

Risk Leadership - Focusing the Attention Where it Counts

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1. How Can it Be?

The struggle many organizations face is not what does good HSE performance look like, but how to go about achieving a sustained improvement in HSE performance? So often the HSE journey feels like one step forward and two steps back. An organisation's HSE performance can be likened to a yoyo, one minute everything seems to be spinning in the right direction and then all of a sudden it comes unhinged. Clarke (1999) framed it helpfully stating that the research had shown that a "positive" safety culture improves safety performance but little guidance has been given to how an organization might achieve this goal.

A leader can often feel like the workplace is on an unpredictable HSE roller coaster. I had a conversation just the other day with a senior leader who shook his head in disbelief. How could it be that we have just had a Stop for Safety meeting to address the findings of a recent workplace fatality and 2 hours later there is a serious near miss, which could have resulted in another fatality? Understandably, this senior leader was left perplexed, frustrated and unsure what to do next. The opposite can also be true, and cause equal unease. Some struggle with the question, are we having a great incident free run due to good system design, risk practices and leadership, or is it merely by random chance? This experience is often compounded by the struggle to know how to make the next big step change in HSE. The thinking goes like this..... we have come so far but we can't seem to break through the "glass floor", our injury rate is low but we still keep hurting people.

2. The Critical Question

The critical question asked in the bid for sustainable HSE performance is *"what are the primary activities we need to embed in our day to day operations that will enable us to achieve a HSE outcome that is continuously improving, and most importantly is sustainable?"* The answer to this question is often framed by where managers, employees, and contractors see the organization in its HSE journey and the recent HSE performance statistics.

All too often the response to the question is driven by a compliance mindset - Have we met the required legislative requirements? Did we meet the objective in the most economical way? Are the elements of the HSE Management System in place? This approach is both understandable and defensible, but tends to drive a reactive "tick and flick" culture. Within this reactive space there is an absence of strategic thinking on risk, a

poorly articulated HSE culture, an ill defined and shared HSE vision, and a lack of clarity over HSE leadership accountabilities and responsibilities.

3. Critical Task – Setting the Acceptable Risk Taking Level

Determining an organisation's level of acceptable risk taking may appear to be an anathema, or at best a contradiction in terms. Surely, the focus should be on reducing risk to the lowest possible level, and in an ideal world eliminating risk altogether. This is given, but the reality is that every activity has an implied level of risk and the challenge a leader faces is determining the acceptable level of risk tolerance, both the organisations and theirs.

The decisions surrounding the setting of the risk tolerance limits are critical as they will permeate every aspect of an organisation's culture. In the end these decisions will be what drive people's beliefs and behaviours, not necessarily what the prescribed HSE Management System dictates.

The understanding and management of risk is also determined by OH&S law in Australia covering common law, duty of care law, criminal law and statute law (legislation). Leaders need to have an in depth understanding of what their managers, employees and contractors are required to know and do in order to ensure where reasonably practicable:

- i. The workplace, plant and substances used are safe, with a minimal risk to health
- ii. Systems of safe work are in place
- iii. Sufficient information, instruction, training and supervision is provided
- iv. Consultative process whereby employees are able to contribute to decisions affecting their health, safety and welfare at work.

In managing risk it is important that the term, "*reasonably practicable*" is well understood. The law defines "*reasonably practicable*" as having feasible regard to:

- i. Severity of any injury or harm to health that may occur if the risk is realized
- ii. Degree or likelihood of the risk eventuating
- iii. Knowledge of the hazard and mitigation steps
- iv. Expense, difficulty or inconvenience of taking alternative action
- v. Any conflicting responsibilities the employer may have

It is important in meeting the OH&S legislative requirements that the leader understands that the balance of the requirements is based on a performance, rather than a prescriptive, standard. In other words, the described OH&S outcome it to provide an effective and efficient HSE system of work, not merely meet all the prescriptive requirements in order to provide a safe place of work. The solution to delivering against all the OH&S performance standards is an applied understanding of risk management principles.

4. What is the Measure of Sustainable HSE Performance?

The question of determining the best measure of safety performance is a vexed question of lag and positive lead indicators and there is no simple one size fits all answer. At the heart of the question is what really drives sustainable improvements in HSE performance?

