Chapter 6

H&S management

January 1996

The H&S Management Charter

Is your organisation committed to health and safety? Does it have an effective health and safety management system (HASMS) which can assure continuous improvement in your control of risks and the safety of your workforce and the public? Can you produce evidence of this?

If the answer to these questions is "yes" then we at RoSPA would like to hear your views about the idea of creating a Health and Safety Management 'Charter'.

The 'Charter' would be a statement of basic health and safety management principles and become the starting point for participation in a unique national health and safety scheme aimed at helping organisations to build on their strengths to achieve lasting improvements in accident and ill health prevention.

The act of registration would allow organisations to use the Health and Safety Charter Registration Mark on their business communications, thus alerting other companies, clients and customers to the fact that their organisation adopts a quality approach to all health and safety matters.

Details of an individual company's HASMS would be entered on a national data base which could then be accessed by organisations and/or individuals wanting to check out health and safety management status.

Basically the Charter scheme would work as follows:

(1) Following specified procedures (including internal and external consultation), an organisation signs up to the 'Charter' and thereby makes a public commitment to follow essential health and safety management principles. The statement is also signed off by an independent and competent third party who can verify the initial claim. This could be done by one of a number of possible routes (see point 7 below).

(2) The statement is submitted to RoSPA, together with certain prescribed details of the company's HASMS. A small registration fee (based on the size of the organisation) will be required to help fund the scheme. As well as a verifier, other parties signing the application registration should include the Chief Executive, organisation's safety adviser, quality manager, and senior workforce representative as appropriate. On registration a company would be entitled to display a signed copy of the 'Charter' and would also be asked to agree to abide by the rules of the scheme.

(3) Periodic reappraisal would then have to be carried out by the verifier to ensure that HASMS standards are being maintained and/or improved, thus enabling the organisation to remain on the register.

(4) Registration would mean that summary details of an organisation's HASMS will be open to inspection (either on-line or manually) to third parties.

(5) The organisation's registration may also be subject to scrutiny by external auditors appointed under the scheme as part of process of ongoing random verification monitoring.

(6) If the scheme's Administrative Board receives a complaint, this would be investigated. Where such complaints were substantiated, the organisation would be required to demonstrate that it has taken remedial action so it can remain on the register. (The Board itself would not initiate complaints).

(7) Examples of ways in companies wishing to register could get their claims verified include:

- successful application for a health and safety award (for example, a RoSPA Gold, Silver or Bronze award);
- on the recommendation of an appropriate auditor (for example following a RoSPA QSA (Quality Safety Audit);
- on the recommendation of certain major contractors which operate RoSPA approved pre-tender safety assessment schemes in relation to sub-contractors;
- on the recommendation of a TEC or IIP assessor;
- on the recommendation of a competent consultant; and
- on the recommendation of certain insurers.

Publicise

Organisations who register would not only be helping to publicise their approach to health and safety, but would also be helping to support a national scheme, the aim of which is to raise standards of health and safety management nationwide. (It should be remembered that reports of major accident enquiries such as those into Zeebrugge, *Piper Alpha*, King's Cross etc showed HASMS weaknesses rather than technical failures).

RoSPA believes that health and safety registration would be particularly appropriate for: contractors and sub-contractors; providers of goods and services to the public; major national companies; and small and medium size companies that want to improve their health and safety image.

If you have views on the merits of such a scheme write to or phone Roger Bibbings, Occupational Safety Adviser, Royal Society for the Prevention of Accidents, Cannon House, The Priory Queensway, Birmingham B4 6BS, tel: 0121 200 2461; fax: 0121 200 1254.

September 1996

Health and safety incentive schemes

At the outset it is worth emphasising that the issues involved cannot really be looked at in isolation from more general prescriptions for improving workplace health and safety. It also begs the question 'what do we mean by performance?' Do we just mean the absence of certain undesirable end points like injuries, damage to health and material damage? Or do we mean the presence on a continuing basis of all those things which will prevent these things from happening in the first place?

To the purist, safety is (and should be seen as) its own reward. If organisations and individuals acted consistently with enlightened self interest the world would undoubtedly be a safer place. The fact that it is not merely testifies to the difficulties which face people at all levels in behaving in a wholly rational manner. As in many areas of life, it is always worth looking to see whether and how the mechanisms of self interest can be oiled with targeted resources to allow larger potential benefits to be fully realised.

The first thing to be said is that incentives or indeed penalties to promote 'safety' cannot in any sense be considered as a substitute for organisations having effective systems to manage risk. What the disasters of the eighties taught us was that organisations with significant hazards and which did not have essential features of health and safety management in place were tragedies waiting to happen. In this sense seeking improvements in performance by rewarding or penalising individuals for success and or failure in accident prevention is likely to be founded on the misconception that safety is all about the behaviour of individuals and not organisations.

Thus, even where incentives or rewards are offered to groups as opposed to individuals for achieving accident performance and similar targets, it is likely that not all the critical factors influencing performance will be under their control. It is no use rewarding people for outcomes which are not wholly due to their efforts, even if the rewards are perceived as being extremely worthwhile.

Where then can incentives be of value? Is it indeed appropriate to think in terms of incentives at all? Does not this conjure up images of crude behaviourist psychology which will be perceived by the target group as insulting and thus prove counterproductive? Is it valid to bribe people to be law abiding?

RoSPA's instinctive preference is to recognise and reward contributions which are over and beyond the call of duty - discrete contributions which are wholly within the gift of the individual/group concerned.

There are many examples of companies and other organisations which currently offer rewards of various kinds to their staff, for example, in the form of cash or points to be spent with catalogue retailers. Or such rewards may be combined with internal competitions, for example, for titles such as 'Safety Champion of the Month'. Group recognition is a powerful motivator: league tables between departments can be highly effective as can publicising exceptional performance in in-house magazines.

To be effective, such systems of reward have to be:

- valid in safety terms;
- appropriate to the circumstances of individuals and groups;
- perceived as 'fair' by the target group;
- effective in complementing health and safety management systems;
- monitored to assess their impact; and
- reviewed periodically to see whether changes are needed.

If rewards become seen as ends in themselves, there is every possibility that they will simply lead to 'points hunting' and the opposite of what is intended by distorting behaviour. It is well known that rewards (and more so, penalties) for accident free working can lead to accidents and near misses being covered up or to peer pressure being applied to injured employees to return to work promptly.

It is essential that incentive systems should act as a support to other forms of management action and not be employed as a substitute for any part of a safety management system. They need therefore to be introduced with full consultation and agreement of the workforce.

That said, appropriately applied incentives can have other useful effects, for example: in reinforcing organisational messages about the economic benefits of safety: promoting team working; enhancing other award schemes (for example for quality); and stressing the high value which the organisation places on the employee (or work team) making additional effort to 'play their part' in the health and safety management system.

Where the organisation's health and safety system as a whole achieves a desired target, for example, targets set in an annual health and safety improvement plan or achievement of a RoSPA award, there may be a case for every member of an organisation to receive some additional reward for the part which they have played.

The fundamental question to be answered whenever incentive schemes are mooted is whether they are being relied on as a primary means of achieving compliance with standards and targets or whether they are merely useful reinforcement. Properly constructed and precisely targeted incentive schemes have their place and can add real safety value. Poorly conceived ones can actually do damage!

January 1997

Strengthening H&S management system auditing

Within organisations, what ensures effective prevention is not simply a question of seeing that specific preventive measures are taken (the provision of guarding for example) but making sure that an appropriate safety management system (SMS) is in place which is capable of 'locking on' to potential problems and dealing with them before unplanned events actually occur.

What the enquiries into the major tragedies of the eighties showed was that organisations dealing with significant hazards but lacking robust safety management systems were 'disasters waiting to happen'. The fact that these tragedies (Bradford City, Hillsborough, King's Cross, Clapham, Zeebrugge, Abbeystead, Piper Alpha) unfolded as they did was, in many respects, merely a matter of chance. In every case it was underlying SMS weaknesses which were the fundamental cause rather than specific features of the hazards which eventually led to death and injury on a large scale.

Without robust systems, hazards will not be identified, risks will not be assessed and control measures will not be introduced and maintained. In this sense a strong SMS can be likened to the body's immune system, which when functioning properly is capable of tackling threats to health from a wide variety of sources.

RoSPA's belief in the power of proactive health and safety management is reflected in the resources which it is continuing to devote to developing and promoting its health and safety systems editing package, 'Quality Safety Audit' (QSA). This is based very closely on HSE's guidance *Successful health and safety management*, [HS(G)65] which in turn has been complemented by similar BSI guidance, *Occupational health and safety management systems* [BS 8800]. QSA examines evidence in detail from documentation, interviews and auditor's observations to reach conclusions about key elements of an SMS.

Audit results can be used to carry out an initial status review, to benchmark performance both within and between organisations and to measure changes in performance over time.

Although strong guidance is given by HSE to companies to make use of SMS auditing (using either internally developed or proprietary systems) - and despite the requirement in Regulation 4 of the *Management of Health and Safety at Work Regulations* for employers to monitor and review the effectiveness of preventive and protective measures - there is still no general requirement for companies to carry out periodic SMS audits. (This is not the case however in acknowledged high hazard sectors like railways, offshore, major hazards sites and the nuclear industries where auditing is now a key tool within new regulatory regimes.

Despite strong encouragement by HSE inspectors for organisations to introduce auditing systems, many senior managers still do not understand the concept and continue to confuse the terms 'monitor', 'review' and 'audit', each of which has a quite separate and distinct meaning within HS(G)65 and BS 8800.

These and other problems have convinced RoSPA that further steps need to be taken to strengthen the role of SMS auditing in the UK occupational health and safety 'system'. Some options include:

- producing simple and widely available HSE guidance, explaining the benefits of auditing and helping businesses to assess what sort of package is likely to be most appropriate to their needs;
- reinforcing the requirements of Regulation 4 of the MHSW Regs to give HSC/E the power to require 'adequate and suitable' SMS auditing, for example in major organisations, in high risk sectors, or possibly following convictions for offences which clearly demonstrate SMS weaknesses;
- developing a national standard for auditing (or at least authoritative guidance) to ensure that all auditing packages currently available are capable of meeting companies' needs;
- giving strong encouragement to a range of potentially influential 'intermediaries', including bodies such as trade associations, major clients and customers to promote SMS auditing;
- pressing the insurance industry to examine the case for introducing transparent procedures for adjusting premia on the basis of audit results;
- expanding the strategy of HSE and local authority enforcers of developing 'central approaches' to large and nationally based organisations, using audit results as the basis for reviewing performance and agreeing standards and targets with major concerns. (This approach may also release scarce HSE inspector resources to concentrate on smaller businesses with significant risks and weak health and safety arrangements);
- pressing trade unions to encourage their safety reps to get involved in joint approaches to auditing, using the results (for example via safety committees) to pinpoint areas where improvements in SMSs are required in order to protect their members;
- encouraging companies to publish summary data from SMS results in their annual reports to provide evidence that their capacity to manage health and safety is continuing to improve; and finally
- developing new approaches to health and safety management audit or review to assist small and medium size companies to understand how to develop an effective SMS approach as part of their overall management development strategy. (In this sense, persuading a small firm to adopt a systematic approach to managing health and safety may prove to be a highly practical way of introducing it to a 'management systems' approach to other key ingredients of business success such as Quality or Environment).

The Society would like to encourage all those who are committed to the improvement of health and safety performance to use their influence to raise awareness of the central importance of auditing as a strategic tool. Without a more comprehensive approach on the above lines, it is doubtful whether the true potential of the HSC/E's current 'management' approach to health and safety can ever be fully realised.

April 1997

Ten commandments for senior managers

I THOU SHALT ENSURE THAT THY ORGANISATION HAS AN EFFECTIVE *HEALTH AND SAFETY POLICY* (FOR THOU SHALT NOT ENDANGER LIFE)

II THOU SHALT NOT PLACE THE PRINCIPLES OF ANY OTHER TEXT BEFORE THE TEXT OF HS(G)65 (*SUCCESSFUL HEALTH AND SAFETY MANAGEMENT*) FOR THIS WILL HELP THEE BUILD AN APPROPRIATE *HEALTH AND SAFETY MANAGEMENT SYSTEM*

III THOU SHALT NOT STEAL THY NEIGHBOUR'S RISK ASSESSMENT BUT DOETH THINE OWN ADHERING TO THE GOSPEL OF IND(G)163L (*FIVE STEPS TO RISK ASSESSMENT*)

IV THOU SHALT NOT ALLOW THY RISK ASSESSMENT TO GATHER DUST IN THE BOTTOM OF THY DESK DRAWER BUT SHOULDST USE IT CONSTANTLY TO CHECK THAT APPROPRIATE *RISK CONTROL MEASURES* ARE IN PLACE (TAKING LEGAL REQUIREMENTS AS A MINIMUM STANDARD)

V THOU SHALT NOT ALLOW THYSELF TO GAIN THE GRAVEN IMAGE OF A WHITED SEPULCHRE BUT SHOULDST ENSURE THAT *HAZARDS ARE ELIMINATED, REDUCED, ISOLATED OR CONTROLLED* THEREBY NOT SHUFFLING OFF ALL THINE OWN RESPONSIBILITY ONTO THINE EMPLOYEES. (FOR WHAT PROFIT IT THEM IF THEY WEARETH THEIR PPE OR CHANGETH THEIR BEHAVIOUR IF THOU HAST NOT CREATED THE SAFEST POSSIBLE ENVIRONMENT?)

VI HONOUR THY MANAGING DIRECTOR AND THY FINANCIAL DIRECT BUT REMEMBER THAT, SINCE THEY READETH ONLY THE BOTTOM LINE OF MOST DOCUMENTS, THEY MAY NOT FULLY UNDERSTAND THE REVELATIONS IN HS(G)65 AND IND(G)163L AND THEREFORE MAY NOT KNOWST THAT *HEALTH AS WELL AS SAFETY RISKS NEED ASSESSING*

VII THOU SHALT NOT COVET NEITHER THY NEIGHBOUR'S COMPANY CAR NOR HIS EXPENSE ACCOUNT NOR HIS COMPETENT PERSON BUT THOU SHOULDST ENSURE THAT THOU HAST ACCESS TO THINE OWN *SOURCES OF COMPETENT ADVICE* TO HELP THY COMPANY MEET ITS LEGAL OBLIGATIONS

VIII THOU SHALT NOT REST ON THY LAURELS BUT SHALT TAKETH LESSONS LEARNT FROM ACTIVE AND REACTIVE MONITORING INTO THY HEART AND SHALT COMMIT THY COMPANY TO *CONTINUOUS IMPROVEMENT*

IX THOU MUST NOT BOW DOWN BEFORE THE SPIRIT OF PESSIMISM BUT SHOULD STRIVETH TO CREATE A *POSITIVE HEALTH AND SAFETY CULTURE* (ENSURING CONTROL OF ALL THY RISK CREATING ACTIVITIES; CO-OPERATING, ONE WITH ANOTHER, ON ALL HEALTH AND SAFETY MATTERS; COMMUNICATING EFFECTIVELY; AND ENSURING HEALTH AND SAFETY COMPETENCE OF ALL STAFF)

X THOU MUST NOT BEAR FALSE WITNESS AND THUS SHOULDST DEMONSTRATE THY *PERSONAL COMMITMENT TO HEALTH AND SAFETY* IN ALL THOU SAITH AND DOETH

X+1 THOU SHALT NOT COMMIT ADULTERY FOR WHATEVER IS SAITH IN THE RISK ASSESSMENT
THERE WILL ALWAYS BE SOMETHING THAT THOU HAST OVERLOOKT

December 1997

Management systems, integrate or bust?

The health and safety professional's prime purpose must be to exercise effective influence over occupational accident and ill health prevention. The constant challenge is to find new ways to influence prevention and to make that influence as powerful as possible.

At one time safety professionals focused almost exclusively on the physical, chemical and possibly the biological origins of accidents. However, while technical and scientific approaches remain fundamentally important, there is now a well developed understanding that accidental harms tend to have their roots in failure to manage prevention. Thus it is accepted that if an organisation's 'health safety management system' or 'process' is right, there is a good chance that the right preventive 'solutions' will follow.

Since the late eighties we have seen the development in Britain of this sort of modern, proactive, risk based, 'management system' approach to health and safety at the workplace. The 'business' as well as the 'moral' case for action on health and safety is now well established, and HS(G)65 and BS 8800 have usefully codified many of these understandings.

Yet despite such progress, there are still many signs that this new approach has not been fully grasped - even by many senior managers who may be quite familiar with a 'management systems' approach in other areas such as 'Quality'. Too many managers, whose perceptions of the subject are still rooted in the 1960s - or even before, continue to perceive health and safety as a bureaucratic constraint and not as a strategic business objective.

Confronting this antiquated view of health and safety is still the challenge facing many safety professionals today. And that is why we need to be able to demonstrate at every opportunity that our discipline is not something to be 'bolted on' to already overstretched budgets and understaffed programmes but that it is a vital ingredient to business success. We have to be able to show that our objectives can only be achieved by working with and through other existing business agendas.

Modern health and safety professionals are influencers or they are nothing. The days of the old fashioned safety officer who was merely a ticker of checklists, or the occasional issuer of safety equipment or of stern warnings about unsafe behaviour are over. The modern health and safety professional is a multi-disciplinary facilitator - not a 'manager' as job titles so often misleadingly suggest. He or she has to be essentially 'a mover and a shaker', working at all levels across their organisation to help others tackle workplace risks as part of their day-to-day work.

The advantages of this type of integration include cost effectiveness; avoidance of duplication of effort and of potential conflicts; and the creation of positive synergies.

However the case for integration rests critically on two further premises. First, that our agenda as health and safety professionals will not be fully credible unless it is

made relevant to other central agendas in organisations (such as quality, environment, fire, security, product safety and even financial management); and second, that we need to integrate if we are to change our colleagues' understanding of what the modern health and safety challenge is really all about.

We need to get all managers to understand that the central challenge is one of being able to work systematically with others to enable the whole organisation to act optimally in the face of multiple uncertainties - whether it is a question of prioritising cost effective action to control the risk of minor accidents or a major disaster or whether it is about business strategies which take account of likely market change. To survive, if not to make progress, we must work closely with all those other disciplines who share the same basic insights about risks and their management, even though the content of the risks we address respectively may be very, very different.

However, the challenge of integration is a daunting one and it is necessary to acknowledge and tackle any negative effects. For instance, it could easily lead to a proliferation of bureaucracy as well as the adoption of the idea in organisations that they no longer need the in-depth and competent advice of health and safety professionals but can rely in future on the services of the all-singing, all-dancing risk managers who, not knowing what they do not know, will inevitably underestimate the challenges of health and safety with disastrous results!

Other major pitfalls are that the systems now being promoted may appear to be the same but in reality have very different content; some systems are subject to certification, others not; a proliferation of forms and procedures; and the danger that one discipline may seek to dominate others.

Integration does not mean assimilation of one discipline by another. It does not mean aggregation of functions or amalgamation of departments. It certainly does not mean simply re-badging an existing Quality system. After all, we all know that it is quite possible to make products to customers' specifications under a certificated quality scheme, but on unguarded machines, and creating unacceptable pollution and fire risks.

