidence from Three Survey Experiments
	Participant observation Semi-structured interviews with 30 frontline workers	Observations and interview data: - 35 hours of observation - 15 interviews with nurses - 15 interviews with doctors	Article A Tangsgaard, E. R. (2021). How Do Public Service Professionals Behave in Risky Situations? The Importance of Organizational Culture. *The American Review of Public Administration*, *51*(7), 17. https://doi.org/10.1177/02750740211010348

The monograph is made up of nine chapters and is structured in the following way. Chapter 2 contains a theoretical conceptualisation of what risk management is in public service delivery. To arrive at a definition of risk management, the chapter examines the concept of risk as it has been put forward in economics, psychology, and sociology, and discusses how these definitions can feed into a concept of risk management that is operationalizable and applicable in the political science subfields of public administration and public management. Based on this, risk management is defined as leadership behaviour targeted towards enabling frontline workers to mitigate negative consequences to service recipients in risky situations. It is theorised to consist of three dimensions: organising work routines before risky situations, discussing professional issues during risky situations, and facilitating follow-up activities after risky situations.

Chapter 3 argues that risk management is dependent on how responsibility is distributed within public organisations. Drawing on blame-avoidance theory and the assumption that actors behave strategically and seek to avoid blame, the hypothesis that risk management is exercised more when distribution of responsibility is collectivised than when it is individualised is derived.

The research design of the monograph is presented in Chapter 4. The comparative design between the healthcare sector and the social services is a most similar systems designs where the two cases – the healthcare and social services sectors – are similar in their contextual conditions but differ in terms of how responsibility is formally distributed. Within each case, the selection of units follows a diverse logic, where the units perform different tasks and thus represent different kinds of risky situations, which resembles a most different systems design. In this sense, this study is designed as a cross-case most similar systems design and within-case most different systems design. Overall, this monograph builds on 29 individual and focus group interviews with a total of 62 frontline managers from hospitals and social services.

Chapters 5-7 make up the analytical bulk of the monograph and build on the 29 individual and focus group interviews. Chapter 5 qualitatively examines how risk management is exercised, following the theoretical conceptualisation from Chapter 2 and the empirically validated structure of the risk management concept from Article B. The qualitative analysis shows how risk management can differ between frontline managers and is subject to prioritisation. The chapter further explores the implications of frontline managers' risk perceptions and willingness to take risks for their risk management practices. Here, a key insight is that frontline managers have different risk management profiles. They prioritise different elements of risk management dependent on how they perceive the potential risks facing their organisations and how willing they are to accept these.

Chapter 6 investigates the hypothesis derived in Chapter 3 and finds support for the expectation that risk management is exercised more when distribution of responsibility is collectivised than when it is individualised. Frontline managers in the social services exercise more risk management than their healthcare sector counterparts. They stand out by establishing fora for collective decision-making, by imposing ad-hoc decision-making programmes, and by actively taking part in the decision-making process during risky situations as opposed to frontline managers in the healthcare sector who primarily set the scene for individual decision-making. Key reasons behind these differences in degree are related to how the frontline managers perceive their roles and the question of responsibility in decision-making.

Chapter 7 investigates how different external actors including political principals, regulatory government agencies, interest groups, and the media condition the risk management practices of frontline managers. A key insight from this chapter is that frontline managers face cross-pressures imposed by these external actors, which, in their experience, leads to excessive documentation of decision-making processes as a means of avoiding blame for potential negative consequences to service recipients.

Chapter 8 broadens the scope and discusses the implications of the findings presented in both this monograph and in the three articles. The discussion addresses theoretical, empirical, and normative issues related to risk management in public service delivery – for instance, whether risk management comes at the cost of organisational effectiveness, and how the concept of risk management contributes to the public administration and public management literatures. Chapter 9 concludes the dissertation as a whole and discusses its contributions and limitations, as well as perspectives for future research on risk management in public service delivery.

By answering the research question, this PhD dissertation makes three overall contributions. First, there is a substantive theoretical contribution in conceptualising risk management in a public service delivery context. This is substantiated by the empirically validated risk management scale, which can be applied in empirical analyses where risk management is a variable of interest. Second, there is an empirical contribution from the in-depth, qualitative comparative analysis of how risk management is exercised and whether this is dependent on the distribution of responsibility. Risk management is a resource-demanding leadership behaviour and therefore a question of priority, as too much risk management may lead to ineffective public service delivery. Third, there is an empirical contribution from the insights on how a managerial focus on risk matters to the risk perception of frontline workers in public service delivery. This also triggers a normative discussion on whether it is in-

herently good to reduce risk perception or whether a sense of risk is instrumental in ensuring the best possible decision-making in risky situations. In this way, this dissertation provides theoretical and empirical insight on how frontline managers handle situations where there are risks to service recipients and where frontline workers rely on their professional knowledge, experience, and discretion, which is a question of high political salience.

Chapter 2. Conceptualising Risk Management in Public Service Delivery

The purpose of this chapter is to conceptualise risk management in the context of public service delivery. Risk is a contested concept in the social sciences. While well established in the fields of economics, psychology, and sociology, risk has received less attention in the public administration and public management literatures (Bullock, Greer, and O'Toole 2019; Bracci et al. 2021). The different approaches to the concept of risk can be challenging to keep track of. To conceptualise risk management in a public service delivery context, it is fruitful to be familiar with how the social science fields in which risk has been widely studied have conceptualised risk. This is achieved by examining different notions of the risk concept in economics, psychology, and sociology. Building on this, and the existing work on risk in public administration and public management, a definition of risk management in public service delivery is proposed. This is followed by an account of the contextual factors that likely condition how risk management is exercised.

2.1 Different Approaches to the Concept of Risk

There are many competing ideas of risk across various fields of study. A significant cleavage in the social science literature is the one between the economic and psychological approaches. The rational assumptions permeating the economic approach in the classic sense (Arrow 1982; Friedman and Savage 1948; Kunreuther 1992; Markowitz 1952) are contested by psychological work on bounded rationality and heuristics. This body of work argues and demonstrates that actors are boundedly rational and rely on heuristics and biases when making decisions in situations characterised by risk or uncertainty (Simon 1997; Kahneman 1994; Kahneman, Slovic, and Tversky 1982; Kahneman and Tversky 1979; Tversky and Kahneman 1986, 1983; Slovic et al. 2004). Further, the sociological field has its own substantive agenda on risk, characterised by a different ontological and epistemological point of departure and therefore different insights. The following sections examine how the fields of economics, psychology, and sociology conceptualise risk.

2.1.1 Economic Perspective

In economic theory, risk is generally defined as the 'probability x consequence' of a given event (Aven 2010; Renn 1992). A key characteristic of the economic conception of risk is that it is measurable, in the sense that you can estimate the probability of an outcome and examine the actor's assessment of the consequences. This is distinct from uncertainty, which is characterised by insufficient information that makes calculating accurate odds infeasible (Knight 1921 [1946]). The assessment of a given risk is dependent on individual preference, and decision-making is assumed to be powered by rationality and transitivity under conditions of complete information and clear, constant preferences among actors (Arrow 1982; Camerer and Fehr 2006). The economic perspective focuses on risk in terms of lost utility, which originates from the subfield of expected utility theory (Starmer 2000; Aven 2010).

Neumann and Morgenstern (1947) derived utility in terms of axiomatic formulations. Underlying these axioms are core economic preference assumptions of cancellation, transitivity, dominance, and invariance (Tversky and Kahneman 1986; Neumann and Morgenstern 1947). Their utility axioms provided the basis of Friedman and Savage's work on utility analysis of choices involving risks. Essentially, they posited that individuals always seek to maximise utility when they have complete information: individuals are frequently faced with choices that have different probabilities of risk attached to them, and these risks should be treated as a class of decisions, rather than a single numerical quantity (Thompson and Dean 1996; Friedman and Savage 1948). The key point is that actors will choose the outcome where they achieve the highest expected utility.

Markowitz criticised the Friedman-Savage hypothesis of utility maximisation for contradicting common observations of behaviour under risk, because actors do not always choose the outcome with the highest expected utility (Markowitz 1952). Instead, Markowitz proposed a hypothesis of utility under risk, stating that actors are willing to accept large chances for a small loss, and small chances for a large gain (Markowitz 1952). To define utility under risk in relation to gains and losses, rather than final asset points, was a game changer, and it was soon widely accepted in experimental measurements of utility (Tversky and Kahneman 1986; Davidson, Suppes, and Siegel 1957).

The expected utility model relies on a set of axioms of rational behaviour that individuals are assumed to follow (Kunreuther 1992). Expected utility theory is relevant to the conception of risk management because it concerns the assessment of situations where actors make decisions without knowing the exact outcome (Neumann and Morgenstern 1947; Friedman and Savage

1948). A strength of expected utility theory is that utility offers a common denominator for attaching value to different outcomes, which enables actors to compare options with different utility profiles and relate them to their overall satisfaction (Neumann and Morgenstern 1947; Renn 1992: 62). In other words, utility functions enable the comparison of different decisions and the individual assessment of the consequences related to those decisions.

There is dispute over the basic assumptions of the economic approach. The ideas of risk as measurable and objective, and that actors' preferences and trade-offs can be revealed through the application of models with strict assumptions about the actors (see for instance Starr 1969), have been criticised for their reliance on rational assumptions that are hard to meet empirically (Fischhoff et al. 1978; Rosa 1998; Arrow 1982). This critique is the point of departure in the work on risk from the psychological and sociological perspectives.

2.1.2 Psychological Perspective

The psychological perspective generally adopts the 'risk = probability x consequence' definition (Sjöberg 2000: 408; Slovic 1998: 74; Kahneman and Tversky 1979). However, the definition has different implications: probability is typically unknown, whereas consequence is in the eye of the beholder – the latter following along the lines of the utility argument (Slovic 1998: 74; Peters et al. 2006: 145). Probability as an unknown contradicts the Knightian argument stressing risk as measurable, which is what separates risk from uncertainty. In this way, the psychological work on risk can be considered as a reaction to the economic perspective's distinction between risk and uncertainty and its strict assumptions about actors.

The common denominator in the field of psychological research on risk is the dismissal of core economic, rational assumptions about the behaviour of actors in relation to risk and decision-making. Psychologists have demonstrated the insufficiencies of these assumptions in a range of experiments (e.g., Kahneman 1994; Slovic et al. 2004; Kahneman and Tversky 1979; Tversky and Kahneman 1986, 1983; Camerer and Kunreuther 1989; Simon 1997). The following sections outline the primary critique of the economic approach as proposed by psychologists and examine the insights about decision-making under risk and uncertainty.

2.1.2.1 Bounded Rationality

The work of Herbert A. Simon is essential to the discussion of decision-making theory and the critique of economic assumptions about rational actors. In his theory of bounded rationality, Simon grappled with the basic assumptions of

economic theory, namely that actors are rational, have complete information, and are utility maximising (Aumann 1997; Wheeler 2020; Simon 1997). In Simon's theory of bounded rationality, decision-makers are assumed to be limited in their rationality and hence their decision-making, because they have insufficient information when making decisions and cannot digest all the information that is available to them (Simon 1997). This is due to a cognitive restraint, which means that even in the unlikely event of all information being available, the actor would not be able to process and use it in a rational manner in decision-making (Simon 1997). Instead of maximising utility, actors apply the strategy of satisficing in decision-making, which is a contraction of *satisfying* and *suffice* (Simon 1997). Although Simon's theory of bounded rationality applies to actors in organisational settings, it has yielded important insights into decision-making in general, which later psychological research on risk perception and decision-making has built upon (e.g., Tversky and Kahneman 1986; Finucane et al. 2000; Kahneman 1994; Tversky and Kahneman 1981). In this sense, Simon paved the way for studying how boundedly rational actors arrive at decisions.

2.1.2.2 Heuristics and Biases

Building on Simon's work, Daniel Kahneman and Amos Tversky conducted systematic studies of how individuals make judgments and arrive at decisions under risk and uncertainty. In other words, they studied the effects of actors' bounded rationality. In a range of studies and experiments, Kahneman and Tversky illuminated the idea of heuristics in decision-making, which violates the rational assumptions of expected utility theory.

A heuristic is a problem-solving method employed by actors in decision-making under uncertainty and risk. A heuristic reduces the complex task of assessing probabilities and predicting values to a simpler one, making it possible to arrive at satisfactory decisions (Tversky and Kahneman 1973, 1974). A heuristic is a rule of thumb, or a mental shortcut. Heuristics are a practical means for making judgments in decision-making, but it is not a 'rational' way of arriving at a decision, as heuristics do not assess all information available. However, it is the fastest and most easily comprehendible strategy in settings where all aspects of a situation are difficult to comprehend or simply unknown to the actor.

Actors employ three different judgmental heuristics when assessing probabilities: 1) representativeness, 2) availability, and 3) adjustment and anchoring (Tversky and Kahneman 1974). The representativeness heuristic evaluates probabilities by the degree to which A is representative of B. Judgment is therefore based on similarity, rather than probability, which leads to a range

of potential errors such as insensitivity to prior probability of outcomes and sample size, misconception of chance, and illusion of validity. The availability heuristic assesses the probability of an event by the ease with which instances are recalled. Judgment based on availability to recall and compare earlier events can lead to various biases like imaginability and illusory correlations. The adjustment and anchoring heuristic makes probability estimates by starting from an initial value, which is then adjusted to yield the final answer. Judgment based on adjustment will often be skewed towards the initial value, which is called anchoring. This process of anchoring is the result of insufficient adjustment and biases in the evaluation of events.

These heuristics are effective in decision-making, but also lead to potential judgmental errors due to the aforementioned biases of insensitivity to prior probability of outcomes and sample size, misconception of chance, illusion of validity, imaginability, and illusory correlations (Tversky and Kahneman 1974). The work on heuristics was elaborated by Zajonc (1980) with the idea of affect in the judgment of risks. In practice, individuals refer to an 'affective pool' that contains all their positive and negative associations to a given object or event, can exist consciously or subconsciously, and has an impact on decision-making and evaluation of probabilities (Finucane et al. 2000: 3).

Heuristics are important in relation to the objective of conceptualising risk management in a public service delivery context. Heuristics represent a different approach to decision-making from the one proposed by expected utility theory and illustrate that actors do not behave rationally when making decisions but rely on heuristics and prior experiences. These insights should be taken into account as they may apply to frontline workers too.

2.1.2.3 Prospect Theory

Kahneman and Tversky extended their critique of expected utility theory and their work on heuristics and biases with prospect theory (Barberis 2013; Kahneman and Tversky 1979; Tversky and Kahneman 1992). Prospect theory is an alternative model to expected utility theory that explains how individuals make decisions in situations involving risk, and the point of departure is still a critique of the rational choice premise underlying expected utility theory (Kahneman and Tversky 1979; Tversky and Kahneman 1992). Kahneman and Tversky view risk as a matter of choice between prospects characterised by 'probability x consequence', but they discard the idea that probability can be determined with certainty and distinguish between outcomes as certain and probable (Kahneman and Tversky 1979: 263).

Kahneman & Tversky showed that actors do not behave rationally when facing risky prospects. In fact, actors attach too much weight to outcomes that

are certain, compared to outcomes that are probable (Kahneman and Tversky 1979). This is known as the certainty effect, and it leads to actors being risk-averse when facing sure gains, and risk-seeking in choices involving sure losses. Actors' decision-making and subsequent behaviour depends on whether they find themselves in the domain of gains or in the domain of losses (Kahneman and Tversky 1979). In the domain of gains, actors are generally risk-averse and prefer a sure gain to a larger gain that is merely probable, because they want to maintain the status quo of being in a winning domain. By contrast, in the domain of losses, actors are generally risk-seeking and prefer a loss that is merely probable to a smaller loss that is certain, because they want a way out of the loosing domain. In short, actors are risk-averse in the domain of gains, and risk-seeking in the domain of losses. This is known as the reflection effect because it implies that actors have opposite preferences, dependent on whether they are in the domain of gains or domain of losses. Kahneman and Tversky (1979) further showed that choices among risky prospects are also subject to an isolation effect, which refers to actors disregarding shared components of different prospects in their assessment. This leads to biases in the decision-making process.

Based on their novel experiments and insights, Kahneman and Tversky promoted the idea that there are two phases when individuals make decisions under risk. The first phase is the editing/framing phase. Here, the actor makes a preliminary analysis of the available prospects of a decision – that is, the outcome and the probability of that outcome. This process organises and simplifies options to make it easier for the actor to arrive at decisions in the subsequent evaluation phase (Kahneman and Tversky 1979; Tversky and Kahneman 1992). Here, the edited prospects are evaluated using heuristics, and the decision falls on the prospect assigned highest value (Kahneman and Tversky 1979; Tversky and Kahneman 1992). The hypothesis that actors choose the prospect with the highest value resembles expected utility theory, and the idea that value is attached to dynamic changes from the status quo, rather than absolute magnitudes, specifically resembles Markowitz's work described earlier.

2.1.2.4 The Dance of Affect and Reasoning: The Experiential vs. Rational System

Parallel to the line of reasoning from Kahneman and Tversky, Seymour Epstein has argued that there are two processing systems in decision-making: 1) a rational, abstract, and analytical system, and 2) an automatic and intuitive system (Epstein 1994). The rational system is analytic, builds on formal logical connections, and is slow in processing, because it is oriented towards delayed

action and justification via logic and evidence (Epstein 1994). In contrast, the experiential system is holistic and intuitive, relying on affective and associative connections to past events, and is fast in processing, because it is oriented towards immediate action via experience and gut feeling (Epstein 1994). The experiential system is believed to be a basic human instinct that is inaccessible to conscious awareness (Slovic et al. 2004). These two systems, which are commonly referred to by Kahneman's (2011) popularised label of 'System 1 and System 2', interact continually in what Finucane, Peters, and Slovic (2003) characterise as 'the dance of affect and reasoning'.

Paul Slovic and colleagues has adopted the idea of two processing systems in decision-making under risk (Slovic et al. 2002; Slovic et al. 2004; Slovic and Peters 2006). They argue that the use of heuristics can be rational, as it allows individuals to consult their experiences and the affect they attach to them (Slovic et al. 2002). In many cases, this can lead to a positive outcome for the actor. However, it also entails the possibility of failing in situations where the outcome deviates from the expectation. In fact, the experiential system misguides actors in two fundamental ways. First, it is possible to manipulate affective reactions. Second, there are inherent biases in the experiential system, because it by default gives precedence to affect and small changes (Slovic et al. 2002; Slovic et al. 2004). These findings are related to the work on heuristics and biases by Kahneman and Tversky. The idea of the two processing systems is relevant in relation to how actors make decisions, and it is therefore important to consider this when conceptualising risk management in public service delivery.

Prospect theory provides compelling evidence that actors are not rational decision-makers, as proposed by expected utility theory. Prospect theory has demonstrated that actors systematically violate the basic assumptions of expected utility theory, illustrated by the certainty, reflection, and isolation effects. However, despite these advancements, prospect theory's emphasis on decision-making under risk as a cognitive phenomenon reflecting the actor's risk perception has been source of criticism. Sjöberg (2000) argues that risk perception should be situated within social psychology, and not cognitive psychology, because it goes beyond individual cognition: risk perception is a social and cultural construct that reflects values, symbols, history, and ideology (Sjöberg, Moen, and Rundmo 2004). In this way, risk perception is a matter of attitude which has many determinants, of which only a few are cognitive. Sjöberg advocates a broader focus that takes the social context into consideration (Sjöberg 2000). This call is to some extent answered by the sociological approach.

2.1.3 Sociological Perspective

The sociological perspective has a different point of departure for conceptualising risk than the psychological perspective. Focus is on how the interplay between social structures and actors shapes the societal perception of risk, rather than the individual perception. The sociological field is marked by the agency-structure debate on whether actors shape society or are in fact shaped by society (Ritzer 2011). This discussion spills over into the conception of risk, where some sociological theories argue that risk is a structural concept, while others argue that risk is a product of social processes constituted by individuals. Further, this debate is concerned with what the normative implications of risk are on a societal level. The following sections outline the key debates on risk in sociology.

2.1.3.1 The Risk Society

Ulrich Beck has to some extent coined the term *risk* with his widely cited theory of the 'Risk Society', in which late-modern society is defined as one dominated by manmade risks. Beck's core argument is that the modernisation process has led to the systematic production of a number of risks and hazards that must be prevented and minimised (Beck 1992: 19). Beck's concept of risk is extensive and includes global issues like pollution and climate change, and issues arising in welfare states where problems are no longer associated with a scarcity of resources but rather an abundance, which leads to health issues (Beck 1992). Risks are the unintended consequences of industrialised society in what Beck calls 'the age of side effects' (Beck 1994, 1997). This covers the idea that the welfare advances enjoyed in late-modern society have an array of related, negative consequences that have not been accounted for and are difficult to place responsibility for (Beck 1997: 51).

In the risk society, risks are visible and tangible, whereas previously risks were invisible and abstract. It is not of interest whether risks are in fact more visible or whether public perception has intensified, because the two sides 'converge, condition, [and] strengthen each other' (Beck 1992: 55). According to Beck, there is no difference between risk and risk perception. Risks exist because they are perceived as such, due to their socially constructed nature.

Awareness of risk is dependent on knowledge and definition, and it therefore holds an element of interpretation (Beck 1992: 51ff). This makes risks inherently disputed, as there is no certain knowledge and no correct interpretation of a given risk. Instead, awareness of risk is shaped by the frame of reference applied (Beck 1992: 63), such as societal or economic, which in turn is shaped by the societal and cultural context in which the frame is embedded. The implication of this is a blurred line, where the ontological status of risk

cannot be separated from the epistemological concept of risk, because the two are mutually constitutive.

2.1.3.2 Changed Risk Profile

Anthony Giddens is also engaged in the debate regarding risk in late-modern society, which he labels a 'risk culture' (Giddens 1991). Giddens asserts that the profile of risk has changed. Prior to modernisation, risk was associated with external hazards that were unpredictable yet expected, like earthquakes, hurricanes, and floods, whereas late-modern society is characterised by manufactured risks as a result of human development and the progression of science and technology (Giddens 1999). The shift from external to manufactured risks does not mean that the risk society is more dangerous than pre-existing forms of social order (Giddens 1999). However, the risks faced are different from those faced earlier, and this is where Giddens and Beck find common ground.

In opposition to Beck, Giddens asserts that late-modern society has reduced exposure to risk significantly. Modern technology has enabled the development of sophisticated methods to better handle external hazards, as well as improved the overall standard of living. Further, Giddens emphasises that willingness to take risks is essential, as initiatives with uncertain outcomes can lead to progress (Giddens 1999). Risk is therefore not a negative characteristic equivalent to danger and hazards, but rather an expansion of choice with some uncertainty related to the outcomes of that choice (Giddens 1999). The notion of risk as an expansion of choice indicates that Giddens confines risk to a man-made construct, which is supported by the idea that 'risks only exist when there are decisions to be taken' (Giddens 1999: 7).

A vital strand of Giddens' later work is his turn toward the political dimension of risk. He has claimed that the modern-day welfare state 'is more correctly seen as a form of collective risk management' (Giddens 1999: 9). The welfare state has in part developed to protect its citizens against the risks of modern-day life, and a good deal of political decision-making is now about managing risks – risks that do not necessarily originate in the political sphere, but have to be managed politically (Giddens 1999). An example of this is the COVID-19 pandemic. The consideration of the political sphere is key to the purpose of developing a concept of risk management in public service delivery, which is essentially a matter of political priority and thus inherently political.

2.1.3.3 Risk, Culture, and Politics

Douglas and Wildavsky (1983) are in the periphery of sociology with their anthropologically inspired approach to risk as a cultural phenomenon. However,

their work on risk and culture is relevant in this context because their conception of risk is different from the ones put forward by Beck and Giddens, where risk is a characteristic of late-modern society. The cultural approach suggests that risks are inherent to any society, and that social processes determine how actors perceive and define risks.

The core argument is that the social process prior to arriving at a risk perception is dependent on and shaped by norms and values in society, and by the biases that are reproduced in social contexts in order to help people grasp the world in which they live (Douglas and Wildavsky 1983). Risk is therefore neither objective nor universal, but subject to the result of a social process, leading to a common consent on the perception of a given risk. This consent could be that a certain risk is manageable, dangerous, or ambiguous, which subsequently informs the societal action that is taken, or the decision not to act (Douglas and Wildavsky 1983).

Paul Slovic argues that to understand public risk perception, we must appreciate the inherent psychological, social, cultural, and political factors that matter to the risk perception (Slovic 1998). The political aspect in particular has received little attention so far in this chapter. The basic argument by Slovic is that societal actors like politicians, citizens, experts, and organisations engage in a process that resembles a game, in which they negotiate how to perceive and assess various situations. The COVID-19 pandemic provides a good illustration again. In most countries, politicians, experts, public organisations, and various societal actors discussed how to assess the severity of the virus, and what measures to take. Essentially, the actors negotiated the extent to which the virus posed a risk to societies, and in what ways.

Taken together, the sociological view on risk as a cultural phenomenon constituted by social processes stands in contrast to the economic and psychological perspectives. The notion that risks or risk perception is neither objective nor the result of an individual internal process is a source of much criticism. The primary critique is that sociological theories attribute excessive weight to structure, denying actors their own cognition and independent decision-making abilities. However, the sociological theories offer important insights into how social opinion, cultural meaning, and power structures shape risk perception. This is important to keep in mind when conceptualising risk management in a public service delivery context, where politics and organisational environment matter.

2.1.4 Recap: Risk and Risk Perception

The previous sections have illustrated the competing ideas of risk in the social science fields of economics, psychology, and sociology. The primary discussions across fields reflect ontological and epistemological differences regarding 1) whether risk is real or a social construct, and 2) whether risks can be assessed objectively or not (Thompson and Dean 1996; Shrader-Frechette 1991).

The economic perspective represents a realist ontology, where risks are real-life phenomena, and an objectivist epistemology where risks are measurable and something you can attach a probability to. Expected utility theory assumes that actors behave rationally and have full information and clear preferences. In relation to decision-making under risk, this means that actors are expected to analyse and assess all relevant aspects attached to all possible outcomes and the probability of each outcome. These assumptions are highly disputed, which work by Simon and later by Kahneman, Tversky, and colleagues demonstrates. However, the economic perspective and expected utility theory hold an important contribution by drawing attention to the preferences of actors, which attach utility to outcomes when making decisions.

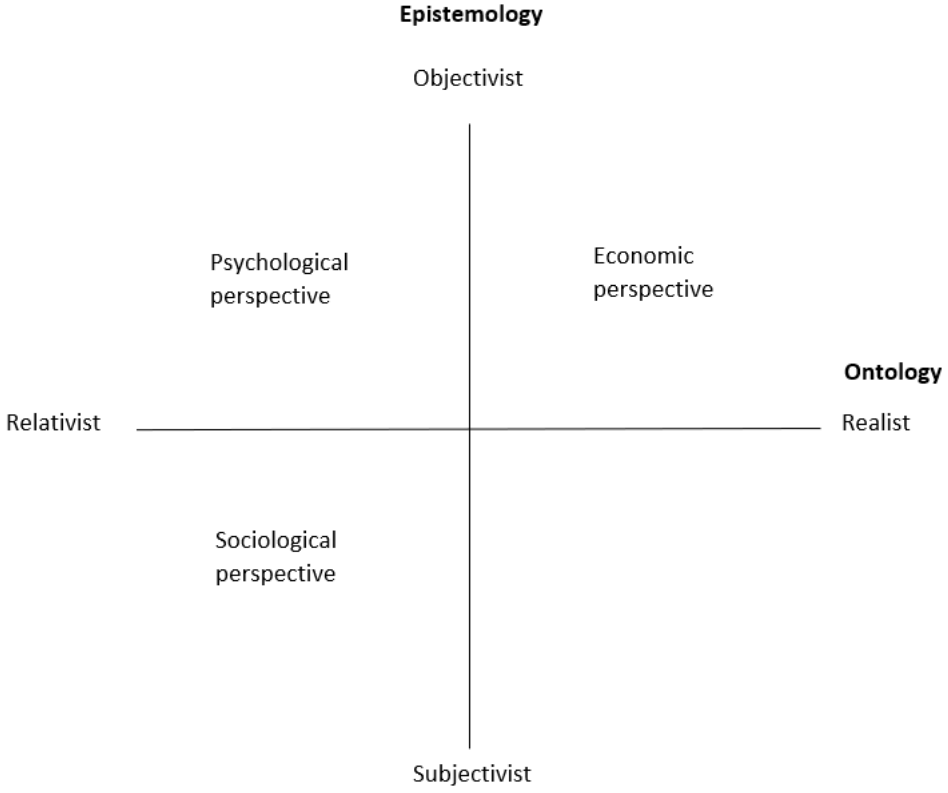
Bounded rationality bridges the economic perspective with the psychological perspective. A core assumption is that actors are in fact not rational: they have limited information and cannot comprehend all relevant aspects of a given situation in decision-making. This is the building block of prospect theory, which shows that actors rely on heuristics and mental shortcuts to arrive at decisions. This is an important insight when analysing decision-making, because it contests the economic assumption of rational actors. The psychological perspective represents a relativist ontology in the sense that risks are subject to individual perception, and an objectivist epistemology in that irrational behaviour and risk perception are demonstrated and measured using experimental designs.

The theories presented from the sociological perspective do not distinguish clearly between ontology and epistemology. Risk is a social construct that cannot be systematically assessed because the assessment in turn would be affected by the contextual setting. In this way, it represents a relativist ontology and a subjectivist epistemology. The sociological perspective conveys important ideas about the negotiation of risk perception at a societal level and the importance of power structures.

Overall, risk is conceptualised and assessed in many ways. Ontologically, it spans from risk as a state of the world (realist) to risk as a state of the world as we see it (relativist), and epistemologically from the probabilistic estimates of risk (objectivist) to the individualised conception of risk as far too subjective

to be measured (subjectivist). Figure 2.1 illustrates the different ontological and epistemological positions and where the economic, psychological, and sociological perspectives fit on these continua. These different conceptions of risk are relevant in relation to the purpose of conceptualising risk management in a public service delivery setting, as they shed light on the different aspects of human decision-making under risk.

Figure 2.1 Concepts of risk on ontology/epistemology continua



2.2 Defining Risk and Risk Management

Across social science fields, there are divergent views on what a definition of risk should hold. The debate is primarily concerned with whether risk is a neutral or a value-laden concept. The value-laden approach asserts that defining risk is essentially a political act, reflecting the value judgements and priorities of the decision-maker regarding different potential consequences of a decision (Fischhoff, Watson, and Hope 1984). This resembles the sociological focus on risk as a social construction that reflects the power structures of society. The neutral position asserts that risk is neither inherently good nor bad, but dependent on the assessor's utility. This resembles the economic and psychological approaches.

The discussion between value-laden and neutral risk definitions implies a discussion of whether risk is positive, negative, or both. A value-laden definition poses a normative judgement on whether the consequence of a risk is positive or not. In contrast, the neutral definition underlines that the nature of the consequence of a given risk is neither *a priori* good nor bad but depends on individual preference and is thus in the eye of the beholder. Essentially, a definition that does not pose a normative, deterministic judgment on its field of applicability is desirable. However, given the purpose of studying how risks are managed in a public service delivery context (which is inherently political), the understanding of risk adopted in this body of work is the value-laden one in the sense that risks to service recipients are something that we as a society generally want to avoid, because they are associated with potentially negative outcomes. From a public administration and public management perspective, this understanding of risks as negative is the most salient, because they are associated with questions of citizens' expectations, democratic accountability, and organisational responsibility. In the next sections, the definition of risk applied in this dissertation is presented alongside a discussion of its implications, which is followed by a proposed definition of risk management and its implications.

221 Risk as 'probability x consequence'

As illustrated by the review of the economic, psychological, and sociological literatures, risk is a contested concept. Following along the lines of the economic and psychological perspectives, risk is here defined as 'probability x consequence'. Recall that in the economic literature, risk is measurable, and you can attach a risk estimate to a given situation. By contrast, the psychological perspective argues that risk is dependent upon individual perception and cognition, while the sociological perspective suggests that risk is a socially negotiated construct.

The argument proposed here is that the definition of risk has different implications when applied in public administration and public management contexts. While accepting the broadly shared idea of consequences being in the eye of beholder – that is, dependent on the actor's utility preferences – probability is argued to essentially be a question of uncertainty, understood as indeterminacy between cause and effect (Meister 1991: 77; Aven 2010; Fowler 2021). This is the case because in the social world, outcomes and consequences of situations are subject to the behaviour of boundedly rational actors, which introduces an element of unpredictability and uncertainty (Simon 1997). In this way, to think of risk in the Knightian sense – where you can estimate the probability of an outcome – does not meet the empirical realities.

The definition proposed here reflects a neutral conception of risk, because it does not suggest that a given risk is inherently good or bad, but rather dependent on individual preference. The two core terms of the definition are thus 1) consequences being in the eye of the beholder, and 2) uncertainty as an inherent characteristic of probability in the social world.

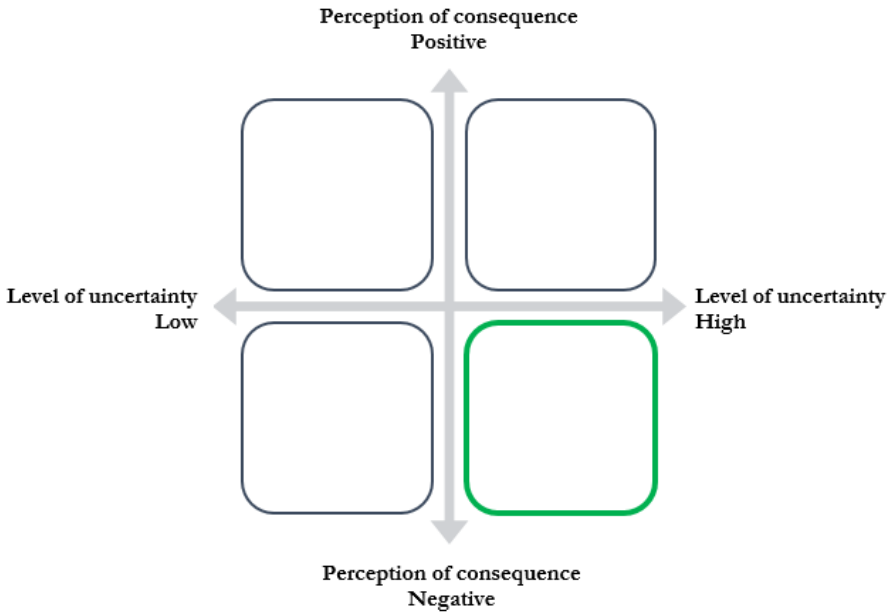
Uncertainty is a matter of degree and dependent on the characteristics of the situation. For instance, in the social services there is little uncertainty about the consequences of not conducting a thorough professional assessment of a child prior to any potential interventions in service recipient's lives. It is, for one thing, against the law, but the thorough assessment is also crucial in order to arrive at the best possible decision in the sense that it is a way of making sure that all the necessary information is collected and made use of prior to decision-making. However, there is a high degree of uncertainty in cases involving removing children from their homes because there is indeterminacy between the cause and effect: is it best for the child to stay at home with their parents and try to make it work, or is it better to remove the child and place them with foster parents? Likewise, in the healthcare sector there is little uncertainty about the consequences of not attaching a label to the medicine you give a patient. The diverted consequence is that others are unable to see what medicine was administered, which increases the likelihood of adverse events. When deciding what treatment to give patients, there is greater uncertainty: will the patient's knee improve from surgery, or is it better to recommend exercise? How severe will the known side effects of chemotherapy be for this particular patient? In this sense, the level of uncertainty can be thought of as a continuum ranging from high to low levels. In public service delivery, decisions with a high degree of uncertainty are in many cases those for which there are no certain rights or wrongs, and frontline workers rely on their discretion – something which we return to later in the chapter.

The consequence of a given risk is in the eye of the beholder, as the assessment of consequences is dependent on individual utility preferences. In other words, actors assess the same consequences differently. In the case of a knee surgery, for instance, there may be uncertainty about the consequences: will the patient be able to run long-distance in a year's time, or 'only' be able to manage 5 km runs? The assessment of the potential consequences of this situation depends on the patient's utility function: how much utility is attached to running long-distance pain-free? To some patients, being able to run 5 km one year after surgery is a positive consequence, while it may be a negative consequence for an experienced long-distance runner. In this sense, the value of the consequence is in the eye of the beholder.

To summarise, risk is understood as the probability x consequence of a given situation, where probability is a question of uncertainty, which ranges

on a continuum from high to low, while consequence is in the eye of the beholder and can be either positive or negative. These two dimensions, and thus the subject matter of risk, are summarised in Figure 2.2.

Figure 2.2 Risk illustration



The practical implication of the risk conception presented in Figure 2.2 is that essentially all situations are risky situations. There is no hierarchy of risk when the assessment of a given situation is subject to the actor's utility preference. However, from a public administration and public management perspective, the situations where there is a high degree of uncertainty or potential negative consequences to service recipients are the most prominent, which is highlighted by the green square in Figure 2.2. This is the case because public service delivery is a question of political priority and an area of high electoral salience. Due to accountability demands, politicians are reluctant to accept negative consequences to service recipients (Hjortskov 2019; James 2011; Van Ryzin 2004). From a public administration and public management perspective, these risky situations are the most salient, as they can trigger political, organisational, and managerial reactions. This was seen for instance in Aotearoa New Zealand where extensive reforms of the state's approach to the removal of children were implemented in 2020 and 2021 following the disclosure of systematic discriminatory treatment in cases of removing Māori tamariki (children) (Boshier 2020; Commissioner 2020a).

In this sense, a core activity for frontline managers in meeting organisational goals is to mitigate the extent to which service recipients face negative consequences in public service delivery. The contextual factors that matter to

risk management in public service delivery are discussed at the end of this chapter, following the proposed definition of risk management.

2.2.2 Risk Management: A Definition

A definition of risk management as a concept in public service delivery must serve two objectives. First, it should outline the purpose of the concept, its field of applicability, and associated concrete leadership practices. Second, it must define the structure of the concept. Leadership is about setting a direction and creating results via and with others to achieve organisational goals (Andersen et al. 2017). This focus on reaching goals and, through that, creating value is also at the core of risk management, where the purpose is to enable frontline workers to mitigate negative consequences to service recipients in risky situations. Focus is on mitigation, rather than elimination, because it is infeasible to fully eliminate risks. In this sense, value is created, when service recipients do not experience negative consequences from their encounters with public service delivery organisations. This purpose also demarcates the risk management concept's field of applicability, which is a public service delivery context.

Gary Yukl describes leadership as 'the process of influencing others to understand and agree about what needs to be done and how to do it, and the process of facilitating individual and collective efforts to accomplish shared objectives' (Yukl 2013: 23). This understanding of leadership emphasises a relational aspect and a processual one. Yukl further emphasises that leadership is not only about influencing and facilitating the current work of the organisation, 'but also to ensure that it is prepared to meet future challenges' (p. 23). In this way, Yukl presents a holistic leadership approach in which there are leadership actions prior to, during, and following a given leadership activity. This idea of leadership practices is helpful to identify the concrete leadership practices of risk management and the structure of the concept.

Building on these insights, risk management is defined as leadership behaviour targeted toward enabling frontline workers to mitigate negative consequences to service recipients in risky situations. Following along the lines of Yukl's processual take on leadership, risk management is theorised to consist of leadership activities prior to risky situations, during risky situations, and following risk situations. Each step of the risk management process has the purpose of enabling frontline workers to mitigate risks to service recipients, and thus reflects the idea of leadership as a means of creating value and reaching specific goals. Based on this, there are arguably three dimensions of risk management:

- Organise work routines: Prior to risky situations, frontline managers make sure that there are suitable conditions for the undertaking of work tasks. This includes recruiting frontline workers who possess different competencies and levels of experience, coordinating which employees do what, and conveying the rules, guidelines, and work procedures to frontline workers.
- Discuss professional issues: During risky situations where frontline workers rely on discretion, frontline managers unpack the various aspects of the situation by encouraging the frontline workers to motivate their professional assessments, and by providing guidance and second opinions in relation to alternative options and the pros and cons of these different prospects.
- Facilitate follow-up activities: Following risky situations, frontline managers clarify what happened with the relevant frontline workers, provide feedback on how the risky situation was handled, facilitate knowledge-sharing among frontline workers, implement necessary changes to work procedures, and impose potential sanctions.

This structure resembles a second-order concept, which has been empirically validated in Article B of this dissertation (Tangsgaard [In press]). The three dimensions constitute a cyclical process of risk management in three phases: risk management prior to, during, and following risky situations. The somewhat broad definition of risk management does not mean that all management is risk management. Recall that the purpose of risk management is to enable frontline workers to mitigate negative consequences for service recipients in situations characterised by a high degree of uncertainty and potential negative consequences. The leadership behaviours associated with risk management directly and indirectly reduce the uncertainty in risky situations and shed light on the potential negative consequences for service recipients. In this sense, risk management is a tool for ensuring the best possible platform for decision-making in risky situations and a means of ensuring that public organisations reach their goals and create value to service recipients. Chapter 5, 'Risk Management as a Leadership Behaviour', explores these mechanisms in greater detail. The next step in conceptualising risk management is to investigate the contextual factors in which this leadership behaviour is exercised.

2.3 Contextual Factors of Risk Management

Acknowledging the contextual factors at play in public organisations is key to comprehending the complexity of risk management in public service delivery. As previously argued, risk is not assessed objectively, but is subject to social

and political negotiations within a given context (Slovic 1998). Public organisations operate in an inherently political environment where they are subject to political prioritisation. This has implications for the frontline managers who, when implementing policies, must navigate upwards, downwards, and outwards to political principals, stakeholders, and frontline workers who exercise considerable discretion (Meier and O'Toole 2011; O'Toole, Meier, and Nicholson-Crotty 2005). A concept of risk management in public service delivery should therefore consider the political context, the organisational context, and the role of frontline workers. The purpose of the following sections is to investigate how these contextual factors are relevant to the concept of risk management and risk management practices in public service delivery.

2.3.1 Political Context

Public organisations are inherently political. This is due to the fact that they implement political decisions and are thus subject to political priorities (Hill and Hupe 2003). Politicians are interested in re-election and vote maximisation, and the quality of the public services delivered is one aspect they are evaluated on (Mansbridge 1990; Bøggild 2016; Boyne et al. 2009). In this sense, organisations that deliver public services are sensitive to political winds and the priorities set by politicians. There are two major reasons for this: politicians are accountable to the electorate, and they are blame-avoiding.

Politicians avoid blame for failed policies because the electorate's negativity bias can compromise their chances of re-election (Weaver 1986; Hood 2007, 2002). A core insight from prospect theory is the identification of the negativity bias and that losses loom larger than gains (Kahneman and Tversky 1979; Ruggeri et al. 2020). Applied to the case of risk in public service delivery, the electorate is expected to attach more significance to cases where there are negative outcomes of risk in public service delivery than to cases where the outcomes are good. This leads to risk-averse politicians (Vis and van Kersbergen 2007), who, in turn, are held accountable by the electorate (Bovens 2007). Empirically, there is little evidence from studies testing the expectations of prospect theory in a public administration setting. Bækgaard (2017), however, has found that citizens prefer certain over risky reforms and are 'more willing to take risks if reforms are associated with gains rather than losses' (p. 927), which is in opposition to the expectation of prospect theory that actors are risk averse in the domain of gains, because they want to maintain the status quo.

A basic premise for organisations that deliver public services is thus that they are embedded in a political context where there are accountability demands and blame-avoiding politicians. The organisations must navigate in an environment that is sensitive to a risk-averse public and to political winds, and

where priorities can change rapidly. The political context was taken into account in this monograph's data collection, where frontline managers were asked to reflect on what it means to be a part of a politically controlled organisation when handling risky situations (see Section 4.2.1 on the interviews). These insights are discussed in Chapter 7.

2.3.2 Organisational Context

Organisations in many ways make up the structural core of public service delivery, and awareness of their contextual setting is important to understand the processes in these organisations (Meier et al. 2015). A key task of public organisations is to prepare and implement public policies, but it is not a given that organisations implement policies 1:1, which has been demonstrated several times (Pressman and Wildavsky 1984 [1973]; Brehm and Gates 1999; Hill and Hupe 2003; Riccucci 2005). However, public organisations are complex entities that not only have to implement public policy, but also have to navigate under economic constraints, be accountable to the public, and recruit and retain qualified staff in order to achieve the numerous goals expected of them, with the ultimate aim of delivering high-quality welfare at the lowest possible cost (Boyne 2002).

There are several external and internal stakeholders in public organisations that can affect or are affected by an organisation's pursued policy objectives (Meier and O'Toole 2011; Freeman 2004; Freeman et al. 2010). Politicians are important external stakeholders, because the performance of public organisations is likely to have an impact on how politicians are evaluated by the electorate, as was pointed out in the previous section. External to public organisations are also the recipients of the public service that is delivered. Recipients are often organised in groups with the purpose of securing representation for their interests, such as patient organisations or associations of the elderly or of parents of school children. These groups are typically strong and well-organised and can exert considerable influence – both in the organisational as well as the political context (Binderkrantz, Christiansen, and Pedersen 2015; Dür and De Bivre 2007). Internally, the stakeholders in public organisations cover employee associations, unions of professionals, and work committees that ensure the interests of employees are considered. Public service delivery and implementation of policy is therefore a highly complex task involving different stakeholders with different views that must be accounted for.

Organisational complexity is important in relation to risks in public service delivery. On the one hand, there is an expectation from external stake-

holders and the public in general that organisations deliver high-quality public services. On the other hand, there are contradictory demands from politicians that public organisations are effective, innovative, and willing to take risks (Vis and van Kersbergen 2007; Jørgensen and Bozeman 2007). Additionally, internal stakeholders demand sufficient resources and settings to perform their jobs to a high, professional standard. In other words, public service delivery organisations juggle many interests, while also ensuring that risky situations are handled in a manner that do not lead to negative consequences for the service recipients. These contrasting demands require that frontline managers in public organisations navigate in these (at times troubled) waters. This was also a theme in the interviews with frontline managers, and the insights are discussed in Chapter 7 'Conditioning Factors of Risk Management'.

2.3.3 Frontline Context

Frontline workers are the object of risk management practices, as underlined in the definition. For this reason, it is important to consider how these workers condition the risk management practices of frontline managers. Frontline managers have to navigate downwards to frontline workers, in addition to managing upwards to political principals, and outwards to stakeholders (O'Toole, Meier, and Nicholson-Crotty 2005). In this sense, they do not just navigate between various internal and external stakeholders who potentially hold different attitudes towards risky situations, but must also set a clear direction for the frontline workers who face the risky situations and make many of the discretionary decisions. The risk perception and risk assessment of frontline managers in public service delivery is paramount because their subsequent risk management behaviour is expected to have an impact on the decision-making behaviour of the frontline workers in risky situations.

Managing frontline workers, or street-level bureaucrats as Michael Lipsky calls them, is no simple task. In his seminal work on street-level bureaucrats (SLBs), Lipsky (2010 [1980]) highlights interaction, discretion, and autonomy as core characteristics of SLBs and the work they undertake. Interaction refers to the fact that SLBs must respond to citizens and their needs and preferences as part of their jobs. This could be a social worker interacting with parents and a child in a case of suspected child neglect. Autonomy is related to the fact that the policies to implement and rules to follow are so many and contradictory that SLBs now and then selectively decide which to focus on. Often, there are not evidently right or wrong answers to the challenges associated with service delivery, and the frontline workers rely on discretion (Lipsky 2010; Tummers

2013). The concept of discretion implies that SLBs hold a substantial amount of power over service recipients' lives.

There are many ideas regarding what shapes the discretionary behaviour of frontline workers. Lipsky does not draw attention to workers' professional backgrounds, and whether this has an impact on their discretionary behaviour (Evans 2011; Nothdurfter and Hermans 2018; Harrits 2019). However, this has been highlighted elsewhere by scholars stressing the role of professional training and background, and the impact it has on the discretionary behaviour of frontline workers, effectively discarding the term 'street-level bureaucrat' for putting excessive emphasis on the 'bureaucrat' notion (Tummers 2013; Evans 2011; Harrits 2019). This literature further emphasises that frontline workers rely on their professional training and norms about how to conduct their work (e.g., Maynard-Moody and Musheno 2003; Evans 2011; Freidson 1994; Harrits and Møller 2014).

The discretionary behaviour and decision-making autonomy held by frontline workers are key in relation to risk management in public service delivery. The three dimensions of risk management – organising work routines, discussing professional issues, and facilitating knowledge sharing – are expected to be constrained by frontline workers with strong professional norms, decision-making autonomy, and discretion. Further, the effect of risk management may be contingent on frontline workers' perception of the risk management practices.[1] These contextual factors are accounted for empirically in Chapter 4, which presents case descriptions of the healthcare sector and social services.

2.4 Conclusion

This chapter set out to conceptualise what risk management is in public service delivery. Based on an account of what risk is in neighbouring disciplines of economics, psychology, and sociology, risky situations are situations where there is a high degree of uncertainty and potential negative consequences. Risk management is the leadership behaviour targeted towards enabling frontline workers to mitigate negative consequences for service recipients in these situations. It consists of three associated leadership behaviours: organising work routines, discussing professional issues, and facilitating follow-up

[1] This is related to the question of a self-other agreement gap between leader-intended risk management behaviour and employee perception, which is discussed in the dissertation's Article B: 'Measuring risk management as a leadership behavior in public service delivery: Multi-dimensional scale development and validation'.

activities prior to, during, and following risky situations. In this way, risk management is a cyclical concept and is comprised of leadership behaviours that feed into each other and the different phases of risky situations. Risk management's field of applicability is situations where there is a high degree of uncertainty, and potential negative consequences.

The last part of this chapter investigated the contextual factors conditioning risk management as a leadership behaviour. Here, it was argued that the political context, with blame-avoiding and risk-averse politicians who are held accountable by the electorate, condition the space in which public service delivery organisations can navigate. Further, frontline managers have to navigate upwards, outwards, and downwards to political principals, internal and external stakeholders, and the frontline workers who hold a considerable amount of discretion and decision-making autonomy in risky situations.

Chapter 3. Is Risk Management Contingent on Distribution of Responsibility?

The purpose of this chapter is to present the argument that risk management is dependent on how responsibility is formally distributed within public service organisations. Risk management is hypothesised to be exercised more when distribution of responsibility is collectivised than when it is individualised. The question of formal responsibility is related to questions of blame and responsibility attribution in decision-making.

The definition of risk management in public service delivery developed in Chapter 2 serves as the point of departure. Risk management is defined as leadership behaviour targeted towards enabling frontline workers to mitigate negative consequences to service recipients in risky situations. This is a somewhat generic definition that does not take formal and informal conditions of public service delivery organisations into account. We know from the literature that informal conditions like professional norms, organisational culture, and the motivation of frontline workers matter to public service delivery and the task faced by frontline managers (Andersen 2009; Sandfort 2000; Riccucci 2005; Brehm and Gates 1999; Loon, Baekgaard, and Moynihan 2020; Bellé 2012; Harrits and Møller 2014; Maynard-Moody and Musheno 2012). These informal conditions were accounted for in Chapter 2, and the role of organisational culture was also investigated in the dissertation's Article A, which showed how organisational culture can be a driver of risk-reducing and risk-seeking behaviours among frontline workers (Tangsgaard 2021). Parallel to these informal conditions are formal conditions that also matter to what happens at the frontlines, such as distribution of responsibility or the regulatory setting. The formal conditions hold important, complimentary explanations for understanding how risk management is exercised in public service delivery.