Recent research into risk leadership and organisational HSE performance suggests there are 10 observable signs of sustainable HSE performance, these are not presented in any order of priority:

1. There is a demonstrable ability to manage the broad range of risks, ranging from the obvious physical hazards, to the threats to reputational damage, and to early warning signs of risks not fully recognized nor understood.
2. Clear HSE leadership, which is built on observable behaviours and clearly communicated behavioural expectations.
3. Employees and contractors are asking how they can better identify and manage HSE risks early and see the HSE Management System as an enabler rather than a disabler.
4. The energy to maintain improvements decreases over time, rather than increases.
5. A clear rationale can be given for why the safety improvements have occurred.
6. HSE performance is owned by the whole workforce not just managers and supervisors
7. Continuous incremental change, which over time shows an improvement in lag and lead indicator performance
8. There is a lessening over time in the lag and lead yoyo indicator effect
9. The glass floor performance barrier is broken
10. The Total Recordable Injury Frequency Rate (TRIFR) is not relied on as a sole measure of HSE performance.

5. What does the Evidence Based Safety Research tell about HSE Performance?

The research indicates that there are several interconnected drivers required to achieve sustained safety performance. It is important to state at the outset that there is no one factor alone that will guarantee safety performance. The four identified factors need to be present and developed in the context of clear shared safety vision and goals.

The strongest predictors of HSE success are:

5.1 Striving for a proactive and generative safety culture.

The organization is striving for a proactive and generative safety culture, where there are high levels of trust, informedness, discovery of what is not fully known, pride in shared HSE standards, genuine HSE passion and striving for aspirational achievements. It's where the statement, "*HSE is how we do business around here*", rings loud and true across the business. (Evolutionary Model of Safety Culture – Hudson 2007).

Kennedy and Kirwan (1998) concluded from their research, *“It is the safety culture of the organisation that will influence the deployment and effectiveness of the safety management resources, policies, practices and procedures as they represent the work environment and underlying perceptions, attitudes, and habitual practices of employees at all levels.”*

5.2 Robust HSE Management System

There is a robust HSE Management System, based on sound risk management methodology, is easy to use, unnecessary data duplication is eliminated, there is disciplined application of the system and meaningful reports are produced and used in day to day decision making. The Hearts and Minds Institute which has pioneered some important safety development work in the oil and gas industry through Shell stated, *“a solidly implemented HSE Management System is an essential basis for good HSE performance”*. But interestingly went on to conclude, *“outstanding performance and continuous improvement will only be achieved when there is a culture in which the elements of the management system can flourish.”*

5.3 Effective HSE Leadership

Effective HSE leadership is established on a blend of transformational and transactional leadership attributes and skills, where the primary focus of the HSE leader is to create and maintain an injury free culture through the continuous reduction in hazards and subsequent risk exposure.

The obvious question that arises from this is what type of HSE leadership is effective?

Professor Anthony Hopkins from Australian National University, argues *“It is the leaders who determine how the organisation functions and it is their decision-making (and behaviour) which determines, whether an organisation exhibits the practices, which go to make up a culture of safety”*.

Richard Goyder, the CEO Wesfarmers, makes the challenging observation, *“To change culture you have to change behaviour. If you can’t change behaviour you change the management”*.

The research and field experience suggests that there are at least 10 tenets of effective HSE leadership.

1. Leaders have a clear grasp of the “big picture” about safety and the ability to communicate that vision in plain English – *“I understand what’s important and I can commit to it.”*
2. Leaders can engage, inspire, influence, motivate and challenge others about safety – *“I am motivated to get involved.”*
3. Leaders are visible and set the example – *“If it can’t be done safely, it can’t be done”*
“The standard you walk past is the standard you have just set.”
4. Leaders set clear, consistent behavioural standards and expectations - *“ALL the time: 100%, no exceptions”*

5. Leaders coach and mentor whilst they “walk the talk” - *“The best way to learn something is to teach it.”*
6. Leaders engage employees and contractors to continuously improve safety - *“Leaders listen aggressively”*
7. Leaders demonstrate and encourage “mindfulness” - *“Think about what can go wrong, not what is going well”*
8. Leaders show genuine care for people and the organisation - *“Good safety is good business”*
9. Leaders have a sound working knowledge of the parts of the HSE Management System they have a responsibility for – *“I know what is required to be done within the system.”*
10. Leaders have earned a high level of trust and respect. *“I can trust what they say and follow, even if I don't fully agree.”*

According to Kraus (2005) the leader sees the right things to do to reach the safety objectives, and engages and motivates the team to collectively achieve the objectives. In a nutshell, *“safety leadership is exercised by decision-making, which is related to the beliefs of the leader and demonstrated by his or her behaviour.”*

5.4 Effective Risk Leadership

It could be argued that effective HSE leadership is really no different from effective leadership in any other management domain, such as quality, productivity, people and performance etc. This is a fair conclusion. It could be said that if someone is an effective leader of people, more than likely they will be an effective HSE leader, so long as one simple caveat is acknowledged, that the leader has an applied knowledge of risk.