What integration means in essence is that the organisation has to: undertake a critical and participative review of its existing systems; have a clear understanding of its needs; have a timetable for achieving them; have the backing of senior directors; and have a means of measuring and reviewing the effectiveness of the integration process.

Like it or not, though, the tide of integration is now running. While there will be King Canutes among us who will command it to retreat, most will recognise that the task before the profession is one of ensuring that the interests of occupational health and safety are actually advanced by the process and are not submerged.

We must all surely accept that organisations have changed and are continuing to change. Flat structures, team-working, multi-tasking and matrix management are not suddenly going to disappear.

The fundamental question, which has to be answered, is not whether, in principle, integration is desirable for the advancement of health and safety: it is. The real

question is whether your particular organisation has reached the necessary level of development and maturity to enable it to embark on the integration path.

January 1999

The future of accredited OS&H certification

Since it started in 1993, I have been a member of BSI's Technical Committee HS/-, which was responsible for producing BS 8800. This guidance (it is not a certificatable standard) was argued over long and hard but, having now been out for two years, it is clear that it has been useful in promoting and reinforcing understanding about the need for a Systematic, proactive approach to OH&S management.

At the latest meeting of the Committee (kindly hosted by Adtranz in Derby) there were two main items on the agenda. The first was international developments - including the proposed amalgamation by the International Standards Organisation of their standards ISO 19000 (Quality) and 14000 (Environment). The second and main item was the vexed question of accredited certification of OH&S management systems.

Nearly all the major industry associations, backed by CBl and FSB, are opposed to accredited certification - despite the fact that there are now numerous providers out in the market place offering non-accredited certification.

The view put at the meeting by the CBI, which was generally shared by all the other industry representatives present (but not those from the 'quality' sector), was that the principle of 'caveat emptor' should apply to these. This was essentially the HSE view too.

The UKAS representative spoke eloquently of the dangers of a proliferation of certification products of inappropriate quality - particularly given the pressure now coming from large clients for contractors and suppliers to produce evidence of health and safety management system integrity and performance. He stated however that the DTI, to whom UKAS is answerable, would not sanction work on an accredited standard unless HS/- agreed - even though BSI's commercial wing is also now in the market place.

His view was that if HS/- failed to agree the need for a single national form of accredited certification at the meeting, many providers who had been waiting to put their own certification products on the market would take such failure as a green light to go ahead.

RoSPA's case was that generally we favour the development of methods to demonstrate implementation of a 'management systems' approach to OH&S - because this helps to focus effort and raise standards, particularly in smaller companies with significant risks but which have yet to get beyond a purely reactive approach.

At the same time RoSPA remains very concerned about any blanket insistence on certification - particularly insistence by clients on its use with smaller businesses (especially 'micro-businesses') for whom it could be inappropriate, bureaucratic and burdensome.

What we need here is better guidance from HSE and BSI on a range of ways in which firms can furnish evidence externally of their general level of OH&S capability and due diligence - pre-qualification health and safety submissions; audit results; awards; benchmarking results; annual company OH&S reports etc.

With positions so polarised at Derby there was a real danger that the whole discussion would simply 'run into the sand'. Thankfully it was accepted eventually that BSI should commission a good quality consultation to seek views on all these issues in the round so that these could be fed back into the review of 8800. Under BSI rules, this has to take place at the latest by 2002.

Together with the evidence from David Smith (tireless chairman of the Committee since it was established in 1993) and others this suggests that, despite the CBI/industry position, there are a large number of companies which, for whatever reason, want certification. Many feel that the fact that such certification is not currently available - as it is for Quality and Environment - means that OH&S tends to be seen by many as the tower status triplet in this family of related topics.

Like other OH&S providers RoSPA is now having to decide whether we wish to offer certification of health and safety management systems integrity to a standard which is a derivative of HS(G)65 or 8800. We are, of course, continuing to develop our own audit package, QSA (Quality Safety Audit), which generates achievement levels relevant in this context. On the whole however QSA is a 'Rolls Royce' route used by fairly large companies who are market leaders in OH&S terms and whose main need is to demonstrate levels of OH&S management achievement to themselves and to identify areas for further development.

RoSPA does have another product, Health and Safety Review, for smaller companies but this produces a qualitative output in the form of a report with prioritised recommendations for action and is not structured in a way that would allow for appropriate QA.

There is also the RoSPA OH&S awards process but, as currently structured, this could not serve as a basis for offering certification. It could however be developed further as a way of delivering credible 'badging' of OH&S management status. However, this would increase costs very significantly and thus present a barrier to access to a scheme which is presently very easy to enter (although relatively hard to excel in).

If RoSPA were to develop an OH&S certification service it would be in competition with many others and one has to ask just how much variety of specification and approach the market could bear? There may be a need for some sort of voluntary accreditation of certificators in the absence of UKAS involvement but these businesses would need to be able to agree a credible 'house' to offer this kind of verification/attestation of quality and they are, it has to be recognised, all in competition with one another!

There may also be a need for some sort of 'exchange rate mechanism' to register and create a degree of equivalence between the various sources of evidence of integrity/performance outlined above - a massive task.

To get beyond the ‘dialogue of the deaf’ in HS/- there might be a case for a special conference or high focus level seminar (in partnership with a commercial conference organiser perhaps) to allow for exchange of information/views between some of the main players, the results of which could written up and disseminated.

Of course, taking its lead from representatives of business, the OH&S sector could decide to do nothing and wait - but my personal view is that, if left to the market, only chaos and confusion will result and the inevitable deficiencies and excesses of those at the fringes of OH&S will serve simply to foster harmful misrepresentations of our subject.

March 1999

Target zero – zero value?

Many companies in the UK, particularly those which are subsidiaries of US companies, have adopted 'Target Zero' as a prime focus against which to measure health and safety performance as well as a motivator for their staff.

For such organisations, the length of time elapsed since their last 'lost time' or 'medically treated' work related injury is given special significance as a principal indicator of success in health and safety management. But how useful or realistic is such an approach?

Often the achievement of a continuously improving accident performance measured on this basis is linked via personal and/or group appraisal to pay and to individual prospects for promotion. One of the more obvious consequences of this approach is to create peer pressure to discourage those suffering from minor injuries from leaving the workplace and thus crossing the 'lost time' threshold; Worse still, it is alleged that, on occasions, it has led to injuries being concealed or falsely attributed to non-occupational causes.

The trouble with thinking that pay incentives can be used to reduce accidents at work, is making the over-simple assumption that lapses in individual behaviour are the main cause of most accidents. In fact, HSE studies show that around 70 per cent of accidents at work could have been prevented had managers put 'reasonably practicable'; precautions in place - and only a minority are wholly attributable to employees failing to follow safe systems of work.

A further problem is that the focus on relatively severe physical injury events tends to shift the attention of organisations away from other kinds of events which have the potential to cause major injury, including 'near misses' and unsafe acts and conditions.

A more severe criticism of this singular (if not at times almost obsessive) focus on ‘lost time injury’ as a sole measure of success or failure is that it ignores measures of proactive safety input.

In defence of the ‘LTI’ system, it is often argued that it is a simple measure that all workers can understand and that there are predictable ratios between 'lost time' injury incidence rates and rates for lower severity events. This is highly questionable since there is rarely a common pattern of causation across all types of accident. In fact, any reasonably intelligent employee can see that the seriousness of an injury caused by an accident (the depth of a cut determining whether stitches are required, for example) is a fairly arbitrary criterion by which to measure safety failure. The real causes of failure are invariably more deeply rooted in ineffective management of operations.

Yet another criticism is that concentrating on accidents as a single performance measure, ignores completely the incidence of work related ill health or indeed unsafe conditions. 'Zero Accidents' therefore fails to communicate an understanding that for most businesses, health problems are currently a much bigger problem than accidents (in terms of morbidity it not mortality). Analyses based on the HSE's *Self Reported Work-Related Injury Survey* suggest that there are some 1.06 million workplace

injuries annually (all non-fatal severities) compared with 2.1 million cases of ill health caused or made worse by work.

Put simply, in a construction operation for example, it is not logical to regard a cut finger requiring stitches as a serious event by which health and safety performance on the site can be measured but to totally ignore cases of vibration white finger. Properly treated the cut finger will heal and there may be little or no loss of function, whereas the VWF is likely to be irreversible and will mean a considerable and continuing reduction in quality of life for the sufferer.

It is no good the advocates of 'Target Zero' arguing that there is a relationship between lost time accident performance and the incidence of health effects because neither modelling nor data are available to support this.

And then there are the problems of interpreting the significance of changes in small numbers of injury accidents over time in both small and large populations. In small organisations the problems are fairly obvious when measuring the incidence of low frequency events. And even when you have large populations, over short periods when incidence rates appear to be low, simple GCSE 'O' level statistics will tell us that there will be a degree of random variation around a mean value - which means that some elements of apparent variations in incidence rates are likely to be attributable to the effects of chance rather than preventative effort.

Furthermore, in very large organisations, some level of severe harm may in fact be inevitable, particularly if one assumes that preventative interventions are always based on incomplete data and understanding and are always likely to involve some non-compliance.

The biggest problem however with using 'lost time accidents' as a single reactive measure of performance is that, once a lost time/medically treated injury has occurred, the 'rest' button is pushed: spirits slump and all progress achieved in reaching higher levels of proactive safety input is ignored.

When fatalities occur it is, of course, difficult to communicate an otherwise excellent health and safety management story. But arguably the results of periodic and well structured health and safety management systems auditing provide a much more valid measure of success or failure over time. An informed observer will want to assess whether fatal accidents are part of a more generalised pattern of health and safety failure or whether they are 'one off' events.

The Government's 'Our Healthier Nation' initiative in public health and the related HSE 'Ten Year Strategy for Occupational Health' have both introduced the idea of setting national health improvement targets (including targets for accidents). The challenge this poses to every business is what sort of targets should they set themselves to help drive their on-going efforts to achieve higher levels of health and safety performance? Should we be expecting, for example, to see notices displayed at the entrance to work sites, not just proclaiming the target of 'zero accidents' but announcing occupational hygiene targets for lower exposures to hazardous agents or even target scores for the next health and safety management systems audit?

In the contemporary health and safety management context, setting a 'zero' (lost time/medically treated) accident target adds little real value. Today's increasingly sophisticated workforce need more relevant measures with which to assess progress in accident and ill-health prevention at work as do other parties such as regulators, insurers, the media and the wider public. Let's forget 'Target Zero' and move on.

December 2000

Target setting..., target meeting

The Government's and the Health and Safety Commission's plans for 'revitalising' health and safety set overarching national targets for improvement. Despite what cynics may say about 'Government by Target', targets are a necessary part of any plan. A sense of where we can, should or must go is vital to any venture. Without targets it is very difficult to envision the idea of going forward - even if later it turns out that the target or objective was not quite what it seemed to be at the beginning. (In practice this does not always matter. For example, from an historical viewpoint, is it important that Columbus set himself the task of reaching China when in fact he discovered the New World?)

In everyday use the term 'target' tends to be used quite loosely alongside the related (although arguably distinct) concepts of 'mission', 'vision', 'aspiration', 'aim', 'goal' and 'objective'. Targets can be aspirational ('zero accidents', reaching China etc) or, in contemporary management parlance, Specific, Measurable, Achievable, Realistic, Time based (SMART). In large organisations or indeed in whole societies, there can be headline targets ('guesstimates' or targets set by 'holding a wet finger in the air'), or umbrella targets developed by aggregating targets set at each subsidiary level.

A number of headline targets have been set in the 'Revitalising' and 'Securing Health Together' strategies: (a 10 per cent reduction in the incidence of fatal and major injuries and a 20 per cent reduction in work related ill health by 2010, and so on). However, the way they have been arrived at is not clear. Some say they are too modest. Some say they will not be measurable. Others say it is not clear whether they are based on an extrapolation of historical trends or on an estimation of the impact of HSC/E's and others' strategic interventions; or whether they are based on aggregation of estimates of achievable improvement upwards from individual businesses to sectors and to the economy as a whole.

For example, simply basing a fatal accident reduction rate target on some fraction of what has been achieved in the past, without assessing historically the relative contribution to such trends of changes in hazard exposure (decline of employment in traditional industries) versus the efficacy of enhanced preventive intervention (new health and safety law), or changes in the wider world of work or Society generally, is not much use. Target setting, if it is to be useful, has to be based on a lot of hard work.

Nevertheless, the headline targets set in 'Revitalising' do challenge every organisation in the British economy to consider what contribution they can make to achieving them (shades perhaps of 'What did you do for the Great Revitalising Effort Daddy?')!

Setting targets raises such questions as 'what measures should we use to define progress'? More importantly it raises the question of by what process can consensus around targets be reached?

At present the 'Revitalising' targets are essentially reductions in what might be termed the national OS&H (occupational safety and health) failure record, particularly the incidence of accidental injuries and work related ill health. But these terms are not directly transferable to most businesses, even to the 25,000 or so major business in the

UK employing more than 50 people - for whom RIDDOR (*Reportable Injuries and Dangerous Occurrences Regulations*) events can be relatively rare. And in Britain's 1.3 million small and micro businesses, even though for them as a sector injury rates may be higher than in larger businesses, in each one the average interval between injuries will be very long indeed.

As work on the targets approach proceeds, there will be a need to indicate a wider range of target points, not just outcome measures such as rates of accidents, 'near misses' and ill-health but more importantly, health and safety process or management targets. Important (and often quite simple) steps in improving the health and safety management process - such as reviewing policy, upgrading organisation and training (particularly enhancing director, manager and workforce involvement), reviewing risk assessments, upgrading controls (eg standards of protection), improving monitoring, review and communications feedback - all need to be translatable into meaningful targets top.

Leading and lagging indicators

In turn this means that we need to encourage a debate to secure a wider and more rounded understanding than hitherto of what is meant by 'health and safety performance', focusing as suggested here on 'process' as well as on 'outcomes' - although 'the proof of the health and safety management pudding has always to be in the eating (i.e. less risk, harm and loss). Performance also needs to encompass 'leading' as well as 'lagging' indicators. In fact, this is one of the emerging conclusions of the current RoSPA DASH (Director Action on Safety and Health) project consultation on 'Measuring and Reporting on Corporate H&S Performance'. A report on this is due early in the New Year - and the whole subject of targets will be taken up as a key issue by RoSPA's National Occupational Safety and Health Committee.

In 'Revitalising', the top 350 companies in the FTSE are challenged to report on their health and safety performance to a common standard by 2001. Every company employing more than 350 is similarly challenged to report by 2004. What the ROSPA DASH consultation is showing is that there are many approaches that could be adopted and that companies need to find the way of doing this that is most meaningful for them.

Yet essentially any report in a business context (even the humblest departmental memo) needs to include, 'where we said we wanted to be', 'where we are now', 'where we plan to be next' and 'how we plan to get there', perhaps with reference to a range of key performance indicators. So far as larger organisations are concerned, many consultees are saying that this should at the very least include information on their health and safety failure record - such as accidents, ill health, sickness absence rates, major dangerous occurrences, enforcement action and associated costs, with some specific detail perhaps on fatal injuries and serious incidents.

Beyond this of course, organisations will want to explain their progress in strengthening their health and safety policy, organisation and arrangements (but how that can best be achieved in a meaningful way and within the constraints of an annual report format, is another rather more complex story which the ROSPA consultation is attempting to unravel).

HSC/E do acknowledge that the existing national level targets in 'Revitalising' have baseline problems. The true fatal accident rate within RIDDOR is fairly well known (though of course it excludes data on fatals in occupational road accidents). (In the light of the discussion exercise to be promoted by the newly formed Work Related Road Safety Task Group, these will subsequently have to be included in the national target for fatal accident reduction). There is also a need to find the true baseline for major injuries under RIDDOR.

On the other hand, with occupational health targets, it is accepted that it is going to be much harder to define the true baseline. The HSE's 'Self Reported Work Related Injury' survey indicates that work related ill-health is a much bigger problem than accidents but the true extent of early death from such causes as well as the true prevalence of serious ill health conditions (even conditions such as asbestos linked cancers, for example) is much harder to identify. As the HSC/E's ten year 'Securing Health Together' strategy bites, there should be an increase in ill health reporting, so there will be a need to reassess original baseline data on health otherwise, to the statistically challenged (including many in the political sphere it has to said), it will look as if HSC/E have failed dismally when in fact the rising figures will testify to considerable success. (Explaining when the figures are getting worse that in fact things are getting better, is a problem for all health and safety folk at every level!)

At present some joint employer/union work has been done in specific sectors (eg Paper and Board and Quarrying) in setting sector level, time based targets, mostly in terms of fatal and major injury reduction. The reasoning underpinning these targets and how they were arrived at, needs to be more widely shared so that all those involved in target setting, whether at a departmental level within a business, or across a whole company or sector can compare their approach with that adopted by others.

If figures are plucked from thin air, they will lack transparency and meaning and they will not be credible and they will not secure workforce and management 'buy-in'. As with good budgeting, they need to be based on a rigorous 'ground up' approach in which, at each stage, the key stakeholders are subject to challenge on their estimates of what can and should be achieved by when.

The workforce (especially via their safety representatives), as keepers of the knowledge about how things work and what is possible, not only have to be consulted but, where they have the appropriate structures and opportunities in place (eg safety committees), they ought to be using these to initiate the debate and be comparing notes with colleagues across their sectors and with others outside.

The achievement of targets invariably requires new inputs, new ways of doing things and fresh resources. So, in partnership with health and safety professionals and managers, they need to be championing the case for fresh investment in OS&H. Targets which merely assert unrealistic goals and without indicating the means by which they can be achieved serve no useful purpose. If this is the case, then it is workforce representatives who need to blow the whistle.

Reviewing progress

Equally, targets which are never subject to review in the light of on-going performance monitoring serve no useful purpose either. Understanding, in the light of experience, why a target was not reached or why it was in fact exceeded is actually what is of fundamental importance. And such review exercises should also include the possibility of changing the goal posts too. If it turns out that the wrong targets have been selected, then they need to be changed or modified. One danger seen in many areas of public and business life is that targets are set for superficial things which are easy to measure (remember Robert McNamara, 'We tend to ascribe false significance to that which we can measure because what is truly significant still defies meaningful measurement?)' People then seek to deliver against them rather than real underlying process requirements. Worse still they may seek to cover things up or redefine events so that they do not come within performance indicator definitions (how many times have 'target zero' driven managers found themselves asking, 'did the accident really qualify as 'lost time?').

So targets are only a means to and end and must never be allowed to become an end in themselves. After all, there is plenty of experience to demonstrate that badly thought-out targets can actually cause harm (for example, targets to improve school performance standards actually led to a huge increase in the number of excluded children).

Nevertheless, despite all these problems the 'targets' philosophy in 'Revitalising' is one which all organisations are challenged to embrace. Indeed, even those organisations with what are considered to be well developed approaches to OS&H performance target setting, should be reviewing their approach - not only to see if there is room for further improvement but to share their knowledge with others. One thing is certain - we will not secure the step change in performance which is envisaged in 'Revitalising' if each of us in the OS&H movement simply go on doing what we have been doing up to now ('if you going on doing what you've always done, you'll always get what you've always got!). We have to change if we are to become more effective.

Never forget, unless we get these things right, there are people at work at present (and, worse still, young people coming into the workforce) who will be needlessly injured in preventable accidents or who will have their health damaged because it has been assumed that what we have been doing up to now is good enough. It isn't and the figures prove it!

