RM³ *2019*

The
Risk Management Maturity Model

Amended 2020

OFFICE OF
RAIL AND ROAD

RM³ *2019*
The Risk Management
Maturity Model

First published   2011 (as the Railway Management Maturity Model)
Second edition   2017
Third edition   2019 (amended 2020)

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Foreword

ORR developed the Risk Management Maturity Model (RM^3), in collaboration with the rail industry, as a tool for assessing an organisation's ability to successfully manage health and safety risks, to help identify areas for improvement and provide a benchmark for year-on-year comparison.

RM^3 has provided guidance to the industry on excellence in health and safety risk management. Best performing organisations are those which have fully integrated health and safety practices into their culture.

RM^3 sets out criteria for key elements of a health and safety risk management system. RM^3 identifies the steps to evaluate an organisation's progress through the five levels of maturity, from ad-hoc to excellent health and safety management capability.

It defines what excellent health and safety management looks like, including:

- Leaders inspiring confidence and commitment, safely leading their teams through periods of change;
- Making full use of employees' potential and actively involving them, to develop shared values and a culture of trust, openness and empowerment and;
- The health and safety strategy is used by the organisation to challenge itself to achieve health and safety performance which is in-line with the best-performing organisations.

ORR, through the cross-rail industry collaborative RM^3 Governance Board, has continued to develop RM^3 to support wider industry achievement of excellence in health and safety risk management.

We want to ensure that RM^3 matures and continues to reflect best practice in risk management. We have drawn on standards, including BS ISO 45001:2018 (Occupational Health and Safety Management Systems) and our experience from the rail industry, and beyond. We have reflected on recommendations from investigations into accidents, incidents and other failures of management systems.

This edition of RM^3, written for and with the support of the rail industry, embraces the developments in risk control which have taken place since we first published the model in 2011. It reinforces the importance of organisational culture in successful health and safety management. Users will find the additional examples of typical evidence make it easier to determine maturity levels, but will also find that some of the criteria, particularly at higher levels of maturity, are more stretching, compared with previous editions.

As industry health and safety capability develops, it is right that RM^3 itself matures to support greater stretch and improvement. We have embraced the improvements made by the industry to develop this new edition.

We want excellent organisations to embed collaboration and innovation into their systems. We see these as key enablers in continuously improving towards excellence in health and safety risk management, where reasonably practicable.

Ian Prosser

Director of Rail Safety
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Introduction

What is the purpose of the Risk Management Maturity Model (RM^3)?

As the independent economic and safety regulator for Britain's railways, the Office of Rail and Road (ORR) has a key role in securing sustained improvement in the health, safety, efficiency and performance of the rail industry. Our role, is to make sure that the health and safety (H&S) of everyone associated with the rail industry is controlled. We achieve this by encouraging railway organisations to achieve excellent H&S management, and ensuring that they identify and assess risks properly, control them effectively, and comply with the law.

This will be enabled through the rail industry achieving excellence in:

- Culture;

- Health, safety and asset management, and;

- Risk control.

As a minimum, this includes properly identifying, assessing and controlling risks and compliance with relevant legal provisions, including:

- The Health and Safety at Work etc. Act 1974 (HSWA 1974) and the Regulations made under it that cover how certain risks should be controlled, including the Management of Health and Safety at Work Regulations 1999 (MHSWR 1999);
- The relevant European law that arises from the Railway Safety Directive 2004/09, implemented under UK law through the Railway and Other Guided Transport Systems (Safety) Regulations 2006 (ROGS);
- EU Common Safety Method (CSM) for risk evaluation and assessment; and
- EU CSM for monitoring.

In order to achieve and sustain this excellence in H&S culture and risk control, we believe that duty holders must have in place excellent health and safety management systems (SMS).

The RM^3 provides criteria for measuring management capability against five maturity levels across 26 criteria, which we have identified as being essential areas of a SMS. It is used by ORR, and increasingly by duty holders, to understand the management capability of the rail industry in a number of business critical areas.

Why have we revised RM^3?

Our vision for RM^3 *2019* is that it is more easily accessible to those just starting out with RM^3, as well as pushing the boundaries of excellence for experienced users.

Since publishing the first edition of RM^3 in 2011, we have gained considerable experience in using the model to assess the organisations we regulate and holding structured and meaningful discussions, to identify strengths and improvements in their SMSs. In producing RM^3 *2019*, we have worked closely with duty holders to ensure that it has matured and adapted to embrace the developments in risk control over the last eight years, since it was launched.

Who has been involved?

In 2015, we created the RM^3 Governance Board, to oversee the development of the model and supporting materials, advice and training. We have invited further members to the Governance Board, representing duty holders and other organisations who are key to driving forward continuous improvement in risk management. This is to ensure that the model itself continuously improves and remains relevant and accessible to the whole of the rail industry.

The Governance Board members have collaborated extensively in the development of RM^3, and so the typical evidence reflected in the five maturity levels represents the vast operational experience of its members in developing, using and assessing SMSs.

As well as ORR policy and inspector colleagues, the following organisations have been key to the development of RM^3 *2019*:
- Rail Safety Standards Board (RSSB);
- Transport for London (TfL);
- Network Rail (NR);
- London North Eastern Railway (LNER);
- CrossCountry;
- Amey and;
- Rail Delivery Group (RDG)
- UK Tram;
- The Heritage Railway Association (HRA);
- National Freight Safety Group (NFSG) and;
- Institution of Occupational Safety and Health (IOSH).

What has changed in the new edition of RM^3?

We have strengthened the model by recalibrating the evidence from the previous edition and expanded the range of evidence in each of the criteria, filling in missing gaps and ensuring evidence builds through maturity levels.

'Organisational culture' is a key enabler to successful health and safety management. In this edition, typical evidence of actions, beliefs and behaviours held by emloyees, at all levels, reflecting the culture of the organisation, are included for every level of maturity in all criteria. We have retained the criterion OC6 (Organisational Culture). It is now used to capture these culture assessments; providing a richer detail than the more limited evidence available under OC6 in the previous edition. It is easier to determine what could be done to address organisational culture issues in each area of the SMS, enabling progress to higher levels of maturity.

The Governance Board expect that, in updating the model, users will see that some assessments of maturity determined from previous editions of RM^3 will change. This is a positive action by the Governance Board, to ensure that RM^3 supports greater stretch and improvement. RM^3 is not an audit or compliance tool. It is a model to structure discussions about evidence and where to go next, either internally in organisations or between inspectors and the organisations we regulate. Any changes in maturity levels associated with using this new RM^3 *2019* edition, will need to be factored into these discussions.

Excellence in health and safety management systems (SMSs)

Excellence is not a theory, it relates to an organisation and what it does and how it does it. The results it gets and the confidence that these results will continue into the future. An excellent organisation not only meets its legal obligations, but goes beyond these in its pursuit of excellence.

RM³ has adopted the framework set out in the Health and Safety Executive's (HSE) publication 'Successful Health and Safety Management' (HSG 65), shown in Figure 1, which is the most widely adopted model of successful health and safety management within the UK .

The RM³ framework incorporates the key features of good practice in Health and Safety Management System's (SMSs) and also draws in knowledge from incident reviews, from both the safety and commercial risk areas. Examples of which include:

- The Baker Report into the Texas City explosion;
- The Haddon-Cave Nimrod Review;
- The Walker report into Governance within the UK Finance sector;
- The UK Government report into the collapse of Carillion;
- The Aircraft Accident Report 1/2017 Hawker Hunter T7 G/BXFI on 22 August 2015 and
- Emerging findings from the Grenfell inquiry and RAIB investigation reports.

