

# **THE TWELVE “P’s” FOR ASSESSING RISK IN ACADEMIC PROCEDURES AND POLICIES**

**A Guide For Those Responsible For The Design,  
Implementation And Assessment Of Academic  
Procedures And Policies In Australian Universities,**

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**INTRODUCTION**

This book has been developed as a guide for those responsible for the design, implementation and assessment of academic procedures and policies in Australian universities. *[An “academic procedure” is anything that “adds value” to the work of the institution and includes teaching, research, and student guidance, as well as purely administrative activities such as collecting fees or recording results . A “policy” determines how the procedure will be implemented].*

Every attempt to add or implement value involves risk, and the purpose throughout the following pages is to suggest ways in which these risks can be identified and minimized.

This is a book written for practitioners and those at the coal face, and for this reason there is a constant emphasis on “how to do things” rather than “why they should be done”. There are few references to the works of others and extremely little theory. While this may dissatisfy those seeking a more formal or academic approach it is believed appropriate for the task in hand, which is not to develop some sublime method for assessing procedures and policies, as might be done by observers from the top of an ivory tower, but rather an attempt to show those in danger of drowning how they might save themselves from the sea.

It is also stressed that this is a “first cut” only, and is not claimed to be a definitive work. Its purpose is to get people thinking in the expectation that they will improve on what is presented here. If the users of this book find certain aspects useful it is hoped that they will spread the word by force of example. In the same manner, if users find this work obscure, or simply plain wrong or pigheaded, it is hoped that they will contact the author, or better still produce something superior from which all can benefit.

It is hoped that all who use this work will gain something for their needs. I have learnt a great deal from its compilation myself and I trust that it may be possible to share a little of this with others.

**SUMMARY –**  
**THE TWELVE “P’s” FOR ASSESSING ACADEMIC PROCEDURES AND POLICIES**

This book is based on twelve single word questions, all beginning with the letter “P”, which have been designed to assess risk in academic procedures and policies. While each will be addressed in greater detail in the pages that follow, they are presented here as a combined summary and index;

PURPOSE? – Why has the procedure or policy been introduced, what is it intended to achieve, and what outcome is it expected to deliver? **[Page 4]**

PARTIES? – Who are the people involved with the policy or procedure? **[Page 18]**

- Those who devised it
- Those who sponsor it
- Those required to administer it
- Those affected by it
- Those who will use the end product

POSITION? – Where does the policy or procedure fit within the wider university system? What tasks, assumptions, processes, etc, precede and follow it, and does what is envisaged integrate smoothly with all of these? **[Page 30]**

PROTOCOL? – Is there a protocol governing its operation (a manual, set of instructions, template, etc,) to ensure consistency, uniformity and accountability? **[Page 38]**

PACE? – How slow or quickly does the process proceed, or the policy implemented, and is this the most appropriate for all participants (both those originating it and those affected)? **[Page 43]**

PACKAGE? – How is the process explained (packaged) to those affected by it? **[Page 53]**

PATTERN? – Does the process conform to the normal procedures within the university? **[P 58]**

PAYMENT? – Who pays for the process or policy (either directly or indirectly)? Does the benefit received outweigh the costs involved? **[Page 65]**

PRODUCTIVITY? – How many staff does the process involve, and is each one of these absolutely essential? **[Page 70]**

PRODUCT? – What does the process ***actually*** produce? Is this what was intended and does this come in a form in which it can be used effectively as an input for subsequent procedures**[Page 77]**

PROGRESSION? – Is the process reviewed at regular intervals and improved as required. **[P 84]**

PREMONITION? – How do the staff feel about the procedure? Are they comfortable with it, or do they fear that something is just waiting to go wrong? [Page 89]

We'll go through each of these questions in detail;

## **1. PURPOSE?** – Just why has the process or policy been introduced and what outcome is it expected to deliver?

There are always two answers to this question – the immediate and the ultimate. Suppose, for example, we are engaged in something that may appear completely obvious and unambiguous, such as asking people whether they are available for a meeting. The immediate purpose is clear. We need to know if a meeting of a specific duration at the time and place indicated can be slotted into their diary, and if this is impractical whether some alternative can be arranged.

The ultimate reason, on the other hand, may be far more important. We are effectively asking whether those involved would be willing to devote time to the meeting, thus foregoing other tasks that may be equally important, and in doing so joining themselves to a particular program or agenda by association, even though it may end up being a complete waste of an afternoon as far as the outcome is concerned.

We therefore ask invitees if they have space in their diary as a face saver – it is much easier for respondents to say that their time is already committed than to court offence by giving a deliberate refusal to attend, particularly when no one is likely to request a copy of their diary as proof that their excuse is justified.

This has immediate implications for risk management as there is always a temptation when one is questioned about the “purpose” of a procedure to give the *immediate* rather than the *ultimate* objective and possibly deceive oneself into the bargain.

Take the case of a person setting up an exam room. If someone asked “What are you doing?” they would almost certainly be treated with derision if not outright hostility. What is taking place is obvious. An exam has been scheduled, the institution has protocols to minimise disruption, to prevent cheating or to safeguard completed manuscripts, and the person concerned is arranging the furniture in accord with those protocols. What is taking place should be clear to anyone with the least familiarity with the system, and the question should be completely unnecessary.

And so it is, at least for the immediate answer, and if the person setting up the room views themselves as nothing more than a mechanical robot it is completely sufficient as well – the rules require that something be done in a particular manner, the institution has always done things this way, and who am I, as a lowly servant to challenge the wisdom of my superiors? The difficulty (and hence the risk) is that a mindless conformity of this nature excludes any possibility of improvement, particularly improvement at an operational or grass roots level where most of the action takes place.

The problem with mindless conformity is that it overlooks the possibility of technical, social or environmental change and hence exposes the process to the risk of obsolescence. Suppose for example that we position the desks in our exam room to completely eliminate the possibility of candidates passing notes to each other but at the same time do nothing to forbid the use of mobile phones, as “there is nothing about mobile phones in our procedures”. We may have conformed to the rules for ensuring a physical separation between students, but we have not addressed the underlying reason for this separation, namely the prevention of communication between examinees.

It is the same with all academic procedures – a mindless conformity opens the door to risk, and this is the very thing that regulatory bodies are anxious to avoid.

For risk to be minimised one must investigate the ultimate objective – not the external aspects of **how** the process is conducted, but **why** it is being done in the first place.

Take the queues that in the past extended out the door on enrolment day. Why did we enrol students any way, and why did we go to so much trouble, frustration and difficulty to do so consistently? As far as students are concerned enrolment tended to become a bureaucratic nightmare. Crowds, delays, the endless completion of forms, a barrage of questions, snap decisions and harsh demands for payments, with the ultimate reward being the issue of a tiny laminated card with a photograph that one would be ashamed to show to one's partner and little information about what actually lay ahead. It was a burden to be endured – a test of stamina if you like – to prove oneself worthy of passage through the portals of academia that has now been replaced electronically.

Those of us who have sat on the other side of the counter at enrolment (or worse, have had to follow up the conflicting, misleading or absurd information on forms – such as claims to have been born in the current year, or perhaps being born on a date that has yet to arrive) might take a similar view, having experienced the frustration, confusion and anger of enrolees times without number, while hoping that the period remaining until the shift ends will pass as quickly and as painlessly as possible.

And yet, why did we enrol students in this manner, and why was everyone exposed to such a nerve racking experience? The immediate answer by those on the enrolment desk was that the system required it (“It is on your statement of duties as a staff member, and you’ll be sacked if you don’t do it”) but this is clearly insufficient. The ultimate answer is that enrolment – whether physically or electronically - is a data collection exercise, and that the queues this produced were simply a means to this end. If the data could be collected in an easier or more convenient way with equivalent accuracy would it not be better to do so rather than perpetuate a time worn tradition? (But don’t say that electronic

enrolment is necessarily any better, particularly when those familiar with computers are unable to access the system and don't know where to seek help)

This is the reason one should always look for the ultimate purpose of a procedure, and mitigate any risks that might arise from collateral damage.

Let's continue with our classic enrolment session. The immediate risks are obvious, although because these can be clearly foreshadowed most are avoided before they become significant. Thus we rarely see students smothered in the rush to get through the door before all places are filled; we rarely see student admin staff emerging bruised and bleeding after the fifth or sixth assault by an irate customer; and we rarely find students walking out in disgust and taking their business elsewhere. These things are readily foreseen and prevented.

The real danger, on the other hand, lies in the things that cannot be foreseen. After the crowds depart the institution is left with a great mountain of data, some of which may be fraudulent or the result of inadvertent error while most is accurate, but who can tell the sheep from the goats in such an enormous yarding? The risk is that a small amount of this inaccurate material will slip through and become part of the permanent record.

Most universities impose a system of checks to limit this as far as possible although it is hard to exclude wilful misinformation. Thus forms are examined carefully while the student is present or on-line, with an explanation sought for any inconsistency. Then the information provided may be examined yet again before the data is amassed for reporting purposes.

The risks involved in enrolment are obvious and universities strive to control them. Students make mistakes (fortunately cases of deliberate misinformation are rare), checkers may be less than diligent, and forms can be misclassified or go astray, all with loss of accuracy.

These things are mere nuisances, however, and are not the real source of risk. Far more serious would be the theft or misuse of personal information, and this is the risk that institutions try to avoid at all cost.

It goes without saying that it should always be the greater risk that must be addressed first, even if less obvious, but to do this it is essential to identify the purpose of what is happening as a whole rather than simply monitor each step.

This is done through a process known as “risk priority mapping”. This involves a listing of all **reasonable** risks in order of likelihood together with the worst consequence that could occur should that risk be realized, the preventative action and the cost of this action verses the benefit, as per the following chart;

### **ENROLMENT RISK PRIORITY MAPPING**

<b><u>RISK</u></b> <i>Examples only</i>	<b><u>WORST CONSEQUENCE</u></b>	<b><u>PROBABILITY</u></b>	<b><u>PREVENTATIVE ACTION TO MINIMIZE THIS RISK</u></b>	<b><u>COST VERSES BENEFIT</u></b>
INADVERTENT PROVISION OF INCORRECT INFORMATION	SUSPECT INFORMATION MAY BE PLACED ON THE STUDENT RECORD SYSTEM, AND IF UNCORRECTED MAY BE REPORTED TO CANBERRA WITH LOSS OF REVENUE TO THE INSTITUTION	BASED ON PREVIOUS EXPERIENCE MAY OCCUR ONCE IN EVERY 250 FORMS	EFFECTIVE CHECKING AT THE POINT OF ENROLMENT, WITH FURTHER CHECKING FOR INTERNAL CONSISTENCY LATER IN THE PROCESS	COST IS MINIMAL IN COMPARISON TO BENEFITS
PROVISION OF DELIBERATELY FALSE INFORMATION BY STUDENTS (TAX FILE No, RESIDENT STATUS, ETC)	EMBARRASSMENT TO INSTITUTION FOR NOT CHECKING  <i>CONSEQUENCES FOR STUDENT MAY BE SEVERE</i>	RARE – POSSIBLY ONCE IN EVERY 5000 FORMS IF THAT	EFFECTIVE CHECKING POST ENROLMENT <i>[PRESSURE OF WORK PREVENTS CHECKING AT ENROLMENT]</i>	COST MAY NOT JUSTIFY THE BENEFIT <i>[UNIV ACCEPTS DATA IN GOOD FAITH]</i>

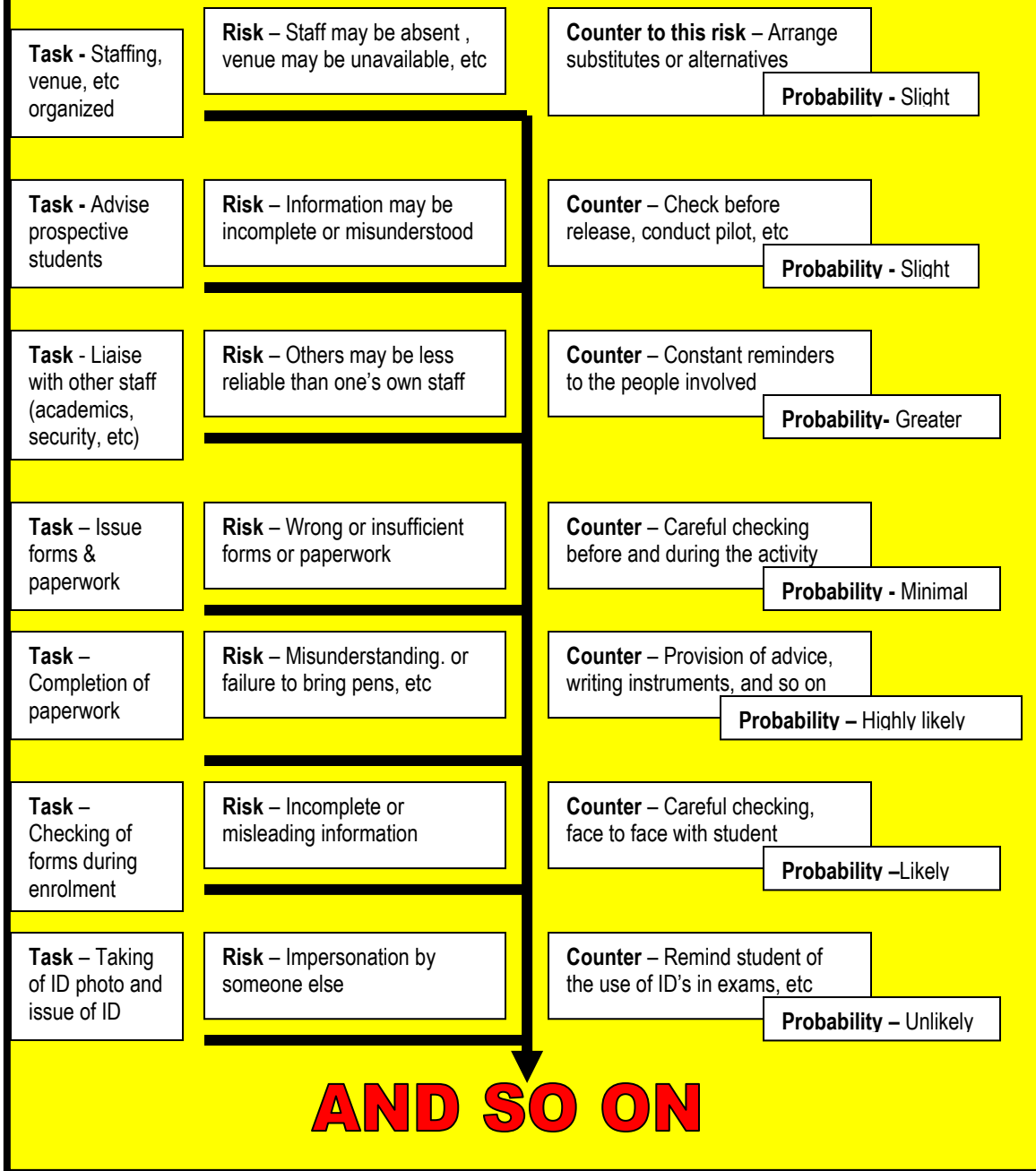


<b>FAILURE TO ENROL IN AN ORDERLY MANNER</b>	<b>DISRUPTION, ABUSE AND POTENTIAL INJURIES TO STAFF AND OTHER STUDENTS. MAY THREATEN THE REPUTATION OF THE INSTITUTION</b>	<b>RARE – NORMALLY ONLY OCCURS AFTER AN UNREASONABLE (AND UNEXPLAINED) DELAY</b>	<b>EFFECTIVE CROWD CONTROL MEASURES WITH APPROPRIATE SCHEDULING AND STAFFING</b>	<b>COST IS MINIMAL IN COMPARISON TO BENEFITS</b>
<b>FAILURE TO MAINTAIN CONFIDENTIALITY</b>	<b>SEVERE LEGAL REPERCUSSIONS, MAY DAMAGE INSTITUTIONAL REPUTATION</b>	<b>COMPARATIVELY RARE, BUT FREQUENT ENOUGH TO BE TAKEN SERIOUSLY</b>	<b>APPROPRIATE STAFF INDUCTION AND CONTROL MEASURES</b>	<b>COST IS MINIMAL IN COMPARISON TO BENEFITS</b>
<b>FAILURE TO PROVIDE SUFFICIENT STATIONERY</b>	<b>MAY CAUSE DELAY AND DISTRUPTION &amp; DAMAGE INSTITUT'AL REPUTATION</b>	<b>RARE THROUGH LEARNING FROM PAST EXPERIENCE</b>	<b>APPROPRIATE STOCK CONTROL &amp; REPROVISIONING</b>	<b>COST IS MINIMAL IN COMPARISON TO BENEFITS</b>

This chart is illustrative only, and no doubt could (and should) be greatly expanded by those familiar with student enrolments. It is important, on the other hand, that the information derived from this table be fully integrated with the mapping of the process concerned.

(See next page for a more detailed process mapping chart)

# ORGANIZATION OF A SIMPLIFIED FACE TO FACE ENROLMENT - PROCESS MAPPING



It is important throughout both the risk analysis and the process mapping procedure that four points be kept in mind;

- What is the purpose of the process or policy **as a whole**? (In other words, what is the activity intended to achieve?)
- What are the risks (and what is the probability of these risks occurring)?
- How can these risks be minimised?
- How likely are these risks to occur (and does the cost of risk minimization justify the benefit)?

Regulators for their part are likely to demand more than platitudes from the institutions they inspect, and this may involve an identification of the risks, an analysis of the probability of their occurrence, the consequences should the worst occur and the way in which these risks can be minimised or mitigated. This in turn will require two sub-sets of information when it comes to the purpose of the activity – the factors immediately applicable and those applying to the ultimate objectives for which the procedure is designed. *(A composite diagram and template is provided on a following page).*

Not all risk carries the same probability, and more will be said about this later. The point to be made here is that risk prevention or mitigation always costs something, and this must be factored into the equation, together with an identification of the person or group who will be required to pay for it. As will be explained shortly, any action taken to minimize risk must be based on whether the benefit outweighs the cost, and it may be that risks will have to be accepted simply because it is too expensive to do anything else. Let me give an example. I could insure my car – no doubt through payment of a hefty premium - against being trampled by passing elephants, but would it be prudent to do so? There is always some faint possibility of an elephant flattening my car even in the heart of the city, but would the cost – something that I would have to pay - outweigh the risk which might never occur? It is the same with academic procedures.