June 2001

Corporate risk management

As from this year, listed companies on the Stock Exchange must start reporting on their systems for 'internal control', following recommendations set out in the *Turnbull Report* published in 1999 by the Institute of Chartered Accountants of England and Wales. Turnbull, which builds on previous reports on corporate governance - including Cadbury, Greenbury and Hampel (Combined Code 1998) - advances the notion of 'holistic business risk management' and is being commended by Government as a set of sound principles for corporate governance of risk.

The range of risks to be addressed is of course very wide - most obviously risks associated with financial decisions but including anything which can adversely impact business continuity and reduce shareholder value.

In this context it should be noted that the HSC too are seeking to catch the Turnbull tide by challenging the top 350 companies and all public bodies to meet minimum standards for reporting on their OS&H performance in annual reports. (They are also drawing attention to RoSPA's *Towards Best Practice* report which advocates a more in-depth approach to performance measurement and reporting.)

Although OS&H is only one of about a dozen significant business risk headings, it is interesting to note how many senior OS&H advisers are being asked to lead Turnbull in their organisations. Stuart Emslie, for example, a long term member of IOSH, gave a fascinating presentation at the IOSH conference earlier this year on the 'Controls Assurance' programme in the NHS. This covers a vast range of risk issues including hospital acquired infection, clinical negligence, food poisoning, security and accidents to patients.

Yet, with tragedies such as BSE, train crashes, foot and mouth, why, one might ask, has Government itself been slow in developing an holistic approach to policy governance of major risks facing UK plc as a whole?

There are many reasons why Government has yet to adopt the same systematic 'quality loop' approach to risk as the major corporates. The UK is a much bigger and more diverse entity than any company. It is a market economy in which the levers of control available to the State are often much less direct than the levers available to senior management in even the largest enterprises. Long term rhetoric about safety often sits uneasily alongside short term political realities.

One is also bound to ask questions about the general level of 'risk literacy' among senior politicians and policy makers. Too many people in public life still talk about accidents as being unforeseeable, exceptional events. Liberal use of terms such as 'freak accident' in the immediate aftermath of disasters continues to contrast with the findings of subsequent investigations and public enquiries which invariably show not only how they could have been foreseen but how easily they might have been averted.

Accidents are not unnatural events but highly natural. The world is pregnant with possibilities for error and harm. Every system has within it the potential for chaos and disorder. The fact that there are not even more accidents is testimony to our relative

success in anticipating error, putting controls in place or mitigating consequences when things do go wrong.

The enquiry which must eventually follow into the present foot and mouth tragedy will no doubt show risk management failure on a massive scale. There will clearly be questions to be answered about the adequacy of (and response to) risk assessment, including not only routes and probabilities of exposure of the national herd to the virus but the consequences of its dissemination via livestock traffic and other means of transmission. Already, reports are coming to light which suggest that important questions about the adequacy of the regime for protecting our farming industry had been raised but not acted on.

Although OS&H is seen as only one relatively minor heading on the overall corporate risk menu, it has potentially much to contribute. It covers just about every form of economic activity, it has a long history and, because it focuses on an area of human activity where things are managed more systematically and with its greater resources, expertise and political commitment, it has been something of a laboratory for development of general principles of risk management. HSE, has, done much useful work aimed at stimulating a more rigorous, risk based approach to policy making at national level.

Last year they sought to reinvigorate public debate on the 'tolerability of risk' with their document, *Reducing Risks, Protecting People*. Two years ago they published a report from the Interdepartmental Group on Risk Assessment (ILGRA) which attempted to compare various approaches adopted to risk assessment by different Government departments. More recently they have published a discussion document on their approach to regulating 'higher hazards' such as nuclear and major hazard plants, railway safety etc.

The latter debate is important, because it offers a further opportunity to review arrangements for the risk policy governance at the highest levels of Government. General lessons distilled from HSE's accumulated experience in regulating risks have much to contribute to ensure stronger risk management regimes in other, quite different domains. In short, HSE have a key role to play in promoting general education on safety and risk concepts from classroom to cabinet.

HSE could also play an influential role in co-ordinating an Interdepartmental Review of approaches to learning from accidents through a comparative review of approaches to investigation.

One major question raised in 'Controls Assurance' is that of 'competence'. At corporate level more testing questions will be asked in future of directors' understanding of risk. How much more important therefore that Ministers and senior public servants should be called to account to show that they have a practical grasp of key safety and risk concepts.

Nearly five years ago, in its report *Health and safety at work: options for future progress*, RoSPA highlighted the importance of good risk information in enabling the health and safety system to foresee and respond quickly to new issues. It put forward the case for establishing a national (if not international) consortium of risk assessment

centres capable of rapid exchange of information and of effective collaboration on joint projects. Such a consortium would be able to promote the development of new risk assessment techniques and would be charged with identifying significant risks before major accidents and health tragedies actually happened.

In the light of many of the more recent disasters in the UK, such a network of specialists charged with 'thinking the unthinkable' is more urgently needed than ever before.

May 2003

Behavioural Safety Programmes: Myth or Magic?

It is now over twenty years since HSE's then Accident Prevention Advisory Unit (now the 'Operations Unit') headed by Richard Warburton (later Director General of RoSPA) first published the results of ground breaking research (*Monitoring Health and Safety Performance*) which showed that some 75 per cent of accidents were due to failure by employers to put 'reasonably practicable' measures in place.

This knocked the 'careless worker model' of safety on the head but since then it has begun to regain ground, partly due to changing social and political ideologies and partly because of a renewed interest in human factors and human reliability as expressed, for example, in HSE's guidance *Reducing error and influencing behaviour* (HSG48). Behavioural Safety Programmes (BSPs), long popular in the U.S.A, are once again flavour of the month - but how much of what is on offer is truly valid? How much are they like old (and not very good) wine being served up again in new bottles?

It is often suggested that successful organisations' H&S performance can be expressed as a downward curve derived from accident frequency plotted against time. According to this model, improvements in the early stages flow from changes in technology (such as machinery guarding), later on from improved systems of work organisation and management and later still from improvements in culture and in behaviour.

In the early stages individuals in the business are directed to comply with safety prescriptions by external forces such as enforcement; in the middle stages by internal organisational requirements derived from risk assessment and in the 'mature' and final stage, by individual competence and commitment. The argument runs that, for organisations which have optimised on the integrity of plant and H&S management systems, the only way forward is to persuade workers to do 'the right thing' consistently.

One immediate flaw in this rather crude evolutionary view is that organisations, particularly those which fancy themselves to be at the cutting edge of safety performance, fondly imagine that none of their recent accidents can be rooted in technological or systems weaknesses. They must overwhelmingly (according to the model which says they have reached a higher stage of H&S development) be due to deficits in individual behaviour of some sort or another. Thus phrases like 95% accidents are due to human error are trotted out endlessly.

Quite apart from the fact that this is a meaningless truism, it tends to be most often repeated by those who fail to understand accidents as inherently complex, multi-branched events and whose attraction to this explanation is not unconnected with the very poor level of accident investigation practice in the UK (as confirmed recently by HSE contract research *Accident Investigation - the Drivers, Methods and Outcomes* CRR 344/2001 - accessible on www.hse.gov.uk.

Where organisations do undertake systematic approaches to investigation, particularly where they use structured methods or other tools to help integrate evidence, results

invariably show employee error as the last link in a whole chain of circumstances, including management weaknesses and other latent errors, which represent many potential accidents 'waiting to happen', not just the ones under investigation.

HSE have been at pains to point out in HSG48 that accident investigation (and conversely, risk control systems) must address safety critical features of: the worker; the organisation; and the job. Focusing on any one in isolation is unhelpful and inappropriate. Certainly telling workers to take more care when working conditions and work organisation are still unsatisfactory is clearly absurd. It was probably frustration at conditions in Britain's then still 'dark, satanic mills' that caused that great pioneer of occupational health Sir Thomas Legge, to lecture people with his famous dictum, '... *until the employer has done everything, the workman can do nothing*'. This still has relevance today.

Admittedly the more sophisticated BSPs on offer do attempt to pay lip service to the need for organisations to have effective H&S management systems in place with all that that implies. Nevertheless, notwithstanding consensus about the importance of underpinning such systems with strong 'H&S culture', BSP providers seem endlessly to repeat the behaviourist mantra that you cannot change attitudes only 'behaviours'. Thus businesses wishing to reduce accident rates must first organise themselves to define and spot those behaviours which are desirable and safe and then use persuasion to eliminate undesirable ones.

(This approach, it is claimed can be applied from the boardroom down. However, the main focus of much behavioural observation and related 'mentoring' is usually on frontline staff rather than on those responsible for setting the parameters within which the latter work.)

Whatever results are claimed for BSPs, the cruder versions gloss over the immense complexity of 'error' and of error/hazard combinations and their wider organisational context. Ex NCO culture (typified, for example, by the late Fulton MacKay in 'Porridge') would still have it that all human error is simply a manifestation of ignorance, stupidity and bloody mindedness. Unfortunately such an outlook is still not that uncommon in the ranks of the safety profession to whom behavioural safety seems very appealing.

Those wishing to address error in any safety context must first begin to get to grips with the immensely powerful taxonomy of error derived from the work of cognitive psychologists such as James Reason which is well explained for a general readership in HSE's HSG48. They would also do well to reflect on the role of 'error' (particularly operator error) in the reports of the many excellent public enquiry reports undertaken into the great disasters of the last twenty five years. Reports such as those into *Piper Alpha*, King's Cross, and Ladbroke Grove show how inappropriate a singular behavioural safety focus on operators would have been in preventing those tragedies. Frontline individuals made errors but the real causes were far more deep-rooted.

What makes Reason's taxonomy so powerful is that he shows clearly how different kinds of error need to be differentiated by dividing error broadly into: 1) slips and lapses; 2) mistakes; and 3) what he calls 'violations'.

We are all prone to unconscious **slips and lapses**. Errors of these kinds can be potentiated by impairment factors (such as stress, workload, inadequate sleep, poor physical and/or mental health) and distractions (interface with technology, communications, intrusive thoughts etc). Few BSPs seem to be health focused, notwithstanding the fact that ill-health caused or made worse by work is twice as big a problem as accidents and that there may be an interesting link between stress and accidents.

We all tend to make **mistakes** which can be either rule or skill based. (Sometimes we can fail to cope safely with hazards through lack of knowledge or skill or we can end up in trouble by applying the wrong rule but for the right reasons.)

Finally we can all commit **violations** (deliberate rule breaking) which may be exceptional or routine. Generally speaking, to violate we need not only the opportunity to do so but we also either need to (to respond to demands placed on us) or we need to want to (for example, because to do so gives us satisfaction). Many violations can often seem quite understandable (for example, cutting a corner to get the job done to meet a deadline) but often they narrow the margins available for recovering from other sorts of error. This is well expressed in Professor Steve Stradling's road safety dictum: 'error (such as failing to see a vehicle ahead braking) + *violation* (travelling in excess of 70 mph on the motorway) = crash'!

If they are to be of any value at all therefore BS programmes need to train people to understand behaviours - and in particular, human errors - in context rather than to simply address them as empirical facts. We need to help safety behaviourists to correctly diagnose and differentiate between different kinds of errors, understand their significance and consider how they might best be addressed. This kind of approach is already adopted, for example, in the aviation sector which trains staff through 'Crew Resource Management' (CRM) programmes.

Slips and lapses cannot be 'trained out' as many imagine but they may be capable of being addressed by removing impairment factors. An experienced but over-stressed worker who fails to operate controls in a correct sequence on a single isolated occasion is unlikely not to repeat the same error in the future simply because he or she subsequently received counselling, mentoring or just a good old fashioned 'telling off'. Behaviourists need to enquire into impairment factors which may have affected an employee's reliability and, if the chances of a similar lapse cannot be discounted in future, system changes may be needed. (Remember the old reliability adage, '*If it can happen, it must not matter: If it can matter, it must not happen*!' and that improving human reliability is at the bottom and not the top of the hierarchy of preferred options for risk control.)

Skill and rule based mistakes may be addressed successfully through training but there is also a need to look at the case for changes in procedures and communications and possibly at design issues too.

Violations need to be tackled by addressing underlying attitudes, perceptions and motivations. Here, contrary to the 'change the behaviour, the attitude will follow' model so favoured by the behaviourists, establishing why people deliberately break rules is vitally important. Frequently people break rules because it is common practice

or it is condoned by line managers who may privately view compliance as burdensome or conflicted by other operational imperatives.

A good example would be to consider how a BSP 'observer' would react to a common violation such as member of a contractor's staff working at height off a ladder. Engaging the person concerned to raise their safety awareness and to change their behaviour would seem an obvious first step but a more effective approach would be to track back to see if CDM procedures were in place in the selection/engagement of the contractor and, if so, whether these had identified the need for an appropriate risk assessment, method statement, training etc. Further, if some or all of those things were in place, why had the individual concerned not been able or willing to comply? As in science, 'what?' must always be followed by 'how?' and then by 'why?' and of the three 'why?' is always the most important.

When considering the place of behavioural safety (and why not behavioural health while we're at it?) programmes in organisations we need to avoid the kind of simplistic, reductionist thinking which says 'to create a safer organisation, we need to create safer people'. It is just as much the case that to create safer people we have to create a safer organisation.

This is not just word-play. It means we have to get behavioural safety in context. A fundamental starting point must be that of looking at the results of recent H&S performance reviews and audits, paying close attention to lessons from recent (preferably team based) investigations and analysing accidents and incidents by type and immediate and underlying cause. Examining the results of recent H&S 'climate surveys' can also be a good starting point. These analyses then help organisations to target specific areas of risk and to define which safety critical behaviours are most significant.

Techniques such as behaviour observation can then be used, not just to engage deviant workers, but to try to understand what factors may be causing them to act as they do and what technological and/or system changes may be needed to reinforce the safety chain. Training in behaviour observation can be very useful for safety reps who may be able to use this approach to gather data to help decide whether systems of work and procedures are realistic or are being conflicted by other operational constraints and imperatives.

Contrary to what the merchants of behavioural safety will say, BSPs are by no means a magic bullet and in reality they have a rather shaky theoretical underpinning. Many of the observational techniques developed within BSPs however can add value, for example, to other traditional forms of active monitoring such as H&S tours and inspections. But their focus on observable external behaviour rather than on underlying feelings, understanding and motivation, particularly when conducting observations of senior managers, is a serious weakness.

Buyer beware!

June 2003

W(h)ither health and safety management?

Based on studies of accidents as well as findings from inquiries into major disasters, the publication in 1991 of HSE's *Successful Health and Safety Management* (HSG65) marked a great step forward in that it encouraged practitioners to consider not just how and why accidents and incidents happen but why they are not prevented in the first place. HSG65, set out to show how safety could be achieved by addressing the policies, people and procedures (or system) which businesses had in place for managing their risks.

It was not rocket science, merely the application of widely accepted Quality Management principles in the H&S field; principles which subsequently have also been the basis for managing other challenges such as Environment and Business Excellence. Indeed, HSG65 has been one of HSE's best sellers, having gone through five re-prints of the first edition with a second edition in 1997. It has been extremely influential both in the UK and internationally and has been reinforced by other parallel publications such as BSI's *Health and Safety Management Systems* (BS8800) now undergoing a major revision.

Given this success, what is perhaps a little worrying is that HSE's appetite for spreading the message about HSG65 and campaigning for this framework to become a cornerstone of improved performance, seems to have become a little muted of late. Raising H&S management system standards was not a major theme in *'Revitalising...*' with a preference instead on HSC's part for prioritising hazard topics (falls from height, slips trips and falls of the level, site transport accidents, manual handling and stress).

These problems are clear priorities for action but, to be able to address them, it is vital that organisations are encouraged (required even) to enhance all the elements that constitute H&S risk management capability.

'*Revitalising...*', for example, did not address how to expand the delivery and uptake of H&S training, particularly management training. RoSPA, the British Safety Council and IOSH have written recently to H&S minister Nick Brown, asking for him to commission a major review in this area.

It is no use raising awareness of risk issues like vehicle hazards on work sites and commending practical precautions to organisations if they do not have the policies, people and procedures in place to respond to what you are asking them to do. At best your efforts will result in one-off short-term responses rather than sustained change.

Looked at in this way, workplace precautions recommended by inspectors to tackle specific hazards can be seen as treatment of individual lesions whereas the real challenge is to enhance an organisation's immune system, namely all the elements which together enable it to lock on to their various health and safety problems and manage them consistently long after the hard pressed inspector has gone on his or her way.

Like BS 8800, HSG65 too now needs revision to take account of many of the issues which have emerged on the OS&H scene over the last six years. Not only is it important that it continues to reflect contemporary understandings and best practice but it now needs to set the whole question of health and safety management in a much wider context with a clear link to the principles of corporate governance in the Turnbull report and emerging debates on Corporate Social Responsibility and 'sustainability'.

Some of the areas where new sections are required and/or existing text requires revision include:

- *Initial status review* (to help answer the question 'where are we now?');
- *Director leadership* (reflecting ideas in the HSE's director guidance www.hse.gov.uk/pubns/indg343.pdf and the results of recent research commissioned by HSE);
- *Workforce involvement and consultation* (elaborating the case for 'partnership' on OS&H issues);
- *Performance measurement* (based on HSE's web based guidance - www.hse.gov.uk/opsuniVperfmeas.htm and similar web based RoSPA guidance on performance measurement);
- *Performance reporting to stakeholders* (based on the HSE guidance underpinning the HSC's 'top 350 challenge' - www.hse.gov.uk/revitalising/annual.htm reflecting CSR requirements and again, the findings of recent HSE research - www.hse.gov.uk/revitalising/csr.pdf - and anticipating RoSPA's forthcoming *'Going Public on Performance*' report on web based corporate OS&H information);
- *Target setting* - see RoSPA's '*Targets for Change*';
- *Benchmarking* (www.hse.gov.uk/pubns/indg301.pdf);
- *Culture measurement* (taking account of HSE's '*Climate Survey*' tool - www.hse.gov.uk/elecprod/noframes/content/online.htm);
- *Accident reporting and investigation* (again, taking account of findings in the recent HSE contract research report www.hse.gov.uk/research/crr_pdf/2001/crr01344.pdf and RoSPA's '*Learning from Safety Failure*');
- *Management of contractors*;
- *Behavioural safety* (locating contemporary understandings about behaviour in the context of health and safety management systems, taking account of the guidance in HSE's recent web based report - www.hse.gov.uk/research/crr_htm/2002/crr02430.htm and links to HSE's excellent '*Reducing Error and Influencing Behaviour*' - HSG48); and
- *New risk issues* (for example, occupational road risk, the subject of the Dykes report - www.hse.gov.uk/road/content/traffic1.pdf) which up to now has not featured on the 'H&S management radar chart' of most organisations).

Above all HSG65 needs to be expanded so that there is a much stronger focus on '*Health and Work*' (taking account of the lessons which have emerged from HSC's '*Securing Health Together*' agenda - www.hse.gov.uk/hthdir/noframes/ohinside.pdf and the need to develop the role of line managers and non OH professionals.