Public service delivery organisations share many similar formal and informal conditions. They are politically controlled and accountable to stakeholders and service recipients, and, further, many are workplaces for frontline workers with specialised theoretical knowledge, professional norms, and substantial discretion and decision-making autonomy (Hupe and Hill 2007; Lipsky 2010; Evans 2011; Harrits 2019). For instance, hospitals, law enforcement agencies, social service agencies, employment agencies, and schools all deliver public services that are subject to political priority, and they are pri-

marily staffed by frontline professionals like healthcare workers, social workers, teachers, and police officers. These shared formal and informal conditions and characteristics make public service delivery organisations comparable, although it is important to recognise the role of specific tasks. This argument is unfolded in greater detail in Chapter 4.

A substantial formal aspect in which public service delivery organisations vary is the distribution of responsibility. In some sectors, frontline workers are individually responsible for the decisions they make on behalf of service recipients, whereas in other sectors responsibility is shared collectively at an organisational level. Formally speaking, this is a dichotomous either/or distinction reflected in whether frontline workers are authorised professionals or not: authorised frontline workers are individually responsible for their decision-making, while unauthorised frontline workers are not. Distribution of responsibility is important, because it makes up a substantial condition of public service delivery that also matters to how blame is put down. Empirically, there are nuances to this distinction, which are described and discussed in greater detail in Chapter 4's case descriptions. The interesting question here is whether and how distribution of responsibility matters to the risk management practices of frontline managers in public service delivery. This is relevant, given the electoral salience of public service delivery where there are strong accountability demands in place. Issues are subject to public discussion and the actors responsible for public service outcomes can therefore expect to be held accountable for the consequences service recipients experience from these encounters (Bøggild 2016; James et al. 2016; Boyne et al. 2009; Larsen 2021).

The dissertation's Article A shows how organisational culture matters to the behaviour of frontline workers in risky situations. It takes the perspective that behaviour can be explained by understanding the impact of a shared culture that exists externally to the individual. However, when it comes to understanding the role of responsibility and managerial practices, a shift of perspective helps account for how frontline managers react to potentially being held responsible for service recipients' outcomes. To theorise about how distribution of responsibility matters to risk management practices, the blame avoidance literature is relevant. In this, the overall assumption is that public actors – be it organisations, managers, or frontline workers – act strategically and seek to avoid blame for unwanted outcomes of their decision-making behaviour (Weaver 1986; Moynihan 2012; Carpenter and Krause 2012). In this way, this chapter takes the perspective that frontline managers seek to maximise their own utility by avoiding blame for outcomes to service recipients.

Examining the role of a formal condition like distribution of responsibility is relevant for different reasons. Theoretically, it presents a complimentary way of understanding risk management practices in public service delivery

that goes beyond the 'usual suspects' of norms, culture, and motivation. The insights will thus add to the knowledge base of how to understand risk management as a specific leadership behaviour. The argument proposed here is that distribution of responsibility is crucial to understanding risk management practices because it makes up a key formal condition. Further, there is an empirical contribution in investigating whether risk management is exercised differently dependent on distribution of responsibility, which may hold policy implications. These are discussed in Chapter 8, 'Implications of Risk Management in Public Service Delivery', which also taps into informal conditions like the role of frontline workers.

The following sections present the argument underlying the hypothesis that risk management is exercised more when the distribution of responsibility is collectivised than when it is individualised. The argument is presented in a simple, stylised fashion building on two core assumptions that were also mentioned briefly in Chapter 2: public managers face accountability demands, and public managers are blame-avoiding. This is followed by an account of how certain conditions of risky situations such as degree of urgency, the frontline manager's risk perception, and level of professionalisation among frontline workers may also matter to how much risk management is exercised in public service delivery.

3.1 Accountability, Responsibility, and Risk Management

Public service delivery typically has high electoral, and therefore political, salience (Green-Pedersen and Jensen 2019; Koop 2011). The encounters between public organisations and service recipients are important from a democratic point of view, because they epitomise why we elect politicians: to decide who gets what, when, and how (Lasswell 1958 [1936]). Public service delivery organisations are therefore responsible to their political principals, external stakeholders like regulatory government agencies and the media, as well as users – and the electorate in general – who expect high-quality performance in return for their taxpayer money (Favero and Kim 2021; Van Ryzin 2004; James 2011; Bovens, Schillemans, and Goodin 2014). Accountability, understood as 'a relationship between an actor and a forum, in which the actor has an obligation to explain and to justify his or her conduct, the forum can pose questions and pass judgment, and the actor may face consequences' (Bovens 2007: 467) is a key concept when grasping how politicians and public organisations are held responsible, and it is a core public value (Brodkin 2008; Hupe and Hill 2007; Jørgensen and Bozeman 2007; Van Der Wal and Huberts 2008; Van Der Wal, De Graaf, and Lasthuizen 2008).

One way of ensuring and enforcing accountability is to distribute responsibility. Legislation formally describes how responsibility is distributed in different areas of public service delivery. As mentioned, in some sectors, this responsibility is placed with the individual authorised frontline worker, while in other sectors it is placed at an organisational level. In the latter type of organisation, the frontline manager bears much responsibility for the decision-making of frontline workers, which is not the case to the same extent when frontline workers are individually responsible. Different empirical examples illustrate how rules surrounding accountability and responsibility are sometimes enforced following negative outcomes for service recipients and used to place blame.

In Denmark, authorised health professionals have been held responsible for the outcomes of their decisions. In 2018, a nurse was penalised and fined for reckless behaviour after giving a patient methadone, a prescription-only drug, without the approval of a doctor. The methadone poisoned the patient, who later died (Krejberg 2018). In 2020, a doctor was fined for severe neglect following the death of a teenage boy from undetected meningitis, despite symptoms pointing in that direction (Gertsen and Frandsen 2020). In 2021, two nurses in a private practice were stripped of their authorisations because they offered so-called cleansing treatments to people who had received the COVID-19 vaccine (Mejlgaard and Gammelgaard 2021). These examples illustrate how authorised health professionals may face individual consequences if their decision-making behaviour does not live up to the Authorisation Act. Stripping doctors and nurses of their authorisations is a last resort and the most intrusive sanction, which is only applied when there is a reasonable suspicion that they pose a danger to patients (Authorisation 2019).[2] Police officers are another example of frontline workers who are responsible for their own decision-making, which is evidenced by disciplinary cases related to their use of force. For instance, in 2020 a number of Danish officers received warnings following what was characterised as 'criticisable' behaviour (Danish National Police, 2021). However, police officers do not make autonomous decisions all the time, as they also react to commands from superiors. This was the case in 2012, for instance, when police officers executed orders from superiors to effectively prevent a pro-Tibet demonstration from taking place while the Chinese president was visiting Denmark (The Tibet Commission, 2017). This illustrates that the question of distribution of responsibility is not always black and white, and that it is possible to place organisational responsibility even in

[2] As of October 2021, 134 Danish doctors and 207 Danish nurses had been stripped of their authorisations (Danish Authorisation Register: https://stps.dk/da/autorisation/opslagautreg/).

contexts when responsibility is individualised. This is accounted for in the case descriptions in Chapter 4.

A case from New Zealand illustrates how responsibility and accountability can be enforced when frontline workers are not authorised. Here, internal and external reviews documented that many newborn Māori babies were removed from their families on insufficient grounds, which led to several frontline managers as well as managers higher up in the hierarchy being dismissed for decisions made at the frontlines, because responsibility here is shared collectively (Commissioner 2020a, b; Boshier 2020; Reid 2019). Similarly in Denmark, managers at different municipal levels have been dismissed following cases where municipal state agencies did not react promptly or satisfactorily to notifications of concerns over children's wellbeing (Tarp 2011; Agger 2015). While severe neglect in professional conduct most likely will lead to consequences for individual frontline workers, the nature of collectivised responsibility implies that decision-making and the outcomes of decision-making at the frontlines is the responsibility of managers higher up in the hierarchy. The finer nuances of the distribution of responsibility, authorised and non-authorised frontline workers, and accountability mechanisms are discussed in greater detail in the case description in Chapter 4.

The question is whether this formal condition of distribution of responsibility is important to understanding how risk management is exercised at the frontlines. Are these formal accountability measures, which are there to place responsibility on frontline workers and their managers, important to how risky situations are handled? For now, a key point is that in organisations with unauthorised frontline workers, managers are expected to be more likely to face the blame for negative consequences to service recipients, while managers of authorised frontline workers are less likely to face blame for negative consequences to service recipients.

3.2 Blame Avoidance and Risk Management

Public managers are generally assumed to be blame-avoiding (Hood 2007; Weaver 1986; Moynihan 2012). This is a key assumption in relation to risk management in public service delivery, because it has an explicit purpose of enabling frontline workers to mitigate potential negative consequences of risky situations. Risks to service recipients are an inevitable condition in public service delivery, but negative consequences sometimes still call for placement of responsibility and blame, and how risks are handled is therefore a question of interest.

Politicians and organisations employ different blame-avoidance strategies. Christopher Hood has identified three types of blame-avoidance strategies from office holders and public organisations: presentational strategies, policy strategies, and agency strategies (Hood 2002: 16; 2007: 200). Presentational strategies cover attempts to utilise spin, timing, and selective argumentation as means to avoid or limit blame – for instance by diverting the public's attention to other important matters. Policy strategies cover attempts to utilise defensive approaches, like referring to inherited policies or selecting a policy position, to avoid or limit blame. Agency strategies cover attempts to design institutional arrangements to minimise or avoid blame, such as the allocation of formal responsibility, competency, or jurisdiction. Formal distribution of responsibility can thus be understood as an agency strategy for politicians and organisations to avoid blame for unwanted consequences to service recipients by placing responsibility in the hierarchy. A study by James et al. (2016) has showed that this kind of delegation of responsibility to public managers in fact reduce citizens' blame of politicians for public service failures.

The blame frontline managers potentially face following risky situations varies, dependent on how responsibility is distributed. When responsibility is individualised, the frontline manager is likely to be blamed for processual elements, like for instance not living up to their managerial responsibility in terms of making sure that there are appropriate decision-making structures in place for frontline workers to navigate in. When responsibility is collectivised, the frontline manager is still likely to be blamed for processual elements, but also for actual outcomes for service recipients. In this way, when distribution of responsibility is individualised, frontline managers are responsible for the processes surrounding handling risky situations. This is also the case for frontline managers when distribution of responsibility is collectivised, but they are furthermore responsible for consequences to service recipients following frontline workers' decision-making. This too is a stylistic distinction, and the nuances of this are accounted for in the case descriptions in Chapter 4.

The question is whether and how distribution of responsibility and the different dynamics of blame matter to how risk management is exercised by frontline managers. Blame avoidance draws on a logic of consequence, which has its roots in rational choice theory and represents ideas about decision-making as based on analysis of different prospects and preference-driven choices (March and Simon 1994). Following the logic of consequence, risk management practices expectedly differ, dependent on whether the frontline manager is responsible for the outcome or not. A collectivised distribution of responsibility in principle favours a high degree of risk management because

the frontline manager is held accountable for both the decision-making process and the outcome from it. In this way, they can guard themselves against potential blame by doing all in their power to enable the frontline workers to mitigate the potential negative consequences of risky situations. The intuition is that when frontline managers formally hold part of the responsibility for decision-making by frontline workers, they will engage wholeheartedly in risk management activities, because they personally have something at stake and can be held responsible. An individualised distribution of responsibility, on the other hand, favours less risk management because the frontline manager is not formally responsible for the outcome of risky situations for service recipients, just the decision-making process. They can, in principle, avoid the blame when frontline workers are not able to mitigate negative consequences to service recipients, as long as the processual elements are in place. The intuition is that frontline managers who are not formally responsible for actual outcomes to service recipients have less incentive to invest a lot of time and resources in risk management practices, because they cannot be held individually accountable for the outcomes – unless they are triggered by inadequate decision-making structures.

In this way, frontline managers are expected to apply different risk management strategies in order to enable frontline workers to mitigate potential negative consequences for service recipients, but also to avoid the blame when service recipients do experience negative consequences after risky situations. Based on this, the following hypothesis is derived:

Risk management is exercised more when distribution of responsibility is collectivised than when distribution of responsibility is individualised.

This is a hypothesis that investigates the role of a formal condition – distribution of responsibility – in public service delivery. Investigating this hypothesis is a significant contribution to the literature in the sense that the findings will add to our understanding of what frontline managers take into account in their risk management practices, and, specifically, whether the formal condition of distribution of responsibility matters. In this sense, the hypothesis adds to our existing knowledge by investigating a complementary explanation to the role of professional norms, organisational culture, and employee motivation when we want to understand the risk management practices of public managers. The hypothesis is empirically investigated in Chapter 6, 'Risk Management and Distribution of Responsibility'.

There are also other relevant conditions that may matter to how much risk management frontline managers exercise. This is related to the idea that risk management practices are not only subject to how responsibility is distributed and to norms, organisational culture, and motivation of employees, but also

to conditions of the risky situations themselves, like degree of urgency, frontline managers' risk perceptions, and the level of professionalisation among frontline workers. Therefore, the last section of this chapter discusses how these conditions may matter to how much risk management frontline managers exercise.

3.3 Conditions of Risky Situations

Chapter 2 accounted for how factors like political, organisational, and frontline contexts are key to comprehending the complexity of risk management in public service delivery. Further, there are characteristics of risky situations that may influence how much risk management frontline managers exercise. One condition of risky situations is the question of urgency. How much time do frontline workers have to assess the risky situation, and how quickly must they react to reduce the potential negative consequences for service recipients? In public service organisations that face risky situations with a high degree of urgency, frontline managers may prioritise the first dimension of risk management, organising work routines. The reason is that measures taken at this stage can prevent routine situations from turning risky, and also support frontline workers in dealing with those risky situations that have a high degree of urgency. By contrast, the second dimension of risk management, discussing professional issues, may be given less priority in urgent risky situations, because there will be a need for swift action that renders time-consuming discussions of professional assessments, alternative paths, and pros and cons infeasible. Facilitating follow-up activities may also receive greater priority when there is a high degree of urgency. Under these circumstances, it is required that the organisation can improve its practices based on experience. The learning extracted from follow-up activities can lead to a better organisation of work routines and thus improved handling of risky situations. In this sense, the follow-up activities feed into the process of organising work routines, underlining the cyclical nature of risk management as a leadership behaviour.

A second condition of risky situations is the risk perception of the frontline manager, which likely also matters to how much risk management is exercised. As accounted for in Chapter 2, individual risk perception is subject to various heuristics and biases that are effective in decision-making but also potentially lead to judgment errors. Further, we know from prospect theory that actors are risk-seeking when facing losses. Does this mean that frontline managers who perceive a risky situation as having definite negative consequences for the service recipient will do little to enable the frontline worker to mitigate

the potential negative consequences? Whether these generic psychological insights on human behaviour apply to frontline managerial behaviour in risky situations at the frontlines of public service delivery is an open question. However, it seems appropriate to investigate whether the link between individual perceptions of risky situations and subsequent behaviour also applies to frontline managers.

A third condition of risky situations is the level of professionalisation of frontline workers, which may matter to the level of risk management exercised by frontline managers. A common denominator of the understanding of frontline workers applied here is that they all hold specialised, theoretical knowledge that equips them to make decisions in relation to service recipients – regardless of whether they are authorised professionals or not. The degree of specialised theoretical knowledge frontline workers hold is reflected in their level of professionalisation (Freidson 2001; Kjeldsen 2012). Professionalisation is viewed as a continuum. For instance, doctors are typically considered to have a high level of professionalisation because they hold six-year university degrees, nurses are considered to have a lower level of professionalisation because they hold three-and-a-half-year occupational bachelor's degrees, followed by nursing assistants that have a lower level of professionalisation than nurses because they hold two-and-a-half-year vocational education and training degrees. The question is whether frontline managers exercise more or less risk management as the frontline workers' degree of professionalisation increases. It may be the case that more professionalised frontline workers call for less management during risky situations because they are better able to assess the risky situation at hand, its different prospects, and alternative options. On the other hand, it could also be that highly professionalised frontline workers call for more risk management because they face risky situations with greater complexity. In this sense, level of professionalisation and distribution of responsibility are related, as the level of professionalisation is likely a determinant of how much risk management is needed before, during, and after risky situations.

The role of these conditions, and whether they to matter to how risk management is exercised by frontline managers, is explored in Chapter 5, 'Risk Management as a Leadership Behaviour', and Chapter 6, 'Risk Management and Distribution of Responsibility'.

3.4 Conclusion

The purpose of this chapter was to present the hypothesis that is investigated in this monograph and the arguments behind it: risk management is expected to be undertaken differently, dependent on how responsibility is distributed

in public service organisations. Concretely, risk management practices are hypothesised to be exercised more when distribution of responsibility is collectivised than when distribution of responsibility is individualised. The factors informing this hypothesis are the accountability demands imposed on public service delivery and the blame-avoiding nature of public managers. When frontline managers are not individually responsible for the outcome of risky situations, and thus directly to blame, they are expected to exercise less risk management than when responsibility is collectivised and they hold much of the responsibility for the decisions made in risky situations.

Further, situational and individual characteristics such as degree of urgency, frontline managers' perceptions of risky situations, and level of professionalisation among frontline workers may matter to the risk management practices exercised. The hypothesis and these situational and individual characteristics are investigated in Chapter 6. The next chapter presents the research design of this monograph and the selection strategy for suitable cases to study the claim that distribution of responsibility matters to how risk management is exercised.

Chapter 4. Research Design and Methodological Approach

This PhD dissertation consists of three single-authored articles and this monograph, as accounted for in Chapter 1. This chapter describes the research design and methodological framework applied to investigate the second research question of the dissertation and arrive at the results reported in this monograph: How is risk management exercised? The overarching purpose of the research design is to enable a sound, qualified answer to this question, and to formally test the hypothesis presented in Chapter 3 that risk management practices are exercised more when the distribution of responsibility is collectivised than when the distribution of responsibility is individualised. Risk management is a concept that we know little about empirically, as argued in Chapter 2. To investigate how risk management is exercised and to test the hypothesis requires a research design that allows for exploring the theorised conceptualisation of risk management as well as formal hypothesis testing.

The chapter is structured as follows. First, the overall comparative research design is presented alongside a discussion of how the selection of cases and units enable answering the research question in a sound manner. This is followed by a presentation of the qualitative data collection, the coding process, and the overall analytical strategy of the empirical analysis that follows in the subsequent chapters. The last sections describe the two cases that are subject of analysis.

4.1 Research Design

A key argument of this monograph is that risk management is conducted differently and has different implications depending on how responsibility is distributed. To test this hypothesis requires a research design where the distribution of responsibility is the main source of variation. A most similar systems design (MSSD) satisfies this criterion, as it is characterised by variation in one independent variable while holding other variables constant (Przeworski 1970). A first requirement of a MSSD is thus that we need cases where responsibility is distributed differently. In some sectors, frontline workers are individually responsible for the consequences following their decisions, whereas in other sectors responsibility is shared collectively at an organisational level, as discussed in Chapter 3. Authorisation is a good indicator for distribution of responsibility. Frontline workers who hold an authorisation are, formally

speaking, individually responsible for their decisions, whereas unauthorised professionals are not. A second requirement following the MSSD logic is that the cases should be similar in other relevant veins. In this way, the main driver of potential differences in risk management practices is the distribution of responsibility. In line with the MSSD logic, Seawright and Gerring (2008) argue that selection of cases must satisfy two objectives: 1) be a representative sample, and 2) feature useful variation on the dimension of theoretical interest. The former criterion implies that the selected case(s) must be representative of the greater population that the researcher aims to make claims about. The latter criterion entails that the selected case(s) must differ in relation to the dimension of theoretical interest.

The healthcare sector and social services meet the two requirements of a MSSD and Seawright and Gerring's (2008) case selection criteria. First, they differ on one key aspect, which satisfies the criterion of useful variation on the dimension of theoretical interest: the distribution of responsibility. In the healthcare sector, health professionals such as doctors and nurses hold an authorisation.[3] This means that, formally speaking, they are individually responsible for the decisions they make and the consequences of those decisions (Authorisation Act). Implied by this authorisation is the fact that health professionals can be stripped of their authorisation, and the right to work as health professionals, if they for instance break with professional conduct. In the social services, on the other hand, social workers are not authorised professionals and, formally speaking, they are therefore not individually responsible for the consequences following their decisions. Here, the municipal state agency as a collective unit is responsible for the decisions made by social workers in cases of interventions in service recipients' lives.

Second, the healthcare sector and social services share similar framework conditions and characteristics that satisfy the criteria of representativeness, such as 1) decision-making with high stakes for the service recipients in question, 2) visible risks, and 3) frontline workers who interact directly with service recipients and hold considerable discretion and decision-making autonomy (Lipsky 2010). These characteristics are relevant in the sense that a core difference between the two sectors is the distribution of responsibility. The two cases thus satisfy the main criteria of a MSSD, and, in this way, enable the investigation of the hypothesis that risk management practices are exercised

[3] Authorised health professionals also include dentists, physiotherapists, optometrists, and chiropractors. For a complete list of authorised health care professionals, see: https://sum.dk/Sundhedsprofessionelle/Sundhedspersonale/Autorisation%20af%20sundhedspersoner.aspx

more when distribution of responsibility is collectivised than when it is individualised.

The decision to consider the two sectors to be alike in all but one key aspect is a source of potential dispute. This take on the two sectors is not intended to minimise the fact that frontline workers in the healthcare and social services sectors have distinct professional identities and norms (e.g., Andersen 2009; Maynard-Moody and Musheno 2003; Musheno and Maynard-Moody 2015; Freidson 1994; Evans 2011, 2018, 2020). Further, some may argue that the two sectors face inherently different problems and make decisions that are non-comparable. This is a methodological challenge that is impossible to overcome, as finding two sectors that are truly alike in all but one aspect is unlikely. The professional identities and norms of the frontline workers and the inherent nature of their decision-making are therefore treated as constants that make up part of the contextual conditions when risk management is exercised, despite the caveats. The role of frontline workers is addressed further in Chapter 8, which discusses the implications of the findings in relation to frontline workers.

The question of how risk management is exercised in public service delivery is on the one hand theory-testing, and on the other hand explorative at its core. It is therefore crucial to collect data that allow for studying the operationalised risk management concept, an in-depth investigation of the risk management practices as exercised by different frontline managers, and testing of the hypothesis that risk management practices are exercised more when distribution of responsibility is collectivised than when it is individualised. A qualitative methodological approach is well suited to these requirement because it is possible to combine deductive and inductive elements, and interviews are particular instrumental for the purpose of testing existing theory and remaining open to new avenues that may prove relevant (Martin 2013).

For these reasons, the analyses presented in this monograph are based on 29 individual and focus group interviews with 62 frontline managers from the healthcare sector and social services. These interviews enabled the application and testing of the risk management framework, while also allowing for other important insights related to risk management in public service delivery to emerge. The 29 individual and focus group interviews had a deductive, theory-testing nature designed to explore the three theorised distinct dimensions of risk management: organising work routines, discussing professional issues, and facilitating follow-up activities. The other purpose of the data collection was to explore what else it at play for frontline managers who handle risky situations, and their reflections on this front. This is a more inductive approach to the overall question addressed by the interviews, namely how risk management is exercised by frontline managers in public service delivery. In

this way, an in-depth understanding of the risk management concept, its mechanisms, and the interplay between the dimensions can be achieved.

4.1.1 Selection of Units

The qualitative study is designed as a comparative, cross-case study that systematically assesses and compares how risk management is exercised in the healthcare sector and social services. A case study is defined as the 'intensive study of a single unit for the purpose of understanding a larger class of (similar) units' (Gerring 2004: 342; 2006). Gerring (2004) provides a tool for distinguishing analytical levels in a case study and the relationship between them. In this terminology, the healthcare sector and social services make up the cases, because they constitute areas of public service where risks are prevalent and risk management is likely to occur. Table 4.1 provides an overview of the analytical levels in relation to the two cases that are studied.

Table 4.1 Analytical levels in case study (cf. Gerring 2004; 2006)

	Case 1: The healthcare sector	**Case 2: The social services**
Population	Healthcare sector.	Social services.
Sample (what is studied)	Two hospitals.	12 municipal state agencies.
Unit of analysis	Frontline managers in 9 hospital wards.	Frontline managers in 12 municipal state agencies.
Observations	8 interviews with clinical directors. 9 focus group interviews with head and ward nurses.	12 focus group interviews with frontline managers.
Variables	Relevant dimensions of risk management and related phenomena of interest (see coding strategy in Section 4.2.2).	Relevant dimensions of risk management and related phenomena of interest (see coding strategy in Section 4.2.2).

The nature of the research question – how risk management is exercised – is somewhat explorative. Given that there is no hierarchy of risky situations, as argued in Chapter 2, units that deal with different kinds of risks to service recipients are of interest. To accommodate these conditions in exploratory research, Seawright and Gerring (2008) suggest diversity as a selection criterion for units, as it achieves variance on dimensions in the cases that may turn out to be of interest. Diversity can be achieved on many dimensions that may matter to risk management practices, for instance unit size, core tasks, or geographical location. The overall guiding principle for the selection of units followed the diversity criterion. This enabled the investigation of how risk management is exercised in organisational units that differ in relation to what their core tasks are. The next sections accounts for how the diversity criterion for

selection of units was implemented and satisfied for each case in the data collection.

4.1.1.1 Case 1: Healthcare Sector

In the healthcare sector, the diversity criterion was satisfied by selecting hospital wards that perform different tasks. One could argue that risk management practices are a subjective matter dependent on the person exercising them, or that they are sensitive to organisational culture or stakeholders in the organisation's environment, as discussed previously. To account for these potential confounding factors, nine different units from two different hospitals participated in the study. This enabled the exploration and understanding of concrete risk management practices in different kinds of routine and risky situations across units to identify general patterns.

The managerial team in hospital wards is typically made up of a clinical director and a head nurse. Individual interviews were conducted with the clinical director at each ward. Leadership tasks are often distributed among nurses in hospital wards in the sense that the head nurse delegates formal responsibility to the ward nurses (Günzel-Jensen, Jain, and Kjeldsen 2018). To account for this in the study of risk management practices, both the ward nurses and their head nurse were interviewed in focus groups. This allowed for the deliberate nature of the leadership practices to unfold in relation to risk management. Table 4.2 provides an overview of the wards and interviewees in the study. In total, eight individual and nine focus group interviews were conducted with 31 frontline managers.

Table 4.2 Hospital ward units and interviewees

Unit	Hospital A interviewees (n)	Unit	Hospital B interviewees (n)
1	Clinical director (1) Head nurse (1) Ward nurse (1)	6	Clinical director (2) Head nurse (1) Ward nurse (2)
2	Clinical director (1) Head nurse (1) Ward nurse (1)	7	Clinical director (1) Head nurse (1) Ward nurse (2)
3	Clinical director (1) Head nurse (1) Ward nurse (2)	8	Clinical director (1) Head nurse (1) Ward nurse (2)
4	Clinical director (1) Head nurse (1) Ward nurse (1)	9	Clinical director (1) Head nurse (1) Ward nurse (1)
5	Head nurse (1) Ward nurse (1)		

Note. The clinical director at Ward 5 did not wish to take part in the project. At Hospital B, it was only possible to recruit four wards.

4.1.1.2 Case 2: Social Services

In the social services, the diversity criterion was satisfied by selecting units that vary in relation to task and size. In Denmark, municipal state agencies typically organise their work in the social services based on legislation from the Act on Social Services. Generally, it can be divided into two broad categories: 1) social psychiatry, marginalised adults, and adults with physical disabilities, and 2) families, children, and adolescents. These groups represent areas with different tasks and levels of uncertainty and therefore different levels of discretion are required. In cases involving families and children, there is often a high degree of uncertainty in risky situations, whereas assessment in cases of entitlements to disabled adults are more programmable and require less discretion. Therefore, the units of analysis reflect different risky situations and different levels of discretion. Additionally, municipal size guided the selection of units to obtain a mixed sample of small, medium, and large municipal state agencies. As in the healthcare sector, this selection of diverse cases from municipal state agencies of different sizes enables controlling for other factors that may matter to risk management practices, like municipal size or organisational culture.

In the social services, decision-making has a collective nature, where managers, team leaders, and social workers engage in discussions about service recipients through deliberative routines (Møller 2021). This implies that risk management practices are not tied to one manager, but to a group of managers who facilitate the case processing. For this reason, managers and team leaders were interviewed in focus groups, reflecting the collaborative nature of decision-making in the social services. The number of managers and team leaders in the focus groups depended on the size and internal organisation of the municipal state agencies. Table 4.3 provides an overview of the units and interviewees in the study. In total, 31 frontline managers and team leaders from 12 different municipalities were interviewed in 12 focus group interviews.

Appendix A provides a complete overview of the units from both the healthcare and social services sectors, the interview participants, and how they are referenced in this monograph.

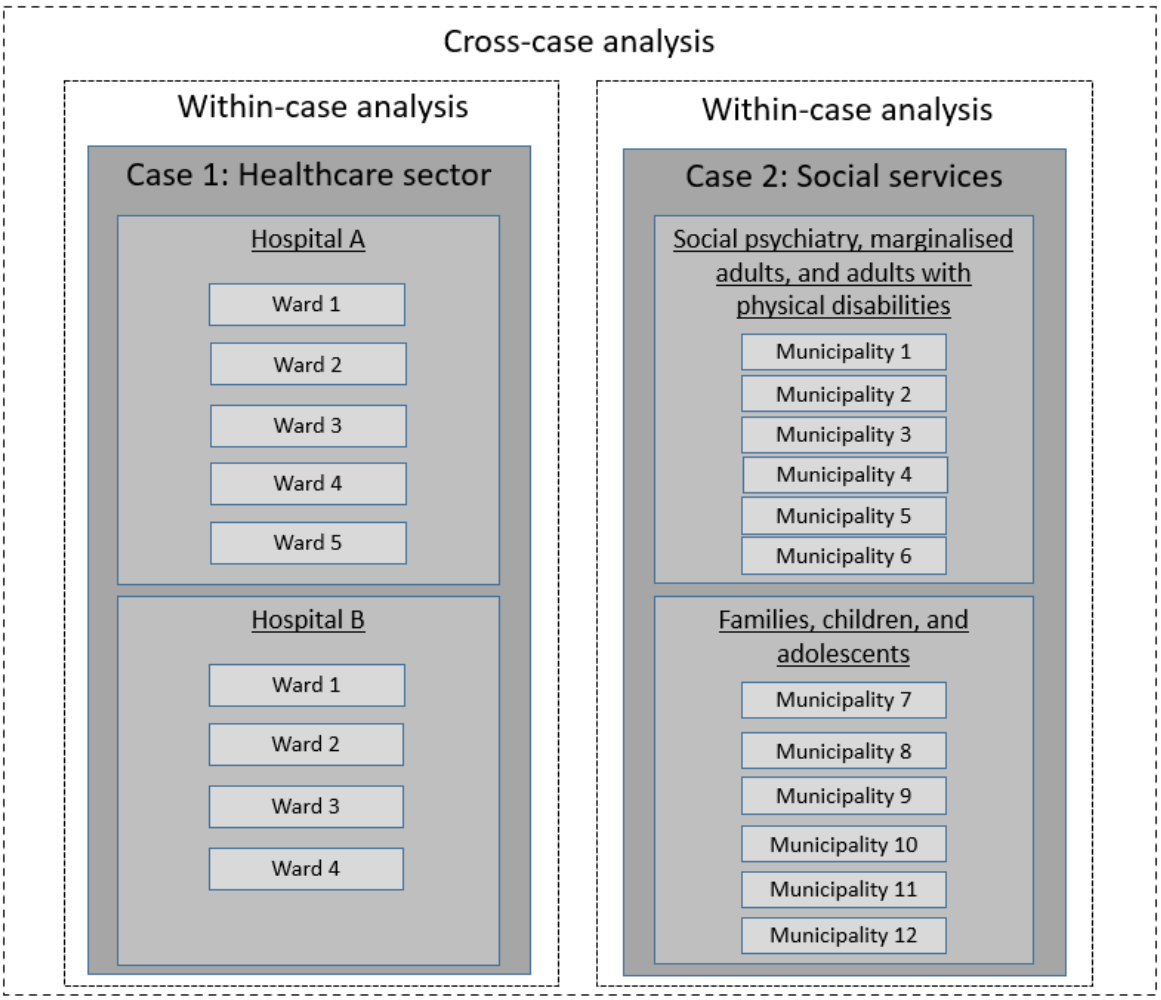
Table 4.3 Municipalities and units of analysis

Type	Unit number (size)	Interviewees (n)
Social psychiatry, marginalised adults, and adults with physical disabilities	1 (large)	Frontline managers (3)
	2 (medium)	Frontline managers (2)
	3 (small)	Frontline managers (3)
	4 (small)	Frontline managers (1)
	5 (large)	Frontline managers (2)
	6 (medium)	Frontline managers (2)
Families, children, and adolescents	7 (medium)	Frontline managers (2)
	8 (large)	Frontline managers (5)
	9 (small)	Frontline managers (3)
	10 (medium)	Frontline managers (4)
	11 (small)	Frontline managers (3)
	12 (large)	Frontline manager (1)

Note. The average size of a Danish municipality was 59,415 as of 1 January 2020. Large municipality >80,000, medium 40,000-79,999, small <40,000.

The overall research design is a most similar systems designs where the two cases – the healthcare and social services sectors – are similar in their contextual conditions but differ in terms of how responsibility is distributed. This embedded, multiple-case design is illustrated in Figure 4.1 (Yin 2014: 50). Within each case, the selection of units followed a diverse logic, where the units included perform different tasks and thus represent different kinds of risky situations, which resembles a most different systems design. In this sense, this study is designed as a cross-case most similar systems design and within-case most different systems design.

Figure 4.1 Illustration of cross-case MSSD and within-case MDSD



4.2 Qualitative Data Collection and Data Processing

To achieve the twofold goal of the data collection – to examine the theoretical conceptualisation of risk management and test the hypothesis that risk management practices are exercised more when distribution of responsibility is collectivised than when it is individualised – 29 individual and focus group interviews were conducted with frontline managers from the healthcare sector and social services. The next sections account for the methodological considerations and decisions behind the interview process and coding of the collected data.

4.2.1 Interviews

To accommodate the dual purpose of deductive theory testing and inductive exploration, the interviews followed a semi-structured interview guide. This

allowed for flexibility in terms of having a fixed set of essential questions that must be asked, while also having the opportunity to diverge and follow interesting leads in the conversation. The questions in the interview guide reflected the overall theoretical notion of risk management as something that happens prior to, during, and following risky situations. Given the purpose of exploring risk management practices, the questions were quite open in order to allow the frontline managers' own perceptions of their management practices to come through. For instance, the interviewees were asked to describe the most recent risky situation they could think of having encountered, which served as a frame of reference and made the conversations less abstract. In order to ensure a uniform point of departure for discussing risk management practices, the interviews had an integrated vignette element (Møller 2016; Jenkins et al. 2010). The frontline managers were presented with a vignette describing a hypothetical, yet realistic, risky situation, which was faced by either an experienced or inexperienced frontline worker.[4] The short vignette (five lines) served as point of departure for a conversation around how the frontline managers would approach that kind of risky situation prior to, during, and after its occurrence. Further, the interviews addressed contextual considerations, like the role of political principals and external stakeholders, that may matter to how risk management is conducted, as discussed in Chapter 2.

In this way, the interview guide facilitated conversations around how frontline managers approach situations where there are risks to service recipients. Table 4.4 shows an excerpt of the interview guide to illustrate how discretion in decision-making and risky situations was addressed in the interviews. The bolded questions were asked as closed questions, while the non-bolded ones were probe questions. The complete interview guides for the healthcare sector and social services are in Appendix B.

[4] The variation in whether the frontline worker is described as experienced or inexperienced is an embedded, randomized experiment in the interviews that is not a part of the analyses presented in this monograph.

Table 4.4 Interview guide excerpt

Theme	Question
Discretion in decision-making	I am very interested in decisions that from a medical/nursing perspective can be approached differently, dependent on the situation. 1. **What type of decisions could that be at this ward?** 2. When are the doctors/nurses uncertain about how to approach work decisions? 3. Do the doctors/nurses ask for something specific in those situations?
Risky situations	In healthcare there are situations where there is not an obvious right or wrong answer. The knowledge you have is conditioned on the sex, age, lifestyle and medical history of the patient. That creates an uncertainty in decision-making, which at the same time potentially lead to negative consequences to the patient. 4. **In what situations is there uncertainty in your work at the ward?** 5. Try to think back on the last time you had a situation where there was uncertainty, and it could lead to unwanted consequences to the patient. How did you approach it? 6. Did you feel that you ran a risk in the situation?

Note. The interview guide was pilot tested on two healthcare frontline managers in October 2019 and three social service frontline managers in February 2020.

The 29 individual and focus group interviews with 62 frontline managers were conducted from March 2020 through December 2020. Data was thus collected during the COVID-19 pandemic. 22 interviews were conducted physically face-to-face, and seven interviews had to be conducted virtually via Skype, Zoom, Teams, or phone, given the restrictions on physically gatherings imposed by COVID-19. All interviews were audio recorded and subsequently verbatim transcribed by student assistants who were issued a detailed transcription guide (Appendix C). The approximately 750 pages of transcribed interview data were coded using NVivo software.

The interviews in both the healthcare and social services sectors were intentionally conducted without COVID-19 as an explicit focus. Although the pandemic received a lot of attention at the time, it was possible to maintain a focus in the interviews on time-invariant risky situations that are unrelated to COVID-19. Particularly in the healthcare sector, this was somewhat surprising. However, this was likely because Danish hospitals were not severely affected by the pandemic, as evidenced by reports from the Danish Health Authority showing normal activity in most areas and slightly reduced activity in other areas (Sundhedsstyrelsen 2020).

4.2.2 Coding Strategy

A primary consideration of the coding strategy was to reflect the deductive and inductive interview elements. To capture both of these, the data was coded in two key cycles, following the recommendation of Miles, Huberman, and Saldaña (2017). The first coding cycle was deductive, where the developed theoretical framework of risk management as a leadership behaviour was applied. The second coding cycle was inductive, where other relevant themes related to risk management as a leadership behaviour could emerge. In a third and final step, all the data was coded again, applying the codes from the first two coding cycles simultaneously.

The specific codes reflect principles of unidimensionality, mutual exclusiveness, exhaustiveness, and saturation (Schreier 2012). Further, there are clear inclusion and exclusion criteria for the codes. For instance, codes related to how frontline managers behave during risky situations only contain data where the frontline managers specifically reflected on how they handle situations where there is a high degree of uncertainty and potential negative consequences to service recipients (i.e., risky situations). For more routine leadership practices, like assembling and structuring groups of frontline workers, the inclusion criteria were broader, because understanding routine behaviour is key to learning how risky situations are different, what they call for, and how frontline managers handle them.

4.2.2.1 First-Cycle Provisional Coding

A way of getting a sense of the data prior to the first-cycle coding is to conduct a preparatory, holistic coding. This strategy, where large chunks of data are assigned a single code, is applicable when one has an overall idea about what is being investigated in the data (Miles, Huberman, and Saldaña 2017). In this case, the holistic code 'risk management' was applied. It is a broad code that included all statements related to how the frontline managers deal with routine and risky situations. Examples of excluded statements are frontline managers describing what tasks their units undertake or describing their experiences navigating in politically controlled public organisations. In this way, the holistic coding zoomed in on the passages from the interviews that were relevant to conducting the first-cycle deductive coding.

The first-cycle coding was strictly deductive and followed the theorised structure of the risk management concept, which has been empirically validated in the risk management scale featured in Article B of this dissertation (Tangsgaard [In press]). The data was coded using sub-codes that reflect the leadership behaviour related to each dimension of risk management. In this way, the 12 sub-codes are the same as the 12 items in the risk management

scale. This is a provisional coding strategy, where there is a start list of researcher-generated codes, based on preliminary (in this case theoretical and empirical) work (Miles, Huberman, and Saldaña 2017). It was a fruitful strategy for first-cycle deductive coding, as it enabled rigorous and transparent analysis of the interview data. The codes and associated definitions are displayed in Table 4.5.

Table 4.5 Start list of codes, first-cycle deductive coding

Code	Sub-code	Definition: Statements that illustrate that the frontline manager ...
Organising work routines	Competence	Assembles groups of frontline workers to reflect different competencies.
	Experience	Makes sure that frontline workers with different levels of experience work together.
	Coordination	Coordinates what tasks the frontline workers undertake.
	Prioritising fixed structures	Ensures familiar and consistent routines around the undertaking of work in routine and risky situations.
Discussing professional issues	Professional assessment	Asks the frontline workers what their professional assessment is.
	Encourage motivation	Encourages the frontline workers to substantiate their professional assessments.
	Alternative options	Asks the frontline workers whether they have considered a different solution.
	Pros and cons	Discusses the pros and cons of the different solutions with the frontline worker.
Facilitating follow-up activities	Feedback	Provides frontline workers with feedback on how they handled the risky situation.
	Utilising examples	Utilises examples from risky situations as points of departure for discussing professional discretion with frontline workers.
	Knowledge sharing	Ensures that knowledge is shared among frontline workers.
	Revision of work procedures	Revises work procedures if a risky situation was handled inappropriately.

Provisional coding has a dynamic nature, in the sense that the codes can be revised throughout the coding cycle (Miles, Huberman, and Saldaña 2017). This is a key feature and strength when studying the empirical content of a theoretical concept. However, to remain loyal to the theory-testing nature of the interviews and the primary purpose of examining concrete leadership practices, the addition of codes was reserved for the second-cycle inductive coding.

4.2.2.2 Second-Cycle Inductive Coding

All the data was coded in the second coding cycle. Here, the approach was bottom-up inductive, as opposed to the first cycle's deductive top-down coding. The transcribed interviews were revisited, and descriptive and in-vivo codes were generated. The scope here was much broader, and all themes that emerged related to decision-making and the role of frontline managers in routine and risky situations were coded either as themes or in-vivo. The inductive coding process allowed dimensions of the interview data to unfold that would have lain dormant and undiscovered if the data had solely been coded deductively through the eyes of the quantitatively validated risk management scale from Article B. Because of this, interesting themes related to risk management practices emerged, which enabled a more nuanced analysis of risk management practices in public service delivery. For instance, many frontline managers talked about their decision-making principles and their experience of the conditions of risk management like the role of information, the organisational environment with external stakeholders and political principals, and financial considerations.

During the process of inductive coding, it became apparent that it was meaningful to sort the different codes into overall categories that reflect what part of the risk management process they constitute or belong to. This is not solely with regard to the temporal idea of risk management prior to, during, and following risky situations, but also related to principles and conditions for decision-making in public service delivery where risks to service recipients are inevitable. These categories are useful tools in the analytical phase, as they support the analyses of how different themes in the data are related. Table 4.6 provides an example of some of the inductively generated codes and their associated categories. Appendix D provides the complete list of inductively generated codes.

Table 4.6 Inductively generated codes, examples

Code	Definition: Statements related to…	Category
Decision-making programmes	concrete guidelines that instruct how to behave in given situations, such as clinical guidelines or demands of specific assessment types in cases of suspected child neglect (e.g. §50)	Before risky situation
Joint decision-making	decision-making in risky situations that is collectivised	During risky situation
Prioritising of tasks	the frontline manager's assisting frontline workers in prioritising work tasks in risky situations	During risky situation
Support decision-making of employees	the frontline manager's attempts to support the decision-making of employees in risky situations	During risky situation
Disregarding guidelines	the frontline manager discussing with the employees whether their professional judgement should overrule the formal guidelines in a risky situation	During risky situation
Enforce/stress guidelines	the frontline manager enforcing or stressing the guidelines as a consequence of a risky situation.	After risky situation
Quality standards/service levels	the politically decided quality standards (healthcare sector) / service levels (social services).	Condition
Legislation	actions initiated by the legislation the organisation is governed by	Condition
Urgency	behaviour of the frontline manager that is conditioned by how urgent the situation is	Condition
Financial considerations	the frontline manager's financial considerations and whether and how they play a part in decision-making	Condition
Risk factors	elements in the organisation that can promote risks, such as busyness, employee turnover, competencies	Condition
Risk perception	the frontline manager's understanding of the risks their organisational unit faces	Condition
Perception of managerial role	the frontline manager's understanding of their role in risky situations	Condition
Decision-making principles	the frontline manager's decision-making principles, such as going with the least intrusive option, involving patients, establish safety for the child.	Principle
Documentation practice	documenting professional considerations, assessments, decisions, and potential deviations from the legislation and/or guidelines	Principle
Willingness to take risks	the frontline manager's willingness to accept uncertainty and potential negative consequences	Principle
Leading upwards	the frontline manager leading upwards in the organisation	Organisational environment
Leading outwards	the frontline manager leading outwards in the organisation	Organisational environment

4.2.2.3 Third-Cycle Coding

In the final coding cycle, all data was coded again, applying the deductively and inductively generated codes simultaneously. No new codes emerged in this process. However, patterns and analytical ideas began to emerge, and these analytical reflections were jotted down in analytical memos (Saldaña 2013). These included, for instance, preliminary insights on similarities or differences between cases, or units that stood out as deviant. Further, many of the insights related to factors that condition risk management, which are discussed in Chapter 7, and the implications of findings discussed in Chapter 8 originate from these analytical reflections. This final round of coding had two clear merits. First, it served as a validation and quality control of the first two coding cycles. The fact that no new codes emerged in this process speaks to the thoroughness of the first two coding cycles. Second, it kicked off the analytical process and identification of patterns and insights. The final coding frame is in Appendix D.

4.3 Analytical Strategy

The purpose of the empirical analysis is to provide an answer to the question of how risk management is exercised in public service delivery, and whether this is dependent on how responsibility is distributed. The study is designed as a cross-case MSSD and a within-case MDSD, and the 29 individual and focus group interviews with 62 frontline managers make up a data structure that enables both within- and cross-case analyses.

To work with large amounts of qualitative data holds the fundamental challenge of presenting insights in a transparent way that allows the reader to assess the validity and reliability of the findings. To achieve this goal of transparency, two main analytical rules are applied in the analyses and presentation of findings: inclusion and authenticity (Dahler-Larsen 2020; Miles, Huberman, and Saldaña 2017). The rule of inclusion implies that all data relevant to the given analytical theme must be presented and accounted for. This is achieved by applying two principles. First, clear purposes and criteria underlining the selection of quotes are presented. This could for instance be quotes that are representative of frontline managers' concrete leadership behaviours, quotes that illustrate disagreement between frontline managers, or quotes that reveal frontline managers speaking with two tongues. Second, rival explanations to the overall insights in the shape of negative and deviant cases are presented and discussed. This way of contrasting and comparing findings is a means to show the heterogenous nature of the empirical reality, and to be open about the complexity of arriving at conclusions. The rule of authenticity implies that data is presented in as complete a form as possible.

This is achieved by incorporating quotes in the text and displaying interview excerpts that have not been reduced to representative cues. The purpose of this is to leave space for the reader to assess the foundation of the analyses and conclusions by enabling the possibility of studying the quotes and seeing how they are activated in the analyses, which seek to identify patterns across the heterogenous interview data. In this way, the rule of authenticity is a safeguard against drawing arbitrary or imprecise conclusions, as, figuratively speaking, all the cards are on the table.

Analytical transparency is thus achieved by the rules of inclusion and authenticity, which allow for the comparison and contrasting of findings, and the examination of rival explanations. In this way, the rules are paramount to presenting transparent, accurate, and nuanced insights on how risk management is exercised in public service delivery, and they are applied to both the cross-case and within-case analyses. The findings are presented in displays to enable overview and comparison, as well as in thicker descriptions with longer quotes in the text.

To address the explorative element of how risk management is conducted, Chapter 5 qualitatively unfolds what risk management as a leadership behaviour entails at the front lines of public service delivery. More specifically, Chapter 5 is designed as a cross-case analysis with the aim of exploring concrete leadership practices that are common and not case-specific. The explorative element of the research question is related to the hypothesis that risk management practices are exercised more when distribution of responsibility is collectivised than when it is individualised. This hypothesis is investigated in Chapter 6 in a within-case comparative analysis of how risk management is exercised in the healthcare and social services sectors. The chapters that follow broaden the scope of the analysis to account for what conditioning factors there are to risk management public service delivery (Chapter 7), as well as a discussion of the trade-offs inherent in risk management and the implications of the findings (Chapter 8). The individual chapters account for the specific analytical strategy in greater detail. Next, the healthcare and social services sectors are presented in greater detail.

4.4 Case Description: Healthcare in Denmark

The Danish healthcare system is universal and based on principles of free and equal access for all citizens, financed by general taxes. The purpose of the Danish healthcare system is to 'advance the health of the population and to prevent and treat disease, suffering, and functional limitations to the individual' (Health Act, §1).

The healthcare system operates at three political and administrative levels: National, regional, and local. At the national level, politicians in parliament make the legislation and prioritise resources and government agencies hold the overall regulatory and supervisory functions. At the regional level, five regions with democratically elected councils are responsible for the somatic and psychiatric care, hospitals, and general practitioners. At the local level, municipalities with democratically elected councils are responsible for providing primary care like rehabilitation and preventive measures. At the regional and local levels, priorities are made politically in terms of determining the service levels – for instance, how much physiotherapy is provided for rehabilitation purposes, or how long families can stay at the hospital maternity ward after giving birth.

4.4.1 Legislation and Regulatory Government Agencies in the Healthcare Sector

Different legislation and regulatory government agencies govern the healthcare sector. The Health Act specifies the overall requirements of the healthcare sector in terms of ensuring that, for instance, individual service recipients have easy and equal access to healthcare, receive high quality and coherent services, and have the freedom to choose healthcare provider. Further, it defines criteria for the maximum time it must take to diagnose and start up treatment of patients. The Danish Health Authority is the supreme health authority that provide guidance and counselling on health issues to state, regional, and local health authorities and health providers. Some of its primary tasks are to organise the healthcare sector to provide coherent care, promote overall health by targeting prevention areas like national cancer screening programmes and childhood vaccination programmes, and developing national clinical guidelines and action plans to be followed by practitioners and employees in the healthcare sector.

Further, two regulatory government agencies are important in the healthcare sector: The Danish Agency for Patient Complaints and the Danish Patient Safety Authority. The role of the Agency for Patient Complaints is to assess complaints over 1) the healthcare a patient has received, 2) claims over violation of patient rights, and 3) complaints over decisions made by the Patient Compensation (*Patienterstatningen*). Based on the assessment of the complaints and available documents, the agency either decides in favour of the patient's claim and issue a criticism of the relevant actors, or they decide against the complaint. In this way, the agency is an important player in ensuring accountability to service recipients in the healthcare sector.

The Patient Safety Authority is the supreme supervisory authority in the healthcare sector, and they work towards promoting a patient-safe healthcare sector with a strong learning-culture among the health professionals. They achieve this by providing counselling advice and by inspecting the practices of authorised health professionals and organisations in the healthcare sector. The inspection is in place to ensure that the patient safety is not compromised, and the authority can issue enforcement notices concerning matters that put patients at risk – for instance how medicine is handled. These notices can be given to the organisational units and to the individual, authorised health professional. This role of the agency is closely related to the distribution of responsibility.