Risk has been defined in ISO 31000:2009 Risk management - Principles and guidelines, as “the effect of uncertainty on objectives”. This implied that the effective leader of risk knows:

1. What the HSE and/or business objectives are.
2. What might impact upon the objectives to cause uncertainty.
3. What effect that uncertainty might have on the achievement of the HSE and/or business objectives.
4. How to measure and quantify the probability and consequence of that uncertainty.
5. How to reduce the effect of the uncertainty.

The effective HSE leader also needs to know how to build within the organisation collective mindfulness. Collective risk mindfulness has been defined by Weick (2007) as being a chronic unease and a focus on what might go wrong, the unexpected. There is a constant questioning of existing expectations and the willingness to refine, differentiate and redefine expectations based on newer experiences. The fundamental hallmark of a mindful organization is the leadership willingness to receive unwelcome or bad news.

The critical point outcome of collective mindfulness is the creation of what Weick termed a High Reliability Organisation. This type of organization focuses on:

1. **Preoccupation with failure** – treat any lapse as a symptom that something is wrong about the system, which could have severe consequences.
2. **Reluctance to simplify interpretations** – refusal to simplify, and take deliberate steps to create a more complete and nuanced picture.
3. **Sensitivity to operations** – there is well developed situational awareness and continuous adjustments are made to prevent errors from accumulating and enlarging.
4. **Commitment to resilience** – develop capabilities to detect, contain, bounce back and learn from inevitable errors which are part of an indeterminate world.
5. **Deference to expertise** – authority is not assigned by hierarchical authority levels but by degrees of expertise.

The primary outworking of effective HSE leadership, strong behavioural leadership and a mature HSE system is the growing of a proactive HSE culture. It is the proactive HSE culture which enables strong and sustainable HSE performance.

6. Growing a Proactive HSE Culture

The term safety culture first came into use following the 1986 Chernobyl nuclear accident, where the accident was attributed in part to a weak safety culture. In the accident research literature, safety culture, in general is defined as something an organisation “is” rather than something it “has”.

Choudhry, Fang and Mohamed (2006) critically reviewed twenty-seven (27) safety culture studies and concluded that an organisation’s safety culture is -

“the product of individual and group behaviours, attitudes, norms and values, perceptions and thoughts that determine the commitment to, and style and proficiency of, an organisation’s system and how its personnel act and react in terms of the company’s ongoing safety performance.”

In essence, an organisation’s safety culture finds expressions through the complex relationships between, people, systems, knowledge and leadership.

Reason (1997) and Uttal (1983) stated that a safety culture is the -

“Shared values (what is important) and beliefs (how things work) that interact with a company’s people, organisational structures and control systems to produce behavioural norms (the way we do things around here).”

Cooper (2000) further distils the safety culture definition to it -

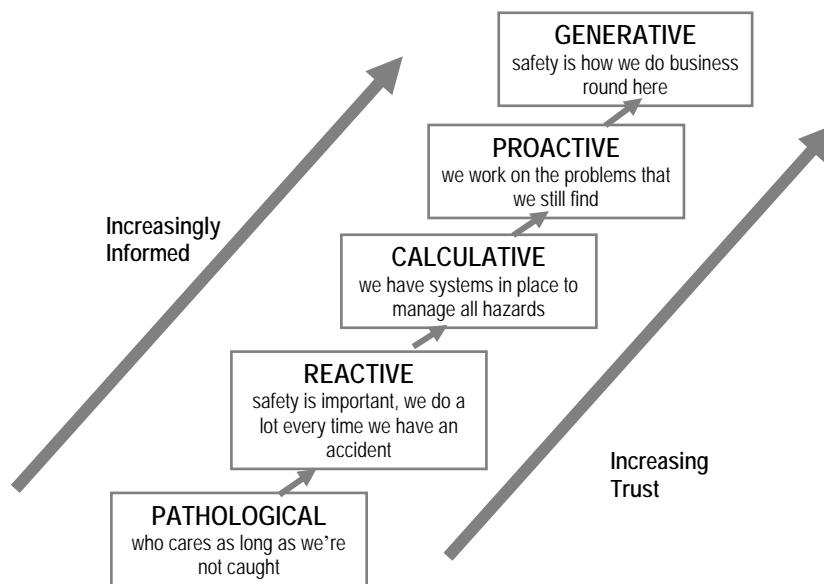
“reflects shared behaviours, beliefs, attitudes and values regarding organisational goals, functions and procedures.”