Figure 1 The Plan-Do-Check-Act cycle (HSG 65 2013)

Use of this approach, allows organisations to manage their operations via the application of a systems process, that is in-line with other management systems standards, such as ISO 9001: 2015 (Quality) and ISO 14001: 2015 (Environmental). These promote the use of the Plan-Do-Check-Act (PDCA) process model. The move towards the PDCA approach, achieves a balance between the systems and behavioural / cultural aspects of management.
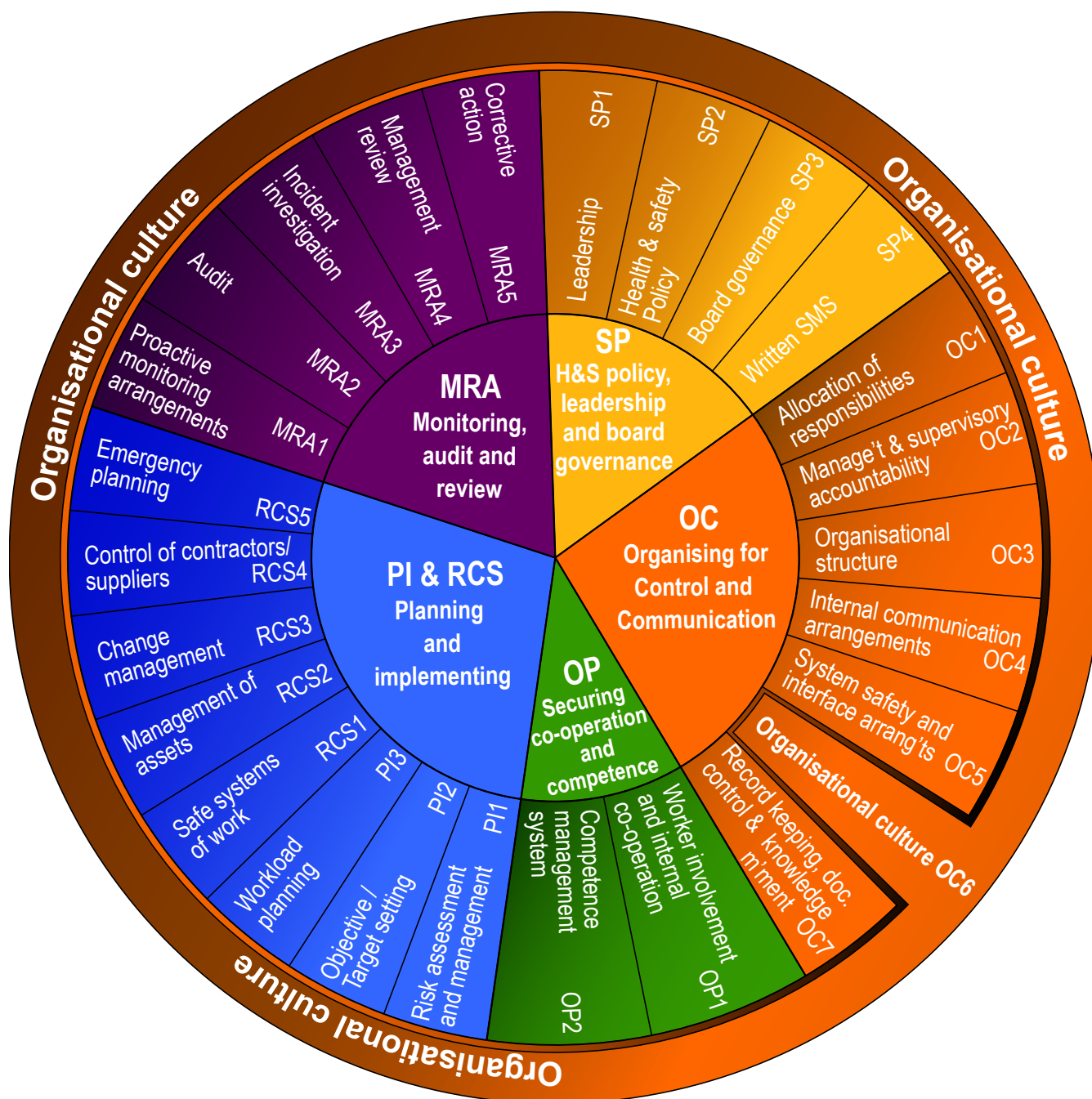
Figure 2 Overview of the Risk Management Maturity Model (RM^3) themes and criteria

The 26 criteria of RM^3

RM^3 describes what excellent management capability looks like by means of a five-point maturity scale, ranging from *ad-hoc* through *managed*, *standardised*, *predictable* and up to *excellence* (Figure 3). The model contains 26 criteria, 25 of these constitute best practice in relation to SMSs and defined assessment criteria are set out.

These criteria enable those carrying out an RM^3 evaluation, to gain a good understanding of an organisation and whether an organisation's SMS can deliver excellence in risk control, across all activities.

Figure 3 RM^3 maturity levels

Organisational Culture

We have taken the opportunity in RM^3 2019 to strengthen the model and identify organisational culture perceptions, expectations and typical behaviours at each maturity level for 25 of the criteria. This will help assessors determine, and organisations improve their maturity. The final criterion (OC6), is now used to collate the indicators of organisational culture identified in the other 25 criteria.

The limited scope of OC6 in previous editions of RM^3, meant that it was seldom used in assessments. The experience of the Governance Board members was that this change was important, as the whole RM^3 model is an indicator of organisational culture. This approach will greatly enhance the model and reinforce the importance of organisational culture in achieving excellence in risk control.

Five themes for excellence in health and safety management systems (SMS)

The following descriptions of excellence have been set for each of the main areas of an effective SMS:

Health and safety policy, leadership and board governance

- The organisation's policies are visionary, based on solid evidence of what the organisation can achieve, and promote a consistent approach to health and safety at all levels of the organisation.
- Leaders of the organisation set and communicate clear direction that reinforces a consistent approach to health and safety and shapes the day-to-day activities, as well as striving to continuously improve risk control.
- Leaders at all levels of the organisation, act in a consistent way that reinforces the values, ethics and culture, needed to meet their organisation's objectives.
- The leadership style throughout the organisation is transformational, as opposed to transactional.

Organising for control and communication.

- The organisation is structured to help put it's policies into practice, as efficiently as possible.
- There is a clear understanding of how each person's role affects the organisation's ability to achieve specific goals and the overall objectives.
- The organisation provides the framework for using people, plant and processes successfully.
- Communications up, down and across the organisation, are highly effective.
- Communications from management should be appropriate for the target audience. The right message should be received at the right time, by the right people, and through the appropriate channels.

Securing co-operation, competence and development of employees at all levels

- Competences (knowledge, skills, experience and abilities) needed to work effectively, efficiently and safely, are understood by the organisation, with the right number of people, in the right place, at the right time, with the right competence.
- Recruitment, selection, training and continued development focus on meeting the organisation's objectives.
- Employees are actively involved in developing processes and making the business successful and safe.
- Trade unions and employee representatives are recognised as an essential means of employee involvement.

Planning and implementation of risk controls through co-ordinated management arrangements

- Organisations systematically implement processes to make sure that the plant, people and processes are fully used, continually improving effectiveness, efficiency and safety to achieve the organisation's objectives.

Monitoring, reviewing and auditing to provide effective governance, management and supervision

- Monitoring is an important part of the organisation's management arrangements at all levels.
- Performance measures and audit programmes, are used to continually encourage everyone to achieve the organisation's objectives and reduce risk to the business.
- Variations from expected outcomes, are reviewed to understand where the organisation is failing and what corrective action is necessary, to restore and improve performance.
- The organisation actively seeks opportunities to identify best practice from both within the organisation and from others across the rail industry.

Criteria development

The generic maturity descriptors

Each RM^3 maturity descriptor for the criteria shown in Figure 3 are based on the Capability Maturity Model (CMM)[1] generic descriptors which originate in the software industry. These are shown below.

Excellence	It is characteristic of processes at this level that the focus is on continually improving process performance through both incremental and innovative technological changes / improvements.
Predictable	It is characteristic of processes at this level that, using process metrics, management can effectively control the AS-IS process (An "as is" business process defines the current state of the business process in an organisation). In particular, management can identify ways to adjust and adapt the process to particular projects, without measurable losses of quality or deviations from specifications. Process capability is established from this level.
Standardised	It is a characteristic of processes at this level that there are sets of defined and documented standard processes established and subject to some degree of improvement over time. These standard processes are in place (i.e. they are the AS-IS processes) and used to establish consistency of process performance across the organisation.
Managed	It is characteristic of processes at this level that some processes are repeatable, possibly with consistent results. Process discipline is unlikely to be rigorous, but where it exists it may help to ensure that existing processes are maintained during times of stress.
Ad-hoc	It is characteristic of processes at this level that they are (typically) undocumented and in a state of dynamic change, tending to be driven in an ad-hoc, uncontrolled and reactive manner by users or events. This provides a chaotic or unstable environment for the processes.

Table 1 Generic maturity descriptors

1 The Capability Maturity Model (CMM) was developed by US Department of Defense Software Engineering Institute (SEI)

Developing the criteria for RM^3 *2019*

RM^3 has become the health and safety maturity model of choice by Britain's rail industry. The RM^3 Governance Board, with representatives from across Britain's rail industry, were key in providing the evidence and direction for RM^3 *2019*. Throughout 2018, we have worked collaboratively to develop the revised set of criteria in this edition.

Our aim is that:

- Evidence in criteria is relevant and meaningful;
- Evidence is mapped to the most appropriate maturity level;
- There is a clear build on lower maturity levels; and
- It is clear what further action needs to be done to continuously improve.

We have gone back to basics with all of the criteria and, systematically, for each maturity level looked at:

- What happens in practice;
- What processes are in place;
- The impact of these processes;
- How standards are applied; and
- The beliefs and behaviours which indicate the organisational culture.

and we tested our findings against the generic maturity descriptors for consistency.