There is an element of risk in everything, but it is only when the consequence is sufficient to justify the cost that it may be necessary to do something about it.

One of the great dangers in risk management – and this applies far wider than higher education – is the temptation to identify all risks and to consider each of equal importance. Thus if any risk is perceived there is a feeling that it must be protected against, even though the probability of the event occurring might well be small. This leads to worry and endless expense, sometimes making the cure worse than the disease.

What is required is an identification of the most serious, or the most probable risks, followed by measures to counter these should they arise, rather than some blanket attempt to cover everything that might arise, no matter how unlikely. In some respects it's a bit like the miser who places his treasure in a strong box, which he then locks in a safe, which he then wheels into a vault, which he then entombs in a sealed room, and around which he subsequently erects a fortress to keep his possessions secure. This might minimise the risk of theft, but pity help him if he needs access to his money in a hurry.

The key to preventing stupidities like this is “purpose” – what is the purpose of a procedure, what are the risks involved, what is the probability of these risks being realized, and what is likely to happen if they occur? If these can be demonstrated one is well on the way to effective risk management.

*[It is important to note that we are talking about “risk management” here rather than “risk minimisation”. Risk management involves wearing a life jacket when you go fishing. Risk minimisation involves not going out at all. The first will provide security while fishing. The second will prevent all possible mishaps, but you won't catch any fish either, and will frustrate the purpose of what was intended. **Look first at the purpose of the activity and then consider the risks involved.** Don't look at the risks first and then shape your activity to avoid them – this may lead to a complete loss of purpose.]*

**COMPOSITE DECISION TREE - PURPOSE ANALYSIS**

What is the purpose of the activity – and is risk management cost effective?

*WHAT IS THE IMMEDIATE  
PURPOSE OF THE ACTIVITY?*

**WHAT RISKS MIGHT  
PREVENT ACHIEVMENT  
OF THESE OBJECTIVES?**

**WHAT WOULD BE  
THE CONSEQUENCE  
IF THESE RISKS  
OCCURRED?**

**HOW LIKELY ARE  
THESE RISKS?**

**HOW CAN THESE  
RISKS BE AVERTED?**

**HOW MUCH WILL  
AVERSION COST?**

*WHAT IS THE ULTIMATE  
PURPOSE OF THE ACTIVITY?*

**WHAT RISKS MIGHT  
PREVENT ACHIEVMENT  
OF THESE OBJECTIVES?**

**WHAT WOULD BE  
THE CONSEQUENCE  
IF THESE RISKS  
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**HOW LIKELY ARE  
THESE RISKS?**

**HOW CAN THESE  
RISKS BE AVERTED?**

**HOW MUCH WILL  
AVERSION COST?**

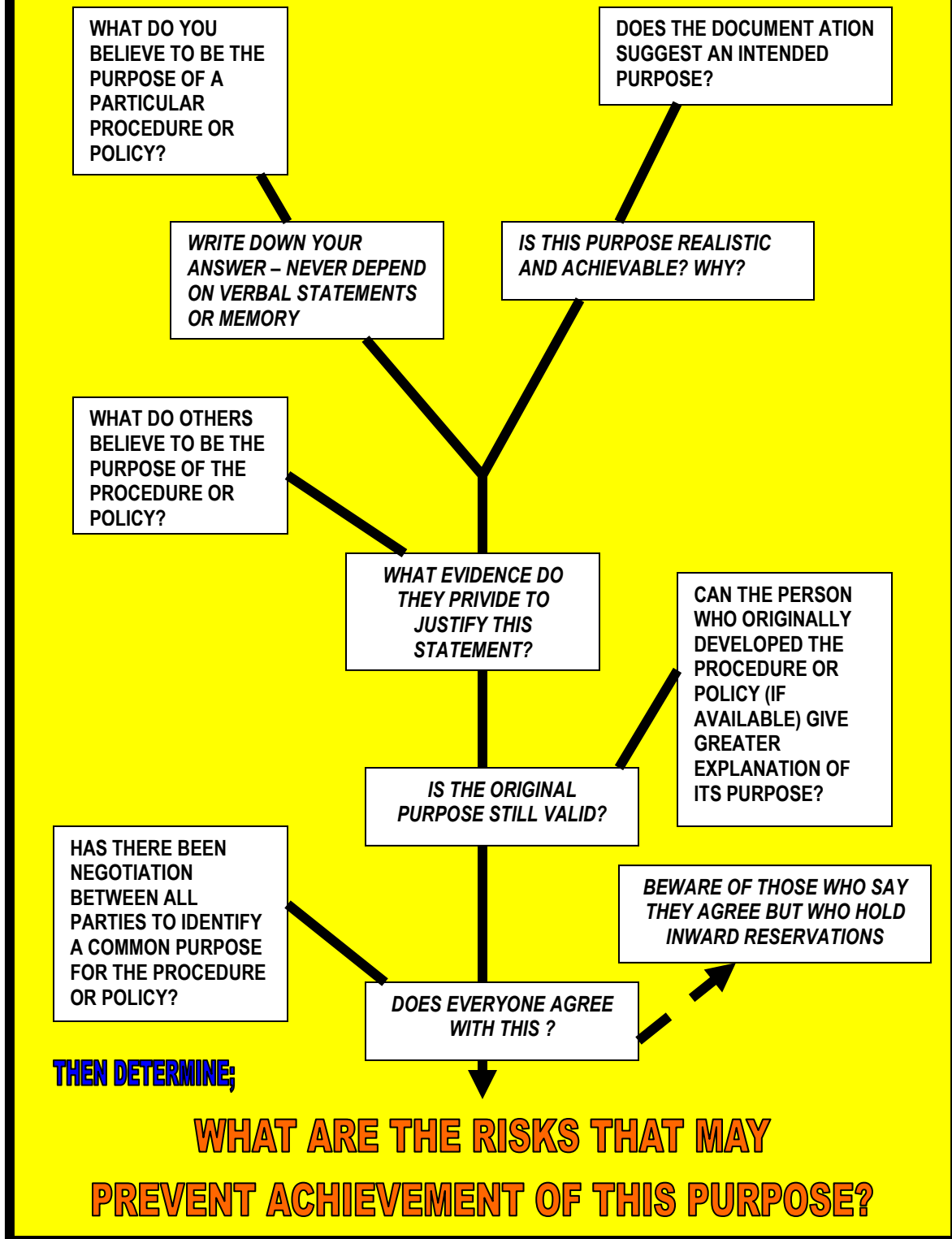
**IN THE END  
DOES THE RISK  
OUTWEIGH THE COST?**

One final point regarding the purpose of academic procedures and policies - unless there is discussion between everyone who contributes to or is involved with what is going on there may be no real understanding about what the **intended** purpose happens to be. If left to our own devices we human beings tend to view the world through our own eyes, and our interpretation of what we see may be radically different from everyone else. This is perhaps the greatest risk with any academic activity – that different groups may be seeking completely different outcomes or purposes without anyone being aware that this is happening – and the only way this can be avoided is through continual liaison between all parties.

It would be far better if all academic procedures and policies commenced with the words “The purpose of this procedure or policy is.....” but unfortunately this is rarely the case. What must be done where this explanation is missing is for each contributor to negotiate with his or her counterparts to develop a common understanding of the purpose of the procedure that will lead uniform outcomes. The greatest risk is that this negotiation will be deferred through pressure of time and will never occur.

There is the further danger that should there be uncertainty about the purpose of a procedure, there are likely to be different agendas, with different standards of performance leading to separate outcomes. Thus returning to enrolment once more, it may be in the interest of front line staff to get as many students as possible through the door each day, the assumption being that the more that are processed the better their performance and the sooner they can go home or return to something more interesting. This may be completely contrary to the wishes of data collection staff who might prefer a slower enrolment with a greater degree of accuracy. This in turn raises the question of the two type of risk inherent in any academic procedure – internal and external risk – which we will comment upon in a moment, but first a chart explaining how negotiations of this type might be brought to a successful conclusion;

## ACHIEVING CONSENSUS ABOUT THE PURPOSE OF A PROCEDURE



Mention was made on a previous page about the question of internal and external risks. **External risks** are those that are beyond the control of the participants. **Internal risk** arises from those immediately involved in the procedure.

Let me give an example. A couple make plans to go on a picnic. There are many things that might prevent this happening – it may be raining on the day, their car mightn't start, the picnic grounds may be closed, their cat may be sick, they may have an accident while travelling, and so on. These are external factors, essentially unforeseeable and beyond their control, and the only preventative action that could be taken would lie in the preparation of contingency plans to retrieve the situation should these things arise.

Alternatively there may be a number of internal factors that interfere with their planned enjoyment. The man may remember a dental appointment, his wife may discover she has nothing suitable to wear, they may learn that a favourite film (or the cricket) will be on TV, or one member of their partnership might change their mind and not wish to go. These are internal rather than external risks, reflecting a change in priorities that are within the control of the people involved. The couple may still intend to go on future picnics but other things have arisen in the meantime and the event is postponed.

INTERNAL AND EXTERNAL RISKS	
<b>EXTERNAL RISKS ARE GENERALLY;</b> <ul style="list-style-type: none"><li>• UNPREDICTABLE</li><li>• BEYOND PARTICIPANT'S CONTROL</li><li>• RESOLVED BY CONTINGENCY PLANNING (OR BY IMPROVISATION IF NO CONTINGENCY PLAN HAS BEEN PREPARED)</li><li>• TREATED AS "ONE-OFF" EVENTS <i>[The fact that they have occurred now does not mean that they are equally likely to occur in the future]</i></li></ul>	<b>INTERNAL RISKS ARE GENERALLY;</b> <ul style="list-style-type: none"><li>* FAR MORE PREDICTABLE</li><li>* WITHIN THE PARTICIPANTS' CONTROL</li><li>* RESOLVED BY COMPROMISE</li><li>* TREATED AS RECURRENT EVENTS <i>[The fact that they have occurred once strongly implies that they are likely to occur again, and this is factored into future planning]</i></li></ul>



It is important to note that neither internal nor external risk affect the “purpose” of a policy or procedure – the purpose remains the same irrespective of the risk - it is simply that when faced with something unacceptable from one cause or another the outcome may need to be achieved through different means.

Suppose a couple wish to marry, but one wants a church wedding while the other would prefer to take their vows in the open countryside. The purpose in both cases is the same – they wish to be married – but there is disagreement on the procedure through which this should be done. There are a number of external and internal risks – the church may be unavailable, it may be pouring with rain should they marry in the open air, they may argue to the point of breaking up altogether, and so on, but we’ll ignore all of these. The key point is that at the end of whatever process they go through they wish to emerge as a legally married couple, lawfully joined in the eyes of society. The means by which this is achieved is of far less consequence than the outcome.

It is the same with academic procedures and policies. It is the outcome – the “purpose” – that is the core element rather than the means through which that outcome might be achieved. It is right and proper to seek outcomes in the most expeditious manner, to impose standard methods of working, and to insist on consistency of throughput, but these remain secondary issues. The most important thing is to achieve the desired outcome legitimately, fairly, and in a timely manner irrespective of the method, but to do this it is essential to be certain of what the outcome happens to be in the first place.

We would laugh at the person who suggested that a wedding should be declared invalid because the bride carried a red carnation rather than a white rose, or that the ceremony should be void because the organist misplayed a note, and yet I fear that this is the sort of thing that occurs so frequently in the assessment of procedures and policies. It is the “purpose” that should be considered, together

with the risks that may prevent that purpose being achieved, rather than simply the minor difficulties likely to be encountered with mechanism of getting there.

**ANALYSIS CHART – THE RISKS THAT MAY PREVENT A PROCEDURE FROM ACHIEVING ITS PURPOSE**

<b>WHAT IS THE PURPOSE OF THE PROCEDURE?</b>	<u>IMMEDIATE PURPOSE</u>
	<u>ULTIMATE PURPOSE</u>
<b>WHAT <u>EXTERNAL</u> RISKS MAY PREVENT THE ACHIEVEMENT OF THESE PURPOSES?</b>	<u>IMMEDIATE RISKS</u>
	<u>LESS LIKELY RISKS</u>
	<u>POSSIBLE BUT REMOTE RISKS</u>
<b>WHAT <u>INTERNAL</u> RISKS MAY PREVENT THE ACHIEVEMENT OF THESE PURPOSES?</b>	<u>IMMEDIATE RISKS</u>
	<u>LESS LIKELY RISKS</u>
	<u>POSSIBLE BUT REMOTE RISKS</u>
<b>HOW CAN THESE RISKS BE AVOIDED, MINIMIZED OR MITIGATED?</b>	

**2. PARTIES?** – Who are the people involved with the procedure or policy? This is an extremely important factor when it comes to identifying internal risk, and it is suggested that these be divided into five groupings;

- Those who devised the procedure
- Those sponsoring the procedure
- Those required to administer or implement the procedure
- Those affected by the procedure
- Those who will use or benefit from the outcome or end product

Each of these may come with their own agenda, and it is from the resulting clash of interests that the internal risks arise.

We have already drawn attention to the need to identify the immediate and ultimate purpose of a procedure or policy as a precursor to developing a risk management plan. What we are seeking now is clarification of the agendas of the individuals or groups that might be associated with a particular activity; the consequence their interest might have for the achievement of its outcome, and the risks that may have to be foreseen to prevent something untoward developing.

There are no policies or procedures that deal exclusively with “things” – all impact upon people, and it is their effect on human beings that governs the potential for risk. Take the case of a lecturer marking assignments. At first glance the interaction might appear to be solely between the marker and the manuscript. The assignment is what is being assessed, and the details of who may have written it – provided nothing illegal is suspected – are essentially irrelevant. It is the document that lies beneath the marker’s pen, not the student. At the same time the script itself gains nothing from being marked. The paper may end up covered in red ink with much swearing from the frustrated evaluator, but the benefit or blame goes solely to the person who wrote it.

Thus there are two individuals, the assessor and the student, who are the ultimate parties to the transaction, not the document itself. No one asks how the assignment feels as it is disfigured by the assessor's pen. The document is inert and experiences neither pain nor pleasure. It is the student and the lecturer who stand to gain or lose – the student from the quality of the outcome and the lecturer from the judgement of peers.

But perhaps this is too simple a case. Let's take something more complex such as a contract for the erection of a university building. The parties in this case are less identifiable and at first sight less personal. The contract is between the "University" and the "Contractor" - a terrible set of collective nouns incidentally as the "University" cannot not share the emotions of a person despite what our legal friends may tell us, nor can the "Contractor" as a corporate body. The "University" in this case really means those officers responsible for the welfare of the institution, while the term "Contractor" draws together those responsible for the completion of a task. Each set of individuals acts as "agent" for a wider community, but in doing so they do not cease to remain human beings, and as such are liable to every weakness and virtue common to humanity

Nor are they the only individuals involved. Others (to their joy or horror) will be required to use the building long after its builders have departed. Lurking somewhere in the background will be an architect responsible for the plans, technical experts, and the financiers who are required to pay for whatever is erected. Also hovering near by are a vast army of regulators and spectators – building surveyors, firemen, lawyers and council representatives – while beyond them again lies the public, the student body and the government. Thus the procedure for the award of a contract is much more than an interaction between faceless anonymities, known collectively as the "University" and the "Contractor". It is an interaction between vast numbers of human beings, many of whom do not even know that they are involved, and therein lies the risk.

At the same time some individuals may be more exposed than others. We'll forget the analogy with buildings for the moment and think of something closer to the home, the preparation of staff payrolls on a fortnightly basis. A Martian, after parking his flying saucer in Broadway and climbing to the 25<sup>th</sup> floor of the Tower Building at UTS would be completely bamboozled by what was going on. Here we have people tapping keys in response to pieces of paper with no money in sight at all. Yet if something goes wrong it will be neither the computer nor the bank that complains – it will be the irate staff member who has not been paid, or has not been given what they reasonably believe they should deserve.

It is for this reason it is suggested that as we divided "Purpose" into two headings ("Immediate" and "Ultimate") in the previous section, with a sub-division of "Risks" into "Internal" and "External" so we should divide the concept of "Parties" to a procedure into two groups - "those involved with the procedure" and "those affected by it" - although it is realised that in some circumstances the same umbrella may cover both.

It is important to remember that in academic policies and procedures the risk invariably arises from humanity rather than from any defect in a mechanical system. *(If the system has worked effectively once it should work unfailingly again provided no change is made, with deviation or breakdown being almost always the result of human interaction).* Thus while the procedures in the payroll office are ostensibly an interaction between forms and keyboards, the process becomes meaningless without consideration of the parties involved. If a mistake is made it is rarely the algorithm underlying the payroll that is blamed - the fault is far more likely to be the person submitting the claim or those making or checking the entry, and if anyone suffers as a consequence it will rarely be the bank or the university – it will be the long suffering employee who finds themselves paid less than anticipated. Thus if risk is to be managed it is essential to target those who govern, support or benefit from an operation rather than simply the procedure or policy itself.

There is a further factor to add complication. Few tasks in academia (beyond the most basic or elementary) are completed from start to finish by one person. Policy development and academic procedures involve teamwork, but each member of a team may bring to the task their own interpretation, hostility or agenda. This in turn introduces even greater potential for risk and uncertainty.

