Governing Safely – A letter to a new non-executive director.

Dear Ned,

Congratulations of your new non-executive director role. It is well deserved.

You asked me to put together some thoughts for you on how you could further develop your effectiveness as a director and provide balanced support and challenge in your new job.

We've not had chance to meet and discuss your current level of knowledge of health and safety so I've set out what I see as some basics which we could use as a foundation for a further conversation. It centres on helping you to integrate health and safety (HS) into your mental models of the business and the board process. It's not so much advice, just food for thought. I acknowledge that I may have used a little too much health and safety jargon and we will need to work together to make sure we are both talking the same language.

I've included a few diagrams which I think will help you to understand some of the issues. Forgive me if this is a little too simple for your needs. It may help if you look at the 'Swiss Cheese' model first at the end of this note.

Context

There is increasing pressure on boards to meet societal expectations and health and safety fits into that agenda. The reports on good governance and section 172 of the Companies Act focus attention on accounting more effectively to the range of both shareholder and stakeholder interests, including employees.

Health and safety (HS), issues can be woven into the governance process. However this is not an easy journey and it is too important to be left to health and safety professionals alone. One of the main challenges is integrating HS issues into business decisions so as to align this with your business model and strategy.

There are several 'models' of corporate governance. For the sake of clarity I have used a four stage 'learning board' process: providing direction; delegating to management; oversight and monitoring; and review.

Direction

Purpose and Policy

Applied appropriately, the UK requirement for a health and safety policy remains a valid way of setting out the relationship of the board with management, employees, customers and the public on HS.

Policies ideally set out the principles and guidelines for decision making. They establish the boundaries or limits within which decisions are to be made and within which judgment must be exercised. They simplify decision making and promote efficiency by removing the need for repeated analysis of recurring problems. Policies permit boards to delegate to management more decisions than would otherwise be the case. They set a framework which aims to avoid unnecessary conflict between HS and other business goals.

At best a HS policy represents the collective view of the 'controlling mind' of the board. HS policies will be unique to the organisation and based on board conversations addressing such things as:

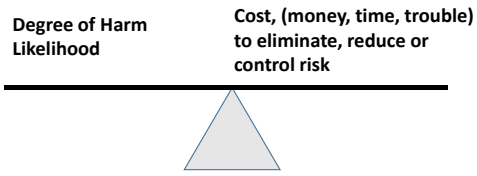
- the purpose of the policy in the context of company activity, business model and vision: why is a HS policy necessary and how will it benefit the company; how does it retain or add value or reputation?
- how the policy sits within the context of the values and ethos of the company and the reward systems. It is a core part of the company culture. An HS policy is part of the 'tone at the top' and 'licence to operate'.
- how the necessary freedom, empowerment and collaboration in the 'entrepreneurial leadership' of the organisation is balanced with the 'prudent control' of HS risk, needs to be understood to avoid conflict in the delegation of activities to management;
- the relative significance of HS risks within the range of business risks and how important HS is to the company.

The policy statement also needs to capture an outline of how a proportionate, (reasonably practicable), approach will be adopted to policy implementation by both the board and management, identifying the principles which will guide decisions and the parameters in which the board and management will operate; the latitude in which discretion will be exercised. For example this could include how the scale of hazard/risks influence such things as:

Reasonably Practicable

Getting the Right Balance on Risk

Reasonably practicable is a UK legal term, setting the minimum standard for the control of risk. It's about getting the right balance between the risk and the cost of prevention. In essence it's about being proportionate



- how the board, (and management) spend time and attention in directing and overseeing implementation of HS policy and performance;
- the effort, resource and detail put into risk assessments;
- the resources, and detail of the controls for risk, including the scope and complexity of the HS management system;

- how the policy will impact on business activities, e.g.
  - how the financial resourcing of HS will form part of the business planning and budgetary control and matched to the hazard and risk profile;
  - how the human resource policies will be affected by the policy, including such things as recruitment, selection, placement, development, competence, involvement and consultation;
  - the sustainability of the enterprise?
  - operational activities and product and service design.

Hazard and Risk Profile

The hazard and risk profile (HRP) of an organisation informs all aspects of the approach to governing safely.