A major milestone in improving health and safety risk management, has been the development and publication of BS ISO 45001:2018 - Occupational health and safety management systems. Governance Board members have been involved in the development of this standard and we validated the revised RM^3 *2019* criteria against it.

Collaboration

In May 2017, The Rail Delivery Group (RDG) and Rail Safety and Standards Board (RSSB) published 'Leading Health and Safety on Britain's Railway - A strategy for working together' which set out the importance of collaborative working, as an enabler to achieving excellence in health and safety risk management.

The RM^3 Governance Board also recognised the importance of collaborative working to achieve higher levels of maturity and evidence of collaboration, is now tested throughout RM^3 *2019.*

Will existing assessed levels change with the application of RM^3 *2019*?

In RM^3 *2019* we have introduced new expected evidence, as well as the evidence from previous editions. All of the evidence has been calibrated against the generic maturity descriptors and this has caused some evidence to lead to a change in assessed levels.

Some evidence previously found in higher levels of maturity, has dropped down a level and some in lower levels has moved up. This will mean that assessors may find that some maturity determinations made using the revised criteria included in this document, are different to assessments made using previous editions.

We know that this change will make it challenging to track progress between assessments using the previous edition and this one, but the real value of RM^3 is in facilitating robust conversations. The changes arising from using this edition will be an important part of these discussions.

Using the criteria

RM^3 supports the evaluation of an organisation's health and safety management system (SMS). The purpose of these assessments, is to identify whether the management arrangements provide and maintain risk-control systems, that protect the safety of people affected by the organisation's activities. The model provides a consistent way of evaluating the management arrangements required by MHSWR[1] and ROGS[2].

Assessors should adopt an evidence-based approach to evaluating the management of risk. Several sources of data, information and knowledge can be used to measure an organisation's current level of risk management maturity.

Information on the performance of organisations can be gathered in a variety of ways: through interviewing individuals at various levels, through inspecting and reviewing documentary evidence and through direct or indirect observation of conditions found at site level.

Figure 4 illustrates the type of information and the collection methods available to assessors in determining an organisation's maturity levels.
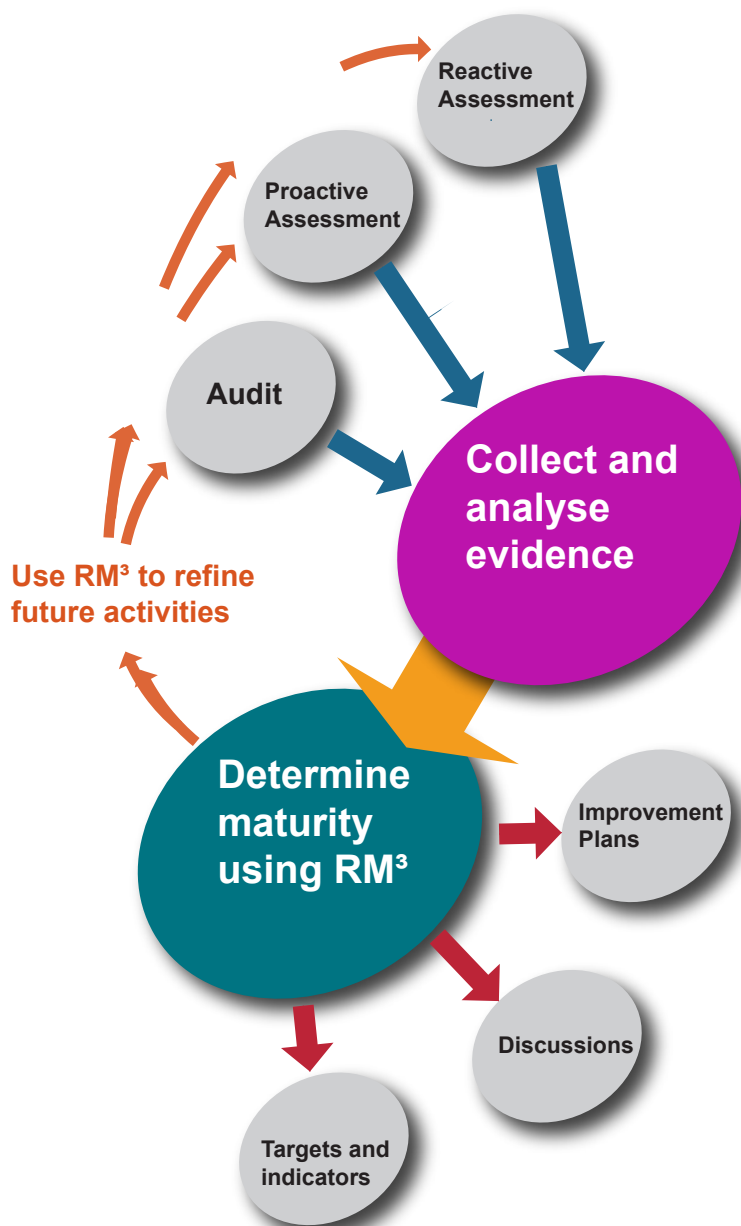
Reactive assessment includes:
- Workplace violations and errors
- Incidents
- Failures to deliver performance objectives
- Complaints

Proactive assessment includes:
- Risk control system review
- Safety verification activity
- Safety certification/authorisation assessment

Audit includes:
- Top down SMS reviews
- Corrective action monitoring
- Internal and external

Figure 4 Information sources and collection methods

1 The Management of Health and Safety at Work Regulations 1999 (MHSWR)
2 The Railways and Other Guided Transport Systems (Safety) Regulations 2006 (ROGS)

SMS assessments may focus on a limited number of risk controls and track them up through the levels of the organisation.

They may also start at senior management level and track the relevant risk controls down through the organisation. However, to form a reliable opinion, the assessor would need to make sure that the whole SMS is assessed against all of the elements set out in RM[3]; and that the size, structure and nature of the organisation are also taken into account.

Evidence of the capability (or otherwise) of the organisation will be built-up during assessment activities. The evidence gathered will only be based on a sample of the information available and so will not be conclusive. It is possible that the evidence collected could fall across a range of maturity levels.

Assessors should use the evidence gathered to inform their opinion of the organisation's management arrangements against the RM[3] criteria. As the volume of evidence increases, there should be greater clarity over where an organisation's maturity lies. Assessors should use their judgement when deciding which criteria and evidence to use. The following issues should be considered:
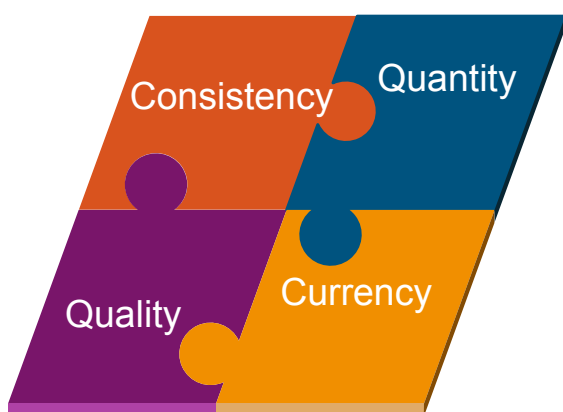
Figure 5 Evidence factors

- **Consistency of the evidence** - if evidence from a number of sources suggests a similar level of maturity, this would indicate that the findings of the assessment are accurate;
- **Quantity of the evidence** - whether there is enough evidence to provide an informed opinion on the organisation as a whole. For example, if evidence on document control for a small depot revealed an 'ad-hoc' level of achievement, is that sufficient to form an opinion on the document control system for thirty other, much larger depots?;
- **Quality of the evidence** - whether the evidence is based on a limited observation from one site or is consistent across a number of sites and;
- **Currency of the information** - when the evidence was initially gathered and whether there are likely to have been any significant changes since then.

Collating findings

When collating findings, assessors should critically review their evidence against the evidence factors and should look at identifying maturity levels, based on the modal average for each criteria.

Evidence collected during assessments and investigations should be compared against the descriptions of each level and a judgement made of the health and safety management capability of the organisation. This will enable the organisation to understand their strengths and target areas for improvement. Evidence could be grouped for a work section, a department, directorate, site, an organisation or a group of companies.

Organisations should never try to roll all maturity assessments together to arrive at an overall maturity level. The value of RM[3] is in the discussions to be had around the findings for each of the 26 criteria. Determining how the SMS works in practice is, in terms of risk management, generally more important, than how it appears on paper. The assessment should focus also on the day-to-day application of the SMS.

A method for collating organisational culture assessments is included in Criterion OC6, see page 41.

Using the RM^3 model, it is possible to identify the gap between the '**work as imagined**' of the written health and safety management system (SMS) and the '**work as done**' actions taken at the sharp end; the '**here** and **now**' of task performance.