For this reason it is essential when attempting to counter procedural or policy risk to consider;

- Who devised the procedure or policy, when did they devise it, and what was the context within which it was devised? (And have circumstances changed sufficiently in the meantime to make any of these things obsolete?)
- Who is the current sponsor of the activity? [*The “sponsor” is the person who authorises its use, and who stands to get into trouble if something goes wrong or if the system fails to deliver*] As a general rule the “sponsor” is not necessarily the person who devised the process or policy – indeed the original developer may be long gone – but they are the ones who have responsibility for it at the moment, and who run the risk of censure through misinterpreting the intent of its creators, the outcome, the work flow of those immediately involved, or the requirements of end users.
- Who handles or administers the policy or process? These are the day to day workers who use the procedure to add value by converting input to output or who oversight the application of a particular policy. Who are they, and what risk do they add as well as any value?
- Who is affected by the procedure? The answer may be obvious (thus an incorrect entry of exam results on the student record system may have an immediate impact on candidates) but this is not always the case, particularly when it comes to the impact on the wider community.

*[Thus, to put things on a local level, who benefits from the daily flow of students across Railway Square, and who would suffer the most if this flow was decreased through, let's say, the removal of UTS or the city campus of TAFE to Parramatta?]* It is important that these groups be identified when any change to procedure or policy is suggested, and the risks managed accordingly.

- Who will use the end product? Every academic process feeds into something else, and amply demonstrates the old computing principle of “garbage in means garbage out”. End users are particularly vulnerable when it comes to academic policies or procedures as they normally lack the time or resources to question what they are given or what is imposed upon them. If the outcome from something at an earlier stage is insufficient (or worse, completely misdirected) those using it later may have little opportunity to go back and redress it.

An example to make this clear. Just how many students does a particular university have at the moment? While we can quote the figure provided by the student record system for the number of “heads”, or their equivalent in EFTSU, just how certain can we be that this figure is accurate or complete? The difficulty is that short of lining up all the students and counting them manually we simply can't be certain, as the assumptions from which this information is derived are dependent on everything that has gone before. Any error that has arisen during admission, data consolidation or at any other stage of the process can convert reality to absolute fiction, no matter what protection is provided by the institution's software or the Commonwealth's oversight. The whole system depends completely on trust and integrity. In a world populated by saints and angels that might be sufficient, but in a world full of fallible humans it can become a recipe for disaster. Who are the end users and can they depend on an outcome dependent on everything else that has gone before?

For these reasons it is important that risks be assessed across all parties and participants. It is easy to assume that it is only those who are immediately affected who should be considered, but this is short sighted. While those immediately involved may have a greater responsibility or vulnerability than others, they may not be the ultimate cause of problems. To identify the risks inherent in any policy or procedure it is essential to take the widest view possible and to consider every individual who may be involved in both an active and a passive sense.

Take for example a group of students travelling to class. The process in which they are engaged – whether they are fully aware of it or not - is the task of getting themselves to a particular place at a specific time. There are many things that might prevent this, some of their own making (*they might dawdle, looking in shop windows or buying coffee, for example*), some that are only partially within their control (*such as waiting for everyone else to arrive before departing as a group*) while others (*such as train delays*) may be completely beyond their control. It may only be only one small incident that makes them late, but it is in their interest to assess all risks and to make allowance accordingly. The prudent person tries to reduce the risks that are within their control, to manage those that are only partially within their control, and to improvise when the unexpected arises.

And what type of risks arise from human involvement in a process? The most obvious is inconsistency (*doing different things at different times even though the circumstances are the same*) and the second is the influence of personal bias even if the person concerned is unaware that either is happening. Both must be factored into the equation.

A specific risk in higher education is the ease with which it is possible to separate policy and procedures from people. Consider a person calculating EFTSU. [*EFTSL = Equivalent to full time student load, a unit of tertiary funding*]. It is easy to forget that the figures floating across a spreadsheet are not simply some



abstract numeric entity – each involves a living human being with feelings and aspirations that are little different from the person doing the operation - but this can be easily forgotten and there is great danger of having perfect procedures but ignoring their impact on those affected by them.

Let's take something a little different, the graduation of students. Let's be honest about this right from the start – graduation is a messy business that disrupts the work of a university and for those on the front line it is a completely thankless task. Normal work gets set aside and there is a vast amount of catching up to do when the ceremonies are over. Nor is there anything novel about a graduation itself – if you have seen one you have seen them all. We live in an age of mass education and amid the chaos of hot gowning, seat allocation, and answering the same questions time and again it is easy to forget that it is a special day for each of these individuals – similar in many respects to a wedding – and it becomes hard to avoid treating graduands simply as objects on a production line involving a handshake, testamur, photograph and prompt removal from the stage, and that three times a day before meals (if that is what one can call the mouldy scones and cold tea served begrudgingly to guests when it's all over). It is only too easy to forget what graduation may mean to those who graduate.

For this reason it is important to identify all parties to an academic process, as shown in the chart on the following page;

**IDENTIFYING THE PARTIES TO AN ACADEMIC POLICY OR PROCESS**

**FIRST SEPARATE THE "PROCESS" FROM THE PARTIES AND THEN ASK;**

**WHO DEvised THE PROCESS? → WHEN DID THEY DEVISE IT? → WHAT WAS THEIR INTENT? → HAS THIS INTENT BEEN SUPERSEDED?**

**WHO IS THE CURRENT PROCESS SPONSOR? → WHAT IS THEIR RESPONSIBILITY? → WHAT IS THEIR INVOLVEMENT? → WHAT RISKS DOES THIS PRESENT?**

**WHO ADMINISTERS THE PROCESS? → HOW MUCH DISCRESSION HAVE THEY BEEN GIVEN? → WHAT CHECKS AND BALANCES EXIST? → WHAT RISKS DOES THIS PRESENT?**

**WHO IS AFFECTED BY THE PROCESS? → WHAT CONTROL DO THEY HAVE OVER THE PROCESS? → HOW IS THIS CONTROL EXERCISED? → WHAT RISKS DOES THIS PRESENT?**  
[INCLUDE ALL WHO MAY BE INVOLVED]

**WHO WILL USE THE OUTCOME FROM THE PROCESS? → HOW WILL THEY USE IT? → IS THIS APPROPRIATE?? → WHAT RISKS DOES THIS PRESENT?**

The identification of the parties is only the first stage of risk assessment. A more important question is the influence of each of these parties on the process and whether what transpires will be fair to all.

There are a number of ways in which this can be done. It is often valuable to ask four questions;

- What would happen if certain of these roles were reversed? In other words, suppose the person responsible for devising the policy or process was called upon to administer it, or if the sponsor was the person directly affected by it. Could one predict any change in emphasis or outcome as a result?
- Who would suffer the most if there was an inordinate delay in completion of the process or the implementation of a policy? It is easy to suggest that this would impact most significantly on those immediately affected, but this may not be the case. It may be that far more sleep would be lost by those sponsoring the process, by those waiting to use the outcome in the next stage or by third party by-standers, if there was inordinate delay. *(For example, take the case of disruption when partly completed building works are delayed. Those who might suffer the most are not the ultimate users of the building – even though they may be the loudest in making complaint - but those who live or work nearby, with noise, stored materials, uncleared rubbish and restricted access Impeding their daily activities)*
- If there any “make-work”, “busy-work” or “introversion” built into the procedure, and if so, who benefits from this?

*[“Make-work” occurs when the time to complete a job is expanded beyond what is necessary as is often found among cleaning contractors. The task could have been finished earlier, but this would mean that people would be forced to stand around doing nothing and possibly attract the displeasure of their bosses. It is always better from a job security point of view to look busy even if one isn’t.*

*Make-work is something introduced by employees for their benefit. “Busy-work” is similar, but is imposed by bosses to keep their people occupied, particularly when the work is cyclic. There is always a risk that surplus staff will be taken by superiors for use elsewhere, thus to maintain sufficient workers to handle peak workloads everyone must appear to be fully engaged at all times, even if doing nothing productive.*

*“Introversion” occurs when a procedure is used to establish a power relationship as opposed to achieving an outcome. Consider this example. Have you ever parked on campus during a university vacation? The place is deserted, there is no one around, and it seems possible to leave your car anywhere without disturbing anyone. One returns to find one’s vehicle festooned with stickers carrying terrible admonitions about the university’s policy on illegal parking and threatening to have the vehicle towed away. Why? Because those administering the car park view the policy as a means of demonstrating their power, irrespective of the need at the moment, or alternatively they see it as a means of demonstrating to their superiors that they haven’t gone to sleep during the vacation and are still on the job. This is a complete “introversion” of the purpose of the procedure.*

*All three are sources of danger, and the key question must always be “If these things are found who benefits from them?” and then “What risk does this present to the procedure or policy itself?” The great danger is that personal interest will sabotage whatever the activity is designed to achieve.]*

- Who would be the embarrassed if the procedure or policy worked perfectly and achieved every outcome intended? This may seem a strange question as it is usually claimed to be the hope of everyone that things will run as smoothly and as consistently as possible. The question, however, involves power relationships and a feeling of being needed. If a procedure or policy works

effectively (and can be guaranteed to work effectively time and time again) there may be certain players who could find themselves redundant, and this causes worry. For this reason there is always a temptation for someone somewhere to disrupt what is going on, simply to prove that they are needed. This may be the sponsor (who can then use their intervention to confirm the incompetence of subordinates); it may be the deviser of the procedure or policy (who can then use the excuse that what was intended was ruined by careless implementation) or it may be the end user, who could be most embarrassed if the desired outcome was received, thus avoiding an excuse they might make for delay or procrastination.

It will be noted that no mention was made of those affected by the procedure or policy in the preceding paragraph. This was not an oversight, although it must be admitted that even those affected by something may not welcome its smooth operation. The more uncertainty there is about the efficacy of a process or the effectiveness of a policy the greater the opportunity to question its necessity, and this can be a source of enormous comfort. Take the case of a student who fails an exam. Was this caused by poor preparation, bad exam management, illegible writing or simply by the fact that the examiner had a grudge against the system and marked down the student accordingly? It is far more comforting to assume that failure was due to the haste, incompetence or indifference of the marker, and was not the fault of the student, and that with a different examiner the results would be different.

It is the same with exclusion from universities. A student facing exclusion will do everything possible to delay the procedure even if the outcome is acknowledged as inevitable. As far as the university is concerned "the sooner he is got rid of the better" and there is every preference for speedy processing. As far as the student is concerned the longer he can take advantage of adjournments and appeals the better, possibly in the mistaken belief that if there is sufficient delay the institution will forget about it, change their mind and allow him to remain. For the student (but not the institution) the efficient working of the procedure is anathema.

There are two other factors. Firstly, the identification of the parties involved enables a human face to be attached to the policy or procedure. It is far more satisfying to be aware that one is dealing with fellow humans – even if one never sees them - rather than a mindless machine, despite the fact that these people are exposed to the same faults and failings as oneself. Human beings can exercise discretion and compassion in a way that is alien to machines, even if this in itself presents a risk, even if this is completely inadvertent.

*Let me give an example. An aggressive student comes demanding that something be done immediately. The person behind the counter feels aggrieved by their behaviour and without thinking about it goes out of their way to ensure that the request is processed as slowly and as mechanically as possible. A second student arrives in great distress and unlike the first arouses the sympathy of the person behind the counter who then drops everything to process their request immediately.*

It is impossible to remove human bias and empathy (and as the alternative would be a mindless bureaucracy that no one would wish to occur) but it always presents a risk. We would be distressed to find that a person from a particular culture favoured the members of their group and dealt with them first and we would quite rightly question their motives, but would the situation be the same if a mother arrived with a pram containing new born twins, or if a local football champion requested that something to be done in a hurry?

The risk is not whether bias exists – it does and this cannot be avoided – but whether this bias will inhibit the purpose, speed or outcome of a procedure or policy. Deliberate bias is rare in academia, but one fears that inadvertent bias (*bias of which the person may be completely unaware*) may be more common than is thought. By identifying the parties to a transaction this risk can be foreseen and minimized.

The second risk in dealing with humanity lies in the certainty that people will change as time passes. As in the case of bias this is inevitable and the only question is “Could this change affect the outcome of the policy or procedure?” People grow older day by day, and as this occurs their attitude and mode of working will vary, although the change may be so subtle that it passes unnoticed. The person may gain experience in their task but may accompany this with the development of cynicism, disillusionment, boredom and mistrust, or alternatively by a sense of euphoria in which they feel completely on top of their job and hence in danger of over confidence and carelessness.

The same risk, of course, applies to supervisors and those affected by a policy or procedure. Supervisors develop trust and confidence in their staff, but this is itself becomes a source of danger if it means that checking becomes seen as insulting or unnecessary. Those affected, in their turn, learn quickly how to “work the system” to their advantage. If a particular excuse can pierce the iron clad heart of a staff member and lead to an extension of time on an assignment or an exemption from an obligation, it is likely that the same excuse (or some variant on it) will be offered time and again, and not simply by that student alone. Those affected have found a flaw that they can exploit, and being humans will use it to their advantage whenever necessary.

These things can be avoided, but the risk is that this may be rarely done or alternatively that intervention may occur so constantly that the efficiency of the process suffers. Both must be factored into the human aspects of a risk management plan.

A blank template that may assist in this is provided below;

**ASSESSING HUMAN FACTORS IN THE RISK MANAGEMENT OF POLICIES AND PROCEDURES**

<u>PARTICIPANT</u>	<u>ROLE</u>	<u>RISK OR DANGER</u>	<u>THIS CAN BE MITIGATED BY</u>


It is important to note that Higher Education regulators do not seek the elimination of all risk (a task that would be unrealistic if not completely impossible). What these bodies seek is **prior identification of likely risks**, to be followed by strategies to minimize the consequences should these risks eventuate.

For this reason it is not a matter of making procedures absolutely foolproof (*with shades of the unsinkable Titanic*) but of making certain that the things that might go wrong have been foreseen and are under control. Of these, one suspects that the vast majority will arise from the failings of human beings.

**3. POSITION?** – Where does the procedure or policy fit within the wider university system?

No procedure or policy exists in isolation. Each draws upon something that has happened earlier in the process and feeds into others that will occur later. ***The question is, “How effectively does the procedure in question integrate with those occurring earlier or later”?***



Take for example the procedures for re-enrolment. Re-enrolment implies progression to a following year, and this in turn assumes that there has been a prior enrolment experience. Thus it might be reasonable to expect that students who are re-enrolling will need less guidance than those who are new to the institution. These students would resent it if they were to be as hand fed as newcomers, but at the same time would not like to be left completely on their own either. Thus the procedure is modified and “re-enrolment” is never simply a repeat of “enrolment” even if done electronically using the same template and software. Reenrolment involves a modification based on the assumption of greater experience and maturity on the part of those involved and its place within the student journey.

The same is true when students experience their first contact with the university. The student may be a neonate as far as academia is concerned, but is hardly a new born when it comes to administrative policies and procedures. Thus every student’s initial enrolment builds on their experience at school or in the workplace. Students have been taught from infancy to queue in their order of arrival, to complete forms correctly, to bring a writing instrument of some sort, and to have handy any documents that may be required, and these tend to be assumed – indeed taken for granted - rather than stated. The university may add its own twist to what is required (*the concept of an all pervading student number might not be something found in schools, nor in most cases was there a need to pose for a photo ID*) but these things are done as additions to something with which students are already familiar rather than an experience completely new.

To confirm the “position” of a policy or procedure within its wider system requires more than simply asking whether it fits smoothly with the events that precede or follow. It is really a matter of asking whether it forms part of a smooth development cycle affecting the individual’s exposure to the institution as a whole.

Problems can occur for many reasons, but it is suggested that there are five key factors that may make the transition from one process or policy to another particularly difficult;

- Where there is no clear distinction between the end of one activity and the beginning of another, so that the two appear to flow together or operate simultaneously. This has the potential to cause confusion, particularly where the procedures or policies are handed by multiple groups but lack a clear point where one team assumes responsibility from the other. *(Beware of “grandfather” or “legacy” arrangements under which current procedures or policies are allowed to continue for those already covered by them, while something different is introduced for newcomers. The existence of both the old and the new at the same time can only cause confusion or error. Similarly beware of instances where the same person covers several stages of a process,, possibly at different points in the cycle. In the latter case there is always a temptation for the person involved to jump from one to the other, missing what lies between, or worse, to go back to an earlier stage to “fix up” something was done before. For safety it is always better for each stage of a process to be handled by a separate person so that when one task is completed that person is not required to handle it again )*
- Where there is an abrupt change that destroys familiarity. The change may be completely necessary (such as the closure of one jurisdiction – and hence its existing procedures – and their transfer to another, or a change in the person interpreting or implementing a policy) but becomes dangerous if not explained fully to participants, or if the explanation is not given sufficient follow up by supervisors. This doesn't apply exclusively to those required to manage the activity or those immediately affected by it. The original deviser may be unaware of everything that has occurred - and this may lead in turn to the inclusion of participants of whom the deviser is unaware, or an outcome that was unintended - or the process sponsor (the person responsible for its oversight) may be unaware of changes in circumstance.

*(This becomes a significant problem with maternity leave, incidentally, or in other cases where a person is asked to relieve temporarily in a higher position. Everyone has their own way of doing things, and most will continue to do as they have done before unless action is taken to brief them beforehand and change their mode of operation. In addition to that, the majority of staff in higher education continue to perform tasks that are not part of their job description – even if nothing more than washing the tea cups - and which are usually taken for granted until their absence leaves something undone. Their replacement may have a different understanding of what is required or have a false impression of the limits of their delegated authority and may over or underplay their role. All of these are serious enough in themselves, but become fatal when the change that occurs causes a distortion of practice, often to the horror of the original person when they return)*

- Where there is poor communication between participants, both those involved with the immediate process and those before and after. This seems so self evident as a point of weakness that perhaps no further comment is necessary although it is essential that the risk be kept in mind. *[Incidentally no one will ever say that there is poor communication with anyone else. All that they will tell you is that “No one ever lets me know what’s going on”]*
- Where there is insufficient recognition or reward for a smooth transition from one procedure to another. Universities make a great song and dance about motivating their students but apply this rather sparingly to their staff. If the transition from one process to another passes off smoothly the majority of institutions appear to take it for granted, and it is only when something goes wrong that it comes to attention and they go looking for someone to blame. Take credit transfer for example. How many staff are thanked when a student moves successfully from VET to higher education with appropriate – but not too much – advanced standing? I would suggest none at all, but who gets blamed when something goes wrong....? Lack of recognition (a symptom of

things being taken for granted) is often the first step towards a discontinuity between procedures.