Patrick Hudson has assisted organizations to better understand their safety culture by developing an Evolutionary Model of Safety Culture. In 2000, Hudson at the Australian OH&S Management Systems National Conference presented this safety culture framework, which was based on extensive work in the Oil and Gas industry and the earlier research of Westrum in 1996.

Lawrie, Parker and Hudson (2005) designed the framework to –

1. Provide a normative framework within which to consider what constitutes a “good” or a “bad” safety culture.
2. Illustrate how safety culture could be improved within the context of the framework.
3. Facilitate the comparison of organizational cultures, and subcultures.

The model describes five types of safety culture, where the safety culture develops on the basis of trust, informedness and engaged leadership.



The statements below help give a sense of what each type of HSE culture looks and feels like.

Safety Culture Maturity Level	Statement
Pathological	When it comes to safety, individuals look after themselves
	“Who cares about safety as long as we don’t get caught

Reactive	Commitment to OH&S and care for colleagues diminishes after a period of good safety performance
	After accidents there is a voiced commitment to care for colleagues by both management and workforce
	“Look out for yourself” it is the rule when it comes to safety
	Safety is important, we do a lot every time we have an accident
Calculative	People know how to pay lip service to safety, but practical components may prevent follow through
	There is a trickle down of management’s increasing awareness of the cost of safety failures
	We have systems in place to manage all hazards
Proactive	The feelings of pride in OH&S and care for colleagues is present but still not universal
	Pride in OH&S is beginning to develop, increasing the workforce’s commitment to OH&S and care for colleagues
	We work on problems that we still find
Generative	Levels of commitment and care are very high and are driven by employees who show passion about living up to their aspirations
	OH&S standards are defined by the workforce
	Safety is how we do business around here

Hudson et al suggest that the way to progress up the Safety Culture Ladder is to:

1. Map where the organization sits at the present moment and what the outlying subcultures look like in the organization. An organization will always find a positive or negative exception to the broad safety culture.
2. Develop the level of trust within the organization so “unwelcome news” can be appropriately communicated and responded to.
3. Build the level of shared knowledge.
4. Decide where the organization needs to progress to on the Ladder and leaders describe and support how the organization will achieve the next cultural milestone.

Interestingly, a completely separate piece of research strongly supports these steps. Choudhry, Fang and Mohamed (2006) described the hallmarks of a “positive” safety culture as being -

1. Management commitment to safety
2. Management concerns for the workforce
3. Mutual trust and credibility between management and employees
4. Workforce empowerment
5. Continuous monitoring, corrective action, review of system and continuous improvement

7. Right Output – Generative HSE Culture is Achieved

In the Generative HSE Culture information is actively sought, even when it is bad news, messengers are trained, responsibilities are shared, failure causes inquiry and new ideas are welcomed.