The way organisations work and the way in which work is organised are of fundamental importance to the protection of people at work and others at risk from work activity. Of course it is easier - more comfortable even - to concentrate on concrete risk issues and to satisfy oneself that one is giving 'practical advice' and not confusing people with theoretical 'mumbo jumbo' about management. Yet, even in the smallest of businesses there is a need to examine who does what, how things are done and, most importantly, how people learn from experience and move forward.

Although this is not the case in HSE's high hazard work there is much anecdotage from senior OS&H practitioners that young inspectors especially (HSE has over 40 per cent of its cadre in training) do not understand management and are less able to engage in informed dialogue about strategic management issues. Trades unions too have failed to focus on management system standards. Nevertheless, the key question for safety reps should be, 'What is the capacity of my employer to manage the risks to which my members are exposed?'

To be effective any venture needs not only adequate financial resources but strong intellectual resources too. Above all they need to develop challenging ideas which provide a lead and give insight into the way ahead. It would be a pity if HSE's apparent reversion to hazards, practical measures and front line topics such as behavioural safety were to mark a turning away from the challenge of developing the HSG65 approach. In its submission to the '*Revitalising...*' consultation over three years ago RoSPA recommended the setting up of an HSC strategic advisory group on H&S management issues.

The need for such a forum remains as strong as ever.

July 2003

'Hearsay and heresy'

How often do we still hear the mantra 'All accidents are preventable' and the accompanying boast 'our target is Zero Accidents' (in reality defined as zero injury incidents rather than zero non-conformances). As I have argued previously in this column, the 'zero injuries' formula may be understandable as a corporate aspiration but it is usually of little value as a target, particularly as benchmark against which to measure progress. At the same time we hear the accompanying mantra 'Most accidents caused by human error'. It would be strange indeed if they were not. Remember the old adages '*to err is human'* and Robert Burns, '*the best laid schemes o' mice an' men gang aft a-gley!*'.

We fail to prevent accidents not just because of incomplete control of the circumstances which give rise to them, but because of our partial knowledge of how things really are and, of course, our inevitably incomplete knowledge of what will happen in the future. Human beings in this sense fail to a greater or lesser extent to bring order to an essentially chaotic and dangerous world - not just because it defies their efforts to control it but because they do not fully understand its complexity and randomness. Accident prevention is thus an incomplete science. Its practice is even patchier. We make progress slowly, often taking one step back for every two taken forward.

On the other hand, the more successful we are at breaking the chain of accident causation in particular circumstances, the rarer accidents, particularly ones with serious consequences, become. Reduction in the RIDDOR reportable injury rate (LFS adjusted) for manufacturing, for example, means that in a firm employing 300 people, on average there will only ever be one injury event leading to an over three day absence every other year. As a result, accidents tend to be viewed not only as rare and unusual happenings but as wholly unnatural events - things which contradict the otherwise smooth and predictable course of the working life which to which we feel we are accustomed. This also gets reinforced by the 'it'll never happen to me/here' syndrome. The result is a potentially dangerous tendency to deny that error and disorder are permanent features of the natural world and of all human undertakings in particular. Yet to what extent are accidents in some sense natural and inevitable? Simply allowing oneself to frame such a question in the privacy of one's own mind might be seen as wholly heretical, particularly for a safety professional!

Good investigation of accidents, where it takes place, tends almost invariably to show that failures to prevent them are rooted either in weaknesses in risk assessment or in the implementation of control measures. Frequently it is the abnormal that slips through the net, for example, the accident occurring during non-planned maintenance as opposed to during normal operation. This is because too often risk assessors seem only to think about risks present under commonly encountered conditions or to base their assessment on what is known to have happened in the past. As a consequence we are constantly seeking to assess and control for risks associated with yesterday's events. Of course, this is taxing enough in itself without having to imagine all those new twists of fate which have yet to materialise.

And this is true far beyond the workplace. We focus quite understandably on preventing and coping with perceived contemporary threats such mass terrorism but ignore, until it is too late, epidemic disease risks like SARS until, that is, the problem actually breaks cover. Yet the potential for intercontinental spread of pandemic disease by mass transit has been well understood for many decades if not centuries (for example, from the Black Death in 1347/50 to the great flu outbreak that swept the world in 1918/19). So why the sense of surprise? Why the lack of preparedness?

This is not a counsel of despair but more a plea for a sense of reality - a sense of modesty perhaps in our efforts to prevent. Unlike the Almighty, human beings, not to mention corporations, can never aspire to be omniscient, omnipotent and omnipresent. However good we get at preventing disasters large or small, we need to recognise that we will fail from time to time. The challenge is not just to reduce the frequency and scale of safety failures but, when they do occur, to confront such failures honestly, welcome them even, as opportunities to deepen understanding and increase our ability to prevent in the future.

This sentiment however is often seen as weak and unambitious and certainly does not always sit comfortably alongside the triumphalism that characterises so much contemporary corporate and political rhetoric. Few board directors - and even fewer Government ministers - would be prepared to say out loud that, during any coming year, they anticipate a certain number of safety failures and associated casualties – but, of course, this is implied in any kind of casualty reduction target above zero. Far easier for those in control to say that they believe things can be made totally safe. Yet it does not take a genius to understand that, were even just some accidents totally preventable, we would have to entertain the idea of zero risk or 'absolute safety'. Quite sensibly we reject this as not just unsound philosophically but as quite impractical since the costs of allegedly 'total' protection in any setting are invariably unsustainable (what good absolute safety if the price is absolute restriction?).

What makes prevention such a challenge are not just the problems involved in successfully assessing risks in the light of those uncertainties we can recognise (for example, uncertainties about the relationship between cause and effect and about things which can breach the envelope of successful risk control), it is also that we know 'a priori' that there are likely to be significant 'unknown unknowns' that can affect our calculations. In other words, we know in principle that 'we don't know what we don't know'. So instead of ignorance being bliss for preventers, if they are honest, the more they know about safety, the greater should be their awareness of the limitations of their current understanding. No wonder so many safety practitioners feel more comfortable if they can retreat into known safety solutions and established formulae and then try to find neat and convenient explanations for why accidents continue to happen ('Do not adjust the risk assessment, there is a fault in reality').

To be even more heretical, one could go one step further and argue that accidents are actually a necessary ingredient for progress in prevention. This is not simply a reflection of Winston Churchill's *'Success is the ability to go from one failure to another with no loss of enthusiasm'*. It is the recognition that only by laying bare the anatomy of real accidents that we can gain insights into the complex interplay of diverse factors which ultimately combine to deliver disaster. John Keats had it better

perhaps than Churchill; '*Don't be discouraged by failure. It can be a positive experience. Failure is in a sense, the highway to success....*'.

Although HSE have still to give as much emphasis to it as they have given to risk assessment, accident investigation remains an essential ingredient for effective health and safety management. Good investigations, particularly where they are team based, not only provide sharp lessons from the real world but they also serve to refresh everybody's understanding of effective health and safety management by making them examine its absence. Accidents leading to injury however are physically and psychologically traumatic and thus, from both an ethical and a practical standpoint, it is far preferable that, rather than waiting for major or fatal injury events to occur, organisations should be prepared to commit significant resources to carry out in-depth investigations to enable them to learn from significant near-misses (or near-hits?)

Alternative approaches can involve learning from accident experiences in other organisations, for example, via the Internet and using realistic, on-site 'accident scenario techniques' to test emergency response and the adequacy of existing risk control systems.

Accidents in this sense are a fundamental safety resource but it would be a brave director or Government minister who would be prepared to say, 'I'm very sorry we've had this accident but I'm really excited about what we are going to learn from it'.

October 2004

Defining performance

As readers of this column will know, over the last six years RoSPA has been pressing hard for health and safety at work to be accepted as a key business performance issue, and not just at boardroom level but also at national level by the Government and the Health and Safety Commission (HSC). Whatever views there may be about the HSC's current strategy, their commitment to pursuing national 'targets' for accident and ill-health reduction has helped to create a consensus that H&S can no longer be seen as just a technical regulatory compliance issue. It has to be seen as an important yardstick, which can be used along with other measures of business performance, to assess the overall performance of any organisation or indeed the economy as a whole. On the other hand there is still huge confusion about what exactly is meant by H&S 'performance' in this context.

As RoSPA has pointed out in its guidance documents (*'Measuring and Reporting on Corporate Health and Safety Performance: Towards Best Practice'* 2001 and '*Targets for Change': a consensus guidance*', 2002 - accessible as PDFs at www.gopop.org.uk), relying on 'outcome' measures such as lost time injury (LTI) rates is far from adequate as a meaningful performance measure. Injury rates are a lagging indicator; from a statistical perspective they are beset by 'small numbers' problems; they do not take account of changes in the hazard profile of an organisation; they do not address health (a far bigger problem than safety); they do not measure H&S management input; they do not address major hazard safety risk management and so on. Nevertheless, LTI data are the data that are regularly collected in most organisations and there is always that temptation '*to ascribe false significance to what can be measured because what is truly significant still defies meaningful measurement*'. (Robert McNamara).

The HSC have been criticised recently by the House of Commons Work and Pensions Select Committee (in their report on HSC/E) for adopting purely 'output' performance measures as a basis for national targets. The Committee have suggested that the HSC should have set some 'upstream' measures such as the proportion of companies undertaking risk assessments and consulting employees or (as RoSPA suggested in its evidence to their inquiry) the number of managers who had undergone some form of H&S training.

Nevertheless to give them credit, the HSC have been continuing to press major organisations to report on their H&S performance in their annual reports (and now on their websites - in line with the RoSPA GoPoP initiative) but again what constitutes 'performance' is not well defined nor explained. The HSC guidance (*Health and safety in annual reports: guidance from the Health and Safety Commission'. 2001* http://www.hse.gov.uk/revitalising/annual.htm) is in effect a rather unstructured collection of indicators and does not connect with earlier HSE guidance which was developed by Norman Byrom and colleagues when at the HSE's Operations Unit in Bootle (*'Measuring Health and Safety Performance'* http://www.hse.gov.uk/opsunit/perfmeas.htm).

Part of the problem is that the recent focus on this issue has spawned at least six different models of H&S performance in guidance aimed at H&S professionals. Besides the HSC guidance on corporate performance reporting, the Byrom document and the RoSPA guidance (which is very similar to Byrom in many respects), there is an IOSH guide on reporting (*IOSH, 2002, 'Guidance on including health and safety performance in annual reports'* - which is similar in some respects to the HSC guide); there is a new annexe on performance monitoring in the revised version of BS 8800 (just published) and there is a further initiative which is being taken forward by consultants Greenstreet Berman (under contract to HSE) to develop the 'Corporate Health and Safety Performance Index' (CHASPI). And, of course, beyond these models there is the whole field of H&S management systems auditing (including RoSPA's QSA, CHASE, BSC 5 Star etc), there is certification to OHSAS 18001, although this is not recognised by the United Kingdom Accreditation Service.

There are also there are models of performance underpinning schemes such as the RoSPA Awards and there are various industry performance schemes including not only those such as '*Responsible Care*' (long operated by the Chemical Industries Association) but others operated by industry bodies which are coming within scope of the Association of British Insurers' '*Making the Market Work'* initiative.

Debate, and diverse development are always to be welcomed in any field but equally one can also question whether the current proliferation of so many models and approaches is really helping. My own view is that we badly need a better consensus on what is meant by 'performance' based around a common conceptual framework. (I believe the 'inputs', 'outputs', 'outcomes' approach in the Byrom and RoSPA models - which draws on Cabinet Office guidance on performance - has much to commend it.) But then one might ask how does this differ from the 'inputs, process, outputs' model in HSG65?

Besides helping directors, managers and safety representatives to focus in a meaningful way on in-company performance (for example, when setting targets within their organisations), the need for clarity here is vital if the H&S community are to catch the tide when it comes to exploiting opportunities presented by the next developments in the field of Corporate Social Responsibility. The HSC have been unsuccessful in getting a requirement for H&S performance to be a mandatory requirement to be included in Operating and Financial Reviews under the revision of company law now underway in the UK but it seems that further changes in this area may occur if and when key features of the U.S. Sarbanes-Oxley Act 'cross the pond'.

Potentially systems like CHASPI are designed to provide an indicator to stakeholders, particularly in the insurance and investment communities, of how well major organisations are able to manage their H&S risks. But how meaningful will a CHASPI rating be, and how easily will it sit along side other corporate risk management indicators, particularly since there is always the problem that systems and approaches which are designed primarily to assess the integrity of financial risk management are not really transferable to areas of operational risk management such as H&S? How useful will what is in effect a 'rough and ready' corporate performance assessment tool be in helping investors to understand H&S risk management capability?

One acid test in validating CHASPI might be to use it retrospectively to see how effective it might have been in pinpointing underlying weaknesses in certain companies which have had major accidents and problems in recent years. The great danger is that the diagnostic power of 'quick and dirty' indicators like CHASPI will be oversold or, worse still, that companies will simply learn what they need to do to get higher scores to impress investors without necessarily changing standards of risk management at ground level.

One part of me says that we need to find meaningful ways of assessing performance to help leverage change in corporate H&S management in the context of CSR; another says that, whatever approaches are eventually developed, they could turn out to be too generic and formulaic to be meaningful in practice while at the same time further increasing the audit burden already faced by busy managers.

Putting such scepticism to one side, it is very clear that organisations must be able to meet the needs of their internal and external stakeholders when it comes to demonstrating their H&S performance. They need to be able to focus on their hazard and risk profile and be able to furnish evidence about their H&S risk management capability. In which case we need some level of common understanding of not only what constitute the various pillars of good performance but how they inter-relate. I would suggest that we need to be able to show that an effective management system (and all that that implies) is in place supported by a strong H&S culture ('input'); we need to be able to show consistency in the application throughout the organisation of appropriate risk control measures ('output') and we need to be able to show an appropriately low (and reducing) level of error, harm and loss ('outcome').

This sort of generic understanding of what constitutes good H&S performance should be as valid conceptually for the major firm of consulting accountants looking at an international corporate as for a local authority client assessing the suitability of a potential contractor or indeed for the local training provider assessing the H&S arrangements of an SME to which trainees are to be sent under Learning and Skills Council funded schemes. (The fact, for example, that, as part of their new 'Safe Learner Framework', the LSC are currently revising their H&S assessment arrangements to cut bureaucracy, raise standards and create more commonality in assessment – is testimony to just how shallow, ritualistic and potentially meaningless much low level H&S performance assessment can become.)

Clearly there is a need for more debate and discussion on this issue. RoSPA for one has argued against a 'one-size-fits-all' approach to performance reporting in annual reports, but equally the flowering of so many different approaches to H&S performance in general poses the danger that H&S professionals will remain confused, not to mention those in the wider CSR debate to whom we are trying hard to make our discipline more relevant.

Readers' views would be welcome.

Performance and reporting

➤ **Public reporting** of corporate health and safety performance has real benefits and also demonstrates transparency and accountability argues RoSPA's occupational safety and health adviser, ***Roger Bibbings***.

Establishing clearly the level of an organisation's health and safety performance and then reporting on this to stakeholders is becoming ever more important to overall business success. Health and safety management capacity and performance trends, for example, are of increasing interest not only to insurers but to institutional investors. Health and safety regulators too will be looking increasingly at this kind of information when targeting use of their scarce enforcement resources.

The Health and Safety Commission (HSC) has recognised this and as part of the follow-up to the government's *Revitalising Health and Safety* initiative challenged the top 350 companies to report annually against their health and safety performance targets. (See HSC's online guidance on reporting at: **www.hse.gov.uk/revitalising/annual.htm**) More recently this approach has also been promoted to organisations in the public, private and voluntary sectors employing more than 250 people.

In summary, the HSC's guidance advises that reports on health and safety performance should cover: the corporate policy context; significant risks; health and safety goals; workforce involvement arrangements; total RIDDOR (*Reporting of Injuries Diseases and Dangerous Occurrences Regulations*) reportable events; the circumstances of any fatalities; the extent of any work-related ill health; total ill health days lost; enforcement notices received; any convictions for health and safety offences; and the total cost of occupational accidents and work-related ill health.

Response

The response so far has been mixed. In 2003, consultants System Concepts published the results of round one of their contract research (RR 134) carried out on behalf of the HSE (**www.hse.gov.uk/research/rrpdf/rr134.pdf**) which looked at the major companies' response to the HSC challenge. The research showed *inter alia* that:

- only 107 reports (30%) included the relevant information;
- 88% had information on corporate health and safety principles;
- 34% had performance data (e.g. number of injuries, accidents and fatalities); and
- only 13% had targets set for improving performance.

In September at the RoSPA Scotland congress, Ansgar Kupper of System Concepts reported on round two of this research, which also looked at progress by organisations (including key parts of the public sector) in covering health and safety performance on corporate websites as well as in company reports. (This report is accessible at: **www.hse.gov.uk/research/rrhtm/rr388.htm**

The research showed a substantial increase in performance reporting, particularly via websites, but there are still major issues and challenges to getting organisations to include hard data on performance such as injury rates, days lost and costs, or progress towards targets such as number of workers trained.

RoSPA has been campaigning for some time for a more transparent approach by organisations to making their health and safety performance publicly available. Indeed, there is nothing new in this idea. *Section 79* of the 1974 *Health and Safety at Work Act* made provision for this kind of public reporting but for various reasons it was never activated.

To help engender interest in this subject RoSPA has launched its own web portal at: **www.gopop.org.uk** – (1) to help focus on key pieces of performance guidance; and (2) to showcase examples of organisations which are reporting via the web.

RoSPA has also issued its own guidance on performance measurement and reporting (**www.rospa.com/occupationalsafety/info/dash.pdf**) which proposes a more comprehensive approach than the HSC, for example, by urging companies to include details of work-related road injuries (WoRRIs) and the results of management system audits. IOSH similarly has published guidance.

These documents and HSC's need to be read in conjunction with a range of other HSC/E tools and guidance which are designed to focus on health and safety as a corporate performance issue.

Examples include guidance on:

- *directors*

(www.hse.gov.uk/pubns/indg343.pdf)
- *worker involvement* (www.hse.gov.uk/workers/involvement/index.htm)
- *Health and sickness absence* (www.hse.gov.uk/sicknessabsence/index.htm)
- *HSE's Ready Reckoner* (www.hse.gov.uk/costs/index.asp)
- *Business benefit/leadership case studies* (www.hse.gov.uk/businessbenefits/index.htm)
- *CHASPI – Corporate Health and Safety Performance Index* (www.hse.gov.uk/research/chaspi.htm)

Lost time data

In the past many organisations have placed strong emphasis on their lost time accident rates as their main measure of H&S performance. This has not been without its problems. For example, when assessing trends, small numbers, (small variations in large populations and large fluctuations in small populations) can present problems of statistical significance. At the margin, employee resilience will determine whether or not non-fatal/non-major injury accidents actually result in time off work.

Modern organisations are constantly changing (for example, through reorganisation and merger) often meaning that changing hazard burdens will affect rates rather than standards of risk management.

Accidents are a lagging, outcome focussed indicator. They do not include ill health (nationally ill health caused or made worse by work is roughly twice as big a problem as accidental injury). Injury rates do not relate to major hazard safety performance and they do not measure health and safety management systems/culture or standards of risk control.

RoSPA, together with organisations such as HSE and IOSH, has argued that other key performance indicators (KPIs) are therefore needed which cover 'inputs' and 'output's rather than just 'outcomes' of better health and safety management like reductions in accident rates.