4.4.2 Distribution of Responsibility

The Authorisation Act grants authority to conduct specific tasks to health professionals that hold specific health qualifications (Authorisation Act 2019). The purpose of granting authority to health professionals with specific competencies is to ensure the safety of patients and promote quality in the healthcare sector. Doctors, nurses, dentists, midwives, and physiotherapists are examples of authorised professional.[5] The authorisation gives the health professionals rights, duties, and responsibilities that apply to their conduct of work (Ministry of Health 2017):

- Rights: The authorisation grants a protected right to actors with specific health qualifications to function as health professionals such as doctors and nurses.
- Duties: Authorised health professionals are obliged to show care and conscientiousness, and they have a duty of disclosure and medical report-keeping obligations.
- Responsibilities: Authorised health professionals have a certain responsibility because they hold great amounts of discretion and autonomy in decision-making that can ultimately be a matter of life and death to patients.

The Danish Patient Safety Authority grants authorisations and keep registers of authorised professionals and oversee that health professionals live up to the rights, duties, and responsibilities they have been given with the authorisation. The Patient Safety Authority can impose different sanctions on health

[5] Authorised health professionals also include dentist, physiotherapists, optometrists, chiropractors. For a complete list of authorised health professionals, see: https://sum.dk/Sundhedsprofessionelle/Sundhedspersonale/Autorisation%20af%20sundhedspersoner.aspx

professionals that demonstrate misconduct. The sanctions make up a hierarchy of different reactions that reflect the severity of the misconduct, ranging from increased surveillance of the professional practice, to enforcing behaviour-regulating changes, to reduction of the professional practice, to ultimately stripping health professionals of their authorisations and potentially banning them from ever re-obtaining it.

The individual responsibility of each authorised health professional does not exempt the organisations from responsibility. In 2018, the Health Act was altered to emphasise the organisational and managerial obligation to ensure a suitable setting for health professionals to undertake their work. In this way, health professionals are still individually responsible for the decisions they make, but if they face work conditions that disqualify them from handling their work tasks professionally sound and in accordance with the Authorisation Act, they are no longer formally individually responsible.

4.5 Case description: Social Services in Denmark

The Danish social services are targeted marginalised and vulnerable families, children, youth and adults, and people with physical and mental disabilities. The Consolidation Act on Social Services (*Serviceloven*) governs the social services. The Act is based on principles of preventing service recipients from needing help and support by promoting their opportunity and developing their ability to care for themselves. Service recipients that need help and support are offered this based on an individual assessment of their needs and qualifications. Finally, 'decisions following the legislation are based on professional and financial considerations' (Consolidation Act on Social Services, §1).

The social services operate at two political and administrative levels: National and local. At the national level, the state holds the overall responsibility for the social services, and the regulatory and supervisory functions related to the legislation and implementation of it. At the local level, municipal state agencies with democratically elected councils are responsible for assessing cases and providing service recipients with the help and support the legislation entitles them to. At the local level, priorities are made politically to determine the service levels – for instance, how many days of respite care disabled persons are entitled to a year, or how often social workers should follow up on implemented interventions in children's lives.

4.5.1 Legislation and Regulatory Government Agencies in the Social Services

Marginalised and vulnerable service recipients that receive help and support based on the Act on Social Services often face multiple challenges. For instance, a disabled adult may also have a reduced ability to work, and parents that neglect their children sometimes have a psychiatric diagnose. The social services, and decisions made based on the Act on Social Services, therefore cut surface with several other legislative areas like the Public Administration Act, Act on Legal Service and Administration in Social Matters, different employment and healthcare acts, which increases the decision-making complexity significantly.

Two regulatory government agencies are of important in the social services: The National Social Appeals Board (*Ankestyrelsen*) and the National Board of Social Services (*Socialstyrelsen*). The role of the National Board of Social Services is to contribute to knowledge-based social services. This is achieved by developing and obtaining knowledge of effective methods and practices in social services and by promoting this knowledge to the municipal state agencies and decision-makers at the frontlines. The Board works in close connection to the municipalities that both participate in the development of new knowledge and receive comprehensive specialist counselling and advice in complex casework.

The role of the National Social Appeals Board is to assess service recipient's complaints over decisions made in the social services, review the decision-making process, and decide whether the decision should be affirmed, altered, reversed, or re-assessed. The Board is the supreme administrative complaints board and thus play a key role in ensuring that administrative principles of legality, proportionality, impartiality, and sufficient examination of cases are followed to arrive at decisions that are in accordance with the legislation. Further, the Board engages in developing and improving the decision-making in the social services through training of caseworkers, counselling services, and so-called 'principal announcements' (*principmeddelelser*). The latter refers to Board's special responsibility in establishing guidelines on how to interpret and apply the complex legislation that regulate the social services. These guidelines have their point of departure in concrete cases and are an important tool for the municipal state agencies. In this way, the National Social Appeals Board have a dual role as both controlling and counselling. On the one hand, the Board ensures that service recipients have due process in their cases and change decisions if necessary and is thus a key player in ensuring accountability. In parallel, the Board works closely with the municipal

state agencies to improve their discretionary decision-making and learn from previous errors in casework or misinterpretations of legislation.

4.5.2 Distribution of Responsibility

The Act on Social Services explicitly places responsibility for decision-making with the local municipal councils. In practice, the politicians delegate this responsibility to managers in the administrative hierarchy and the politicians are only involved in decisions where children are forcibly removed without consent from their parents. This formal distribution of responsibility must be considered in connection with the fact the social workers who conduct the casework and make many decisions are not authorised professionals – unlike the healthcare professionals. Together this means that the social workers are not individually responsible for their decision-making, but that the responsibility for decision made in the social services lies with the municipal state agency as a collective unit. The collectivised distribution of responsibility is reflected in the deliberative nature of decision-making routines in the social services, where the complexity of the cases often requires that social workers discuss them in different formal and informal fora before reaching a decision (Møller 2021).

The collectivised distribution of responsibility does not exempt the individual social worker for responsibility. They are responsible for their actions and if they, for instance, display strong negligence in their casework and do not involve the service recipient in the process, they are likely to face direct and indirect sanctions imposed by their frontline managers, such as enforced documentation requirements, closer inspection of their work processes, or, ultimately, warnings of being dismissed. In this way, the collectivised responsibility implies that the social workers cannot be held individually responsible for decisions made concerning service recipients, but they are responsible for their own professional conduct.

4.6 Conclusion

This chapter has accounted for the research design, methodological framework, data collection, and analytical strategy behind the insights presented in this monograph. The qualitative study into how risk management is exercised in public service delivery resembles a cross-case most similar systems design and a within-case most different systems design in the sense that the healthcare sector is compared to the social services sector (most similar), but the selection of unit cases is diverse within the two sectors (most different). In

total, 29 individual and focus group interviews were conducted with 62 frontline managers from the healthcare and social services sectors. The data from the interviews was coded in a three-step process of deductive and inductive coding that enabled a thorough processing of data and subsequent cross-case and within-case analyses. To enable the individual reader to assess the validity and reliability of the insights, transparency is a key principle behind the presentation of findings and analyses. This is achieved by applying the rules of inclusion and authenticity, which provide clear criteria for the presentation of quotes and discussion of deviant or contrasting findings.

The two case descriptions account for the formal governance of the healthcare sector and the social services. The two sectors have several common denominators, despite the fact they solve fundamentally different tasks. Both are sectors where there are visible risks to service recipients, high stakes for the service recipients, and the frontline workers rely on considerable amounts of discretion and have decision-making autonomy. A primary difference between the two sectors is the distribution of responsibility: Healthcare professionals are authorised professionals and therefore, formally speaking, individually responsible for their decisions, whereas in the social services, the municipality as a collective unit is responsible for the decisions made. It is important to keep in mind that while this distinction, formally speaking, is somewhat black and white, this is not the case in practice. As emphasised, hospitals and other healthcare providers do hold a responsibility in ensuring a suitable work setting for the health professionals, and social workers are responsible for their own professional conduct even though responsibility for decision-making is collectivised.

These design and methodological choices and considerations enable the thorough investigation of risk management practices in different contexts in the healthcare sector and social services. Importantly, this supports the generation of insights that are applicable to other public organisations that deliver public services with similar contextual conditions of facing risks to service recipients, and frontline workers who hold considerable autonomy and exercise discretion.

Chapter 5. Risk Management as a Leadership Behaviour

The purpose of this chapter is to qualitatively unpack what the risk management concept as a leadership behaviour entails at the frontlines of public service delivery. The chapter sheds light on the second part of the overall research question of this dissertation, namely how risk management is exercised by frontline managers. Recall that risk management is defined as the leadership behaviour targeted towards enabling frontline workers to mitigate negative consequences to service recipients in risky situations. Specifically, risk management is theorised to hold three dimensions: organising work routines, discussing professional issues, and facilitating follow-up activities prior to, during, and after risky situations. This risk management construct has been empirically validated in this dissertation's Article B 'Risk management in public service delivery: Multidimensional scale development and validation' (Tangsgaard [In press]). This chapter is an important step following the theoretical conceptualisation and empirical validation of the risk management construct, as it also explores the interplay between the three risk management dimensions. In this way, there are two distinct empirical and theoretical contributions from this chapter. First, it supplies an in-depth, qualitative sense of what the different dimensions of risk management hold in terms of specific leadership practices. Second, it builds an understanding of the interplay and synergies between the three risk management dimensions.

The chapter presents insights from the 29 individual and focus group interviews with 62 public service frontline managers from the healthcare and social services sectors. The insights build on the closed coding of the data, where leadership activities within each dimension were identified in the first coding cycle, as described in Chapter 4. For instance, statements on how frontline managers consider the role of employee competency in relation to situations with uncertainty and potential negative consequences were coded as 'competency'. The findings are organised to show which concrete leadership practices and activities are associated with each element of risk management within each dimension. Throughout the analysis, the nuances and different emphases expressed by frontline managers are presented to underscore and illustrate how risk management takes different shapes.

The structure of this chapter reflects the specific content of the validated risk management scale (Article B). The four leadership activities included in

each dimension of the risk management scale are thus the same four leadership activities outlined in each section. As mentioned, the idea is to achieve an in-depth, qualitative sense of what specific leadership practices the different dimensions of risk management hold. The risk management construct constitutes a second-order latent variable structure, as described in Chapter 2 and in the scale development article (Tangsgaard [In press]). For this reason, there are overlaps between the leadership behaviours within each dimension. This is expected, and stresses the point that the different behaviours constitute the same shared, latent dimension. The analyses outlining the three dimensions are followed by a discussion of the interplay and synergies between the three risk management dimensions and, specifically, how this is related to frontline managers' risk perceptions and willingness to accept risks. An important insight is that frontline managers have different risk management profiles and prioritise the elements of risk management differently. This is discussed based on the second-cycle explorative coding, which provided insights on, *inter alia,* frontline managers' risk perception and willingness to take risks.

5.1 Organising Work Routines

This section unpacks the first risk management dimension of organising work routines. The analyses are based on the following four closed codes, which reflect the structure of the risk management scale construct: 1) competence, 2) experience, 3) coordination, and 4) prioritising fixed structures.

The risk management dimension of organising work routines covers leadership activities prior to risky situations. Specifically, it entails activities aimed at making the organisational unit fit to meet its challenges and prepare its frontline workers to handle the risky situations they inevitably face in public service delivery. One frontline manager, for instance, underlined the responsibility to ensure that their frontline workers operate in 'a work setting that enables them to complete their tasks completely safely and to the highest standard' (H-8-CD). Essentially, the purpose of organising work routines is to be as well prepared as possible to handle the risky situations that inevitably occur, and to prevent normal, routine situations from turning into risky situations. This is pursued through designing decision-making structures. Concretely, this dimension involves leadership activities related to composing employee groupings in terms of competencies and experience (Section 5.1.1), as well as coordinating the tasks that frontline workers undertake and prioritising fixed structures in the daily undertaking of those tasks (Section 5.1.2). Theoretically, these practices are related to how Yukl (2013) conceives of leadership as a process of influencing others to understand what needs to be done

and how to do it, and also the process of facilitating structures that enable the achievement of organisational goals, which was discussed in Chapter 2.

Together, the leadership activities make up the foundation of how routine tasks are handled in public service delivery, which subsequently matters to how frontline workers react to risky situations when routine behaviour no longer suffices. Organising work routines is thus a way of anticipating and preventing risky situations by making sure that the undertaking of routine work tasks is well organised to create the best possible platform for decision-making.

5.1.1 Composition of Employees: Competencies and Experience

Composition of frontline workers is one of the leadership activities highlighted most by the interviewed frontline managers. One explained that 'it is not only based on experience, but also competency and personality [...] Some make use of their full potential, while others may use a potential that is not quite there. So it is always a good idea to combine them, so they balance each other' (H-2-N2). The composition of employees is one way of achieving this balance. The element of employee composition essentially rests on two considerations, as illustrated by the quotation: competency and experience.

The employee competencies consideration refers to the continuous managerial effort of putting together and retaining a group of frontline workers that reflects the different competencies that are required to handle the challenges the organisational unit faces in its public service delivery. This is for instance the case in the administration of the legislation for vulnerable and disabled adults. Given the complexity of the legislation and the high financial costs associated with granting supportive measures, one frontline manager emphasised that it is key to have social workers who have in-depth, specialised knowledge of the legislation in order to navigate and make the best possible decisions in risky situations (SS-6-FM2).

The second consideration of employee composition is employee experience. This is comprised of the continuous managerial effort of putting together and retaining a group of frontline workers that reflects different levels of experience with the core tasks undertaken by the organisation. This is the case in the healthcare sector, for instance, where experienced health professionals usually play a key role in ensuring clinical quality; not only do they have clinical routine, they also supervise new and inexperienced colleagues.

The purpose of composing the group of frontline workers to reflect different levels of competencies and experience is to increase the quality of the de-

cision-making process. This is achieved by putting together a group of employees that complement each other's skills. Different competencies reduce the element of uncertainty when facing risky situations, as described by a ward nurse who emphasised that nurses work together based on their competencies as a way of 'trying to anticipate many cases of doubt' (H-6-N2).

Likewise, experienced frontline workers have seen many different situations and thus have a routine for and confidence in decision-making, which also reduces uncertainty. However, as one manager puts it, 'it is not always good to be struck by experience', as you may turn a blind eye to risky situations (SFC-7-FM2). This is where inexperienced frontline workers can contribute greatly, as they enter organisations with fresh ideas, state-of-the-art knowledge, and perhaps new ways of approaching the challenges the organisation unit encounters. A mix of competencies and experience thus reduces the element of uncertainty in risky situations and sheds light on potential negative consequences, by enabling experienced and inexperienced frontline workers with different skills to work together and supplement each other's assessments and decision-making in both routine and risky situations. Or, as a ward nurse explained: 'As soon as you have the right mix of competencies in place, you have greater opportunity to take action in acute situations' (H-4-N2). Table 5.1 displays some of the different ways in which frontline managers consider the composition of frontline workers to improve decision-making, anticipate doubt, and reduce uncertainty in risky situations.

Table 5.1 shows that there are various considerations at play in terms of employee competency. The question of what competencies are needed is approached differently. A clinical director stressed that it is a key requirement that the doctors in the ward have a mind and competencies for professional and organisational development, as this is a way of ensuring that the ward meets its professional standards. On a related, but slightly different, note, a head nurse from a different ward pays attention to the taxonomies of the nurses in the sense that their competencies taken together reflect the necessary competency levels. Both insights reflect a consideration by frontline managers as to how long-term professional consistency is sustained, but they have different ways of getting there: a focus on recruiting doctors with a clear preference for professional and organisational development is one way of ensuring clinical quality, while having nurses at different professional taxonomies learn and feed off each other is another way.

Table 5.1 Composition of Employees

Composition of Employee Competencies	Composition of Employee Experience
'Regarding taxonomies, we actually keep track of our nurses, and how we like the distribution of nurses to reflect the different levels of competence we work with.' (H-4-N1)	'There is no doubt that if I am going into the weekend with a very experienced nurse together with a less experienced nurse, then I immediately think that the weekend is better covered than a weekend with three young nurses scheduled. So [employee] organisation has a really important role.' (H-4-N2)
'We only employ chief physicians if they are leaders. That is, we do not employ clinical directors to just be in the clinic. We want ones that are developers, because we are a new area of specialisation. If you are not minded to take responsibility for developing this ward, well, then you cannot be a chief physician.' (H-1-CD)	'We have a lot of talented, young, inexperienced social workers who manage to stay curious – professionally curious – exactly because they do not have their experience to rely on. So that curiosity... it does something good for the work. Because that is where you develop and learn. That is where you call a psychiatrist and ask, "I need to know what you think about this?" You [are willing to] call any professional just to broaden your knowledge a bit more.' (SFC-10-FM2)
'So the question is whether you should specialise further, because the consequences of specialising too much can also be that you lose competencies [...] It is also important to have a wide range of skills.' (SS-6-FM2)	'When we get new, recently qualified employees, we strategically place them together with an experienced employee – if nothing else, then physically. And they get a mentor. [...] With the new ones, I am alert in the beginning, because I have to get an instant impression of where we are. Because some are off to a flying start, while others need extra support.' (SFC-8-FM4)
'Managerially, we have assessed tasks and resources. When we go into the resource part itself, we look at the competencies [...] and we also work with partners, where during a shift you follow each other in pairs of two: an experienced and inexperienced, or a highly competent and a less competent.' (H-5-N1)	'I can organise it in a way where I make sure that, whenever possible, there is some sort of distribution of the experience we have at hand. [...] I have a planner who tries to assemble a team where we have different levels of experience together [...] and where you have some stations at the lower levels where they can make decisions based on less experience.' (H-1-CD)
'[You] cannot learn it. Either you can do it, or you cannot. [...] [We] have lots of young people who are really, really capable and who can cope with the situation, [...] and then we also have some who just cannot, [...] where you have to admit it just does not work because you cannot learn these things. It's such a deep part of one's personality whether or not one can cope with it. Of course, you can get some tools to develop it, but I think we have experienced that there are some who can cope with it and then there are some who just cannot.' (SFC-9-FM2)	'We have a great educational obligation, so when we plan, it is often a young doctor together with a very experienced nurse so you also get the mix with interdisciplinarity: "Well, here you just have to remember that...". In contrast, you cannot [put] inexperienced with inexperienced; it does not work as well, you know?' (H-7-N2)

Note. Based on the closed codes 'Competence' and 'Experience'.

Table 5.1 further reveals a consideration of the question of specialised versus general competencies among frontline workers. Although this chapter is focused on the general insights on how risk management is conducted, there are some interesting differences between the two sectors here. In healthcare, specialisation is desirable, as it is associated with better treatment of patients and, ultimately, better attainment of organisational goals. In the social services, there appears to be a trade-off between specialised social workers and ones with more generic competencies, as described by the frontline manager expressing concern that too much specialised knowledge will lead to an inability to handle a wider palette of cases. This challenge is particularly pronounced in smaller municipalities, because there are fewer social workers who must therefore cover a broad spectrum of cases and understand the associated legislation.

One last consideration regarding employee competency is the emotional aspect of dealing with difficult cases. For instance, in the social services, social workers deal with cases of physical and sexual molestation of children, substance abuse problems, and mentally and physically disabled service recipients, and the social workers hold a lot of autonomy and discretionary power in terms of what will happen. The point made by some of the managers is that the hardship of the risky situations and decisions faced by frontline workers cannot be captured by any 'right' level of competency. Some frontline workers are simply not cut out for the extreme complexity and difficulty of the risky situations they face, and that is a more abstract employee competency to have an eye for.

The right-hand column in Table 5.1 displays that frontline managers hold short-term and long-term considerations in relation to employee experience. Short-term, the consideration is first and foremost about creating a work environment that is safe to both frontline workers and service recipients. This is achieved by having a mix of frontline workers with different levels of experience working together, so the inexperienced always have a senior, more experienced colleague to ask. However, it is also a question of making sure that decisions are made at the right level of experience to ensure efficient decision-making, as emphasised by a clinical director (H-1-CD). For instance, it would create a bottleneck situation if the most senior doctor was consulted every time someone in the hospital ward made a routine assessment. This insight on a mix of experience is further substantiated by a frontline manager emphasising that 'there are the more organisational factors like creating an overview, prioritising, and coordinating. […] Here, it becomes evident that you cannot just have inexperienced [staff] at work, because you need someone with the clout to say "OK, my plan was this, but now Mr. Hansen is really unwell, so I have to help Sophie, who cannot do it herself, because she is unsure"' (H-4-

N1). In this way, the consideration of handling risky situations while they are occurring matters to how the group of frontline workers is composed in terms of experience.

Second, there is a short-term consideration of enabling the frontline manager to assess the skills of inexperienced frontline workers. This purpose is achieved by making sure that experienced and inexperienced employees work together, so the frontline manager in this way can assess whether the inexperienced need more decision-making support or development of specific competencies. This second short-term consideration of frontline worker development feeds into the long-term consideration regarding employee experience. Long-term, frontline managers are aware of an obligation to teach and pass on knowledge to the inexperienced 'next generation', as they will eventually be the ones taking the reins. Composing the group of frontline workers to reflect different levels of experience is a way of future-proofing the organisation.

Lastly, Table 5.1 holds an important nuance regarding the consideration of employee experience. While many frontline managers appear to consider experience to be the golden ticket to safe decision-making in risky situations, some also acknowledge that experience is not everything. This is the case, for instance, with the frontline manager who emphasised that inexperienced employees are usually very curious *because* they are inexperienced. This makes them seek out new avenues and ask for second opinions, which is another way of ensuring the quality of decision-making in risky situations (SFC-10-FM2).

Overall, Table 5.1 reflects that frontline managers have many considerations guiding the composition of frontline workers. The common denominator is that a mix of competencies and experience holds both short-term and long-term advantages in terms of ensuring the best possible decision-making, and through this, better anticipating the risky situations that occur.

5.1.2 Coordinating Employees and Prioritising Fixed Structures

The task of employee composition is supplemented by the leadership practices of organising the actual undertaking of work tasks and prioritising fixed structures around these. This could, for instance, be in the shape of 'daily, integrated meetings where [we] collect the threads and get an overview of 'What are our priorities today?'" as explained by a ward nurse (H-5-N2). Coordinating frontline workers is a practice associated with the manager's efforts to ensure that there is a match between the tasks at hand and the competency level and experience of the frontline worker undertaking them. These efforts are

based on the composition of employees, which was illustrated by a clinical director who noted that you 'have to allocate the right doctors to the right tasks' (H-1-CD).

Parallel to coordinating frontline workers is the prioritisation of fixed structures surrounding their work tasks. This leadership practice is associated with efforts aimed at ensuring familiar and consistent routines around the work, and to maintain these even when work pressure is high. This could take the shape of formalised weekly meetings where social workers get to discuss the cases they have, for example, or daily morning conferences where doctors get an overview of the day ahead and an opportunity to discuss patients who pose potential challenges.

The underlying reason behind coordinating employees and prioritising fixed structures is to ensure better decision-making by promoting routine behaviour. This way, frontline workers know how things are done and what to do when risky situations or unexpected events occur. This is achieved in two ways: 1) routine behaviour and decision-making are supported and enforced when employee competencies and experience have been coordinated to match the situation at hand, and 2) frontline workers are better prepared for risky situations when there is a mix of colleagues with different levels of competency and experience. In this way, the fixed structures are closely tied to the composition of frontline workers' competencies and experience, and they are an underlying support mechanism for decision-making – in both routine and risky situations. A frontline manager explains that 'as managers, we are responsible for not making mistakes or causing inexpediencies for the patients' (H-7-N1). Table 5.2 displays the different ways frontline managers achieve this coordination and the reasoning behind it, what the fixed structures look like, and how they are enforced.

Table 5.2 displays the different ways frontline managers coordinate frontline workers. Essentially, it involves directing work procedures related to who does what, when, and why. These coordination efforts are associated with three overall principles. The first is related to employee competency and is a principle of having the right mix of competencies at hand in the organisation of daily routines. Frontline managers follow this principle by pursuing a certain mix of specialisation among frontline workers, reflected in notions about competency plans and complex legislation handled by specialised units of frontline workers. The second principle is one of frontline workers having the ability to handle both routine and risky situations. This is for instance explained by the clinical director who emphasises that doctors must be accustomed to routine surgeries in order to be prepared for acute surgeries, where the risk is potentially greater.

Table 5.2 Coordinating Employees and Prioritising Fixed Structures

Coordinating Employees	Prioritising Fixed Structures
'There is a competence plan in relation to what the social workers themselves can put in motion, and what the frontline leaders can put in motion, and what has to go through our visitation committee.' (SFC-9-FM1)	'Well, there is a visitation meeting once a week, where the social workers have to have recommended the case for decision no later than Friday morning the week before. And then there actually is a description of the workflows in relation to the visitation meeting. What documents are required for the case: you know, relevant case material, overall professional assessment or full-fledged investigation, action plan. And then they must fill out a visitation form. It is fairly well described.' (SS-1-FM1)
'Our point of departure is that you have to see planned patients and their course of treatment in order to have the competencies to also treat them in urgent cases. For example, a surgeon who operates on hips, broken hips, and thighbones must have experience from planned hip surgeries to be any good at the urgent surgeries. [...] The way we do things at the ward is that the youngest doctors ALWAYS have access to a specialist doctor. There is never a young doctor sitting alone in the clinic. There are always older doctors to seek advice from. [...] The very young doctors are accountable for broad patient groups where the decision-making is at a relatively low level.' (H-9-CD)	'In general, you can say that our team meetings are where we have the granting authority in some individual areas. When you present a case and argue for funding based on these rules and clauses, then you must submit the case in written form. That is your report and your professional assessment, and then you must also be able to present the case.' (SS-6-FM2)
'What [we] do in practice is assign tasks to the care group relative to the level at which they can lift the tasks, right? You know, you would never delegate a very complex task to a newly qualified nurse, because we do not want to make mistakes.' (H-7-N1)	'I very much believe in what is called continuity in ward rounds. It means that people typically get several days in a row. It also means that you get to know your patients. As a patient, I think that matters. And it also means that when you show up on day two, then you know the patient's medical history. It is nice to see whether the things we talked about yesterday, well, are they working? Did it go well? Did it go wrong? The tests you ordered yesterday, you actually ordered them because you knew that if you did not, you would have to do it tomorrow. You might as well just get it done.' (H-7-CD)
'Because the legislation is so complex and specialised, I try to make some small specialised units so we are comfortable in what we are working with.' (SS-3-FM3)	'This applied to our surgeries too, where we have our junior doctors on shift during our acute surgeries. They have always been conferred at the morning conference or they can always ask. And there will always be extra hands you can call on and have physical help available to you directly in the operating theatre.' (H-9-CD)
'Some of the legislation we deal with is administratively quite challenging, so there are two employees who only deal with that.' (SS-5-FM2)	'We have our morning conferences, and we have our afternoon conferences, which are like defusing moments, where you can come if you have experienced something. You can come and talk about it there.' (H-2-CD)
'I know it's a buzzword, but I like team thinking. There is something to it because you just make sure no one is riding solo. [...] We have different teams. We have a disability team, we have a psychiatry team, we have a [legislative] Section 100 team.' (SS-6-FM1)	

Note. Based on the closed codes 'Coordination' and 'Prioritising fixed structures'.

This is achieved by making sure that all doctors train and maintain their routine surgery skills – even though this may pose practical challenges. The third principle is one of ensuring that no frontline workers are left to make decisions on their own in risky situations. This is achieved by organising frontline workers in teams, and in this way facilitating reliable access to second – and senior – opinions when routine situations turn risky.

These three principles are frontline managers' way of fostering clear decision-making procedures in their respective organisations. As a ward nurse explained: 'When we organise work tasks in teams to minimise the risk, it is important to us that we have a mix of the different competence profiles available at the ward. In this way, we protect the patients by ensuring that there is always a second opinion and risk minimisation present in each shift. […] It matters greatly because it gives a sense of psychological safety when making decisions. These things can be designed and organised' (H-5-N2). In addition to the point regarding risk minimisation, the point on psychological safety is interesting. It links back to the point raised earlier that, given the hardship of decision-making in public service delivery, it is paramount to have a work environment where frontline workers feel safe when they face complex decisions. This is addressed in Chapter 8, 'Implications of Risk Management in Public Service Delivery.

The frontline managers emphasised two overall ways in which the prioritisation of fixed structures supports frontline workers' decision-making processes. First, clearly defined work procedures are emphasised as key by frontline managers. As illustrated in Table 5.2, this is related to frontline managers' perception that they are very specific about what they expect and require of their frontline workers in routine situations – for instance, when frontline managers make sure that social workers account for specific factors when they assess cases, or that surgeons always have a back-up on call during routine surgeries, or when continuity in ward rounds is imposed because the frontline manager believes it ensures the best quality for the patient. Frontline managers believe that continuity and set ways of 'doing things' lead to predictability in routine situations and enable frontline workers to focus on the task at hand. Further, clearly defined work procedures and continuity enable frontline workers to detect when situations seem out of the ordinary and may pose a risk to the service recipient.

Second, team meetings and conferences on a standing, regular basis are uniformly emphasised by frontline managers as another way of supporting the decision-making process. They describe how these regular meetings give frontline workers the opportunity to get an overview of the tasks at hand, and, just as important, to discuss cases or patients that are out of the ordinary or in

any way causing professional doubt in terms of what to do. In this way, professional deliberation is put into a system and becomes a routine behaviour where frontline workers know when it takes place and what is expected of them. This is illustrated in the social services, for instance, where a frontline manager stresses that you must be able to present your case and argue for your professional assessment at the team meetings where cases are discussed (SS-6). These fixed structures and work procedures support routine behaviour and professional deliberation. Although we do not know whether this is actually the case and the experience of the frontline workers, frontline managers emphasise that these leadership behaviours make frontline workers better equipped to handle risky situations, which was summarised by a ward nurse: 'We basically have some routines in our working day that kind of have to reduce the risks, including when things get busy' (H-5-N2).

Overall, Table 5.2 reflects the different principles that guide frontline managers' coordination of frontline workers to ensure that decisions are made at the right competency level. Further, it shows that prioritising fixed structures is a question of ensuring both clearly defined work procedures and regular occasions for frontline workers to get an overview of the tasks at hand and potential risky situations.

5.1.3 How Organising Work Routines Enables Frontline Workers to Mitigate Risks

The aim of this chapter is to achieve an in-depth understanding of what specific leadership practices risk management in public service delivery entails, and to explore the interplay between the three dimensions. Related to the former, the qualitative analysis shows that frontline managers use different tools to support the decision-making behaviour of frontline workers prior to risky situations. An overriding principle is to facilitate and feed routines for how work tasks are undertaken. This is achieved by leadership activities that ensure a composition of employees that reflects both different competencies and different levels of experience, as well as coordinating who takes on which work tasks, and prioritising fixed structures around the work tasks.

These managerial efforts at organising work routines in public service delivery indirectly enable frontline workers to mitigate negative consequences of risky situations. First, a diverse group of frontline workers with different strengths and abilities in terms of professional competency and different levels of experience constitutes a workplace where frontline workers can supplement and rely on each other in routine and risky situations. Further, this mix in composition reduces uncertainty when routine situations turn risky. As one

ward nurse said: 'Even though it is an inexperienced nurse facing the situation, she knows that she has a more experienced colleague she can call on [...]. In that way, it makes a difference, including in urgent situations, even though we cannot plan for them' (H-4-N2). Organising the composition of employees to reflect different levels of competency and experience is thus a way of attempting to design optimal decision-making structures in public service delivery and to be better prepared if and when (routine) situations turn risky.

Second, coordination of frontline workers and prioritisation of fixed structures surrounding the work supports desired work routines. The systematisation of work routines, including regular meetings for professional deliberation and clear, predictable decision-making structures, is a way of anticipating risky situations: it enables frontline workers to focus on the work at hand without putting too much thought into the organisational aspects of how the work is organised. Further, coordinating what work tasks frontline workers undertake with reference to their competency profile enables them to navigate in both routine and risky situations, and ensures that decisions are made at the right competency level.

The organisation of work routines holds interesting prospects related to supporting frontline workers' decision-making processes. Insofar as frontline managers are successful with the different elements of organising work routines and enable frontline workers to utilise their different strengths and weakness, it reduces the uncertainty about potential outcomes in risky situations. Organising work routines is thus a way of supporting a decision-making culture with clear principles and routine professional deliberation, which promotes risk-reducing behaviour among frontline professionals (Tangsgaard 2021). Related to the second purpose of understanding the interplay between the risk management dimensions, these leadership activities tap into the second dimension of risk management – discussing professional issues – as the organising of work routines sets the scene for how risky situations are dealt with when they occur.

5.2 Discussing Professional Issues

This section describes the second risk management dimension of discussing professional issues. The analyses are based on the following four closed codes, which reflect the structure of the risk management scale construct: 1) professional assessment, 2) encourage motivation, 3) alternative options, and 4) pros and cons.

The risk management dimension of discussing professional issues covers leadership activities during risky situations. Specifically, it entails closely related activities where the leader – together with the frontline worker – sheds

light on the risky situation they face by unfolding the different prospects of it: what is the frontline worker's assessment, what alternatives are there, and what are the associated pros and cons of the potential consequences to the service recipient? As described by a frontline manager: 'We spend a lot of time arriving at the right decision by discussing it. That is, what does our experience tell us, what theory can we lean on, what speaks for going in this direction, what speaks for going in the other direction?' (SFC-9-FM2). Theoretically, this is linked to the insights from decision-making theory that were discussed in Chapter 2, 'Conceptualising Risk Management in Public Service Delivery'. From prospect theory, we know that actors do not behave in a rational way under risk and uncertainty, but instead rely on their prior experience and different heuristics (Kahneman and Tversky 1979; Tversky and Kahneman 1974). This is a challenge that frontline managers address by discussing professional issues in risky situations and challenging frontline workers' assessments.

Risky situations are a product of uncertainty and potential negative consequences. The leadership activities associated with discussing frontline workers' professional assessments of risky situations, and the motivation behind them, is a way of reducing the element of uncertainty during risky situations and making sure that the situations are thoroughly assessed (Section 5.2.1). The leadership activities associated with discussing alternative options with the frontline workers, and the pros and cons of these, is a way of getting an overview of the (potentially negative) consequences of risky situations and in this way strengthening the basis of the decision at hand (Section 5.2.2).

Together, these leadership activities reduce the uncertainty of the risky situation and create an outline of the potential consequences, which, ideally, leads to an improved basis for decision-making. Discussing professional issues is thus a way for frontline managers to support frontline workers' decision-making processes during risky situations by actively ensuring that the different aspects of risky situations are investigated.

5.2.1 Professional Assessment and Encouraging Motivation

All frontline managers explained that most frontline workers seek decision-making support when they face risky situations that they are unsure how to approach. One way of supporting frontline workers' decision-making in risky situations is to reduce uncertainty. Frontline managers achieve this by becoming familiar with the professional assessment of the risky situation made by the frontline worker, and the arguments underlining it. The managers simply ask the frontline workers to unpack the risky situation, the prospects it holds, and what their assessment of the situation is: given the risky situation at hand and their specialised, professional knowledge, what do they believe is the best

approach? To this end, frontline managers sometimes play devil's advocate, asking frontline workers to articulate the motivation behind their professional assessment. A manager from a municipality explained that she asks 'these slightly annoying questions, where they have to argue for one or the other' to make sure that the social workers have covered all their bases when assessing and making decisions in risky situations (SFC-7-FM1).

There are multiple purposes of shedding light on frontline workers' assessments of risky situations. Most importantly, it promotes the aim of reducing the uncertainty element of risky situations, just as it enables both manager and frontline worker to grasp the potential consequences of the risky situation. Further, it spurs a process of reflection in the frontline worker when they are asked to account for and justify their (initial) professional assessment in risky situations. These activities not only support the frontline workers in the risky situation, but also improve their overall decision-making abilities. Table 5.3 displays how frontline managers become familiar with frontline workers' professional assessments in risky situations, and how they encourage that frontline workers substantiate these assessments.

Table 5.3 reflects an overall managerial approach of understanding risky situations and what is at stake to service recipients. This is achieved by asking questions intended to clarify the matter at hand, and through that reduce uncertainty. The interview excerpts reflect that frontline managers ask frontline workers in different ways to describe the risky situation, account for their considerations about different prospects, and generally make them articulate what is at play in the risky situation. In this sense, frontline managers tend to ask more questions than they answer in order to understand the frontline worker's assessment – although only in risky situations they judge to not be an urgent matter. They see their role in risky situations as one of supporting frontline workers' decision-making processes and strengthening their decision-making capabilities. The underlying idea is to make sure that frontline workers make most decisions independently within the scope of their decision-making capacity, and, further, that these leadership activities qualify frontline workers' decision-making and make them reflect on the risky situation, as described by many frontline managers (e.g, SFC-8, SFC-9, H-9-CD).

Table 5.3 Professional Assessment

Professional Assessment	Encourage Motivation of Professional Assessment
'I really want to make them proficient and make them reflect. So we usually book a time slot, and then we unpack the case together, and say like, "With what you know now, what do you think the next step should be?" So, it is very much a coaching approach.' (SFC-8-FM3)	'It is my job to try to clarify it in a professional way, so that it does not turn into these "I think, believe, argue, reckon", but that it is actually professionally founded, and that you are not locked on something. We do it in two steps, because then we get the case mapped and unfolded, and you can ask, "Well, what might happen if you put yourself in little Peter's shoes and looked at this, how would that look like?"' (SFC-11-FM2)
'Our most important task is to prepare them as best as possible to be able to make these decisions, because I try as much as possible to get them to make decisions themselves, so that we can discuss them [...] We take the time to discuss the case, open it up, and ask curious questions.' (SFC-9-FM2)	'I would probably be more hesitant in relation to an experienced employee and hear much more about what they themselves think and what they themselves have researched. So, be more hesitant to begin with. In the case of an inexperienced employee, I would ask more questions. For instance: "What have you done? What are your thoughts on it? Is there anything else you could think of in that regard? Are there any legislative avenues here? Are there any possibilities we have not explored?" In this way, I lead them on their way to having this reflection themselves.' (SS-4-FM1)
'We ask questions in order to shed as much light on the issue as possible. In the end, I believe this is what gives the social worker the most peace of mind.' (SS-1-FM1)	'I will draw my own decision-making processes into this and try to be a kind of coach for this experienced doctor. What have you thought about? What is the experience if we do nothing? What is the result for the patient if nothing is done? Do you believe that is sufficient for the patient? Alternatively, if you do something and, for instance, operate on the patient, what does the patient achieve if it goes well? What does the patient risk if it does not go well? What is your experience taking action on this?' (H-9-CD)
'Well, I would review the patient with him [...], and then I would want to know what treatments he has in mind and how he imagines the possible outcomes. And then, together with the doctor in question, I would talk to the patient to learn what the expectations essentially are.' (H-6-CD2)	'I will always try to exert a counter-pressure, because I am not going to be the one you just call and get to make decisions. I do not believe in that management style. I believe in involved leadership. I believe that is [...] more sustainable organisationally.' (H-1-CD)
'So it is really about getting them to talk, you know. [...] To listen to the considerations and where the doubt emanates from.' (H-9-N1)	'Well, I both have to be the one who supports some of them, I also have to be the one who challenges. [...] Because otherwise you will not learn and develop if you do not make some decisions and get to experience the consequences of your decisions. [...] You can be sheltered all your life if you never make a decision yourself.' (H-3-CD)
'I would simply ask the nurse to describe what was going to happen. You know, what procedures or treatment or whatever that was going to start, and ask to hear her reflections on what she could imagine doing about it.' (H-3-N2)	
'To me, as a leader, it is important that you also hear what the nurses themselves think. What are the possibilities? Let her come up with a proposal to create some reflection.' (H-5-N2)	

Note. Based on the closed codes 'Professional assessment' and 'Encourage motivation'.

This focus on improving the decision-making capabilities of frontline workers is specifically pronounced in the right-hand column, displaying how frontline managers encourage frontline workers to motivate their professional assessments. Two overall strategies for pursuing this emerge from the interview excerpts. First, frontline managers offer a counterpressure to the frontline worker's assessment. Frontline managers are somewhat apprehensive to directly provide their opinions and assessments to frontline workers – unless there is a high degree of urgency. Two clinical directors and a municipal frontline manager (SFC-11-FM2) describe how they do not just provide answers, but actively challenge the assessment of the frontline worker in question and thereby help them refine their argumentation and assessment. The purpose of this is to enable learning and improve frontline workers' decision-making capabilities. These are very idealistic goals, and here it is important to keep in mind that there can be a wide gap between what frontline managers believe they do and how the frontline workers facing the risky situation actually perceive these leadership practices (Vogel and Kroll 2019; Jacobsen and Andersen 2015; Fleenor et al. 2010).[6]

The second way in which frontline managers improve frontline workers' decision-making capabilities is to establish what the background is for the professional assessment. They do this through coaching-style questions designed to let the frontline worker arrive at the answers themselves. Several frontline managers reported that they engage in this tactic regardless of whether they are interacting with an experienced or inexperienced frontline worker. Nevertheless, most tended to emphasise that they follow the decision-making behaviour of the inexperienced frontline workers more closely than the experienced ones, as explained by one frontline manager (SS-4-FM1). This stands somewhat in contrast to the realisation, also mentioned in the previous section, that experience does not always mean a frontline worker has all the right answers in risky situations. A head nurse explained it the following way: 'The young ones are very controlled by the textbook and are perhaps not as qualified to make a clinical judgement. That comes with experience, right? […] But we also risk having some older employees who maybe act more on their intuition, and that is very dangerous too, right? Because then we encounter that you are so experienced, you do not have to acquaint oneself with all the new stuff. […] But what are our clinical assessments really based on? Is it your knowledge? Your intuition? Or the article we read yesterday?' (H-7-N1). This

[6] This question of a self-other agreement gap between leader-intended and employee-perceived risk management practices is addressed in the dissertation's Article B 'Measuring Risk Management as a Leadership Behavior in Public Service Delivery: Multi-Dimensional Scale Development and Validation'

underlines the point that experience is not an absolute advantage if it leads to decision-making based solely on prior experience and gut feeling.

The leadership activities of discussing frontline workers' professional assessments and the underlying arguments in risky situations serve a dual purpose: they support immediate decision-making by reducing uncertainty, and they also qualify future decision-making in similar situations. This reflects the short-term concern of assisting frontline workers who ask for second opinions in risky situations, and a long-term concern of qualifying frontline workers' decision-making processes, so they are better equipped for handling similar risky situations in the future. However, this is dependent on the urgency of the risky situation, as there may not always be time to engage in activities that foster the frontline worker's professional decision-making. This is the case in the immediate removal of children, for instance, where a frontline manager explains that 'these situations are different in that we do not have a solid investigation to lean on, which can provide certainty that we are doing the right thing for this and this reason. We do not have that when it is urgent. Here, we have a notification of concern and must act' (SFC-11-FM1). The question of the urgency of risky situations is addressed in greater detail in Chapter 6 'Risk Management and Distribution of Responsibility'.

Overall, Table 5.3 reflects how frontline managers strive to reduce the uncertainty element of risky situations by enabling frontline workers to account for what they know, but also by challenging their professional assessments. The other reason for discussing professional issues is to shed light on the potential consequences of the risky situation, which is achieved by discussing alternative options and pros and cons of the different prospects with frontline workers.

5.2.2 Alternative Options and Pros and Cons

Leadership activities associated with discussing professional issues also involve frontline managers discussing alternative options and the pros and cons of the different prospects of risky situations with frontline workers. Here, managers ask more specific questions related to what avenues the frontline worker has sought out. They may also propose different takes on the risky situation, and discuss what speaks for and against the different alternative routes that can be pursued and the potentially negative consequences they hold. One frontline manager describes how she approaches this aspect of risk management: 'First, I would establish what different paths are there? […] Next, I ask "What are the potential consequences?"' (SFC-11-FM2). In this way, the other element of risky situations, the potential negative consequences, is addressed by frontline managers.

By engaging in these discussions with frontline workers, managers ensure that the potential negative consequences of the risky situations are considered in the decision-making process, and that the most promising path is chosen. One manager explained that it is all about 'asking the social worker some questions that give rise to the fact that there are pros and cons to everything' (SS-1-FM2). The primary purpose of discussing alternative options and the pros and cons of different prospects is to shed light on the potential negative consequences of risky situations. This is realised by managers through questions where frontline workers are encouraged and pushed to consider whether there are other potential ways to handle the risky situation, and the positive and negative implications of these potential decisions. The ways in which managers achieve this, and their reflections behind these actions, are displayed in Table 5.4.

Table 5.4 displays the different ways in which frontline managers discuss alternative options with frontline workers. Together with the frontline workers, they list the different decisions and discuss what would happen if Decision A was made over Decision B. Further, many frontline managers have clear expectations that the frontline workers present them with more than one scenario for how to handle the risky situation. One frontline manager explains that this is to ensure that decision-making is 'not locked in a certain direction, but that the different perspectives are unpacked. We try to eye "Well, where are our gaps, and where are we certain?"' (SFC-11-FM2). In this way, frontline managers make sure that frontline workers do not simply act and make decisions based on their immediate, routine reactions and gut feelings, but that they consider the different prospects and their potential consequences. However, it is important to keep in mind that the frontline managers themselves are potentially subject to predispositions and biases that make it hard to achieve the goal of closing all gaps.

Table 5.4 Alternative Options and Pros and Cons

Alternative Options	Pros and Cons
'Make some counter-arguments like, "Well if we chose to do it this way, what would it be like; what would it look like in reality?"' (SFC-10-FM1)	'We do not have those rigid personalities, where 2 and 2 are 4. That is just not the case in our field, [and] that is why we can go many ways. I think we spend a lot of time discussing with each other to make sure we are doing the right thing. So, what do we know from experience, what do we know from theory, what speaks to going this way, what speaks to going the other way?' (SFC-9-FM2)
'We [ask] them to consider alternative proposals for the clear-cut intervention they think should be put in place in relation to the service recipient. So, for instance, if it is a social housing offer, well what is the alternative to this social housing offer that the service recipients wants, or that the social worker deems appropriate? So, is there an alternative, and what is the price of what they are suggesting and of the alternative?' (SS-1-FM1)	'You have to start by saying, "Well, what is the goal? What do the service recipients want, what is the objective here?" And then you have to analyse: How do you reach it if you do it one way, and how do you reach it if you do it the other way? Maybe you cannot reach it at all. Then you should not do it.' (SS-2-FM2)
'Then I will probably say "Well, let us take an hour where we discuss the case", and where I ask the person to present the relevant scenarios, and go through the scenarios in terms of whether they are legally valid and also whether we are missing any information that we need to obtain to make the right decision.' (SS-6-FM2)	'So it must be a professional deliberation that makes them form some suggestions for what it could be, and then we could talk about what the disadvantages would be and what the advantages would be.' (SS-3-FM3).
'Ask the specific doctor who is calling what he has [already] thought about, what were the alternatives? And slowly but surely, we are able to list some alternatives, and based on that, I actually try to get the doctor to come up with what he thinks is the right thing to do.' (H-2-CD)	'It is to listen to this doctor and their considerations. What are the pros and cons in this? What is good about one treatment? What is the risk? What is good about the other? And what is the risk?' (H-8-CD)
'You can try different options when the person presents different options. But it is never forbidden to say "Listen, you can do this too" if the person has not thought about that possibility. Then you can guide them into it.' (H-6-CD2)	'It is more like teamwork, where you have to ask, "What do you think about this? What is your position on this? And what is my position?" And then we discuss back and forth [...] What speaks for and what speaks against, and then we see whether we can agree that I think we go this way, right?' (H-3-CD)
'It is really a lot about the professional deliberation, saying "On the one hand, on the other hand". And in the end say "Yes, we are making this decision together, based on what you have put forward", and saying "Well I stand right behind you and right next to you".' (H-3-N2)	'It is about getting the individual nurse to say, "Well, what pros and cons do you think there could be to this method or to this scenario, and what about this scenario?"' (H-5-N2)

Note. Based on the closed codes 'Alternative options' and 'Pros and cons'.

Discussing alternative options is closely related to the other leadership activity displayed in Table 5.4: discussing the pros and cons of the different decision scenarios. Here, the frontline managers, based on the different decision scenarios, discuss the pros and cons of each potential decision with the frontline worker. This activity serves the purpose of exposing and illuminating the potential (negative) consequences of different decisions, as illustrated by several of the interview excerpts. Some frontline managers highlight how it is key to be aware of the service recipients when assessing the pros and cons of different decision scenarios. For instance, a municipal manager explains that if a drug addict is not motivated to receive help, 'then you stand with the tough decision of saying that "We actually do not have to offer any treatment, because the service recipient essentially does not want it, and is not capable of…" And now, there is nothing we can do to help the person out of his substance abuse' (SS-2-FM1). This dilemma essentially reflects a decision-making principle of taking the wishes of the service recipient into account in decision-making in risky situations, which is a recurring theme across the interviews with frontline managers.

A common denominator for the two leadership practices presented in Table 5.4 is that these discussions serve the purpose of ensuring a balanced risk assessment and solid decision-making basis by making frontline workers think along different avenues. This is fostered by discussing alternative decision-making scenarios and their associated pros and cons. There are two main outcomes that frontline managers believe they achieve with these leadership practices. First, by discussing different prospects and their pros and cons, frontline managers believe it is possible to arrive at better decisions, because different scenarios are considered. Second, by outlining different decision-making scenarios frontline managers believe it is possible to assess the costs of a decision against the expected benefits. While the latter is not emphasised uniformly by all managers in the study, considerations of the return on investment in public service delivery are kay to all public service delivery organisations that have limited resources and infinite demand (Lipsky 2010). This is further related to how frontline managers perceive and tolerate risk, which is addressed later in this chapter.

Overall, Table 5.4 reflects the different ways in which frontline managers try to enable workers to shed light on the potentially negative consequences to service recipients in risky situations by having them account for and discuss alternative options and their associated pros and cons.

5.2.3 How Discussing Professional Issues Enables Frontline Workers to Mitigate Risks

Related to the first purpose of obtaining an in-depth qualitative sense of different risk management practices, this section shows that frontline managers have different ways of supporting frontline workers' decision-making processes during risky situations. A fundamental objective is to enable better decision-making by not providing answers and directives when they discuss professional issues with frontline workers in risky situations. This is achieved by asking them to account for their professional assessments and the underlying arguments, and by discussing alternative decisions and their associated pros and cons.

These managerial activities related to discussing professional issues enable frontline workers to mitigate risks to service recipients in two ways. First, discussing the frontline worker's professional assessment and the arguments behind it reduces the uncertainty of the risky situation by shedding light on all relevant aspects of the situation. A frontline manager describes the perceived utility of this in the following way: 'We ask questions to clarify as much as possible, [...] which in the end makes the social worker comfortable with the decision' (SS-1-FM2). These insights were described in the first part of the analysis of discussing professional issues. Second, discussing alternative options and their associated pros and cons maps the potential negative consequences of the risky situation and thus leads to a better basis for decision-making. This process is explained by a frontline manager from a municipality: 'There can be positive consequences, but also negative consequences, associated with choosing one path over the other. But I think we also find ourselves to be clearer on why we make the decisions we do, the more we have clarified the process. Because it is a choice what path we decide to follow' (SFC-11-FM2). These insights were described in the second part of the analysis of discussing professional issues.