- When there is no overarching vision of how things hold together. Universities are large and complex organizations, and there are few staff with a knowledge of the three dimensional interlocking that makes such a diverse organism effective (and these who have this understanding are normally so isolated from day to day operations as to make this knowledge meaningless) One fears that the majority of staff may be specialists in their own domain, but are blissfully unaware of anything that may be happening beyond their immediate environment. This presents an enormous risk.

One of the most searching questions to ask a university is whether there is an overall map of its operations (or if this is too hard an overall map of a smaller part of its operations) showing who is dependent on who, and where gaps and bottlenecks may occur. In the majority of cases such a document either doesn't exist, or is a fantasy designed by management consultants that bears no relation to reality, or is so outdated as to be useless, and even if such a paper can be found its existence (much less its veracity) tends to be completely unknown to staff. This represents a serious threat to the efficiency of procedures.

*[We laugh at the concept of the crew straightening the deck chairs on the Titanic, but what if those doing it were unaware that the vessel was sinking in the first place, or worse, that it was simply a job that was required to be done at a particular time irrespective of the circumstances? This may have many implications for universities]*

The solution to this enigma is to ask staff to describe a process from beginning to end, but to give them no guidance on where to start or finish. See where they start the process – and beware lest it commence at their own

desk – and where they take it, and then determine their knowledge of the things they have left unsaid.

The twin dangers in all higher education procedures are ignorance (which I have already mentioned) and self centeredness, the latter involving the risk of an individual thinking that they themselves are the most vital link in the chain. Their contribution may be important – indeed vital, and no one disputes this, but the very concept denigrates what occurs before and after. Unless each process fits smoothly into the jigsaw of its institution there is great danger of it becoming an activity in its own right rather than something contributing to the welfare of the whole and hence being a nuisance rather than a benefit.

Take the case of cleaning. How many times have you entered a room during a university vacation to find the cleaners hard at work even though the room has not been used since their last visit? The contract requires the cleaners to perform their procedures at regular intervals and this is just what occurs whether their services are needed or not. At the same time note the number of overflowing bins left putrid and stinking around campus after departmental Christmas parties. The bins are emptied on a particular day irrespective of the time of the year, and does it matter if the day for clearance happens to fall after the university has closed for Christmas? The procedure in both cases has overtaken its purpose and become an end in itself.

There are four further risks regarding the positioning of procedures;

- Procedures can become ritualized and fossilized once they are taken out of context. Why does a mace figure so predominantly at in academic processions? In the olden days the mace was a weapon to protect the dignitaries and was both heavy and dangerous (as was the person who carried it!). Now its power is purely symbolic. Why do the most important people walk last in an academic procession? Because

this was the practice of the medieval church, where the most significant humbled themselves by coming last, and so on. As soon as the context is removed the purpose of a procedure can be lost until it becomes an empty show.

- Procedures can get out of sequence until the cart precedes the horse. Take the case of enrolment once again. We may be so busy getting students onto class lists as early as possible that we fail to remember that these things mean little until lectures begin, and then we find ourselves pursued by hoards demanding the right to change. It might be better to regard class lists as tentative only until the second week of lectures rather than to regard them as fixed and immutable.
- Procedures that have lost their context get in the way of each other. Take the case of a person teaching reading. If one teacher can get a child to read in six months would two teachers be able to achieve the same thing in three, or – taken to extremes – would, let's say 1000 teachers working simultaneously be able to teach the child to read within a few seconds? Obviously not, as the multiplicity of teachers would get in each others way and confuse rather than assist the procedure. And yet this is exactly the risk that we run in higher education. A group devises a procedure to achieve a particular end. Another group does the same thing for a similar purpose, as does a third. All are done with the highest purpose but collectively each gets in the way of the others. (A classic example is the use of surveys. There appear to be dozens of surveys in conduct at any time to the point where staff and students become "surveyed out". All represent an honest attempt to achieve a legitimate aim, but in the end they repulse rather than support the surveyee)

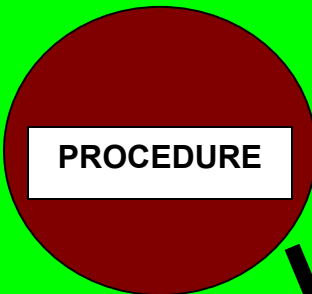
- Closely associated with this is the prioritisation of procedures. Put simply, if there is insufficient time to do everything which things are the most important? This presents no problem where a clear hierarchy (as defined by a process map or a knowledge of the context) exists. The issue can become insurmountable where it does not. What tends to happen under these circumstances is that it is the easiest job that is done first irrespective of its importance. Thus we find that staff members may be too busy ordering stores or replenishing the photocopier to handle the core business of the office, with the most important (albeit the more difficult) tasks being left undone.

It is for this reason that a knowledge of the “position” of each procedure within the system of which it forms a part is absolutely vital for risk identification and management. With this knowledge the system can move smoothly towards achieving its aim. Without it there is grave risk of confusion and chaos.

**POSITION – WHERE DOES THE PROCEDURE FIT  
WITHIN THE WIDER UNIVERSITY SYSTEM?**

WHAT COMES  
BEFORE –  
IMMEDIATE AND  
ULTIMATE?

WHAT VALUE DOES THIS  
PROCEDURE ADD TO WHAT  
HAS GONE BEFORE?



WHAT COMES AFTER  
THE PROCEDURE –  
BOTH IMMEDIATE AND  
ULTIMATE?

WHERE DOES THE  
PROCEDURE FIT  
WITHIN THE OVERALL  
STRUCTURE?

**DOES WHAT IS DONE CONTRIBUTE TO  
THE WELFARE OF THE SYSTEM AS A  
WHOLE?**



**4. PROTOCOL?** – A “protocol” implies a set way of doing things, normally enshrined within (but not strait-jacketed by) written documentation. Is there a “protocol” to guide all who may be involved with the procedure, and has this been factored into the risk management assessment?

A written protocol is of little use unless it is known to users, and then enforced, reviewed, and amended as required, and above all it must never be allowed to become settled or stable. This last point is critical. A stable protocol is a dangerous one because it so frequently tends to be taken for granted. It is far better for all documentation to be tentative (and thus be open to challenge by users and reformers) than for it to become fixed and permanent.

There are two forms of protocol – that prepared in advance and that developed in the light of experience, and both will be discussed here, **but it is deadly to combine the two.** Protocol prepared in advance is really a statement of intent – “This is the way we plan to do things”. On the other hand a protocol developed in the light of experience is a confession – “This document reflects the lessons we have learnt from our mistakes”.

The two are incompatible and cannot co-exist. Protocols prepared in advance are a form of planning – “This is what we intend doing, and these are the resources we’ll need to do it”. Protocols developed in the light of experience are a form of admonition to those who come later - “Mark our words! Do it this way in future - it won’t work as well otherwise”. The danger (and hence the risk) lies in the transition from the former to the latter. Protocols prepared in advance are theoretic and must eventually be replaced with something superior gained from experience, but it is generally impossible to substitute one for the other at a moment’s notice. For this reason the two are forced to live unhappily side by side pending their divorce. The risk is that one will so contaminate the other as to render both useless.

Protocol in both its forms is a good servant but an extremely bad master. If used effectively it provides consistency, uniformity and accountability. If allowed off its leash for an instant, however, it can become a task master working its unfortunate slaves to death, and that for no purpose whatsoever.

I am reminded of the story (surely apocryphal) of the young person being taken at death's door to a hospital. "You'll have to take him away" said the triage nurse, "We must have a copy of his birth certificate as otherwise we won't know whether to place him in a children's or an adolescent's ward". Here we have protocol – and possibly good protocol developed in the light of experience – but acting to the disadvantage of the victim. (and if you are inclined to laugh think of what we require from our international or mature age students in our own universities, and just how much of this is really needed!)

Academic protocols try to avoid similar incidents in a number of ways;

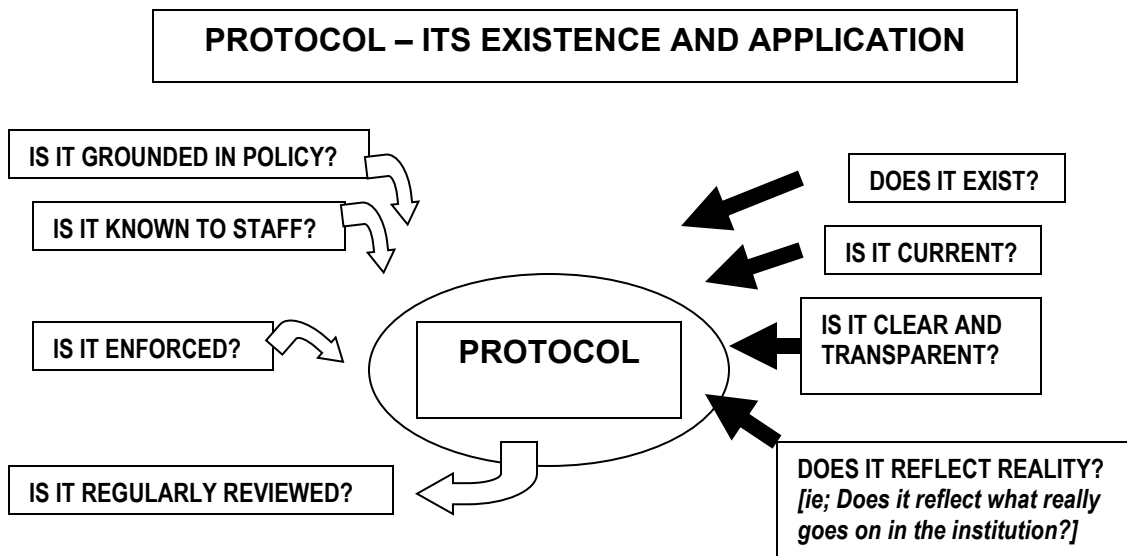
- By providing guidelines rather than complete instructions. While these require interpretation by users depending on the circumstances (and this in itself is an area of risk) the flexibility this provides generally outweighs the dangers. For this reason beware of over prescriptive protocols – they may be over restrictive as well.
- By requiring guidelines to be shared across several users, each of whom discusses their understanding of the protocol with their peers. Thus there is less risk of serious misinterpretation by a single individual, and the fact that others are constantly involved gives stability, while allowing change if needed. Be careful of protocols that have no need to be shared with others, even at a senior level

- By insisting that a common philosophy apply across the institution. This philosophy may be verbalized (sometimes as part of the university's motto) but is often simply assumed as a cornerstone of the culture of the organization. This philosophy then guides the operation of the institution, including its procedural protocols, establishing a fall back position where documentation fails. For this reason beware of a situation where staff seem unaware (or uncomfortable with) the philosophy of their institution, or are unable to apply it within an appropriate scenario. It signifies a staff at risk.
- By rotating staff at regular intervals. Staff who are left in one place too long tend to take root in more senses than one, and can be completely intransigent in their approach, to the point where what they do becomes the complete opposite to published protocols. These are the same people who will tell everyone they can buttonhole "We tried that forty years ago and it didn't work – let's not waste our time doing it again", forgetting that much might have changed in forty years, including themselves. For this reason it is always wise to view failure to rotate staff at regular intervals (both academic and administrative) as an indicator of risk.
- By making certain that protocols keep up with technology. There was a set way of doing things in the medieval university, with Latin registers maintained by quill sharpening clerics who set aside their velum documents to attend chapel in accord with the monastic hours, but this would be completely inappropriate in a modern institution. Times have changed and so must procedures. There is, on the other hand, always a danger that technology will move much faster than its supporting process documentation, with one rushing forward while the others dig in its heels through reluctance to change. *(Take for example the problems caused by electronic delivery in face to face institutions – the Zoom university - and the difficulties this causes to administrators and administrative systems)*

One way to avoid accidental obsolescence is to set a “use by” date on every protocol. In other words for the institution to declare in advance that the existing protocol will expire at a certain time and must be replaced before that happens, similar to what happens in aircraft maintenance. This is expensive, and some may consider it a waste of resources, particularly if there seems to be nothing wrong with the existing protocol, but it remains essential if the documentation of procedures is to keep up with what is actually occurring across the campus. For this reason assessors are often asked to determine risk by questioning when the current protocol for a particular procedure was prepared and how work is progressing on its replacement, remembering that it is usually the most successful protocol that will need to be replaced the earliest, as it will wear out first.

- By publicising these protocols to those within and beyond the university. Publicised protocols (provided that are up to date and reflect what actually occurs) provide transparency, and this in turn generates trust. Hidden or private protocols (or worse, their old, misleading or obsolete equivalents) do exactly the opposite. Always ask where protocols can be consulted, preferably on a website where they are available to everyone.
- By instructing staff in the protocols relevant to their task before they start work. Unfortunately this is an area in which many universities fall short. A vacancy occurs and the work piles up before it is filled. The person selected is no doubt the one considered best qualified for the task, but as a result of this is thrown into the deep end of the pool where they are expected to swim or drown. In most cases they manage to struggle through, but with personal difficulty and at the cost of constant distraction of their fellows as they ask them what to do. It is sometimes a valuable exercise to ask (once it is established that a protocol exists) how the staff learnt of it, and what instruction, if any, they may have received in its use.

- The final way in which universities maintain the quality of protocols is to link them closely to their policies, normally by cross referencing the policy to the protocol and visa versa. A published protocol is incomplete unless grounded in policy and a policy is incomplete without a link to the protocols established under its authority, and if one is changed the other needs be examined to see whether it should be changed as well. Beware of “orphan protocols” (or protocols that appear to apply to only one group within the institution, particularly in fringe areas such as Facilities Management, IT or Student Services) – they may no longer be in accord with policy.



### THE EVIDENCE FOR RISKY PROCEDURAL PROTOCOLS

- **THERE IS NO DOCUMENTATION**
- **THERE IS BELIEVED TO BE DOCUMENTATION SOMEWHERE BUT NO ONE KNOWS WHERE TO FIND IT**
- **THERE IS DOCUMENTATION BUT NO ONE CLAIMS TO UNDERSTAND IT**
- **THERE IS DOCUMENTATION BUT EVERYONE KNOWS THAT IT OUT OF DATE**
- **THERE IS DOCUMENTATION, BUT NO ONE MAKES ANY ATTEMPT TO FOLLOW IT**
- **THE INSTITUTION CLAIMS THAT ITS PROTOCOLS ARE THE BEST IN THE SECTOR (and hence will make no attempt to review or reform them)**

**5. PACE?** – How slow or fast does the process proceed, or in the case of policy how quickly are defaulters disciplined, and is this the most appropriate speed under the circumstances? It should be noted that the time to finalisation on its own is rarely an indicator of quality as it is often important that an opportunity be provided for the consolidation of information, reflection, and the input of others. In spite of this, no one enjoys the frustration of unnecessary delay and this must be avoided..

Cynics sometimes suggest that “Delay is the best form of denial”, and they may be right as objection to a response becomes impossible while a process is still working its way slowly through the system or a policy is awaiting approval, similar to a court case held up by endless adjournments where there is much talk, great cost, but no outcome. At the same time no one appreciates a precipitate, careless or indifferent handing of policies and procedures either. The key is to find some golden mean between excessive haste and inordinate delay that is acceptable to all parties – a task that is often elusive and difficult.

The cause can usually be traced back to a lack of understanding of what is required, and this in turn reflects poor communication between client and operator. Those affected by a procedure expect immediate action and will not be satisfied with less. Those responsible for implementing the procedure, however, may view things through different eyes. There may be hidden delay through a backlog of work, incomplete information, a need for consultation, or a requirement to consider factors or precedents of which the “customer” is unaware. There is also the question of priority. No one would suggest that accident victims should be treated solely in their order of arrival at a hospital – some may have greater need than others, some may require resources that the hospital cannot provide, while a few may be at the point of death and unable to benefit from anything that might be done. For this reason when multiple ambulances arrive triage nurses are forced to make hard decisions on who should be treated first.

A bureaucracy, on the other hand, is expected to handle all of its clients impartially (one hesitates to say “with equal indifference” even if this is often the case) and this causes frustration as is often seen in places such as Centrelink offices or motor registries. It is worse when there is no physical queue and there everything is handled on paper. When this occurs few of those affected by a procedure are aware of the numbers ahead of them, the pressure on staff, or the difficulty of getting partners down the chain to make timely replies, and thus everyone impacted upon by an academic procedure tends to believe that it drags for far too long.

This in turn impacts on those assessing academic policies or procedures, who if they listened solely to complaints could quickly reach the wrong conclusion, and this may be unjust. The difficulty is that those making complaints have the loudest voice and generally have little insight into what might be going on behind the scenes.

There are five factors to be considered in determining whether the pace of a policy or procedure is appropriate;

- The purpose of the process or policy and its consequences for the system itself, as well as those affected by it. We have already discussed the question of purpose and have no wish to revisit this topic, but must stress once again that **not all procedures or policies are of equal importance under the prevailing circumstances and that one must always consider the impact that a change in activity will have on the system as a whole.** *[The words in bold are stressed deliberately. To those immediately involved their case is by far the most important and deserves to be addressed, irrespective of its effect on the system as a whole. The difficulty is that those administering a procedure or policy are required to consider the broader picture and to do what is best for their employer and the pool of supplicants as a whole, and this can change priorities between what is possible and what those affected may deem desirable]*

Thus it may or may not be appropriate to deal with cases out of order, or to delay work on one activity if this will assist the completion of another. The key point is the effect this may have on the system as a whole. Thus it is not the delay that ensues that should be examined more closely, but the justification provided for the harm done to the system as a whole. Is there sufficient reason to change priorities and thus rob Peter to pay Paul?