This approach enables assessors to interpret information to:

- identify and address the progress of the organisation towards excellence in SMSs;
- identify what activities are in place to support the development of an excellent health and safety culture;
- identify deficiencies in management systems that may impact on issues wider than safety, such as efficiency and performance, especially in relation to asset management;
- provide a roadmap to forming an action plan to assist an organisation's progress towards excellence;
- build on the existing safety validation process;
- inform future regulatory activity within the rail industry, or with particular organisations; and
- provide assurance that system safety is being managed by all the interdependent organisations in the railway industry.

Key principles to remember when undertaking an assessment using RM^3 are that:

- Both health and safety are most effectively managed when they are integrated with other management activities and managed in the same way.
- Any unsafe act, unsafe condition, near miss or accident is a symptom of a possible failure of a part of the management system.
- SMSs should focus on making sure that the physical, managerial, procedural, behavioural and cultural and elements of the organisation are managed.
- The SMS should take account of, and be shaped by, the culture of the board and the organisation as a whole.
- There is no one right way to achieve excellence in H&S management in an organisation. However, there are some common characteristics that are seen in organisations that manage H&S risks well.

The Risk Management Model (RM^3) Criteria

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SP Health and safety policy, leadership and board governance

Purpose:

- To make sure that the organisation is effectively governed and led.
- To make sure that each policy clearly expresses the top-level management expectation, accurately defining what the organisation wants to achieve, how it will achieve it (through effective leadership) and how management will know when that expectation has been met.
- To make sure that the organisation (specifically the board) effectively challenges whether a policy and its associated activity is correct, in place and effective.

Introductory notes

The organisation's policies are forward-thinking and based on solid evidence of what it can achieve. Together with effective leadership, the policies promote a consistent approach to health and safety (H&S) at all levels of the organisation.

- Leaders of the organisation set and communicate a clear direction for the organisation that reinforces a consistent approach to H&S.
- Leaders at all levels of the organisation act in a consistent way to reinforce the values, ethics and culture needed to meet the organisation's objectives.
- The governance arrangements make sure that the organisation remains accountable for the H&S of its workers, passengers and members of the public affected by their work.

Poor leadership has caused many high-profile H&S failures. A failure to consider H&S risks when the board makes decisions can have catastrophic results.

An organisation's approach to H&S inevitably reflects the attitudes of those who make business decisions, and it leads the opinions and attitudes of the staff who work within the organisation.

The criteria in this section include:

- **SP1 - Leadership** from the top which provides consistent example and inspiration for leaders at all levels of the organisation;
- **SP2 - Health and safety policy** and arrangements that capture the top management view of how H&S contributes to business success and sets a framework for making balanced business decisions at all levels;
- **SP3 - Board governance** - effective at providing clear direction, leadership and oversight for H&S – setting 'the tone from the top' and;
- **SP4 - A written safety management system (SMS)** designed to control all H&S risks which arise as a consequence of the business activities.

SP 1   Leadership

Leadership from the top, provides a consistent example and inspiration for leaders at all levels of the organisation. Good leadership in health and safety (H&S) management involves:

- The attitudes and decisions of senior managers aligning with the H&S policy and culture;
- Identifying and promoting the styles of leadership and management practices at all levels, which best support a positive H&S culture;
- Promoting effective collaboration and engagement of all workers and business partners to achieve continuous improvement on H&S;
- Aligning the leaders in operational management, organisational functions and operational and support units in pursuit of the common H&S purpose, strategies and goals;
- Assessing H&S leadership and management behaviour to motivate and reward success, in improving the control of risk and;
- Adjusting the performance-management and reward systems, so they help the organisation achieve its goals and strategies for improving health, safety and performance.

Excellence

- Leaders at all levels of the organisation demonstrate shared values which strive towards continuous improvement.
- Leaders search within and outside the organisation for opportunities to improve risk control in their area of the organisation, to ensure it is as effective and efficient as possible.
- Leaders always consider how they influence others, recognising that good leadership is compelling, not coercive.
- They pro-actively promote a positive culture and encourage H&S improvements in all areas of organisation
- Leaders recognise that better H&S results are achieved through exercising power with, rather than control over, employees.

Culture
Leaders recognise they have an obligation to foster the kind of organisational climate where people find it easy to speak up and share when they have made mistakes rather than covering up errors.

- Leaders encourage people and enable them to join forces and to participate as responsible individuals in a collaborative institutional enterprise.
- Non-technical management skills development is recognised as world-class.
- Leadership demonstrates and reinforces the values and culture of the organisation and ensure these lead to engagement and empowerment across all levels.

Predictable

- Leadership activities are consistent with and reinforce the organisation's H&S policies.
- Leaders at all levels of the organisation are credible and open to ideas for improvement.
- Leaders take responsibility to ensure that the SMS achieves its intended outcome.
- Leaders inspire others within the organisation to work to deliver against the H&S vision of the organisation.

Culture
Leaders take responsibility for developing, leading and promoting a positive culture in the organisation that supports effective H&S risk management.

- Non-technical management skills are recognised and developed within the organisation.

Standardised	• The organisation is built around a command and control structure with some feedback. • There is a rule book-based approach to H&S management, this can result in unwavering adherence to standards with little innovation or flexibility. • Collaboration occurs as specified in 'the rules'.	**Culture** Leadership is still largely viewed as a senior management role. • Non-technical skills are specified and employees receive appropriate training.
Managed	• There may be managers with health and safety leadership skills, but these are not proactively developed by the organisation. • Managers demonstrate leadership skills, but these are not recognised by everyone or used consistently within the organisation. • The organisation's goals and priorities are not understood by all leaders in the organisation. • Some collaboration occurs, but often by chance rather than planned, and depends on the individuals involved rather than being systematic.	**Culture** Leadership is viewed solely as a senior management role. • There is no consistency over how non-technical management skills are developed in the organisation.
Ad-hoc	• There is no evidence of positive H&S leadership at any level in the organisation. • H&S leadership is not considered to be important in staff development. • No effective application of H&S leadership standards in the organisation. • Leaders do not collaborate internally or externally.	**Culture** Employees consider there is little effective leadership in H&S at any level of the organisation. • H&S leadership skills and other non-technical management skills are not recognised or developed within the organisation.

Guidance and further reading:
- INDG 277 'Leadership in the Major Hazard Industries': Health and Safety Executive (HSE)
- INDG 417 'Leading Health and Safety at Work': HSE

SP 2 — Health and safety policy

The health and safety (H&S) policy should capture what the top management view is of how H&S contributes to an organisation's success and sets a framework for making balanced business decisions at all levels.

The H&S policy and arrangements should:

- Represent the collective view of the 'controlling mind' of the board, following suitable discussion, challenge and agreement;
- Explain the business benefit of the policy in context of company purpose, activity, business model, vision, strategy and culture etc..;
- Explain the relative significance of H&S risks within the range of business risks and how important H&S is to the organisation;
- Explain how the necessary empowerment and collaboration in the 'entrepreneurial leadership' of the organisation is balanced with the 'prudent control' of H&S risk to avoid goal-conflict in the delegation of roles, responsibilities and accountabilities;
- How the hazard / risk profile of the business determines the amount of resource time and effort put into H&S and how a reasonably practicable (proportionate) approach informs:
  - How the board and management spend time and attention in directing and overseeing implementation of H&S policy and performance;
  - The scope and complexity of the SMS and risk assessments;
  - How the financial resourcing of H&S will form part of the business planning and budgetary control and matched to the hazard / risk profile;
  - Human resource policies (including values, recruitment, development, competence, motivation, leadership style, culture, continuous improvement, corporate memory, involvement and consultation) and;
  - Technical support functions and policies such as design, planning and asset management.

Excellence

- The H&S policy is used to challenge the organisation to achieve business performance that is in-line with the best-performing organisations.
- The H&S policy of the organisation includes a realised active commitment to collaborate throughout the management chain and with external parties to achieve the H&S policy objectives.
- The H&S policy forms part of the supplier accreditation process and the organisation ensures that all new suppliers meet the intent of the policy requirements.
- The H&S policy explains how the risk profile of the organisation determines the amount of resource time and effort put into H&S.

Culture
The H&S policy as implemented demonstrates that managing H&S risks is not a separate function but an integral part of a productive, competitive, profitable organisation, which strives for continual improvement.

- The H&S policy leads to a realised continual improvement of risk management.
- The H&S policy explains how H&S is integral to operational activity and the relevant responsibilities follow management hierarchies with H&S specialists acting as advisers and / or challengers.

Predictable

- The organisation recognises the importance of reviewing the policy, proactively with change.
- The H&S policy includes a commitment to consultation and participation of workers, and where they exist, worker representatives.
- All the organisations policies are:
  - Consistent with each other;
  - Reviewed and revised to drive improvements and;
  - Interpreted in the same way by all parts of the organisation that apply them.

Culture
The actions of everyone acting in the management chain are consistent with the H&S policy.