Reporting

RoSPA believes that there are real and potential benefits to reporting on corporate health and safety performance. It demonstrates transparency and accountability.

It can also provide important information for key stakeholders (in this sense it enhances 'sustainability' and Corporate Social Responsibility (CSR) reporting); and it can facilitate best practice benchmarking with other organisations.

It can also help in demonstrating progress over time; it can help to highlight successes, improvements and corporate commitment to health and safety; and it can be a useful way of signposting other more detailed information (e.g. special health and safety reports, environmental reports, CSR reports) and other external sources of information.

More importantly, it can help organisations to gain competitive advantage, for example, by demonstrating performance excellence to business partners and other key stakeholders.

The range of 'need-to-know' stakeholders is really very wide indeed. For example, key constituencies include:
- *employees* (existing staff and recruits wanting an overview of the company's approach);
- *senior managers* (being able to reference key performance data);
- *investors* (including institutional investors profiling the organisation);
- *trade unions* (researching data to advise their members);
- *customers* (assessing ethical and quality management issues);
- *clients* (reviewing organisational health and safety competence, for example in pre-tender selection);
- *contractors* (being clear about the company's record and requirements);
- *insurers and brokers* (reviewing performance when setting premia);
- *regulators* (understanding policy and performance when deciding on prioritisation of interventions such as inspections);
- *competitors/peers* (benchmarking); and
- *the general public* (for example, checking up on health and safety performance of business neighbours).

Web-based

Many organisations report internally on their health and safety performance (for example, via their Intranets) but do not 'go public on performance'. RoSPA believes that there are real advantages to reporting via the Internet. The Internet is an instant, dynamic and accessible form of communication. It can also be a more democratic way of communicating.

There are many challenges, however, if Internet reporting is to be used successfully. These include: coping with constant change as information needs to be added or modified. RoSPA's research suggests that much performance information on the web is out of date and is not maintained to meet user needs. Also, it can be confusing for users, for example, if information is removed without prior warning.

RoSPA's research also suggested that many organisations still perceived significant disadvantages and/or 'barriers' to reporting on performance. These can include, for example: 'possible adverse impact on corporate reputation'; 'problems in verifying data'; 'insufficient resources for maintaining, updating and reviewing information'; 'absence of comparative data against which to judge performance'; 'doubts about whether the data would be of any interest outside the company'; and 'lack of certainty about whether health and safety staff would get support from senior management'.

RoSPA advises that reporting of health and safety information on corporate websites should become the norm. At the very least, publishing 'top line' data with web signposting complements coverage in annual reports. Clear decision-making is needed in organisations however to ensure consistency and commitment. H&S performance information can often be hard to find since key links are not always easily found in a vast network, even when using search engines. There needs therefore to be clear location of health and safety performance information on corporate sites and consideration needs to be given to integrating it with the organisation's CSR agenda.

Quality and relevance to user needs are key. Public reporting of health and safety performance should at least meet the HSC's suggested minimum recommended standard but organisations also need to ask themselves how relevant their information is to their key audiences. For example, many have yet to include important additional information such as the number of WoRRIs they experience or the results of recent health and safety management system audits.

Finally, the website content needs to be reviewed and updated periodically. A checklist for reporting online is available at: **www.gopop.org.uk/pdfs/report.pdf**

Verification

Just as financial results need to be signed off by independent auditors, so there is a need for organisations to be able to show that their health and safety performance results have been verified by an external, independent and competent organisation. RoSPA would like views from readers on whether they see a need for a new service on these lines. This could be focussed

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primarily on verification of published 'hard copy' corporate health and safety performance data but it could also provide on-going consultancy advice to help organisations to improve their communication of key performance data in internal reports, via their Intranets, in their annual reports, in special external reports and on the Web.

Verification assurance could be provided at three levels:

1) that the data reported were appropriate and covered all the headings recommended by the HSC, RoSPA and IOSH;
2) that the organisation had reporting systems and methods of analysis in place which enabled it to measure key performance parameters and deliver valid corporate results; and
3) that sample audits of those systems had revealed no significant gaps which might invalidate reported data.

Delivering verification at level 3 would obviously be more challenging than at levels 1 and 2 and organisations might wish initially to opt for verification at these first two levels.

Future action

There may also be a need for a briefing package or one-day course on measuring and reporting on corporate performance. RoSPA sees merit in encouraging more good practice links via showcase portals such as those on **www.gopop.org.uk**

Reporting can also help organisations to secure wider recognition of their performance achievement, for example, via routes such as certification (OSHAS 18001) and awards. The *RoSPA Occupational Health and Safety Awards* are now in their 50th year and our awards methodology is being further developed to bring it into line with contemporary performance concepts. Entrants will be invited to submit details of their performance reporting via the web. Many organisations however fail to secure a RoSPA award at the level they might because they submit inadequate evidence packages. Organisations might benefit from help to ensure that their submission is complete and has been properly prepared to enable them to maximise their chances of securing recognition of their performance via an appropriate award.

Organisations might also benefit from advice in identifying options for future corporate priorities and targets and in finding corporate partners with whom they can engage in 'one-to-one' performance benchmarking. They may need help to complete health and safety performance indices (such as HSE's CHASPI) or with assessment schemes (such as required by Learning and Skills Council funded training providers). And many businesses need help to prepare health and safety pre-tender assessment information for potential clients.

RoSPA would welcome views on the subject of reporting as well as suggestions about ways in which it might help in this area. These should be sent to: *rbibbings@rospa.com*

Consistency & cohesion

➤ **Underpinning** HSE's approach to raising standards of health and safety management is a very substantial body of guidance. But is there sufficient consistency and cohesion across this guidance? RoSPA's occupational safety adviser, ***Roger Bibbings***, asks: Is there a need for an HSE doctrine management system?

The Health and Safety Executive (HSE) is committed to raising standards of health and safety management. This involves sharing common understandings about core elements of this challenge, both between HSE, local authority staff and with (and among) duty holders and intermediaries. Much of this is achieved during the training of inspectors and in day-to-day exchange of experience. But underpinning HSE's approach is a very substantial body of guidance on health and safety management. But is there sufficient consistency and cohesion across this guidance? Is there a need for an HSE doctrine management (DM) system?

The term 'doctrine management' might sound rather sinister, conjuring up visions of religious cults or extreme ecclesiastical rigour but it seems to be emerging as an established notion in large organisations with focused missions and diverse fields of operation, particularly in bodies such as the military and the police service.

The US Army, for example, says: *"It* [doctrine] *embodies fundamental principles by which military forces or elements guide their actions in support of national objectives. It is authoritative but requires judgment in application. It concisely expresses how army forces contribute to unified action in joint campaigns, major operations, battles and engagements… Doctrine facilitates communication among soldiers no matter where they serve and contributes to a shared professional culture…"*

Put simply there is a need to ensure not only that all those within an organisation (and external partners also possibly) are able to sing from 'the same mission hymn sheet' but also that all the other hymn sheets in the organisation's repertoire are broadly in accord with this core song.

Core doctrine

The core (or in US Army parlance, 'capstone') HSE publication is *Successful Health and Safety Management* (HSG65). Published in 1991 and revised in 1997, it is HSE's best selling publication and is widely taught and examined as part of a whole range of syllabi. It is the basis of auditing and certification, award schemes, pre-qualification assessment and so on. **Its core doctrine (a management system approach based on policy, organisation, planning and implementation, monitoring and review or POPIMaR) is based on established ideas about quality management.** It is also paralleled by BSI's BS 8800 *Health and Safety Management Systems* which embodies virtually similar concepts.

HSG65 draws on ideas about health and safety management that were developed by the HSE's Accident Prevention Advisory Unit in the 1980's, many of which in turn owe their origins to the *Robens Report* of 1972 and before that to the *Report of the Joint Industrial Advisory Council on Accident Prevention* of 1956.

In parallel with HSG65, HSE has elaborated further subsidiary or parallel guidance on key elements of health and safety management.

For example:

- Although HSG65 is highly relevant in the context of 'safety cases' required under major hazards and offshore legislation, there is a different emphasis on safety leadership and management contained in the HSE Nuclear Installations Inspectorate's *Nuclear Safety Management Safety Assessment Principles* (see: **www.hse.gov.uk/nuclear/saps/saps2006.pdf** paras 43 to 69).
- HSE's *Five steps to risk assessment* (INDG163 rev) published as part of its simplification plan (a response to *'Better Regulation'*) has recently been re-issued as an entry level document, particularly for SMEs. It is based on a hazard spotting approach rather than a process or task analysis approach to risk assessment adopted in HSG65 and BS 8800.
- *Leading health and safety at work* which gives advice on the responsibilities of directors (INDG417) and which was developed jointly between HSE and the Institute of Directors, reflects many of the core messages about senior management

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leadership that are in HSG65 but it adopts a four steps approach to health and safety management (the TQM 'plan, do, check, act' model) which is similar to but different in some respects to the POPIMaR approach.

- In 1997 HSE published *The Costs of Accidents at Work* (HSG96) which is an important but possibly now somewhat dated publication, given that it is based on a limited study of accidents in a defined number organisations. It seeks to explain the insured and uninsured costs of work-related accidents and ill health. It is regarded as important however in supporting HSE's arguments for the business case for health and safety management. HSE also has an *'Incident cost calculator'* (INDG355).
- In 1999 HSE published *Reducing error and influencing behaviour* (HSG48) which supersedes the first edition of this guidance previously entitled, *Human factors in industrial safety: An examination of the roles of organisations, jobs and individuals in industrial safety and a practical guide to control*. HSG48 explains the part played by human error in accidents in an organisational context but it is a matter for discussion whether it locates ideas such as latent organisational errors, for example, sufficiently within the HSG65 model.
- HSE has also produced various publications over the years concerning 'health and safety culture' such as *'Common Topic 4: Safety Culture*, which is regarded as important in providing the organic 'hearts and minds' glue to hold together and lubricate the various elements of health and safety management systems.
- In December 2001 HSE published their web-based *Guide to measuring health and safety performance* (**www.hse.gov.uk/opsunit/perfmeas.pdf**) which discusses a broadly based view of performance and links closely to key ideas on this subject in HSG65. There is no clear connection however between this and HSC guidance on health and safety performance reporting in annual reports (**www.hse.gov.uk/revitalising/annual.htm**).
- And again there is no clear connection between HSE's *Guide to measuring health and safety performance* and online performance assessment tools such as CHASPI (*Corporate Health and Safety Performance Index*) or HSE's *Health and Safety Performance Indicator* (The Indicator). Aimed at SMEs, this can be accessed at: **www.hspi.info-exchange.com** – this assessment tool is hazard rather than management focused.
- There is also practical guidance for SMEs such as *An introduction to health and safety in small businesses* (INDG259) and *The absolutely essential health and safety toolkit for the small contractor* (INDG344) and guidance for health and safety management in many specific sectors.
- In 1995 HSE published *Health risk management. A practical guide for managers in small and medium-sized enterprises* (HSG137). This does not follow a POPIMaR approach and is based on problem recognition and implementation and monitoring of solutions. It links to other guides such as *Health surveillance at work* (HSG61). (One criticism that can be made of HSG65 is that it does not deal in sufficient depth with health and work.)

Clearly the inventory of HSE documents relevant and linked to health and safety management is very extensive. (One might wonder if any single person in HSE has actually read and absorbed all of them!) While there are many common threads, there are also significant divergences in use of terminology and/or overall approach: for example, focusing on systems versus hazards; management of processes versus problem solving; and not all the guides explain clearly how they fit within an overall conceptual or practical framework.

As a first step there is a need for an overview appraisal of the whole suite of documents, looking back at how and why they originated, their target audiences and purpose(s), and how well they link together as a coherent set of guides around a core doctrine.

And beyond that there is the question of how the core or spinal doctrine itself is to be modified to reflect the insights and approaches that are embodied in new underpinning documents as they emerge. (To use an evolutionary analogy, the spine has to be re-engineered as both the internal organs and limbs change!) Further, does HSG65 still resonate with ideas about organisational management as taught in business education courses?

Clearly HSE faces a twin challenge, not only that of updating and modernising doctrines of health and safety management but doing so successfully in the context of increasing Government and business demands for ever greater simplification of health and safety requirements and guidance.

But the argument that the core HSE doctrines about health and safety management are not easily accessible to SMEs should not be used as an excuse for setting aside much of what has already been developed. Rather, a fit-for-purpose doctrine management system needs to be put in place within HSE to preserve and further develop its guidance legacy in this field. Indeed, unless this is done there is a danger not only of re-invention of guidance wheels in the future but that many key understandings that can be made accessible to SMEs (for example, in a simpler form) will actually be lost.

Comments are sought on the observations and suggestions made in this column.
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Competent to advise?

➤ **Under** the *Management of Health and Safety at Work Regulations 1999*, employers are required to appoint one or more 'competent persons' to assist in complying with the requirements of H&S law. Recently, the Work and Pensions Select Committee recommended that the Government should introduce recognised accreditation for health and safety consultants and advisers. RoSPA's occupational safety adviser, ***Roger Bibbings***, discusses how this could work.

Giving evidence to the recent Work and Pensions Select Committee inquiry into the work of HSC/E, Richard Jones, policy and technical director at the Institution of Occupational Safety and Health (IOSH), said: "…the sad fact is that anybody can set themselves up as a health and safety consultant and start operating, anybody can call themselves a health and safety adviser without any level of qualification or experience, which we think is wrong."

His concerns were echoed by HSE Board chair, Judith Hackitt, and the Department for Work and Pensions' (DWP) minister covering health and safety, Lord McKenzie of Luton. All were worried that poorly qualified but over-zealous health and safety advisers are encouraging employers to produce over-burdensome risk assessments, adding needlessly to the burden of compliance.

And, in its end of inquiry report (**www.publications.parliament.uk/pa/cm200708/cmselect/cmworpen/246/246i.pdf**), the committee recommended that the Government, in consultation with IOSH and the new Risk and Regulation Advisory Council, should introduce recognised accreditation for health and safety consultants and advisers, with appropriate sanctions for malpractice. Lord McKenzie has now begun to take soundings to see how this whole issue might be addressed.

Legal duties

Under *Regulation 7* of the *Management of Health and Safety at Work Regulations 1999* (MHSWR), employers are required to appoint one or more 'competent persons' to assist in complying with the requirements of health and safety law. Sufficient numbers have to be appointed, taking account of the nature and scale of risk and the nature, scale and complexity of the undertaking.

With regard to competence, the regulations say: 'A person shall be regarded as competent … where he has sufficient training and expertise or knowledge and other qualities properly to undertake the measures referred to…'

Sub paragraph 8 adds: 'Where there is a competent person in the employer's employment, that person shall be appointed … in preference to a competent person not in his employment.'

But for a long time, concerns have been expressed that many employers are not engaging people with the right qualifications and experience to carry out the 'competent person' role, whether they are in-house or from outside consultancies.

But how big a problem is it?

Despite much anecdotal evidence from various quarters, there is little reliable, research-based evidence with which to assess the extent of alleged problems.

Given the Government's general insistence on evidence-based policy making, there is clearly a need for better data on the extent of access to expert advice generally (whether internal or external), what roles advisers perform, their overall impact and so on.

Specific questions that need to be addressed include: the full extent of wasted expenditure on poorly performing consultants; consequent dissatisfaction with 'elf and safety' generally; discouragement from trying again to find better consultants; and resulting persistence of unsafe and unhealthy working conditions. To what extent are workers actually being harmed because of the activities of rogue consultants?

Research might also seek to establish to what extent and exactly how 'advice about OS&H advice' is being given by business advisers in trade associations, Business Links and other key intermediary bodies.

To support guidance in the MHSWR package itself, HSE has issued two further documents: *Getting specialist help with health*

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and safety (INDG420) (**www.hse.gov.uk/pubns/indg420.pdf**), which is aimed at helping employers to decide if they need access to external help and the HSE *Statement to the external providers of health and safety assistance* (**www.hse.gov.uk/pubns/externalproviders.pdf**), which sets out advice about competence and delivering value for money.

HSE's preference is that all firms, including small ones, should strive to become as internally self-sufficient as possible. (This has obvious merit, although it does not fully recognise the problem of 'unconscious incompetence' (firms not knowing what they don't know) when identifying the limits of their own knowledge and skills.)

Yet all too often, when firms **do** identify the need for action on OS&H, they choose to buy-in a consultant in the expectation that he/she will 'deliver health and safety for them'.

Because firms are often unaware of exactly what they require, this can and does create opportunities for the over-selling of inappropriate services. The good consultant on the other hand will always attempt to build the client's internal OS&H capacity to the maximum extent, even though, on the face of it, this may seem counter to their longer term business interests.

There is much good practice out there and yet many HSE inspectors report cases of firms producing lengthy written risk assessments prepared by consultants which are of little practical value.

Accreditation

One of the problems in contemplating accreditation is that OS&H advice is obtained from a broad range of disciplines, not only the generalist health and safety practitioner, but occupational health nurse practitioners, occupational hygienists, ergonomists, occupational physicians, insurance risk managers, food hygiene specialists, chemists, architects, engineers, as well as specialists in areas such as noise, vibration, radiological protection, microbiology, psychology and so on.

Most of these professions have their own definitions of competence and there are many areas of overlap. Identifying a level of core competency for all, that was sufficiently inclusive, would be a major challenge. (POOSH – Professional Organisations in Occupational Safety and Health – **www.poosh.org** – exists to help such disciplines to interact).

Since its inception, IOSH has sought to commend its professional qualifications to employers as benchmark standards for in-house OS&H professionals and for consultants. It has set up a register of professional H&S consultants (**www.iosh.co.uk/index.cfm?go=consultancy.register**) and published the free guide – *Consultancy – good practice guide* (**www.iosh.co.uk/files/consultancy/Consultancygoodpracticeguide.pdf**).

But there are many different organisations which provide health and safety information to firms (**www.hse.gov.uk/org**). And often the borderline between information provision and elementary advice can be quite blurred.

Many of the people who carry out this work are not professionally qualified in OS&H but they still do very valuable work. Safety groups, for example, exist to help local businesses and to signpost them to solutions. Any attempt to regulate the provision of professional advice would need to ensure that it did not restrict the important role of OS&H information providers, such as safety groups, by making them unnecessarily over-cautious.

In the same vein, were the bar for professional competence to be set too high, many unqualified consultants currently providing very basic but adequate advice to lower hazard businesses might be excluded in future from making what is actually a very worthwhile contribution.

Also, accreditation might exclude employee workplace health and safety advisers (such as those who were employed under HSE's Workplace Safety Advisers' Scheme) from engaging with employers.

Limiting the provision of health and safety advice to formally qualified professionals could also have the effect of increasing costs unnecessarily or discouraging many small businesses from seeking advice altogether because it was deemed too expensive.

Enforcement & regulation

Any measures to accredit professionals would need to be capable of being enforced and there would also need to be robust systems to deal with complaints, for example, about poor performance. On the other hand, the requirements of *Regulation 7* of the MHSWR themselves are very rarely enforced so it would be strange if employers and/or consultants faced enforcement around questions of competence when there was still litle real enforcement action to ensure services were used in the first place.