The common denominator behind the different leadership activities that make up the dimension of discussing professional issues is that they shed light on the decision at hand and help ensure that decisions are made on enlightened grounds, where there has been actual discussion and reflection on the risky situation and how it can best be handled. This improves the basis for decision-making, which ideally mitigate negative consequences for service recipients.

Discussing professional issues holds interesting prospects related to frontline workers' decision-making in risky situations. In the short run, it arguably reduces the professional doubt frontline workers may face by spurring reflection and making them consider the different prospects of risky situations. In

the long run, it may lead to improved decision-making capabilities among frontline workers when their managers insist that they substantiate their professional assessments in risky situations and consider alternative decision scenarios and their pros and cons. A manager calls it 'sustainable leadership that you make people capable of making decisions and make them take ownership, instead of just telling them what to do' (SFC-8-FM3). Overall, this dimension of risk management is a way of fostering professional deliberation and reflection, and is thus a means of reducing uncertainty and shedding light on potential negative consequences in risky situations. While the outcomes of these leadership activities are not investigated here, they are related to the second purpose of understanding the interplay between risk management dimensions, as they are indirectly decisive to how frontline managers facilitate follow-up activities after risky situations.

5.3 Facilitating Follow-Up Activities

This section unpacks the third risk management dimension of facilitating follow-up activities. The analyses are based on the following four closed codes, which reflect the structure of the risk management scale construct: 1) feedback, 2) utilising examples, 3) knowledge sharing, and 4) revision of work procedures.

The risk management dimension of facilitating follow-up activities covers leadership activities after risky situations. Specifically, it is concerned with how frontline managers handle the outcomes of risky situations and utilise them to improve future decision-making in risky situations. This involves concrete feedback to frontline workers on how they handled a specific risky situation, and activities that utilise risky situations as a point of departure for making a professional assessment with frontline workers, enabling knowledge sharing, and, if necessary, implementing revised work procedures following risky situations. Feedback and utilisation of examples from risky situations represent a retrospective and immediate clarification of what happened in the risky situation and why. These are the focus in the first part of this analysis (Section 5.3.1). Knowledge sharing and revision of work procedures, meanwhile, are forward-looking activities that serve a long-term purpose in the sense that they are directly focused on learning from what has happened and improving future decision-making in risky situations. These are the focus in the second part of this analysis (Section 5.3.2).

The purpose of facilitating follow-up activities is to support frontline workers in learning from risky situations and thereby improve decision-making and the structures around it in future risky situations. Theoretically, this is related to the transactional leadership styles of management-by-exception, in

the sense that frontline managers are focused on correcting misconduct and deviances from professional standards, but there are also transformational elements of ensuring learning (Bass and Riggio 2005).

Facilitating follow-up activities does not directly reduce uncertainty and mitigate negative consequences, but it is a way of systematically putting structures in place in which frontline workers learn from the risky situations they face and thereby improve future decision-making. In this way, this risk management dimension feeds into the two other dimensions of organising work routines and discussing professional issues.

5.3.1 Feedback and Utilisation of Examples

Most frontline managers emphasise that it is important to talk to frontline workers about how they handled a given risky situation. The leadership activities associated with following up on risky situations are feedback and utilisation of examples from risky situations. When providing feedback, frontline managers typically talk through the risky situation with the involved frontline worker(s) to spur reflection on questions related to the risky situation. A frontline manager summarised these activities in the following way: 'We talk about "What was difficult in this patient case? What did we do well? What could we have done differently? And what must we remember next time?"' (H-8-N3). Feedback may also involve the frontline manager calling out decision-making behaviour that did not meet the expected professional standards.

Another way of facilitating follow-up activities based on concrete risky situations is to utilise them to spur reflections in a broader setting among frontline workers by asking similar questions: What happened in the risky situation? How was it handled? What went well? What could have been handled differently? In this way, risky situations become a point of departure for discussing professional practice in (future) risky situations. The purpose of both these leadership activities is to encourage frontline workers to pause and think through what happened in risky situations – those with both positive and negative consequences. Table 5.5 displays the ways frontline managers provide feedback and utilise examples following risky situations, and their thoughts behind these leadership activities.

Table 5.5 illustrates the different ways frontline managers facilitate follow-up activities after risky situations. Overall, three steps in the feedback process can be deduced. First, frontline managers assist frontline workers in obtaining clarity of the sequence of events. This is a somewhat descriptive process where the purpose is to know what was up and what was down in the risky situation. Next, feedback is provided on how the risky situation was handled by the frontline worker. A head nurse described it the following way: 'There are of

course a lot of situations where you subsequently have to give the nurse feedback. […] How did it go? How was it? Did you find the right solution? Is there something we have to rectify?' (H-5-N1). In a third step, a frontline manager may have a more general talk with the frontline worker that points forward to future decision-making in risky situations.

Frontline managers explain that in their feedback they consider the context of the risky situation and what they could have reasonably expected of the frontline worker(s) handling it. If they judge that the way the risky situation was handled reflects inadequate skills in the frontline worker, they address this by pointing it out and proposing ways forward. As one ward nurse puts it, 'as a leader you have to address this and say, "Do you know what, you did not know this, which you probably should have known. But you did not, and therefore you made this decision. We have to work on this, and work on how you get the necessary knowledge and skills to handle these issues"' (H-3-N2). This forward-looking approach and emphasis on constructive feedback is stressed by many frontline managers, as illustrated in Table 5.5. Behind this feedback principle is an acknowledgement of the complexity of the decisions frontline workers make in risky situations and the hardship they face, exemplified by the clinical director pointing out that children sometimes die in their hands. For these reasons, the frontline managers highlight the need to cultivate a work environment that is psychologically safe for their frontline workers, so they can receive and use feedback on how they handled risky situations without having to fear sanctions. This is discussed further in Chapter 8 'Implications of Risk Management in Public Service Delivery'.

Table 5.5 Feedback and Utilisation of Examples

Feedback	Utilisation of Examples
'We have a talk about "what you did and why you should have done something different another time maybe? But it was good that you did something, right?"' (SFC-8-FM4)	'I think it is important to share our successes and failures. And here the uncertainty comes into play. You can be very unsure and have discussed the matter at length, and then we actually succeeded. We decided to share it. But also when we did not succeed.' (SFC-8-FM3)
'We have had quite a few where the measures have been handled according to a different section of the legislation than they should have been and where we talked about, "Well, listen. In this type of case, with the needs and challenges there are, then it is actually this section of the legislation, and not the one you usually use."' (SS-2-FM2)	'During the case, and a decision has been made, and it has been approved and implemented, then there is feedback in the group: "How did it go?" That is where the learning lies.' (SS-5-FM2)
'Sometimes it happens that someone misjudges their own competencies – it cannot be avoided in our organisation – and then we have to perform surgery again. But we have a culture where no one ever gets scolded. Instead, one is corrected. But it is with a good educational tone. It is constructive criticism, not a scolding.' (H-9-CD)	'That someone comes and says, "I have just experienced a really interesting patient, I would like to share it with you, because I think I have learned something from it, or there is learning potential in it for all of us." We have that culture in the ward, it is really important. So you could say that this is like a preventive measure.' (H-8-CD)
'If I experience something of a certain character, where I think "I should probably just be a little observant", then I will subsequently contact the doctor or doctors in question and ask what exactly happened there, and are you okay? Because we are going to find ourselves in troubled waters at some point. We have children dying in our hands. We do. [...] So there is something about creating a psychological safety that allows it.' (H-2-CD)	'We have what is called team talk, which is a way of relaying, after someone has completed a process, "What works well, was there anything we could have done differently, what did we learn, what was the situation?" Like a brief feedback with professional discussion.' (H-4-CD)
'It is actually to facilitate that you can have these dialogues and to follow up a lot if things are not going well, and praise when things go well. Because I think this is part of our lives. Our goal is not that they [mistakes and adverse events] should not be there. But it is about being able to be so comfortable that you can face them, and I think it is fair to say that that is not the easiest thing to do.' (H-4-N1)	'One can reflect afterwards, but then they have a weekly meeting where they can share: "Here are the ones I was in doubt about this week". So you can put it on the agenda, so they follow up on it.' (H-6-N3)
	'If a patient dies, and we had actually seen some signals, but we were not aware that he was as ill as he was [...] Then we sit down, and then we simply go through the process from A to Z. What happened? Who said what? Who did what and when? Is there anything here we need to open our eyes to and learn from?' (H-5-N1)

Note. Based on the closed codes 'Feedback' and 'Utilising examples'.

The second way examples are utilised for follow-up activities is through formal assessments and systematic audits. Here, set procedures are applied to get to the core of the risky situations by turning every stone, going 'from a-z', and thus learning what happened. Subsequently, frontline managers facilitate discussion of the insights from the assessments and audits and what can be extracted from them to improve future decision-making: 'What should we do differently? What could we have done differently? It is an attempt to draw learning out of cases where it, most often, did not turn out as one could have hoped' (SFC-8-FM5). A key insight from many frontline managers is that they emphasise the need to systematically facilitate these opportunities for professional reflection among frontline workers to support the best future decision-making possible. This could be through 'team talks' (H-4-CD), for instance, or, as in one hospital ward, weekly 'Thursdays of Reflection', where the nurses take up risky situations that have been sources of uncertainty and discuss them from different perspectives. The head nurse describes the advantage of this systematic utilisation of risky situations in the following way: 'We address many issues in times of peace and create some reflection about them, so we know how to handle them moving forward' (H-5-N1). In this sense, utilising examples from risky situations is a preventive measure, as pointed out by a clinical director in Table 5.5, which also feeds into the organising of work routines.

Overall, Table 5.5 reflects the short-term leadership activities following risky situations. Frontline managers provide frontline workers with feedback on how they handled the risky situation, and they utilise risky situations with both positive and negative outcomes to service recipients to facilitate reflection among frontline workers.

5.3.2 Knowledge Sharing and Revision of Work Procedures

The leadership activities of ensuring knowledge sharing and implementing revisions of work procedures make up the more long-term approach to facilitating follow-up activities after risky situations. Knowledge sharing is the leadership activity that ensures actual dissemination of the knowledge and learning that are generated following risky situations. This is achieved in different ways, and includes meetings with teaching and discussions, and simpler means like digital newsletters, intranet updates, and notes on notice boards.

Some risky situations reveal a need to change existing work procedures or guidelines that organise the undertaking of work tasks to improve future decision-making. Frontline managers also engage in implementing any necessary changes and conveying these to the frontline workers: '[Risky] situations can be the incentive to change work procedures, so they are used for learning'

(H-9-N2). The purpose of knowledge sharing and revision of work procedures is to disseminate the learning and insights from risky situations to enable improved decision-making in future risky situations. Table 5.6 displays the concrete measures that frontline managers take to ensure knowledge sharing and how they work with revision of work procedures following risky situations.

Table 5.6 illustrates how frontline managers approach the long-term aspects of facilitating follow-up activities after risky situations. One element is to ensure knowledge sharing, while the other is to implement revised work procedures if necessary. The point of knowledge sharing is to ensure that the insights from the formal audits and informal discussions following risky situations are disseminated to the entire group of frontline workers. Frontline managers ensure this in different ways. Collectively targeted activities include staff meetings that may involve some teaching, or presentations of the new insights by either a frontline worker, the frontline manager, or an external consultant. Individually targeted activities include newsletters, updated guidelines on shared network drives, or e-mails summarising what learning took place at the staff meeting. In this way, knowledge sharing runs through two parallel tracks: a collective one where the frontline workers together receive and discuss the new knowledge, and an individual one where the frontline workers can access the information and familiarise themselves with new knowledge when it suits them and when they need it.

To ensure knowledge sharing is closely tied with the leadership activity of implementing revised work procedures and guidelines. Any revisions – both small and large – are based on audits and professional discussions of them. A head nurse described how they work with revision of work procedures and knowledge sharing as two sides of the same coin when following up on risky situations: 'When we have completed the technical assessment, we implement by calling the nurses together. This could for instance be teaching or a themed discussion about a specific issue in this patient case. Then we discuss the patient case, what has happened, what we have learned, and what the changes are moving forward. And then we make sure that they have got the message both written and orally' (H-5-N1). How the frontline managers prioritise the different means of knowledge sharing depends on how they perceive the risky situation and the severity of its consequences. This is essentially a question of risk perception, which is addressed later in this chapter in the discussion of implications of the risk management concept.

Table 5.6 Knowledge Sharing and Revision of Work Procedures

Knowledge Sharing	Revision of work procedures
'"Now someone has learned something new" or "Now we have this experience", and then you may give a small presentation to your colleagues. We also have a consultant who is often here to follow up on decisions [...]. Then she does a 15-30 minute presentation which we disseminate, so we have roughly the same knowledge about those things.' (SS-1-FM3)	'After all, there were some completely different conditions that had to be met, and then you have to bring it up and say, "Listen, moving forward, we have to do it this way and it is because of this and that". Common small mistakes, they are corrected.' (SS-2-FM2)
'If there are decisions from the National Social Appeals Board, whether it is an affirmation or a reassessment, the explanation from the National Social Appeals Board will be presented to everyone in the team. This is also to make sure that we align our practices based on the decisions from the National Social Appeals Board [...] And in addition to that, in our IT system we have some folders that are accessible to all of us where a lot of useful information can be retrieved.' (SS-6-FM2)	'We have a fairly safe system concerning the guidelines. They are evaluated after a fixed number of years. In this way, it is constantly assessed whether something should be changed. Or if something new comes along, then we have to look at the guidelines and whether to implement it here.' (H-8-CD)
'It is teaching, and it is e-doc, which is updated and ... then you can say that something may come in that takes effect on Monday, so then you get an email about that in your electronic postbox.' (H-8-CD)	'They [errors and adverse events] also go through our quality team. There are also some things at staff meetings, and then some things where we make guidelines [...] There may be some things where we kind of say, "Well, we need to have a guideline for how to handle this". [...] To the patient it is really important that you read the medical record and what the plan is, what are we supposed to do. You can NEVER provide treatment and care based on an oral hand-over, because who is responsible? You must proceed from what is stated in the patient's medical record. So therefore, we have removed the oral hand-over. It is not something we are praised for. But it is something we expect will optimise patient safety. We have to make some structural changes to optimise patient safety.' (H-9-N1)
'We usually make a short summary that we distribute to the ward's staff, saying "This is what has happened" and "This is what we can learn from it".' (H-3-CD)	
'We send out a newsletter to everyone: What are some of the issues we have dealt with [in the management team]? What solutions have we come up with, and what have we continued working on? And then we bring it up at staff meetings.' (H-6-N2)	'New structures and new workflows so that we are constantly evolving organizationally, and that we develop in terms of professional knowledge. We also had an urgent situation where we called our MAT team [mobile acute team]. Essentially, we discovered that our nurses were not sufficiently prepared for the MAT team arriving. Then we analysed, "What are some of the elements that the MAT team at the very least require to be ready?" Then we designed a process with some people from the anaesthetic unit to say, "What do you expect from us?" And then get that professionalism in place, and get some guidelines, and a pocket card made for all our nurses, so they are not in doubt next time.' (H-5-N1)
'At the morning meetings where we have had the opportunity to reflect, we actually make a short summary, which is uploaded to our shared drive. In this way, you can generate knowledge even though not everyone can be present.' (H-4-N1)	

Note. Based on the closed codes 'Knowledge sharing' and 'Revision of work procedures'.

However, there are specific managerial practices related to revising work procedures, as displayed in Table 5.6. In some public service organisations, these revisions are put into a system, so all work routines and guidelines are revisited regularly (H-8-CD). In most organisations, revisions are initiated as a reaction to how a risky situation was approached and handled by frontline workers. Two major triggers of revision appear from Table 5.6. First are the revisions triggered by inappropriate conduct by a frontline worker. This is the case at the ward where the head nurse describes how they had to strictly enforce the documentation requirements when handling over patients, for instance, because the nurses preferred to do it orally, which posed a risk to the patients (H-9-N1). The second trigger is when professional development is required because the frontline workers are not equipped to handle the risky situations they face. This was described by another head nurse, explaining that they had to revise work procedures and implement new routines after realising during a risky situation that they were not prepared to handle it (H-5-N1). In this way, knowledge sharing and revision of work procedures are closely related leadership activities that have a common denominator of improving future decision-making in risky situations.

Overall, Table 5.6 reflects how frontline managers work with longer-term considerations of facilitating knowledge sharing and revising work procedures following risky situations. How these follow-up activities are prioritised is a question of the individual frontline manager's risk perception, but also their tolerance for accepting future similar risky situations.

5.3.3 How Facilitating Follow-Up Activities Enables Frontline Workers to Mitigate Risks

Related to the first purpose of obtaining an in-depth qualitative sense of the risk management dimensions, this section shows that frontline managers facilitate follow-up activities after risky situations in different ways. The common denominator is that the activities strive to improve frontline workers' decision-making in future risky situations. This is pursued by providing them with feedback on how they handled the risky situation, utilisation of prior examples to discuss the use of professional discretion, knowledge sharing, and revision of work procedures. Together, these practices enable frontline workers to retrospectively learn from risky situations, and prospectively become better prepared to handle future risky situations.

The leadership behaviours related to facilitating follow-up activities after risky situations indirectly enable mitigation of risks by improving the basis for decision-making in future risky situations. First, receiving feedback and discussing what happened in risky situations with a high degree of uncertainty

and potential negative consequences enable learning and thereby reduction of uncertainty in future similar risky situations. Further, the follow-up activities shed light on the consequences that follow from risky situations and again spur reflection on how negative consequences can be alleviated and positive consequences promoted. A clinical director describes this process as one where 'it is like having a ship that is sailing, and then you have to trim the sails now and then' (H-1-CD).

Facilitating follow-up activities after risky situations constitutes a learning opportunity for frontline workers and their managers in public service delivery. They get to ask questions related to risky situations, including: What went well? What could have gone better? Can we learn anything moving forward? Do we need to implement any changes to our guidelines and work procedures? The answers to some of these questions feed into the organisation of work routines prior to future risky situations, and how professional issues are discussed during risky situations, just like the regular audits and follow-ups are a way of organising work routines. This is related to the second purpose of understanding the interplay between the risk management dimensions, as it underlines the cyclical nature of risk management: the outcome of follow-up activities to an extent feeds into how future risky situations are handled prior to and during their occurrence.

5.4 Implications of the Risk Management Concept

A key insight from the in-depth qualitative analysis of the risk management concept is that the three dimensions of risk management constitute a cyclical process. How work routines are organised matters to how risky situations are handled, which is decisive to the follow-up activities that subsequently feed into the organisation of work routines and discussion of professional issues. In this sense, there are clear synergies between the three dimensions as they can amplify each other. Realisation of these synergies demands active prioritisation on the frontline manager's part. For instance, when work procedures and guidelines are revised following a risky situation, this only spills over into the organisation of work routines when frontline managers incorporate these changes in how they organise work routines.

A common denominator between the leadership practices within the three risk management dimensions is that they are resource-demanding. They take up time on behalf of the frontline managers who facilitate and carry out these activities, as well as the frontline workers who must partake in regular meetings and collaborative discussions prior to, during, or following risky situations. In this way, there is a trade-off between enabling frontline workers to mitigate risks on the one hand, and allowing them sufficient time to exercise

core public service activities on the other. Given this trade-off, and the fact that organisations face different risky situations, the risk management dimensions do not per default amplify each other. Instead, they are subject to the prioritisation, or lack thereof, of the individual frontline manager.

The question is, what drives these priorities? As described in Chapter 4, the interview data was coded in three stages to reflect both the deductive purpose of investigating the theoretical concept of risk management (first-cycle coding), and the explorative purpose of understanding what else is at play for frontline managers who handle risky situations (second-cycle coding). From the second-cycle coding process it appeared that frontline managers' risk perceptions and willingness to take risks seem to matter to their risk management practices and the decision-making principles underlining them. Different frontline managers have different ideas of what risk is, and, as a result, different attitudes to how risks are best handled in public service delivery. The following sections explore whether and how these insights can improve our understanding of risk management as a leadership behaviour, and the inherent priorities associated with it. Section 5.4.1 explores how frontline managers perceive risk and the implications they believe this has for their behaviour. Section 5.4.2 dives into frontline managers' willingness to accept risk and the decision-making principles that are associated with their level of risk tolerance. The last section ties together all the insights from this chapter and suggests that different risk management profiles can be extracted from the different leadership behaviours related to risky situations.

5.4.1 Risk Perception

'You cannot hit a hole in one on every golf course' (H-1-CD). This golf metaphor represents a clear common denominator from the interviews: frontline managers are all keenly aware that risks are a basic condition of the public services they deliver. They inevitably must respond to situations with a high degree of uncertainty and potential negative consequences, but they are aware that they cannot always handle them in a way that prevents negative consequences to the service recipients.

The frontline managers emphasise different aspects of risky situations, which reflects their different perceptions of them. A social service manager dealing with children and families where there is suspicion of abuse and neglect said that 'we do not have a crystal ball where we can see what the right thing is for the individual child, and there are legal requirements stating that we must act based on individual needs' (SFC-11-FM1). The crystal ball analogy points to the complexity and uncertainty of risky situations. In addition to this and the potential negative consequences to the child and the family, frontline

managers and workers must also navigate within the boundaries of complex legislation that poses demands on when and how they conduct their professional assessments.

An inherent dilemma in risky situations is that you do not know the outcome of the counterfactual situation. A ward nurse explained this with the example of a hip replacement: 'If you get a hip replacement, it will give you these opportunities. There are potential complications too. If you do not have the surgery, those risks are gone. But then your life might be so miserable that you will not be able to leave your house' (H-6-N3). The example illustrates the trade-off inherent to any risky situation: there are potential negative consequences to most prospects that involve a level of uncertainty due to incomplete information, as illustrated with the hip replacement where it is a decision between the status quo and surgery – both of which hold potential negative consequences. The issue of not knowing the counterfactual outcome is magnified by the additional factors that increase uncertainty in risky situations. A clinical director explained how factors like the patient's age, lifestyle, and medical history add a significant element of uncertainty to any assessment and subsequent decision they make: 'Nothing is black and white. Everything is grey. To function as a doctor, you must learn to accept that everything is grey and that we sometimes make decisions on well-founded grounds, and other times these decisions rest on fragile foundations' (H-2-CD).

Overall, frontline managers put different emphases on the elements of uncertainty and the potential negative consequences of risky situations. Table 5.7 displays the different ways frontline managers perceive risky situations. The composition of the table is intended to reflect the different ways frontline managers think of decisions they face in risky situations and what they consider to be the implications of these perceptions.

These frontline managers share the realisation that they inevitably face situations where decisions with potentially negative consequences to service recipients must be made on insufficient grounds, because the uncertainty cannot be alleviated, but also because these situations are not black and white.

The interview excerpts point to different implications of frontline managers' risk perceptions. A distinct red thread is the acceptance that negative consequences to service recipients are inevitable, no matter how carefully designed the decision-making structures are, and that this cannot keep you from making decisions. This was bluntly described by a clinical director who stated that 'all surgeons have their own private cemetery. If they do not, they have done too little' (H-3-CD). This attitude is also apparent among social service managers, as illustrated by the ascertainment that they cannot save the world. Other frontline managers are less stark and emphasise that frontline workers

must carefully document the decision-making process, live up to their responsibilities, and do the best they can, knowing that sometimes negative consequences to service recipients are inevitable.

Table 5.7 Perception of Risky Situations and Implications

'We do not know where the cases end up and which children end up exposed [to danger]. It would be a lot easier if we knew that, but we do not. That means we just have to do the best we can. It is also about living up to our responsibilities, talking to the kids as many times a year as we are supposed to. Because then we could actually not have done anything differently, and that is the peace of mind we must have and give to our social workers, because no one wants a case [with a negative outcome] to end up on their table and become a part of it.' (SFC-9-FM2)
'We have experienced that in the adjudication or in the decision at the visitation meeting we write that "we are making this decision based on this and that, because you cannot obtain information on this and that." If there is something that we profoundly think, "We should have information on this, but it is not possible to get it", then we actually write that we do not have that information. [...] Then we have to take on the role of law-keeper, and say, "then we cover ourselves in this way". And it is to protect ourselves, so we are not blamed afterwards like: "It is awful that you made a decision without talking to the service recipient himself, and we cannot see from the case that you tried in any way". '[...] But it is very much about documenting that you are well aware of the risk you have taken.' (SS-2-FM1)
'There are cases where we say, "Well, we cannot save the whole world. They have the parents they have. There is no basis for a forced removal, and they will not cooperate with what we can offer and what we believe is relevant and right." And then the child suffers, right?' (SS-3-FM3)
'We want to reach a place where we neither overcompensate nor undercompensate but actually reach the level where it is assessed that we should be in terms of compensation.' (SS-4-FM1)
'If you acquiesce, you may even overcompensate – you can also do that sometimes. Because once a service recipient has received something, it can be difficult to change.' (SS-6-FM12)
'Sometimes it happens that even if you have done everything according to the law, things do not always work out as you expect them to.' (H-6-CD2)
'There is always a trade-off in terms of whether we run unnecessarily large risks on behalf of the patient. Does it measure up to what we may gain by ignoring it? It is an ongoing balancing of "What do we risk and what can we gain?"' (H-2-CD)
'We are not in a sphere where things are black and white, right? We know the answers afterwards. We cannot calculate them. So we continuously have to make an assessment based on the information we have and what we think this might be about, how quickly things should be done, and how quickly they need to be treated, and all those sorts of things. [...] That is the uncertainty we are constantly working with. It is a basic premise.' (H-3-CD)
'We can have a tightly knit safety net, but something can still happen that we had a hard time anticipating. Even though we had the guidelines, we had the necessary people, the relevant competencies were present. Yet something in this setup made it happen anyway.' (H-1-N1)

Note. Based on the open code 'Risk perception'.

Some of the frontline managers emphasise that you can only do so much to mitigate risks. The costs associated with reducing uncertainty by obtaining more information are high, and this comes with the realisation from frontline managers that uncertainty will never be eliminated. It is simply a basic characteristic of the risky situations they face. This is related to the balancing between different aspects of risky situations, where frontline managers describe

how they weigh different decisions against each other in terms of the effort they require and the potential risks they hold to service recipients. This is indicative of frontline managers' risk tolerance, which is the focus of the next section, but also some of the trade-offs related to organisational effectiveness that are inherent to risk management, which are discussed in Chapter 8 'Implications of Risk Management in Public Service Delivery'.

The implication of frontline managers' risk perceptions and their different emphases is that they employ different risk management practices. As illustrated earlier, some prioritise organising work routines, while others emphasise the need to discuss professional issues as they occur in risky situations, and still others emphasise the need to follow up after risky situations and learn from what happened. Despite the common denominators of risk perception, the frontline managers have quite different levels of risk tolerance. This leads to different considerations regarding when risky situations require managerial action, which is reflected in frontline managers' decision-making principles in risky situations.

5.4.2 Willingness to Accept Risks

The frontline managers' willingness to accept risks falls on a continuum, with risk aversion at one end and risk tolerance at the other. While all frontline managers accept the basic premise that risks are inevitable, they engage with these risks in different ways. Essentially, risk attitudes are associated with decision-making principles that guide what risk management practices frontline managers employ. This is the case, for instance, in how much decision-making competency frontline workers are granted. One frontline manager explains that the social workers 'do not make any decisions themselves' (SS-1-FM3). The reason behind this decision-making principle is a concern that too much decision-making autonomy among social workers leads to poor decisions that will eventually have negative consequences for service recipients. In this way, it reflects a risk-averse frontline manager who, consequently, lends no decision-making autonomy to their frontline workers.

On the other hand, there are managers who emphasise that for the organisation to function efficiently and deliver public services, they must work around the risks and occasionally accept that they run risks on behalf of their service recipients. This was described by a clinical director, for instance, who explained that sometimes they settle with assessments that dismiss a specific concern, but do not prioritise running further assessments that clarify what might be causing the patient's symptoms: 'You could say that everyone does not get everything. They do not. But we try to make it probable [that the patient does not have a specific condition], and we must never believe that we

are God who holds the truth' (H-7-CD). Here, a risk to the service recipient, and the potential negative consequence of an undetected condition, is accepted because it is incredibly resource-demanding to fully eliminate the uncertainty element and map all the potential causes of the patient's symptoms. In this way, frontline managers have different profiles in terms of how much risk they are willing to accept, which is reflected in their decision-making principles.

Table 5.8 displays different decision-making principles that reflect how willing the frontline managers are to accept risks. As mentioned, the risk aversion/tolerance distinction should be thought of as a continuum in the sense that none of the interview excerpts represents either a complete risk aversion or a complete risk tolerance.

The interview excerpts in Table 5.8 illustrate that different levels of willingness to engage with risks come with different decision-making principles. Among the frontline managers with risk-averse attitudes, this is reflected in decision-making principles related to stressing the documentation requirements of frontline workers' professional assessments, restricting frontline workers' decision-making capacities, and an emphasis on early detection of risky situations to prevent them from turning into urgent risky situations. The reasoning behind these principles is that these actions are an investment and a means to prevent negative consequences of risky situations for service recipients. Even though it is resource-demanding, the risk-averse frontline managers are willing to prioritise these decision-making principles.

Among the frontline managers with more risk-tolerant attitudes, there is a pragmatic approach to decision-making. Concretely, there is a willingness to deviate from the guidelines and formal procedures for the undertaking of work, a willingness to sit tight and see what happens in the risky situations where they have tried to reduce uncertainty, and a willingness to seek out new ways of working that may improve future decision-making. The reasoning behind these principles is linked to the acknowledgement that risks are inevitable. To the risk-tolerant frontline managers, there is simply a trade-off between reducing the uncertainty element and the resources it would take – especially given the realisation that they may well never obtain complete information on the risky situation at hand. For these reasons, it is accepted that some service recipients may experience negative consequences in public service delivery. Further, risk tolerance appears to be associated with financial incentives. This is evident from the clinical directors who do not prioritise efforts to reduce uncertainty and clarify patients' symptoms in all cases, and by the frontline managers who encourage social workers to actively see how far they can go within the confines of the law.

Table 5.8 Risk Acceptance and Decision-Making Principles

Risk Aversion	Risk Tolerance
'I do put a lot of energy into telling them "Well, cover your own back". You know, document it. Document everything, [...] So it is not in the paper one day like "The municipality did nothing, now he is dead".' (SS-2-FM2)	'Sometimes it is a process, both as a social worker and as a leader, where we have to dare to say "Now, let us keep our cool, because we will have to wait and see what we actually find out." And in the meantime, the child is still with their family without any visible changes – to the child, that is. That is our starting point, which of course creates a dilemma.' (SFC-11-FM1)
'I have an employee who specifically handles all the transferred cases from the child and family department [...] This is an important source in our department [which handles adult cases] and is a source that we should have a pretty good handle on, as it is rarely surprising when a service recipient turns 18.' (SS-5-FM2)	'We can have service recipients in external placements where we get so much divergent information in relation to the service recipient's need for support that we kind of think "Well, maybe it does not matter that we let the service recipient go home." It may well be a less supportive setting than the service recipient had in the external placement, but we can quickly adjust our internally provided options. Therefore, we have the guts to say "Well, then we must let the service recipient go home and then get a sense of what they really need".' (SS-1-FM1)
'We need consistency. We cannot have serious errors that get repeated.' (SS-4-FM1)	'The grey areas are simply the most interesting part of our field, and we have to test the limits of the legislation. This is something I communicate a lot to social workers: "We have to go out and have these complaints filed against us". But not just to have them – you know, we should not bother any service recipients without reason or be unethical in our behaviour or anything like that.' (SS-5-FM2)
'We do not take any chances.' (H-6-CD1)	'This is going to come out wrong, but I believe that it is about taking chances sometimes. Because, you know, when we have had our case processing machinery at work, and it has resulted in a professional assessment, we just have to trust it sometimes, instead of constantly doubting it. [...] We gamble on an enlightened basis. We take chances on an enlightened basis.' (SS-6-FM1)
'The very young [doctors], they have a broad group of patients and they take on decision-making at a relatively low level' (H-9-CD)	'We are a ward where we try out many different ways of working. We work a lot with trials. [...] If YOU came in with a given condition, well, then we would go all the way for you. But it may be that what we really want to do will cause more pain to a patient suffering from dementia. In fact, we have to say, "Let us see whether we can weather the storm by doing it in this way". And that is basically deviating from the guidelines. The patient may not receive the full package.' (H-7-CD)
'We simply do not have the time to not do it, [...], because it is the early detection, right? If we only do urgent things, well, then more things become acute, right? And that is a priority we have to make, right?' (H-9-N1)	'Sometimes, I have to push the issue a little to get a patient discharged. [...] We do not have an inexhaustible source of either physical places or nurses that can take care of and look after the patients. And the doctors may well think that I am a little cold at times because they think, "Would it not be nice for him to stay until tomorrow?" I really wish he could too, but it is my responsibility to make sure that there is space for the next patients that come in. That is also the doctors' responsibility, but I am much more willing than the doctors to take a risk and send Svend home this afternoon instead of tomorrow.' (H-3-N2)

Note. Based on the open code 'Willingness to take risks'.

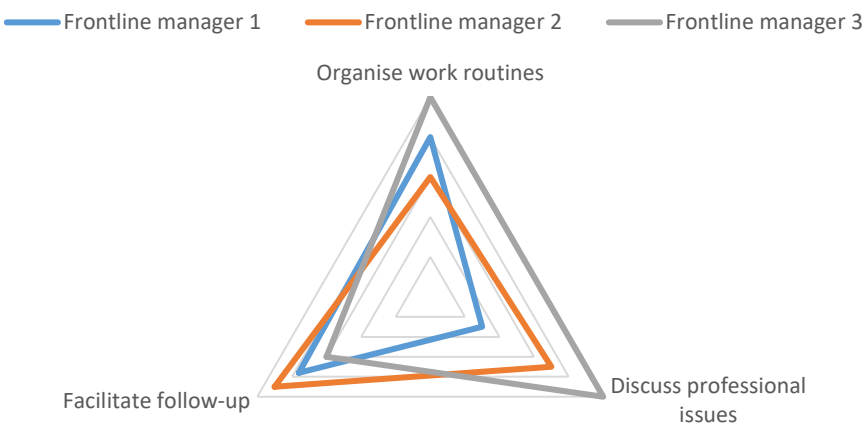
Some decision-making principles do not fit neatly into the risk aversion/tolerance continuum. This is the case with the common principle of making the least intrusive decision to service recipients. For instance, if you can facilitate safety for a child within their family and help the parents learn new patterns of behaviour to master their parenting responsibilities, this is preferred to removing the child. One frontline manager explained it the following way: 'From the case material you think, "Oh, that is not going to hold, the child should probably be placed out of home". But because placements have enormous consequences to a child's upbringing – we know that, it is not just a financial question – we kind of try to say "Let us try with some preventive measures. We start out with some respite care and family treatment and see whether that works out", even though we may only believe in it 10 percent. My take is that we owe it to the child, because removal holds such grave consequences for the child' (SFC-9-FM1). This example encapsulates the dilemmas of risky situations and reveals an interesting contradiction in what risk acceptance/risk tolerance really is. One could argue that it is evidence of risk aversion to not uproot the child, because in that way you do not have to face all the potentially negative consequences associated with placing a child out of their home. However, one could also argue that it is risk-seeking to not uproot the child if the parents do not change their behaviour. This is reflected in the way the frontline manager essentially speaks with two tongues. On the one hand, she acknowledges that the child in question would probably be better off removed and placed outside of the home. However, at the same time, she argues that removing children is complex and may not help the child significantly. Therefore, they follow a preventive strategy – even though the frontline manager, based on the social worker's assessment, believed that the child should be removed from home. Further, the frontline manager acknowledges that the financial aspect is also considered when making decisions in risky situations.

The different levels of risk aversion and risk tolerance spill over into different decision-making principles surrounding risky situations. Essentially, risk-averse frontline managers will go a longer way to reduce uncertainty and clarify and prevent the potentially negative consequences the service recipients may face in the risky situations, while the risk-tolerant frontline managers are more willing to accept that service recipients now and then will experience negative consequences in public service delivery. Further, the risk-tolerant frontline managers point to the trade-off between reducing risks and resource efficiency in public service delivery. This is discussed in Chapter 8 'Implications of Risk Management in Public Service Delivery'.

5.4.3 Risk Management Profiles

A key insight from this chapter is that frontline managers prioritise which risk management practices they exercise to enable frontline workers to mitigate risks to service recipients. The synergies between the three dimensions of risk management are contingent on 1) the characteristics of the risky situation, 2) the frontline manager's risk perception, and 3) the frontline manager's risk aversion/tolerance. A risk-averse frontline manager will likely prioritise leadership activities on all three dimensions of risk management, while a risk-tolerant frontline manager will put less effort into the different risk management practices, and prioritise the ones judged to yield the highest benefit in terms of enabling risk mitigation. In other words, different frontline managers have different risk management profiles, which is hypothetically illustrated in Figure 5.1. The more risk management practices you exercise within each dimension, the more risk management you exercise all together.

Figure 5.1 Risk Management Profiles



The notion of different risk management profiles illustrates that risk management is not one distinct leadership behaviour, but a set of associated leadership practices that all serve the purpose of enabling frontline workers to mitigate negative consequences in risky situations. Among risk-averse frontline managers, the different leadership practices amplify each other in the sense that they have a holistic all-around view of how they can best support decision-making in risky situations and enable frontline workers to mitigate risks to service recipients. Among risk-tolerant frontline managers, the different risk management practices are prioritised in the sense that they are willing to engage with risks and accept that service recipients will now and then experience negative consequences in public service delivery if it means they can ensure efficient public service delivery.

Overall, the potential synergies between the risk management dimensions are not necessarily realised. This is because the risk management leadership activities are resource-demanding and thus subject to the priorities of the individual frontline manager. This prioritisation is dependent on the manager's risk perception and their willingness to take risks. To risk-averse frontline managers, the three risk management dimensions feed into each other, while risk-tolerant frontline managers prioritise when to apply the different leadership practices. Chapter 8 both addresses the question of prioritisation and trade-offs inherent in risk management practices, and how risk management as a leadership concept is related to other leadership concepts and practices, which has only been briefly touched upon in this chapter.

5.5 Conclusion

This chapter set out to qualitatively unpack what risk management as a leadership behaviour entails at the frontlines of public service delivery. In the first part, the specific leadership activities associated with each risk management dimension were exemplified and described using insights from interviews with 62 frontline managers. The qualitative insights add significant and important nuances to our understanding of the specific leadership practices that the three dimensions of risk management hold, and added nuances that show how risk management can differ between frontline managers and is subject to prioritisation.

These differences were the point of departure for the second part of the chapter, which explored the implications of frontline managers' risk perceptions and willingness to take risks for their risk management practices. Here, a key insight is that frontline managers have different risk management profiles. Dependent on how they perceive the potential risks facing their organisations and how willing they are to accept these risks, the frontline managers prioritise different elements of risk management. While there are clear potential synergies where the three risk management dimensions can amplify each other, these are likely only realised when frontline managers prioritise investing the time and resources to do so.

Chapter 6. Risk Management and Distribution of Responsibility

The purpose of this chapter is to investigate the hypothesis that risk management is exercised more when the distribution of responsibility is collectivised than when the distribution of responsibility is individualised. This is an important hypothesis to investigate because distribution of responsibility makes up a key difference in organisations that deliver public services, and may matter to how frontline managers exercise risk management. The theoretical drivers of the hypothesis were unfolded in Chapter 3, 'Is Risk Management Contingent on Distribution of Responsibility?', which highlighted the accountability demands imposed on public service delivery and the blame-avoiding nature of public managers.

Frontline workers have many commonalities across organisational contexts, like specialised theoretical knowledge, autonomy, and discretion, but they differ in how their responsibility is distributed. Some frontline workers are authorised professionals and therefore, in a formal sense, individually responsible for the decisions they make. Other frontline workers are not authorised, and in these organisations, responsibility for decision-making and the consequences of decisions for service recipients is, formally, shared collectively. In this study, the healthcare sector represents an individualised distribution of responsibility, while the social services represent a collectivised distribution of responsibility. How the two sectors reflect the individualised and collectivised distributions of responsibility was described in greater detail in Chapter 4, which also accounted for the nuances in these somewhat black and white categories.

To investigate this hypothesis, the analysis is structured as a systematic comparison of the healthcare and social services sectors and presents insights from the 29 individual and focus group interviews with 62 public service frontline managers from the two sectors. The findings build on the codes from the second, inductive coding cycle. These codes were generated bottom-up, as opposed to the first-cycle provisional coding that focused strictly on risk management practices and thus reflected a top-down deductive coding strategy. In this second-cycle coding process, insights emerged that appeared to matter to the frontline managers' risk management practices – for instance, how frontline managers' perceptions of their role in risky situations condition how they facilitate and prioritise risk management practices. The analysis is based on codes like 'distribution of responsibility', 'perception of managerial role', and

'decision-making principles', which all shed light on how frontline managers approach risky situations. Compared to the strictly deductive analytical strategy applied in Chapter 5 ('Risk Management as a Leadership Behaviour'), the advantage of the more explorative approach applied in this chapter is that it enables the investigation of how risk management practices are approached by frontline managers, while systematically accounting for the role that distribution of responsibility plays. A key insight from Chapter 5 is that frontline managers have different risk management profiles. How they prioritise between the different dimensions of risk management is dependent on their risk perception and the nature of the tasks undertaken by their organisational unit. This is relevant to the assessment of 'how much', which is based on a qualitative and comparative overall assessment of how frontline managers prioritise different risk management practices and whether any differences are associated with how responsibility is distributed.

This chapter is structured to enable the systematic comparison of risk management practices in the healthcare and social services sectors. A basic premise for investigating the hypothesised differences in degree of risk management exercised is that frontline managers are aware of how responsibility is distributed. Therefore, the first section investigates and compares the frontline managers from the healthcare and social services sectors and their reflections on the distribution of responsibility, and how this is related to their self-perception and decision-making principles concerning their risk management practices. This is followed by three sections that systematically compare risk management practices in the two sectors, reflecting the structure of the risk management concept. The sections that compare leadership practices within the three risk management dimensions do not hold the same level of detail as the previous Chapter 5. Focus is on elucidating and illustrating similarities and differences in risk management practices between two sectors where responsibility is distributed differently. The last sections discuss the identified mechanisms and their implications. Specifically, the degree of urgency of risky situations, level of specialisation in the organisational unit, and decision-making autonomy of the frontline workers are discussed.

6.1 Does the Premise Hold?

To investigate the hypothesis that risk management practices are exercised more when distribution of responsibility is collectivised than when it is individualised, we need to be sure that the basic premise holds. Therefore, this first section dives into how frontline managers in the two sectors think about the distribution of responsibility, and how they perceive their roles as frontline managers in risky situations. These analyses are based on the open, second-

cycle coding of the data. Specifically, Subsection 6.1.1 builds on statements related to frontline managers' awareness of the distribution of responsibility, and their reflections on what this entails in practical terms. Subsection 6.1.2 builds on statements related to the concrete considerations of the frontline managers in terms of their own role in risky situations, and the risk management they exercise.

In this way, these two steps serve as a reality check: if the frontline managers are aware of how responsibility is distributed in their organisations and have reflected on what their role is in risky situations, it makes sense to take the next step and investigate whether and to what extent the risk management practices are different, dependent on distribution of responsibility.

6.1.1 Frontline Managers' Awareness of How Responsibility Is Distributed

A basic premise for decision-making in the healthcare and social services sectors is that responsibility for the decisions made is individualised and collectivised, respectively. The frontline managers in both sectors are aware of this, and it shows in different ways. In the social services, frontline managers uniformly recognise that the social workers, formally speaking, are not responsible for the decisions they make. A frontline manager explains that 'What is special about the administration, the municipal administration, is that we as an authority make a decision. So it is not [the social workers] who make all the decisions and carry responsibility themselves. It's a wider range' (SS-3-FM2). This frontline manager emphasises that it is not the individual social worker, but the municipal state agency as a collective unit that makes decisions and carries the associated responsibility for the consequences and outcomes. In another municipality, the frontline managers address the question of responsibility slightly differently: 'We make a huge effort to communicate that it is not the individual's responsibility. It is [the municipal state agency] that is responsible for these families' (SFC-11-FM3). Parallel to acknowledging this collectivised responsibility, one of the other frontline managers in this municipality emphasises that the individual social worker has an obligation to inform their supervisor of potential delays or other issues related to their casework: 'There is a clear rule that as a social worker, if there are tasks you do not complete on time, and you have not told anyone, then you are responsible for that. If you have told your frontline manager that you cannot complete your task on time, and then something happens, then it is the frontline manager's responsibility; if they have passed it on to me, and I have neglected a priority, then it is my responsibility' (SFC-11-FM1). Alongside this collectivised responsibility there are thus clear expectations that the individual social worker takes on the

task of keeping frontline managers in the know. Once they have done this, the frontline manager takes the full organisational responsibility for the priorities made and what happens from there.

Given the collectivised responsibility, the decision-making autonomy of the social workers is constrained by the frontline managers. Several frontline managers explain that social workers' 'decision-making autonomy is very constrained' (SS-5-FM1) and that 'it is a shared responsibility [...] Here they do not make any decisions themselves. So they will never be left with the responsibility because the management has a hand in all decisions' (SS-1-FM3). In one municipality, the frontline managers explain that the social workers have decision-making autonomy in questions of less extensive measures or interventions that are not too costly (SS-2-FM2), but they are never alone with 'decisions that drive costs' (SS-2-FM1). This reveals interesting considerations of the financial aspect of decision-making, which is discussed further in Chapter 7, 'Conditioning Factors of Risk Management'.

Apart from the formal, legal aspect of collectivised responsibility, the frontline managers further refer to the emotional hardship of the decisions social workers face, which was described in Chapter 5. Given the potential emotional strain of becoming acquainted with service recipients in a vulnerable position that you cannot necessarily help them out of, some frontline managers emphasise the need to take the feeling of responsibility off the social workers' shoulders: 'So it is obviously very difficult when you have entered the life of such a person and then have to think, "I must be able to do something, I mean, we should be able to, and we have to call his sister. We just have to...". Because you want to do something. But in Denmark, service recipients can just say "No", right? And in those situations, I think it is really important to remove responsibility for the individual social worker' (SS-2-FM2). In this way, the social workers' limited decision-making autonomy is not only reasoned to be a function of collectivised responsibility, but also of the fact that they face complex situations that can be emotionally difficult to cope with.

Parallel to the social services, the frontline managers in the healthcare sector recognise the distribution of responsibility in different ways. They particularly emphasise the individual's responsibility in relation to delegated tasks and the high degree of autonomy that health professionals have. For instance: 'We [have] many competencies that are delegated. Some [nurses] are authorised to write prescriptions for certain types of medication, and legal documents have been written for this. So that is okay. But it is the nurses who make the professional judgment, based on their knowledge and their professional nursing background, whether to increase [dosage] and how much, and which drug to choose' (H-7-N2). Others are more direct about the implications of individual responsibility when they simply say that the health professionals

'are the ones who will get into trouble' (H-9-N1), or 'know themselves that it is their authorisation [at stake]' (H-1-N2). These quotes reflect the fact that healthcare professionals, formally speaking, have a high degree of decision-making autonomy and discretion, and that this comes with an associated responsibility for the decisions they make.

However, in practice, the distribution of responsibility in the healthcare sector is not as clear-cut as it may appear. Parallel to their focus on the responsibility that comes with authorisation and decision-making autonomy, the healthcare managers uniformly emphasise that they hold the overall responsibility for how things are run in the wards, and thus, the decision-making structures that the healthcare professionals operate in. One frontline manager explains that 'I am responsible for ensuring that things are organised' (H-8-N3), while another explains that 'when all is said and done, I know that I am responsible' (H-7-CD). The healthcare managers have a kind of 'meta-responsibility' in the sense that they are indirectly responsible for decision-making, because they are responsible for how work is organised, how competencies are delegated, and for ensuring that there are clear work procedures and clinical guidelines, as explained by a head nurse: 'As managers, we are responsible for ensuring that our employees are not given tasks they do not have the competencies to perform, and they must be instructed, and be able to handle the task, right? And that implies that they say "no". The individual employee is responsible for saying no. If they say, "I cannot do this, I have never done it before, or I doubt whether I can do it" [...] But it is very important that we make sure that they are introduced [to work tasks] and that they have the relevant guidelines available and that they are updated and so on. And they need to know that it is up to them to say no' (H-2-N1). What is emphasised here is the managerial responsibility related to delegation of competences and clear guidelines for the undertaking of work. Interestingly, at the same time this healthcare manager repeatedly underlines that healthcare workers must be able to put their foot down and say no when they face risky situations they may not be able to handle. This is another way of stressing the individual responsibility that authorised professionals hold and the extent of managerial responsibility: each healthcare worker must know the boundaries of their own abilities and refrain from taking on tasks they cannot handle. These managerial expectations of healthcare workers' ability to ring the alarm is analogous to the insight from the social services managers who also expect that social workers will let them know if they are struggling to perform their tasks.

This idea of healthcare managers' confined responsibility is phrased differently by a clinical director who experiences a paradox: 'As employee, you basically want a large degree of autonomy, but you do not feel like making the decisions. There are some decisions that you really prefer to park with the

manager. So I would like to commit my doctors to using the decision-making authority when I grant it to them and delegate responsibility' (H-2-CD). The discretion and autonomy given to and enjoyed by healthcare professionals thus come with the expectation of a certain decision-making capacity and willingness to take on individual responsibility in relation to patients. In other words, you cannot have your cake and eat it too.

Overall, the frontline managers in the social services and healthcare sectors operate according to their respective formalised distributions of responsibility. There are, however, important nuances to keep in mind. In the social services, the frontline managers expect to be in the know on what happens, given that the individual social worker cannot be held formally responsible for their decision-making behaviour. Meanwhile, even though healthcare professionals are individually responsible for the decisions they make, they do not make discretionary decisions in a vacuum decoupled from organisational context. The question is what the implications of these insights are in terms of risk management practices. This is related to how the frontline managers perceive their roles and responsibilities, and we therefore turn to this next.

6.1.2 Perception of Role as Frontline Manager in Risky Situations

Frontline managers' risk management practices are associated with how the managers perceive their managerial roles in complex and risky situations. Based on the open coding of data, three considerations persist across the board when frontline managers describe and reflect on their role in risky situations. These were captured in the following three codes: in public service delivery, frontline managers must address considerations of (1) legality, (2) professional standards, and (3) financial considerations. A frontline manager from the social services described it this way: 'I have the overall responsibility for finances in our jurisdiction, for personnel management, and of course overall professional responsibility for ensuring that we comply with the legislation and have a compliant practice. Make the right decisions' (SFC-11-FM1). These three considerations reflect basic circumstances that condition the leadership practices of frontline managers. This section investigates how these conditions are reflected in the frontline managers' self-perceptions and how they relate to risky situations.