- The H&S policy includes a commitment to maintain or improve risk management standards, even through periods of change.
- The H&S policy forms part of the supplier accreditation process and the organisation ensures that all new suppliers meet the intent of the H&S policy requirements.

Standardised

- The H&S policy and any other associated policies, are used as a focus for managers, which results in them being consistently interpreted by all employees.
- Employees across the organisation are actively involved in reviewing and revising the H&S policy and how it is applied.
- The H&S policy and any other associated policies are used as a focus for managers, which results in them being implemented consistently throughout the organisation.

Culture
The H&S policy and any other associated policies are used as a focus for managers, which results in them being responded to in the same way by all employees.

- The H&S policy includes a commitment to eliminate hazards and reduce H&S risks relevant to the organisation.
- The H&S policy is relevant and appropriate, documented, communicated within the organisation and to interested parties as appropriate.

Managed

- The H&S policy is up-to-date and is communicated within the organisation, but local managers and supervisors have inconsistent approaches or interpretations. This results in the policy being applied in different ways across the organisation.
- The H&S policy has been formally consulted with senior trades union representatives in the organisation.
- The H&S policy is not consistently used to achieve successful risk management.

Culture
The purpose and content of the H&S policy is not understood or applied consistently by everyone in the organisation at all levels.

- The H&S policy includes a commitment to fulfil legal and other requirements.
- Some managers communicate policy on H&S to contractors etc., but there is no systematic approach.

Ad-hoc

- The H&S policy statement is out of date or has not been communicated within the organisation.
- There is no evidence of employees being consulted.
- The H&S policy statement is unrealistic for the risks of the organisation.
- No communication of H&S policy to outside parties, even close collaborators.

Culture
Employees are not aware of the H&S policy or why it is relevant.

SP 3   Board governance

An effective board provides clear direction, leadership and oversight for health and safety (H&S) – 'the tone from the top'. From a H&S perspective, this involves:

- Setting direction by defining H&S policies, vision, strategies, goals, values and culture which are aligned with the organisation's purpose and strategic direction;
- Defining the arrangements to manage risk and ensure H&S risks are considered when identifying the organisation's business risks;
- Ensuring appropriate resources for controlling H&S risk are provided;
- Leading by example to promote a leadership style which supports an appropriate culture for H&S;
- Delegating to management through organisational structures and a health and safety management system (SMS) which promotes collaboration and engagement with employees and other business partners;
- Developing human resource policies and reward systems which align with H&S objectives, minimising conflict with other business goals and explaining how conflicts should be resolved;
- Defining measures of the organisation's business goals, and performance measures for the activities to achieve the business goals;
- Providing oversight and challenge to guide management in learning how to pursue improved control of H&S risk and improve the effectiveness of the SMS and:
- The board reviewing their approach and effectiveness of the direction, leadership and the oversight they provide for H&S.

Excellence

- All members of the board show a commitment to identifying areas for improvement and effectively encourage continuous improvement in risk management through collaboration and innovation, including providing necessary resources.
- Board members are ready, able and encouraged to test strategies put forward to reduce exposure to risk from whatever source.
- The organisation actively measures its activities against recognised good practice in H&S risk management and corporate governance.
- The board carries out a formal and extensive evaluation of its own performance against H&S objectives. This process takes account of the context, complexity and hazard / risk profile of the organisation in question, including procedures which safeguard effective decision-making.

Culture
The board promotes a culture of continuous improvement, challenging the executive function to improve, supporting that with examples of good practice from outside the organisation that have the capability to be implemented in a way that adds value to the business.

- The board are prepared to endorse excellence from within the organisation by sharing examples and experiences and to learn from other organisations / industries.
- The board secures effective engagement with its work force and other stakeholders.

Predictable	• H&S risk is recognised as an essential part of the overall risk to the organisation. • The corporate risk register is updated following changes to organisational structure, risk profile or new operations added to undertakings. • Where appointed, non-executive directors (NEDs) have a strong and independent role in challenging H&S issues.	**Culture** The board seeks balanced indicators of safety assurance and has mechanisms in place to demonstrate the integrity of the organisation's assurance regime. The board demonstrates a systematic approach to understanding risk and sets clear tolerances and expectations. • The board provides regular updates to stakeholders, including information following changes within the organisation.
Standardised	• The board and executive show a clear, wide-ranging understanding of the organisation as a system, including H&S management. • H&S has a champion on the board with H&S training. • The corporate risk register is complete and maintained, so the board is able to use it to direct strategy and define the organisational risk appetite. • The board is aware of and complies with the UK Corporate Governance Code.	**Culture** The role of the board and the executive in managing H&S is understood. A clear expectation of risk tolerance is communicated. • The board ensures that stakeholders receive sufficient and relevant information to allow them to challenge the board on H&S issues as appropriate and makes provision for such challenge.
Managed	• The board considers H&S risk management, but not in a consistent manner. • H&S performance is considered at board meetings, but there is no systematic review of risk management performance. • A corporate risk register is in place and this covers the H&S risk within the organisation, but lacks sufficient detail for the organisation to be able to sufficiently direct strategy in a way that maximises safety.	**Culture** Some, but not all parts of the organisation believe that the board are interested in H&S. • If requested, the board communicates on H&S matters to stakeholders, but does not welcome challenge.
Ad-hoc	• The board shows little or no consideration of H&S issues. • Board meetings do not include reviews of H&S performance measures. • The corporate risk register does not cover H&S issues. • The board are focused to prevent reputation damage from litigation.	**Culture** Throughout the organisation, individuals do not believe the board and executive are interested in H&S. • There is no communication from the board to stakeholders regarding H&S.

Guidance and further reading:

- Leading Health and Safety on Britains Railway
- Baker Report into the Texas City explosion
- Haddon-Cave Nimrod Review
- UK Corporate Governance Code
- The UK Government report into the collapse of Carillion
- The Aircraft accident report 1/2017 Hawker Hunter T7 G/BXFI on 22 August 2015

SP 4 — Written health & safety management system (SMS)

A written health and safety management system (SMS) is designed to control all health and safety (H&S) risks which arise as a consequence of the organisation's activities.

The SMS should:

- Set out the arrangements for the control of H&S risk describing the Roles, Responsibilities, Authorities and Accountabilities, (R2A2) of those at all levels of the organisation and how these are integrated into business operation;
- Identify:
  - Those who 'own' H&S risks in each part of the organisation, (individuals or business functions) and implement risk controls;
  - The process owners responsible for creating and maintaining systems of risk control;
  - The contribution of H&S and professional advisers to decision-making; and
  - Those who provide audit (internal or external) of the SMS;
- Identify proportionate and appropriate hazard identification, risk assessment methods, and the design of risk controls which:
  - Consider personnel as well as process / system risks;
  - Are based on the reality of the way work is done and engage employees, volunteers and / or their representatives;
  - Recognise the impact of ageing assets;
  - Recognise the impact of interfaces and shared risk and involve business partners;
  - Apply human factors knowledge about behaviour and consider both H&S risks; and
  - Consider both the risks of performing work and the impact of work on other risk controls;
- Identify the mechanisms for engaging all employees at all levels, in learning from experience.

Excellence

- The SMS demonstrates how the organisation will identify opportunities to improve, not only against its own targets but against other organisations' targets which have been identified as being excellent.
- The SMS clearly demonstrates how the organisation is kept aware of good practice in the rail and other industries, so that continuous improvement can be maintained.
- The SMS is adaptable and responsive to change, to accommodate emerging issues / risks and reasonably foreseeable developments in legislation, technology, social, environmental and political influences, whilst maintaining assurance.

Culture
The SMS demonstrates a commitment to measuring and improving organisational culture.

- The SMS is an integral part of the organisation's overall management system.
- Stakeholders are consulted on and informed of best practice, to continually improve collaborative relationships and shared risk reduction.