- Adherence to deadlines. Academia almost always operates on a “batch process system” rather than a continuous production line. The year is broken into semesters and these semesters are broken onto weeks, with different things occurring at different times, and there are certain periods when the students and staff will simply not be on campus at all. To ensure that tasks will be completed within their allocated time span academia depends on adherence to deadlines – dates by which things must be done for the system to function – and these may vary according to the teaching or administrative cycle. Thus in assessing the risks that may challenge an academic process it is far more important to ask “Was the task completed before the stated deadline?” rather than “How long did it take from start to finish?”

Clients rarely appreciate the impact that deadlines have on academic procedures or policies, and would prefer every task in which they are involved to be handled immediately, forgetting that - provided the work is completed within deadlines - it remains unquestionably “on time”. There may be a need in certain instances for deadlines to be brought forward and the time between them to be reduced, but this is a different point entirely. **Indeed, provided stated deadlines are met it is safe to conclude that the activity has run to time, even though a considerable period may have elapsed from start to finish.** This is normally preferred by staff as well - with published deadlines there is agreement on when something should have been completed and there can be no suggestion of tardiness by those involved



At the same time there are two things to be avoided if risk is to be minimised. The first is the possibility that staff may not commence a task until the deadline is perilously near, particularly if it is a job that they don't feel competent about, don't want to do, or is crowded out by other work. This is virtually identical to the attitude taken by some students towards the completion of assignments and as a fundamental aspect of human nature is extremely hard to change. The solution generally lies in a better scheduling of workloads rather than a variation to deadlines as the latter may have an impact on everything else down the line.

The other is that clients may be unwilling to accept what they regard as an unnecessary delay between submission and outcome, although this impatience normally reflects poor communication rather than bad practice.

To avoid both it is usually to everyone's advantage to publish "batch deadlines" well in advance – and to make these known to clients as well as staff - so that everyone is aware of when something should be done and the task completed.

A more serious risk is failure to close off once deadlines arrive – and by this is meant allowing late comers or emerging factors to engage with the activity after the date for doing so has passed. The difficulty here is that deadlines lose all value if not respected. Suppose for example that a bank claimed to close at 4:00pm on Mondays to Thursdays but still allowed customers through its doors as late as 5:00pm. There would be little incentive for any customers to be at the bank on time and its work would be delayed. It should be the same with academic policies and procedures, but here the risk is that human kindness – a quality with which university staff are well endowed – will allow exceptions on humanitarian grounds and thereby wreck the system for everyone. There is always the risk of being too kind in a university and this is possibly even worse than being too cruel.

- The quality of outcome. Clients may imply that their first requirement is immediate action, even though they are really seeking a more favourable outcome rather than simply a faster turnaround. If haste leads to error little is gained, and the pace at which a process moves through the system must always be slow enough to ensure this doesn't happen. It is important, on the other hand, to avoid going too far in the opposite direction. Unnecessary checking or excessive bureaucracy will almost always slow a process and may also lead to an outcome as unrewarding as a hastily decision.

Both can be avoided through the use of “tolerances under delegated authority”.

A thing that has always surprised me is the inability of academic systems to come to grips with what are known in engineering as “tolerances”. No machining is ever “to specs” - when measured some jobs will be slightly oversize while similar work from the same machine using the same numeric input will be cut a fraction too small. Industry makes allowance for this by providing “tolerance limits” – it doesn't matter whether the item is too large or too small in absolute terms provided it fits within the range of tolerance prescribed by the designer. Academic procedures on the other hand tend to be completely opposite and seek zero errors, or in the case of policy a universal applicability, a state of perfection that is laudable but rarely achieved. For this reason there must always be a compromise between the pace of a policy or process and the quality of the outcome. Those involved must accept the fact that if you want quality – which everyone does – it will involve the commitment of time. More time equals fewer mistakes, less time often means more mistakes. Clients can rarely have both at once.

- Consistency of processing time. In the world of mathematics when two units are added to two more one **always** gets a total of four irrespective of who is doing the calculation. There can be no exceptions to this rule - at least in conventional mathematics – and such a calculation is normally made instantaneously, where the speed of processing is limited solely by the speed of mental impulses in the brain. The processing time for non-mathematical things becomes less predictable as the range of variables increase and the dependence on human frailty piles up, and everyone understands this, but at the end of the day those affected by academic policies and procedures still expect the “period of processing” to be consistent from one occasion to the next, irrespective of the supplicant, the person receiving the form, or the priority of other tasks within the work cycle. Thus in their eyes a task that takes one hour on Monday mornings should take no more than a similar time on Friday afternoons. The point overlooked in such arguments is that the pressure of work is never consistent in academia and the fact that something can be done in a short time in a slack period gives no guarantee that this should be taken as the norm – and yet this is exactly what the majority of clients (and often employers) expect and there is severe pressure on those implementing procedures or framing policies to conform to this expectation. This in turn leads to haste, risk, and uncertainty.

Indeed one of the earliest signs of system breakdown (detected long before any increase in mistakes becomes apparent) is inconsistency in the speed of processing. Let's say a special effort is made to get a particular task finalized by a certain date. Everything else is dropped, and through sacrifice and dedication the target is achieved. The difficulty is that as soon as people see that the work can be completed that quickly they assume that what they have seen should become the standard processing time, and are distressed when the performance can't be repeated.

The risk in all of this is that those assessing policies and procedures – as opposed to those engaged in designing or doing them - may listen to the loudest voice when things appear to be going too slowly and misjudge those responsible. This can only be avoided by considering the context within which the work takes place and the environmental impact of all other things.

- The fatigue of the implementers. As a general rule “Practice makes Perfect” and one might expect constant repetition to lead to a consistent improvement in performance - and so it does, but only to a point. There is a stage at which repetition leads to boredom and this in turn causes errors and misjudgement. The question to be asked in assessing this risk is “How fatigued are the implementers of this procedure or the developers of this policy, and does it remain the challenge it originally presented?” (*If it is seen as a challenge people will strive to do better. Once anything ceases to be a challenge it tends to become a drudge*)

There are various rules of thumb about how long a person should perform a particular role (the actual period varies with the role) which we will not go into here, but once this point is reached further improvement plateaus, and then decline sets in. The impediment to everything is habit. At first the task is challenging and the implementer is cautious. Then the work becomes routine and caution dissipates. The speed of processing is much improved while the mental concentration and input is much reduced, until eventually the person can do it “with their eyes closed”. This may be satisfactory while the work remains static, but when an exception arises it may be allowed to pass unnoticed, or worse still be treated in an inappropriate manner. (*Let me give an example from the exam room. There can be nothing more boring than exam supervision, watching candidates bent low over their desks in a ghastly silence broken only by the turning of pages and the scratching of pens. The invigilator has to walk around because otherwise he or she risks going to sleep, and even then their concentration*

*drops because nothing ever happens. These are the very circumstances in which cheating is most likely, but this is generally prevented by providing relief and allowing those supervising exams to take a break)*

It is the same with academic procedures. One can work far too long at the same task, even if the period of work is not continuous. It is the person who “can do things with their eyes shut” who is the danger, and we should no more entrust an academic process or policy to such an operator than we would turn them loose on the highway with a similar blindfold or mindset. The test of fatigue, rather strangely, is the ability to do things without thinking, even if what is being done is performed well. Once this point is reached habit sets in, indifference arises, bad practice starts, and the person needs to be relieved from their task. Indeed the longer a person has been doing the same thing the greater the risk to the policy or procedure.

There are a number of false ways for measuring pace, and these are mentioned solely to be refuted. **Beware of comparisons based on;**

- The pace with which similar procedures are conducted elsewhere. This is a most misleading benchmark, but we mention it to forestall those who might otherwise support its inclusion. The pace at which other universities might do something is irrelevant because the circumstances will almost certainly differ markedly from one institution to another in terms of staff, the demand of clients, the pressure of work, the conflict of priorities, the complexity of the process and the quality of service, and it is as unrealistic to compare the performance of institutional staff ostensibly engaged in the same task across several institutions as it is to compare apples to lemons. It is equally unrealistic to compare workflow across different sections of the same institution – each has its tasks and no section is likely to be compatible to other. Assess pace on the five criteria mentioned in the previous section, not on performance elsewhere

- The satisfaction of those affected by the process. As already mentioned this is a dangerous instrument, firstly because those affected by academic procedures rarely have standards for comparison, and secondly because their assumptions are likely to be completely unrealistic, in that they are likely to measure performance on the basis of speed of processing – something easily determined - rather than the quality of outcome or decision making. In many respects their position is similar to a person going shopping. In this age of financial restraint no one wants to pay more than the lowest price, and if shoppers can find something that has been greatly reduced they may emerge believing they have gained a bargain. Their satisfaction level is high, and they may report extremely favourably to a customer exit survey. They may have a completely different perspective should they go home and find the goods defective, incomplete, over ripe, ill-fitting or unreliable. Someone gained a bargain all right, but it wasn't the shopper!

Customer satisfaction with academic procedures is very similar – the client may be pleased with the immediate aspects of the transaction, such as the pace, but thoroughly disgusted with the outcome after they have had time to consider it thoroughly. As a measure of the quality with which an academic procedure a policy development has been conducted customer satisfaction is completely unreliable.

- The satisfaction of one's employers or peers. It may seem strange to mention this as a defective instrument, but when it comes to academic procedures employers and peers often value "throughput" more than quality. Throughput (a derivative of "pace") can be measured quickly, can be compared against past operations, and can be used to provide economies of scale. (The faster a job is done – all other things remaining equal - the fewer staff required to do it and hence a reduction in the cost).

It also means that those involved with the following stages can commence their work earlier with the procedure as a whole completed sooner – a “win-win” situation for all concerned.

At the same time a concentration on this measure overlooks the hidden problems of inaccurate data, discriminatory (or inconsistent) behaviour, or the long term welfare of those affected by what occurs. Suppose for example an examiner is able to get through a thousand exam manuscripts in a single evening. This is an excellent turn round, and will no doubt attract favourable comments from those involved in the following stage (such as the staff entering marks into the student record system) and even more from superiors. At the same time such a hurried job is unlikely to do justice to students. Other examiners, who may take a fortnight to complete an equivalent task (and even then may need to be reminded of their responsibility to get finished by end users) may attract approbation rather than praise, but these people may have been far more diligent than their speedy contemporary and possibly much fairer to students.

The satisfaction of employers and peers may be much appreciated, but it can be most misleading in assessing the “pace” of an academic procedure.

There is another issue involving pace - the older a procedure gets the slower it usually becomes. This might seem paradoxical, but lies in the fact that as things become routine they tend to become ritualized and this in turn means that they drop to the lowest common denominator as far as pace is concerned.

A classic example is the time it used to take for a bank to clear a cheque. Banks, in common with universities, have long claimed to be leaders in technology and can transfer vast sums around the world at the speed of light. Why then did it take a week for the funds contained in a cheque deposited at my local branch to eventually be shown on my account? The reason lies in the fact that the

clearance of a cheque followed a time honoured procedure, a process that had varied little since the age of high stools, silk hats and quill pens.

The cheque clearing procedure – now about to disappear from Australian banking - has become hallowed by antiquity, and while it could be speeded it would be vastly to the disadvantage of everyone in the bank to do so – indeed such a reform would be disruptive in the conservative (and near monopolistic) world of banking and could cost jobs. It is the same in academia. Old customs slow down to a minimum pace, similar to the snail like crawl of academic processions, where to rush forward at normal pace would be to dishonour the circumstances, until the procession – like a wedding march - scarcely moves at all.

For this reason always consider the age of a practice when assessing its pace. Procedures and policies, like their human counterparts, tend to get slower as they age, usually to the inconvenience of everyone – but it becomes part of a time hallowed tradition. (*ie; “Its always taken us three or four weeks. We could do it faster but no one’s ever said anything and why burst your boiler when no one complains?”*) The more venerable the process the greater the risk that it may have slowed down.



## THE PROBLEM OF PACE - HOW FAST VERSES HOW SLOW

### IF A PROCEDURE IS TOO FAST THE RISKS ARE;

- ERRORS DUE TO HASTE
- INCOMPLETE INFORMATION
- MISJUDGEMENTS THROUGH FAILING TO CONSIDER ALL ISSUES
- THE RAISING OF FALSE EXPECTATIONS IN THE MINDS OF SUPERVISORS AND CLIENTS

### IF A PROCEDURE IS TOO SLOW THE RISKS ARE;

- INJUSTICE DUE TO DELAY
- THE PROCEDURE BECOMING A SOURCE OF POWER AND CONTROL  
*[I WON'T DO IT UNTIL I'M READY!]*
- INABILITY TO MONITOR THE OUTCOME FROM START TO FINISH
- STAFF GOING TO SLEEP ON THE JOB, AND THINGS GETTING LOST

## THE QUESTION IS; HOW CAN WE STRIKE A BALANCE BETWEEN THESE TWO?

**6. PACKAGE?** – “Package” involves the way in which a process or policy is presented and explained to those affected by it. *[We talk about the packaging of a chocolate or a breakfast food, which is designed specifically to attract the attention of potential purchasers while still on the shelves. The “packaging” of a process is the same – how are these products presented (or “sold”) to those affected by them?]*

In the past, bureaucracies exercising a monopoly (such as the motor registry) made little attempt to “package” their procedures. *[ie; “If you want a driver’s license you must come to the registry, where you will be required to wait in any*

*queue we may establish, put up with the rudeness of staff and the indifference of examiners, and then pay every cent of the money we demand. If you're not happy with these arrangements it's just too bad. You can't get your license any other way"]*

Fortunately this attitude is passing but its legacy remains, particularly where a monopoly exists, as for example in the majority of university procedures. *(Thus there is only one Admissions Office per institution, one Finance Division, one IT Help, and so on. You cannot go elsewhere if you want the service provided by any one of these facilities – you either accept things on their conditions or you go without).* This in turn means that there is rarely any need to explain “why” things are done, much less to provide a justification for doing it in that particular way. It is far easier to make every enquiry a case of “do this because I tell you – don't challenge it, and don't answer back, or you will receive no service at all”.

At the same time an attitude such as this rarely strengthens a procedure or justifies a policy. The “customer” who feels aggrieved evokes a similar response from those on the other side of the counter and the activity then becomes a drudge to all concerned. Worse, the same feeling may spread to other policies or procedures until it becomes a matter of “us” versus “them” at every transaction. The “risk” involves preventing this happening.

To measure this risk it is essential to note how a procedure is “packaged” *[ie; how it is explained and justified]* as this will impact on both those who implement it and those affected by the outcome.

The risk can be evaluated by examining five questions;

- Is the process clearly documented? *[We have mentioned this before, but if there is inadequate documentation it is most unlikely that the packaging – the presentation of the process or policy to users - will be satisfactory]*

- Does the documentation provide a justification for what is involved? *[This is more than an explanation of what needs to be done. The documentation should explain why the tasks or responsibilities imposed on clients and users are required, what flexibility is available, why the process is conducted in the manner prescribed, and the outcome that might suggest that the operation has proceeded as intended. The justification should always be an attempt to persuade, never simply the harsh voice of authority requiring people to conform]*
- Does this justification disadvantage anyone? *[It is easy for operational efficiency or some other factor to override the interests of a party to a transaction, particularly where these people have no say in what goes on. Thus what voice do I have as an exam candidate if I find the various sessions too close together? If I object I am likely to be told that no alternatives are possible, that it is impractical to rearrange the workings of the examination process simply to satisfy the wishes of one student, and that if they did it for one they would need to do it for all – and all of this may be completely true. The point, however, is not the refusal of the university to bend to my will and do things my way, but its failure to anticipate that there could be someone left in my position in the first place. If it is likely that a procedure or policy will disadvantage someone – even if completely unintended or inadvertent – it should be mentioned in the documentation, even if nothing can be done to change it]*
- Is the explanation made clear to everyone, particularly those immediately affected by it? *[It is one thing for those responsible for implementing a procedure to be aware of its purpose and quite another for the clients immediately affected by it, and yet the latter are the very people who most need this information. This does not mean that a full and complete justification is required for every sentence – after all a surgeon might give*

*a much simpler justification for an operation to a patient than he would to a fellow doctor – but it must be adequate under the circumstances]*

- Is the justification believable? *[We have all heard exasperated mothers making shocking threats to screaming toddlers, such as “If you don’t eat all your vegetables I’ll give you back to the stork that brought you here”, or “If you’re not good Santa won’t call”, and so on, but it is most unlikely that any of these exclamations would be appropriate for teenagers. It is exactly the same with the explanation for procedures, some of which seem to be little better than the recorded telephone message “Your call is important to us, please hold the line”, or the ritualized chant of “Enjoy your meal” given to departing customers at MacDonalds. If the explanation for a procedure is naive or unbelievable it will convince no one, and will simply hold the developers of that procedure up to ridicule]*

There is another aspect of packaging that we can take from the retail market. No manufacturer ever allows its packaging to fossilize. While the Coke bottle retains its iconic shape, and the stylized label remains unchanged, Coca Cola makes certain that its display procedure and its promotional material undergoes constant change, simply to prevent people from becoming too familiar with what they see and hence taking it for granted.

It is the same with the packaging of procedures and policies. The activity itself may remain unchanged but the manner in which it is presented and justified to those immediately affected must be continually revised. This is something that I fear higher education authorities fail to recognize, preferring to continue with old practices and ancient justifications (as though hallowed by the custom and tradition of their Gothic buildings) rather than embracing anything new, and in the process losing the goodwill of their staff and students. *[I am unaware of any Australian university that still requires its applicants to complete their admission form in Latin, but I wonder whether the same clinging to the past might not apply*

*to other aspects of higher education administration. If procedures and policies are not continually presented in a new and fresh light – even if they are exactly the same before – there is a serious risk that people will become indifferent to the things with which they are familiar before disregarding them all together]*

There is another point arising as an off shoot. A procedure or policy that is continually “rebadged” suggests a procedure that is continually being revised and improved, and this gives confidence. This need not mean “change for change sake” – remember we are talking only about the packaging here not the content – but it does imply that someone somewhere is monitoring the situation and has everything under control.