Also any attempt to regulate OS&H consultants would need to be consistent with 'open market' requirements for services across the EU. Were the UK to regulate for the competence of OS&H professionals, European institutions would need to be consulted. (ENSHPO – the European Network of Safety and Health Practitioner Organisations provides a network for health and safety professional organisations in Member States.)

The way ahead

Despite all these challenges, on the face of it, there are strong reasons to regulate so that OS&H advice is only delivered by persons who are competent and can ensure quality and proportionality. Besides technical competence, consultants also need the right soft skills to work successfully with smaller enterprises, understanding their culture and tailoring practical solutions that will really deliver better OS&H outcomes.

The debate about accreditation – and how to get unscrupulous or unqualified consultants to withdraw from the market – needs to go on. In the interim, however, there are other options which could help:

1. A general awareness raising campaign around *Regulation 7* of MHSWR to help employers understand their legal obligations and the options for meeting them.
2. As part of this, much better guidance for those in trade associations and Business Links who give advice about OS&H advice and services.
3. A campaign against the cowboy element, for example, empowering businesses to complain, perhaps via some kind of ombudsman linked to onward referral to Trading Standards for enforcement.
4. Embedding questions about qualifications of consultants in client-led pre-qualification schemes for contractors.

Whatever path is chosen, it will obviously need to be based on a full analysis of costs and benefits. And, above all, the health and safety profession will need to avoid giving the impression that it is simply seeking to secure restrictions for the economic benefit of its members. Improving H&S performance at work has to remain the overriding consideration.

In practice, the question of ensuring provision of advice that is competent cannot be divorced from the wider question of how to promote uptake of OS&H services generally.

Better intelligence on the current state of play would help and would be a timely contribution to HSE's next strategy consultation round, especially since being able to meet its injury and disease reduction targets depends so much on it working with and through other OS&H professionals to help raise standards of H&S management.

Readers' views are welcome.
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When the going gets tough...

➤ **With the western banking system close to meltdown** and UK 'negative growth' increasingly a certainty rather just than a possibility, RoSPA's occupational safety adviser, ***Roger Bibbings***, asks what are the likely effects on health and safety at work?

The effects of the credit crunch on health and safety at work is one of the questions that has got to be at the top of the thinking of the new HSE Board, which is about to go out to public consultation on the seven key themes in its new H&S strategy. But it has also got to be an issue that is at the forefront of the thinking of every health and safety professional and activist who understands the need to maintain standards when the business going gets tough.

Being able to defend (if not advance) work on accident and ill health prevention is essential if we are to avoid needless health and safety casualties being part of the price to be paid by workers and members of the public for a sustained economic downturn.

The worst case scenario includes: further government restrictions on HSE funding; companies cutting back on essential health and safety training; shelving H&S improvement programmes; employees not speaking up because of fear for their jobs; cuts in subscriptions to information services; less use of consultants and essential specialists; even redundancies for health and safety advisers.

There is a distinct danger that health and safety will be seen at both a government and an enterprise level as a problem largely solved – a 'nice-to-have' rather than a really essential social and economic ingredient. Planning horizons are likely to become more short term, increasing the temptation to cut corners, reduce standards or delay introducing essential protective measures.

Of course we all know that health and safety measures based on risk assessment are not optional extras but are a legal requirement. And the regulators obviously have a key role to play in signalling their intention to enforce wherever necessary, particularly in the case of flagship projects such as the Olympic build. (It appears that this project may now be affected by financing difficulties and thus it will more important than ever for HSE and the Olympic Delivery Authority to signal their determination to ensure this massive and internationally prestigious undertaking is completed without loss of life or major incident. We must show the rest of the world that it can be done.)

But what are the other arguments that can be deployed in support of the case for maintaining standards during hard times?

Responsibility

The first surely has got to be corporate credibility. With so many organisations trumpeting 'health and safety' as a core value during a sustained period of growth, their commitment to this aspect of corporate social responsibility (CSR) is going to seem like so much empty rhetoric if, during tougher times, they renege on their earlier promises to keep health and safety at the top of the agenda.

Secondly, in contrast to earlier periods when the health and safety regime was not so developed, the focus on poor performance (and more significantly the focus of the enforcing authorities) is unlikely to diminish. Corporate manslaughter and increased attention in the courts on the role of directors and boards will be coming into sharper focus just at a time when businesses may be tempted to cut back.

Similarly there is unlikely to be any relaxation in the number of those who are entitled to seek and receive compensation for injury or health damage caused by negligence. And in a harder market, premia for Employers' Compulsory Liability Insurance are bound to rise.

But the third and in some ways more compelling argument is that investing in measures to prevent accidents and consequential losses makes even more 'bottom line' sense when order books are weak and turnover is static or in decline.

Waste caused by failure to manage risks and ensure good health and safety may be tolerated by an organisation in times when the business is buoyant, but when new business has dried up and existing customers are curbing their demands, the cost of accidents (particularly large ones) can literally be the straw that breaks the camel's back. When there is little prospect of increasing turnover by securing more sales, then modest spending on controlling loss makes even better sense than it does during the good times.

There are other compelling business reasons why organisations that face temporary economic difficulties need to keep faith with

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health and safety. Not least of these is the need to preserve their principal asset, the people they employ.

Avoiding not just injuries but ill health early retirements is crucial in preserving key personnel and corporate memory. In fact, investing in employees' health and wellbeing may be something quite practical that businesses can still afford when other more costly forms of remuneration are not possible. Never forget, morale is more important in retreat than during an advance. People who are unfit and depressed are less likely to endure the sacrifices that are necessary in a recession.

On top of all this, during a period of downturn, when competition for contracts is likely to become more intense and clients who are looking for quality will still be looking for high health and safety performance, the business which thinks it can afford to trim back in this area will find itself losing out.

Another key point is that health and safety management is a core organisational competence. There is a clear need to maintain core capabilities like health and safety so that these can be grown again when the corner is turned.

Does all this mean that the health and safety professional should simply be seeking to ring fence all budgets marked 'H&S'? Is this reasonable? Is it realistic? At a time when others are going to be asked to tighten belts or worse, can the health and safety community expect special treatment?

There is no simple answer here. Certainly where risk levels are substantial and any relaxation in standards could spell disaster on a large scale, clearly it is the duty of safety people to draw lines in sand, stand their ground etc. The consequences of a disaster at a major hazard plant due to corner-cutting during boom times are likely to be exactly the same as the consequences due to neglect during a slump. The public will be no more tolerant of the latter than they are of the former.

The real H&S challenge in these tough financial times will be how to maintain pressure for action on equally serious but less obvious issues like occupational road risk or managing asbestos, especially in organisations that may still be waking up to these dangers.

Focus

Of course a further factor is that health and safety is under more political and media pressure now than at any other time in its history. With the endless drip, drip of silly stories in the popular press about 'health and safety killjoys' and political leaders promising 'to end the health and safety culture' (would they prefer a death and disease culture?), those committed to ensuring safe and healthy conditions at the workplace face an uphill struggle.

Certainly we need to continue to present ourselves in business as 'can do' people who actually help things to happen safely, as opposed to alleged jobsworths or Jonahs who can only stand on one side, drawing breath though their teeth, seeking to ban or stop things 'because they might be dangerous'. But we also have to be tougher when essential health and safety measures come under attack. If we don't defend the case for sensible health and safety – who else will?

There is a wider and more strategic point, however, that needs to be made and that is the case for unity and joined up working across the whole health and safety community. In the past we may have assumed HSE (and their local authority allies) to have been the prime movers in the health and safety system (and in many ways they still are). We (H&S stakeholders and practitioners) have tended to wait for them to set the agenda and the pace. Also we have been content for the various third sector health and safety organisations to compete with one another.

Now, however, HSE is in a stretched condition. There are now many more professional health and safety personnel outside HSE than there are within it.

With this in mind, HSE needs to recognise that it can only deliver on its targets by working more closely with and through other bodies. And, with all the organisations on the health and safety 'supply side' facing a common threat to their fortunes as well, there not only has to be greater emphasis on joined up working between them and HSE, but those bodies in turn need to moderate their sense of rivalry and join forces to advance the case for better health and safety performance during tougher economic times. A common statement on the need for companies to maintain their level of investment in health and safety training would seem like an obvious first step.

In summary, the aftershocks from the financial crunch are going to prove quite testing for our movement. But as the saying goes: *'When the going gets tough, the tough get going!'*. It's time for some clear thinking and a new sense of resolution. Remember there are individuals who are alive and well out there today who will surely suffer in the future if we fail.

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H&S management

➤ **RoSPA's** occupational safety adviser, ***Roger Bibbings***, charts impending changes to guidance on H&S management and considers whether our notions about what good H&S management is, are just a reflection of what has been said in existing guidance over many years rather than the result of sound research.

Earlier this year I urged HSE to draw together the many excellent but nevertheless disparate guidance documents on H&S management it publishes into a more coherent suite of linked guidance (see *Parting Shots*, *OS&H* April 2008). There are currently over twenty key HSE documents on the subject but they all use slightly different management models, terminologies and so on.

Since then, a number of other developments focusing on H&S management have started to come to fruition.

- Firstly there is the revision of the *BS OHSAS* series of standards and guidance which now underpins certification of H&S management systems. The new 18002 and 18004 standards are due to be published soon (**www.bsi-global.com**). Amongst other things, changes to the standards reflect new emphases in H&S management practice in recent years, including board and senior management leadership, workforce involvement, occupational health and investigation of incidents.
- At the same time, HSE, via Birmingham University, has been conducting a Delphi study, the aim of which is to look at the spread of expert views (the group includes H&S experts and business leaders) on factors which are thought to promote or inhibit effective health and safety management (**www.hsmc.bham.ac.uk/research/Delphi_Study.shtml**).

A particular focus of the study has been an attempt to measure consensus on those factors which support both general business success and the effective management of health and safety (and vice versa).

One of the issues that has concerned me and others taking part in the study, is the extent to which 'the good health and safety is good business' mantra seems to have influenced the views of experts and non-experts alike.

Of course, I would not wish to deny that this slogan remains very useful for countering those sceptics in business and elsewhere who still see H&S management as a burden and not a benefit – but even so, it was interesting that none of the H&S experts or business leaders in the group identified any of the factors listed in the Delphi study as 'good for H&S but bad for business'.

My concern here is that our notions about what good H&S management looks like may just be a reflection of what has been said in existing guidance over many years rather than the product of sound, empirical research. And many of the established nostrums here go back well before the early nineties to the *Robens Report* of 1972 and even appear, for example, in the *Report of the Joint industrial Council on Accident Prevention* of 1956!

Good ideas stand the test of time one might argue but equally they can just as easily become holy writ which no one ever dares to question.

In my comments to the HSE study I have argued that in seeking to identify factors that promote good H&S management, in particular in SMEs, there is a need to undertake robust forensic investigations in a sample of 'higher performers' to try and discover exactly how and why they manage to establish and maintain safe and healthy working. It may not be quite for the reasons we imagine.

If we can learn how good SMEs actually do it, we might be able to replicate this elsewhere and adjust our theories accordingly.

The results of the HSE Delphi study, which have yet to be published, are intended to inform further revision of HSE guidance based on what factors are agreed to support both good H&S and good business.

HSE seems keen to recast their existing H&S management guidance so that it resonates and aligns more closely with current ideas about business management processes generally and is not seen as something separate and apart. This seems sensible.

Some have suggested that the 'plan, do, check, act' model embodied in HSE's key H&S management guidance document *Successful health and safety management*

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(HSG65) – which derives from Total Quality Management – is 'too 1980s and is now well out of date. Revision is clearly needed but it is reassuring (particularly given how widely HSG65 is now embedded in training and in auditing) that HSE is saying that it will not be abandoning this core text wholesale but will be looking at a more evolutionary approach.

Model

The problem with the HSG65 type of management model approach is that it is only speculative and – it is only a model. It assumes that if work is planned, organised and delivered on the basis of established guidance, with enough feedback loops, then flawless operation will result. Whereas in reality all sorts of other things are going on to create the necessary and sufficient conditions for safe and healthy working.

The problem is then compounded by some practitioners who try to force daily management practice through the mesh of the model (for example, trying to separate artificially overlapping process like 'planning' and 'implementing') rather than understanding that the model is a purely heuristic device to try to get a handle on something much more organic and thus much more complex.

It might seem fairly obvious that, in organisations which have weak or patchy management processes, a gap analysis based on an audit against the HSG65 model could only be helpful in assisting those concerned to improve their formal capacity to manage health and safety. Yet the belief that a systems audit is a 'good thing' can still give rise to a rather worrying kind of collusion between those in organisations who feel a certificate or badge will provide reassurance to both internal and external stakeholders and the providers of certification for whom it is a lucrative line of business.

In my view, the overselling of management systems auditing/certification is not only of concern because of the false impression it may give that compliant organisations are 'safe', but it may also be helping to overcomplicate health and safety and thus inflate the all-too-prevalent perception that H&S management is all about having documented systems. This paper heavy approach to H&S is then made worse by the lawyers and insurers who counsel that, without a fully documented management system in place backed by a full audit trail to show compliance, following the first serious accident, all the directors in the firm will surely go straight to jail.

As ever, over-cautious advice about what is required does little to encourage the more practical and common sense approach which in reality will deliver effective risk control, particularly in small firms. This is not to argue that smaller businesses do not need to manage their affairs with some degree of system and rigour. After all, whatever the HSE research eventually shows, even in the smallest outfit, it seems fairly unlikely that safe and healthy working will come about simply through some kind of telepathy or group intuition.

So should smaller businesses in particular be driven early in the direction of certification? Clearly the answer should be an emphatic 'no' – if they are not ready for it – and this has been one of the many reasons why RoSPA has been pressing hard for the simplification of pre-qualification H&S requirements that are operated by major companies/clients and pre-qualification schemes. Pre-qual schemes themselves can become a paper chase which does little to improve safety.

Simplification

RoSPA has been arguing for a set of widely agreed 'core criteria' to simplify matters and to enable mutual recognition between such pre-qual schemes. On reflection, these criteria might be a much better starting point for most smaller businesses than the OHSAS series. (Is it now time for BSI British Standards to turn their attention to assuring the competence of those currently operating in the H&S pre-qualification area?).

Perhaps what is still missing in both the HSE and British Standards lexicons is an entry level portal through which businesses can pass on their climb up the ladder of H&S management excellence.

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Counting the cost

➤ **RoSPA's occupational safety adviser**, ***Roger Bibbings***, argues that increased control of avoidable losses due to accidents and work-related ill health has a significant part to play in improving the bottom line.

Work-related accidents and ill health cost the UK economy between £20 and £30 billion annually – around £1,000 per employee.

The financial importance to business of cutting the waste and disruption caused by easily preventable accidents has long been understood, so why then are so many businesses cutting back on health and safety spending, viewing it as 'nice to have' rather than core expenditure?

Indeed, if the business case for health and safety is so compelling, why are other motivators such as legislation and enforcement still so necessary to ensure that vital protective measures are in place?

Less than half of the annual cost of accidents and ill health is borne by employers. A very high proportion of the longer tail costs are borne by the Exchequer and by victims' families. Nevertheless, the impact of uninsured losses on employers arising from H&S risk management failures is very substantial indeed. So why is it that so few businesses chose to track those costs systematically, in order to identify opportunities for spend-to-save investment?

In part it is because the 'business case' for health and safety (campaigned for by many bodies such as HSE over the last thirty years) has been allowed to become a general mantra prayed in aid of decisions about health and safety investment taken mainly for ethical, legal or contract compliance reasons. Few, if any, safety professionals and managers actually sit down and work out which lives it is cost effective to save and which are too expensive to safeguard.

In addition, when focusing effort on priorities such as slips and trips or reducing work-related road crashes, the motivation is to reduce injuries; cutting costs due to lost time, business interruption, higher insurance premia and all the other forms of loss associated with accidents is seen very much as a bonus. And yet often the biggest contribution which such prevention programmes make to the bottom line are not simply cost reduction due to fewer casualties but savings as a result of having less material damage and waste and other intangibles such as improved morale, relationships and numerous efficiencies which help the process of product or service delivery.

Yet, despite all this, when it comes to investing very significant sums in health and safety the 'business case' does start to encounter a much steeper gradient. Most significantly, short term restrictions on cash make long term savings less attractive, especially when H&S is competing with other investment options that will show earlier returns.

Expenditure on one budget may well produce savings in another for which the first budget holder is not responsible. And, very significantly, management information may not be good enough to track all the 'below-the-water-line' costs associated with accidents. Indeed many large organisations have great difficulty in simply tracking data on basic issues like staff attendance and absenteeism.

Readers will of course be familiar with HSE's famous 'iceberg' model which suggests that for every one pound of accident loss regained via insurance somewhere, between eight and thirty-two pounds are accounted for as uninsured losses. But a systematic failure to cost accidents, ill health and material damage can lead to the perception in many firms that such losses are small or even non-existent, even though very significant sums of money are literally draining out of the organisation down many tiny gutters. And this lack of awareness can be reinforced, particularly in small and medium sized firms, by the fact that the average interval between serious accidents is very long, meaning that the serious investigation of unplanned events

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is likely to be a rarity with the result that there are fewer opportunities to reflect on the true costs of accidents – that is until a very serious event occurs (such as a fire or the loss of a key worker) which then literally spells the end of the business.

The situation is not helped by the failure of most insurers to incentivise better health and safety performance. Insurers are in business to make money and in practice it is not worth their while to fine tune their business processes to make lower premia a real incentive for better performance, particularly in SMEs.

And then there is the widespread general perception, still fostered by some government departments and the general media, that H&S legislation (which in practice provides the framework for cost effective H&S risk management) is actually a burden holding business back rather than helping it to remain competitive.

Action

Given all these obstacles, what can H&S professionals do to focus attention on the contribution which their discipline can make to ensuring their organisation's survival?

The first and most obvious step is to start costing incidents.

Action Point 1 of HSE's *"Revitalising Health and Safety' strategy was "… to publish and promote a 'Ready Reckoner' supported by case studies to drive home the business case for better health and safety management"*. (Readers who have not already done so should visit HSE's *'Ready Reckoner'* webpage at: **www.hse.gov.uk**.) The purpose of the Ready Reckoner is to promote the ongoing message that "good health and safety is good business" and the site provides information on the business and economic costs of not managing H&S adequately. Interactive tools are provided to allow businesses to work out what these costs may mean to their organisation.

Case studies are also included showing the business benefits that can be gained from good health and safety management. There is also an incident cost calculator form to help record the real costs of incidents in a business (this is available as a printable version for completion by hand and an interactive version with online help and indicative cost values). There is also an option to submit the completed form for inclusion on the website. A report can also be printed out and there is a fully downloadable version available. There is also an interactive screen to illustrate what accidents could cost an organisation annually.

Focusing on ill health, the site includes an introduction to ill health costs, covering the various types of work-related ill health such as back pain and stress.

The site also provides advice on how to undertake real time and retrospective cost studies (and combinations of the two methods), in order to show more accurately where losses are occurring, how much they cost and to provide a baseline data to track how much losses change over time.

Other online 'costing' tools include the US Occupational Safety & Health Administration's *'Safety Pays'* programme (**www.osha.gov/dcsp/smallbusiness/safetypays**), which is designed to assist employers in estimating the costs of occupational injuries and illnesses and the impact on a company's profitability.