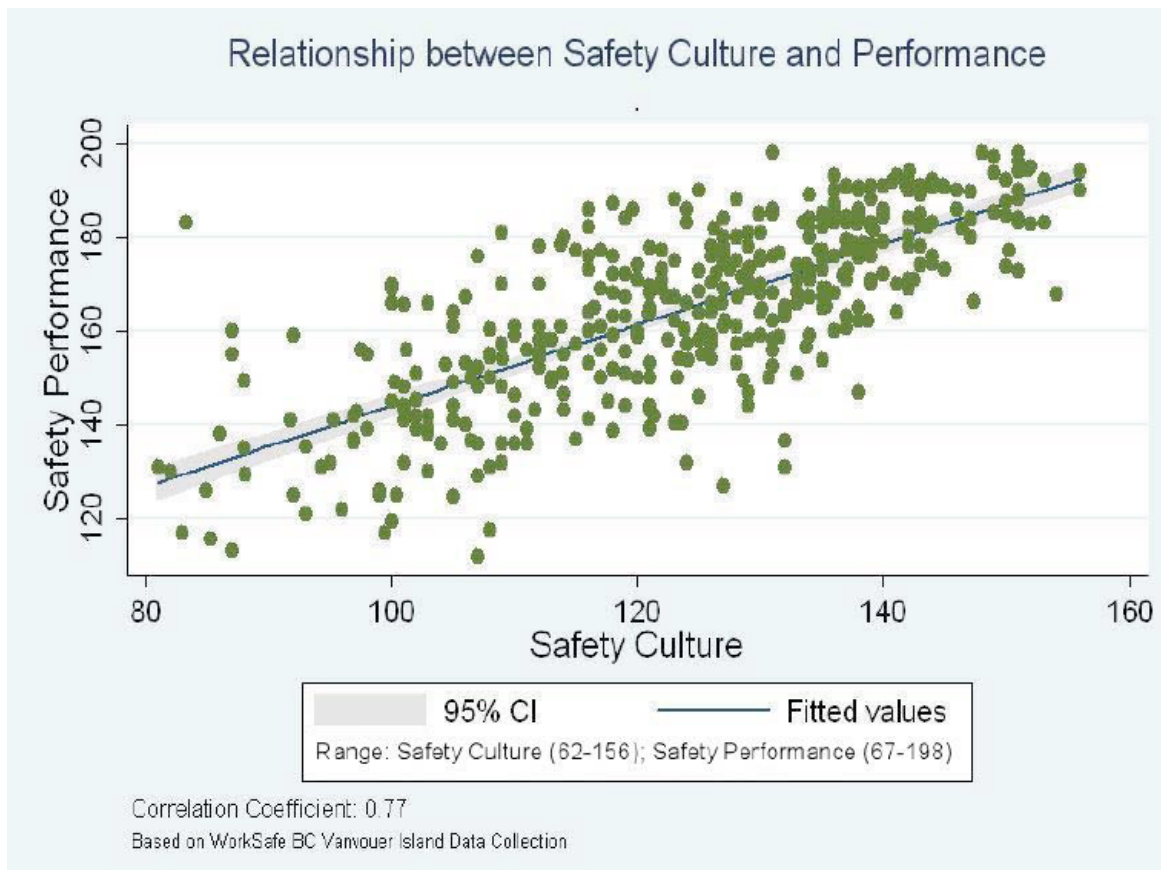
Some practical examples of the excellent generative safety culture are:

Aspect	Beliefs, Values and Behaviour
Statistics/Benchmarking	All levels are involved in identifying action points for improvement. Benchmark hard and soft measures outside the industry.
Audits/Reviews	Full audit system running smoothly with strong follow up. Continuous search for non obvious problems. Fewer audits on hardware and systems more at the behavioural level.
Incident/accident reporting & investigation	Driven by a deep understanding of how accidents happen. Real issues identified through information aggregation. Follow up is systematic and changes are maintained.
Hazard and Unsafe Acts	All levels actively access and use the information in daily work.
Work Planning	Polished planning process with anticipation of problems. Employees are trusted to do most planning. There is less paper and more thinking.
Contractor Management	No compromises to work quality. Find solutions together with contractors to achieve expectations even if this means postponing the job until requirements are met.
Competency/Training	Attitudes become as important as knowledge and skills. Development is seen as a process rather than an event. Needs and learning methods are proposed by the workforce – integral part rather than passive receivers
Worksite Safety Tools	Job safety analysis is revised regularly in a defined process. People are not afraid to tell each other about hazards.
Who checks safety on a day to day basis?	Everyone checks for hazards, looking out for themselves and work mates. Supervisor inspections are largely unnecessary. No problem demanding a shutdown of operations.
Size/status of OH&S Dept	May not be an OH&S Dept because it's not needed, OH&S responsibilities are distributed throughout the company. If there is a department it's small but powerful.
Rewards for good safety performance	Recognition is seen as of high value. Good OH&S performance is intrinsically motivating
Who causes accidents in the eyes of management?	Blame is not an issue. Management accepts it could be responsible when assessing what they personally could have done to remove root causes. Take a broad view looking at interaction of systems and people
Risk Management	Risk management is integrated into the day to day decision making and encompasses behavioural examples of I will conduct a risk assessment when required. I will proactively manage all risk issues.

These defined aspects provide a good place to start in defining a world class HSE culture.

The other obvious question to ask - is there a relationship between a strong safety culture and an organisation's actual safety performance?

A large study of heavy industry in Canada showed a remarkable correlation between a positive safety culture and actual overall safety performance and would suggest that it is a worthwhile endeavour strengthening the safety culture.