Every organisation will have its own profile. This is the starting point for determining the greatest health and safety issues for the organisation. In some businesses the risks will be tangible and immediate safety hazards, whereas in other organisations the risks may be health-related and it may be a long time before the illness becomes apparent.

A HRP examines:

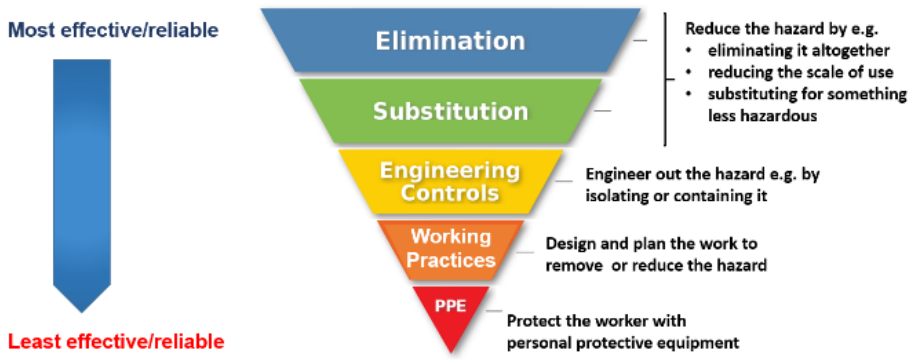
- the nature and level of the threats faced by the organisation
- the likelihood of adverse effects occurring
- the level of disruption and costs associated with each type of risk
- the effectiveness of controls in place to manage those risks

The outcome will be that the right risks have been identified and prioritised for action, and minor risks will not have been given too much priority. It also informs decisions about what risk controls measures are needed.

Strategy

Strategic choices for HS need to be informed by an understanding of how HS risks may impact on achieving strategic business objectives and plans. Conversely strategic business choices may impact negatively on HS risks by introducing greater hazards or by relying on more fragile methods of risk control lower down the hierarchy of control.

Hierarchy of Controls The hierarchy illustrates the preferred priority for controlling the risks created by hazards



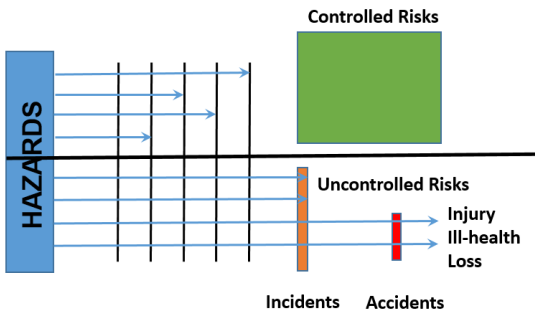
Strategic choices are at the heart of providing direction and turning aspirations into reality. A key question for the board is where resources, (money, time, attention), will be allocated across the business. The board needs a big picture overview of HS hazards and risks. This is the starting point for reflecting on how the board and the organisation provide appropriate resource to the control of HS risk, ensuring that resource is allocated in proportion to the scale of the hazards and risks across the business. A starting point is knowing in broad terms the hazard profile; what are the critical risks which arise from the main HS hazards.

Strategic objectives also need to acknowledge the nature of the HS challenge. There are many variables involved in the control of HS risks; the aim to eliminate all risk is unrealistic. The purpose of a HS strategy is to contain the negative impact of risk on both people and the business. The task is never finished; it requires ongoing learning and adaptation in the face of changing circumstances.

In broad terms the main strategic choices include both learning from success and failure.

HS Strategic Choices: Learn from Success and Failure

The diagram shows a section through the Swiss cheese model – see end on note.



Learning from success, e.g.

- Reduce hazards
- Find and fix latent conditions
- Apply defences further up the hierarchy of control
- Improve implementation of defences
- Find and where people are compensating for weak defences.

Learning from failure, e.g.

- Investigate incidents and accidents to reveal both latent conditions and human variability

Focusing on, e.g.

- Accidents with severe outcomes
- Accidents and Incidents where there was potential for more serious outcomes
- Accidents and incidents involving the significant hazards and risks of the business

Risk

Most business risks impact on the company, (the legal body corporate); either directly or indirectly - usually in a financial way. Such risks impact on individual persons indirectly through loss of income or livelihood.