This system uses a company's profit margin, the average costs of an injury or illness, and an indirect cost multiplier to project the amount of sales a company would need to generate in order to cover injury costs. Businesses can use this information to predict the direct and indirect impact of injuries and illnesses and the estimated sales needed to compensate for these losses.

Change

With so much free expert help available why has the costing of H&S failure not become the norm in virtually every organisation? The HSE/IoD guidance for directors, *Leading health and safety at work*, suggests that, as part of their overall monitoring role, boards should be tracking these costs. Indeed, it could be construed that boards are actually obliged to engage in this kind of activity in response to the monitoring duties of employers in the *Management of Health and Safety at Work Regulations*.

What action is needed to promote more widespread and effective costing and reporting? Are further changes required to the Combined Code or indeed company law? Does there need to be a renewed focus on this issue in the training of H&S professionals? Are new benchmarking groups needed? Would additional expert consultancy help? Would HSE be prepared in certain cases to issue enforcement notices requiring costing?

RoSPA is keen to open up a dialogue with readers on the successes they have had in promoting accident and ill health costing in their organisations, as well as some of the barriers they have faced and how they have overcome them. How, for example, have they gone about engaging senior mangers, including financial directors? Might RoSPA be able to help with online discussion, workshops or new consultancy services?

Readers' views welcome.
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Hallmark of capability?

➤ **RoSPA's** occupational safety adviser, ***Roger Bibbings***, argues that HSE should positively encourage businesses and organisations to test their health and safety management capability against appropriate standards.

Improving OSH competence across all businesses and organisations and reaching out to small firms particularly to help them manage health and safety are two of the key themes set out in the Health and Safety Executive's latest strategy to reduce workplace accidents and work-related ill health in Great Britain.

By selecting these themes, HSE clearly recognises that: (1) if it is to secure lasting change it needs to build the capacity of organisations to manage their risks; and (2) if it is to use its limited resources to best effect, it needs to focus on the poorest H&S performers with the greatest risks.

In its submission during the public consultation on the strategy RoSPA argued that there needs to be closer and more creative working between HSE/local authorities (LAs) and other health and safety stakeholders to develop this approach. In particular, we suggested that to help prioritise their pro-active enforcement effort, HSE and LAs should indicate to employers the kind of evidence which they can put in the public domain (for example, via the internet) which will enable not just inspectors but other important stakeholders to take an informed view about both the organisation's capacity to manage H&S and the level of H&S performance achievement. We stressed that this should not be limited to HSE-sponsored systems such as the Corporate Health and Safety Performance Index (CHASPI – **www.chaspi.info-exchange.com**) but include a much wider range of systems and indicators currently in use.

In this context, RoSPA was not advocating that achievement, for example, of OSHAS 18001 certification should lead to an 'inspection holiday' or that use of proprietary audit schemes such as RoSPA's Quality Safety Audit (QSA) could substitute for inspection by regulators. HSE must remain free to intervene as and when necessary but it and many others on the health and safety scene need good intelligence to help them to make rational decisions when dealing with organisations, be it prioritising inspection, setting insurance premia, developing tender lists or deciding where it is safe to place trainees or work experience students.

In RoSPA's view, all organisations should be urged to have a health and safety improvement plan which has been developed with employee input and sets clear targets. They should also be urged to report publicly on their health and safety performance (see: **www.gopop.org.uk**).

When CHASPI was being developed we questioned why this sort of parallel, 'stand alone' HSE approach was necessary when there were already so many different schemes, tools and standards on the market designed to help organisations to assess their health and safety management status. These include not only OHSAS and the major audit schemes, but pre-tender H&S qualification standards, various health and safety awards schemes, industry and sector schemes.

In addition, there are many other bodies which 'run the health and safety rule' over organisations to assess their capability and performance, be they colleges, brokers, training providers, major clients and so on. Indeed there is now such a plethora of schemes and options that this in itself is creating unnecessary bureaucracy that is both hindering sensible health and safety management and damaging the 'health and safety brand'. This particular problem was the focus of the second stage of RoSPA's National Occupational Safety and Health Committee's inquiry into the health and safety assistance given to small

Parting Shots

firms (see: **www.rospa.com/occupationalsafety/sme/index.htm#reports** for details).

I suspect that HSE is just as confused as the rest of the health and safety market about the bewildering array of standards and schemes on offer and how to establish differences and similarities between them. But it also faces other problems. As a government body it cannot favour any one scheme over another, especially where they are offered commercially. And, more fundamentally, HSE may have doubts about the appropriateness and rigour of the assessment methods used in each case and how relevant and/or reliable results might be for inspectors at ground level.

Too often the audit processes involved in determining compliance with particular standards are heavily biased towards scrutiny of documentation as opposed to interviews with key staff and site based evidence gathering. And even in the best run companies with numerous forms of H&S accreditation, HSE and LA inspectors all too frequently report finding isolated examples of unacceptably poor practice. This can be a problem, for example, where, as a result of mergers, newly-acquired business units have not yet caught up with the health and safety excellence of their new owners, or when contractors have been brought on board at the last minute without adequate health and safety checks.

Another potential problem is that looking systematically at all the schemes and standards on offer might open various cans of worms which HSE might prefer not to have to deal with. CHASPI might appear quite 'lite' in comparison with some of the 'higher resolution' audit tools. And, at the other end of the scale, some schemes might turn out to be disproportionately burdensome or just totally ill-conceived.

In RoSPA's view, it would be a mistake if these kinds of problems led the Health and Safety Executive to consign the task of reviewing the health and safety performance hallmarks scene to the 'too difficult box'. If nothing else, businesses and their advisers want authoritative guidance on what is on offer and what might be appropriate to their needs. One approach might be to try to tackle the problem sector by sector but this would be slow and many schemes span all sectors.

HSE is also likely to be wary of getting too enthusiastic about external assessment of organisations' health and safety competence because it may increase pressure, for example, from the advocates of deregulation, for the formalising of a non-intervention approach such as that adopted under 'Voluntary Protection Programs' in various US states (see: **www.osha.gov/dcsp/vpp/index.html**).

I have always taken the view that were such an approach to be introduced in the UK, it would only take one serious accident in an organisation which had been approved for non-intervention for searching parliamentary questions to be tabled and for pressure groups to tip off their media contacts. And, in practice, far from seeking freedom from inspection, health and safety professionals (especially those in higher performers that are likely to be granted this status) actually value their contacts with HSE quite highly, both to seek confirmation of their practices and on occasions to remind their senior colleagues of the ever present threat of enforcement action. For these reasons, arguments about use of health and safety management hallmarks and the possible case for deregulation need to be clearly decoupled.

There are other important strategic reasons, however, why HSE should give positive encouragement for organisations to test their health and safety management capability against appropriate standards. The first being that, on balance, such activity is likely to help organisations to identify areas for improvement and thus improve standards at ground level. A second is that it will also expand the number of 'higher performers' whose example others can be urged to learn from and emulate. This has always been a key objective, for example, behind the RoSPA awards and it underpins the 'Higher Performers Forum' (**www.rospa.com/occupationalsafety/scottish/index.htm**) which RoSPA has set up in Scotland and a similar initiative underway in the North West. (These forums are designed to help larger, more committed firms, to promote health and safety in SMEs, including via the supply chain and community links.)

A third reason why HSE should encourage a 'score on the door' approach to health and safety is that it will help to encourage a culture of openness and accountability in organisations, especially those that have still got some way to go to develop a fully rounded approach to corporate social responsibility.

In RoSPA's view the time is right for HSE to grasp this particular nettle, especially since it is also currently in the throes of deciding what might replace – or at least supplement – its long-standing and best selling guidance, HSG65 (*Successful Health and Safety Management*).

RoSPA's core idea in its response to the strategy consultation earlier this year was for there to be 'a new dynamic' between HSE and the rest of the health and safety market, so that the regulator and other professional providers of services could work together much more effectively to save lives, reduce injuries and safeguard health. Tackling the health and safety hallmarks challenge lies right at the heart of this approach. It's a difficult one but has huge potential.

Readers' views welcome.
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Parting Shots

Team leading

➤ **Team leaders** are the vital link in the delivery of high standards of health and safety performance but what does good H&S leadership look like at the team level? To find out, RoSPA is launching a 'Big Workplace Discussion' on the subject and your views are needed. RoSPA's occupational safety adviser, ***Roger Bibbings***, explains.

Besides formal management systems, consistent safe and healthy working depends on a strong health and safety culture underpinned by leadership, involvement and competence. These cross-cutting themes apply at all levels within organisations and beyond and are being addressed as key strands in HSE's latest strategy for the UK health and safety system.

Of the three, arguably the most critical is leadership.

Focusing on the health and safety responsibilities of board level directors, HSE and the IoD have worked together to define core actions and good practices which characterise leadership at this level (see: *Leading Health and Safety at Work* (INDG417) – **www.hse.gov.uk/pubns/indg417.pdf**). They have highlighted the business case for good health and safety performance and the importance of 'visible, felt leadership' by directors and senior managers.

However, in practice, the delivery of high standards of H&S performance depends not just on actions at board level but critically on standards of leadership at the operational level. In particular, it is the quality of leadership exercised daily by team leaders and line managers which is so important in ensuring that safe and healthy working practices are adopted.

Yet when it comes to avoiding accidents or damage to health, team leaders are that vital link in the management performance chain that often gets overlooked, even though they not only have the role of guiding and supporting team members in the safe delivery of the business output, be it a physical product or a service, but are crucial in securing workforce involvement in H&S and in feeding back vital information to other management colleagues.

Just as with the term 'director', the idea of 'team leader' or 'line manager' embraces a great diversity of roles and arrangements in different kinds of organisation. Team leaders need not only the skills, knowledge and experience to delegate, direct, instruct and check, they also need to be able to communicate expectations, provide advice and encourage their team members to:

- contribute their knowledge of what actually goes on;
- share their concerns; and
- feed in their ideas and suggestions.

The effective team leader is the one who can not only turn plans into operational reality by engaging team members collectively and individually but who can identify problems and solutions and harness the full potential of their colleagues.

Team dynamics vary enormously from one organisation or sector to another. From construction to utilities, from the health service to the entertainment sector, from food manufacturing to retailing – there are huge differences in the ways in which people work together to deliver results. And there is a massive diversity of good practice experience to draw on. Conversely there is very much more poor practice, especially in those less advanced organisations that pay scant regard to health and safety or which, despite ostensibly caring about the subject, have still not invested heavily enough in essential know-

ledge and skills, including for their front line managers.

Yet despite this enormous range of operational experience and performance, it ought to be possible, drawing on both extremes, to begin to distil what good H&S leadership looks like at the team level. Just as HSE and IoD have done for directors, it ought to be possible to develop a set of widely applicable, indicative principles that can be used for example, in:

- selecting future team leaders with H&S responsibilities
- identifying their learning and development needs
- developing training approaches
- providing a framework for CPD

Such principles would need to be generic and encompass not only necessary behaviours but underlying attitudes and values as well. Of course, when it comes to defining the essential characteristics of a successful team leader several models already exist, including competence criteria in vocational qualifications. But in the context of leading health and safety at the sharp end the challenge might be framed essentially by asking 'what is it that team leaders and line managers need to: feel; think; understand; say; know; and do to lead their teams safely?'.

Experience

As with safety generally, the starting point for advancing understanding of good practice is not necessarily pure conjecture nor indeed the study of success but the lessons that emerge from the investigation of H&S failures. In this respect any seasoned health and safety professional can cast their mind back over numerous accident and incident investigations and identify cases where line managers may have:

- paid less attention to safety than they should have
- focused more on the delivery of other performance objectives
- been sceptical about health and safety generally
- regarded essential procedures as unnecessary or burdensome
- not have had any H&S or supervisory skills training
- not been aware of past accidents or near misses or doubted that accidents could happen
- believed all accidents were due to wilful worker carelessness if not stupidity
- not bothered to be safety conscious outside work, for example, at home or while driving
- been impervious to safety suggestions and rarely sought team members' views
- regarded concerns raised by colleagues as mischievous or even as insubordination
- turned a Nelsonian eye to obvious hazards and bad practices
- failed to stand up to individual group pressure not to comply with essential standards and safe working practices

Obviously such a catalogue of weaknesses is a gross caricature of the ineffective and unsafe team leader but by inverting such ugliness – by turning each of these faults inside out – one can begin to identify and explore further some of those things which characterise team leaders at the other end of the H&S performance spectrum.

Because successful team leadership is so critical for the delivery of consistently high OS&H standards – and because up to now it has been largely neglected in the HSE guidance lexicon, RoSPA wants to initiate a new exploration of this whole issue.

Although rigorous academic research has its part to play here, we are more interested in the first instance in stimulating a major nationwide discussion on this issue at the workplace level. We want to talk to as many people face-to-face as possible and we want as many people, especially people in the workplace, to take some time out to reflect on and talk through these issues and then write in to us with their thoughts and suggestions.

For example, in your experience:

- What makes a good safety leader?
- What has your experience (good and bad) taught you in this respect?
- What are some of the barriers to be overcome?
- What are some of the opportunities for change and improvement? and
- What might help to achieve these?

If you are a member of a safety committee, or if you have a safety moment before team meetings, ask your colleagues to make space on the agenda to discuss these questions and let us know their views.

If you are a trainer – get your students to tell you what they think. If you are a consultant, an investigator or an enforcer – let us have the benefit of your experience.

Core principles

In short, what we want to encourage is a national conversation about what good team leadership of health and safety looks like and what can be done to make it the norm in all workplaces. Our challenge, together with partners and stakeholders, will then be to distil from everything we have heard and learned a set of clear, easy-to-understand but widely applicable core principles backed by essential good practices. And in turn we will then have to campaign to win widespread acceptance of these at all levels and continue to build up an expanding bank of resources, key links and case studies of 'what works'.

Does this ring any bells? If you are brutally honest, are some of your existing line managers not as effective as others when it comes to health and safety? If so, rather than heaping all the blame on them, have you thought about what some of the underlying reasons might be? Have you got ideas or suggestions for change?

Over the next 18 months RoSPA will be working hard on this project. As in other areas in safety we do not have all the answers but we are well placed to act as a means to capture good practice and to act as a conduit to enable lessons learned at the cutting edge to be made available to all. Can you help us?

Readers' views are welcome.
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High reliability

➤ **RoSPA's occupational safety adviser *Roger Bibbings*** explores the idea of High Reliability Organisations. A concept based on the theory that accidents can be prevented through good organisational design and management.

Inquiries now well underway into the BP subsea spill in the Gulf of Mexico will no doubt serve to refocus debate onto what it is to be a 'High Reliability Organisation' and how far BP's and its partners' operations fell short of this ideal.

Indeed it will be impossible for those leading and guiding the various inquiries to avoid this question, especially given the BP Texas City refinery fire of July 2005 (**www.texascityexplosion.com**) and the findings of the Baker report published in April 2007 (**www.bp.com/liveassets/bp_internet/globalbp/STAGING/global_assets/downloads/Baker_panel_report.pdf**). This report found that BP management had not distinguished between "occupational safety" (ie. slips, trips and falls, driving safety etc.) and "process safety" (ie. safe case considerations, maintenance, process upset reporting etc).

The current inquiry process, however, has become intensely politicised. Serious students of the events that led up to the accident on 20 April this year – and the subsequent response to it – may need to adopt an independent and critical frame of mind when trying to understand all the complex technological, organisational and interface issues involved.

Accidents (particularly major ones) concentrate minds and present unique opportunities for capturing the attention of those who need to think more deeply about how to move further towards High Reliability Organisation (HRO) status. The Deepwater Horizon tragedy is one such opportunity.

The concept of the HRO arose from work by US researchers in the late eighties who studied organisations that had obviously succeeded in avoiding catastrophes in hazardous environments where accidents might be expected to occur quite frequently due to significant risk factors and complexity.

HRO theory has developed against the background of disasters such as the Tenerife air crash (March 1977), the Three Mile Island nuclear incident (March 1979), the Bhopal chemical leak (December 1984), the Challenger explosion (January 1986), the Chernobyl fire (April 1986) and the Columbia explosion (February 2003) – to mention only some. The understanding that these events had complex technological, organisational and behavioural roots has led to an ongoing search for a set of characteristics which can 'disaster proof' an organisation.

In the disaster rich world of the 1980s and 1990s there was an intense study of what one might think of as the corporate health and safety genome, to see if it was possible to identify the kind of organisational DNA that could ensure reliability and guarantee the ability of organisations to cope with the unexpected, including stopping incipient disasters escalating out of control.

The project had obvious attractions. Apart from this being the Holy Grail in safety, it would obviously be a great feather in any corporate cap to be able to say that you had the right safety DNA and then regulators and all other stakeholders could all sleep a little easier in their institutional beds.

Needless to say, it's not that simple.

First of all you cannot describe yourself as an HRO simply by showing that you have a high ratio of potential disaster situations to actual ones (on the assumption that you must be inherently safe because you seem to be very successfully 'barriering off' the pre-cursors of disasters large and small). For example, you may have an impressively high number of unsafe act/condition reports at the base of your Heinrich triangle but still quite a number of fatalities at the top. And then there is the problem of latency of effect, be it the accident waiting to happen in the future because of a poor decision taken some time ago – or the long-term (but as yet undetected) effects of exposure to a carcinogen.

How inherently safe you are cannot be measured simply by asking how infrequently things have actually gone very badly wrong compared with the large number of occasions on which conceivably they could have done. Indeed such a measure is probably the perfect prescription for complacency and the kind of assessment which can actually increase the risk of major corporate safety failure in the future.

Neither can you describe yourself as an HRO simply because you have an exhaustive set of procedural responses to every conceivable threat. This too may actually increase risk. Just as SMEs can be swamped with too

much information and guidance and need a lot of hand-holding to be able to navigate to the precise information they need, so too this can be the case with the busy manager in the large organisation who is expected to have an encyclopedic recall of every corporate policy or guideline. Having a prescription for every eventuality does not make you safe (although there is a still a worrying tendency among many health and safety auditors to spend too much time examining the completeness of documented processes rather than studying what actually happens in day-to-day practice and why).

HRO principles

So whether you are an HRO is actually quite hard to pin down and thus the more thoughtful students of the concept have tried to construct a set of principles which describe the way the 'HRO organisation' goes about its work. According to Professor K. E. Weick and other leading thinkers in this field, an HRO exhibits:

1) Preoccupation with failure: recognising that success can breed complacency; being always alert to the possibility of failure; always searching for lapses and errors which can precipitate disaster; in this context having good systems for reporting near misses, process upsets and failures of all sorts which might be indicators or even precursors of serious adverse events; being rigorous in analysing and prioritising the warning signs received so as to sort out and distinguish between important signals of impending disaster (however weak) and 'background noise'; anticipating the unexpected; and always being prepared to listen and act in a timely way in response to early warnings.

2) Reluctance to simplify interpretations: when simplifying their data in order to make decisions, not discarding information as unimportant or irrelevant, especially when it may have implications for safety; in this context, recognising complexity and unpredictability, deliberately creating scenarios, encouraging staff to notice more, investing sufficiently in monitoring and checking; having sufficient organisational 'slack' to be able to analyse 'weak signals' and determine the significance of warning signs and to question and learn from operational experience.

3) Sensitivity to operations: having front line operators who strive to maintain situational awareness, being highly informed about operations as a whole, not being 'siloed' within their own small sphere of influence and failing to consider the wider impact of their activities; managers being sensitive to the experience of their front line operators and empowering them to speak up and voice their concerns and being attentive to the detail of work activities.