6.1.2.1 Legal Considerations

Public service delivery is essentially a question of political priorities regarding who gets what, when, and how (Lasswell 1958 [1936]). The question of legality

is related to the fact that both the healthcare sector and the social services are governed by legislation that describes their purpose and provides service recipients with rights addressing the who, what, when, and how from Lasswell's definition. In the social services, this could for instance be legislation describing what is required of the social services when a municipal state agency is notified about concerns regarding a child, while in the healthcare sector it could be patients' rights outlining how long it should take to diagnose and start up treatment for cancer patients. This was described in greater detail in Chapter 4. Based on content from the inductively generated codes 'perception of managerial role' and 'legislation', the frontline managers from the two sectors put different emphases on the question of legality. In the social services, frontline managers emphasise the invariable requirement that the state agencies and social workers act in accordance with the law, and that this is their responsibility as frontline managers: 'The tasks I am in charge of are also a form of quality assurance in case work, in case reviews. Constantly making sure that the legislation is complied with, and constantly talking things through with the social workers in relation to how they approach cases and how they handle the different situations they are in' (SFC-9-FM2). At the same time, frontline managers also describe how the complexity of the legislation poses a serious challenge to them and the social workers, because they make decisions 'in a reality where the legislation is utterly elastic and we cannot really measure and weigh on any of it. The most important word for us is "significantly". I mean, what the hell does "significantly" mean? Before we can help you, you must be "significantly disabled". When are you significantly disabled? It is very difficult to put in writing. So there is a lot of professional judgment in these cases, all the time'. In this sense, complying with the legislation can be a challenge due to the sheer complexity of it and the cases they face. These circumstances require extensive discretion in risky situations, which in turn potentially challenges equal treatment under the law for service recipients if discretion is not exercised uniformly.

The frontline managers from the healthcare sector put less emphasis on the role of legislation. However, when they did, it was considered an underlying condition for their undertaking of work, as described by a clinical director: 'There are a lot of requirements to quality and efficiency and the right of inquiry and the right to treatment, and well, that is the kind of field we are working in and leading in. And we change our wards routines, processes, patient care, collaboration, and interfaces accordingly' (H-8-CD). What is conveyed here is that the requirements stated in the legislation matter to how they organise the work routines in the ward and how they relate to other actors. In contrast to the social services, frontline managers in the healthcare sector are not faced with complex legislation that is difficult to interpret and apply.

6.1.2.2 Professional Considerations

The second consideration – professional standards – covers the expectation that decision-making in public service delivery reflects the highest professional standards. The frontline managers in both the healthcare and social services sectors acknowledge this, but they have slightly different perceptions of what their roles are in ensuring these standards. While they agree that they are responsible for creating and overseeing the structures that lead to the highest professional standards, they differ in terms of how this should be executed. In the social services, frontline managers appear to play a key role in ensuring that the highest professional standards are met, which reflects the collectivised distribution of responsibility. They do this by discussing decision-making in risky situations with the social worker in question, but also by facilitating forums where social workers and frontline manager(s) can discuss risky situations with one another: 'Another thing I have had great success with is, for example, to unpack the case at a team meeting, where we draw it on the board and say "Here is the service recipient. What kind of challenges are there? What do we see that could be [a challenge]?" So we kind of brainstorm, make a mind map, and that way unfold it and say, "What really belongs here?"' (SS-4-FM1). This way of discussing professional issues collectively is related to the second dimension of risk management, which we return to later in this chapter.

In the healthcare sector, things are less clear-cut. The frontline managers have different perceptions of what their roles are in ensuring professional standards in the wards. Some believe they themselves should be the professional expert at the ward, as described by one clinical director: 'You need to be or previously have been a professional lighthouse. You need to have the professional respect of your colleagues, because otherwise you will never succeed as a leader. If you have been, pardon my French, a wimp professionally, then they have no respect for you, and how would they ever respect you as a leader?' (H-6-CD2). Other frontline managers in the healthcare sector do not believe that their leadership authority is dependent on their professional expertise – or lack thereof. Instead, they focus on what they can do to support healthcare professionals' decision-making in order to achieve the highest professional standards: 'I am not the best at caring for surgical patients, because I never did that until I became a manager. And I do not look after the patients in the same way as the nurses do, so there are a lot of procedures that I do not know enough about or cannot perform as well as they can. So it is really very much about professional discussion: "On the one hand, on the other hand."' (H-3-N2). In this way, frontline managers in the healthcare sector are not necessarily involved in all risky situation decision-making, which contrasts with the

social services where frontline managers are deeply engaged. This is one tangible difference between the two sectors that reflects the different ways of distributing responsibility.

6.1.2.3 Financial Considerations

The final consideration – of the financial side of things – is related to the fact that public service organisations do not have infinite resources. Frontline managers are responsible for ensuring that each municipal state agency or hospital ward does not spend more money than it has been allocated. This is reflected in different ways among the frontline managers. In the social services, most of the frontline managers are upfront about how risky situations also have a financial aspect. If there are several ways of helping a service recipient in a risky situation, they will usually go with the least intrusive option – both because this is a decision-making principle, as described in Chapter 5, but also because it is cheaper, and it is always possible to 'make adjustments [to interventions] at a later stage' (SFC-7-FM2). A frontline manager emphasises that: 'I have the budget responsibility. And sometimes I have to decide that we cannot grant a Mercedes, but we can grant a Fiat. […] I always say to the social workers, if they come to me and say something about it, "Well listen, it is not a question of who will benefit from it, it is a question of who cannot live without it"' (SFC-9-FM1). In this way, this frontline manager explains that not all service recipients can receive the gold standard from the municipal state agency (the Mercedes); some will have to make do with help or support in risky situations that is simply sufficient (the Fiat).

Similar considerations appear in the healthcare sector. Here, financial considerations are reflected in how resources are prioritised in terms of the assessments and treatments patients are offered, but also in terms of productivity, where there are certain expectations. A clinical director illustrates these considerations with an example from a risky situation: 'I had a young man come in who had been bitten by a tick four months ago. It was just in the last week that he developed this rash. We have taken a sample from his spinal fluid and we have taken blood samples from him. And he still has symptoms, but he does not have Lyme disease or anything else, which is was what he was afraid of. And I examine him and say, "I do not know what is wrong with you, but I do not think it is dangerous." That is risk, taken on his behalf, right! Because I had reached a point where we cannot investigate any more. He is awake, he is alert. I cannot measure blood pressure or take a temperature or take a blood test that shows that anything is wrong. But he has symptoms and I make a choice on his behalf that says "I cannot do that much more. If you have more problems, contact your own general practitioner". It is a risk, and

that day I go home and think about it and come to work again the next day and double check that what I have done was alright because it is a risk. Now imagine if it were fused symptoms of multiple sclerosis or something? In cases like these, we make some decisions. Can I be sure he will do as I say and go to his doctor and get examined for his symptoms? I cannot be sure about that. Do we have the resources to MRI scan everyone from head to toe? No, we do not. So here we create a risk, right? Did he get better by being in here? Well, he knows he does not have Lyme disease. He knows he is not acutely, dangerously ill from something. But is his problem solved? No, it is not' (H-1-CD). There are several interesting insights from this example. First, it describes a risky situation and the role of professional discretion. There is a high degree of uncertainty: why is the patient feeling unwell, when none of the tests return anything? There are also potential negative consequences to the service recipient, as the patient did not get any clarification regarding his symptoms and was left to wait it out to see whether he felt better. Further, the example illustrates how the clinical director did not prioritise the resources needed to exhaust all opportunities with an MRI scan. This illustrates his reflections on the risky situation and the professional assessment and associated trade-off he makes: they can only do so much for the patient, as it will be too resource-demanding to exhaust all options to determine what the patient could possibly be suffering from.

Frontline managers from both the healthcare and social services sectors strive to strike a balance between the three considerations of legality, professional standards, and the financial side of things. A part of striking this balance is to set clear expectations for how work tasks are approached in risky situations, but also to prioritise how resources are spent on service recipients – illustrated by the metaphor that not everyone can have the Mercedes, and some will have to make do with the Fiat. The considerations of legality, professional standards, and the financial side of things at times cause dilemmas among frontline workers who experience that they are at odds with each other. How frontline managers handle this is addressed in Chapter 7 'Conditioning Factors of Risk Management'.

A source of difference is how the frontline managers perceive their roles in relation to their professional standards. In the social services, where responsibility is formally collectivised, frontline managers take it on their shoulders to meet professional standards by being experts themselves who can provide second thoughts and play devil's advocate. In this way, they believe they ensure the highest possible standards for decision-making. In the healthcare sector, where responsibility is formally individualised, frontline managers are less uniform in how they perceive their roles in relation to their professional standards. Some consider it integral to their managerial credibility that they

themselves are experts in their field, while others emphasise that the frontline workers are supposed to be the experts and their role as managers is to facilitate structures in which frontline worker expertise can be exercised. The latter attitude reflects a strong focus on the individualised distribution of responsibility in the sense that it is essentially the individual healthcare worker's problem if they are not performing to the highest professional standards. This is in stark contrast to the social services, where it is a collective problem if social workers do not perform to the highest professional standards in risky situations.

This first section has investigated how frontline managers consider the distribution of responsibility. A key insight is that the reality is not as clear-cut as the legislative principles. In the social services, frontline managers expect that social workers can ask for decision-making support, and in the healthcare sector, doctors and nurses do not make discretionary decisions in a vacuum decoupled from their organisational context. In this way, the distribution of responsibility is not strictly dichotomous, but more of a continuum. It is in this space that frontline managers exercise risk management. The question is, how is the distribution of responsibility reflected in their risk management practices? That is the focus of the next section.

6.2 Risk Management Practices

To investigate the hypothesis that risk management practices are exercised more when distribution of responsibility is collectivised than when it is individualised, the following sections compare the two sectors. The comparison is made to follow the structure of the risk management concept. There are thus three subsections comparing the dimensions of organising work routines (6.2.1), discussing professional issues (6.2.2.), and facilitating follow-up activities (6.2.3). Focus here is on how the frontline managers in each sector specifically practice the three associated leadership behaviours of organising work routines, discussing professional issues, and facilitating follow-up activities. This is in contrast to Chapter 5, which focused on the common denominators and general aspects of risk management as a leadership behaviour targeted towards enabling frontline workers to mitigate negative consequences for service recipients in risky situations. In this way the following sections shed light on the differences – if any – in how risk management is approached in the healthcare and social services sectors.

6.2.1 Organising Work Routines

The risk management dimension of organising work routines covers leadership activities prior to risky situations. Specifically, it entails activities aimed at making the organisation fit to meet its challenges and prepare frontline workers to handle the risky situations they inevitably face in public service delivery. Chapter 5 focused on the four leadership behaviours identified in the risk management scale construct. A key insight was that all frontline managers to a greater or lesser extent employ frontline workers with different competencies and levels of experience, prioritise fixed structures, and coordinate frontline employees' work. In this way, all frontline managers are aware of their responsibility to organise work routines that enable frontline workers to reduce the element of uncertainty prior to risky situations. The question is whether frontline managers approach this differently in the healthcare and social services sectors. Here, focus is on how the fixed structures are created and overseen, and the role of decision-making programmes in this process.

6.2.1.1 Overseeing Fixed Structures

Chapter 5 showed that frontline managers from both healthcare and social services put heavy emphasis on prioritising fixed structures for the undertaking of work tasks. How these structures are created and overseen is the focus of this section. The insights are based on the inductively generated code 'perception of managerial role', which covers statements related to how frontline managers reflect on their role related to risky situations.

Frontline managers ensure fixed structures differently. In the healthcare sector, frontline managers are concerned with setting up the playing field for autonomous health professionals to operate in. In the social services, there appears to be less of a focus on setting the scene, and more focus on establishing fora for assessment and decision-making. Table 6.1 displays the different ways in which the frontline managers from the healthcare and social services sectors leverage fixed structures for the undertaking of work routines.

The frontline managers from both the healthcare and social services sectors focus on their managerial responsibility to organise work routines. They put similar emphasis on their role in creating structures to facilitate the best possible decision-making. This is for instance achieved by prioritising fora where risky situations are discussed. However, the frontline managers from the healthcare sector seem to apply more concrete tools to create and oversee the fixed structures. They emphasise their responsibility in ensuring that there are the right structures for the undertaking of work tasks to mitigate risks to patients. The question is whether they do this as a way of avoiding blame.

Given the individualised distribution of responsibility, what frontline managers can do prior to risky situations in healthcare is to make sure that there is the best possible decision-making launch pad. If they achieve this, the responsibility for the consequences related to decision-making rests solely with the individual healthcare worker who made the call.

Table 6.1 Overseeing Fixed Structures

Healthcare	Social service
'Yes, I am a leader formally, but I am not the one who has to make all the decisions. The right decisions need to be made in the right places. [...] But I try a lot to be a facilitator.' (H-2-CD)	'And my work assignments consist of, how can I put this [...] what is the strategy? And how do we meet our budget? How do we get the work organized where we do things a certain way, so we move in the same direction, and we follow the strategy and the financial resources we have to reach our goals [...] with reasonably quality and high quality.' (SS-2-FM2)
'I think that as a leader you have a responsibility to organise your department so there is room for reflection to bring up stuff [...] It could be my specialist manager or my care coordinator, but I am responsible for getting it organised and talking to those who are struggling... I do not think I have to be the best clinician to do that. But I have to create a framework for it to take place in practice. And also their introductory program. I am responsible for the framework being alright.' (H-8-N3)	'In general, it is to handle the daily operation of the department. It is to coordinate our efforts across the department. It is to manage the finances and strategy in our area.' (SS-1-FM1)
'This is often something we decide on as soon as the patient is admitted. Is this a patient who needs a full level of treatment? Is this a patient who is so chronically ill already that you have to start out by discussing the level of treatment with the individual patient and their relatives? So we cannot say that we are waiting for an emergency situation to arise, and then make up our minds. In other words, you are actually assessing the patient right from the start of their hospitalisation, to see whether we can anticipate that there will be situations that we have to deal with.' (H-5-N2)	'My task is to lead and distribute on a daily basis and make sure that we are on par with professional standards and that we work according to the vision that the municipality has defined in their strategy. And then also to make sure that the service recipients get the best possible offer based on the existing legislation. I take great pride in being cross-cutting to the extent possible with a high degree of interdisciplinarity.' (SS-4-FM1)

Note. Based on the code 'perception of managerial role'.

6.2.1.2 Decision-Making Programmes

Another way of creating fixed structures for the undertaking of work routines is through decision-making programmes. These are similar to March & Simon's notion of performance programmes, which are a set of organised responses to different stimuli (March and Simon 1958). For instance, a scan showing a shaded area on a lung will set off an immediate set of responses to determine whether it is cancer. March & Simon distinguish between pro-

grammes that are applicable in routine situations and problem-solving activities that are activated when a situation is out of the ordinary. Decision-making programmes are applicable in routine situations.

In healthcare, a great deal of routine decision-making is described in clinical guidelines that reflect evidence-based knowledge. The frontline managers raised awareness of the sometimes-limited applicability of these clinical guidelines. Many emphasised during interviews that the guidelines do not hold all the answers and that they often have patients that fall into a grey area: 'There are guidelines and I hate them. Because the field we play on, the task we have, it is so variable that a large number of patients just do not fit into a guideline. We can make care descriptions, and it can be good when we have some procedures defined and ready, like "If you have a blood clot in your brain, then we have to do this". But a very large part of our patients do not have a guideline that we can follow. What if you are old and lonely and have a urinary tract infection and do not have the network at home to deal with it? So what kind of guideline should we follow? Where should the patient go?' (H-1-CD). This clinical director describes how there are patients who do not 'fit' into a clinical guideline. It is in these situations that the problem-solving activities and clinical discretion are activated because the patients do not always fit neatly into the routine descriptions.

In the social services, decision-making is perceived as context-dependent and something that cannot be formally described, as evidenced by the debates over the implementation of evidence-based decision-making programmes in Denmark (Møller 2018). However, there are still a fixed set of responses and activities that start when, for instance, a municipal state agency receives a notification of concern regarding a child, and various analytical approaches applied by social workers making assessments. This dualism is explained by a frontline manager in the following way: 'The legislation states that in the Act on Social Services it is a "concrete and individual assessment", and that is not possible with fixed paradigms. You can follow some existing levels, but you can never say that they are always valid' (SS-2-FM2). This reflects that while it is difficult to programme decision-making in highly context-dependent cases, there are other means of achieving uniformity and consistency in decision-making where the same legislation is applied. Table 6.2 illustrates how frontline managers in both sectors work with facilitating decision-making programmes as a means of prioritising fixed structures for the undertaking of work routines.

Table 6.2 Decision-Making Programmes

Healthcare	Social services
'We actually follow the guidelines quite systematically. We discuss them regularly when new guidelines come out. But we also sometimes agree to deviate from them, and then we write exactly why we do it. And I think that is the way it should be. Guidelines are not laws. They are guidelines, recommendations.' (H-7-CD)	'Different methods determine what needs to be documented. So we have some methods, something called "VUM" for adults and "BUM" for children, and those are the methods for documenting. But the analysis and professionalism itself lies in the discretion. […] And then we try to make some work process descriptions.' (SS-3-FM3)
'There are national clinical guidelines for how to treat different ailments. We rely on them when we can, and at other times, we have some regimes within the department that say: "Well, when a fracture looks like this we treat it this way… and there is evidence for that, or otherwise it is something that we usually do because it gives us good results." Orthopaedic surgery has traditionally been characterised by eminence rather than evidence, but it has become much more evidence-based.' (H-9-CD)	'In addition, I try to support [by…] making some templates and having some procedures. For example, for the self-payment area, which is an area in most municipalities that is difficult to deal with for social workers, because all of a sudden you start calculating, or dealing with finances, and then most, they just freeze up, and everything is just difficult. So I try to say that this is what we are doing now, this is the way we are going, also to clarify interfaces with other departments. Who helps with what? Where should we send our contracts, if we make one – are we even allowed to make contracts ourselves at all? Who signs this? If we get a data deal, what do you do with it? So all these things, there has been a lot of uncertainty about them in the past, and then processes end up being reinvented every time. What I am trying to do now is say "Well, there really has to be clarity around that so we do not have to spend resources figuring it out".' (SS-4-FM1)
'Cardiology is the specialty that probably has the best joint decisions in Denmark, in relation to the treatments we have to offer our patients. A set of national treatment guidelines has been prepared, so if in doubt, you can simply look it up and see whether the patient has such and such blood pressure, heart rate, blood test results, such and such, then the patient is a candidate for a particular pacemaker, a particular heart valve or whatever. So we very, very rarely stand around and discuss whether this is the right treatment or not.' (H-7-N1)	'We have methods to clarify cases. There is always a lot of discretion when you are a social worker, so we work a bit with – not that discretion is not OK – but obtaining information in the same way. So we align a little bit and write decisions and try to professionalise a little without having to infringe on the social workers' discretion, because there is still discretion, but there should preferably not be so much discretion that decisions are made at random.' (SS-6-FM1)
'But we have a lot of them, that apply to our entire department, procedures and guidelines for how to act in a given situation […] And we are sure that we are systematic in relation to our guidelines and that they are in order and updated and such.' (H-2-N1)	'As soon as we have a tool that is based on prose, then – all things being equal – with the words we end up using, there will be a differentiation of information, and then there must somehow be some minimum standardisation. And how do you ensure standardised language? It can sometimes be a difficult thing.' (SS-6-FM2)

Note. Based on the code 'decision-making programmes'.

The insights from Table 6.2 indicate that there are more formalised decision-making programmes in the healthcare sector than in the social services. The

frontline managers describe national, clinical guidelines for how to approach different patients and conditions, and how these guidelines are applied systematically. In highly specialised wards, where the decision-making rests on solid research, the clinical guidelines are detailed to a point where the healthcare professionals, figuratively speaking, can tick off a list that will tell them what must happen to the patient in question. This is for instance described by the clinical director and head nurse in Ward H7, which is a highly specialised ward. In this context, risk management practices are related to making sure that the guidelines are updated and followed by frontline workers. The frontline managers uniformly believe that the clinical guidelines, when applicable, support healthcare professionals' decision-making. The greatest risk is in situations where there is a high degree of uncertainty on how to approach a given patient. This could for instance be 'a complex patient who has a hip fracture, is in chemo treatment for cancer, is taking anticoagulant medicine, has bad kidneys, and is going through dialysis. Then the complexity starts to increase, and here, it is key to have your background knowledge' (H-5-N1). The head nurse describes how professional assessments are more challenging when the clinical guidelines are only partly applicable. Conversely, the lowest risk is in situations where every step in the process is described in detail in clinical guidelines and is applicable to most patients.

In the social services, the decision-making programmes are different by nature and can be grouped into two types: the methodological assessment approaches, and the work and procedural descriptions. The former consist of standardised, methodological approaches to the casework and how to approach different elements in this process, developed by The National Board of Social Services. The latter consist of procedural descriptions of different assessments, descriptions of how to conduct different assessment-related tasks, and templates for assessments. These are developed ad hoc by the individual frontline manager to make sure that social workers cover all the bases required in their casework. The purpose of these decision-making programmes is to standardise professional discretion and assessment, and, in this way, ensure accountability to service recipients. The informal, ad hoc decision-making programmes reflect the collective responsibility that characterises the social services.

Related to distribution of responsibility, it is apparent that decision-making programmes serve different purposes. In the healthcare sector, the purpose of the clinical guidelines is to support the decision-making routines of health professionals who are individually responsible for the decisions they make. This is also their purpose in the social services, but because responsibility is shared collectively, they also serve the purpose of standardising decision-making and limiting professional discretion among social workers. The

decision-making programmes are particularly applicable in highly specialised units where it is possible to describe a set of responses to different situations that are not too sensitive to the service recipient in question. But it remains clear from the analysis that decision-making programmes cannot anticipate all risky situations or eliminate the need for discretionary decision-making. As one clinical director explained: 'Nothing is black and white. Everything is grey, [...] and we sometimes make decisions on a reasonably well-founded basis, and other times on a flimsy basis' (H-2-CD).

Overall, the comparison shows that there are differences in how frontline managers organise work routines in the healthcare and social services sectors. In the healthcare sector, frontline managers emphasise how they essentially set the scene for individual decision-making when they organise work routines. This is for instance achieved through formalised decision-making programmes, where as managers they are responsible for ensuring that these are in place, but the individual healthcare worker is responsible for how they implement their decision-making and therefore also for the associated consequences. In the social services, frontline managers emphasise how they establish fora for collective decision-making. Further, many describe how they develop and implement their own ad hoc decision-making programmes on top of the limited number of formalised programmes. The latter is a means of controlling the discretion exercised by the social workers. These findings are summarised in Table 6.3.

Table 6.3 Summary Organising Work Routines

	Healthcare	**Social services**
Organise work routines	– Setting the scene for individual decision-making. – Formalised decision-making programmes (dependent on the degree of urgency and level of specialisation).	– Establishing fora for collective assessment. – Formalised and ad-hoc decision-making programmes.

These observations – that healthcare managers focus on setting the scene for individual decision-making while social service frontline managers focus on establishing fora for collective decision-making and creating ad hoc decision-making programmes to tighten the reins on discretionary decision-making – offer mixed, preliminary support for the hypothesis that risk management practices are exercised more when distribution of responsibility is collectivised than when it is individualised. In the healthcare sector, where responsibility is individualised, frontline managers do a lot to organise work routines that support decision-making, for instance through formalised decision-making programmes. This is the case to a lesser extent in the social services, where

instead frontline managers create informal, ad hoc decision-making programmes designed to restrict the discretionary space for social workers. In this way, there is mixed evidence for the hypothesis. Next, we dive into how frontline managers across the two sectors handle risky situations when the decision-making programmes do not apply, and, in March & Simon's terms, there is a need for problem-solving activities.

6.2.2 Discussing Professional Issues

The risk management activity of discussing professional issues covers leadership activities during risky situations. Specifically, it entails interrelated activities where the leader – together with the frontline worker – sheds light on the risky situation they face by unpacking the different prospects at hand: what is the frontline worker's assessment, what alternatives are there, and what are the associated pros and cons of the potential consequences to the service recipient? A key insight from Chapter 5 is that discussing professional issues enables frontline workers to mitigate risks in two ways: the uncertainty of the risky situation is reduced, and the potential negative consequences are mapped, which leads to a more enlightened basis for decision-making. The question is whether there are any differences between how frontline managers go about discussing professional issues dependent on their sectoral affiliation.

The insights are based on the inductively generated codes 'perception of managerial role', 'collective discussion', and 'joint decision-making', which cover statements related to how frontline managers reflect on their roles related to risky situations, statements related to professional discussions that are collectivised, and statements related to decisions being made collectively.

In both the healthcare and social services sectors, frontline managers have a clear idea about what their role is during risky situations where frontline workers need to discuss professional issues. One way of facilitating professional discussions is to establish fora where risky situations are discussed, and frontline managers from both sectors emphasise their role in facilitating and enabling fora for collective decision-making where the frontline workers can discuss professional issues when the decision-making programmes prove insufficient. Whether the frontline managers partake in these fora or not depends on whether they consider themselves to be experts. This is related to managerial perceptions of their roles and expertise, as discussed above. An overall difference is that the frontline managers in the social services, without exception, partake actively in these collective decision-making processes during risky situations, while this is not the case in the healthcare sector. Here, frontline managers facilitate the process of discussing professional issues and primarily engage if they hold a certain expertise. Table 6.4 summarises the

different reflections the frontline managers have on how they partake in and facilitate collective discussions of professional issues and subsequent decision-making during risky situations.

Table 6.4 Collective Decision-Making to Facilitate Discussing Professional Issues

Healthcare	Social services
'We spend a lot of time conferring with each other and conferring "up the system", as we call it. To be sure that there is as much experience and expertise behind the decisions being made as possible. […] So the youngest doctor goes and talks to the second youngest doctor and says "I cannot cope with this", and then you go and talk to someone who is a specialist. And that way you often get things clarified relatively quickly […] And, it is not something [risky situations] an inexperienced doctor has to decide on, so therefore it is good they come and say, "I just came across this, what can we do", and then it may well be that it is so complex, so I do not even make a decision, but I call in my colleagues who do the same as me. And then say, it is a kind of team decision regarding what do we do, what opportunities do we have, are there other things we can do to maybe get closer to the problem or get some more information that can help us in our decision-making?' (H-3-CD)	'They can bring a case to the WHOLE children and youth group for a discussion. This makes really good sense, because it is also feedback and input across the teams. So as I usually put it, it is the social workers' forum to use each other and get their cases unpacked.' (SFC-9-FM3)
'But there may be some cases of doubt where I get involved. Otherwise I think they also involve each other. That is, discussing with each other.' (H-4-CD)	'So when we have been through that part of the discussion, it is a time-consuming discussion, and it is often in these complex cases that we do it, so that the team acts as a reflective team, where the social worker who has the case mostly sit quietly with the lips zipped and listen to what their colleagues think based on what has been presented. And then it goes back again, and then the social worker can say, "Well, I will think about all of this and take it with me in my work." It may well be that you choose not to take anything with you, but then you have chosen on a professional foundation, so you are also aware that you are doing this because such and such.' (SFC-11-FM2)
'If they are in doubt, they confer with colleagues or with medical peers. Sometimes they discuss with me too. I cannot always answer their questions because I do not always know that level of detail so well.' (H-7-N2)	'Another thing I have had great success with is, for example, to unpack the case at a team meeting, where we draw it on the board and say "Here is the service recipient. What kind of challenges are there? What do we see that could be [a challenge]?" So we kind of brain-storm, make a mind map, and that way unfold it and say, "What really belongs here?" And then getting it separated in relation to sector responsibility. We must be careful we are not doing anything that actually falls under the Health Act.' (SS-4-FM1)
'Well, a nurse who is in doubt … Before she even goes to her manager, she will talk to the doctor who is the contact doctor for the patient. Initially she might go to her nursing colleagues, I actually think, and talk to a colleague about it in terms of considering the treatment options.' (H-1-N2)	
'The nurse in question always has the opportunity to discuss a given decision with a colleague or the team she is part of that day … or a doctor. You do not have to stand alone with things, not at all.' (H-2-N1)	

Note. Based on the codes 'joint decision-making' and 'collective discussion'.

A common denominator is that frontline managers from both sectors generally try to facilitate collective decision-making. However, they do this differently. In the social services, these fora are quite formalised, and the frontline

manager participates. This, again, reflects the collectivised distribution of responsibility: the frontline managers are responsible for the decisions made and therefore have an interest in being a part of the decision-making. In the healthcare sector, these fora are only formalised for the daily morning conferences. When new risky situations occur during the course of the day, these collective discussions of professional issues are more ad hoc between healthcare professionals, and the frontline managers are not necessarily a part of them. This reflects that responsibility for the decisions made essentially lies with each healthcare professional, so the frontline managers are not necessarily motivated to partake actively in all decision-making. Further, it is not feasible or efficient to be a part of all decision-making, especially on topics where they do not consider themselves to be experts.

6.2.2.1 Urgent Risky Situations

Some risky situations call for urgent action, while others allow time for assessment. In both the healthcare and social services sectors, the urgency of the risky situation determines how much a professional issue is discussed. A situation with a high degree of urgency could, for instance, include notifications in a child case that are so severe that they may require immediate removal of the child in question. A frontline manager described the process around a case of potential sexual abuse the following way: 'Then a social worker on duty will drive out and have a talk with the child, without the parents' knowledge or consent. Afterwards, depending on what the child says, they will conduct interviews with the parents or contact the police. […] There are many paths one can take, but that is the procedure. […] Overall, one can say that it is a matter for the intake process to uncover, whether this is a case where one can talk about the child needing special support according to Chapter 11 of the Act on Social Services. So it is kind of completely rigid, right? It is not really that hard to assess because we have some very, very strong criteria for when we do one thing or another in these types of cases' (SFC-10-FM1). An interesting insight from this example is that in these urgent situations, there is very little doubt and uncertainty about what to do. They are simply not perceived to be very complex, and therefore it is possible to apply decision-making programmes with strict criteria on what to do when and why.

The same appears to be the case in the healthcare sector, as described by a clinical director: 'The sickest, they are the easiest to deal with. […] If you are feeling very ill and come in, we make a call, and things almost always run on autopilot. It is incredibly rare that it is difficult to deal with. Of course you can say, "Is there a hole here or there?" But we have methods to find out. […] So trauma and what is called acute medical calls and stuff like that, that is not

where we fail to do what is needed. […] This is one of the situations I am most comfortable with; to go in to someone who is brought in unconscious, with an ambulance, because there we use our checklists. We have practiced so many times that we are totally at home. I do not feel any risk there' (H-1-CD). The point here is that the more urgent a risky situation is, the more well-defined work routines there are to handle it. In this way, discussing professional issues is out of the question, because who does what, how, and why are all highly programmed. The frontline manager's role therefore is to ensure that the work routines are sufficiently well organised to handle these urgent risky situations. In both sectors, the potential pitfall thus appears to be whether the frontline workers comply with these decision-making programmes during urgent risky situations, as explained by a clinical director noting that they must stand firmly on these guidelines (H-2-CD).

Overall, the comparison shows that there are substantial differences in how frontline managers go about discussing professional issues during risky situations. In the healthcare sector, the frontline managers emphasise the formal and informal decision-making fora that the frontline workers have. The frontline managers do not necessarily take part in the informal fora, unless they are actively involved by the frontline workers or consider themselves to be experts. This corresponds with the individualised distribution of responsibility in the sense that frontline managers do not engage in decision-making when they do not hold responsibility and therefore will not face potential blame for negative consequences for service recipients. In the social services, the frontline managers have a different approach to discussing professional issues during risky situations. This is a core managerial activity in the sense that it is through these formal, deliberative decision-making procedures that assessments and decisions are made. This corresponds with the collectivised distribution of responsibility in the sense that frontline managers actively partake in the decisions that are made in risky situations that may hold negative consequences for service recipients. These findings support the hypothesis that risk management practices are exercised more when distribution of responsibility is collectivised than when it is individualised. The social service frontline managers simply do more to ensure that the best decisions are made to mitigate potential negative consequences for service recipients, which falls well in line with the fact that they may face the blame for the consequences. These findings are summarised in Table 6.5.

Table 6.5 Summary Discuss Professional Issues

	Healthcare	Social services
Discuss professional issues	– Formal and informal collective decision-making fora. – Frontline managers engage in discussing professional issues if they consider themselves experts.	– Frontline managers engage actively in formalised, collective decision-making.

6.2.3 Facilitating Follow-up Activities

The risk management activity of facilitating follow-up activities covers leadership practices following risky situations. Specifically, it is concerned with how frontline managers handle the outcomes of risky situations and utilise them to improve future decision-making in risky situations. This involves concrete feedback to frontline workers on how they handled a specific risky situation, and activities that utilise risky situations as a point of departure for discussing frontline workers' professional assessments, enabling knowledge sharing, and, if necessary, implementing revised work procedures. A key insight from Chapter 5 is that these practices support frontline workers in retrospectively learning from risky situations, and prospectively becoming better prepared to handle future risky situations. The question is whether frontline managers approach this differently in the healthcare and social services sectors. That is the focus of this section. The insights are based on the codes 'perception of managerial role', 'distribution of responsibility', and 'knowledge sharing'.

The differences in how frontline managers approach facilitating follow-up activities after risky situations are subtle. The main source of difference appears to be how the frontline managers consider their role in facilitating follow-up activities. In the healthcare sector, two overall considerations reappear across the interviews. First, the frontline managers emphasise that part of the reason they facilitate follow-up activities is to protect the healthcare professionals. One head nurse described it the following way: 'We have to make structural changes when we observe that here there is actually a potential risk of making mistakes. Where YOU can be held responsible [...]. Because it is still your responsibility what you do' (H-9-N1). Two interesting things are said here. First, guidelines are revised to protect the healthcare professionals from future risky situations and potential errors. Second, the reason the frontline manager wants to protect the healthcare professional is because they are individually responsible and therefore the ones who will get into trouble if they do not handle a risky situation appropriately. What the frontline manager in question does not mention is that revising the clinical guidelines is also a way

lifting her responsibility and ensuring that there are updated decision-making programmes for the undertaking of work routines.

The notion of getting into trouble as a motivation for follow-up on risky situations is also emphasised by a clinical director. He explained that 'In general, we go to great lengths to follow clinical guidelines, and that means that we unfortunately – and this is the trend we observe in the healthcare sector – more and more carefully follow these guidelines, and we do it simply because when we do not, we know that then you are potentially at risk of getting in trouble' (H-2-CD). This insight is related to the fact that public service delivery organisations are accountable to the multiple stakeholders in their organisational environment who have expectations regarding how they should perform, as described in Chapters 2 and 3. This is a key point related to risk management practices, and something that is explored and discussed in greater detail in Chapter 7, 'Conditioning Factors of Risk Management'.

The managerial responsibility to react to risky situations that are not handled appropriately is emphasised by a ward nurse who explained that 'when we as leaders become aware that something is missing, or there is a breach, then it is our responsibility to create a setup that enables the frontline workers to improve things in practice' (H-8-N3). Overall, the frontline managers in the healthcare sector acknowledge their responsibility while at the same time maintaining that, in the end, the decisions are the responsibility of the individual healthcare professional.

In the social services, the frontline managers emphasise follow-up activities targeted both towards the individual caseworker and towards the municipal state agency as a collective unit. Follow-up activities targeted towards individual social workers only happen when the frontline manager judges that a given social worker should have handled a risky situation differently (SFC-8, SFC-11). The frontline managers emphasise that collective follow-up activities, meanwhile, are a way of ensuring that the knowledge gained from risky situations is disseminated in the organisational unit. One explained the challenge of striking a balance between individual follow-up activities and collective ones: 'I generally think it is a topic where we have not been good enough. At least I am not good enough at it. I think that some initiatives have been made, and I know that processes have been set in motion where cases are selected for annual checks, audits, or reviews, where you talk about "what has happened? What should we do differently? What could we have…?" It is an attempt to draw learning from cases where it has not gone as well as one might wish. But it could also be cases where it went well. […] I think there are a lot of situations where I do not cultivate [this learning] enough. Sometimes I do it with the social worker and ask, "What did you do then in that situation, and how did it go, or how…". But to get it out to the collective is a challenge. It is

sometimes not that effective, I think' (SFC-8-FM5). What is explained here is the challenge of facilitating follow-up activities that lead to learning and potentially improved decision-making. In other municipal state agencies, frontline managers describe how they systematically facilitate collective meetings where risky situations are discussed after they happen. As described in Chapter 5, this both entails specific cases, but also insights that are applicable across cases: 'We follow up on individual cases. But we also have case reviews twice a year, where we review all the cases with the social workers. Here, we also look at patterns where we can see that they never follow up on these cases or there was never an action plan or anything. Then we have a special focus on that' (SFC-11-FM1). Facilitating follow-up activities after risky situations is both an individual affair, but also a collective one where patterns are elucidated and ways of moving forward are discussed. Although the frontline managers find this difficult to facilitate, this risk management dimension points forward to the organising of work routines, as the outcome of follow-up activities is either revised or maintained work routines.

A common denominator across the social services is the role of the National Social Appeals Board that can affirm, alter, reverse, or impose re-assessment of municipal state agencies' decision-making, as described in Chapter 4. The frontline managers uniformly describe how decisions from the Board are a sure trigger of collective follow-up activities, as they have a decisive agenda-setting role in how legislation is interpreted and implemented and thus how discretion is exercised. A frontline manager explains that the only systematic follow-up activity they have is 'if there are decisions from the National Social Appeals Board, whether it is an affirmation or returned decision, the explanation from the Board will be presented to everyone in the team. This is also to make sure that we align our practices based on their decisions' (SS-6-FM2). The National Social Appeals Board is one way in which the frontline managers consider actors in their organisational environment – just like the frontline managers in the healthcare sector are accountable to stakeholders in their environment.

There are not large differences in how frontline managers facilitate follow-up activities in the healthcare and social services sectors. The main source of difference is that follow-up activities are primarily directed at the individual healthcare worker, whereas the frontline managers in the social services emphasise both individual and collective follow-up activities. This is related to an interesting difference in the frontline managers' espoused motives behind their approaches to facilitating follow-up activities. In the healthcare sector, follow-up activities are a way of protecting the healthcare professionals who are individually responsible for their decisions, while the main motive in the social services is to align discretionary behaviour. Both motives are related to

the role of external stakeholders' accountability demands, which is emphasised by the frontline managers. This is discussed further in Chapter 7, 'Conditioning Factors of Risk Management'.

Overall, the comparison shows that there are small yet somewhat significant differences in the approaches to how follow-up activities are facilitated by frontline managers. In the healthcare sector, the frontline managers target their follow-up activities directly at the individual healthcare professional and only engage the collective group of frontline workers when there is a specific learning potential for all. In the social services, the frontline managers also target follow-up activities towards the individual, but they primarily emphasise the need for collective follow-up activities. The purpose of these is to learn from risky situations and, again, to streamline discretionary decision-making. This approach reflects the deliberative nature of decision-making in the social services.

Frontline managers from both sectors have considerations related to their organisations' external stakeholders. To appear accountable, they must reflect a willingness to follow up on risky situations and learn from the situations where service recipients experienced negative consequences. Frontline managers in the social services do a little more to follow up on risky situations, because they more often involve the whole group of frontline workers, and not just the individual who was involved in a given situation. In this way, there is support for the hypothesis that risk management practices are exercised more when distribution of responsibility is collectivised than when it is individualised. These findings are summarised in Table 6.6.

Table 6.6 Summary Facilitating Follow-up Activities

	Healthcare	**Social services**
Facilitating follow-up activities	– Activities targeted towards the individual healthcare professional. – Considerations of external stakeholders.	– Activities targeted towards individuals, but primarily towards the collective unit with the purpose of streamlining discretion. – Considerations of external stakeholders.

6.3 Discussion of Implications

Taken together, the findings support the hypothesis that risk management practices are exercised more when responsibility is collectivised than when it is individualised. Frontline managers in the social services exercise more risk management than their healthcare sector counterparts in the sense that they go to great lengths to ensure the best possible decision-making in risky situations. They develop and implement ad hoc decision-making programmes

prior to risky situations, they partake in collective decision-making during risky situations, and they facilitate collective follow-up activities following risky situations. All these measures are taken to restrict and streamline social workers' discretionary behaviour and decision-making autonomy, because the individual social worker, formally speaking, cannot be held responsible for the decisions they make. The frontline managers in the healthcare sector do not apply these measures (or do not apply them to the same extent), because they focus on setting the scene for healthcare professionals' individual decision-making. They do, however, emphasise their responsibility to ensure that the individual healthcare professional operates under well-organised conditions that support their decision-making behaviour in routine and risky situations. These findings are summarised in Table 6.7.

Table 6.7 Summary of Findings

	Healthcare	**Social services**
Distribution of responsibility	Individualised, with collective elements	Collectivised, with individual elements
Organising work routines	– Setting the scene for individual decision-making. – Formalised decision-making programmes (dependent on the degree of urgency and level of specialisation)	– Establishing fora for collective assessment. – Formalised and ad-hoc decision-making programmes.
Discussing professional issues	– Formal and informal collective decision-making fora. – Frontline managers engage in discussing professional issues if they consider themselves experts.	– Frontline managers engage actively in formalised, collective decision-making.
Facilitating follow-up activities	– Activities targeted towards the individual healthcare professional. – Considerations of external stakeholders.	– Activities targeted towards individuals, but primarily towards the collective unit with the purpose of streamlining discretion. – Considerations of external stakeholders.

The insights call for discussion of the underlying mechanisms and implications. This section focusses on risk management and degree of urgency, risk management and level of specialisation, and risk management and frontline workers' decision-making autonomy, as these are all themes that arose, and were briefly touched upon, in the investigation of the hypothesis.

6.3.1 Degree of Urgency

The findings indicate that the degree of urgency in risky situations is decisive of what risk management activities are needed. Organisations that face risky situations with a high degree of urgency have highly organised work routines with fixed structures around decision-making. This is because there is little time for professional discussion when risks are urgent. In these situations, the frontline workers are required to act, and this is made possible by well-organised work routines and clear decision-making programmes, as explained by a frontline manager in relation to a specific acute situation they often face: 'Here, it is not possible to discuss matters for long. But we have guidelines, and we know what we do, and we do not discuss it' (H-7-N1). This shows that when the degree of urgency is high, healthcare units must rely on sufficiently well-organised work routines and decision-making programmes, because there is little time to discuss professional issues. This is also evident in the social services, where frontline managers explained that there are very clear procedures for how to handle urgent situations where a service recipient, for instance a child, may be harmed.

When the degree of urgency is low, frontline managers emphasise other means of handling risky situations. Specifically, they emphasise the utility of frontline workers discussing professional issues with each other, as this is a way of reaching a higher, common ground for decision-making by reducing the question of uncertainty and shedding light on the potential consequences to service recipients. As described previously, these deliberative routines are an integrated part of decision-making in the social services, while they happen on a more ad hoc basis in the healthcare sector, despite the formalised morning conferences. Further, the role of the frontline managers also differs. In the social services, the frontline managers actively take part in these discussions, while this is not necessarily the case in the healthcare sector unless the frontline manager considers themselves to be an expert on the subject. This indirectly reflects both sectors' distributions of responsibility, in the sense that the collectivised responsibility in the social services induces managers to be a part of the joint decision-making process. This is the rational thing to do, as in the end they hold responsibility for the decisions made by social workers who are not individually responsible for their decision-making. The frontline managers in the healthcare sector, on the other hand, facilitate discussion of risky situations among frontline workers, but do not take part in the decision-making process. For them, this is the rational thing to do, as it is the individual frontline worker who holds responsibility for their own decision-making, while the frontline manager is responsible for ensuring the best possible decision-making structures around the frontline workers. A way of managing risky

situations is thus also to make sure that the frontline workers face the best possible conditions.

Overall, risky situations with a high degree of urgency call for well-organised work routines and decision-making programmes, while situations with a low degree of urgency also call for well-organised work routines as well as good structures for collective deliberation and joint decision-making. This is closely related to the question of specialisation, as the urgent risky situations require highly specialised guidelines in order to be handled effectively and safely.

6.3.2 Level of Specialisation and Decision-Making Autonomy

A key insight in this chapter is that frontline managers strive towards having decision-making programmes that are as detailed as possible. These reduce uncertainty in risky situations and further align the discretionary behaviour of frontline workers. However, much of the decision-making in risky situations cannot be formalised in decision-making programmes because there is insufficient evidence of what works, or because the evidence is compromised by contextual factors. For instance, much medical research, which the clinical guidelines are based on, is conducted among specific groups of patients, which at times makes the inference to other groups – for instance young women – difficult. Further, lifestyle factors (like smoker/non-smoker, obesity, and mental health), medical case history, or comorbidities may make it difficult to apply the guidelines to specific patients, as complexity increases the more the patient diverts from the clinical trial group. In this way, the applicability of clinical guidelines as decision-making programmes can be quite limited and difficult to leverage in risky situations. The same is the case in the social services, where there may be evidence-based practices behind some of the decision-making programmes, but at the same time challenges surrounding how to implement these in the specific contexts of service recipients (Strandby et al. 2017).

Under context-sensitive circumstances, the utility of decision-making programmes may thus be limited as they are designed to be applicable to general cases where there is sufficient information and little uncertainty. When this is the case, the frontline managers emphasise the importance of collective discussion and joint decision-making to reduce the uncertainty of the risky situation and shed light on the potential consequences to service recipients. The primary purpose of these decision-making programmes is to streamline the use of discretion and thus reduce the element of arbitrariness in decision-making by frontline workers. Given this, the question is whether it is unconditionally desirable to streamline discretion, or whether it would in fact be a

good idea to provide frontline workers with more professional discretion in the hopes it will improve the quality of decision-making in public service delivery. This is a particularly relevant discussion in the social services, where the discretion of social workers is restricted.

A key insight from the social services is that frontline managers in many cases restrict social workers' decision-making autonomy. The reasoning behind this is a perceived need to align the discretionary decision-making of social workers and ensure that decisions are not based on their gut feelings. However, one frontline manager stood out with a different attitude towards the role of social workers, their discretion, and decision-making autonomy. This frontline manager argued that limited decision-making autonomy is a barrier to improving social workers' discretionary decision-making. Because social workers do not have any formal responsibility, they have little incentive to take on and balance the three considerations of legality, professional standards, and financial matters, discussed in the beginning of this chapter, in their decision-making processes. According to the frontline manager, this is the reason that various documentation requirements and decision-making programmes are imposed on them by political principals and frontline managers who in this way try to avoid blame (SFC-12-FM1). The next chapter turns to the role of political principals and other actors surrounding public service delivery organisations that may condition the risk management practices of frontline managers.

6.4 Conclusion

The purpose of this chapter was to investigate the hypothesis that risk management practices are exercised more when the distribution of responsibility is collectivised than when it is individualised. Overall, the findings support the hypothesis. Frontline managers in the social services exercise more risk management than their healthcare sector counterparts. They particularly stand out in relation to the organising of work routines, where they establish fora for collective assessments and decision-making, as opposed to frontline managers in the healthcare sector who primarily set the scene for individual decision-making. In both sectors, formalised decision-making programmes make up part of the organising of work routines, but in the social services, many frontline managers add their own ad hoc decision-making programmes to restrict the discretion of social workers.

The social service frontline managers further stand out in relation to the second risk management dimension of discussing professional issues. Here, they actively take part in formalised, collective decision-making, which is in contrast to the frontline managers in the healthcare sector who only take part

if they consider themselves to be professional experts on the risky situation that is being discussed. The differences related to the third risk management dimension of facilitating follow-up activities are more subtle, as it is a question of whom these activities are targeted towards. The social service frontline managers primarily target the collective unit with the purpose of streamlining discretion, while the healthcare frontline managers target the individual health professional.

Key reasons behind these differences in degree are related to how the frontline managers perceive their roles and the question of responsibility in decision-making. The frontline managers are aware of how responsibility is distributed and the potential implications for them and their frontline workers. The frontline managers in the healthcare sector are very articulate on how responsibility is distributed, exemplified by statements like 'there is no doubt that I hold a lot of responsibility, but that does not exempt the doctor in question' (H-2-CD), and 'it is important that we hold on to the individual responsibility, but it is a collective task at the unit' (H-9-N1). This is important as it shows that risk management is not exercised in a vacuum decoupled from organisational context, and it falls well in line with the insight that healthcare frontline managers do not abdicate all responsibility. They acknowledge that they hold responsibility for ensuring that work routines are properly organised to enable the best possible grounds for decision-making in risky situations. The implications of these findings were discussed in relation to degree of urgency of risky situations, level of specialisation, and decision-making autonomy.

Chapter 7. Conditioning Factors of Risk Management

The purpose of this chapter is to investigate different external factors that condition public service delivery and explore how they enable and constrain risk management practices. This is important because risk management is not exercised in a vacuum decoupled from political and organisational context. Chapter 5 showed that frontline managers have different risk management profiles, and that these are dependent on the frontline manager's risk perception and willingness to take risks, while Chapter 6 showed that although risk management practices are exercised more when responsibility is collectivised than individualised, this is also related to degree of urgency and level of specialisation. A common denominator for these insights is that, apart from degree of urgency, they concern internal factors that are somewhat subject to the frontline manager's control.

However, in the interviews, many frontline managers emphasised that they do not exercise risk management decoupled from the organisational environment they are part of. In particular, they find themselves facing externally imposed cross-pressures between several interests that at times are conflicting: 'As managers, we are exposed to this cross-pressure of sitting between politicians and an executive board that have some expectations at a general level. The politicians, naturally, want their electorate to have the best, and, at the same time, they want us to save money. We have to navigate in this cross-pressure all the time. But this also means that we have to be on top of our social workers. […] You know, say that they may be doing the right thing in relation to the service recipient, but if they do not get their documentation sorted and register the activities correctly in the system, then I cannot extract the management information that enables me to show the politicians that we are compliant with the law. Then I can only say, "I think we are"' (SS-3-FM1). This interview excerpt illustrates that frontline managers not only have to consider the service recipients in public service delivery, but also how to balance the interests of external actors in the organisational environment. The organisational environment include stakeholders external to the public service delivery organisations, like political principals, interest groups, and the media, which all have stakes in public service delivery, as well as formal contextual conditions made up of legislation and local service standards that outline what public services are to be delivered.

The factors that are analysed and discussed in this chapter further originate from the inductive second-cycle coding of data, which was described in detail in Chapter 4. In this way, the insights reflect the contextual factors of political and organisational environment described in Chapters 2 and 3, while the concrete content of these abstract concepts of political and organisational environment are empirically driven from the inductive coding, because they have not been heavily theorised in this body of work. While the factors do not necessarily directly matter to concrete risk management practices, they condition the behaviour of frontline managers and frontline workers, which may indirectly enable and constrain risk management practices and decision-making behaviour.

Chapter 4 emphasised that the design choices were made to accommodate the overall purpose of this monograph, namely to investigate the question of how risk management is exercised, and to formally test the hypothesis that risk management is exercised more when the distribution of responsibility is collectivised than when the distribution of responsibility is individualised. Therefore, the design resembles a cross-case most similar systems design and a within-case most different systems design, in the sense that the healthcare sector is compared to the social services sector (most similar with distribution of responsibility as main source of variation), but the selection of unit cases is diverse within the two sectors (most different in the sense that they face different kinds of risky situations). Given the semi-structured nature of the interviews, the organisational environment and contextual conditions were discussed in most of the interviews with frontline managers. From this follows that the data material holds insights that are relevant to varying extents to investigating organisational environment. Therefore, this chapter does not present a formal test or investigation of how contextual factors condition risk management practices, but rather an explorative, inductive analysis that explores the ways these contextual conditions external to frontline managers condition their risk management practices, and what is at play when frontline managers talk about organisational environment in relation to risk management and how risky situations are handled.