Predictable	• The SMS presents a clear approach to managing health and safety. It shows how the organisation proactively controls risk, through continual improvement of its internal arrangements, including through periods of change. • Everyone in the organisation can explain their role or how they might be involved in the SMS and know where to find things. • Standards are reviewed to ensure that the SMS uses and delivers the up-to-date standards. • The SMS is proportionate to the organisation's hazard / risk profile and features appropriate risk assessment methods.	**Culture** There is a collaborative approach across the organisation in implementation and reviews of the SMS. • The SMS remains accurate and the relevant parts subject to change, through a formal change management system as and when necessary. • Stakeholders are regularly informed of any changes to the SMS.
Standardised	• The SMS meets the elements laid down in relevant standards and regulations. • Each document contained within the SMS has its own author / owner and it is approved and authorised as being fit for its intended purpose. • The SMS reflects clearly the systems in place to manage risk effectively. • The SMS clearly indicates the standards on which it is based and those it is intended to achieve.	**Culture** There is a clear understanding at all levels and across the organisation of how the SMS sets out to control risks and to what standard. • The SMS is communicated to stakeholders.
Managed	• The SMS presents a systematic approach to controlling risk, with appropriate checks and balances, and all aspects of health and safety are considered. It reflects the PLAN-DO-CHECK- ACT model. • There is a process in place within the organisation to produce and maintain a legally compliant SMS, but once produced, the SMS is not consistently applied in all parts of the organisation. • Both H&S receive proportionate consideration in the SMS to the levels of risk they present.	**Culture** SMS is understood by most employees as an important part of how risk is managed. • There is inconsistent application of standards in the implementation of the SMS. • The SMS is communicated internally and to regulators, but not to collaborators and those with shared risks.
Ad-hoc	• There is no written SMS, or if there is one it is poor and does not reflect the business activities, operations and risks. • The SMS is based on a template or copied from another organisation. It does not reflect the business's activities, operations and risks. • The SMS does not address all the H&S risks within the organisation e.g. occupational health.	**Culture** The SMS is seen as unimportant and poorly understood. • It is not clear what standards the organisation is using. • Employees who should be aware and involved in the SMS are not.

RSSB products relevant to
health and safety policy, leadership and board governance:

- **Leading Health and Safety on Britain's Railway (LHSBR):** Looks at 12 priority risk areas, a framework for the collaborative improvement of health and safety risk.
- **LHSBR Quarterly Monitoring Report:** a summary of implementation actions in the LHSBR priority areas.
- **Measuring Safety Performance Guidance**: to help you identify the best safety performance indicators to monitor for your key risks.
- **Safety Assurance Guidance:** for Heads of Safety, explains how to meet the requirements of CSM monitoring and improve the implementation of your safety management system.
- **Safety Management System Principles – Moving Beyond Compliance**: for those who want to take their existing safety management systems beyond minimum legal requirements.
- **Safety Culture Toolkit:** one-stop-shop for safety culture assessment, improvement and good practice exchange.

RSSB Disclaimer and Intellectual Property Statement

OC | Organising for control and communication

Purpose
- To set out responsibilities for meeting the organisations health and safety (H&S) objectives.
- To make sure that important information is available to those making decisions.
- The organisation's arrangements and actions promote a culture that makes excellence in risk control possible.
- Organisations have controls in place so that risks are identified and adequately controlled.

Introductory notes
H&S policies set the direction for H&S, but organisations need to create a strong framework for management activities, setting out the roles, responsibilities, authorities and accountabilities that will improve performance. Two important issues are **control** and **communication**.

Control is the foundation of a positive health and safety culture.
- Maintaining control is central to all management functions. Control of H&S is achieved by allocating and carrying out responsibilities which relate to H&S objectives.
- Organisations rely on the empowerment and engagement of employees and the organisation has to balance giving the necessary freedom and flexibility with the need for good control of risk. The boundaries of discretion need to be clearly drawn – it should be clear when strict adherence to health and safety procedures is essential. In many cases learning from trial and error and experience is too costly for those involved.
- H&S and employee representatives make an important contribution. Employees / volunteers should be focused on developing and maintaining systems of control before events happen – not on blaming people for failures after events.

Communication is often a challenge to organisations.
- It is important that the messages which senior managers want people to understand are the ones the people actually hear.
- Effective, proactive and reactive communication about H&S relies on accurate and clear information coming into the organisation, flowing within it, and going out from it.

Organising for Control and Communication ensures:
- **OC1 Allocation of responsibilities** - the organisation is structured to put the organisation's policies, strategies and plans into practice as efficiently as possible, as part of its operation.
- **OC2 Management and supervisory accountability** - those with H&S responsibilities are motivated and held accountable for performance, in-line with systems and methods used for other parts of the organisation.
- **OC3 Organisational structure** - organisational structures facilitate flexibility and collaborative working.
- **OC4 Internal communication arrangements** - communication throughout the organisation is sufficient and suitable to ensure those making decisions which impact on H&S are appropriately informed with up-to-date relevant information.
- **OC5 System safety and interface arrangements** - there is effective collaboration on H&S risk across system and organisational boundaries.
- **OC6 Organisational culture** - the significant ways of thinking and doing which underpin a positive H&S culture suited to the organisation, are identified and applied.
- **OC7 Record keeping, document control and knowledge management-** suitable information is collected, stored and is readily retrievable, to support H&S decision-making and, effective and reliable control of risk at all levels.

OC 1   Allocation of responsibilities

The organisation is structured to implement it's policies, strategies and plans into practice as efficiently as possible, as part of its operation.

This means:
- Clear delegation of roles, responsibilities, authorities and accountabilities for health and safety (H&S) are aligned and integrated into the operation of the organisation;
- The roles of risk owners and advisers are clear;
- Allocating people and teams roles, tasks and objectives which secure effective collaboration in meeting the organisation's H&S objectives;
- The potential for conflict between H&S and other business objectives is acknowledged and minimised and there is a process for resolving conflicts and;
- Having the right people, doing the right thing, at the right time.

Excellence

- The organisation looks externally for factors which offer opportunities for continuous improvement of risk control and allocates roles and responsibilities to support this.
- Individuals at all levels across the organisation take responsibility to seek improvement in risk control from within and outside the organisation.
- Individuals with H&S roles and responsibilities routinely look at how they might develop themselves and processes to continuously improve risk control.

Culture
Employees seek to improve organisational performance by taking on additional tasks and responsibilities especially those relating to H&S.

- Roles and responsibilities are reviewed to ensure they remain in-line with standards in recognised high performing organisations.
- Individuals from collaborating organisations recognise and undertake roles and responsibilities allocated during collaborative activities.

Predictable

- Responsibilities are systematically identified with clear links between the organisation's objectives and individual's responsibility, and are adaptable to changes in circumstances.
- H&S activities and decision-making activities are given to the people who are best placed to carry them out.
- Individuals involved in commercial and other decision-making roles know what is expected of them, in relation to their H&S responsibilities and demonstrate they contribute to effective risk control.

Culture
There is a culture of employees at all levels taking responsibility for H&S within a strong management framework.

- H&S responsibilities are allocated with the same consideration as other business responsibilities. This makes sure that the right resources are available and used.
- The responsibilities allocated include those for ensuring risk control in collaborative situations.

Standardised	• Responsibilities are systematically identified and given in writing to teams or individuals, who accept them in order to meet H&S objectives. • Senior management ensure that the responsibilities set out in the H&S management system (SMS) are assigned and communicated at all levels within the organisation and maintained as documented information. • Operational staff at each level across the organisation assume responsibility for those aspects of the SMS over which they have control.	**Culture** Employees at all levels know what is expected of them in relation to their H&S responsibilities with a belief that the right people are doing the right thing at the right time. • Responsibilities and authorities are assigned for ensuring that the SMS conforms to relevant standards and reporting on the performance of the SMS to senior management. • The system for setting performance standards is integrated into the contractor management system.
Managed	• H&S roles are allocated mainly to those dedicated to H&S functions, e.g. H&S team or individuals who control site safety. • H&S responsibilities appear in job descriptions or objectives, though not consistently. • There is no overall policy on, or evidence of, responsibility being allocated in a consistent and systematic way. • Inconsistent application of performance standards in the organisation.	**Culture** Employees recognise when performance standards exist and use them if available. Most employees, but not all, know what is expected of them in relation to their H&S responsibilities. • Some performance standards exist for collaborative situations, but no consistency in their application.
Ad-hoc	• H&S roles, tasks and objectives are not defined. • Responsibilities relating to H&S are not allocated to individuals and teams. • There is no process for identifying performance standards relating to H&S responsibilities, so no standards are identified or applied. • Areas of collaboration are not identified.	**Culture** Employees do what is necessary to get the job done, if it is done safely then all the better.

OC 2   Management and supervisory accountability

Those with responsibilities for health and safety (H&S) are motivated and held accountable for performance in-line with systems and methods used for other parts of the business.

All those with roles, responsibilities, authorities and accountabilities, tasks and objectives relating to H&S are:

- Motivated and rewarded in-line with the organisation's reward systems with an emphasis on positive rewards for good work in risk control and;
- Held accountable for meeting those expectations.

Adequate supervision is provided. Spans of control and supervisory ratios are appropriate and realistic, taking into account the nature of the work, the dispersion of staff and human factors considerations.

Excellence

- The organisation actively shares best practice whilst learning and implementing improvements from wider industry groups.
- The processes allow the organisation to actively participate in sharing good management practice from other industry groups.
- The organisation proactively takes ownership to influence improvements to H&S risk control.
- Good supervision and effective supervisory roles are embedded within the organisation's corporate structure and operational delivery.

Culture
The organisation understands the wider-industry culture and takes active participation to improve H&S risk control.