8. Effective Risk Leadership Reference Points

Returning briefly to understanding risk and the relationship to effective leadership there are four reference points that the leader needs to focus on. The Leader needs to:

1. Build in others the capacity to display situational awareness where –
 - a. Correct information is gathered and hazards are not accepted or tolerated.
 - b. The gathered information is correctly interpreted.
 - c. The correct mental model of what is happening around the person is adopted
 - d. Information that is difficult to detect is detected.
 - e. Memory errors are reduced through the simplification of processes
 - f. Appropriate anticipation and foresight is applied.

2. Motivate others to search for the unexpected and not normalize their initial observations.
3. Build an environment where all hazards and risks can be freely reported, discussed and appropriate actions taken.
4. Facilitate a risk learning environment, where overtime people's capacity to identify and manage risk is improved

9. Developing HSE Safety Leadership Capabilities

The leader plays a pivotal role in driving improvements in the organisation's HSE culture and the subsequent HSE performance. It is the leader who develops the safety vision and blueprint, maps out the strategic plans, determines the HSE objectives and allocates the resources to improve safety. In this context the leader is viewed as all managers and every person when it comes to implementing the agreed HSE strategy and achieving the set HSE goals and targets.

In summary the HSE leader is the person who:

1. Understands, interprets, and explains with passion the organisation's HSE vision, values and priorities.
2. Enables others to understand the relevant HSE priorities in their work area and roles models those priorities in the way they lead.
3. Makes decisions that directly impact the exposure people have to hazards and how the risks are managed.
4. Interacts with others, and through their behaviour sets the climate for the workgroup, which either supports or diminishes the desired HSE culture.
5. Allocates and manages the resources in order to work safely.
6. Proactively manages poor HSE behaviours and performance which directly impact upon the individual and others including the wider team.
7. Has the legal obligation to ensure that they, and others, continually operate in a safe workplace.

This is supported by Barling and Hutchinson, (2000) and Zacharatos et al., (2005) findings that the use of commitment oriented, rather than control-oriented management practices led to improved safety. The research suggests that an effective HSE leader needs to competently apply both transformational and transactional leadership principles that are soundly based upon values based leadership.

In essence the safety leader needs to work with the whole person through engagement, influence, inspiration, motivation and challenge to align their values, beliefs and behaviours with described direction. The effective HSE leader is working for change which is permanent and self driven.

In order to shift an organisation's HSE culture the HSE leader needs to also demonstrate a strong transactional leadership style. The HSE leader needs to be able to effectively use:

1. Rational persuasion
2. Clear contingent reward, where if successfully done, it will facilitate coalition building, where others are motivated to appropriately encourage others to act in accordance within the agreed behaviours and procedures.

In summary there are 12 attributes and skills the effective HSE leadership needs to display including:

1. Capability to communicate the HSE vision in a way that gains people buy in and commitment.
2. Being seen by others to "Walk the Talk", displaying strong HSE credibility.
3. Engaging in open communication around HSE.
4. Being HSE action orientated – delivering on agreed safety actions and commitments.
5. Having an applied knowledge of the safety management system – knowing what you need to know.
6. Holding people accountable to agreed HSE plans and actions.
7. Constructively correcting unsafe acts/attitudes and praising positive contributions.
8. Initiating meaningful and challenging HSE conversations with others.
9. Mentoring upcoming HSE leaders.
10. Building a team who can deliver on the agreed safety commitments.
11. Helping others see and manage risk at a personal and enterprise wide level.
12. Care for people and having fearless commitment to their safety.

Finally, the effective HSE leader is the one that others describe as a HSE Champion. The HSE Champion passionately drives the safety agenda, acts with courage and displays genuine care for people's HSE wellbeing.

10. Where to From Here

The obvious question is well I have read the paper so what's next?

Without trying to oversimplify the critical HSE culture change drivers can be summarized through 5 Cs -

Clear strategic HSE planning

Committed HSE leadership

Courage to speak up about unwelcome news

Care for people's safety

Competency to manage risk

Here are five things you might like to consider:

1. What is the quality of risk leadership in my organization?
2. What's my personal level of risk knowledge and tolerance? What impact does that have upon others?
3. What are the overall strengths and weaknesses of my organisation's HSE culture, and how is this connected, or not connected to, the HSE leadership within the organisation?
4. What do I need to do to address the strengths and weaknesses of our safety culture?
5. What 5 behaviours could I consistently display that would enhance my HSE leadership?

Why not use your answers to drive the development of your own personal HSE leadership development plan?

Remember small steps lead to big changes.