The chapter is structured to facilitate exploration of how frontline managers take their organisational environment into account, and how it may enable or constrain their risk management practices at the frontlines of public service delivery. The insights are based on the second-cycle inductive coding of the interview data with 62 frontline managers from the healthcare and social services sectors, and cover codes like ‘managerial condition’, ‘leading upwards’, ‘leading outwards’, ‘financial considerations’, ‘formal conditions’, and ‘frontline manager competence requirements’. The conditioning factors of organi-

sational environment are relevant regardless of type of public service delivered, and the insights are presented in a way that sheds light on what is at play to the frontline managers and how they navigate in this.

7.1 Organisational Environment

Chapters 2 and 3 addressed the contextual conditions in which risk management is exercised. The frontline managers all share one condition: 'We have a lot of principals. In other words, a lot of people think they should have an opinion on how to run a ward like ours' (H-7-N3). The principals the ward nurse refers to include politicians, managers higher up in the hierarchy, and external stakeholders like the media and interest groups. These principals may have conflicting interests, which exposes the frontline managers and employees to cross-pressures between what is politically prioritised and what service recipients expect. Frontline managers must balance these demands and conflicting interests and ultimately ensure that the legislation is administered correctly.

The frontline managers uniformly acknowledged that actors in their organisational environment condition their room for manoeuvre. This is both in general and specifically in relation to risky situations, as explained by a clinical director: 'Well, politicians have.... It only takes a few cases, because then there may be a thread to pull at or something to profile themselves on, so they definitely have opinions about it. To a large extent. We are a window display' (H-1-CD). A negative outcome for a service recipient can lead to dire consequences for politicians and the organisation's reputation if picked up by the media and/or powerful stakeholders. This requires that frontline managers be able to account for the decisions that are made in public service delivery: 'I constantly have to explain, "why my dad was hospitalised yesterday, and he was in a ward for seven hours and only one person checked on him twice". Then I have to try to explain, "well, that was because your dad was stable and all of that", right? When things are in full swing, they go to the media and say, "It was such a mess at the ward I was in. How can that be?" And then I have to defend myself to the media. It requires that I have eyes like a prey on the savanna, because there is a large horizon to keep an eye on, at all times, in terms of what might be coming' (H-1-CD). This frontline manager does not emphasise the potential negative outcome for the patient but focuses on the concern of having to defend his priorities and decision-making, which forces him to constantly keep his eyes on what external actors on the horizon may throw at him. On the horizon are politicians, the formal contextual conditions public services are delivered in, and external actors like regulatory government agencies, interest groups, and the media. The following sections investigate the role

of these actors and how they condition risk management in public service delivery.

7.2 The Role of Political Principals

Public service delivery is a question of political prioritisation. In a Danish context, politicians are distinguished at two levels: the national level and the local/regional level, as described in Chapter 4. At the national level, one role of politicians is to signal their visions. This was for instance the case when the Prime Minister stated in her 2020 New Year's address – somewhat controversially – that more children should be removed from dysfunctional families, or when she stated in March 2020 that each COVID-19 death was a tragedy and thus set the bar for the Danish COVID-19 response. A key role of politicians is to convert these visions into policies and legislation. The politicians in parliament negotiate and pass legislation that sets the scene for public service delivery, including how much money is spent on healthcare, education, and social services annually and the allocation of rights to service recipients, such as for instance a 30-day diagnosing guarantee (Health Act, 2021) or the right to a carer's allowance if you provide care for a terminally ill next of kin (Act on Social Services, 2021). The legislation on the one hand poses constraints on public service delivery, while on the other hand it leaves significant discretion to implementers at the frontlines. A frontline manager from the social services explains the schism related to risk management: 'the legislation restricts the space for action that we are required to fill. But you know, we are in this position because there is a legislation that we have to administer. And then it is interesting to see, well, how much can we spread our wings within these constraints' (SFC-11-FM2). In both sectors, the frontline managers are generally fully aware that they are operating within a political context and a politically given mandate that defines what their core tasks are, while leaving space for the public service organisations to decide how to implement the policies and legislation locally. In this way, the legislation makes up the contextual frame in which risk management is exercised by constraining the opportunity space in public service delivery.

The actual policy implementation is where local politicians come into play. They play a significant role as they decide how the budget is prioritised locally and are directly accountable to the local electorate. For the social services, this happens at the municipal level, where the politicians set the so-called local service standards: what can you expect as a service recipient in this municipality within the frames of the legislation? In the healthcare sector this happens at the regional level, where politicians allocate resources between hospitals. However, the role of politicians and the accountability mechanisms are

essentially the same, as they set the direction for public service delivery by prioritising resources locally. This way of organising public service delivery, where legislation and financial priorities confine the space for public service delivery while leaving room for considerable discretion, places frontline managers between politicians and service recipients: 'We are in the tension field between patients and the political system, [and] and that is the challenge' (H-8-N2). On the one hand, public service delivery organisations must deliver politically prioritised services, but this happens in a setting of limited resources, which requires prioritisation between service recipients. These conditions put frontline managers in a difficult position between multiple interests and agendas, which, in risky situations, is further complicated by risk-averse politicians who seek to avoid blame when service recipients experience negative outcomes.

The risk-aversion of politicians is felt by the frontline managers in risky situations. They describe a delicate balance in which local politicians set the direction for public service delivery by prioritising resources, but may interfere with professional and administrative decisions at the frontlines in risky situations that could have negative consequences for service recipients. Especially in the social services, the notion of 'mayor calls' is widespread. These are cases where the mayor overrules an administrative decision, typically following pressure from external actors like the media, interest groups, or the service recipient in question. There is nothing keeping the mayor from doing this as the agency's decision-making competence is formally delegated to them by the mayor's administration, but it signals that access to politicians may reverse administrative decisions that service recipients are unhappy with, and it may also create precedents for future similar decisions. In the healthcare sector, the politicians cannot interfere with decision-making in the same way, but they have other means of keeping an eye on what goes on at the frontlines, for instance by setting targets related to patient satisfaction, share of readmissions, or average length of hospitalisation.

The inductive coding of the interview data points to three overall ways in which frontline managers handle local politicians in relation to risky situations: they exert counterpressure, they cooperate, and they shirk or feign to accommodate political demands. The common denominator for these three strategies, which are analysed in the following paragraphs, is that they involve leading upwards in the organisation, as accounted for in Chapter 2.

The most common way to handle political interference with decision-making in relation to risky situations is to cooperate with the politicians and enable them to understand the grounds for decision-making. This happens both in cases where the frontline managers may expect political attention but also in

cases where the politicians are already involved. When frontline managers expect that a risky situation may lead to political attention, they make sure to inform the politicians about what is happening: 'So we involve both politicians and executives when it is necessary. And this is very much related to the unrest it causes in the system, because these service recipients are not afraid to contact the politicians. And the politicians have to know what is coming, where we are, who they have to refer the service recipients to, and what is being done in these cases' (SFC-11-FM1). Another frontline manager describes that it is key to inform politicians about how the legislation poses constraints on what the municipal state agency can do to help service recipients in risky situations: 'we may encounter politicians who wonder why we do not grant psychological help or something else. But when we explain to them what we can do within the constraints of the law, they say "I see. What a shame that we cannot do anything, but I understand. But that is not an option then"' (SS-2-FM1). In this way, frontline managers involve politicians in their grounds for decision-making in an attempt to avoid interference in risky situations. However, not all conflict is diverted by frontline managers keeping their political principals in the know.

When decision-making in risky situations does not pan out to the service recipient's advantage, frontline managers may face politicians who promise change to accommodate the service recipient's discontent. A frontline manager from the social services described how in these situations he tries to exert counter-pressure by showing politicians what the implications of their intervention are: '"We can do what you ask me to do. But given that we stand on a legal basis, and that everyone in principle are entitled to these benefits, you have to know that if you say "yes" to this one person, we have to say "yes" to the other 200 too." It has a certain pedagogical effect to say "we can do that, but we need you to raise the budget. Or we have to do something else, or save money somewhere else"' (SS-5-FM1). By illustrating what the financial consequences are of accommodating all service recipients facing similar risky situations, the frontline managers try to keep the politicians at bay. In this way, they signal to politicians that it is costly to fend off every potential conflict related to consequences of risky situations.

Frontline managers generally prefer that politicians do not interfere with how decisions are made. A head nurse explains that 'We insist that politicians do not meddle in work processes. We are happy to discuss how you run a hospital in general terms. When politicians and administrators in the region interfere in individual cases, we try to keep them at bay, because that is not their job' (H-7-N1). One way of keeping politicians at bay is to accommodate their requirements by shirking or feigning: 'As a management team, we have to prioritise "where is our focus right now" and then find the easiest way of giving

the executives the numbers they want and get past that quickly. But what is really important to us at this moment may be how to improve our service delivery and performance. Maybe this implies that we do not focus on our goals related to average waiting-times, because that is not where our focus is. But we can at least satisfy some politicians or the executive administrators by saying "yes, we are working on it" and then it is ticked off the list. Sometimes, it is about seeing how you can satisfy them with minimal effort' (H-1-N1). In this way, one strategy in relation to a lack of political arm's length in risky situations is simply to do one thing that a politician requests, but maintain focus on what the frontline manager judges to be the best priority given the challenges faced. This is closely related to Brunsson's idea of the organisation of hypocrisy, which describes how organisations gain legitimacy by appearing to do what their organisational environment expect of them, while internally doing what is best for them (Brunsson 2002).

To summarise, frontline managers in both the healthcare and social services sectors are well aware that they operate in politically controlled organisations. At times, this poses the challenge of balancing between responsiveness to the preoccupations of politicians and the peace to work and deliver the public services that they are charged with. Frontline managers handle this cross-pressure in three overall ways: they exert counterpressure upward in the organisation, they cooperate and explain to politicians how matters stand, and they shirk or feign to be able to focus on what they find most important. These insights spur reflection on how political principals and their role in public service delivery matter to the risk management practices of frontline managers, and it would be interesting for future studies to systematically incorporate the role of political principals in studies of risk management.

7.3 Formal Contextual Conditions

A downstream consequence of the role of political actors is the formal contextual conditions that frontline managers must navigate in. These are made up of national legislation and governance structures, and the local quality standards and service levels that are politicians' way of setting a direction for public service delivery by defining its scope and boundaries. These boundaries are instrumental in relation to risky situations where frontline workers sometimes face the dilemma of wanting to do more than they are formally obliged to in order to prevent a service recipient from experiencing negative consequences. A frontline manager explains how she handles these dilemmas with frontline workers: 'We are civil servants who work within a scope that is set by politicians. [...] I think it is important to articulate that and say "well, we are civil

servants who administer the legislation." In this way, it does not become personal. You do not feel that guilt, or, "did I do well enough?", or "would they have received help if I as social worker had examined the case more carefully?" "No, you examined it just fine. But you are a civil servant and there is a political system that has decided that she is not entitled to it [specific helping measure]"' (SS-2-FM2). By emphasising that they deliver politically prioritised services, the frontline manager makes it clear to employees that the services they provide are constrained by political priorities. In this way, the restricted room to manoeuvre is utilised by the frontline manager to remind frontline workers that they cannot always do everything in their power to help service recipients, and that if they have, for example, followed the relevant legislative articles and illuminated cases sufficiently to provide the best platform for decision-making, they have done their job. This way of referring to how political priorities limit their room for manoeuvre in risky situations has implications for risk management practices in two ways. First, it is an effective way of shutting down discussions of 'more' that some frontline managers have with their frontline workers. Second, it is a way of supporting frontline workers' acceptance of the fact that they are not supposed to do everything in their power to mitigate all potential negative consequences to service recipients. This may give frontline workers a stronger sense of psychological safety and less perceived uncertainty in risky situations, which is discussed in Chapter 8 'Implications of Risk Management in Public Service Delivery'.

In both the healthcare and social services sectors, there are formal systems that impose requirements on what activities frontline workers must report in order to assess their performance. These are referred to as performance management systems (Moynihan 2008). There are multiple purposes of these systems, but one is that they inform the political principals how different organisational units are performing on specific parameters. In this way, they are a means of ensuring accountability in politically controlled public service delivery organisations (Moynihan 2008). There are, for instance, elaborate systems for documenting decision-making processes, and performance is assessed on indicators like productivity and staying within budget, and often coupled with incentives. These performance management systems have the potential to work as a risk management tool in the sense that their documentation requirements provide frontline managers with insight into frontline workers' decision-making processes. These insights can, in principle, be systematically utilised to follow up on risky situations, learn from risky situations and revise work procedures, and organise work routines. However, the inductive coding of interviews showed that the documentation requirements are perceived more as ineffective rules that enable frontline workers and frontline managers to keep their noses clean and avoid blame in risky situations, and thus more

as red tape than green tape (Dehart-Davis 2008). This is a point that we return to later in this chapter.

Frontline managers emphasise different consequences of these performance management systems and their associated incentives that appear to condition risk management practices and how risky situations are handled in public service delivery. One consequence is that frontline managers and workers must balance between legal requirements, financial considerations, and professional assessments. This refers to the insights from Chapter 6 and the fact that the legislation must be followed in public service delivery, but that frontline workers sometimes face a trade-off between financial and professional considerations. Frontline managers openly acknowledge that they operate within economic constraints that force them to prioritise how resources are allocated to service recipients. This is by no means controversial, and some of the priorities that come with the financial constraints of public service delivery were discussed in Chapter 6 and can be summarised with the point that not all service recipients can have the Mercedes – some will have to make do with the Fiat.

The question is how these priorities are made in risky situations and what – if any – trade-offs frontline managers make in this process. When asked whether financial considerations sometimes outweigh professional ones, a frontline manager replied: 'I am not supposed to say this out loud, but the answer is yes' (SS-6-FM1). The frontline manager explained how politicians sometimes decide that a certain amount of money must be saved, and that it is the responsibility of the frontline manager to find ways of doing this within the boundaries of the legislation. This is echoed by another frontline manager from the social services who explained that 'Our point of departure is, of course, that we make professional decisions and discuss what the best decision is to the service recipient. But obviously, we also consider, well, "what do we get for our money in this case, and what do we get for our money in this case?"' (SS-1-FM1). This frontline manager further reasons that this is loyal to the decision-making principle of making the least intrusive intervention in service recipients' lives, which was discussed in Chapter 5. However, it is relevant to keep in mind that this decision-making principle is quite convenient when there are financial constraints, as the least intrusive option is often also the cheapest.

The hospital wards also face these trade-offs between financial considerations and professional assessments. A clinical director explains that 'the quality-improving work that develops us may crash with what we call "production". Or, it does. That is self-evident' (H-7-CD). In relation to risky situations, a head nurse states that financial management is a question of 'how much do we dare, knowing it has diverted consequences for patient safety' (H-5-N1).

This priority particularly inhibits the third dimension of risk management, facilitating follow-up activities, as this developmental, quality-improving work is deemphasised over productivity demands. These insights further underline that frontline managers have considerations other than mitigating negative consequences to service recipients in risky situations, as they are also assessed on other performance measures. In this way, risk management becomes a question of priority, which was also discussed in Chapter 5. Chapter 8, 'Implications of Risk Management in Public Service Delivery', addresses the trade-offs in risk management in greater detail.

Another consequence of formal performance management systems is that they potentially limit frontline workers' space for thinking creatively as professionals. A frontline manager explains that 'I think all these deadlines, case numbers, case reviews, and managerial systems have put a brake on the professional creativity and competence in the professional assessment' (SFC-12-FM1). This frontline manager more than hints that poorer decision-making is an adverse outcome of the management systems that pose specific documentation requirements on frontline workers. This is a challenge to handling risky situations and imposes requirements on frontline managers to support frontline workers' ability to make professional assessments. However, as underlined in Chapter 6, many frontline managers consider the guidelines and performance management systems to be a valuable resource when organising work routines, and a useful way of constraining the discretion and aligning the decision-making behaviour of frontline workers.

To summarise, frontline managers and workers in the healthcare and social services sectors operate within formal systems that constrain their practices. These formal contextual conditions are instrumental in setting the boundaries for how frontline workers prioritise in public service delivery, and the management systems impose demands on how decision-making at the frontlines is documented. Further, frontline managers and frontline workers have to balance between legal requirements, financial considerations, and professional assessments, which sometimes involves a trade-off to the advantage of the financial considerations. In one way, these formal systems enable better handling of risky situations, because they support the organisation of work routines by imposing requirements on how to document practices. On the other hand, they also limit the discretion of frontline workers, which may lead to poorer decision-making and have detrimental effects on frontline workers' self-determination (Ryan and Deci 2000; Deci and Ryan 2012; Deci, Olafsen, and Ryan 2017). The latter observation points to future studies focused on formally investigating whether and how formal contextual conditions matter to frontline workers' decision-making capability in risky situations and their experiences of autonomy, competence, and relatedness, which

are core elements in self-determination theory. Chapter 8 'Risk Management in Public Service Delivery' addresses the question of self-determination theory in greater detail.

7.4 External Stakeholders

External stakeholders are the last element of the organisational environment that frontline managers have emphasised condition how risk management is exercised. Based on the inductive coding of interviews, three groups of stakeholders appear to be particularly salient in relation to risk management and handling of risky situations: regulatory government agencies, interest groups, and the media.

7.4.1 Regulatory Government Agencies

Different government agencies keep an eye on the services that public organisations deliver. The role of these was described in greater detail in the case descriptions in Chapter 4. For the purpose of this section, it is sufficient to recall that the roles of the regulatory government agencies are a bit different: in the healthcare sector, the Danish Health Authority and the Danish Patient Safety Authority exercise regulatory control and oversight and develop guidelines, while in the social services, the National Social Appeals Board and The National Board of Social Services also exercise regulatory control and oversight and develops guidelines, but also provides decision-making support to the municipal state agencies. Even though all frontline managers must respond to these regulatory government agencies as part of their job, these differences are likely the reason that the frontline managers in the healthcare sector did not dwell much on the role of these regulatory agencies in interviews – they primarily deal with them *post hoc* in risky situations. This is opposed to social service frontline managers who, by contrast, had quite strong opinions on the role of these regulatory government agencies.

The interviews showed that some frontline managers find the agencies supportive as a means of learning and quality improvement, while others struggle to see how they improve public service delivery in substantive terms. The former is articulated by a frontline manager from the social services who describes the National Social Appeals Board as 'a fantastic place that gives us a very good direction. […] It is great to receive something in return where you think "God, yes, here is something we must be aware of"' (SS-1-FM2). The National Social Appeals Board supports casework and decision-making in risky situations by providing direction on how to interpret and apply complex legislation. A few frontline managers highlighted that among social workers there

is a tendency to perceive the National Social Appeals Board as an opponent they are competing against: 'a strange attitude has formed where you have failed if you lose a case in the National Social Appeals Board. I do not think so at all. [...] It might as well be learning. When the Board rules against us in these cases, and a social workers says "I lost", I tell them "well, there are no winners or losers in a case like this. It is not a trial"' (SS-2-FM2). Some frontline managers thus have the task of explaining to the social workers what the role of the National Social Appeals Board is, and how it is a partner that can help them in complex casework and risky situations. These insights further illustrate how the National Social Appeals Board can be a strategic partner in all aspects of risk management, as they can provide decision-making support during risky situations, feedback on assessment and decision-making following risky situations, and input on how best to organise work routines prior to risky situations.

The notion of the National Social Appeals Board as a partner and decision-making supporter is contrasted by the attitude among other frontline managers that it is not particularly helpful. Here, quite a few are somewhat critical of the role of the Board and the relationship they have with them. One frontline manager explains that: 'the quality of that cooperation varies, dependent on who you get a hold of. [...] If we call to get advice and counselling in a case that is more complex than our usual cases, I think it now and then is a little... Sometimes, we are a long way from getting a clear idea of what the solution is. And maybe, again, that is because these are complex cases. In reality, they have to use their discretion too' (SFC-10-FM2). What is revealed here is a frustration that the experts from the National Social Appeals Board do not necessarily provide clear guidance on the risky situations faced by the municipal state agencies. Still, this frontline manager appreciates that this is likely due to the sheer complexity of the cases. Another frontline manager emphasises the somewhat rigid ways of the Board and how it creates more work for the municipal state agency: 'The National Social Appeals Board requires an incredible level of detail in our case work. We have to document everything. And we may think that we have documented our work sufficiently in one way, but they want us to do it in another way' (SS-3-FM1). The documentation requirements can thus be a source of frustration for some frontline managers because they are perceived as double work and as a clash between their world of real-life risky situations and the theoretical, legal world of the National Social Appeals Board (SS-3-FM3).

The frontline managers in both the healthcare and social services sectors point to the (sometimes excessive) documentation of decision-making procedures as a consequence of the oversight from the regulatory government agencies. In terms of decision-making in risky situations, the documentation is key,

because it reflects the decision-making process and how different information factored into a decision: 'When we make decisions, we have to justify them. But this is even more important in risky situations where the outcome can go both ways. Here, we have to show "what considerations have we made?" [...] As a general rule, we have to assess the cases in a way where we can prove that we have done what we were supposed to do. Not just according to the legislation, but also the professional assessments, for instance. Sometimes we are in a situation where we can see that, "well, yes, looking back, we should have walked right, but we went left. That was a choice we made and we did it on these grounds. Once we had walked a kilometre down that road, we got new information or saw something different and then we decided to change course. And that is how it is." You know, we have to stand by our decision' (SFC-9-FM2). What is emphasised here is that documentation is an integrated part of professional practice when you make a decision on a service recipient's behalf. However, there is also a heavy emphasis on the documentation serving as protection in cases where risky situations have negative consequences for service recipients. A clinical director referred to the latter as 'defensive leadership. Every time you make a decision, you have to defend it' (H-8-CD). This strategy of using documentation to avoid blame in case of negative consequences for the service recipient was emphasised by several frontline managers (e.g., H-2-CD, SS-2-FM1, H-1-CD), although 'keeping your nose clean does not cure the patient', as one clinical director remarked (H-1-CD).

To summarise, the frontline managers have mixed feelings about the regulatory government agencies. Some find them to be supportive when they are facing risky situations, while others find them to be a bit burdensome. A common denominator across the healthcare sector and social services is that oversight from the agencies leads to perceived excessive documentation as a way of avoiding blame. The role of documentation is closely related to the role of interest groups and the media, which are the focus of the next two subsections. Future studies could profitably investigate whether and how these blame-avoidance strategies matter to the risk management practices of frontline managers.

7.4.2 Interest Groups

Interest groups seek influence over policy agendas and policy outputs on behalf of the actors they represent (Binderkrantz, Christiansen, and Pedersen 2015). The groups of interest here are the ones that represent the service recipients. This could for instance be different patient associations, like the Dan-

ish Heart Association, or, in the social services, the Disabled People's Organisations or an association that represents children's interests like Save the Children.

Much in line with the perceptions of regulatory government agencies, the frontline managers expressed mixed attitudes on the role of interest groups and whether they strengthen decision-making in risky situations or contribute to the cross-pressures that frontline managers experience. A frontline manager from the social services explains how she spends a lot of time on external actors like interest groups: 'A big part of my job, and of the managing director's job, is also to listen to "what are they saying? What is at stake here?" and help them to understand what we can do and what we cannot do. How the legislation constrains us' (SS-2-FM1). This approach indirectly reflects a strategic consideration of attempting to keep interest groups in check. By explaining what the municipal state agency can do within the boundaries of the legislation and the politically determined local service levels, the frontline manager is leading outwards to stakeholders in risky situations. This way of pointing to the legislative constraints resembles the policy blame avoidance strategy, mentioned in Chapter 3, in the sense that the existing policy and associated legislation is used to fend off potential criticism and blame from external actors. Further, engaging in dialogue with actors that may be critical of the municipal state agency's decision-making is also a way of nurturing the organisation's reputation.

Interest groups add to the cross-pressures that frontline managers must navigate by engaging actively in the decision-making processes. A frontline manager explains how interest groups indirectly force the municipal state agency to be on their marks in the decision-making process: 'It is wonderful that somebody asks questions here and there and actually takes part in qualifying decisions. And sometimes, when they are a little annoying, it is because they point to something that we already know we have to do differently. And, really, that is OK. It is a double-edged sword. […] We really have to watch our steps and not overcompensate someone, because we are afraid of ending up on the front page or afraid to make decisions that are in fact lawful. […] We also have a professional assessment' (SS-4-FM1). Interest groups thus both positively contribute to the decision-making process and pose challenges internally in terms of balancing interests and not being led by the fear of strong stakeholders that are unhappy with an administrative professional decision. This is particularly relevant to risk management, as negative consequences will most likely trigger reactions from the interest groups. By exerting decision-making oversight, and the threat of potential reactions, these interest groups (in)directly exert pressure in risky situations. In a sense, they act as police patrols (McCubbins and Schwartz 1984). Therefore, an important task

for frontline managers is to keep these interest groups in check, so they do not have to spend excessive amounts of time dealing with defending decision-making and the outcomes of risky situations.

This notion of a double-edged sword is further related to the consequences of interest groups' involvement and the pressure they exercise. One consequence is increased documentation, which occurs in both the healthcare and social services sectors. The other is the need for legal counselling, which is primarily the case in the social services. The frontline managers in the healthcare sector did not spend a lot of time in interviews discussing the role of interest groups. Yet they have a clear idea of what the implications of these stakeholders' involvement are, which is evidence that they do consider their role one way or the other, and that interest groups and the pressure they exert also hold consequences in the healthcare sector. The frontline managers primarily emphasised the role of documentation as a means of avoiding blame, which was also emphasised as a consequence of the oversight from regulatory government agencies.

In the social services, the frontline managers were concrete about the consequences of interest group involvement in relation to risky situations. One frontline manager described an 'annoying tendency that resource-wise, you have to send two people to meetings that are, in principle, quite uncomplicated except for the occasionally very aggressive manner we meet' (SS-1-FM2). Another frontline manager described that the focus on decision-making from both interest groups and the National Social Appeals Board 'means that we need a legal expert involved at all times to ensure that we have responded correctly. That cannot be right. I have documented decisions in writing for 40 years, and, I mean, it cannot be true that I now need a legal expert to do it every time. I just do not think that is OK' (SS-3-FM3). The common denominator in these interview excerpts is that the frontline managers experience they must prioritise resources in a way that is not meaningful to them in order to avoid blame and fend off negative reactions to outcomes of risky situations – before they even know what the outcomes will be. Related to the role of interest groups is a concern among frontline managers that disagreement may lead to, or spark, media interest and potentially spiral out of control.

To summarise, the role of interest groups in risky situations is a double-edged sword, according to the frontline managers. On the one hand, the frontline managers perceive them as able to constructively contribute to decision-making, while on the other hand, they exert considerable amounts of pressure on public service delivery organisations. Some frontline managers engage with interest groups as a way of reducing this pressure and avoid blame, but most emphasise that the primary consequence of interest groups' role is increased documentation of the decision-making process. These insights raise questions

of whether influential interest groups take precedence over less resourceful actors in risky situations because they are better able to mobilise pressure, as has been documented in other public bureaucracies (Binderkrantz, Christiansen, and Pedersen 2015; Reenock and Gerber 2007).

7.4.3 Media

The media is the third external stakeholder that frontline managers emphasised as important in interviews. Recurring media attention has been given to the quality of decision-making in the healthcare and social services sectors following negative outcomes of risky situations. A head nurse referred to the highly profiled 2018 'Svendborg case' where the Danish Patient Safety Authority took a doctor to court for negligence following the death of a patient that most likely could have been avoided. This was a case that received extensive media coverage, and although the doctor was acquitted of all charges in the High Court, the head nurse recalled the consequences of the case: 'It has changed a lot. I mean, the fear of what will happen to you when you make mistakes. […] We all safeguard ourselves a little bit and […] the documentation increased substantially, because you needed to account for all steps of the decision. We are judged on our results, but you also have to be able to account for the steps leading there' (H-9-N1). Two things are worth noting. One is that the high-profile case led to an experience of more careful documentation practices by healthcare professionals in risky situations as a means to avoid blame in case something were to happen to any of their patients. The second is the point about patient outcome versus process. Here, the frontline manager seems to be of the conviction that documentation of the process primarily matters when things do not go as expected with a patient. The head nurse mentions the fear of consequences from making mistakes as an important factor in the increased documentation.

The potential threat of being put on the spot in the media feeds the fear of mistakes in the social services too. Frontline managers describe how service recipients use the media as a threat when they are not happy with the casework or decision-making process, which puts social workers under great pressure to perform perfectly (SFC-9-FM2, SS-1-FM3). This pressure is intensified when the service recipients take matters into their own hands and use social media, like Facebook, to share their experiences with the service delivery. The rules of the game are different on social media, and it is not unusual that criticism of frontline workers involves mentioning their names and specific workplaces. This poses a challenge to frontline managers, who struggle to protect their employees in situations with risks to service recipients, as they cannot engage in these very context-specific discussions in a public forum. Further,

social media sometimes serves as an outlet for frustrations and emotions on the service recipients' part, which the frontline managers explain comes at the cost of acknowledging the actual professional assessment. A frontline manager referred to an episode where a service recipient who complained about her treatment at a hospital ward on Facebook clearly had misunderstood that her relatively harmless diagnosis did not require a resource-demanding MRI scan: 'here, we have to stand on our professionalism and keep out of it. Even though it is hard, because they attack the professionalism in an arena where I cannot respond, and that is difficult' (H-9-N1). To leave allegations like these undisputed is a source of frustration to the frontline managers because it hits their own professional pride, but also the organisation's reputation. The latter is the reason that some frontline managers engage in dialogue with unhappy service recipients and media outlets and explain what they can do within the boundaries of the legislation and the locally set service levels, and why the outcome of the risky situation was what it was (SS-5-FM1).

To summarise, the frontline managers experience that they must pay attention to and be aware of the potential media interest that comes with delivering salient public services. High-profile media cases and the threat of service recipients taking to social media with their dissatisfaction again leads to a focus on making sure that all steps in the decision-making process are thoroughly documented in case someone takes an interest in it. Some frontline managers emphasise that this in part is driven by frontline workers' fear of being put on display. Moving forward, it would be interesting to investigate whether and how frontline managers alter their risk management practices dependent on how much media attention they experience.

7.5 Concluding Discussion

The purpose of this chapter was to investigate different external factors that condition public service delivery and explore how they enable and constrain risk management practices. In this way, it has taken a different point of departure from the leader-centric Chapters 5 and 6 by focusing on the organisational environment that frontline managers cannot directly exert influence on. The risk management practices of frontline managers are enabled and constrained in different ways by political principals, formal contextual conditions, and external stakeholders like regulatory government agencies, interest groups, and the media. Table 7.1 provides an overview of the different actors in the organisational environment, how they condition risk management practices in public service delivery, and what the implications are.

Table 7.1 Organisational Environment, Conditioning Factors, and Implications

	Conditioning factors	Implications
Politicians	– Legislation and scope conditions for public service delivery – Overall priorities and local service levels/quality standards	– Responsiveness to political demands at the expense of core focus on the task at hand.
Formal contextual conditions	– Documentation requirements – Regulatory requirements	– Restricted room for professional discretion – Trade-off between financial considerations and professional assessment
External stakeholders	– Regulatory requirements – Cross-pressure	– Documentation

The analysis and discussion throughout this chapter has shown that there are different ways in which these conditions matter to risk management practices. First, the political principals and the formal contextual conditions constrain the scope of what public service organisations are expected to do to mitigate negative consequences to service recipients in risky situations. However, these constraints also turn out to be an enabling factor, as the frontline managers refer to priorities made by external actors in order to avoid blame over negative outcomes and to explain to frontline workers that there are limits to what they are supposed to do to mitigate negative consequences to service recipients in risky situations.

Second, the frontline managers uniformly emphasised that (sometimes excessive) documentation is a consequence of the focus from external actors on their decision-making in risky situations. There are mixed perceptions regarding whether these documentation requirements are a type of green tape or red tape: some frontline managers emphasised that documenting decision-making procedures is not necessarily a bad thing, as it is a way of avoiding blame following negative outcomes of risky situations. On the other hand, some frontline managers consider the documentation requirements to be a suboptimal consequence of the pressure exerted by risk-averse actors – from politicians to interest groups to the media. This poses questions and challenges regarding how best to strike a balance between accountability and responsiveness, effective service delivery, and accepting that some service recipients will experience negative consequences as an outcome of their encounter with public service delivery organisations. These somewhat normative questions are discussed in the following chapter, which also discusses how frontline managers can support the motivation and self-determination of frontline workers facing risky situations, and finally, risk management as a leadership concept.

Chapter 8. Implications of Risk Management in Public Service Delivery

The purpose of this chapter is to discuss the implications of the findings presented in Chapters 5-7 of this monograph, and the findings from the three articles that together make up this dissertation. The qualitative analysis in this monograph has illustrated how different risk management practices are exercised in public service delivery (Chapter 5) and showed that risk management is exercised more when distribution of responsibility is collectivised than when it is individualised (Chapter 6). Furthermore, risk management is conditioned by the organisational environment in the shape of political principals, formal regulation, and external stakeholders like regulatory government agencies, interest groups, and media (Chapter 7). A key insight is that risk management is resource-demanding and therefore subject to prioritisation. Frontline managers make these prioritisations based on their risk perceptions, the degree of urgency of the risky situation, and their willingness to accept or avoid risks. Article A shows that organisational culture can be a driver of risk-seeking and risk-reducing behaviours among frontline workers, while Article B empirically validates a scale designed to measure risk management practices. Article C studies how a managerial focus on risk affects the risk perception of frontline workers and finds that it significantly reduces the risk perception of junior hospital doctors, nursing students, and social work students, and that the effect diminishes as level of professionalisation increases. These insights raise different normative and theoretical questions.

Overall, three questions are discussed. First is the question of trade-offs in risk management: does risk management come at the cost of organisational effectiveness, given the fact it is a resource-demanding leadership behaviour? Second is the question of how risk management matters to frontline workers; specifically, the questions of employee motivation and psychological safety that were already touched upon in Chapters 5 and 6. Third is the question of the risk management concept and its relation to other leadership concepts. These questions receive priority because they address – in different ways – theoretical, empirical, and normative issues related to risk management in public service delivery. The chapter is structured around these three questions.

8.1 Is Risk Management at Odds with Organisational Effectiveness?

Every action that frontline managers take reflects a prioritisation. This is not a novel insight, but it is relevant to the question of trade-offs in risk management. Risk management is a leadership behaviour directed towards the decision-making of frontline workers before, during, and after risky situations. The findings in this monograph show that the risk management practices of organising work routines, discussing professional issues, and facilitating follow-up activities can, by different means, reduce uncertainty in risky situations and shed light on the potential negative consequences for service recipients. Article C studies how a managerial focus on risk in the shape of discussing professional issues matters to frontline workers' risk perception and finds that shedding light on the risky situation and discussing the prospects and pros and cons associated with alternative options reduces risk perception among frontline workers.

However, the findings in Chapters 5, 6 and 7 also show that risk management is a resource-demanding leadership behaviour. Risk management requires active prioritisation on behalf of frontline managers because it comes at the cost of other leadership and frontline worker activities. For instance, discussing professional issues during risky situations takes time away from other activities, and follow-up activities constitute a waste of time if they do not result in learning from risky situations and improved future decision-making. The question, then, is whether risk management practices are at odds with organisational effectiveness. Organisational effectiveness refers to the achievement of formal goals related to quantity and quality of output, for instance the number of patients diagnosed and treated, the average case assessment time from enquiry to decision, or the outcome for service recipients (Jacobsen et al. 2021; Boyne 2003).

There are two poles in the literature related to the question of organisational effectiveness which are relevant when discussing the trade-off between risk management practices and organisational effectiveness. At one end is the argument that all slack and procedures that do not add value should be minimised in organisations. This is represented, for instance, by Taylorism and the LEAN literature (Rahbek Gjerdrum Pedersen and Huniche 2011; Melander and Adamsen 2009; Taylor 1916). At the other end is the argument that excess slack, or redundancy, is a key element of reliable and accountable organisations. This is represented, for example, in the literature on organisational resilience and external shocks (Landau 1969; O'Toole and Meier 2010; Duit 2016; Cyert and March 1963). Taken to the extreme, the former approach may imply risk management practices where frontline managers react just in time

to enable frontline workers to mitigate potential negative consequences for service recipients. While this is effective in terms of resources, it will likely also increase the number of service recipients who experience negative consequences from risky situations, because the prospective elements of risk management are reduced to an absolute minimum. Taken to its extreme, meanwhile, the latter approach may imply risk management practices where frontline managers prioritise all available resources to enable frontline workers to mitigate potential negative consequences for service recipients. While this will likely lead to few service recipients experiencing negative consequences of risky situations, it is also resource-intensive, meaning that something else will not be attended to or that resources cannot be utilised elsewhere. These two poles illustrate extreme situations that probably occur only rarely, but they prove the point that there is no constant ideal balance regarding how much risk management to exercise: it is context-dependent. The essence, however, is that risk management is problematic when it is excessive. Sometimes, the right thing to do may be to run a small risk in favour of getting things done.

Risk management is, in a sense, an investment with unknown returns. Even when work routines are well organised, professional issues are discussed, and follow-up activities are performed, service recipients still experience negative outcomes from risky situations. Mitigating risks completely is practically infeasible. For these reasons, there is an inherent trade-off in risk management between reducing uncertainty and shedding light on potential consequences on the one hand and organisational effectiveness on the other. Does this imply that we should discard risk management in order to not compromise organisational effectiveness? The answer to this question is in the eye of the beholder, as it depends on how one weighs the consideration of reducing risk against the consideration of organisational effectiveness. However, given the salience of public service delivery and the risk-averse nature of key actors, it seems fair to assume it unlikely that giving up on mitigating risks to service recipients would be well received. Organisational effectiveness is not the sole consideration in public service delivery, where political actors are accountable to service recipients and the electorate, as discussed in Chapters 2, 3 and 7. The question is thus one of how to strike a balance between reducing uncertainty and obtaining clarity over potential consequences in risky situations without unduly compromising organisational effectiveness.

This requires a political discussion of trade-offs and how much risk to service recipients we are ready to accept. For instance, the question of when to induce labour for women constitutes a trade-off between reducing the risk of babies dying and the increased pressure it will put on maternity wards if they have to start inducing labour earlier than the current standard. Similarly, in

cases of suspected child neglect, there is a trade-off between how much evidence is needed to implement precautionary measures and the increased pressure this would put on the systems vis-a-vis accepting that less-than-ideal decisions will sometimes be made. These examples highlight that discussing the trade-off between mitigating risks to service recipients and effectiveness can be a very sensitive topic, given the normative aspect of the level of severity in consequences to service recipients we are willing to accept. These normative questions do not have straightforward answers, but it is important to keep in mind that assessments and priorities in relation to reducing risks and ensuring effectiveness are made in other aspects of public service delivery.

8.1.1 What Severity of Outcomes to Service Recipients Can We Accept?

Three different cases illustrate trade-offs related to the severity of consequences we can accept at the cost of other considerations in public service delivery where there are risks to service recipients: traffic design, medicine approval, and COVID-19.

Traffic design is an area of public service delivery where there are trade-offs between time and risk of accidents. This is for instance the case when deciding whether to install roundabouts or traffic lights to regulate traffic in intersections: roundabouts reduce the risk of collision compared to traffic lights, because drivers are forced to slow down and orientate themselves. Speed limits are another example that represent a compromise between the value of people's time and the risk of accidents. Injuries following collisions would be minor if we were driving very slowly on all roads, but this would come at the cost of lost time and thus be ineffective. These examples illustrate that making a trade-off between effectiveness (here, time) and risk is common and that societies are accustomed to accepting that some people will be injured or die on the roads for the benefit of getting many people from A to B quickly, with all the associated effectiveness gains that holds.

In welfare states that provide universal healthcare, commissioning new medicine holds a trade-off between cost to society and gain to the individual patient. For instance, is it money well spent to prolong the life of a terminally ill cancer patient by two years using very specialised and expensive medication? Or is it money well spent to provide medication that slows down the progression of a rare disease that will eventually make the patient blind? Essentially, these are questions of whether the cost measures up to the benefit. In many countries, including in Scandinavia, these decisions are delegated by politicians to independent medicines councils that, based on pre-defined principles and tools such as the quality-adjusted life year model (QALY), make

cost-benefit analyses and recommend whether a new medicine should be commissioned or not. Indirectly, these councils weigh big ethical questions of how to assess quality of life or what value x number of years of life hold. Their existence illustrates that trade-offs related to medicine, and ultimately questions of quality of life, are formalised, which reflects a political decision that spending on medicine must be prioritised according to its effect. Further, the existence of independent medicines councils is an excellent example of how politicians can avoid blame over sensitive issues by delegating decision-making competence to councils who are at arm's length. In this way, when the medicines councils reject a medicine, for instance to treat muscular dystrophy, it can be presented as the product of a societal contract reflecting that we cannot cure all diseases without considering the cost, and not as the political priority that it essentially is.

The COVID-19 pandemic is a third example of how trade-offs are made related to the severity of consequences that we can accept. When the pandemic hit in early 2020, governments around the world faced the question of whether and how to impose lockdowns to contain the spread of coronavirus. These decisions held many inherent trade-offs related to public health and the potential negative consequences of a lockdown, such as increased unemployment, mental health burdens, and compromised freedom rights. Essentially, the question was how much people's freedom can be compromised to save other people from dying of COVID-19, and what the long-term consequences would be related to trust in government. As of November 2021, almost two years into the pandemic, it is clear that politicians have targeted these questions and trade-offs differently: some chose a laissez-faire strategy, others imposed strict lockdowns, and others chose a pragmatic middle-of-the-road-position. Further, the reactions from respective populations have demonstrated how people have different perceptions about what measures should be taken in the name of the pandemic, showing the complexity of the trade-offs.

These examples illustrate that while setting up the trade-offs is quite simple and essentially reflects cost/benefit analyses, the actual compromises are rife with dilemmas to which there are no easy fixes. Actors have different risk preferences and perceptions, which was accounted for in Chapter 2 and illustrated empirically in Chapter 5. For instance, in some countries 2.5 COVID-19 deaths per 100,000 would be a great success, while in other places it would be considered unacceptable and evidence of a welfare state that has failed to protect its citizens.

The same mechanisms are likely at work in public service delivery. To some, removing a child from their family on insufficient grounds is unacceptable because it compromises the legal rights of the parents, while others are

more willing to accept it because it is testament that someone reacted to warning signs and acted to help the child in question. For this reason, it is difficult to imagine arriving at a consistent equilibrium between considerations of reducing uncertainty and obtaining clarity over potential consequences, and maintaining organisational effectiveness in risky situations, because actors have different risk perceptions and risk profiles. The different risk perceptions are the exact reason there is a need to discuss the trade-offs between reducing risks and maintaining organisational effectiveness, as these discussions have implications for risk management practices and their assessment.

8.1.2 The Role of Politicians in Trade-offs

If obtaining a balanced trade-off between reducing risks and maintaining organisational effectiveness is deemed infeasible, then where does that leave us? The argument proposed here is that these trade-offs should, at a minimum, be discussed up front – at all levels of public service delivery, from politicians to managers to frontline workers. The findings in Chapters 5 and 6 show that frontline managers are well aware that mitigating risks to service recipients comes with the cost of lost effectiveness. Chapter 7 shows that frontline managers experience that actors in their organisational environment, including political principals, regulatory government agencies, interest groups, and the media, exert pressure on them in a quest to avoid negative consequences for service recipients, and that producing excessive amounts of documentation is a way of avoiding blame when negative consequences occur. In other words, frontline managers acknowledge that negative consequences are inevitable when handling risky situations, but they experience a mismatch between this reality and the high expectations of service recipients and stakeholders and the politicians who tend to set the bar accordingly to win or maintain popularity.

The question is, what does it take to have these discussions in relation to public service delivery? How do we reach a state where it is not deemed too delicate and sensitive to stand up and say, 'Yes, despite the systems we put in place, some patients will experience negative consequences from going to hospital and occasionally someone will die on our watch', or 'In cases of suspected child neglect, we make discretionary assessments where we at times have limited information to make a fully informed, timely decision within the constraints of the law. Therefore, it will sometimes happen that children are removed from their families on insufficient grounds, and that other children who should be removed from their families are not. However, we do our best to avoid this by having clear routines and decision-making structures'? Facing the nature of risky situations is a first step to accepting that risks to service

recipients are a basic condition of public service delivery and, further, to aligning service recipients' and external stakeholders' expectations with what is realistic in risky situations.

It requires political courage and leadership to pose and discuss questions like: How far are we willing to go to reduce the occurrence of risky situations? What severity of negative consequences from frontline decision-making can we accept? How do we make these assessments? These are normative questions that have no simple answers. However, they deserve to be discussed. Not with the aim of providing definite answers, but to recognise the fact that the trade-offs exist, to discuss what their implications are, and to determine how they should be approached. Part of this political leadership also entails that politicians stand their ground, trust the systems that are in place to handle risks, and do not change policies every time the media picks up on a service recipient who has experienced a negative outcome. In other words, it is vital that (political) principals are willing to accept risks, which was also emphasised by the Danish Leadership Commission in 2018 (Ledelseskommissionen 2018).

A potential consequence of a greater risk acceptance at the political level is that it may trickle down in the public organisations that face situations where there are risks to service recipients. More realistic expectations on both the politicians' and service recipients' part may give the frontline managers of public service delivery organisations more space to work and determine professional priorities, and thus fewer reasons to engage in blame-avoiding behaviour like excessive documentation of decision-making processes. Further, openness about trade-offs and what is at stake in risky situations is normatively desirable from a democratic perspective, given that transparency is a virtue and a means of ensuring accountability in government, governance, and public organisations (Meijer 2014; Ferry and Eckersley 2015).

8.2 Risk Management and Frontline Workers

Aside from the question of trade-offs between reducing risks and maintaining organisational effectiveness, risk management also has implications for the frontline workers who face the risky situations. The purpose of risk management is to enable frontline workers to mitigate negative consequences for service recipients in risky situations. The findings in Chapter 5 show that frontline managers have different risk management profiles in the sense that they exercise risk management to different degrees, dependent on the situation at hand, their risk perception, and their willingness to accept risks. Article A finds that organisational culture matters to the behaviour of frontline workers

in risky situations, as it can promote both risk-seeking and risk-reducing behaviours. Taken together, these findings raise questions of whether and how risk management matters to frontline workers. Article C targets this question and shows that a managerial focus on risk significantly reduces the risk perception of junior hospital doctors, nursing students, and social work students, and that the effect diminishes as level of professionalisation increases. This part of the discussion dives further into the question of the potential implications of risk management on frontline workers' sense of psychological safety and their self-determination and motivation.

8.2.1 Psychological Safety

In Chapter 5, it was highlighted that some frontline managers believe their risk management practices promote a sense of psychological safety among frontline workers facing risky situations. Psychological safety is defined as 'the general belief that one is comfortable being oneself—being open, authentic, and direct—in a particular setting or role' (Nembhard and Edmondson 2012: 2), and denotes a feeling of being safe to express concerns and suggestions regarding something in the workplace. Psychological safety is desirable because it has positive consequences for behaviour among frontline workers, organisational performance, and other outcomes like learning, creativity, innovation, work engagement, and commitment (Grailey et al. 2021; Newman, Donohue, and Eva 2017; Nembhard and Edmondson 2006). The findings in Article A on organisational culture and behaviour in risky situations are aligned with the insights from psychological safety theory: when frontline workers are in an organisational culture of trust and open dialogue, which arguably reflects a psychologically safe environment, they are more open to engaging with colleagues and asking for second opinions in risky situations, whereas in organisational cultures characterised by lower levels of trust and little dialogue about decision-making, frontline workers are reluctant to ask for second opinions and to follow up on risky situations. In this way, organisational culture can be a driver of either risk-reducing or risk-seeking behaviour among frontline professionals (Tangsgaard 2021). The question is how the different risk management dimensions may promote a greater sense of psychological safety among frontline workers who face risky situations.

8.2.1.1 Mechanisms that May Promote Psychological Safety

The first dimension of risk management, organising work routines, covers leadership activities before risky situations. Their purpose is to make the organisational unit fit to meet its challenges and to prepare frontline workers to handle the risky situations they will inevitably face. The specific practices of

composing groups of employees to reflect different levels of competence and experience, the coordination of employees, and prioritising fixed structures may promote a sense of psychological safety among frontline workers by providing and ensuring supportive decision-making structures. Familiarity with the work routines in both routine and risky situations may promote a sense of comfort as the role of the individual frontline worker and how they contribute are clearly defined.

The second dimension of risk management, discussing professional issues, covers leadership activities during risky situations. Its purpose is to shed light on the risky situation at hand by unpacking its different prospects together with the frontline worker facing the situation. The specific practices of discussing the frontline worker's assessment of the risky situation and the pros and cons of different alternatives may promote a sense of psychological safety among frontline workers by reducing the uncertainty of the risky situation as well as enabling an overview of the situation's potential consequences. The fact that the different prospects are discussed with the frontline manager may further add to the sense of psychological safety, as more eyes on the risky situation reduces potential assessment errors.

The third dimension of risk management, facilitating follow-up activities, covers leadership activities after risky situations. Their purpose is to deal with the outcome of risky situations, to derive learning, and to improve future decision-making in risky situations. The specific practices of providing feedback and utilising examples to share knowledge and potentially revise work procedures may promote a sense of psychological safety among frontline workers by providing clear structures for learning and quality improvement. Knowing that these structures are in place may promote a sense of comfort during the actual decision-making process in risky situations as there is a kind of assurance that the consequences – positive as well as negative – will be addressed in a different setting focused on learning and quality improvement.

To summarise, risk management may promote a sense of psychological safety among frontline workers facing risky situations. Psychological safety among frontline workers likely supports the purpose of risk management, to enable frontline workers to mitigate negative consequences for service recipients, by providing a safe space for decision-making and for processing doubts and uncertainties in relation to decision-making. Research that formally investigates these notions is needed.

There is little doubt that psychological safety among frontline workers has many advantages, including when it comes to decision-making in risky situations. However, it is worth pondering whether psychological safety among frontline workers is unconditionally desirable in relation to risky situations.

The devil's advocate may argue that a sense of risk in risky situations is instrumental, insofar as it keeps frontline workers on their toes out of sheer blame avoidance and fear of making mistakes. This issue is also raised in Article C, based on the finding that a relatively conservative vignette with a managerial focus on risk significantly reduced the risk perceptions of junior hospital doctors, nursing students, and social work students. On the other hand, the findings in Article A on organisational culture show that frontline workers in organisational cultures with little trust and professional discussion are more likely to engage in risk-seeking behaviours that increase the likelihood of unintended negative consequences. For this reason, it is hard to justify a leadership practice that does not promote risk-reducing behaviour, as it would be indicative of poor accountability.