- The organisation uses the mechanisms in place to instigate change and have the confidence to use them.
- The organisation seeks out wider opportunities across the sector's key stakeholders and beyond, to learn from and share best practice with other industries.

Predictable

- Individuals can adapt and manage change in accountability to influence improvements in standards and risk management.
- The processes provide individuals with the confidence to challenge organisational norms and proactively and independently seek out improvements to the risk management systems.
- Managers and supervisors fully understand how taking accountability lends itself to risk reduction methodology.
- Individuals pro-actively take ownership to influence improvements to H&S risk control.

Culture
Individuals recognise the risks and are proactive in informing others and forming groups that support a culture of risk minimisation.

- The individuals understand the mechanisms in place to instigate change and have the confidence to use them.
- Individuals actively seek additional roles and accountabilities to achieve the organisation's strategic risk management aims.
- Changes in supervisory arrangements and accountabilities are planned as part of any change.

Standardised	• Teams and individuals responsible for controlling significant risks, know and understand their responsibilities and apply them in the correct manner. • There are processes in place to allow managers to manage appraisal systems to reward and correct behaviours and outcomes, but also to make sure there are no unintended consequences of these appraisals. • Individuals are clear on their roles and responsibilities and effectively deploy and actively engage to improve H&S risk controls. • There are effective procedures and processes in place for all significant risks.	**Culture** There is recognition and acceptance between individuals in the organisation over roles and responsibilities and mutual involvement to achieve business objectives. • Collaboration is effective and individuals are given and accept additional responsibilities. • Supervision and supervisory roles are adequate. • Supervisory arrangements are proportionate and adaptable to control risks associated with those new to a job, learning new processes, carrying out infrequent high risk work and remote / lone working.
Managed	• Some managers and supervisors hold their employees accountable, but there is no consistency of application. • Some processes for controlling responsibilities exist, through procedures or performance reviews, but not for all significant risks. • Individuals are unclear on some roles and responsibilities relating to control of H&S risks. • There are some procedures and processes in place, but not for all significant risks.	**Culture** Individuals know their responsibilities, but there is no consistent evidence of ownership across the organisation. • There is some definition of collaborative arrangements, but with minimal impact on collaboration.
Ad-hoc	• Managers and supervisors rarely, if ever, hold their employees to account for their H&S duties. • There is inconsistency between accountability for H&S and accountability for other business activities. • Individuals are unclear on their roles and responsibilities relating to control of H&S risks. • There is a lack of procedures and processes to ensure accountability for H&S. (e.g. in job descriptions).	**Culture** There is a culture of non-acceptance and lack of understanding of responsibilities. • Supervision and supervisory roles are not clearly defined or consistently applied. • Collaboration arrangements are undefined and there is no proactive inclusion of employees involved (a failure of organisational structure).

OC 3 Organisational Structure

Disaggregated organisations, such as railway and tram companies, are complex operations requiring flexible and collaborative working, both within the organisation and through interfaces with other business partners.

The clarity of roles for health and safety (H&S) between front-line operations, support staff and technical experts, needs careful thought, to ensure that H&S roles, responsibilities, authorities and accountabilities, fit sensibly into management structures and to ensure there are no gaps in responsibilities. Layers of management structure complicate reporting lines and accountabilities.

Maintaining an effective organisation structure is a continual challenge, as operational conditions and demands change.

Excellence

- The organisational structure is designed to be flexible to respond to internal and external changes, whilst still delivering H&S objectives and continual improvement.
- The board and senior managers look to learn from the structure of other organisations, who are effectively managing H&S, and identify improvements for their own organisation.
- The organisational structure evolves to continuously improve performance in risk management.

Culture
Individuals believe that the organisational structure is evolving to drive continuous improvement in risk management.

- The organisation actively seeks new or improved standards to drive continuous improvement.
- Pre and post-collaborative project reviews are carried out, to learn and drive continuous improvement.

Predictable

- The organisational structure is designed in-line with the H&S policy and objectives.
- Responsibilities for risk control are allocated from the top to the bottom of the organisation, not just at working levels.
- There is systematic alignment of the H&S policy and objectives with organisational structure.
- The organisation remains structured to deliver objectives stated in H&S policies and procedures, even after changes to structure or operations are undertaken by the organisation.

Culture
Individuals believe that structures are sufficiently flexible to ensure effective risk management even in periods of change.

- Organisational structures are sufficiently flexible to continue to effect risk management during periods of change.
- Organisational structures for collaborative projects are sufficiently flexible to continue to effect risk management during periods of change.

Standardised	• The structure of the organisation means that all of the H&S risks are managed by the people or teams carrying out the work, and there is effective control of risks, which are shared between teams. • Responsibility for risk control systems is in-line with responsibility for other business objectives. This provides clarity and consistency between similar activities and business units. • Standards are identified and used to ensure that organisational structures are best able to deliver effective risk management.	**Culture** Individuals believe that the organisation's structure is planned to achieve effective risk management. • Overall policies and strategies are consistent with those of the relevant business units. • There is a systematic approach used to implement collaborative management structures, well-suited to deliver effective risk management.
Managed	• The structure of the organisation means that most risks are managed by the people or teams carrying out the work, but some risks are shared between teams, so that responsibilities could still be confused, missed or duplicated. • There is little consistency between the activities of a business unit and the wider aims of a strategy or policy. • Some collaborative ventures have management structures developed to allow effective risk management, but no systematic approach.	**Culture** Some individuals understand the link between structure and effective risk management but there is no system in place to ensure it happens. • There is conflict between H&S and other objectives. • There is inconsistent use of standards.
Ad-hoc	• The organisation's management structure is not aligned with its H&S objectives. Employee responsibilities and accountabilities are easily confused, missed or duplicated. • The organisational structure is not linked to the SMS or risk management systems. Organisational structure is as it is for historical reasons, rather than being tailored to needs. • The objectives of the SMS are not achieved, because key roles are not in place.	**Culture** There is little or no understanding of the need for organisational structures to enable effective risk management. • There is ineffective use of any standards. • The structure of departments involved in collaboration are not considered in terms of risk management.

OC 4   Internal communication arrangements

Communication throughout the organisation is sufficient and suitable to ensure those making decisions, which impact on health and safety (H&S), are appropriately informed with up-to-date relevant information. Arrangements make sure that all those making a decision or performing a task, which impact on H&S, have the right information, in the right form and by the right method, including things such as:

- Corporate messages;
- Procedures and standards;
- Factual data, (plans, diagrams, records) and intelligence; and
- Instructions and reports.

Excellence

- Employees are able to communicate any concerns and issues or identify improvements to information, instructions, standards and procedures. This is acted upon by managers and feedback is given promptly.
- The organisation looks at how other organisations communicate H&S information and implements best practice.
- There is active pursuit of continuous improvement in communication within the organisation.

Culture
There is a culture throughout the organisation of open communication which is effective and supports continuous improvement.

- There are active attempts to continuously improve the two-way exchange of risk management information with collaborators.
- Effective risk management is based on the provision of adequate information.

Predictable

- Users are involved in regular reviews of information, instructions, standards and procedures to ensure they remain current and relevant.
- The right information is available to support the making of correct decisions.
- Effective procedures for gathering feedback, ensure that communications are understood and there is effective two-way communication.

Culture
There is a culture of employees reporting their performance / experiences and these are routinely acted on by the organisation.

- Communication of changes to task instructions, systems of work etc.. with collaborators (including contractors and suppliers) is an integral part of ensuring successful change.

Standardised	• Information, instructions, standards and procedures for controlling significant risks are in formats optimised for users. The information is readily available. • Employees routinely look towards the relevant instructions and procedures before performing tasks or making decisions and understand the reasons why the information should be followed. • Managers give instructions which reinforce H&S procedures.	**Culture** Factual information is used to share experiences and guide future performance and decisions among the various levels and functions of the organisation. For example through safety bulletins.
Managed	• Some procedures and standards relating to risk controls are available to staff. • Most employees recognise importance, of instructions, standards and procedures and use these to make decisions or guide them in performing a task. • Managers give instructions and receive reports relating to controlling risks, but there is a lack of consistency. • Some information is used to guide decisions.	**Culture** Decisions are made on the basis of what information is available, even if this is incomplete. • Some information is shared, but this is inconsistent and depends on individuals, rather than a systematic approach.
Ad-hoc	• Employees making decisions or performing tasks make little or no attempt to find relevant procedures. • There is no formalised system to ensure knowledge is imparted to those who need to use it. • Managers do not talk to employees, or talk ineffectively, so that the right risk control actions are not followed. Employees are not alerted to the presence of new or changed procedures.	**Culture** There is a culture of employees making decisions on their own judgement without reference to documents or other personnel. • No intelligence is collected or shared to demonstrate the effectiveness of the risk control information. • Little or no information is shared as part of collaborative enterprises.