HS risks are part of the risks faced by a business but are distinct. Whilst the body corporate is exposed to risks, it is real people who are exposed to personal harm by HS risks. A board needs to address how the risks to real 'persons' are balanced against the risks to the 'corporate body' of the company?

A key question is, what is the 'risk appetite' for harming people as part of the business activity?

Financial costs to the business are associated with HS failures. For many firms the main recurring costs of accidents arise from the more frequent minor events and inefficiencies created through for example poor mental health. Not all of these costs are covered by insurance.

Delegating to management

Culture

People are both the key strength and a vulnerability in any organisation. Creativity, insight and tenacity are essential to business success; inconsistency, fatigue and excess risk taking are some of the things that cause businesses to fail. The tendency to misjudgement and error is not unique to those at the sharp end of the business. Misdirection and misalignment at the top can just as easily sow the seeds of failure as can mistakes at the bottom[1].

Structure

Boards need to guard against focusing too much on front line and immediate supervision when it comes to behavioural safety and culture building. Boards need to focus equally on the behaviour of themselves and those who report directly to them. Their influence is significant and often down played in the safety management process. Positively reinforcing behaviours which promote a positive safety culture is key but very difficult.

A positive safety culture relies on a community of common purpose and practice, based on a common understanding of how to respond to HS risks. How the board motivates its senior managers and how they motivate their teams is a key issue for delegating. Boards need to be aware that the organisation's culture, structure or management processes could be source of error and inappropriate risk taking.

Boards also need to give sufficient attention to how management sets about implementing controls to safeguard their people from injury and promoting a positive culture of health and safety. There is a tendency to rely on the 'safety management system' without examining how this aligns with the way the business really runs. Aligning leadership style, management structures, human resource policies, and accountability and reward systems with the management of people risks is a key to success.

Business relies on the competence and flair of its people. However the necessary entrepreneurial risk taking at times may conflict with the need for caution over personal safety. How the necessary freedom, empowerment and collaboration in the 'entrepreneurial leadership' of the organisation is balanced with the 'prudent control'

[1] 'Roads to Ruin – The Analysis' http://www.reputability.co.uk/files/press/Roads_to_Ruin_The_Analysis.pdf

of personal risk, needs to be understood to avoid conflict in the delegation of activities to management. When it comes to safety the boundaries of discretion need to be clearly drawn. In many cases learning from trial and error and experience is too costly for those involved.

Oversight and monitoring

Boards are always short of time, so two key questions for boards about HS are: where do we best spend our time and what do we do to achieve best benefit?

Organisations survive so a long as they adapt at least as fast as the pace of change. Oversight and monitoring of HS is much about learning to cope with change.

Accidents and incidents provide significant opportunities for learning but boards may get diverted into a purely reactive mode by focusing only on accident data. Using accident and injury data alone to monitor performance is like driving by only looking in the rear view mirror. You divert your attention away from what is ahead. And an absence of accidents is not evidence of an absence of risk or good risk control. Good health and safety is about repeating good performance, drawing both on success and failure. See the earlier diagram on Strategic Choices.

Good board conversations about HS provide insight and challenge to management understanding of the adequacy and implementation of controls; their understanding of vulnerabilities and how they are solving them. The hazard profile of the business is a good indicator of where to give attention. Whatever the controls in place significant hazards will always present the potential for a serious event and injury.

A board needs a proportionate approach to the hazards/risk of the business looking at both successes and failures, and giving attention to things such as:

- the greatest hazards and the robustness of the critical systems designed to prevent serious outcomes;
- vulnerabilities – those areas where degradation in precautions can be expected, such as those which rely heavily on procedures and people; and those where from inspections and audits there is evidence of failing implementation;
- finding and fixing latent conditions;
- cultural development with views from stakeholders around the business.