4) Commitment to resilience: not being disabled by errors or crises but being able to mobilise in special ways when such events occur so as to be able to deal with them; in other words not being error free but error proof; having sufficient redundancy, diversity and variety available to catch, cope with and correct errors; and being able to capture and learn from the such experiences.

5) Deference to expertise: recognising that when operations are being carried out under pressure, the focus of decision-making needs to move to those with the greatest expertise or knowledge, even though they may be lower in the organisational hierarchy (but protecting against unintentional consequences by focusing on principle three) and recognising that when pressures ease, the focus of decision-making moves back up the hierarchy.

In summary, these characteristics are described by Professor Weick as a state of 'organisational mindfulness' and they were used, for example, in the wake of the Columbia space shuttle disaster as a template against which to judge the behaviour of NASA.

At this level of generality the whole idea of an HRO can seem, paradoxically, to be both hideously complex and blindingly obvious. So what can be learned from this approach by non-major accident hazard organisations, especially those chasing the elusive goal of 'zero harm'? Is HRO theory applicable only to large complex organisations and not to small ones, which after all can be just as complex but in a more organic way perhaps?

Best practice

Clearly the idea of an HRO is a model, an ideal type of undertaking which organisations can aspire to become. They may exhibit some of the essential characteristics more clearly than others, recognising of course that the underlying characteristic of those wishing to move towards HRO status is an organisation committed to openness and safety learning.

Accidents that should not have happened, especially when preceded by detectable early warnings – or worse still, ones which bear striking similarity to those that have already happened elsewhere in the organisation – should serve not just as timely reminders for everyone to redouble their safety efforts but to ask much deeper questions about how the organisation actually operates.

On the current safety scene there seems to be an unfortunate but fairly constant swing of the theoretical pendulum. On the one hand, following accidents we stress the importance of re-engineering rules, procedures and structures, and on the other we have those who stress the need to enhance 'H&S culture'. The former argument holds that safety must be led from the top/centre and that to be 'safe' everything must be planned and delivered in a systematic way. The latter stresses that when fairly coarse systems and procedures fail to prescribe exactly what is required to ensure safe working (as they inevitably will), we have to rely increasingly on 'culture'. This means recognising that in practice, notwithstanding the importance of safety rules, local expertise and initiative are invariably required to produce the necessary degree of 'fine fit' with the fine grain of operational reality.

The key point to grasp, however, is that it is not a case of either improving 'systems' or changing 'culture' (we need both) but looking at the way information about safety issues is actually generated and flows within organisations and the way this in turn affects key, safety critical decisions.

Practical steps

Many organisations seem hooked on the philosophy of the so called 'Bradley curve' (safety development expressed as accident rates versus time). According to this, they say *'we got our technology and rules right several decades ago and rates came down. Then we then tightened up our systems and rates came down further. Now the only way forward is by improving our 'culture' to change behaviours'.* The underlying intention here is good obviously but it's still a bit superficial since most investigations of major events, if properly conducted, tend to show gaps in all three areas.

My own view is that impassioned calls for yet more work to change attitudes and behaviours, especially of front line staff – even to 'profile' and weed out error prone individuals – can distract managers from thinking more deeply about why things do actually go right most of the time and conversely why occasionally they go badly wrong. This is not idle theorising but really can yield powerful insights as well as practical steps that even small organisations can take to help them proof against the unplanned and the unexpected.

For further information on HRO, see: **www.high-reliability.org**

Readers' views are welcome. Email: rbibbings@rospa.com

Sharing & comparing

➤ **Sharing best practice and comparing health and safety performance** are key parts of developing a professional approach to operations, says RoSPA's occupational safety adviser ***Roger Bibbings***.

Is good health and safety simply a matter of complying with the law or is it fundamentally a key aspect of overall business performance, linked inextricably to quality, HR, environmental targets and business excellence generally?

Most businesses that embrace the idea that they should strive to be 'good corporate citizens' regard compliance with H&S law as a very basic minimum and seek to go further by achieving a cycle of continuous improvement based on good, if not best, practice. They tend to start from the premise, '*What if there were no law? What would we want to do?*'. They tend to see assured safe and healthy working as not just about reducing suffering and harm to people but also about reducing the costs that are associated with the unplanned and the disruptive. They see it as a key part of developing a professional approach to operations and also of enhancing their reputation. Such an approach, however, is clearly a matter of choice by companies that aspire to be 'world class' and is well ahead of the rather minimalist approach to health and safety currently being promoted by ministers who remain obsessed with the idea that attention to health and safety is burdensome and inhibits economic performance.

Seeing good H&S as an overall business goal in turn demands a more sophisticated understanding of performance in this sphere, ie. more than a mere absence of RIDDOR notifiable events or even lost time injuries (LTIs). It demands a focus on a much wider array of 'leading' and 'lagging' indicators which seek to measure 'inputs' (organisation and preparedness), 'outputs' (indicators of safe and healthy working) as well as 'outcomes' (measured in terms of a reducing rate of error, harm and loss).

It is an approach which recognises the need for accountability for performance at every level (particularly among senior managers), with reporting not just within the management structure but externally, for example, to other business partners, to shareholders and investors, to insurers, unions, political representatives and to the wider public, including via the media. And it is this focus on accountability which inevitably engenders a sense of healthy competition, not just between divisions and departments but between rival organisations.

A competitive frame of mind is inevitably part of the DNA of most modern organisations – necessarily so. It can on occasions, of course, lead people to be less than honest about the weak sides of their performance or to report in a purely cosmetic way. Nevertheless, in the health and safety field it is generally a positive force and one which we have sought to harness in RoSPA's long-established health and safety awards scheme. Now in its 56th year, this scheme was inaugurated by the late Sir George Earle (our top trophy bears his name), chairman of Rugby Portland Cement, quite specifically to foster a sense of competition to help reduce accident rates.

What is intriguing, however, is that despite the fairly intense rivalry that exists in the awards, particularly at sector ('best in breed') level, there is also a deep desire among H&S professionals and managers to learn from what other businesses are doing and to share good practice with their competitors.

Inevitably, when faced with performance data, CEOs and directors will ask not just, *'Are we improving fast enough?'* but *'How does our Accident Frequency Rate* (or lost time injury per million hours worked) *compare with our closest market rivals?*'. Where competitors are achieving what seem to be superior results, the next question is, '*What*

are they doing differently to us?'. It is then the H&S professional's job to find out and see what lessons can be learned and applied successfully to steal a march on the competition.

Unlike other areas of business practice where commercial confidentiality is a high priority, health and safety seems to be an area where most progressive businesses are much more relaxed about sharing key data and leading edge information. Unless such information contains details of commercially sensitive specifications, plans or techniques, most H&S professionals seem not just to be given a free hand to share ideas, key performance indicators (KPIs) and solutions, but are often positively encouraged to do so.

At sector level, quite a few trade associations have set up data collection systems and publish league tables to help their member companies to assess H&S performance (usually but not exclusively around LTI, sickness absence and so on). And many establish working groups and networks to share information on safe working practices and improved solutions to risk control. Bulletins, alerts and a whole host of communication techniques are also used to raise awareness and spread understanding of 'what works'. A fuller range of what trade associations do to promote and support health and safety can be seen in the criteria we have developed for the *RoSPA SME Assistance Trophy* (**www.rospa.com/awards/whichaward/sme-assistance-trophy.aspx**).

There are also bodies like the Safety, Health and Environmental Intra Industry Benchmarking Service which shares quantitative and qualitative data as well as various government-run schemes set up to promote business-to-business learning more generally. And, of course, there are proprietary auditing schemes which generate performance levels and scores (like RoSPA's QSA – see **www.rospa.com/consultancy/safetyaudits/healthandsafety/qsa/default.aspx**) as well as online tools such as HSE's CHaSPI (**www.chaspi.info-exchange.com**), although this has not been as widely used as was originally intended.

HSE

Although at sector level HSE is often quietly at work behind the scenes (and has its own sector tripartite advisory committees), apart from publishing sector guidance and many very useful good practice case studies, it does not take a strong lead in actively promoting inter business sharing and learning. Arguably, even though its resources are now very constrained, HSE could do more – and at little extra cost – to stimulate this kind of sharing and comparing, not just within sectors but across different areas of economic activity.

Suspending disbelief and being prepared to go and look at and learn from what others are doing to tackle similar problems but in a quite different sector can often be very instructive. Lawrence Waterman, head of H&S at the Olympic Delivery Authority (ODA), has commented recently on how the innovative approaches developed during the Olympic 'Big Build' towards planning, leadership and worker engagement have proved eminently transferable from such a massive construction project to other settings as diverse as aircraft carriers and the NHS. (For more on this see the Olympic H&S Learning Legacy at: **http://learninglegacy.london2012.com/documents/pdfs/health-and-safety/266-delivering-h-s-aw.pdf** and **www.hse.gov.uk/aboutus/london-2012-games/index.htm**).

RoSPA has argued over a number of years for much greater use to be made by HSE of information technology to enable rapid sharing of lessons learned from companies' own investigations of accidents and incidents. Not just to circulate 'alerts' but to grow a bank of case data which can be used creatively in risk assessments, investigation work and in training. NB: The full potential and promise of such a system developed by the 'Step Change' movement offshore has yet to be realised (**www.stepchangeinsafety.net**).

RoSPA has also sought to promote uptake of HSE's little known advice on one-to-one benchmarking (*Health and Safety Benchmarking, improving together* – **www.hse.gov.uk/pubns/indg301.pdf**). Although this has been around since 1999, it is not referred to that often but it gives simple but really valuable advice on how to go about selecting and working with benchmarking partners to promote the most effective and mutually beneficial exchanges of information. Casual conversations and networking with colleagues by attending events, for example, can only achieve so much. To secure real added value from benchmarking, a much more planned and disciplined approach is needed and this is where the HSE advice can help. To be successful sometimes a lot of preparatory work is needed to enable partners to focus down onto those areas where exchange of data and ideas is going to be most fruitful. The HSE guidance advises that firms need to:

1) decide what to benchmark;
2) analyse where they are now;
3) select partners;
4) work with them; and
5) act on lessons learned.

Benchmarking in H&S needs to be seen as an important part of the overall effort needed for businesses to become 'learning organisations' and a key part of their overall approach to corporate social responsibility (CSR); not keeping powerful knowledge to themselves but sharing it to help others, for example, in their supply chains where, as the client or main contractor, they have a direct economic interest in ensuring that their learnings are shared to help raise standards and cut wholly unnecessary and highly costly accidents and incidents.

Engagement

Of course, benchmarking always needs to be used to support creative adaptation and improvement of existing practices rather than mere slavish copying of what seems to be in vogue. It can have a really important part to play in developing both director leadership and workforce involvement, which is why it should not just be limited to H&S professionals but involve a team approach with senior managers and safety reps. And in today's 'time poor' business environment this does not mean necessarily taking precious time away from the workplace for endless 'industrial tourism'. Much can be achieved through remote communications, video conferencing, email groups and so on.

When asking businesses why they do not engage in one-to-one benchmarking I hear various excuses. Often it's, '*We are unique. No one else is quite like us*'. Or, (from businesses with much to be proud of) '*We're not certain we're that good. We don't want to benchmark until we're world class*' (how will they know?). Or '*We're so big that if it doesn't exist in our own organisation it hasn't been invented*' (then why are they not sharing their knowledge with others?). All these are, as I've said, just excuses. The real barriers to sharing and comparing are lack of curiosity and fear of the unknown.

Business-to-business learning needs leadership. Wouldn't it be great for example, if instead of constantly associating the words health and safety with 'red tape', 'bureaucracy' and 'burden on business' our political leaders were to refocus on ways in which organisations of all kinds can reap the benefits which are to be had by promoting both more competition and more cooperation and sharing in this vital area.

Readers' views are welcome. These should be sent to me at: rbibbings@rospa.com

Don't walk on by

➤ **RoSPA's occupational safety adviser *Roger Bibbings*** argues that developing the confidence to raise concerns at work about acts, conditions or systems which are unsafe or potentially unhealthy is all part of the contemporary skills toolkit.

Not ignoring things which are unsafe is a key theme in many organisations' safety values and is often inculcated in behavioural safety (BS) programmes. But to what extent should we encourage people to follow this principle when they come across blatantly unsafe acts and conditions outside the workplace?

Most forms of BS training, for example, focus on the importance of safety aware workers having 'positive safety conversations' with their colleagues when they find the latter are acting inappropriately. Often this is about asking fellow workers to think about the importance of wearing PPE or following a necessary safety procedure. It's usually much harder for behavioural safety champions to have a positive safety conversation with a senior director who, for example, has failed to assess satisfactorily the health and safety implications of a particular strategic decision. (Good behavioural safety should address all the behaviours in an organisation that assure its safety, not just the behaviours of those at the sharp end.)

As part of my advisory role here at RoSPA I get a steady stream of phone calls and emails (usually referred to me via the RoSPA Helpline) from employees who are worried about health and safety issues in their workplace – often quite simple things like manual handling, vehicle safety and so on. I usually send them what information and guidance I can and I always advise them to raise their worries with their supervisors – and if they have one (few people do these days) with their safety rep too.

In higher performing organisations, the ability of an individual employee or contractor to speak up and voice health and safety concerns – and be thanked for doing so (even when they may actually be some way off the mark) – is a sign of maturity of that organisation's health and safety culture. Where you see '*Report it, sort it*' posters, report cards and '*You said, we did*' boards, you get a sense that employees' input really is valued.

On the other hand, not everyone has the benefit of working in such an environment and often when callers come back to me saying that they cannot get action to put things right, it is very clear to me just how difficult it can be for people in positions with little authority to exercise 'positive safety influence'. Indeed on occasions, by giving

Parting Shots

them just a little bit more information and knowledge than their supervisor, I suspect I may actually be making things worse for the complainant who is a subordinate and who now, better informed, appears to be challenging their line manager. That is not how it should be but when it happens it is usually a sign of much more deep-seated shortcomings in the management regime, and usually it is a sign of how health and safety are not being led by senior managers.

So, in many workplaces the sad reality is that it is still hard to complain or just make positive suggestions.

If all else fails employees (and indeed members of the public) have the right to raise their concerns with the appropriate health and safety enforcing authority, either the Health and Safety Executive (HSE) or their local authority (LA).

Complaints

HSE has guidance on its website (**www.hse.gov.uk/contact/workplace-complaints.htm**) on how to raise complaints. It explains which authority to approach but stresses the need for complainants to try first of all to raise and resolve matters with the employer or person concerned. It points out that HSE can only intervene where it is the appropriate authority and it lists other enforcing authorities that deal with other kinds of risks.

If the complainant cannot secure a satisfactory resolution of their concerns at local level, it asks them to complete an online form and to be prepared to provide: their name, address and contact details; the name and address of the workplace or activity they are concerned about; a description of their concern, including who is at risk and why, if the risk is happening now, how long it is likely to go on for, how often it happens and when and where any incident occurred; and details about what the complainant has done to try and resolve the issue.

HSE then commits to check that the complaint relates to a work activity where it is the responsible enforcing authority. HSE seeks to identify from the information provided: who is responsible for health and safety at the location, who is at risk of injury or ill health or has no adequate welfare facilities; what injury or ill health could result; and how likely is this. This then enables an HSE complaints officer to assess each complaint and place it into one of the following categories: red (serious risk and a complaints officer will follow it up as a high priority within 24 hours of receipt – or it will be passed to an inspector for an on-site investigation); amber (significant risk and a complaints officer will follow it up within five days of receipt); and green (low risk, in which case it will not be followed up by HSE). If a complaint relates to a major hazard industry – such as an offshore, nuclear or major chemical site – then it will be assessed by an inspector and assigned a priority appropriate to the circumstances.

HSE points out that it cannot successfully follow up a 'red' or 'amber' complaint if, from the information provided, they are not able to identify or establish who is responsible for the work being complained about or if the complaint has been made anonymously. They will, however, provide feedback and also explain when they have assessed a complaint as being low risk ('green').

With HSE so hard pressed due to resource constraints, we should all perhaps think very carefully before taking an issue to this level and consider what responsibility we have as citizens to try to secure better health and safety outcomes. This is true not just when we are at work but when we come across circumstances where workers or members of the public may be being put at unacceptable risk of injury or harm to health due to unsafe acts and conditions.

Increasingly we are being urged to act as responsible and active citizens to help fight all kinds of crime such as fraud, child abuse or just good old-fashioned larceny. We all have a moral duty to help prevent harm and loss to individuals and the community. But if raising issues at work can be challenging, how much more is this not the case in the public sphere? Because not everyone is a natural advocate/persuader there are all kinds of organisations which are there to help the potential whistleblower (see Public Concern at Work at: **www.pcaw.org.uk**). And, if they are responsible corporate citizens, all organisations should have transparent, fair and easily accessible complaints procedures, for example, as part of their customer relations arrangements.

But what can or should ordinary citizens do when, for example, they come across unsafe construction activity next to pedestrians or they see workers engaged on working at height without proper protection? And, of course, in an increasingly customer facing and road mobile economy there are numerous points where work organisations and members of the public interact and where arrangements to manage safety effectively may be deficient if not totally absent.

Some might question whether we do actually have a moral duty to try to intervene ourselves in such circumstances. Should we, for example, try to have 'positive safety conversations' directly with workers who are unsafe? Or is it probably better to approach their employer? But what if danger is serious and imminent?

Should we try to record the circumstances/events? With the ubiquity of video on everyone's mobile phones, more and more clips of unsafe acts and conditions are being posted on *YouTube* and *Vimeo*. Indeed, the other day I was directed towards one of these (see *www.bing.com/videos/search?q=Two+idiots+cleaning+a+roof&view=detail&mid=4713671E8F4CB918F1274713671E8F4CB918F127&first=0&FORM=NVPFVR*) by an unknown caller who did not come back to me to explain the circumstances. I put it to HSE that, given that this is effectively 'public space', they ought perhaps be trying to scan the internet systematically for this sort of evidence. Obviously HSE has to prioritise effort and so it might be more convenient for it to turn a Nelsonian eye. But agencies concerned, for example, with child protection or national security obviously search the net in an effort to uncover sources of danger.

Confidence

The easiest thing to do is just to walk on by, saying to yourself, 'it's not my responsibility'. '*Why should I get involved?'. 'Might I not be putting myself at risk of abuse – or worse – if my intervention provoked a hostile reaction?*'.

Obviously, whether or not to act in particular circumstances is always a matter of judgement. We certainly need to avoid armies of risk averse 'elf and safety' busy bodies going round irritating people by focusing on trivial risks (see HSE's Myth Busters Panel cases at: **www.hse.gov.uk/myth/index.htm**). But if lives are at stake, particularly innocent members of the public, then anyone who failed to step in would surely have it on their conscience if later an accident or injury occurred.

Developing the confidence to be able to raise concerns at work about acts, conditions or systems which are unsafe or potentially unhealthy is all part of the contemporary skills toolkit, particularly for managers, supervisors and safety reps. If we really believe that safety is a 24/7, 360 degree priority then exercising vigilance and intervening appropriately when we identify intolerable risks outside work should also be an inescapable duty.

Comments to rbibbings@rospa.com