The packaging of these things is not an easy matter, but it is essential that it be done, particularly where an educated and highly critical clientele is involved, as on a university campus. The risk, of course, is that this will simply not be done. If users and clients can be persuaded that a task is necessary, and the steps involved (no matter how painful or frustrating) are essential for an outcome to be achieved, the process or policy will be accepted, even if it involves much grumbling. If on the other hand these mysteries are left unexplained, not only will efficiency be lost but the good will of all concerned will vanish just as quickly.

# THE PACKAGING OF PROCEDURES AND POLICIES

## THE RISKS

## THE EVIDENCE THAT THESE RISKS HAVE BEEN ADDRESSED

THE PURPOSE OF THE ACTIVITY MAY BE MISUNDERSTOOD



A CLEAR STATEMENT ABOUT WHAT THE PROCEDURE OR POLICY IS MEANT TO ACHIEVE THAT IS COMPREHENSIBLE BY ALL USERS

THAT REQUIRED INPUTS MAY BE UNCLEAR



CLEAR EXPLANATION OF THE INPUTS REQUIRED, THEIR CERTIFICATION, THE MANNER IN WHICH THEY SHOULD BE SUBMITTED AND WHETHER ANYTHING WILL BE RETURNED AFTERWARDS

THE PROCEDURE OR POLICY MAY BE CONSIDERED UNFAIR OR DISCRIMINATORY



CLEAR JUSTIFICATION OF WHAT IS INTENDED AND THE REASON FOR EACH COMPONENT, PARTICULARLY WHERE MINORITY GROUPS ARE CONCERNED

THE PROCEDURE OR POLICY MAY BE CONSIDERED TOO STRICT, UNNECESSARY OR OVER REGULATORY



JUSTIFICATION FOR THIS RIGOR CLEARLY EXPLAINED [SUCH AS THE JUSTIFICATION FOR INSISTING UPON PRE-REQUISITE SUBJECTS, RESTRICTIONS ON ENTRY, etc]

THE PROCEDURE MAY APPEAR INCONSISTENT WITH CURRENT PRACTICE OR POLICY



CLEAR LINKS TO BE SHOWN BETWEEN THE PROCEDURE AND POLICY (AND VISA VERSA)

THE POLICY OR PROCESS MAY NOT BE UNDERSTOOD BY THOSE AFFECTED BY IT



CLEAR STATEMENT OF HOW EACH STAGE WORKS, PREFERABLY ON A WEBSITE THAT CAN BE ASSESSED EXTERNALLY

THE PROCESS MAY BE OBSOLETE OR NOT REFLECT CURRENT NEEDS OR TECHNOLOGY



EVIDENCE OF REGULAR CYCLIC REVIEW AND THE UPGRADING (IF APPROPRIATE) OF EVERY ASPECT OF THE PROCEDURE

**HOW CAN THE PROCEDURE BE "SOLD" TO THOSE WHO IMPLEMENT OR ARE AFFECTED BY IT?**

**7. PATTERN?** – “Pattern” involves a standardization of procedure. Does the process conform to the normal pattern of procedures with which everyone within the university is familiar? *[Let me give one example where it doesn't occur – timesheets and payment preparation. Have you ever been forced to sit in a faculty office and go through the timesheets for the various levels and types of academic and non-academic staff? A frustrating business because different staff are paid at different rates for different tasks, and the number of hours worked in one capacity may not correspond to the budget allocated for time spent in another. And yet one cannot afford to come up with dodgy figures. Staff – for some reason known only to themselves - seem unduly sensitive to being underpaid, while Deans are even more alarmed about excessive disbursements.]*

The difference in time sheets that we are forced to endure in universities are a legacy of the range of industrial awards and agreements that cover staff in our industry and which we are unable – even in this age of award rationalization - to get away from. The problem, of course, is that so many are different from each other and this impedes processing.

Now imagine what would happen if something similar occurred across a wider set of academic procedures and policies. Processing would be slowed, and errors would multiply, simply because each would be different. For this reason almost all institutions try to impose as much uniformity as possible to their internal activities, firstly to simplify staff training and secondly because it aids efficiency.

There is a danger, however. It is always possible to be too uniform, and to impose a rigidity that locks rather than assists a policy or procedure. This risk is usually brought to light through a lack of flexibility or discretion, a lack of explanation or an excess of paperwork, and should be avoided as far as possible. It is the responsibility of these handling procedures or developing policy

to minimize this by establishing a balance between rigidity and flexibility in their day to day operations even if this is not written into the text of the actual document.

This in turn requires the university to trust its staff to apply this balance in the light of circumstances, and alarm bells should ring if it becomes apparent that the institution does not trust its staff, and thus seeks to hedge them around with rules which may or may not be applicable, but which must be followed just the same because they establish the authority of management over staff.

*[It is important to note the difference between lack of trust in an individual and lack of trust in the staff as a whole. Individuals can err and there can be no objection to the provision of checks and balances to make certain this is minimised. This is quite different from the assumption that the staff of complete units or divisions – or perhaps the entire university – are likely to fall into error and must be guarded against transgression through draconian rules. If this is the case why were such incompetent, unreliable and childlike people employed in the first place, and doesn't this show bad judgment on the part of the university?]*

To assess the risk of whether a particular process or policy fails to adhere to the “institutional pattern” it is necessary to ask eight questions;

- To what “family” of procedures does this particular process or policy belong? *[Most policies or procedures can be grouped into common families, either through a common method of processing, the need to feed data to a common end user, or because they are under the control of a common overseer, such as a pay roll office or an accounts system. It is important that the “family” be identified, even if this is the only procedure of that family that is processed or implemented in that particular place or by that particular team. For example, a research centre may employ casual staff on the rarest of occasions. Even though the procedure for the employment of*



*casuals may be used infrequently by the centre it would need to follow the standards in place across the university, and one would expect such an activity to be grouped within the “Employment of Casuals” family as an HR process.]*

- Does the procedure or policy follow a similar pattern to others in its family? *[There may be natural variance to accommodate specific criteria or circumstances, but does the process in question follow the common model for its family in its pattern and application? These last words are important. It may be far less important to note what the documentation may say than to see how the activity is applied in practice]*
- Is there appropriate justification if the process or policy fails to follow a similar pattern to others in its family? *[It would be most unusual if procedures or policies conducted across a range of jurisdictions were completely identical. Local circumstances, such as the size and experience of staff, the pressure of work, the ability to intervene, and the volume of paper may force modification from one centre to another, but where this occurs (particularly if it is a marked departure) the reason should be appropriate and fully documented]*
- Who does the actual processing or monitoring? *[This question is frequently overlooked, and it is important when conducting an assessment to ensure that processing or monitoring is conducted by people with a similar level of experience across the institution, irrespective of their location. Three things are likely to happen if it is not. The first is that the rate of processing or implementation will differ from one centre to another, and this may suggest laggardness rather than inexperience on the part of the tardy. The*

*second is that dissatisfaction will arise if it becomes known that the outcome in one location is markedly different from what occurs elsewhere. The third is that those responsible for the policy or process may feel under-valued or disadvantaged if the person doing the work in one centre is markedly lower in power or status from those doing similar work elsewhere.*

*Thus it may be most unsettling for those affected by a procedure to find that a task entrusted to a person on HEW 7 or above in one location is given to a person on HEW 4 elsewhere. These lower paid people may do a perfect job, far superior to that performed by their counterpart in a higher grade, but as pay normally reflects competence and experience it may be hard to convince those affected by such discrimination that this is so].*

- What oversight is exercised from one centre to another? *[This follows from the previous bullet point, but in this case it involves the person responsible for oversight of the process or policy rather than the person actually involved. The amount of supervision that any task requires is never an easy question, and becomes even more complex if a process is handled by a team rather than an individual. As a general rule the same supervision should be given to procedures and policies from similar families at all locations, but this is rarely practical as it overlooks both the reliability and/or level of experience of the operator or the time available to the overseer. Despite this there may be cause for concern if it could be shown that a process is tightly monitored in one office but allowed to proceed with indifference in another]*

- What staff training is provided for this “family” of policies or procedures from one location to another? *[There is always a danger that when the pressure of work mounts staff training will be the first thing to be sacrificed, a situation made worse when the training is provided by a central body such as a staff development unit. (Staff development programs are only as good as the willingness of offices to release their staff for training. If the pressure is on, staff will simply not be released and the best instruction in the world will be ineffectual).*

*It may be useful to compare staff training for similar procedures from one location to another, and to ensure that it is compatible. This is particularly the case where staff turnover is frequent, or where university entities are concerned. (University entities – believing themselves either a part of the university or completely independent from it as suits their convenience - generally have their own way of doing things, and this is rarely the best thing for common procedures, particularly where the staff in entities are working in isolation from the university as a whole or are employed on fixed or limited term contracts)*

- Is there anyone familiar with the process or policy – to the point of being able to step in and take over – if anything happens to the current operator? *[Succession planning is often another victim of pressured work loads, where a lack of the time and opportunity to train staff for future roles means that there may be no one available if a position falls vacant. “Understudies” working in the shadow of mentors are essential for continuity. Unfortunately what normally happens is that in a pressured office staff end up being only half trained in a particular procedure or policy, to the point of being able to implement it – and thus getting the office off the hook while*

*giving a false impression of competence – but without any realization of the place of that activity in the wider operations of the university. Those who like to ask embarrassing questions might consider the issue of would happen if the person responsible for a particular process or policy was suddenly transferred elsewhere (or better still – if they won the lottery and resigned the same day). Would the office be able to cope without disruption?]*

*[The acid test involves policies and processes that are used infrequently, such as those that occur only once a semester. Find out who normally handles these things and then ask what the situation would become if that person took ill and was uncontactable. Beware of situations where one is told that a replacement could be borrowed from elsewhere. If it is a task that is required only once a semester there is a strong probability that every office will be required to do the same thing at around the same time and may have no one to spare. If a substitute is nominated the person should come from **within that particular office**, never from outside]*

- Is the process or policy given a higher priority in one place than in others? *[This is another issue relating to “pattern”, as strictly speaking procedures from the same family should be given the same priority everywhere. One realizes, of course, that this may not be practical, and that local circumstances will overrule the ideal. At the same time end users and those affected by a procedure or policy remain dependent on the outcome, and if it is found that there is a serious discrepancy in the priority of processing or the implementation of policy from one location to another it may indicate that a particular group – quite apart from those actually responsible - is being disadvantaged. This becomes worse where*

*one centre gives a higher priority to a process or policy than the remainder of the institution. While the extra attention and quick turnaround may be appreciated by those who benefit, the fact that they have been given priority treatment may seriously disadvantage the rest of the institution (ie; the processing of grant and scholarship applications)*

**DOES THE PROCEDURE FOLLOW THE STANDARD PATTERN FOR THE UNIVERSITY?**

**QUESTION**

**RISK**

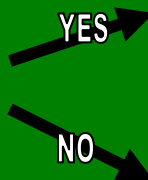
**DOES THE PROCEDURE OR POLICY BELONG TO A "FAMILY" WITHIN THE UNIVERSITY?**



**THE PROCEDURE OR POLICY MAY BE AN "ORPHAN" FOR WHOM NO ONE TAKES RESPONSIBILITY**

**THE PROCEDURE OR POLICY MAY BE "DRAGGED DOWN" BY POOR PRACTICE IN FAMILY MEMBERS**

**IS THE PROCEDURE OR POLICY PERFORMED INDEPENDENTLY IN SEVERAL PLACES OR BY UNRELATED TEAMS?**



**THERE MAY BE INCONSISTENCY IN APPROACH OR APPLICATION**

**A PARTICULAR GROUP MAY CLAIM EXPERTISE AND REFUSE ADVICE OR INPUT FROM OTHERS**

**IS THE PROCEDURE OR POLICY OVERSEEN EXTERNALLY? *[ie; from outside the group responsible for implementation]***



**THE PROCEDURE MAY BE DOMINATED BY THOSE UNFAMILIAR WITH IT**

**THERE MAY BE INADEQUATE CONTROL**

## **8. PAYMENT?** – Who pays for the process, and does the benefit

outweigh the costs? This is a question that is raised a little too infrequently in higher education. In the olden days, when Australian university administration followed the practices of the state public service the question of who might be required to pay for a process (and whether they received value for their money) was rarely asked. If it was a required procedure instituted by the university it was the university who paid – and no one ever worried about the source from which the institution gained its funding – or if it was a special one off service (such as the issue of a replacement transcript) the cost was paid by the beneficiary, and even then there was rarely any attempt to determine whether the fee received bore any relationship to the expenditure of time or resources.

These days have long gone, and the question of what each procedure or policy “costs”, who pays the price, and the issue of whether these groups or individuals receive value for their money cannot be avoided.

In general it is extremely hard to conduct a cost/benefit analysis for any higher education policy or procedure. It is possible – after making a few assumptions – to give a rough “guesstimate” of the cost of doing something, either per episode or per operator, but this tells us little as the “pay off” may be many years in the future. *[Thus, what benefit is derived from a lecture? We may be able to work out both the direct and indirect costs of having a person take the class while the institution provides light, air conditioning and cleaning as well as the depreciation on lecture theatres, but we remain completely in the dark when it comes to whether this exceeds or falls short of the value of activity]*

At the same time it is important to work with whatever information we might happen to possess, or to at least make people aware that there is no such thing in academia as a “free lunch” – someone, somewhere, will always have to pay for whatever goes on, and this may often be those who receive the least benefit from it.

I have no intention of giving a “line by line” explanation of how one should cost an academic activity. It is enough that one should agree that everything that is done does cost someone something even if the actual figure or the actual payee may escape us. It may also be charitable to concede that some academic processes are likely to be more costly than others, even if we can’t confirm this relationship with hard figures. A far more important issue (and this is where the risk comes, even if we are unable to reduce the question to cardinal numbers) is whether the person or organizational group that has made the payment is receiving value for their money.

There are several questions to be asked in reviewing this aspect of an academic policy or procedure;

- Who is actually paying for the operation? *[This is a deceptively difficult question. Most of the direct costs of an academic procedure or the development and implementation of an academic policy are tied up in labour. The person (or persons) performing the action expect to be paid for their service and this normally comes from the cost centre of the organizational unit. The cost of technology is spread over a broad base and forms only a small component of this figure, while other incidentals such as the provision of a workstation, electricity, air conditioning, staff training, printer paper, etc, is shared with others and hidden within overheads. In theory the cost of a process or policy for which no separate fee is charged should be met from within the budget of the organizational unit responsible. In reality this is not always the case as a separate provision may be made for the cost to be chargeable to another cost centre or to the institution as a whole, particularly when the task is cyclic and repetitious, with the group performing the process acting simply as agent. Thus who pays for the entering of exam results (which varies from institution to institution), the hiring of*



*rooms, the control of parking or the provision of remedial education? Someone must, but who does so?*

*There is also the question of foregone costs. In other words, what might have been done with these funds had they not been required for this process? Could it be that something valuable had to be foregone to enable the process or policy to proceed, and if so, was this sacrifice justified?*

*I make no attempt to answer these questions as the answer will vary from case to case. My point is simply to make those who assess the risk to academic policies and procedures aware that they are dealing with something that costs real money (even if the actual sum - or its payer - is unknown) and that someone – even if unknowingly - must always meet the bill]*

- *How much does it cost? [As mentioned previously it is normally difficult to express the cost of an academic procedure or policy in hard figures, although the simple ratio of the gross cost per hour of the employee – remembering that this is gross not net as while much of a person's salary may never reach the employee's pocket - such as deductions for tax, superannuation, health funds, union fees, and so on, it must still be found by the employer – against the time taken to complete the activity may give some guidance. It will be found in most cases that the cost of a procedure or policy (even something as basic as changing a student's enrolment or correcting a computer error) will be far greater than anyone might have imagined. It is often salutary to reflect on whether the job might have been started on the first place had this been known.]*

- What benefit does the person for whom the action is being conducted receive? *[Again this is not an easy calculation as the outcome is unlikely to be immediate. Thus who benefits from traffic regulation or campus ovals? It may be better to approach this question from the opposite direction and to ask what disadvantage the person would experience if the procedure or policy was left undone or unenforced, or worse still done badly]*
- Could this benefit have been provided in a more cost effective manner? *[Here it is not a question of whether other possibilities might exist – they always do if one looks hard enough – but whether those involved would welcome an alternative solution. Let me give a ridiculous example, the taking of photo ID's. There are many ways in which students can be identified without a photo, but few of these (such as hot branding a student number on the forehead, tattooing it on an arm, or inserting a chip in the ear as is done for farmyard animals) are likely to be acceptable to students. Photo ID's are not cheap, and are lost far more easily than a number of alternatives, but they offer a cost effective compromise. It is the same with other procedures or policies. The key point is that it needs to be shown that alternatives have at least been considered, even if this is only to prove them impractical.]*
- Would those affected be prepared to pay for the procedure or policy if it was unfunded by the university? *[This is an important question. Universities provide many procedures without cost to the immediate users, to the point where these things are now taken for granted. Would those immediately involved still want the tasks conducted on their behalf if they had to pay hard cash for them, and if they were obliged to pay, how much would they be prepared to fork out? If it was found that they would be happy to forego the process, policy or*

*amenity on the grounds that it would not be worth it financially, is there any justification for its continued funding by the institution?]*

There is a lot more that one could say about the cost of academic procedures but I have no wish to turn this handbook into a manual of university accounting. It is perhaps sufficient to bring the issue to the attention of users and to ask that they remember that nothing in higher education is ever free. The overriding risk is that this is so easily forgotten.

**WHO PAYS FOR A PROCEDURE – AND ARE THEY RECEIVING VALUE FOR THIS MONEY?**

**WHAT DOES A PARTICULAR PROCEDURE COST?**

**WHO PAYS THIS COST?**

**WHAT OTHER THINGS MAY BE FOREGONE TO MEET THIS COST?**

**DOES THE PAYEE RECEIVE VALUE FOR THEIR MONEY?**

**BEWARE IF PEOPLE ARE UNABLE TO ANSWER THESE QUESTIONS!**

**THE RISK ARISING FROM BEING UNAWARE OF THESE MATTERS MAY BE SERIOUS**

**9. PRODUCTIVITY?** – Productivity is a measure of efficiency. In other words how many “operators” does it take to complete a process or implement a policy, how many stages does this involve, and how many individual cases can be processed or finalized within a given time. One of the great difficulties faced in higher education is that so many assume – both within and outside the academy - that universities are running a charity rather than a business. In the olden days (and we are talking about the medieval monks here) higher education was indeed a charity. There was no suggestion that there should be any relationship between an activity, its cost or its outcome, much less that this should be expressed in monetary terms. The monks gave their time freely and viewed their actions as a form of worship completely opposed to any means for generating income, and if they expected a reward at all for their services it was not payable in this life.