8.2.2 Self-Determination and Motivational Crowding

Self-determination theory argues that employees have three basic psychological needs that must be satisfied to promote and support their autonomous motivation and performance: autonomy, competence, and relatedness (Deci, Olafsen, and Ryan 2017). The satisfaction of these needs is considered to be 'strongly influenced by managerial styles' (ibid.: 23) and is also directly related to employee motivation, which is a predicter of performance. A study by Battaglio, Belle, and Cantarelli (2021) provides causal evidence that meeting the three basic needs increases employee satisfaction. The question is how risk management practices potentially support or thwart basic needs satisfaction and, subsequently, the motivation of the frontline workers who are subjected to these practices.

8.2.2.1 Autonomy

The basic psychological need of autonomy refers to the experience that behaviour is self-determined, in the sense that one makes one's own choices and does not have them imposed by others (Ryan and Deci 2000). Autonomy ranges on a continuum of degrees from high to low (Deci, Olafsen, and Ryan 2017). Risk management practices can arguably both support and thwart this need. The organising of work routines, and particularly practices related to ensuring fixed structures and coordinating employees, hold an inherent element of constraining the autonomy and discretion of frontline workers in order to align their decision-making, as discussed in Chapter 6. Some frontline workers may experience these risk management practices as something that constrains their autonomy, while others may be quite content with highly organised work routines. This is likely related to whether the frontline workers

are authorised professionals or not. With authorisation comes decision-making autonomy, and for this reason authorised frontline workers are likely to experience risk management practices as more constraining than unauthorised frontline workers. Further, level of professionalisation may also be decisive to whether risk management practices are perceived as thwarting or supporting autonomy. Highly professionalised frontline workers are accustomed to high levels of decision-making autonomy, and therefore likely to experience risk management as something that impedes their autonomy. Frontline workers with lower levels of professionalisation may not experience this at all, as they do not have the same level of decision-making autonomy. On the other hand, the risk management practice of facilitating follow-up activities engages individual frontline workers in establishing the course of events following risky situations and learning from them, which may support their sense of autonomy by activating their competencies.

8.2.2.2 Competence

The basic psychological need of competence refers to the experience of self-efficacy in decision-making, and the need to develop and sustain skills that support a sense of efficacy (Ryan and Deci 2000). Risk management practices are in place to improve the grounds for decision-making, but they can arguably both support and thwart the need for competence. Organising work routines to some extent constrains frontline workers' discretionary space by providing guidelines and decision-making structures, which may come at the cost of their sense of competence. In contrast, facilitating follow-up activities may support frontline workers' sense of competence, as they are engaged in actively taking part in learning and knowledge-sharing after risky situations. The risk management practice of discussing professional issues during risky situations may give frontline workers a greater sense of competence as they are actively involved in decision-making. On the other hand, some frontline workers may perceive this risk management practice as a signal that they are not competent enough to make decisions themselves in risky situations. Likewise, highly organised work routines may be perceived by some as supportive of their sense of competence, while others may interpret fixed structures and coordination efforts as signs that they are not sufficiently competent. These points are likely associated with authorisation and level of professionalisation in that highly professionalised and authorised frontline workers may be less tolerant of having their sense of competency compromised.

8.2.2.3 Relatedness

The basic psychological need of relatedness refers to a sense of belonging and connectedness to the unit where you conduct your work (Ryan and Deci 2000). Here again, risk management practices can arguably both support and thwart this need. Highly organised work routines may have an alienating impact as they provide guidelines and fixed ways of doing things that are essentially designed to limit the need for conferring with colleagues in routine situations. In this way, frontline workers may experience a lower degree of relatedness because many routine decisions can be made independently. However, the other risk management practices of discussing professional issues and facilitating follow-up activities may create a greater sense of relatedness as these require frontline workers to interact with their manager and colleagues as a means to improve decision-making in risky situations.

Overall, risk management practices are likely to both support and thwart the basic needs satisfaction of frontline workers. This is arguably dependent on how the individual frontline worker experiences the risk management practices, whether they are authorised or not, their level of professionalisation, and what it takes to satisfy their basic needs of autonomy, competence, and relatedness. Regardless, the expected association between risk management practices and basic needs satisfaction has implications for the motivation of frontline workers. Too many factors that thwart self-determination potentially lead to a crowding-out effect on frontline worker motivation, while supporting factors potentially lead to crowding-in effects (Frey and Jegen 2001; Jacobsen, Hvitved, and Andersen 2014). In this way, risk management is a question of balance.

The balancing act required in risk management practices related to basic needs satisfaction and motivational crowding is therefore another trade-off related to risk management. However, it is important to keep the purpose of risk management in mind: namely, to enable frontline workers to mitigate negative consequences for service recipients in risky situations. Perhaps it is acceptable to compromise basic needs satisfaction in some cases if it prevents service recipients from experiencing negative consequences? This is related to the fact that risk management is essentially concerned with outcomes for service recipients, which is one way in which the concept is different from other leadership behaviours.

8.3 Risk Management as a Leadership Concept

According to Montgomery Van Wart, a problem in the leadership literature is 'the Balkanization of the field with innumerable aspects of leadership' (Van Wart 2013: 537). His point is that the different leadership concepts that have

emerged in the past 20-odd years can be hard to keep track of and distinguish from one another, which results in a fragmented field with nomenclature at a 'sophisticated level' (p. 538). The risk management concept is sensitive to this critique, given its relative novelty in the public leadership literature (Bullock, Greer, and O'Toole 2019; Tangsgaard [In press]). Therefore, this last section of the discussion reflects on what kind of leadership concept risk management is, how it relates to other leadership concepts, and what it adds to the public administration and public leadership fields. To structure this reflection, the distinction between leadership concepts proposed by Vogel and Masal (2015) serves as the point of departure.

Based on their review of the public leadership literature, they distinguish four clusters of public leadership approaches: functionalist, reformist, behavioural, and biographical. Overall, the approaches are distinguished based on how they differ on 1) level of analysis (micro vs. macro continuum) and 2) scientific theoretical approach (objectivist vs. subjectivist continuum) (Vogel and Masal 2015). Risk management does not fall neatly into one of the four clusters. There is little controversy on the level of analysis. In this dissertation, risk management is conceptualised as a micro-level leadership behaviour, because it is concerned with the interaction between the individual frontline manager and frontline worker. This leaves the functional and reformist clusters out of the question. However, matters are less obvious when considering whether risk management reflects an objectivist (behavioural approach) or subjectivist (biographical approach) philosophy of science.

The behavioural approach (micro-level and objectivist) covers literature that examines the complex and turbulent organisational environment public leaders face, and how they cope with and adapt to these (Vogel and Masal 2015). Goal-oriented leadership behaviours like transformational leadership and transactional leadership are dominant in this cluster. The biographical approach (micro-level and subjectivist) covers literature that examines the normative foundations of public leadership, and how public leaders cope with environmental complexity and the contradicting demands that follow from this complexity (Vogel and Masal 2015). This cluster holds leadership behaviours like ethical leadership and studies of how public leaders commit to core values of public services like accountability. There is thus a thematic common denominator of adaption to environmental complexity at the micro-level between these two clusters, which primarily differ in their philosophy of science, as reflected in the continuum.

It is not clear-cut where risk management falls on the objective-subjective continuum. This was touched upon in Chapter 2 in relation to the contested nature of the risk concept. There, it was argued that risk, ontologically, can be

seen as a state of the world (realist) or as a state of the world as we see it (relativist), and that, epistemologically, risk can be considered to be something to which you can attach probabilistic estimates (objectivist) or to be something that is subject to individual conception and far too subjective to be measured (subjectivist). A key argument throughout this dissertation is that risk is in the eye of the beholder, and therefore not objective. This was also demonstrated in Chapters 5 and 6, which show how risk perception matters to risk management behaviour. Based on this, risk management can be argued to fall into the biographical approach cluster on the continua, which covers the micro-level of analysis and the subjectivist philosophy of science, because what is considered a risky situation is something of a moving target.

On the other hand, risk management also reflect elements from the behavioural cluster, which covers the micro-level of analysis and objectivist philosophy of science, because risk management is not exercised in a vacuum. It is a leadership behaviour that has implications for the organisational environment and therefore requires frontline managers to actively cope with and adapt to these conditions, which was investigated in Chapter 7. In this way, risk management also has clear ties to the behavioural approach cluster. The risk management concept thus reflects elements from both the biographical and behavioural clusters, which underlines the point made by Vogel and Masal that the distinction between objectivist and subjectivist philosophy of science is not dichotomous but should be thought of as a continuum.

The question of clusters and leadership approaches has implications for the research questions we study. A biographical conception of risk management implies a research agenda focused on the normative foundations of risk management, and how frontline managers balance considerations of political and administrative responsiveness to ensure accountability. A behavioural conception of risk management implies a research agenda focused on risk management practices as a means of frontline managers to cope with and adapt to environmental changes in order to achieve organisational goals. In this way, it matters when either a 'biographical' or 'behavioural' leadership approach label is put on risk management, because it narrows the scope of the subsequent research questions investigated. This is the reason it is important to remember that the labels are a way of structuring our understanding of leadership approaches and not definitive boxes that determine how we study risk management and its implications.

8.3.1 Risk Management and Other Leadership Concepts

The positioning of the risk management concept in relation to the typology by Vogel and Masal (2015) leads to the question of how risk management is demarcated from other leadership concepts that we find in the behavioural and biographical clusters, such as transformational, transactional, and ethical leadership.

Public service delivery organisations like hospitals and social service agencies have a place in the world because they create value for service recipients; for instance, in diagnosing and providing treatment to patients, or helping vulnerable children and families. The point of departure for this PhD dissertation, however, attests to the fact that value is not always created and that service recipients occasionally experience negative outcomes from their encounters with public service delivery organisations. Here, risk management is defined as a leadership behaviour targeted towards enabling frontline workers to mitigate negative consequences for service recipients. Two specific features of the conceptualisation of risk management make it stand out from other leadership concepts in the behavioural and biographical clusters.

First, risk management has a narrower scope of applicability. Risks to service recipients are a basic condition faced by frontline workers in public service delivery, but not all situations are risky. A distinct feature of risk management is that it is only applicable in situations where there is a high degree of uncertainty and potentially negative consequences for service recipients. The three dimensions of risk management are, individually, well-known leadership practices. However, together, they constitute a leadership behaviour that is uniquely targeted towards enabling frontline workers to mitigate risks to service recipients by organising work routines, discussing professional issues, and facilitating follow-up activities, which reduces uncertainty and increases clarity over potential consequences in risky situations.

In this dissertation, focus has been on risk management as a way of mitigating risks to service recipients, which leads to the second specific feature of the concept. Risk management goes beyond the leader-follower relationship by having an espoused focus on service recipients, who are at the receiving end of decision-making in risky situations. This is different from leadership practices like transformational leadership, transactional leadership, and ethical leadership. The former two are goal-oriented leadership behaviours that seek to activate employee motivation as a means of attaining organisational goals (Jensen et al. 2019; Jensen, Andersen, and Jacobsen 2019), while ethical leadership has the purpose of promoting ethical conduct among employees (Brown and Treviño 2006). These leadership behaviours cover many different types of organisational performance outcomes, such as employee motivation,

value congruence, and outcomes to service recipients (Brown and Treviño 2006; Bellé 2014; Jensen 2018; Bro and Jensen 2020; Jacobsen et al. 2021). Risk management has a different focus and approach to increasing organisational performance, given the explicit purpose of enabling frontline workers to mitigate negative consequences for service recipients. In this way, risk management is narrowly coupled to one performance dimension of creating value for service recipients.

To summarise, risk management is a distinct leadership concept with its focus on risky situations and emphasis on creating value for service recipients. These two features, and the specific leadership behaviours, are what distinguish risk management from other micro-level leadership behaviours. Further, there is a significant contribution in the systematic conceptualisation of an under-theorised leadership concept (Tummers and Knies 2016). The focus on service recipients is a strength of the risk management concept and a way of taking the literature and empirical analyses one step closer to focusing on outcomes in public service delivery and how leadership approaches can support this, and by extension support the accountability of public organisations. Given that risk management is a context-dependent leadership practice, it is important to keep in mind that it is not an alternative to more generic leadership behaviours, such as visionary or transactional leadership. Instead, risk management is a leadership behaviour that frontline managers can exercise in combination with other styles of leadership.

8.4 Conclusion

This chapter set out to discuss the implications of this dissertation's findings. Three overall themes have been touched upon. First is the question of whether risk management is at odds with organisational effectiveness. There is a trade-off between reducing risks and maintaining organisational effectiveness, which calls for a normative discussion of how to make this trade-off in order to have accountable public service delivery organisations. Second is the question of the potential implications of risk management for frontline workers. Risk management may increase frontline workers' sense of psychological safety by reducing their risk perception, which subsequently raises the question of whether it is inherently desirable to reduce risk perception or whether a sense of risk is instrumental to ensuring the best possible decision-making. Further, risk management can either support or thwart the basic needs satisfaction of frontline workers, which implies that risk management requires a balancing act in order not to crowd out motivation. Last is the question of risk management in relation to other leadership concepts. Risk management is a

distinct leadership concept because it is narrowly applicable to certain situations and it has the explicit purpose of creating value for service recipients, which is different from other micro-level leadership concepts.

Chapter 9. Conclusion

The purpose of this PhD dissertation was to position the concept of risk management in the public administration and public management field, and further, to provide empirical evidence of how risk management is exercised and how it affects the frontline workers that face situations where there are risks to service recipients. This has been pursued by answering the research question: *What is risk management, how is risk management exercised, and how does a managerial focus on risk matter to the risk perception of frontline workers?*

The research question has been answered in different ways, utilising different theoretical and methodological approaches: By theoretically conceptualising what risk management is and developing and validating an associated scale, by qualitatively unpacking how risk management is exercised by frontline managers in the healthcare and social services sectors, and by experimentally investigating how a managerial focus on risk matters to the risk perception of frontline workers. In this final, concluding chapter, focus is on the overall findings from the dissertation, their implications and contributions to the theoretical and empirical field, and a discussion of perspectives for future research on risk management that builds on this dissertation.

9.1 Findings

9.1.1 What is Risk Management?

Risk management is defined as the leadership behaviour targeted towards enabling frontline workers to mitigate negative consequences to service recipients in risky situations. The theoretical conceptualisation and the three dimensions of organising work routines, discussing professional issues, and facilitating follow-up activities has been empirically validated in the dissertation's Article B 'Risk management in public service delivery: Multi-dimensional scale development and validation'. The article develops and tests a standardised, individual-level scale to measure risk management as a leadership behaviour, based on the theoretical framework of risk management.

The empirical analysis presented in Chapter 5 of this monograph qualitative unfolds the actual leadership practices associated with risk management and finds that frontline managers have different risk management profiles in the sense that they exercise more or less of the different risk management dimensions, dependent on their risk perception and willingness to accept risk.

Steps for future research would be to implement and validate the risk management scale in other public service delivery contexts, and to study different risk management profiles in greater detail and whether they may or may not predict frontline workers' behaviour and outcomes to service recipients.

9.1.2 How is Risk Management Exercised?

The empirical chapters of this monograph investigate the second research question of how risk management is exercised. The chapters qualitatively shed light on what concrete risk management practices look like in the healthcare and social services sectors, and how risk management is both a question of prioritisation and the frontline manager's risk perception and willingness to accept risk. A key insight is that risk management practices are exercised more when distribution of responsibility is collectivised than when it is individualised. Specifically, the frontline managers in the social services, where distribution of responsibility is collectivised, stand out by establishing fora for collective decision-making, by imposing ad-hoc decision-making programmes, and by actively taking part in the decision-making process during risky situations. This contrasts with the frontline managers from the hospitals, where distribution of responsibility is individualised, who primarily set the scene for individual decision-making and only take part in the decision-making during risky situations if they are asked to or consider themselves professional experts on the decision in question.

The analysis further investigates how different factors in the organisational environment condition the risk management practices of frontline managers. In particular, the role of political principals, formal contextual conditions, and external stakeholders like regulatory government agencies, interest groups, and the media that in different ways enable and constrain the risk management practices of frontline managers. The findings show that somewhat excessive documentation of decision-making processes in risky situations, across sectors is a way of avoiding blame for risky situations that have negative consequences to service recipients.

9.1.3 Does a Managerial Focus on Risk Matter to the Risk Perception of Frontline Workers?

The last part of the research question is concerned with whether and how risk management matters to the risk perception of frontline workers. Article C 'Does a Managerial Focus on Risk Affect Frontline Workers' Risk Perception? Evidence from Three Survey Experiments' investigates this using a survey-experimental design. The findings show that a managerial focus on risk in the

shape of discussing professional issues (the second dimension of risk management) significantly reduces the risk perception of junior hospital doctors, nursing students, and social work students, and that the effect diminishes as level of professionalisation increases.

Article A 'How Do Public Service Professionals Behave in Risky Situations? The Importance of Organizational Culture' targets the question of frontline workers risk perception and subsequent behaviour in risky situations. The findings show the importance of organisational culture. In organisational cultures with high levels of trust and dialogue about decision-making, the frontline workers rely on each other and ask for second opinions, when making decisions in risky situations. Conversely, in organisational cultures with little trust and professional discussion, the frontline workers are less likely to ask for second opinions and follow up on risky situations, which increases the possibility of unintended, negative consequences. In this way, organisational culture can be a driver of risk-reducing and risk-seeking behaviour among frontline professionals. This is a very important insight that underlines the relevance of risk management, as it is a managerial responsibility to promote and support an organisational culture where the frontline workers react appropriately to risky situations.

The qualitative analyses in Chapters 5 and 6 show that some frontline managers believe that their risk management practices lead to a sense of psychological safety among frontline workers. The mechanism is that the risk management practices on the one hand reduces the uncertainty of the risky situation, and, on the other hand, provide clarity of the potential negative consequences to the service recipients. Together, this gives frontline managers a belief that the psychological safety among the frontline workers is increased. Future research could profitably look more into the effects of risk management and formally investigate how it, for instance, matters to the psychological safety of frontline workers.

9.2 Contributions and Implications of the Findings

This dissertation holds significant theoretical and empirical contributions. Overall, the dissertation provides insights on what risk management is, how risk management is exercised in public service delivery, how frontline workers behave in risky situations, and how a managerial focus on risk matters to the risk perception of frontline workers in risky situations.

Theoretically, the public administration and public management literatures now have an applicable, validated concept of risk management as a leadership behaviour at the frontlines of public service delivery, and an associated

scale for measurement. This theoretical progress holds the potential to improve future studies of risks to service recipients and risk management, as it provides a structured framework to understand leadership practices in risky situations. Further, the concept opens new avenues of research where risk management can be coupled with variables of theoretical and empirical interest, like for instance decision-making behaviour at the frontlines and outcomes to service recipients.

Empirically, the dissertation provides in-depth qualitative knowledge of how risk management is exercised in public service delivery. Given risk management at the frontlines of public service delivery has not been formally theorised or studied up until now, these insights are novel and provide unique insights into frontline manager's risk perceptions and willingness to take risks, and their reflections on what is needed of them in risky situations. The notion of risk management profiles is a way to explain and understand differences in the risk management practices of frontline managers.

An important explanation to the differences in risk management is the distribution of responsibility. A key finding in this dissertation is that risk management is exercised more when responsibility is collectivised than when it is individualised. This is evidence that distribution of responsibility is a formal condition that matters to how frontline managers exercise risk management in the sense that the frontline managers are quite well-reflected on how the distribution of responsibility confines their managerial space. The dissertation further provides evidence that a managerial focus on risk reduces the risk perception of frontline workers, which is testament that it is a leadership behaviour that changes how frontline workers assess the risky situations at hand. These contributions attest to the utility and importance of the risk management concept to understand what happens in the relation between frontline managers and frontline workers when there are risks to service recipients in public service delivery, although it remains an open question whether a reduced risk perception among frontline workers is desirable.

A substantive insight from the empirical analyses is that risk management is a resource demanding leadership behaviour that requires active prioritisation on the frontline manager's part. Risk management comes at the cost of other leadership activities and therefore opens the discussion on the trade-offs there are inherent in risk management: Should we try and mitigate risks to service recipients at any cost? Can we accept that some service recipients experience negative outcomes of their encounters with public service delivery? How do we make this trade-off? Think back on the example from the introduction and Chapter 6 regarding the patient who had been bitten by a tick and had symptoms, but tests eliminated Lyme disease. Here, the doctor had two options. Either, he would push the big machinery button and have the patient

assessed from head to toe to leave out any little suspicion of undetected diseases. Or, he would hold his horses and tell the patient that they had eliminated Lyme disease and that his blood tests were normal, and they therefore could not explain what caused his symptoms. The first option is resource-demanding and ineffective, because pushing the big machinery button would mean that other patients received less priority. In return, the risk to the patient of an undetected disease is reduced greatly. The second option is effective, because more patients can be attended to and treated. In return, it leaves a risk to the patient of an undetected disease.

If a criterium of successful public service delivery is that few or no service recipients experience negative consequences from risky situations, we must accept some level of ineffectiveness. If a criterium of successful public service delivery is effectiveness, we must accept risks which in some cases will lead to negative outcomes to service recipients. These are normative questions that require politicians to step into the game and acknowledge the fact that risks to service recipients is a basic condition in public service delivery, and further, openly discuss how public service delivery organisations strike a balance between reducing risks without compromising organisational effectiveness too much.

9.3 The Future of Risk Management in Public Administration

The focus of this dissertation has been risk management at the frontlines of public service delivery. Given that risks to service recipients is a basic condition in public service delivery, there is ample room for future research that builds on this agenda and, ultimately, provide knowledge that can inform efforts to improve outcomes to service recipients. Here, three avenues for future research on risk management are presented.

The first avenue is one that pays closer attention to the frontline workers who are at the receiving end of risk management. This dissertation has taken a first step with the survey-experiment that investigate how a managerial focus on risk changes the risk perception of frontline workers. However, more research is needed to study whether and how risk management practices matter to frontline workers and, for instance, the role of their motivation, their sense of autonomy, self-perceived performance, and their occupational self-efficacy (Deci, Olafsen, and Ryan 2017; Guarnaccia et al. 2018; Rigotti, Schyns, and Mohr 2008; Van Loon et al. 2018). More research on the link between risk management and the frontline workers who face the risky decisions is important to fully comprehend how risk management works and to become more knowledgeable on the prospects of risk management practices that are

targeted frontline workers whose decision-making processes benefit particularly from it. This is further related to the coupling to relevant outcome variables that make it possible to come closer to an assessment of whether the frontline manager is exercising risk management successfully.

The second avenue is one that studies risk management beyond what happens at the frontlines of public service delivery. There is an abundance of diverted risks that goes beyond what may happen to service recipients following risky situations. For instance, frontline managers face a substantive cross-pressure in risky situations, which was discussed in Chapter 7, and they further face the risk of being fired if their organisational unit repeatedly fails to perform satisfactorily. Likewise, at an organisational level there are diverted risks following the outcome of risky situations like a potentially damaged organisational reputation, failure to meet organisational goals, ineffective public service delivery, or a high degree of turnover among frontline workers (Bustos Pérez 2021; Carroll 2018; Boyne 2003). More research on what happens at different hierarchical levels would enable a more complete picture of how public service delivery organisations handle risks – both to service recipients and in a more general sense.

The third avenue is one that reverses the narrative and considers that risky situations may not be all that bad. This dissertation has had a demarcated focus on the potential negative outcomes to service recipients that risky situations hold. However, the essence of the uncertainty-element of risk is that outcomes of risky situations can be positive too. Related to one of the examples from the introduction, a risky cancer treatment may, for instance, have unexpected, positive effects on the patient that would not have been discovered had it not been for the risk taken. In this sense, risky situations hold a potential to innovate practices, which ultimately may lead to improved decision-making and improved public service delivery at the frontlines (Brown and Osborne 2013; De Vries, Bekkers, and Tummers 2016; Flemig, Osborne, and Kinder 2016). Future research could profitably investigate how frontline managers and managers at other hierarchical levels best handle this ambiguity of risky situations without smothering potential innovative ideas because of their risk-averse nature and fear of negative outcomes to service recipients (Hood 2007; Borins 2006).

Risks to service recipients is a condition in public service delivery. The way these risks are handled by frontline workers matters to the outcome that service recipients experience from the risky situations. Risk management is the leadership behaviour targeted towards enabling frontline workers to mitigate negative consequences for service recipients. By organising work routines, discussing professional issues, and facilitating follow-up activities, the frontline

managers improve the decision-making grounds in risky situations and support the frontline workers who rely on the information they have available, their professional knowledge, their experience, and their discretion. This dissertation has conceptualised what risk management is and developed and validated a scale to measure risk management at manager and employee-level. Further, the dissertation has investigated how risk management is exercised and how a managerial focus on risk reduces the risk perception of frontline workers. A key insight is that risk management is a resource-demanding leadership behaviour that requires prioritisation. There is a trade-off between reducing risks to service recipients and maintaining organisational effectiveness, and we need a normative discussion of how these trade-offs are best made to ensure that public service delivery is accountable to service recipients.

Appendices

Appendix A: Overview of Units, Interviewees, and Reference Style

Case	Unit	Participants (Danish term)	Reference style
Hospital A	1	Clinical director (Ledende overlæge)	H-1-CD
		Head nurse (Oversygeplejerske)	H-1-N1
		Ward nurse (Afdelingssygeplejerske)	H-1-N2
	2	Clinical director (Ledende overlæge)	H-2-CD
		Head nurse (Oversygeplejerske)	H-2-N1
		Ward nurse (Afdelingssygeplejerske)	H-2-N2
	3	Clinical director (Ledende overlæge)	H-3-CD
		Head nurse (Oversygeplejerske)	H-3-N1
		Ward nurse (Afdelingssygeplejerske)	H-3-N2
		Ward nurse (Afdelingssygeplejerske)	H-3-N3
	4	Clinical director (Ledende overlæge)	H-4-CD
		Head nurse (Oversygeplejerske)	H-4-N1
		Ward nurse (Afdelingssygeplejerske)	H-4-N2
	5	Head nurse (Oversygeplejerske)	H-5-N1
		Ward nurse (Afdelingssygeplejerske)	H-5-N2
Hospital B	6	Clinical director (Ledende overlæge)	H-6-CD1
		Clinical director (Ledende overlæge)	H-6-CD2
		Head nurse (Oversygeplejerske)	H-6-N1
		Ward nurse (Afdelingssygeplejerske)	H-6-N2
		Ward nurse (Afdelingssygeplejerske)	H-6-N3
	7	Clinical director (Ledende overlæge)	H-7-CD
		Head nurse (Oversygeplejerske)	H-7-N1
		Ward nurse (Afdelingssygeplejerske)	H-7-N2
		Ward nurse (Afdelingssygeplejerske)	H-7-N3
	8	Clinical director (Ledende overlæge)	H-8-CD
		Head nurse (Oversygeplejerske)	H-8-N1
		Ward nurse (Afdelingssygeplejerske)	H-8-N2
		Ward nurse (Afdelingssygeplejerske)	H-8-N3
	9	Clinical director (Ledende overlæge)	H-9-CD

		Head nurse (Oversygeplejerske)	H-9-N1
		Ward nurse (Afdelingssygeplejerske)	H-9-N2
Social psychiatry, marginalised adults, and adults with physical disabilities	1	Frontline manager (Myndighedschef)	SS-1-FM1
		Frontline manager (Frontlinjeleder)	SS-1-FM2
		Frontline manager (Frontlinjeleder)	SS-1-FM3
	2	Frontline manager (Myndighedschef)	SS-2-FM1
		Frontline manager (Frontlinjeleder)	SS-2-FM2
	3	Frontline manager (Myndighedschef)	SS-3-FM1
		Frontline manager (Frontlinjeleder)	SS-3-FM2
		Frontline manager (Frontlinjeleder)	SS-3-FM3
	4	Frontline manager (Myndighedschef)	SS-4-FM1
	5	Frontline manager (Myndighedschef)	SS-5-FM1
		Frontline manager (Frontlinjeleder)	SS-5-FM2
	6	Frontline manager (Myndighedschef)	SS-6-FM1
		Frontline manager (Frontlinjeleder)	SS-6-FM2
Families, children, and adolescents	7	Frontline manager (Myndighedschef)	SFC-7-FM1
		Frontline manager (Frontlinjeleder)	SFC-7-FM2
	8	Frontline manager (Myndighedschef)	SFC-8-FM1
		Frontline manager (Frontlinjeleder)	SFC-8-FM2
		Frontline manager (Frontlinjeleder)	SFC-8-FM3
		Frontline manager (Frontlinjeleder)	SFC-8-FM4
		Frontline manager (Frontlinjeleder)	SFC-8-FM5
	9	Frontline manager (Myndighedschef)	SFC-9-FM1
		Frontline manager (Frontlinjeleder)	SFC-9-FM2
		Frontline manager (Frontlinjeleder)	SFC-9-FM3
	10	Frontline manager (Myndighedschef)	SFC-10-FM1
		Frontline manager (Frontlinjeleder)	SFC-10-FM2
		Frontline manager (Frontlinjeleder)	SFC-10-FM3
		Frontline manager (Frontlinjeleder)	SFC-10-FM4
	11	Frontline manager (Myndighedschef)	SFC-11-FM1
		Frontline manager (Frontlinjeleder)	SFC-11-FM2
		Frontline manager (Frontlinjeleder)	SFC-11-FM3
	12	Frontline manager (Myndighedschef)	SFC-12-FM1

Appendix B: Interview Guides

Interview Guide Healthcare Sector

Theme	Question
Briefing	Thank you for participating in this interview, which is being audio recorded for transcription purposes. The purpose of this interview is to get insights into what risk management entails in public service delivery. I am interested in your experiences, rather than what may be considered as "correct" answers.
Background	7. Will you start out by telling me a little bit about yourself and your managerial tasks? 8. How long have you worked as a doctor/nurse, and how long have you been at this ward as chief physician/head/ward nurse? 9. Can you tell me a little bit about the ward and the challenges you meet in everyday life?
Discretion in decision-making	I am very interested in decisions that from a medical/nursing perspective can be approached differently, dependent on the situation. 10. **What type of decisions could that be at this ward?** 11. When are the doctors/nurses uncertain about how to approach work decisions? 12. Do the doctors/nurses ask for something specific in those situations?
Risky situations	In healthcare there are situations where there is not an obvious right or wrong answer. The knowledge you have is conditioned on the sex, age, lifestyle and medical history of the patient. That creates an uncertainty in decision-making, which at the same time potentially lead to negative consequences to the patient. 13. **In what situations is there uncertainty in your work at the ward?** 14. Try to think back on the last time you had a situation where there was uncertainty, and it could lead to unwanted consequences to the patient. How did you approach it? 15. Did you feel that you ran a risk in the situation?
Management in risky situations	We have talked about the type of situations of uncertainty you face, and what the doctors/nurses need in those situations. I would like to dive more into this and your role as a manager in these situations. I will read a description of a fictitious situation to you. After that, I would like you to consider it. Image a situation where it is possible to treat a patient in different ways. There are pros and cons to each treatment, but you know that each of them potentially can lead to negative consequences to the patient. An [experienced/inexperienced] doctor/nurse is in doubt about what to do and ask for your advice as the supervisor. [Illustrate with decision-making tree].

16. **How will you approach the situation?** (Both prior, during, and after)
17. What is you most important task as a leader in this situation?
18. Do you give concrete recommendations in these situations? Do you expect them to be followed? (distribution of responsibility, authorisation)
19. Do you discuss the situations with the doctors/nurses? How? Conditioned on experience?
20. Try to consider how you would handle the situation before it occurs?
21. Does the way you organise work tasks matter to these situations? (e.g., roster)
22. How do you make sure that the doctors/nurses are prepared to handle these situations? (before/after)
23. How do you follow up on situations characterised by uncertainty? (e.g., increased control, documentation, knowledge sharing).
24. How do you make sure that knowledge and experience from these situations are not lost at the ward? (e.g., mails, ward meetings, boards).

Organisational and political context

We have talked about how situations characterised by uncertainty about consequences matter to your decision-making.

25. **Are there other in your organisational environment that are interested in these decisions?** (e.g., hospital board of directors, politicians, patient groups, media etc.)
26. How does this matter to your leadership?
27. Do you think there is a trade-off between efficiency and reducing uncertainty in your decision-making? (e.g., slack in documentation, follow clinical guidelines)
28. How do the organisational environment matter to your treatments at the way you see the patients? (e.g., diagnosing rights, patient involvement)

There are several examples from recent years where errors at hospital wards have reached a political level (e.g. Svendborgsagen, meningitis, breast cancer screening).

29. Have you thought about these cases related to how you leadership in situations characterised by uncertainty?

Debriefing

I do not have more questions. Is there something you would like to add?
Thank you for participating.

Interview Guide Social Services

Theme	Question
Briefing	Thank you for participating in this interview, which is being audio recorded for transcription purposes. The purpose of this interview is to get insights into what risk management entails in public service delivery. I am interested in your experiences, rather than what may be considered as "correct" answers.
Background	1. Will you start out by telling me a little bit about yourself and your managerial tasks? 2. What is your educational background, and how long have you been a manager at this unit? 3. Can you tell me a little bit about the unit and the challenges you meet in everyday life?
Discretion in decision-making	I am very interested in decisions that from a professional social work perspective can be approached differently, dependent on the situation. Situations, where the professional discretion is activated. 4. **What type of decisions could that be in this unit?** 5. When are the social workers uncertain about how to approach work decisions? 6. Do the social workers ask for something specific in those situations?
Risky situations	In the social services, you face situations where there is not an obvious right or wrong answer. The information you have is limited. That creates an uncertainty in decision-making, which at the same time potentially lead to negative consequences to the service recipient. 7. **In what situations is there uncertainty in your work in the unit?** 8. Try to think back on the last time you had a situation where there was uncertainty, and it could lead to unwanted consequences to the service recipient. How did you approach it? 9. Did you feel that you ran a risk in the situation?
Management in risky situations	We have talked about the type of situations of uncertainty you face, and what the social workers need in those situations. I would like to dive more into this and your role as a manager in these situations. I will read a description of a fictitious situation to you. After that, I would like you to consider it. Image a situation where it is possible to make different decisions in a case. There are pros and cons to each decision, and you know that each of them potentially can lead to negative consequences to the service recipient. An [experienced/inexperienced] social worker is in doubt about what to do and ask for your advice as the manager. [Illustrate with decision-making tree]. **10. How will you approach the situation?** (Both prior, during, and after) 11. What is you most important task as a leader in this situation? 12. Do you give concrete recommendations in these situations? Do you expect them to be followed? (distribution of responsibility, authorisation) 13. Do you discuss the situations with the social workers? How? Conditioned on experience? 14. Try to consider how you would handle the situation before it occurs?

15. Does the way you organise work tasks matter to these situations? (e.g., team structure, procedures notifications of concern, legislation)
16. How do you make sure that the social are prepared to handle these situations? (before/after)
17. How do you follow up on situations characterised by uncertainty? (e.g., increased control, documentation, knowledge sharing).
18. How do you make sure that knowledge and experience from these situations are not lost in the unit? (e.g., mails, ward meetings, boards).

Organisational and political context

We have talked about how situations characterised by uncertainty about consequences matter to your decision-making.

19. **Are there other in your organisational environment that are interested in these decisions?** (e.g., municipal council, municipal board of directors, interest groups, media etc.)
20. How does this matter to your leadership?
21. Do you think there is a trade-off between efficiency and reducing uncertainty in your decision-making? (e.g., slack in documentation, follow the legislation vs. the intent of the legislation, relax decision-making programmes)
22. How do the organisational environment matter to your treatments at the way you see the patients? (e.g., messy cases)

There are several examples from recent years where case assessment errors in municipal state agencies have reached a political level (e.g. Tøndersagen, Brønderslevsagen, national Social Appeals's Board map of insufficient case assessments in municipal state agencies).

23. Have you thought about these cases related to how you leadership in situations characterised by uncertainty?

Debriefing

I do not have more questions. Is there something you would like to add?
Thank you for participating.

Appendix C: Transcription Guide

Transcription Guide	
Transcription Method: Start out by downloading the 'Express Scribe' software, or similar, or transcribe the interview in NVIVO or Word. Procedure: 1. Read this transcription guide thoroughly so you know how to transcribe. 2. If necessary, listen through the audio file at high speed so you are familiar with the content. 3. Spend a couple of minutes to find the transcription speed that suits you and decide what short-cut keys that work best for you when you need to use the 'start' and 'stop' key, and when you want to rewind slowly. 4. If you have a pedal, you can use it to stop and restart. 5. Start the transcription. 6. When you stop transcribing, always remember to insert the time in the interview. This makes it easier to resume. 7. Insert line numbers in the completed transcription (separator: 5).	
Guide	**Examples**
Interviewer (Emily) is called 'Iw'.	Iw: Will you start out by telling me a little bit about yourself and your managerial tasks?
Respondents are called 'CD', 'HN', 'WN1', 'WN2', 'FM1', 'FM2', 'FM3' etc.	WN1: I am a ward nurse at [ward name]. Specifically, the preparation before surgery.
Note down the interview question in accordance with the interview guide (as often as you can).	Question 1) Iw: Will you start out by telling me a little bit about yourself and your managerial tasks? WN1: I am a ward nurse at [ward name]. Specifically, the preparation before surgery.
Start a new line when a new person speaks.	Iw: Will you start out by telling me a little bit about yourself and your managerial tasks? WN1: I am a ward nurse at [insert ward]. Specifically, the preparation before surgery.
Ignore 'ahm' and interpret these as pauses written as '…' Ignore laugther, coughs, and the like completely.	Iw: Will you start out by telling me a little bit about yourself and your work at the ward? WN[x]: Well, my name is [insert name]. I am a nurse and have been at this ward for two years. I am also supervising students.
Interruptions (e.g., if a respondent/interviewer interrupts the other) are written as '– '	Iw: Okay, so you attend to all that come in and then – WN[x]: Yes, all the ones that are delegated to me.

Other comments about the transcription are put in squared brackets. E.g., if someone interrupts the interview or if something happens that cannot be written in the transcription.	[The interview is shortly interrupted by a phone call/someone steps into the room].
Comma is used if the respondent/interviewer does not finish a sentence but uses new words.	IW: Can you tell me a little about what a normal day looks like at this ward. WN[x]: Yes, well… On a typical day shift, we start out by discussing what patient we have, also in relation to competences, because we have many new nurses and also a few experienced, so it is about the weight of the different patients.
If a word is emphasised, capitalise it	LO: Sometimes, it becomes SO complicated to do normal things.
Leave out if the interviewer (Emily) for instance says 'yes', 'no', 'ah', 'mmh' or in other ways expresses that she is listening to the interviewee answering questions.	
If something is indecipherable, write UNCLEAR and the time in the interview in squared brackets.	Iw: Can you describe the culture at this ward? CD: There is very good communication here. We have good habits, but we experience challenges in the communication with the municipalities and region, because they [UNCLEAR 00:04:03] and they have issues with their staff and unstable functions.
If there is a word that you do not understand, write: FORREIGN WORD and the time in the interview in squared brackets.	CD: There was a patient that came into the emergency room because of a car accident, a trauma, and… at [FOREIGN WORD 00:13:32] and they dispatch the patient.
Every time specific information or the names of persons are mentioned, which can lead back to them/breach the anonymity of the hospital/ward/interviewee/ colleague/patient, write '#' next to it. In case you are in doubt: On # too many is better than too few.	# CD: We have specific problems with foreign doctors at [ward name], where there are communication barriers and they come from another culture. This is difficult for both colleagues and patients.
Read through the transcription and listen to the interview again to check the transcription when you have completed it.	

Appendix D: Coding List

Inductively generated codes

Code	Definition Statements related to …	Category
Decision-making programmes	concrete guidelines that instruct how to behave in given situations, such as clinical guidelines or demands of specific assessment types in cases of suspected child neglect (e.g. §50)	Before risky situation
Preparing employees	how the frontline manager prepares the employees to handle their discretion prior to risky situations	Before risky situation
Meeting activity	the frontline manager facilitating, prioritising, and coordinating regular meetings for professional discussion and questions of doubt	Before risky situation
Team and simulation training	activities that practice the team work by simulating risky situations	Before risky situation
Joint decision-making	decision-making in risky situations that is collectivised	During risky situation
Limited information	limited information available when making decisions in risky situations	During risky situation
External help	the organisation receiving external help in risky situations, e.g., VISO or university hospitals	During risky situation
Space for action	the frontline manager pulling back in the risky situation to let the employee assess and make the decision	During risky situation
Action instructions	the frontline manager giving the employee concrete instructions on what to do in risky situations where they ask for a second opinion	During risky situation
Collective discussion	the group of employees discussing risky situations together	During risky situation
Opportunity space	the frontline manager unfolding the different opportunities in risky situations	During risky situation
Prioritising of tasks	the frontline manager's assisting frontline workers in prioritising work tasks in risky situations	During risky situation
Support decision-making of employees	the frontline manager's attempts to support the decision-making of employees in risky situations	During risky situation
Disregarding guidelines	the frontline manager discussing with the employees whether their professional judgement should overrule the formal guidelines in a risky situation	During risky situation
Debriefing	the frontline manager debriefing with the employees following risky situations.	After risky situation
Enforce/stress guidelines	the frontline manager enforcing or stressing the guidelines as a consequence of a risky situation.	After risky situation

Core cause analysis	a specific way of following up on adverse events in the healthcare sector.	After risky situation
Handling	the frontline manager asking the employees involved whether they could have handled anything differently in the risky situation.	After risky situation
Managerial conditions	the frontline manager's perception of the conditions they face for exercising risk management	Condition
Characteristics of employees in need of risk management	the frontline manager's perception of what characterises employees that need risk management	Condition
Information level	how level of information matters in risky situations	Condition
Frontline manager competence requirements	the demand that risky situations pose on the frontline manager's competences.	Condition
Quality standards/service levels	the politically decided quality standards (healthcare sector) / service levels (social services).	Condition
Legislation	actions initiated by the legislation the organisation is governed by	Condition
Employee needs	what the frontline manager experiences that employees need when they face uncertainty and risk	Condition
Formal conditions	the formal conditions that regulate the organisation, such as financial and productivity requirements	Condition
Urgency	behaviour of the frontline manager that is conditioned by how urgent the situation is	Condition
Financial considerations	the frontline manager's financial considerations and whether and how they play a part in decision-making	Condition
Professional ethics vs. Bureaucratic culture	a perceived schism between professional ethics and bureaucratic culture in risky situations	Condition
Risk factors	elements in the organisation that can promote risks, such as busyness, employee turnover, competencies	Condition
Organisational culture	the role organisational culture plays in relation to risky situations	Condition
Risk perception	the frontline manager's understanding of the risks their organisational unit faces	Condition
Risky situation	situations where there is a high degree of urgency and potentially negative consequences to service recipients	Condition
Perception of managerial role	the frontline manager's understanding of their role in risky situations	Condition
Distribution of responsibility	how much responsibility the employees are given and how much responsibility the frontline manager takes in relation to risky situations	Principle

Decision-making principles	the frontline manager's decision-making principles, such as going with the least intrusive option, involving patients, establish safety for the child.	Principle
Involving service recipients	involving service recipients in the decision-making process	Principle
Discrepancy between manager and employee assessment	how the frontline manager handles disagreement with frontline workers over the professional assessment	Principle
Documentation practice	documenting professional considerations, assessments, decisions, and potential deviations from the legislation and/or guidelines	Principle
Error tolerance	different types of errors and the frontline manager's perception of them	Principle
Reflection	the frontline manager making themselves available for reflection before, during, and after risky situations	Principle
Willingness to take risks	the frontline manager's willingness to accept uncertainty and potential negative consequences	Principle
Managerial visibility	the frontline manager prioritising being available to employees when they experience uncertainty	Principle
Apprenticeship	the idea that experienced frontline workers teach less experienced frontline workers	Principle
Leading upwards	the frontline manager leading upwards in the organisation	Organisational environment
Leading outwards	the frontline manager leading outwards in the organisation	Organisational environment
Transactional leadership	leadership activities that resemble transactional leadership	
Transformational leadership	leadership activities that resemble transformational leadership	
Distributed risk management	other actors taking part in risk management practices	
Psychological safety	the frontline manager's efforts at creating a work environment where the employees experience a psychological safety in risky situations.	
Resilience	the frontline manager's efforts at promoting employee resilience in relation to risky situations	

Final coding frame

Code	Definition Statements related to…	Category	Deductive/ inductive
Decision-making programmes	concrete guidelines that instruct how to behave in given situations, such as clinical guidelines or demands of specific assessment types in cases of suspected child neglect (e.g. §50)	Before risky situation	Inductive
Preparing employees	how the frontline manager prepares the employees to handle their discretion prior to risky situations	Before risky situation	Inductive
Meeting activity	the frontline manager facilitating, prioritising, and coordinating regular meetings for professional discussion and questions of doubt	Before risky situation	Inductive
Team and simulation training	activities that practice the team work by simulating risky situations	Before risky situation	Inductive
Joint decision-making	decision-making in risky situations that is collectivised	During risky situation	Inductive
Limited information	limited information available when making decisions in risky situations	During risky situation	Inductive
External help	the organisation receiving external help in risky situations, e.g., VISO or university hospitals	During risky situation	Inductive
Space for action	the frontline manager pulling back in the risky situation to let the employee assess and make the decision	During risky situation	Inductive
Action instructions	the frontline manager giving the employee concrete instructions on what to do in risky situations where they ask for a second opinion	During risky situation	Inductive
Collective discussion	the group of employees discussing risky situations together	During risky situation	Inductive
Opportunity space	the frontline manager unfolding the different opportunities in risky situations	During risky situation	Inductive
Prioritising of tasks	the frontline manager's assisting frontline workers in prioritising work tasks in risky situations	During risky situation	Inductive
Support decision-making of employees	the frontline manager's attempts to support the decision-making of employees in risky situations	During risky situation	Inductive
Disregarding guidelines	the frontline manager discussing with the employees whether their professional judgement should overrule the formal guidelines in a risky situation	During risky situation	Inductive
Debriefing	the frontline manager debriefing with the employees following risky situations.	After risky situation	Inductive

Enforce/stress guidelines	the frontline manager enforcing or stressing the guidelines as a consequence of a risky situation.	After risky situation	Inductive
Core cause analysis	a specific way of following up on adverse events in the healthcare sector.	After risky situation	Inductive
Handling	the frontline manager asking the employees involved whether they could have handled anything differently in the risky situation.	After risky situation	Inductive
Managerial conditions	the frontline manager's perception of the conditions they face for exercising risk management	Condition	Inductive
Characteristics of employees in need of risk management	the frontline manager's perception of what characterises employees that need risk management	Condition	Inductive
Information level	how level of information matters in risky situations	Condition	Inductive
Frontline manager competence requirements	the demand that risky situations pose on the frontline manager's competences.	Condition	Inductive
Quality standards/service levels	the politically decided quality standards (healthcare sector) / service levels (social services).	Condition	Inductive
Legislation	actions initiated by the legislation the organisation is governed by	Condition	Inductive
Employee needs	what the frontline manager experiences that employees need when they face uncertainty and risk	Condition	Inductive
Formal conditions	the formal conditions that regulate the organisation, such as financial and productivity requirements	Condition	Inductive
Urgency	behaviour of the frontline manager that is conditioned by how urgent the situation is	Condition	Inductive
Financial considerations	the frontline manager's financial considerations and whether and how they play a part in decision-making	Condition	Inductive
Professional ethics vs. Bureaucratic culture	a perceived schism between professional ethics and bureaucratic culture in risky situations	Condition	Inductive
Risk factors	elements in the organisation that can promote risks, such as busyness, employee turnover, competencies	Condition	Inductive
Organisational culture	the role organisational culture plays in relation to risky situations	Condition	Inductive
Risk perception	the frontline manager's understanding of the risks their organisational unit faces	Condition	Inductive
Risky situation	situations where there is a high degree of urgency and potentially negative consequences to service recipients	Condition	Inductive

Perception of managerial role	the frontline manager's understanding of their role in risky situations	Condition	Inductive
Distribution of responsibility	how much responsibility the employees are given and how much responsibility the frontline manager takes in relation to risky situations	Principle	Inductive
Decision-making principles	the frontline manager's decision-making principles, such as going with the least intrusive option, involving patients, establish safety for the child.	Principle	Inductive
Involving service recipients	involving service recipients in the decision-making process	Principle	Inductive
Discrepancy between manager and employee assessment	how the frontline manager handles disagreement with frontline workers over the professional assessment	Principle	Inductive
Documentation practice	documenting professional considerations, assessments, decisions, and potential deviations from the legislation and/or guidelines	Principle	Inductive
Error tolerance	different types of errors and the frontline manager's perception of them	Principle	Inductive
Reflection	the frontline manager making themselves available for reflection before, during, and after risky situations	Principle	Inductive
Willingness to take risks	the frontline manager's willingness to accept uncertainty and potential negative consequences	Principle	Inductive
Managerial visibility	the frontline manager prioritising being available to employees when they experience uncertainty	Principle	Inductive
Apprenticeship	the idea that experienced frontline workers teach less experienced frontline workers	Principle	Inductive
Leading upwards	the frontline manager leading upwards in the organisation	Organisational environment	Inductive
Leading outwards	the frontline manager leading outwards in the organisation	Organisational environment	Inductive
Transactional leadership	leadership activities that resemble transactional leadership		Inductive
Transformational leadership	leadership activities that resemble transformational leadership		Inductive
Distributed risk management	other actors taking part in risk management practices		Inductive
Psychological safety	the frontline manager's efforts at creating a work environment where the employees experience a psychological safety in risky situations.		Inductive

Resilience	the frontline manager's efforts at promoting employee resilience in relation to risky situations	Inductive
Competence	Assembles groups of frontline workers to reflect different competencies.	Deductive
Experience	Makes sure that frontline workers with different levels of experience work together.	Deductive
Coordination	Coordinates what tasks the frontline workers undertake.	Deductive
Prioritising fixed structures	Ensures familiar and consistent routines around the undertaking of work in routine and risky situations.	Deductive
Professional assessment	Asks the frontline workers what their professional assessment is.	Deductive
Encourage motivation	Encourages the frontline workers to substantiate their professional assessments.	Deductive
Alternative options	Asks the frontline workers whether they have considered a different solution.	Deductive
Pros and cons	Discusses the pros and cons of the different solutions with the frontline worker.	Deductive
Feedback	Provides frontline workers with feedback on how they handled the risky situation.	Deductive
Utilising examples	Utilises examples from risky situations as points of departure for discussing professional discretion with frontline workers.	Deductive
Knowledge sharing	Ensures that knowledge is shared among frontline workers.	Deductive
Revision of work procedures	Revises work procedures if a risky situation was handled inappropriately.	Deductive

References

Agger, Simone. 2015. "Børn- og ungechef i Tønder fyret efter alvorlige fejl." TV2, accessed 2 November. https://nyheder.tv2.dk/2015-07-07-boern-og-ungechef-i-toender-fyret-efter-alvorlige-fejl.

Andersen, Lotte Bøgh. 2009. "What determines the behaviour and performance of health professionals? Public service motivation, professional norms and/or economic incentives." *International Review of Administrative Sciences* 75 (1):79-97. doi: 10.1177/0020852308099507.

Andersen, Lotte Bøgh, Louise Ladegaard Bro, Anne Bøllingtoft, Tine Louise Mundbjerg Eriksen, Ann-Louise Holten, Christian Bøtcher Jacobsen, Ulrich Thy Jensen, Jacob Ladenburg, Poul A. Nielsen, Heidi Houlberg Salomonsen, Niels Westergård-Nielsen, and Allan Würtz. 2017. *Ledelse i offentlige og private organisationer*. 1. udgave ed, *Statskundskab ; nr. 20*. Kbh.: Hans Reitzel.