Review

Drawing on a diversity of sources annual reviews examine the effectiveness of management and board performance. Assessments from the ‘three lines of defence’ can usefully include:

- views and assessments of management (the ‘first line’ – who ‘own’ the risks), of the perceived successes, failures, strengths and weaknesses of the HS performance;
- views and assessments from the ‘second line’ – HS advisers and others who assist and advise on the design of risk controls and facilitate implementation of effective HS management practices, who can provide an independent perspective;
- evidence from the ‘third line’ – audit activity, (internal or external) which can cover how effectively the organisation assesses and manages its HS risks and will include assurance on the effectiveness of the first and second lines of defence. This could also include learning opportunities from external sources through benchmarking, reviews of significant HS incidents in other firms both in similar and other industries.
- The Covid crisis has also emphasised the need for boards to stay alert to those unlikely risks which have potentially serious (unacceptable) consequences

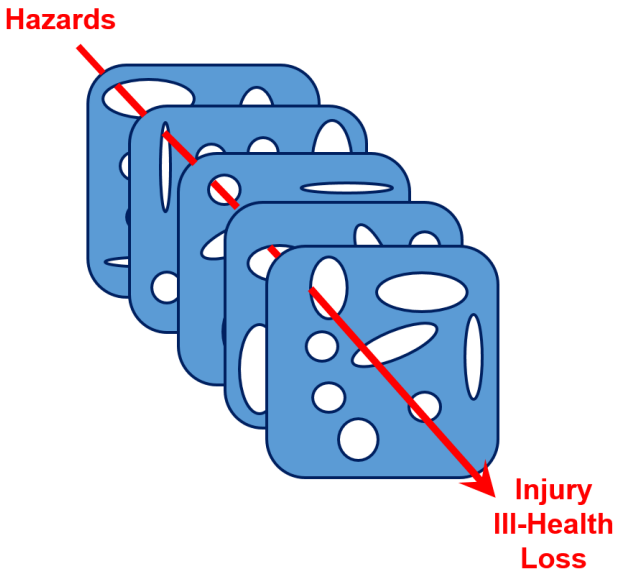
Good practice for corporate governance also expects a board to conduct an annual evaluation of its own performance and its committees....’ Applying this to HS some of the issues which can be addressed are:

- What time and attention has been given to HS issues in board, other director and committee meetings?
- Have the board HS discussions been reactive or based a structured examination of the HS risks and the adequacy of the HS risk management arrangements in a proportionate manner?
- What has been the content and ‘quality’ of the conversations and has this involved meaningful challenge and dialogue with management on HS?
- How does the time, attention and quality of conversations align with the hazard/risk profile and the vulnerabilities on HS?

Comments and enquiries should be made to Ostiarius at ostiarius@hsg65.com.

The Swiss Cheese Model

The Swiss cheese model is one descriptive tool by which to visualise how organisations seek to prevent ill health, injury and loss. It can be used as a framework for thinking about where to direct time and attention to improving and sustaining the control of HS hazards and risks.



The model envisages a series of layers of defence, barriers, and safeguards which aim to prevent hazards resulting in ill-health, injury and loss, (figure).

In an ideal world each defensive layer would be intact and provide perfect protection. But things are never perfect and in reality, each layer of protection can be seen as slices of Swiss cheese, having holes - though unlike in the cheese, these holes are continually opening, shutting, and shifting their location.

The presence of holes in any one “slice” does not normally cause an issue. Bad outcomes arise when the holes in many layers momentarily line up to permit a trajectory of accident opportunity—bringing hazards into damaging contact with victims.

Some of the weaknesses in the defences arise from decisions made by designers, builders, procedure writers, risk assessors and top level policies and strategic decisions. These are often referred to as latent conditions. They are created by people making decisions and judgements somewhat remote in time and place from the present. They are history – in the past.

Latent conditions can translate into error provoking conditions within the local workplace (for example, time pressure, understaffing, inadequate equipment, fatigue, and inexperience) and they can create long-lasting holes or weaknesses in the defences (untrustworthy alarms and indicators, unworkable procedures, design and construction deficiencies, etc.).

The impact of latent conditions can remain dormant for long periods until variability in the behaviour of those involved triggers an alignment of the weaknesses, (or holes) to result in an adverse event.

So, human fallibility at various times and levels in an organisation can lead to ill health, injury or loss. Conversely people can prevent latent conditions leading to adverse events by compensating for weaknesses in precautions.

Human fallibility at all levels of an organisation can be a potential source of failure. Identifying both latent conditions and triggering behaviour are necessary to improve risk control.

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