In a monastic environment time was irrelevant, and it was the quality of the action that counted rather than the speed and efficiency with which it was performed. Thus if it took a monk five years to copy a manuscript for the monastic library the time spent in the scriptorium was given willingly, provided the finished product would be acceptable unto God.

I fear that the ghost of the medieval monastery continues to lurk within a number of our academic systems and procedures, where the emphasis is on quality and accuracy rather than speed and productivity. Unlike the monks in their cloister, however, modern institutions pay their staff and cannot neglect the passage of time, and for this reason “through-put” rather than perfection must become the mantra. The risk, of course, is that in a quest for perfection driven by the ghost of academic tradition this may be forgotten.

Every person who contributes to an academic activity attempts to add value to what they are doing. The issue is whether this “value” fully justifies the cost, time and effort involved.

There are a number of questions to be asked in the assessment of risks based on productivity;

- How many stages are there in a process or the development of a policy, and can each of these be justified? *[Apart from the most elementary transactions virtually all academic procedures are multi-stage and many require more than one operator. The question to be asked is just how many stages are involved, and whether every one of these can be justified.]*

*As a general rule the stages in an academic procedure or the development of an academic policy can be divided into five categories or types;*

- **Stages that take the process from one level to another** as it progresses towards finalization (such as making certain that an applicant meets admission requirements before allowing them to complete their enrolment, or gaining endorsement for a policy)
- **Checking stages to ensure that previous actions are correct** and that the process remains on track (such as making certain that all documents to be supplied by the applicant have in fact been received and are attached to the form)
- **Holding stages**, either deliberately introduced to prevent some hasty action or inadvertently caused by other work being given a higher priority (in other words “I’ll think about that over the weekend and make a decision on Monday” or alternatively “Hold off that photocopying until you have less to do. This other work is more important”)

- **Waiting stages**, where one is waiting for input from someone else (such as waiting for an academic to get back to you in regard to the recognition of previous study, a student's missing grade, and so on)
- **Archival stages**, where one records what has happened for future reference. It is often easier to determine which is which through drawing a "process map" of the procedure in question.



*Irrespective of the category the key question must always be “does this stage add to the value of the operation, or is it something included through custom, as a relic of previous technology, or simply as “make-work” to keep people occupied?” **If the stage cannot be justified it should not form part of a procedure or policy.***

- How many “operators” are involved in the process and is this number appropriate? *[One of the chronic difficulties of academia is shortage of staff, and this leads either to restrictiveness (where particular tasks are confined to one person only, either because there has been neither the time nor opportunity to train anyone else, or because no one else has access to the system) or “Jacktradianism” (where everybody does everything as “Jacks of all trades” simply because they happen to be on hand when the work arrives). Examples of both can be found in Student Admin offices, where perhaps only one person has authority to access certain parts of the student record system while at the same time it may be “all hands to the counter whoever you are” during busy periods.*

*There are dangers in both these practices, quite apart from the opportunities for fraudulence so beloved by auditors. Enormous inconvenience can be caused when “the only person in the office who can do something” is away, and equal chaos arises when something can be done by any one at random, to the point where it becomes everyone’s business but no one’s responsibility. It is important that there be an effective compromise between both extremes.]*

- How productive are the staff? *[This is a tricky question as there are few academic procedures or policies that produce constant workloads (with the possible exception of certain recurrent financial or payroll functions). The quantity of work will fluctuate throughout the semester cycle and thus it can never be a question of “how many” of a particular process a staff*

*might get through in a given time, but rather “how many of the procedures associated with that process or policy are still waiting to be done”.*

*In certain respects academic processing has striking parallels with the funeral industry. An undertaker cannot increase the rate at which his clients die and thus increase the number of funerals he might be called upon to conduct (or at last we hope not!) but once summoned to a death bed must act with promptness and dignity to ensure that the body is laid to rest within a reasonable period. Thus in the funeral industry it is not the number of funerals that is important – provided there are sufficient to prevent the company becoming insolvent - but the satisfaction of survivors with the process.*

*It is the same with academic procedures. Staff have little opportunity to drum up additional business, and have even less control over the rate at which work comes their way, but must handle what ever falls into their in-tray as expeditiously as possible. Thus productivity should never be a matter of numbers (ie; “We processed 300 claims this morning and only 299 of these were sent back to us for correction”) but should be a measure of client satisfaction.*

*And how does one measure client satisfaction in academia? Unlike the funeral director who can only give the departed one funeral per lifetime those handling academic procedures have ample opportunity for repeat business. Client satisfaction – which is ultimately a function of confidence – is reflected by the amount of repeat business provided to a unit combined with an absence of complaints. It might be suggested that the monopolistic function of each office in higher education compels people to come to it – after all there can be only one admissions office, one payroll office, and so on – but the question is whether clients come willingly or as a last resort, the latter perhaps like visits to the dentist.*



- What is the theoretic productivity of the unit, and does the actual productivity approach this? *[Again, this is a question that needs to be handled carefully as it is not a matter of determining how lazy or indolent the staff might be (possibly as a precursor to sacking the lot!) but more an investigation of how the procedure interfaces with the group responsible for it. I was once told that anyone who claimed to be respectable golfer should be able to get around an eighteen hole course in no more than eighteen strokes. This assumes of course that each tee will produce a “hole in one”, and may be a little more than the average player can manage. At the same time eighteen strokes is the theoretic minimum for a round of golf, and it would be amazing (and no doubt a complete breach of the rules) should one should contemplate completing an eighteen hole course in fewer strokes.*

*Yet strangely enough we simply don't find that anyone – even the greatest professional – ever seems to come in with only eighteen on the card, and if someone submitted such a score they would most certainly be treated with derision. The reason is that it is simply impossible for a normal human being to complete a game of golf in a mere eighteen strokes and anyone who claims to have done so immediately proclaims himself a charlatan and liar.*

*It is the same in academic processing. There is a maximum rate at which things “could” be done if there were no interruptions, distractions or staff fatigue, and there is a practical rate at which things are actually done because the ideal never happens. In reality the theoretic rate at which something might be done is both unrealistic and unapproachable and should be disregarded. A far better measure of productivity is consistency and accuracy. Is the handling for today of the same order as it was yesterday, last week or last year, and has there been improvement or decline in the accuracy?]*

## ASSESSING THE RISKS IN PRODUCTIVITY

### QUESTION

HOW MANY STAGES OCCUR IN THE PROCESS?

ARE ALL OF THESE STAGES NECESSARY?

HOW MANY STAFF DOES THE PROCESS INVOLVE?

IS THIS AN EFFECTIVE USE OF STAFF?

WHAT IS THE LEVEL OF CLIENT SATISFACTION?  
[As judged by the amount of repeat business and the willingness of people to deal with the unit]

DOES CLIENT SATISFACTION JUSTIFY THIS LEVEL OF SUPPORT?

*[Remembering that "client" includes those who will use any information that may be generated as well as those immediately affected by it]*

### RISK

+ THERE MAY BE TOO MANY STAGES IN THE PROCESS

+ SOME OF THESE STAGES MAY BE MAKEWORK OR BUSYWORK

+ THE LEVEL OF STAFFING MAY BE INSUFFICIENT OR EXCESSIVE

+ STAFF SKILLS MAY NOT BE USED EFFECTIVELY

+ CLIENT SATISFACTION MAY BE INADEQUATE OR EXCESSIVE

+ IT IS POSSIBLE TO PROVIDE A LEVEL OF SERVICE THAT IS INAPPROPRIATE TO THE EXPECTATIONS OF CLIENTS

THIS MAY BE "TOO GOOD" AS WELL AS "TOO BAD"

**10. PRODUCT?** - The question should be expanded to read “what does the process or policy actually produce?” We would suggest that unless the outcome produced is something that is different and more valuable than the “input” with which the process or policy commenced there is little point in bothering. *[Thus, is there any point in banning cars painted red from parking on campus on Wednesdays while allowing those coloured yellow, white or black to do so? If there isn't, why do it?]*

The question of what a process or policy “produces” is often overlooked by those responsible for its operation, possibly they are too close to what is going on. All processes add value, but those engaged in their implementation are frequently too interested in what they are doing (and on the tasks for which they are ultimately judged) to spend time taking a broader view. The difficulty is that while all processes add value, the value added from a particular episode may not be what the end users require.

Let me give an example. When one sells a car privately it is always advisable to “detail” the vehicle to gain a better price. Thus prudent vendors clean the vehicle inside and out, degrease the engine, wash the upholstery, tighten the fan belt, top up the battery, get rid of under body mud (unless frightened that prospective buyers will see the rust, in which case more mud needs to be added!) and generally do everything possible to create the best impression in a buyer’s mind. In detailing a car the seller adds value to the vehicle in the hope that this will produce a financially superior outcome.

A person would be foolish, however, in detailing their car if they proposed taking it no further than the nearest wrecking yard. The diligent owner may have added value to the vehicle through his sweat and effort, but there is no way in which this value can be recouped, and his exertion would be a complete waste of time. A wrecker does not want a glossy vehicle that looks as though it had just left the

factory – all he is seeking is a source of parts, and if a seller presented a vehicle in such a pristine condition the wrecker may wonder from whom it had been stolen and offer even less.

The example may sound ridiculous, but this is exactly what can happen in an academic procedure. The next stage of the process - the work that is done after the outcome leaves your work station – may require something completely different from what you have provided, and this is likely to mean that you have not simply wasted your own time but added to the frustration of the person down the line as well.

This risk can be minimized by asking a number of questions;

- What is the ultimate purpose of the task? *The ultimate purpose may not be the same as the small component for which the operator is personally responsible, and by concentrating on the immediate the person may be frustrating the ultimate. Let me give an example. A temp is taking photographs for student ID's at enrolment, and is judged on the speed with which she can complete the process as well as the quality and clarity of the photographs. A person turns up wearing a Santa suit, complete with red hat, beard and dark glasses. The temp could of course take a photograph of the student just like that, and the outcome might be a classic example of the photographer's art, perfect in focus and format with every detail clearly defined, completed in less than a fifteen seconds. Such a photo may be a prize winning a work of art, and an exemplar of skill and diligence on the part of the photographer, but for ID purposes it would be completely useless. We would commend the temp for refusing to take a photograph under these circumstances and for requesting the student to return wearing more conventional clothing.*

*This may seem an extreme example, but I fear that something similar happens in many of our time stressed situations. The pressure is on to get the job out of the way, and the quicker this can be done the better. There are performance standards involved and these may be adhered to rigorously, but the end result – unless the final purpose is taken into account – may be no better than an ID photograph of our new enrollee in a Santa suit.*

*One of the great fears of those who check academic procedures or policies should be an outbreak of the dreaded “Black Hole Syndrome” – when asked where the outcome goes or how it is used in future stages the assessor is simply told “I don’t know” – in other words the material produced goes into a “Black Hole” and as far as the person responsible for that activity is concerned it is unlikely to be seen again (and good riddance too – the faster one can get rid of these things the better their performance rating!). It might well be salutarily to move those making such statements to the next stage of the process where they can see how the material they prepare is used and how frustrating it can be if it comes incomplete or developed indifferently.*

*There is risk in this matter that is unlikely to pass unnoticed by quality and regulatory agencies, and it should be addressed before they get there. Indeed one of the first questions to be asked should always be “Where does this go after it leaves you, and what do they do with it once it gets there?”*

- What are the performance criteria? *It is easy in this age of understaffed offices and exploding workloads to put emphasis on the throughput of documents or the speed of processing as these are things that can be measured easily. The difficulty with this “academic Taylorism” (the ghost of Frederick Winslow Taylor and his “Scientific Management” continues to*

haunt the academy long after its exorcism from other spheres) *is that the volume handled is only one aspect of what is required. Of course we want speedy processing, but we need care, forethought and accuracy far more. One of the difficulties unfortunately is that this second component is rarely given weight in assessing performance criteria – if in fact any performance criteria exists at all.*

*It is most disheartening when asking about performance to be told “our standard is nothing less than perfection” – in other words “We expect everything we do to be absolutely perfect” - as this happy state is rarely attainable. Those performing procedures are human and as fallible human beings are subject to all the lapses of humanity. The question is “How many slips should be allowed?”*

*The wise manager – like the wise production engineer – allows for a margin of error even if it means that certain work-pieces will need to be scrapped or machined a second time. Failure to allow for this – or worse, failure to predict and document the acceptable range of error – suggests an ill devised or poorly managed procedure. Put simply, perfection is rarely attainable, and any attempt to achieve (much less sustain) it will almost certainly lead to errors.*

- What checking is provided? *Those who remember the early days of computing may be familiar with the punch card operator and her “verifier” – a two person team who entered the same data on the same cards in the hope that the “second entry” would bring to light errors and miskeyings. I remember my original surprise that these girls – it was a completely feminine operation in those days – could work with such a high degree of accuracy while at the same time sharing local gossip and their most intimate problems with each other. Such multi-skilling would be beyond the capacity of any male!*

*Verifiers were important as considerable loss could arise from a single misplaced hole in a punch card. One wonders whether a similar level of monitoring is required for academic procedures. "Possibly not" I hear you reply, even though the consequences may be equally serious, and to overlook the need for checking may be a source of considerable risk.*

*One is often provided with variants on the three standard excuses for a lack of checking of academic procedures or policies;*

- ***"If it is wrong someone will complain"***. Yes, maybe, but this is similar to an aircraft engineer basing the quality of his work on the number of planes that failed to crash last week. There will always come a time when no one will raise a complaint – possibly through fear or ignorance - and the lack of complaint will then be taken as evidence of correctness. This is a major risk in any procedure or policy.
- ***"But we/they have been doing it for years!"*** – Yes, and many drivers who experience serious accidents say exactly the same thing. They have never had an accident before and on the basis of probabilities shouldn't be having one now. Unfortunately familiarity with a process is never a guarantee of reliability.
- ***"We don't have time for checking"***. This is a dangerous statement and one wonders whether those making it would accept a similar level of service from their doctor before being "put under" for an operation. What the statement means is "We don't give the same priority to checking as we give to doing", or in other words "Our aim is to get rid of things as quickly as possible so that we will be judged efficient". Both concepts bristle with risk.

- When was the last time you checked personally? *Checking is easy to delegate to someone else, often a person less competent than the one who conducts the process. This carries obvious risks, particularly if the person responsible for checking sub-contracts the work to someone even further down the pecking order.*

*A person can only be satisfied that a job has been done correctly if he or she checks it personally. This brings to light any problems that may exist and sets an example for staff. Checking is often the most boring task, particularly if there are few errors, and attention can drift. For this reason it is much better that it be done at the highest level rather than the lowest.*

There is great danger that those working at the coal face will come to regard what they are **doing** as far more important than what they happen to be **producing**. Take the case of a dressmaker sewing seams. The seam may be perfect but the customer will be most disappointed if the resulting dress – the product the dressmaker is producing - fails to fit. The same is true in a dental surgery. A dentist may be an absolute craftsman, drilling neat holes and filling them with a colour matching amalgam, such that his or her work would receive a first prize at a dental convention. The patient, on the other hand, is not so interested in that. What he is seeking is relief from pain, and if this is not achieved he is unlikely to give twopence for the work of artistry created within his mouth.

It is for this reason that it is essential to look at what a process actually produces or achieves as opposed to conducting some minute examination of the stages involved. The risk, of course, is that this will be overlooked. Those engaged in the process will concentrate on the immediate rather than the ultimate and in doing so will lose their way.



There is another way of looking at this that makes the risk even plainer. Consider a person entering a hospital to have a baby and all the worries that are on her mind. I have been told that pregnancy focuses the mind alarmingly, but suppose the mother concentrated solely on what might await her in the labour ward and neglected anything that might occur beyond this. She might well be able to withstand the pain, discomfort and inconvenience of giving birth to a child, but this is not what she is there for. The “product” she is seeking is not her personal survival throughout the accouchement but rather the taking home of a healthy baby. It is the same with academic procedures and policies. It is easy to concentrate on the immediate at the expense of the ultimate. It is the product, however, that is important, not the process through which that product was achieved, and there is a grave risk that this may be forgotten.

*[See the diagram on the following page]*

## RISKS ARISING FROM DISREGARDING THE “PRODUCT” OF A PROCEDURE

### QUESTIONS

WHAT DOES THE PROCESS ACTUALLY PRODUCE?



HOW IS THIS PRODUCT USED, AND BY WHOM?



WHAT ERRORS CAN ARISE FROM FUTURE USE OF THE PRODUCT?



HOW CAN THESE ERRORS BE PREVENTED OR MINIMIZED?

### RISK

- \* THAT THOSE RESPONSIBLE FOR THE PRODUCT MAY BE UNAWARE OF THE IMPORTANCE OF WHAT IS PRODUCED
- \* THAT THOSE RESPONSIBLE FOR THE PRODUCT MAY BE UNAWARE OF THE TIMELINESS WITH WHICH IT IS REQUIRED
- \* THAT THOSE RESPONSIBLE FOR THE PRODUCT MAY BE UNAWARE OF THE USE TO WHICH OTHERS MIGHT NEED TO PUT THIS MATERIAL
- \* THAT THOSE RESPONSIBLE FOR THE PRODUCT MAY BECOME FIXATED ON THE PROCEDURE RATHER THAN THE OUTCOME
- \* THAT THOSE RESPONSIBLE FOR THE PRODUCT MAY FAIL TO TAKE STEPS TO REDUCE ERRORS AND MISUNDERSTANDINGS

**11. PROGRESSION?** – Progression represents development and improvement. In other words, is the process reviewed at regular intervals and improved as required? Ideally this review should be cyclic, and should occur before problems arise rather than after. It is equally important that the review not be conducted solely by those responsible for management of the process, or by those who might have some vested interest in it.