Arrow, K. J. 1982. "Risk Perception in Psychology and Economics." *Economic Inquiry* 20 (1):1-9. doi: 10.1111/j.1465-7295.1982.tb01138.x.

Aumann, Robert J. 1997. "Rationality and Bounded Rationality." *Games and Economic Behavior* 21 (1-2):2-14. doi: 10.1006/game.1997.0585.

Authorisation, Act. 2019. Authorisation Act [Bekendtgørelse af lov om autorisation af sundhedspersoner og om sundhedsfaglig virksomhed (LBK nr. 731 af 8. juli 2019)]. In *Lovbekendtgørelse nr. 731*, edited by Sundheds- og Ældreministeriet [Ministy of Health] SUM. Retsinformation: Retsinformation.

Aven, Terje. 2010. "On how to define, understand and describe risk." *Reliability Engineering and System Safety* 95 (6):623-631. doi: 10.1016/j.ress.2010.01.011.

Barberis, N. C. 2013. "Thirty Years of Prospect Theory in Economics: A Review and Assessment." *Journal of Economic Perspectives* 27 (1):173-195. doi: 10.1257/jep.27.1.173.

Bass, Bernard M., and Ronald E. Riggio. 2005. *Transformational Leadership*. Mahwah: Taylor and Francis.

Battaglio, R. Paul, Nicola Belle, and Paola Cantarelli. 2021. "Self-determination theory goes public: experimental evidence on the causal relationship between psychological needs and job satisfaction." *Public Management Review*:1-18. doi: 10.1080/14719037.2021.1900351.

Beck, Ulrich. 1992. *Risk society : towards a new modernity*, *Theory, culture & society*. London: SAGE.

Beck, Ulrich. 1994. "Self-Dissolution and Self-Endangerment of Industrial Society: What Does This Mean?" In *Reflexive Modernization: Politics, Tradition and Aesthetics in the Modern Social Order*, edited by Ulrich Beck, Scott Lash and Anthony Giddens, 174-183. Cambridge: Polity Press.

Beck, Ulrich. 1997. *The reinvention of politics : rethinking modernity in the global social order*. Cambridge: Polity Press.
Bellé, Nicola. 2012. "Experimental Evidence on the Relationship between Public Service Motivation and Job Performance." *Public Administration Review* 73 (1):143-153. doi: 10.2307/23355447.
Bellé, Nicola. 2014. "Leading to Make a Difference: A Field Experiment on the Performance Effects of Transformational Leadership, Perceived Social Impact, and Public Service Motivation." *Journal of Public Administration Research and Theory* 24 (1):109-136. doi: 10.1093/jopart/mut033.
Binderkrantz, Anne Skorkjaer, Peter Munk Christiansen, and Helene Helboe Pedersen. 2015. "Interest Group Access to the Bureaucracy, Parliament, and the Media." *Governance* 28 (1):95-112. doi: 10.1111/gove.12089.
Borins, Sandford. 2006. *The Challenge of Innovating in Government*. Second ed: IBM Center for The Business of Government.
Boshier, Peter. 2020. He Take Kōhukihuki. Pūrongo e Tūhura ana i ngā kaupapahere, tikanga me ngā hātepe mō te tango i ngā pēpi hou a Oranga Tamariki. [A Matter of Urgency. Investigation Report into policies, practices and procedures for the removal of newborn pēpi by Oranga Tamariki, Ministry for Children]. edited by Ombudman. Tari o te Kaitiaki Mana Tangata. Wellington, New Zealand: The Office of the Ombudsman.
Bovens, Mark. 2007. "Analysing and Assessing Accountability: A Conceptual Framework." *European Law Journal* 13 (4):447-468. doi: 10.1111/j.1468-0386.2007.00378.x.
Bovens, Mark, Thomas Schillemans, and Robert E. Goodin. 2014. Public Accountability. In *The Oxford Handbook of Public Accountability*, edited by Robert E. Goodin Mark Bovens, Thomas Schillemans. Oxford: Oxford University Press.
Boyne, G. A. 2002. "Public and private management: What's the difference?" *Journal of Management Studies* 39 (1):97-122. doi: 10.1111/1467-6486.00284.
Boyne, G. A. 2003. "Sources of Public Service Improvement: A Critical Review and Research Agenda." 13 (3):367-394. doi: 10.1093/jpart/mug027.
Boyne, G. A., O. James, P. John, and N. Petrovsky. 2009. "Democracy and government performance: Holding incumbents accountable in english local governments." *Journal of Politics* 71 (4):1273-1284. doi: 10.1017/S0022381609990089.
Bracci, Enrico, Mouhcine Tallaki, Giorgia Gobbo, and Luca Papi. 2021. "Risk management in the public sector: a structured literature review." *International Journal of Public Sector Management* 34 (2):205-223. doi: 10.1108/ijpsm-02-2020-0049.
Brehm, John, and Scott Gates. 1999. *Working, shirking, and sabotage : bureaucratic response to a democratic public*. Paperback ed. ed, *Michigan studies in political analysis*. Ann Arbor, MI: University of Michigan Press.

Bro, Louise Ladegaard, and Ulrich Thy Jensen. 2020. "Does transformational leadership stimulate user orientation? Evidence from a field experiment." *Public Administration* 98 (1):177-193. doi: 10.1111/padm.12612.
Brodkin, Evelyn Z. 2008. "Accountability in Street-Level Organizations." *International Journal of Public Administration* 31 (3):317-336. doi: 10.1080/01900690701590587.
Brown, Louise, and Stephen P. Osborne. 2013. "Risk and Innovation." *Public Management Review* 15 (2):186-208. doi: 10.1080/14719037.2012.707681.
Brown, Michael E., and Linda K. Treviño. 2006. "Ethical leadership: A review and future directions." *The Leadership Quarterly* 17 (6):595-616. doi: 10.1016/j.leaqua.2006.10.004.
Brunsson, Nils. 2002. *The organization of hypocrisy : talk, decisions and actions in organizations*. 2. edition ed. Oslo: Abstrakt.
Bullock, Justin B., Robert A. Greer, and Laurence J. O'Toole. 2019. "Managing Risks in Public Organizations: A Conceptual Foundation and Research Agenda." *Perspectives on Public Management and Governance* 2 (1):75-87. doi: 10.1093/ppmgov/gvx016.
Bustos Pérez, Edgar Oliver. 2021. "Organizational Reputation in the Public Administration: A Systematic Literature Review." *Public Administration Review*. doi: 10.1111/puar.13363.
Bækgaard, Martin. 2017. "Prospect theory and public service outcomes: Examining risk preferences in relation to public sector reforms." *Public Administration* 95 (4):927-942. doi: 10.1111/padm.12324.
Bøggild, Troels. 2016. "How Politicians' Reelection Efforts Can Reduce Public Trust, Electoral Support, and Policy Approval." *Political Psychology* 37 (6):901-919. doi: 10.1111/pops.12303.
Camerer, C. F., and E. Fehr. 2006. "When does "economic man" dominate social behavior?" *Science* 311 (5757):47-52. doi: 10.1126/science.1110600.
Camerer, C. F., and H. Kunreuther. 1989. "Decision processes for low probability events: Policy implications." *Journal of Policy Analysis and Management* 8 (4):565-592. doi: 10.2307/3325045.
Carlsson-Wall, Martin, Kalle Kraus, Anita Meidell, and Patrik Tran. 2019. "Managing risk in the public sector - The interaction between vernacular and formal risk management systems." *Financial Accountability & Management* 35 (1):3-19. doi: 10.1111/faam.12179.
Carpenter, Daniel P., and George A. Krause. 2012. "Reputation and Public Administration." *Public Administration Review* 72 (1):26-32. doi: 10.1111/j.1540-6210.2011.02506.x.
Carroll, Craig E. 2018. Reputation Management. In *The International Encyclopedia of Strategic Communication*, edited by Robert L Heath and Winni Johansen: John Wiley & Sons.
Citizens, Ministry of Social Affairs and Senior. 2021a. Act on Social Services. In *1548*, edited by Social- og Ældreministeriet. Copenhagen: Lovtidende.

Citizens, Ministry of Social Affaris and Senior. 2021b. Consolidation Act on Social Services. edited by Ministry of Social Affaris and Senior Citizens. Retsinformation: Retsinformation.
Commissioner, Office of the Children's. 2020a. Te Kuku O Te Manawa. Ka puta te riri, ka momori te ngākau, ka heke ngā roimata mo tōku pēpi. A review of what needs to change to enable pēpi Māori aged 0-3 months to remain in the care of their whānau in situations where Oranga Tamariki-Ministry for Children is notified of care and protection concerns. Wellington, New Zealand: Office of the Children's Commissioner.
Commissioner, Office of the Children's. 2020b. Te Kuku O Te Manawa. Moe ararā! Haumanutia ngā moemoeā a ngā tūpuna mō te oranga o ngā tamariki. A review of what needs to change to enable pēpi Māori aged 0-3 months to remain in the care of their whānau in situations where Oranga Tamariki-Ministry for Children is notified of care and protection concerns. Wellington, New Zealand: Office of the Children's Commissioner.
Cyert, Richard M., and James G. March. 1963. *A Behavioral Theory of the Firm*, *Prentice-Hall International Series in Management*. Englewood Cliffs, N.J: Prentice-Hall.
Dahler-Larsen, Peter. 2020. "Displays." In *Metoder i Statskundskab*, edited by Lotte Bøgh Andersen Kasper Møller Hansen, Sune Welling Hansen, 228-248. København: Hans Reitzels Forlag.
Davidson, Donald, Patrick Suppes, and Sidney Siegel. 1957. *Decision making; an experimental approach*, *Decision making; an experimental approach.*: Stanford University Press.
De Vries, Hanna, Victor Bekkers, and Lars Tummers. 2016. "INNOVATION IN THE PUBLIC SECTOR: A SYSTEMATIC REVIEW AND FUTURE RESEARCH AGENDA." *Public Administration* 94 (1):146-166. doi: 10.1111/padm.12209.
Deci, Edward L., Anja H. Olafsen, and Richard M. Ryan. 2017. "Self-Determination Theory in Work Organizations: The State of a Science." *Annual Review of Organizational Psychology and Organizational Behavior* 4 (1):19-43. doi: 10.1146/annurev-orgpsych-032516-113108.
Deci, Edward L., and Richard M. Ryan. 2012. "Self-determination theory." In *Handbook of theories of social psychology, Vol. 1*, 416-436. Thousand Oaks, CA: Sage Publications Ltd.
Dehart-Davis, L. 2008. "Green Tape: A Theory of Effective Organizational Rules." *Journal of Public Administration Research and Theory* 19 (2):361-384. doi: 10.1093/jopart/mun004.
Douglas, Mary, and Aaron B. Wildavsky. 1983. "Risk and Culture." In. Berkeley: University of California Press. http://ez.statsbiblioteket.dk:2048/login?url=https://ebookcentral.proquest.com/lib/asb/detail.action?docID=470821
https://www.statsbiblioteket.dk/au/#/search?query=recordID%3A%22ebog_ssj000365380%22.

Duit, Andreas. 2016. "RESILIENCE THINKING: LESSONS FOR PUBLIC ADMINISTRATION." *Public Administration* 94 (2):364-380. doi: 10.1111/padm.12182.

Dür, Andreas, and Dirk De Bivre. 2007. "The Question of Interest Group Influence." *Journal of Public Policy* 27 (1):1-12. doi: 10.1017/S0143814X07000591.

Epstein, Seymour. 1994. "Integration of the Cognitive and the Psychodynamic Unconscious." *American Psychologist* 49 (8):709-724. doi: 10.1037/0003-066X.49.8.709.

Evans, Tony. 2011. "Professionals, managers and discretion: Critiquing street-level bureaucracy." *British Journal of Social Work* 41 (2):368-386. doi: 10.1093/bjsw/bcq074.

Evans, Tony. 2018. "Orientations of professional discretion in the welfare service state." *Social Work and Society* 16 (2).

Evans, Tony. 2020. "Creativity: Re-thinking Professional Discretion." *Social Work and Society* 18 (1):1.

Favero, Nathan, and Minjung Kim. 2021. "Everything Is Relative: How Citizens Form and Use Expectations in Evaluating Services." *Journal of Public Administration Research and Theory* 31 (3):561-577. doi: 10.1093/jopart/muaa048.

Ferry, Laurence, and Peter Eckersley. 2015. "Accountability and Transparency: A Nuanced Response to Etzioni." *Public Administration Review* 75 (1):11-12. doi: 10.1111/puar.12303.

Finucane, Melissa L., Ali Alhakami, Paul Slovic, and Stephen M. Johnson. 2000. "The affect heuristic in judgments of risks and benefits." *Journal of Behavioral Decision Making* 13 (1):1-17. doi: 10.1002/(SICI)1099-0771(200001/03)13:1<1::AID-BDM333>3.0.CO;2-S.

Finucane, Melissa L., Ellen Peters, and Paul Slovic. 2003. "Judgment and Decision Making: The Dance of Affect and Reason." In *Emerging Perspectives on Judgment and Decision Research*, edited by James Shanteau and Sandra L. Schneider, 327-364. Cambridge: Cambridge University Press.

Fischhoff, Baruch, Paul Slovic, Sarah Lichtenstein, Stephen Read, and Barbara Combs. 1978. "How safe is safe enough? A psychometric study of attitudes towards technological risks and benefits." *Policy Sciences* 9 (2):127-152. doi: 10.1007/bf00143739.

Fischhoff, Baruch, Stephen R. Watson, and Chris Hope. 1984. "Defining risk." *Policy Sciences* 17 (2):123-139. doi: 10.1007/bf00146924.

Fleenor, John W., James W. Smither, Leanne E. Atwater, Phillip W. Braddy, and Rachel E. Sturm. 2010. "Self–other rating agreement in leadership: A review." *The Leadership Quarterly* 21 (6):1005-1034. doi: 10.1016/j.leaqua.2010.10.006.

Flemig, Sophie, Stephen Osborne, and Tony Kinder. 2016. "Risky business—reconceptualizing risk and innovation in public services." *Public Money & Management* 36 (6):425-432. doi: 10.1080/09540962.2016.1206751.
Fowler, Luke. 2021. "How to implement policy: Coping with ambiguity and uncertainty." *Public Administration* 99 (3):581-597. doi: 10.1111/padm.12702.
Freeman, R. Edward. 2004. "The Stakeholder Approach Revisited." *Zeitschrift für Wirtschafts- und Unternehmensethik* 5 (3):228.
Freeman, R. Edward, Jeffrey S. Harrison, Andrew C. Wicks, Bidhan Parmar, and Simone de Colle. 2010. *Stakeholder theory: The State of the Art*. Cambridge: Cambridge University Press.
Freidson, Eliot. 1994. *Professionalism reborn : theory, prophecy and policy*. Cambridge: Polity Press.
Freidson, Eliot. 2001. *Professionalism: The Third Logic*. Oxford: Polity Press.
Frey, Bruno S., and Reto Jegen. 2001. "Motivation Crowding Theory." *Journal of Economic Surveys* 15 (5):589-611. doi: 10.1111/1467-6419.00150.
Friedman, Milton, and L. J. Savage. 1948. "The Utility Analysis of Choices Involving Risk." *Journal of Political Economy* 56 (4):279-304. doi: 10.1086/256692.
Gerring, J. 2004. "What Is a Case Study and What Is It Good for?" *The American Political Science Review* 98 (2):341-354. doi: 10.2307/4145316.
Gerring, J. 2006. *Case study research: Principles and practices*. Cambridge: Cambridge University Press. Book.
Gertsen, Line, and Morten Frandsen. 2020. "16-årig døde af meningitis: Nu får læge bødestraf." Danmarks Radio, accessed November 11. https://www.dr.dk/nyheder/indland/16-aarig-doede-af-meningitis-nu-faar-laege-boedestraf.
Giddens, Anthony. 1991. *Modernity and Self-Identity: Self and Society in The Late Modern Age*. Oxford: Polity Press.
Giddens, Anthony. 1999. "Risk and Responsibility." *The Modern Law review* 62 (1):1-10.
Grailey, K. E., E. Murray, T. Reader, and S. J. Brett. 2021. "The presence and potential impact of psychological safety in the healthcare setting: an evidence synthesis." *BMC Health Services Research* 21 (1). doi: 10.1186/s12913-021-06740-6.
Green-Pedersen, Christoffer, and Carsten Jensen. 2019. "Electoral competition and the welfare state." *West European Politics* 42 (4):803-823. doi: 10.1080/01402382.2019.1565736.
Guarnaccia, Cinzia, Fabrizio Scrima, Alba Civilleri, and Laura Salerno. 2018. "The Role of Occupational Self-Efficacy in Mediating the Effect of Job Insecurity on Work Engagement, Satisfaction and General Health." *Current Psychology* 37 (3):488-497. doi: 10.1007/s12144-016-9525-0.
Günzel-Jensen, Franziska, Ajay K. Jain, and Anne Mette Kjeldsen. 2018. "Distributed leadership in health care: The role of formal leadership styles

and organizational efficacy." *Leadership* 14 (1):110-133. doi: 10.1177/1742715016646441.
Harrits, Gitte Sommer. 2019. "Street-level bureaucracy research and professionalism." In *Research Handbook on Street-Level Bureaucracy. The Ground Floor of Government in Context*, edited by Peter Hupe, 193-208. Edward Elgar Publishing.
Harrits, Gitte Sommer, and Marie Østergaard Møller. 2014. "Prevention at the Front Line: How home nurses, pedagogues, and teachers transform public worry into decisions on special efforts." *Public Management Review* 16 (4):447-480. doi: 10.1080/14719037.2013.841980.
Health, Danish Ministry of. 2021. Health Care Act.
Hill, Michael, and Peter Hupe. 2003. *Implementing Pblic Policy: Gvernance in Teory and practice*. Edited by Michael Hill and Peter Hupe. Reprint. ed, *Sage politics texts*. London: Sage.
Hjortskov, Morten. 2019. "Citizen Expectations and Satisfaction Over Time: Findings From a Large Sample Panel Survey of Public School Parents in Denmark." *The American Review of Public Administration* 49 (3):353-371. doi: 10.1177/0275074018765822.
Hood, Christopher. 2002. "The Risk Game and the Blame Game." *Government and Opposition* 37 (1):15-37. doi: 10.1111/1477-7053.00085.
Hood, Christopher. 2007. "What happens when transparency meets blame-avoidance?" *Public Management Review* 9 (2):191-210. doi: 10.1080/14719030701340275.
Hupe, Peter, and Michael Hill. 2007. "STREET-LEVEL BUREAUCRACY AND PUBLIC ACCOUNTABILITY." *Public Administration* 85 (2):279-299. doi: 10.1111/j.1467-9299.2007.00650.x.
Jacobsen, Christian Bøtcher, and Lotte Bøgh Andersen. 2015. "Is Leadership in the Eye of the Beholder? A Study of Intended and Perceived Leadership Practices and Organizational Performance." *Public Administration Review* 75 (6):829-841. doi: 10.1111/puar.12380.
Jacobsen, Christian Bøtcher, Lotte Bøgh Andersen, Anne Bøllingtoft, and Tine Louise Mundbjerg Eriksen. 2021. "Can Leadership Training Improve Organizational Effectiveness? Evidence from a Randomized Field Experiment on Transformational and Transactional Leadership." *Public Administration Review*. doi: 10.1111/puar.13356.
Jacobsen, Christian Bøtcher, Johan Hvitved, and Lotte Bøgh Andersen. 2014. "Command And Motivation: How The Perception Of External Interventions Relates To Intrinsic Motivation And Public Service Motivation." *Public Administration* 92 (4):790-806. doi: 10.1111/padm.12024.
James, Oliver. 2011. "Managing Citizens' Expectations Of Public Service Performance: Evidence From Observation And Experimentation In Local Government." *Public Administration* 89 (4):1419-1435. doi: 10.1111/j.1467-9299.2011.01962.x.

James, Oliver, Sebastian Jilke, Carolyn Petersen, and Steven Van De Walle. 2016. "Citizens' Blame of Politicians for Public Service Failure: Experimental Evidence about Blame Reduction through Delegation and Contracting." *Public Administration Review* 76 (1):83-93. doi: 10.1111/puar.12471.

Jenkins, Nicholas, Michael Bloor, Jan Fischer, Lee Berney, and Joanne Neale. 2010. "Putting it in context: the use of vignettes in qualitative interviewing." *Qualitative Research* 10 (2):175-198. doi: 10.1177/1468794109356737.

Jensen, Ulrich Thy. 2018. "Does Perceived Societal Impact Moderate the Effect of Transformational Leadership on Value Congruence? Evidence from a Field Experiment." *Public Administration Review* 78 (1):48-57. doi: 10.1111/puar.12852.

Jensen, Ulrich Thy, Lotte Bøgh Andersen, Louise Ladegaard Bro, Anne Bøllingtoft, Tine Louise Mundbjerg Eriksen, Ann-Louise Holten, Christian Bøtcher Jacobsen, Jacob Ladenburg, Poul Aaes Nielsen, Heidi Houlberg Salomonsen, Niels Westergård-Nielsen, and Allan Würtz. 2019. "Conceptualizing and Measuring Transformational and Transactional Leadership." *Administration & Society* 51 (1):3-33. doi: 10.1177/0095399716667157.

Jensen, Ulrich Thy, Lotte Bøgh Andersen, and Christian Bøtcher Jacobsen. 2019. "Only When We Agree! How Value Congruence Moderates the Impact of Goal-Oriented Leadership on Public Service Motivation." *Public Administration Review* 79 (1):12-24. doi: 10.1111/puar.13008.

Jørgensen, Torben Beck, and Barry Bozeman. 2007. "Public Values." *Administration & Society* 39 (3):354-381. doi: 10.1177/0095399707300703.

Kahneman, Daniel. 1994. "New Challenges to the Rationality Assumption." *Journal of Institutional and Theoretical Economics (JITE) / Zeitschrift für die gesamte Staatswissenschaft* 150 (1):18-36.

Kahneman, Daniel. 2011. *Thinking, fast and slow*. London: Allen Lane.

Kahneman, Daniel, Paul Slovic, and Amos Tversky. 1982. *Judgment under uncertainty : heuristics and biases*. Cambridge: Cambridge University Press.

Kahneman, Daniel, and Amos Tversky. 1979. "Prospect Theory: An Analysis of Decision under Risk." *Econometrica* 47 (2):263-291. doi: 10.2307/1914185.

Kjeldsen, Anne Mette. 2012. "Sector and Occupational Differences in Public Service Motivation: A Qualitative Study." *International Journal of Public Administration* 35 (1):58-69. doi: 10.1080/01900692.2011.635452.

Knight, Frank H. 1921 [1946]. *Risk, uncertainty and profit : (6. impr.), Series of Reprints of Scarce Tracts in economic and political Science ; No. 16*. Boston, Houghton Mifflin: The London School of Economics and political Science.

Koop, Christel. 2011. "Explaining the Accountability of Independent Agencies: The Importance of Political Salience." *Journal of Public Policy* 31 (2):209-234. doi: 10.1017/s0143814x11000080.

Krejberg, Lars. 2018. "Dommen er faldet: Overlæge fra OUH frifindes efter patient-dødsfald." *Fyens Stifstidende*, February 2 2018. Accessed October 11 2021. https://fyens.dk/artikel/dommen-er-faldet-overl%C3%A6ge-fra-ouh-frifindes-efter-patient-d%C3%B8dsfald.

Kunreuther, Howard. 1992. "A Conceptual Framework for Managing Low-Probability Events." In *Social Theories of Risk*, edited by Sheldon Krimsky and Dominic Golding, 301-320. Westport, Conneticut: Praeger.

Landau, Martin. 1969. "Redundancy, Rationality, and the Problem of Duplication and Overlap." *Public Administration Review* 29 (4):346. doi: 10.2307/973247.

Larsen, Martin Vinæs. 2021. "How Do Voters Hold Politicians Accountable for Personal Welfare? Evidence of a Self-Serving Bias." *The Journal of Politics* 83 (2):740-752. doi: https://doi.org/10.1086/710325.

Lasswell, Harold D. 1958 [1936]. *Politics, who gets what, when, how*. Reprint. ed, *Meridian Books ; M 58*. New York: Meridian Books.

Ledelseskommissionen. 2018. *Sæt borgerne først : ledelse i den offentlige sektor med fokus på udvikling af driften : anbefalinger fra Ledelseskommissionen*. Kbh: Ledelseskommissionen.

Lipsky, Michael. 2010. *Street-level bureaucracy : dilemmas of the individual in public services*. 30. anniversary expanded ed. ed. New York: Russell Sage Foundation.

Loon, Nina M., Martin Baekgaard, and Donald P. Moynihan. 2020. "Stability not change: Improving frontline employee motivation through organizational reform is harder than it looks." *Public Administration*. doi: 10.1111/padm.12639.

Mansbridge, Jane. 1990. "Self-Interest in Political Life." *Political Theory* 18 (1):132-153. doi: 10.1177/0090591790018001007.

March, J. G., and H. A. Simon. 1958. *Organizations*, *Organizations*. Oxford, England: Wiley.

March, James G., and Herbert A. Simon. 1994. *Organizations*. 2. editon, reprint 1994. ed. Oxford: Blackwell.

Markowitz, Harry. 1952. "The Utility of Wealth." *Journal of Political Economy* 60 (2):151-158. doi: 10.1086/257177.

Martin, Cathie Jo. 2013. "Interview Research in Political Science." In *Interview Research in Political Science*, edited by Layna Mosley, 109-124. Ithaca, UNITED STATES: Cornell University Press.

Maynard-Moody, Steven, and Michael Musheno. 2012. "Social Equities and Inequities in Practice: Street-Level Workers as Agents and Pragmatists." *Public Administration Review* 72 (1):S16-S23. doi: 10.1111/j.1540-6210.2012.02633.x.

Maynard-Moody, Steven, and Michael C. Musheno. 2003. *Cops, teachers, counselors : stories from the front lines of public service*. Ann Arbor: University of Michigan Press.

McCubbins, Mathew D., and Thomas Schwartz. 1984. "Congressional Oversight Overlooked: Police Patrols versus Fire Alarms." *American Journal of Political Science* 28 (1):165. doi: 10.2307/2110792.
Meier, K., S. C. Andersen, L. J. O'Toole, N. Favero, and S. C. Winter. 2015. "Taking Managerial Context Seriously: Public Management and Performance in U.S. and Denmark Schools." *International Public Management Journal* 18 (1):130-150. doi: 10.1080/10967494.2014.972485.
Meier, K., and Laurence J. O'Toole. 2011. "Comparing Public and Private Management: Theoretical Expectations."
Meijer, Albert. 2014. Transparency. In *The Oxford Handbook of Public Accountability*, edited by Robert E. Goodin Mark Bovens, Thomas Schillemans. Oxford: Oxford University Press.
Meister, David. 1991. "Uncertainty and Indeterminacy." In *Advances in Human Factors/Ergonomics*, edited by David Meister, 77-120. Elsevier.
Mejlgaard, Ole Fink, and Jakob Gammelgaard. 2021. "Birgit og Trine og ærkeengel i kamp mod vacciner: Nu må de ikke kalde sig sygeplejersker." *Nordjyske*, August 30 2021. Accessed October 13 2021. https://nordjyske.dk/nyheder/frederikshavn/trine-og-birgit-healer-mod-corona-vacciner-nu-maa-de-ikke-kalde-sig-sygeplejersker/0f3f9085-c3b2-4a5d-9fb9-0ee91ad5eb94.
Melander, Preben, and Kim Adamsen. 2009. *Lean med lederskab : fra systematisk produktivitetsjagt til forankret innovationskultur*. 1. udgave. ed. Kbh: Jurist- og Økonomforbundet.
Miles, Matthew B., A.M. Huberman, and Johnny Saldaña. 2017. *Qualitative data analysis : a methods sourcebook*. Edited by Matthew B. Miles, A. M. Huberman and Johnny Saldaña. Third edition. ed. Thousand Oaks, Califorinia: SAGE Publications, Inc.
Moynihan, Donald P. 2008. *The dynamics of performance management : constructing information and reform*, *Public management and change series*. Washington, D.C.: Georgetown University Press.
Moynihan, Donald P. 2012. "Extra-Network Organizational Reputation and Blame Avoidance in Networks: The Hurricane Katrina Example : BLAME AVOIDANCE IN NETWORKS." *Governance* 25 (4):567-588. doi: 10.1111/j.1468-0491.2012.01593.x.
Musheno, Michael, and Steven Maynard-Moody. 2015. "'Playing the rules': Discretion in social and policy context." In *Understanding Street-Level Bureaucracy*, edited by Michael Hill Peter Hupe, Aurelien Buffat. Bristol: Policy Press.
Møller, Anne Mette. 2021. "Deliberation and Deliberative Organizational Routines in Frontline Decision-Making." *Journal of Public Administration Research and Theory*. doi: 10.1093/jopart/muaa060.
Møller, Anne Mette f. 2018. *Organizing knowledge and decision-making in street-level professional practice : a practice-based study of Danish child*

protective services. Kbh.: University of Copenhagen, Faculty of Social Sciences.
Møller, Marie Østergaard. 2016. "“She isn’t Someone I Associate with Pension”—a Vignette Study of Professional Reasoning." *Professions and Professionalism* 6 (1). doi: 10.7577/pp.1353.
Nembhard, Ingrid M., and Amy C. Edmondson. 2006. "Making it safe: the effects of leader inclusiveness and professional status on psychological safety and improvement efforts in health care teams." *Journal of Organizational Behavior* 27 (7):941-966. doi: 10.1002/job.413.
Nembhard, Ingrid M., and Amy C. Edmondson. 2012. Psychological Safety: A Foundation for Speaking Up, Collaboration, and Experimentation in Organizations. In *The Oxford Handbook of Positive Organizational Scholarship*, edited by Gretchen M. Spreitzer and Kim S. Cameron. Oxford: Oxford University Press.
Neumann, John von, and Oskar Morgenstern. 1947. *Theory of games and Economic Behavior*. Princeton: Princeton University Press.
Newman, Alexander, Ross Donohue, and Nathan Eva. 2017. "Psychological safety: A systematic review of the literature." *Human Resource Management Review* 27 (3):521-535. doi: 10.1016/j.hrmr.2017.01.001.
Nothdurfter, Urban, and Koen Hermans. 2018. "Meeting (or not) at the street level? A literature review on street-level research in public management, social policy and social work." *International Journal of Social Welfare* 27 (3):294-304. doi: 10.1111/ijsw.12308.
O'Toole, L., K. Meier, and S. Nicholson-Crotty. 2005. "Managing upward, downward and outward: Networks, hierarchical relationships and performance." *Public Management Review* 7 (1):45-68. doi: 10.1080/1471903042000339419.
O'Toole, Laurence J., and Kenneth J. Meier. 2010. "In Defense of Bureaucracy." *Public Management Review* 12 (3):341-361. doi: 10.1080/14719030903286599.
Palermo, Tommaso. 2014. "Accountability and Expertise in Public Sector Risk Management: A Case Study." *Financial Accountability & Management* 30 (3):322-341. doi: 10.1111/faam.12039.
Peters, Ellen, Paul Slovic, Judith H. Hibbard, and Martin Tusler. 2006. "Why Worry? Worry, Risk Perceptions, and Willingness to Act to Reduce Medical Errors." *Health Psychology* 25 (2):144-152. doi: 10.1037/0278-6133.25.2.144.
Police, ([Rigspolitiet]) Danish National. 2021. Resolved Disciplinary Proceedings in the Police from January 1st 2020 to December 31st 2020 [Afgjorte disciplinærsager i politiet fra 1. januar 2020 til 31. december 2020]. Danish National Police.
Pressman, Jeffrey L., and Aaron Wildavsky. 1984. *Implementation : how great expectations in Washington are dashed in Oakland; or, Why it's amazing that federal programs work at all : this being a saga of the economic*

development administration. 3. ed. ed, *Oakland Project series*. Berkeley: Univ. of California Press.
Przeworski, Adam. 1970. *The logic of comparative social inquiry*. Edited by Henry Teune, *Comparative studies in behavioral science*. New York: Wiley-Interscience.
Rahbek Gjerdrum Pedersen, Esben, and Mahad Huniche. 2011. "Determinants of lean success and failure in the Danish public sector." *International Journal of Public Sector Management* 24 (5):403-420. doi: 10.1108/09513551111147141.
Reenock, C. M., and B. J. Gerber. 2007. "Political Insulation, Information Exchange, and Interest Group Access to the Bureaucracy." *Journal of Public Administration Research and Theory* 18 (3):415-440. doi: 10.1093/jopart/mum021.
Reid, Melanie. 2019. "NZ's own 'taken generation'." *Newsroom*. https://www.newsroom.co.nz/2019/06/11/629363/nzs-own-taken-generation.
Renn, Ortwin. 1992. "Concepts of Risk: A Classification." In *Social Theories of Risk*, edited by Sheldon Krimsky and Dominic Golding, 53-79. Westport: Praeger.
Riccucci, Norma. 2005. *How management matters : street-level bureaucrats and welfare reform*, *Public management and change*. Washington, D.C.: Georgetown University Press.
Rigotti, Thomas, Birgit Schyns, and Gisela Mohr. 2008. "A Short Version of the Occupational Self-Efficacy Scale: Structural and Construct Validity Across Five Countries." *Journal of Career Assessment* 16 (2):238-255. doi: 10.1177/1069072707305763.
Ritzer, George. 2011. *Sociological Theory*. 7 ed. New York: McGraw-Hill.
Rosa, Eugene A. 1998. "Metatheoretical foundations for post-normal risk." *Journal of Risk Research* 1 (1):15-44. doi: 10.1080/136698798377303.
Ruggeri, Kai, Sonia Alí, Mari Louise Berge, Giulia Bertoldo, Ludvig D. Bjørndal, Anna Cortijos-Bernabeu, Clair Davison, Emir Demić, Celia Esteban-Serna, Maja Friedemann, Shannon P. Gibson, Hannes Jarke, Ralitsa Karakasheva, Peggah R. Khorrami, Jakob Kveder, Thomas Lind Andersen, Ingvild S. Lofthus, Lucy McGill, Ana E. Nieto, Jacobo Pérez, Sahana K. Quail, Charlotte Rutherford, Felice L. Tavera, Nastja Tomat, Chiara Van Reyn, Bojana Većkalov, Keying Wang, Aleksandra Yosifova, Francesca Papa, Enrico Rubaltelli, Sander Van Der Linden, and Tomas Folke. 2020. "Replicating patterns of prospect theory for decision under risk." *Nature Human Behaviour* 4 (6):622-633. doi: 10.1038/s41562-020-0886-x.
Ryan, Richard M., and Edward L. Deci. 2000. "Intrinsic and Extrinsic Motivations: Classic Definitions and New Directions." *Contemporary Educational Psychology* 25 (1):54-67. doi: 10.1006/ceps.1999.1020.
Rømeling, Lise Højer, Christian Stemann, and Jonas Deiborg. 2017. "Jordemoder tog telefonen da 17-årig døde af meningitis." Danmarks Radio,

accessed December 15. https://www.dr.dk/nyheder/regionale/hovedstadsomraadet/jordemoder-tog-telefonen-da-17-aarig-doede-af-meningitis.
Saldaña, Johnny. 2013. *The coding manual for qualitative researchers*. 2. ed. Los Angeles, Calif: Sage.
Sandfort, J. R. 2000. "Moving Beyond Discretion and Outcomes: Examining Public Management from the Front Lines of the Welfare System." *Journal of Public Administration Research and Theory* 10 (4):729-756. doi: 10.1093/oxfordjournals.jpart.a024289.
Schreier, Margrit. 2012. *Qualitative content analysis in practice*. Los Angeles, California: SAGE.
Seawright, Jason, and John Gerring. 2008. "Case Selection Techniques in Case Study Research." *Political Research Quarterly* 61 (2):294-308. doi: 10.1177/1065912907313077.
Shrader-Frechette, K. S. 1991. "Risk and rationality : philosophical foundations for populist reforms." In. Berkeley: University of California Press. http://publishing.cdlib.org/ucpressebooks/view?docId=ft3n39n8s1;query=;brand=ucpress.
Simon, Herbert A. 1997. *Administrative behavior : a study of decision-making processes in administrative organizations*. 4.ed. ed. New York, N.Y: Free Press.
Sjöberg, Lennart. 2000. "The Methodology of Risk Perception Research." *Quality and Quantity* 34 (4):407-418. doi: 10.1023/A:1004838806793.
Sjöberg, Lennart, Bjørn-Elin Moen, and Torbjørn Rundmo. 2004. "Explaining risk perception. An evaluation of the psychometric paradigm in risk perception research." *Rotunde* 84.
Slovic, Paul. 1998. "The risk game." *Reliability Engineering and System Safety* 59 (1):73-77. doi: 10.1016/S0951-8320(97)00121-X.
Slovic, Paul, Melissa L. Finucane, Ellen Peters, and Donald G. MacGregor. 2004. "Risk as Analysis and Risk as Feelings: Some Thoughts about Affect, Reason, Risk, and Rationality." *Risk Analysis* 24 (2):311-322. doi: 10.1111/j.0272-4332.2004.00433.x.
Slovic, Paul, Melissa Finucane, Ellen Peters, and Donald G. MacGregor. 2002. "Rational actors or rational fools: implications of the affect heuristic for behavioral economics." *Journal of Socio-Economics* 31 (4):329-342. doi: 10.1016/S1053-5357(02)00174-9.
Slovic, Paul, and Ellen Peters. 2006. "Risk Perception and Affect." *Current Directions in Psychological Science* 15 (6):322-325. doi: 10.1111/j.1467-8721.2006.00461.x.
Starmer, C. 2000. "Developments in non-expected utility theory: The hunt for a descriptive theory of choice under risk." *Journal of Economic Literature* 38 (2):332-382. doi: 10.1257/jel.38.2.332.
Starr, Chauncey. 1969. "Social Benefit versus Technological Risk." *Science* 165 (3899):1232-1238. doi: 10.1126/science.165.3899.1232.

Strandby, Martin Williams, Amalie Martinus Hauge, Emily Rose Tangsgaard, Katrine Nøhr, and Tine Rostgaard. 2017. Kortlægning af lovende praksisser på området for overgreb mod børn og unge. In *Rapport*. Kbh: VIVE - Det Nationale Forsknings- og Analysecenter for Velfærd.

Sundhedsloven. 2018. Bekendtgørelse af sundhedsloven. edited by Sundheds- og Ældreministeriet. Retsinformation: Lovtidende.

Sundhedsstyrelsen. 2020. COVID-19: Monitorering af aktivitet i sundhedsvæsenet. Beskrivelse af udviklingen i aktivitet i sundhedsvæsenet under COVID-19 epidemien – 5. rapport [COVID-19: Monitoring of the activity in the healthcare sector. Description of the activity-development in the healthcare sector during the COVID-19 pandemic - 5th report]. In *COVID-19: Monitorering af aktivitet i sundhedsvæsenet. Beskrivelse af udviklingen i aktivitet i sundhedsvæsenet under COVID-19 epidemien*. København: Sundhedsstyrelsen.

Tangsgaard, Emily Rose. 2021. "How Do Public Service Professionals Behave in Risky Situations? The Importance of Organizational Culture." *The American Review of Public Administration* 51 (7):17. doi: 10.1177/02750740211010348.

Tangsgaard, Emily Rose. [In press]. "Risk management in public service delivery: Multidimensional scale development and validation." *International Public Management Journal*. doi: https://doi.org/10.1080/10967494.2021.2004270

Tarp, David. 2011. "Chef i Brønderslev-sagen raser over fyring." accessed 2 November. https://www.berlingske.dk/samfund/chef-i-broenderslev-sagen-raser-over-fyring.

Taylor, Frederick Winslow. 1916. *The principles of scientific management*. New York: Harper og Brother.

Thompson, Paul B., and Wesley Dean. 1996. "Competing Conceptions of Risk." *RISK: Health, Safety and Environment* 7 (4).

Tibetkommissionen. 2017. Tibetkommisisonens Beretning [Report from the Tibet Commission]. Copenhagen: Tibetkommissionen.

Tummers, Lars. 2013. *Policy Alienation and the Power of Professionals : Confronting New Policies*. Cheltenham, UK: Edward Elgar.

Tummers, Lars, and Eva Knies. 2016. "Measuring Public Leadership: Developing Scales for Four Key Public Leadership Roles." *Public Administration* 94 (2):433-451. doi: 10.1111/padm.12224.

Tversky, Amos, and Daniel Kahneman. 1973. "Availability: A heuristic for judging frequency and probability." *Cognitive Psychology* 5 (2):207-232. doi: 10.1016/0010-0285(73)90033-9.

Tversky, Amos, and Daniel Kahneman. 1974. "Judgment under Uncertainty: Heuristics and Biases." *Science* 185 (4157):1124-1131. doi: 10.1126/science.185.4157.1124.

Tversky, Amos, and Daniel Kahneman. 1981. "The framing of decisions and the psychology of choice." *Science* 211:453.

Tversky, Amos, and Daniel Kahneman. 1983. "Extensional versus intuitive reasoning: The conjunction fallacy in probability judgment." *Psychological Review* 90 (4):293-315. doi: 10.1037/0033-295X.90.4.293.
Tversky, Amos, and Daniel Kahneman. 1986. "Rational Choice and the Framing of Decisions." *The Journal of Business* 59 (4):S251-S278. doi: 10.1086/296365.
Tversky, Amos, and Daniel Kahneman. 1992. "Advances in Prospect Theory: Cumulative Representation of Uncertainty." *Journal of Risk and Uncertainty* 5 (4):297-323. doi: 10.1007/BF00122574.
Van Der Wal, Zeger, Gjalt De Graaf, and Karin Lasthuizen. 2008. "WHAT'S VALUED MOST? SIMILARITIES AND DIFFERENCES BETWEEN THE ORGANIZATIONAL VALUES OF THE PUBLIC AND PRIVATE SECTOR." *Public Administration* 86 (2):465-482. doi: 10.1111/j.1467-9299.2008.00719.x.
Van Der Wal, Zeger, and Leo Huberts. 2008. "Value Solidity in Government and Business." *The American Review of Public Administration* 38 (3):264-285. doi: 10.1177/0275074007309154.
Van Loon, Nina, Anne Mette Kjeldsen, Lotte Bøgh Andersen, Wouter Vandenabeele, and Peter Leisink. 2018. "Only When the Societal Impact Potential Is High? A Panel Study of the Relationship Between Public Service Motivation and Perceived Performance." *Review of Public Personnel Administration* 38 (2):139-166. doi: 10.1177/0734371x16639111.
Van Ryzin, Gregg G. 2004. "Expectations, Performance, and Citizen Satisfaction with Urban Services." *Journal of Policy Analysis and Management* 23 (3):433-448. doi: 10.2307/3326260.
Van Wart, Montgomery. 2013. "ADMINISTRATIVE LEADERSHIP THEORY: A REASSESSMENT AFTER 10 YEARS." *Public Administration*:n/a-n/a. doi: 10.1111/padm.12017.
Vis, Barbara, and Kees van Kersbergen. 2007. "Why and how do Political Actors Pursue Risky Reforms?" *Journal of Theoretical Politics* 19 (2):153-172. doi: 10.1177/0951629807074268.
Vogel, Dominik, and Alexander Kroll. 2019. "Agreeing to disagree? Explaining self–other disagreement on leadership behaviour." *Public Management Review* 21 (12):1867-1892. doi: 10.1080/14719037.2019.1577910.
Vogel, Rick, and Doris Masal. 2015. "Public Leadership: A review of the literature and framework for future research." *Public Management Review* 17 (8):1165-1189. doi: 10.1080/14719037.2014.895031.
Weaver, R. Kent. 1986. "The politics of blame avoidance." *Journal of Public Policy* 6 (4):371-398.
Wheeler, Gregory. 2020. Bounded Rationality. In *The Stanford Encyclopedia of Philosophy*, edited by Edward N. Zalta. Stanford University: Metaphysics Research Lab.
Yin, Robert K. 2014. *Case study research : design and methods*. Fifth edition ed. Los Angeles: SAGE.

Yukl, Gary A. 2013. *Leadership in organizations*. 8. ed. ed. Harlow: Pearson Education.
Zajonc, R. B. 1980. "Feeling and thinking: Preferences need no inferences." *American Psychologist* 35 (2):151-175. doi: 10.1037/0003-066X.35.2.151.

English Summary

Risks to service recipients are a basic condition faced by frontline managers and their employees in public service delivery. There are rarely right and wrong answers to the challenges they face, so frontline workers rely on their specialised theoretical knowledge, experience, and discretion in decision-making. The question is how frontline managers can support the decision-making behaviour of frontline workers in risky situations, where there is a high degree of uncertainty and potential negative consequences to service recipients.

The purpose of this PhD dissertation is to position the concept of risk management in the public administration and public management fields, and to provide empirical evidence of how risk management is exercised and how it affects frontline workers who face situations where there are risks to service recipients. This is achieved by answering the research question:

What is risk management, how is risk management exercised, and how does a managerial focus on risk matter to the risk perception of frontline workers?

Theoretically, the dissertation builds on literature about public leadership, decision-making under risk, and blame avoidance. A mixed-methods approach employing observations, interviews, scale development, and survey experiments is utilised to answer the research questions. The findings are presented in this monograph and in three articles.

In the dissertation, risk management is conceptualised as leadership behaviour targeted towards enabling frontline workers to mitigate negative consequences to service recipients in risky situations. It is theorised to hold three dimensions: organising work routines before risky situations, discussing professional issues during risky situations, and facilitating follow-up activities after risky situations. This conceptualisation is empirically validated in a scale that enables measuring leader-intended and employee-perceived risk management practices (Article B).

To obtain an in-depth sense of how risk management is exercised, the dissertation draws on individual and focus group interviews with 62 frontline managers from the healthcare and social services sectors. A key insight is that risk management practices are exercised more when distribution of responsibility is collectivised than when it is individualised. The findings further illustrate how risk management practices are conditioned by different actors in the organisational environment, such as political principals, formal contextual

conditions, and external stakeholders like regulatory government agencies, interest groups, and the media.

Finally, the dissertation studies frontline workers' behaviour in risky situations and their risk perceptions. One study finds that organisational culture can be a driver of both risk-seeking and risk-reducing behaviours among frontline workers (Article A). A second study finds that a managerial focus on risk in the shape of discussing professional issues during risky situations significantly reduces the risk perception of frontline workers – an effect that diminishes as level of professionalisation increases (Article C).

The dissertation has theoretical and empirical contributions. Theoretically, the conceptualisation of risk management and associated scale is a substantive contribution to the public administration and public management literatures. Empirically, the dissertation provides insights on how risk management is exercised at the frontlines of public service delivery, how this is dependent on the distribution of responsibility, how frontline workers behave in risky situations, and how a managerial focus on risk matters to frontline workers' risk perception.

The dissertation further demonstrates that risk management is a resource-demanding leadership behaviour. This gives rise to a discussion of whether there is a trade-off between reducing risks to service recipients and organisational effectiveness, which is related to how accountability in public service delivery is best achieved.

Dansk resumé

Risici for borgere er en grundlæggende betingelse, som offentlige ledere og deres medarbejdere skal forholde sig til i leveringen af velfærdsydelser. Der er sjældent rigtige eller forkerte svar på de udfordringer som frontlinjemedarbejdere møder, og de beror derfor på deres specialiserede teoretiske viden, erfaring og professionelle skøn, når de træffer beslutninger. Spørgsmålet er, hvordan frontlinjeledere kan støtte frontlinjemedarbejderes beslutningsadfærd i risikosituationer, hvor der er en høj grad af usikkerhed og potentielt negative konsekvenser for borgerne.

Formålet med denne ph.d.-afhandling er at positionere begrebet risikoledelse i forvaltnings- og ledelseslitteraturen, og at tilvejebringe empirisk viden om hvordan risikoledelse udøves og hvordan det påvirker frontlinjemedarbejdere som står i situationer, hvor der er risici for borgerne. Formålet indfries ved at besvare forskningsspørgsmålet:

Hvad er risikoledelse, hvordan udøves risikoledelse, og hvordan påvirker et ledelsesmæssigt fokus på risiko frontlinjemedarbejderes risikoopfattelse?

Teoretisk bygger afhandlingen på litteratur om offentlig ledelse, teori om beslutningstagning under risiko, og blame avoidance. Forskellige metoder som deltagerobservationer, interviews, udvikling af måleredskab, og surveyeksperimenter anvendes til at besvare forskningsspørgsmålet. Resultaterne præsenteres i denne monografi og tre videnskabelige artikler.

Risikoledelse konceptualiseres i afhandlingen som en ledelsesadfærd rettet mod at sætte frontlinjemedarbejdere i stand til at afbøde negative konsekvenser for borgerne i risikosituationer. Begrebet har tre dimensioner: organisering af arbejdsrutiner før risikosituationer, faglig sparring under risikosituationer, og facilitering af opfølgningsaktiviteter efter risikosituationer. Denne konceptualisering er empirisk valideret i et redskab, der gør det muligt at måle lederintenderet og medarbejderopfattet risikoledelse (Artikel B).

Afhandlingen bygger på individuelle og fokusgruppeinterviews med 62 frontlinjeledere fra hospitals- og socialområdet for at opnå en dybdegående forståelse af, hvordan risikoledelse udøves. En central indsigt er, at der udøves mere risikoledelse, når ansvar for beslutninger er kollektivt, end når det er individualiseret. Desuden er risikoledelse betinget af forskellige aktører i organisationens omgivelser i form af politiske principaler, formelle styringsmæssige rammer, og eksterne aktører som statslige styrelser, interessegrupper og medierne.

Endelig undersøger afhandlingen frontlinjemedarbejderes adfærd i risikosituationer og deres risikoopfattelser. Et studie viser, at organisationskultur

både kan fremme risikosøgende og risikoreducerende adfærd blandt frontlinjemedarbejdere (Artikel A). Et andet studie finder at et ledelsesmæssigt fokus på risici i form af faglig sparring i risikosituationen reducerer risikoopfattelsen blandt frontlinjemedarbejdere – en effekt der bliver mindre i takt med at graden af professionalisering stiger (Artikel C).

Afhandlingen har både teoretiske og empiriske bidrag. Konceptualiseringen af risikoledelse og det tilhørende måleredskab udgør et væsentligt teoretisk bidrag til forvaltnings- og ledelseslitteraturen. Empirisk bidrager afhandlingen med viden om, hvordan risikoledelse udøves i leveringen af velfærdsydelser, hvordan det er betinget af ansvarsdeling, hvordan frontlinjemedarbejdere handler i risikosituationer, og hvordan et ledelsesmæssigt fokus på risici påvirker frontlinjemedarbejderes risikoopfattelse.

Afhandlingen viser at risikoledelse er en ressourcekrævende ledelsesadfærd. Det giver anledning til en diskussion om hvorvidt der er en afvejning mellem at reducere risici for borgere og sikre organisatorisk effektivitet, hvilket er relateret til spørgsmålet om, hvordan offentlige organisationer bedst holdes ansvarlige for de velfærdsydelser, de leverer.