An example to make this clear. In the early days of motoring driving tests were quite different from what is required today. Not only did the prospective licensee have to demonstrate to a sceptical policeman their ability to navigate a vehicle down a road at what we would now regard as a ludicrously slow speed, but had to be aware of the danger their presence might constitute to pedestrians and horses. Thus if a horse driven vehicle approached the driver stopped and waited until it had passed, and failure to do this could constitute grounds for refusal of a license. It was exactly the same with pedestrians – if a person was seen to be crossing any part of the road the driver was obliged to give way and to wait until they had completed their passage. One shudders to think of the implication if this was still applied to modern traffic.

The fact of the matter is of course that while these requirements still exist in Australia (particularly the one “giving right of way to horses” they rarely need to be enforced as the world has changed and horse drawn vehicles are notorious for their absence. The procedures for gaining a license have been revised to reflect current legislation, social norms and the emergence of technology, and a police infringement notice based on these earlier rules – even if still legal - would be regarded as quaint if not crazy by the courts

It should be the same with academic procedures and policies. Geriatric procedures or policies – now long past their “use-by” date - carry the seeds of their own destruction, and unless constantly revised will cause confusion rather than efficiency.

At the same time there is little point in abolishing something simply because of the passage of time. It costs time and money to introduce something new, and if an aged procedure or policy is still doing its job there may be every reason to retain it. The key point is “how does one know?”, and for this reason it can never be a matter of how many “ancient” procedures can be got off the books, but rather how many of these have been reviewed over the previous period and still found serviceable?

There are a number of questions that may expose risks;

- When was the practice last reviewed? *This of course implies that there is some system of formal review in the first place as well as the fact that a review actually occurred. It should also be beyond question that if a “formal” review took place – informal reviews don’t count – there should remain some documentation to attest to this fact, even if the review was completely satisfactory and no change was thought necessary.*
- Who conducted the review? *Beware of reviews conducted without external involvement. While self review (ie; review by those immediately involved) is better than having no review at all, the credibility is greater if the review is conducted by knowledgeable people with no direct involvement. (The word “knowledgeable” is used deliberately – a review is pointless if conducted by those who are ignorant of what the process is designed to achieve or how it is intended to achieve it)*
- What was the outcome of the review? *A review need not lead to change. It may be that no variation or improvement was felt necessary, and hence the procedure or policy was continued without amendment, but the key point is that those responsible for the outcome must always be aware of what the recommendation from the review happened to be.*

*It must also be remembered that a “clean bill of health” only indicates that the procedure or policy was acceptable **at the time of the review**. This can give a false level of confidence as the circumstances may have changed. The danger lies in the fact that as academic activities reflect their environment, any change in that environment can make sound practices obsolete, and this can occur suddenly and unexpectedly. [Thus suppose an institution that had only taught face to face in the past decided to offer classes on-line and off campus using new technology. The change in mode of delivery could make obsolete many of the procedures previously found satisfactory]*

- *Who signed off the review? This can be an important piece of information, as the person who “signs off” is ultimately the one who takes responsibility for the consequences. Beware of reviews that are signed off at a level significantly higher than the operation itself – these people, with the best will in the world, may not be aware of the nuances, and might simply be “rubber-stamping”.*
- *When will the process be reviewed again? Be wary if no one seems to know the answer to this question as it strongly implies that reviews of policy and procedures are not cyclic and may only occur when something goes wrong. Ideally the planning for a review should commence as soon as the previous review is finished, and should involve those immediately involved as well as external facilitators.*
- *What is the ultimate life of this policy or procedure? No procedure can be expected to last forever. It can be patched through regular review (similar to the repairs to a car to get it through registration) but there will come a day when it will simply have to be discarded, and it is best for everyone to keep that “use-by” date in mind to ensure that something better will be developed before it arrives.*

*Let me give an example. No one expects a student to remain enrolled forever, least of all the university. There is a set time for the completion of awards, and if graduation requirements cannot be satisfied within that period the student can expect exclusion. Exactly the same thing must happen with academic procedures. There should be a limit set on the life of every process or policy. This can be extended if circumstances require, but by and large the “date of death” should be determined in advance and then rigorously enforced. If this is not done it is extremely easy to end up with a vast raft of obsolete procedures and policies that no one will follow in any case as they no longer meet a need.*

- What improvements do you have in mind for the future? *Be careful if there are none. This suggests a robot administration with sleeping supervisors. If staff can make no suggestion for improvement it implies either that they have not been following the procedure in the first place, or alternatively that their initiative has been stifled by supervisors. Both are grounds for risk.*

It is one thing to read documents that tell you about the progression of a practice and quite another to see these things being implemented on campus. Most procedures will establish their own level of compliance – the staff will do as much as seems necessary to meet current need and regard the rest of what is published as “too difficult” and disregard it. This in turn leads to a divergence between what it is claimed should be done and what actually occurs, and this alone presents numerous risks.

Let me give an example. How is recognition for prior learning (RPL) granted at your university? Does it follow the lengthy (and sometimes tedious) pathway prescribed by Academic Board, or are there shortcuts hallowed by past practice to simplify the procedure? **Beware of these things – they will catch you out!**

## THE RISKS ASSOCIATED WITH PROGRESSION

### QUESTIONS

WHEN WAS THIS PROCEDURE LAST REVIEWED?



IS IT NORMAL PRACTICE TO REVIEW ALL PROCEDURES REGULARLY?



WHAT CHANGES WERE MADE AS A RESULT OF THE LAST REVIEW OF THIS PROCEDURE



WHAT ARE THE ARRANGEMENTS FOR FUTURE REVIEWS – AND WHEN WILL THESE OCCUR?

### RISKS

- o THE PROCEDURE MAY NOT HAVE BEEN REVIEWED
- o IT MAY NOT BE NORMAL PRACTICE TO REVIEW PROCEDURES ON A CYCLIC BASIS
- o THE PROCEDURE MAY HAVE BEEN REVIEWED, BUT THE OUTCOME WAS DISREGARDED
- o STAFF MAY NOT BE AWARE OF THE CHANGES MADE, POSSIBLY BECAUSE THEY ARE NOT FOLLOWING THEM IN ANY CASE
- o THERE MAY BE NO ARRANGEMENTS FOR A FUTURE REVIEW OF PROCEDURES. THIS CAN BE EXTREMELY DANGEROUS

**ANY OR ALL OF THE ABOVE SHOULD RING WARNING BELLS. PROCEDURES WITHOUT PROGRESSION GET INSTITUTIONS INTO TROUBLE**

**12. PREMONITION?** – “Premonition” refers to the user’s gut feeling about what they are working with. How do they feel about the procedure or policy - are they comfortable with its operation and their contribution towards achieving it, or do they fear that something is just waiting to go wrong?

Premonition is an inner feeling, and because it is completely subjective it is often overlooked in a “scientific” examination of procedures or policies, and yet it so frequently proves itself to be right. The majority of those who express their “uneasiness” with a process are unable to ascribe the cause – they just feel that something is not right but remain powerless to do anything about it.

Premonition can only be discovered by asking people how they feel about what they are doing, and this in turn requires trust on both sides. At the same time, if the person involved with a process feels uncomfortable about what they are doing there may be good reason to check further – there is rarely smoke without fire.

Even if the user’s fears prove groundless the fact that they feel uncomfortable about what they are doing may impair their efficiency and damage the process. For this reason it is strongly suggested that any uncertainties for which no explanation can be given should be verbalized and investigated.

There is another factor as well. Those assessing risks cannot exclude their own values and beliefs. An auditor must be impartial and unbiased, but this does not mean abandoning everything they hold dear, particularly when something goes (or appears to go) against their conscience. Personal bias (which can sometimes be irrational and misleading) can be minimised by using multiple auditors, but if several people feel the same way about something it may well be a sign that something is wrong, even if this is based on nothing more than gut feeling.



There are five tests that should be used to distinguish between personal feeling and group premonition;

- Is the premonition felt by more than one person? *If several people feel that something is wrong – even though they can't explain why they feel that way – there is a strong probability that there is.*
- Is it the process itself or the place (or manner) in which the process is performed that is worrying you? *It is important to distinguish between concern about the place where the procedure is being performed and the procedure itself. An uncomfortable working environment (with a screaming boss, unsustainable workloads, gossiping co-workers, etc) disorients the best of us, but here it is the place rather than the process that is at fault. The test is to ask whether the person feeling uncomfortable would be happier doing the same work elsewhere, or whether they would be happier doing different work in the same workstation.*
- Are you being asked to do something against your conscience? *Let's take something completely different, a teetotaler who is asked to prepare alcoholic beverages for guests (yes, this too can be regarded as an academic process, albeit one rarely mentioned in procedural manuals!). The teetotaler happens to be strongly opposed to alcohol in any form on religious grounds and has to force themselves to act against their conscience to get through the process of pouring drinks. This might not trouble another person, although that second person might become equally distressed if the guests lit cigarettes and filled the room with passive smoke, or if they started telling off colour stories that demeaned women.*

- Are you concerned that the outcome may harm someone? Some procedures and policies, such as the exclusion of students for poor performance, are designed as deterrents, and to be effective they may have to be painful. (If they didn't hurt there would be no deterrent). The majority of those working in higher education are kindly individuals who hate to inflict pain on anyone, and thus they find themselves in a bind. If the procedure is to be effective it will have to hurt, but those concerned don't want to be the ones who contributes to this suffering. The test, of course, is whether they would be equally upset if exclusion was caused by something completely different (such as expulsion for continual residential drunkenness, chronic insubordination, or campus hooliganism). If not, it becomes a matter of personal feeling and the solution would be to replace the operator rather than change the procedure. If the feeling was the same in all cases, on the other hand – and let's say that the exclusion procedure at that particular university involves something really degrading, such as placing the defaulter on public display in a set of stocks kept for that purpose in the quad, before burning their student ID card, bashing them with the university mace, and having them thrown into the street by a bouncer from security to the cheers of onlookers – it may be the procedure that needs to be changed rather than the operator.
- Do you trust the university to do the right thing in following the procedure or policy? The question of trust is something that is generally assumed rather than discussed by university staff. Yet the fact that it is so rarely discussed may well be the reason it can lie festering beneath the surface. Put simply, the staff member with responsibility for the procedure or policy may simply not trust the university to do the right thing when it is implemented. Let me give an example. Suppose a procedure is in place to identify people with a drug problem (ostensively to provide them with support and to ensure the safety of others in labs and practical classes). Could this information be used for something more sinister (such as

*barring these persons from laboratory classes altogether)? If trust is insufficient the person performing the procedure may still go through with it, but hardly with goodwill or efficiency.*

The gut feeling that “something’s not right” is a strong survival trait in humans, and has no doubt saved many of our ancestors from meeting a premature demise in the jaws of hungry beasts. It should not be disregarded in assessing the risks of academic procedures.

**CONCLUSION** – This is a work that has been developed to meet an emerging need, and like everything of this nature may well contains errors and misconceptions that I have overlooked, but which I would like users of this book to bring to my attention as early as possible.

As stated at the beginning, this is a book about risk, and risk is essentially the balance between what one expects might happen and the probability that it will actually occur. It will never be possible to eliminate risk entirely and any attempt to do so would be a waste of time and effort. The most that can be done is to predict the likelihood of risk and to develop strategies and systems in advance to manage or mitigate the consequences should they occur. I suspect that a demonstration of this will be the least that quality agencies such as TEQSA will require.

I have attached a summary for “Applying the Twelve P’s” as an appendix. I would appreciate feedback and comment on the utility of this from end users.

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**APPLYING THE TWELVE “P’s” – A SUMMARY OF THE EVIDENCE THAT QUALITY AGENCIES MAY REQUIRE**

<b><u>ISSUE</u></b>	<b><u>RISK</u></b>	<b><u>QUESTIONS TO BE ASKED</u></b>	<b><u>EVIDENCE THAT THE RISK HAS BEEN RECOGNIZED AND ADDRESSED</u></b>
<b>PURPOSE</b>	THE PROCESS MAY HAVE NO CLEAR PURPOSE, OR THE DECLARED PURPOSE MAY BE UNNECESSARY OR INAPPROPRIATE	“WHY ARE YOU DOING THIS, AND WHAT OUTCOME ARE YOU SEEKING AT ITS CONCLUSION?”	CLEAR AND CONVINCING JUSTIFICATION OF THE PURPOSE OF THE PROCEDURE
<b>PARTIES</b>	THE PROCESS MAY BE DEPENDENT ON ONE KEY INDIVIDUAL (WHO COULD LEAVE), OR WHOSE PERSONAL BIAS OR MISINTERPRETATION COULD DISADVANTAGE THOSE AFFECTED BY IT	“WHO DEVELOPED THIS PROCEDURE, WHO IS RESPONSIBLE FOR ITS OPERATION, AND WHO COULD BE AFFECTED BY THE END RESULT (AND HOW COULD THEY BE AFFECTED)?”	THE DEVELOPMENT OF “UNDERSTUDIES” WHO CAN TAKE OVER IF REQUIRED [SUCCESSION PLANNING] COMBINED WITH A KNOWLEDGE OF THE CONSEQUENCES FOR OTHERS [THIRD PARTY EMPATHY]
<b>POSITION</b>	THE PROCESS MAY BE OUT OF SYNC WITH RELATED UNIVERSITY SYSTEMS	“WHAT PROCEDURES FEED INTO THIS PROCESS, AND HOW IS THE OUTCOME FROM THE PROCESS USED?”	APPRECIATION OF WHERE THE PROCESS FITS WITHIN THE LARGER PICTURE, PREFERABLY WITH CONTEXT MAPPING
<b>PROTOCOL</b>	THE PROCESS MAY BE INADEQUATELY DOCUMENTED	”CAN YOU SHOW ME SOME DOCUMENTATION THAT CLEARLY EXPLAINS THE PROCESS?”	PRODUCTION OF APPROPRIATE (AND UP TO DATE) DOCUMENTATION
<b>PACE</b>	THE PROCESS MAY DISADVANTAGE OTHERS THROUGH OPERATING TOO QUICKLY OR TOO SLOWLY	“HOW LONG DOES IT TAKE TO COMPLETE THE PROCESS FROM BEGINNING TO END, AND HAS THERE BEEN ANY COMPLAINT ABOUT THIS?”	EVIDENCE THAT THE TIME TAKEN IS REASONABLE AND CAN BE JUSTIFIED <i>[WARNING – Do not compare with the time taken elsewhere]</i>
<b>PACKAGE</b>	THE PROCESS MAY NOT HAVE BEEN CLEARLY EXPLAINED TO (OR UNDERSTOOD BY) THOSE AFFECTED BY IT	“HOW HAVE YOU EXPLAINED THIS PROCESS TO OTHERS, AND HOW CAN YOU BE CERTAIN THAT THIS EXPLANATION HAS BEEN UNDERSTOOD?”	EVIDENCE OF CLEAR EXPLANATION (GENERALLY IN WRITTEN FORM OR ON A WEBSITE) THAT IS UNDERSTOOD AND ACCEPTED BY THOSE AFFECTED

<b><i>PATTERN</i></b>	THE PROCESS MAY BE OUT OF KILTER WITH SIMILAR PROCESSES ELSEWHERE WITHIN THE UNIVERSUTY	“IS THIS THE SAME AS WHAT OCCURS ELSEWHERE (EITHER WITHIN THE UNIVERSITY OR MORE WIDELY ACROSS THE SECTOR)?”	EVIDENCE THAT THE PROCESS FOLLOWS SIMILAR PATTERNS TO THOSE USED ELSEWHERE IN THE UNIVERSITY AND BEYOND
<b><i>PAYMENT</i></b>	THE PROCEDURE MAY NOT GIVE VALUE FOR MONEY	“WHO PAYS FOR THIS PROCESS, AND DOES THE BENEFIT RECEIVED OUTWEIGH THE COSTS INVOLVED?”	EVIDENCE THAT USERS ARE AWARE OF THE COST OF THE ACTIVITY AND ARE THEREFORE EXERCISING THE GREATEST ECONOMY
<b><i>PRODUCTIVITY</i></b>	THE PROCESS MAY INVOLVE TOO MANY STAFF OR STAGES	“HOW MANY PEOPLE ARE INVOLVED IN THIS PROCESS AND COULD ANY BE ELIMINATED?”	EVIDENCE THAT THE STAFFING IS ADEQUATE BUT NOT EXCESSIVE
<b><i>PRODUCT</i></b>	THE PRODUCT ( <i>THE OUTCOME FROM THE PROCEDURE</i> ) MAY BE OUT OF SINC WITH THE PURPOSE INTENDED	“WHAT OUTCOME DOES THE PROCESS PRODUCE AND IS THIS WHAT WAS ORIGINALLY INTENDED?”	EVIDENCE THAT THE OUTCOME IS “FIT FOR PURPOSE”
<b><i>PROGRESSION</i></b>	THE PROCESS MAY NOT BE REVIEWED REGULARLY AND MAY BECOME OBSOLETE OR INEFFICIENT OVER TIME	“WHEN WAS THIS PROCESS LAST REVIEWED, HOW WAS IT REVIEWED, AND WHAT WAS THE OUTCOME?”	EVIDENCE OF REGULAR AND SYSTEMATIC REVIEW AND CONSEQUENT UPDATING.
<b><i>PREMONITION</i></b>	THE STAFF MAY FEEL UNCOMFORTABLE WITH THE PROCESS (OFTEN AN EARLY WARNING OF TROUBLE, EVEN IF NO CAUSE CAN BE ASCRIBED)	“HOW DO YOU FEEL ABOUT YOUR INVOLVEMENT IN THIS PROCESS? DO YOU HAVE ANY HIDDEN DOUBTS OR FEARS?”	EVIDENCE THAT STAFF ARE COMFORTABLE WITH THE PROCEDURE AND CONFIDENT IN ADMINISTERING IT