OC 5   System safety and interface arrangements

There is effective collaboration on health and safety (H&S) risk control across system and organisational boundaries. Risk Management (PI1) deals with the identification of interfaces and the associated risk controls.

Effective teamwork and co-operation are needed to implement these controls and make sure systems across the organisation and between organisations are safe.

Organisations need to collaborate to agree a common understanding of interface / shared hazards and risks and the development, and the implementation of compatible means of risk control, in pursuit of common goals and priorities.

Safety management system methods and requirements are aligned to facilitate common working.

Excellence

- The organisation looks to other sectors and countries to identify system-safety issues and controls and there is evidence that this has led to continuous improvement.
- The procedures and standards drive the organisation to strive for continuous improvement and look for best practice from other industries in the UK and internationally.
- Best practice is drawn from, implemented and shared with other organisations in the UK and internationally.
- There are arrangements for sharing information between organisations with shared H&S risks, in order to promote effective reviews and continual improvement.

Culture
There is a culture that people are empowered and encouraged to understand and share information beyond their own organisation to continually improve the control of shared, common and emerging risks.

Predictable

- There is effective use of industry knowledge and collaboration across direct and indirect interfaces leading to clear understanding and control of shared and common risks.
- The procedures and standards are effective and consistently used to control both shared and common risks, including emerging risks.
- There are regular discussions with other organisations to agree objectives, standards, processes and arrangements.

Culture
There is an organisational culture which enables proactive management of emerging risks across direct and indirect interfaces.

- All system safety interface risks are reviewed within specified timescales. These reviews ensure awareness is given to changes at any level.

Standardised	• Organisational arrangements are in place to ensure direct interfaces are identified and there is effective collaboration and implementation of shared risk controls. • Procedures and standards are in place and consistently used to control shared risks. • Communications outside the organisation make sure that anyone making a decision relating to risk controls with cross-organisational boundaries is in possession of the right information in the form of procedures and standards, factual data and intelligence, and instructions and reports.	**Culture** There is an organisational culture which enables effective understanding, sharing and risk control across direct interfaces. • Organisational oversight results in the procedures and standards for shared risks being owned, reviewed and effectively implemented.
Managed	• Procedures identify interfaces between business units at a working level. There is liaison with other organisations over procedures and standards implemented. • Procedures are used by employees for some shared risk controls. • There is co-ordination of practical issues at working level between individuals of organisations, but there is no overall organisational oversight, resulting in inconsistent planning and execution.	**Culture** There is a culture of sharing information generally only at working levels. • There is a culture of sharing information generally only at working levels.
Ad-hoc	• The organisation makes little attempt to identify or collaborate on work with other organisations in respect of shared risk controls. • Procedures to identify and manage shared risk control do not exist or are weak. • No information is collected or shared.	**Culture** People work in isolation with little understanding or concern of how their activities may influence and affect others.

The significant ways of thinking and doing, which underpin a positive health and safety (H&S) culture suited to the organisation, are identified and applied.

Culture is a lever, which can assist the board and senior managers to improve company and safety performance. Setting out a culture strategy for H&S as part of a health and safety management system (SMS) is a necessity for excellence.

Culture consists of the shared of ways of thinking and doing in respect of the most significant risks of the organisation, which underpin the approach to devising and implementing the SMS.

Current thinking suggests there are 'seven attributes of an integrated H&S culture', these are shown opposite.

Different positive cultural characteristics may be more relevant to some parts of the business. For example, a just and fair reporting culture, may be more pertinent to enhance learning in front-line work, whereas a process safety culture of doubt, and a challenge culture of questioning, may be more relevant to those in engineering functions concerned with the high hazard systemic risks of the infrastructure.

Testing organisational culture and RM^3

There are different ways of finding out about an organisation's H&S culture:

1. By routinely gathering informal information about the H&S culture during monitoring, inspections, investigations and other dealings with employees / volunteers, interfacing organisations and the supply chain. For instance, workers on site during a routine preventive inspection may comment that performance pressures sometimes take priority over risk controls. In this case, as well as investigating the allegation, the background should be recorded to build-up a picture of the organisation's H&S culture.

2. Organisations can conduct H&S culture or safety climate assessments, using techniques and toolkits, such as the RSSB's Safety Culture toolkit. These assessments can provide useful information on the current safety culture, and provide information and views about leadership, communications, learning culture, employee involvement and attitudes to blame.

3. RM^3 is not intended to be a substitute for other safety culture assessment tools, but in this version there are highlighted 'culture call-outs' against every level of maturity in all criteria. Assessors using these 'call-outs" will see elements of the 'seven attributes' throughout the RM^3 criteria. The 'call-outs' suggest typical actions, beliefs and behaviours held by employees, at all levels, suggesting the culture of the organisation.

An explanation of how to collate and use the culture indications from the 'call-outs' is provided on pages 40 and 41.

Seven attributes of an integrated health and safety culture[1]

- **Shared awareness of the most significant risks**, anticipate risks beyond what the most frequent accidents reveal:
  - Indicators other than incident rate;
  - Explain the content of the safety case / certificate and;
  - Fight against fatalism.

- **Questioning attitude**, share the conviction that risks are never fully controlled:
  - Culture of doubt;
  - Culture of sensitivity to operations;
  - Shared vigilance;
  - Search for the root causes of events and;
  - Learning culture.

- **Integrated culture everyone is mobilised**, acknowledging that no single person has all the knowledge necessary to ensure safety:
  - Senior management, managers, employees / volunteers;
  - Support departments;
  - Interface management;
  - Employee representative bodies and;
  - Contractor companies.

- **Right balance between rule-based and managed safety**, anticipate as best as possible and deal with the unexpected:
  - Preparation for crises and unexpected events;
  - Developing resilience and;
  - Flexible culture.

- **Constant attention to the three pillars:**
  - Human and organisation factors;
  - Health and safety management system; and
  - Technical safety.

- **Management leadership and employee involvement**, encourage safe compliance and proactiveness:
  - Importance given to safety decision-making;
  - Participative directive leadership;
  - Dialogue;
  - Role of work groups and;
  - Debates between professionals.

- **Culture of transparency,** anticipate as best as possible and deal with the unexpected:
  - Just culture;
  - Information flow;
  - Consistency between words and actions and;
  - Truthful external communication.

1 'Attributes to an integrated safety culture' model from 'The essentials of safety culture'; ICS 2017

How to use the culture 'call-outs':

For each criteria maturity-level there is a culture 'call-out- box' this identifies the typical values, and behaviours associated with the maturity level.

For all criteria except OC6.

- Use the culture 'call-out', in the same way as the other bullets, to determine a maturity level for the criteria. Apply the same evidence factors of **Quality, Quantity, Currency** and **Consistency**.

- The culture maturity level may be different to the assessed level you determine (which should be based on the modal average). If the culture maturity level is the same or higher than your assessed level, this will probably mean that there is an understanding, commitment and willingness, which will support continuous improvement. Where the culture level is lower, than the assessed level you determine, progression to higher levels of maturity may be more challenging.

For this criterion, OC6.

- You could use the template opposite to capture an indicated level of maturity for your organisations culture. This is available on our website at orr.gov.uk.

- The template includes other commonly used maturity level descriptors, as well as the familiar descriptors used throughout RM[3].

Organisation Name:				Fenrail Limited			
Team/Area/Division assessed:				Whole Organisation			
RM³ assessment by:				Alison Jones		Date:	23/11/18
		SP	OC	OP	PI & RCS	MRA	Row totals
Excellence	Continually improving						
Predictable	Cooperating	SP1 SP4			PI1 RCS4 RCS5	MRA5	6
Standardised	Involving	SP2 SP3	OC3 OC4	OP2	PI2 RCS1 RCS2	MRA3 MRA4	10
Managed	Managing		OC1 OC2 OC5	OP1	RCS3	MRA1 MRA2	7
Ad-hoc	Emerging				PI3		1
Not assessed			OC7				1
Organisational culture maturity indicated level			Standardardised/Involving				

Figure 6 Organisational culture template

OC 7 Record-keeping, document control and knowledge management

Suitable information is collected, stored and is readily retrievable to support health and safety (H&S) decision-making and effective and reliable control of risk at all levels.

Preserving 'corporate memory' on H&S within the health and safety management system (SMS) is essential for learning and continuous improvement. Learning what does and does not work, is the basis of repeating good performance and avoiding repeating mistakes.

This includes information, such as:

- Records of assets, design parameters and calculations, diagrams and drawings;
- Processes and procedures;
- Hazard studies and risk assessments;
- Progress with strategies and plans, monitoring, audit and review; and
- Records of important decisions.

The SMS needs to identify key information and processes for updating the information and storage and retrieval systems, to enable ready access by those who need to know, so they can make informed decisions.

Knowledge management processes capture the experience and learning of those who are leaving the organisation.

Excellence	- Records, decisions and information from outside the industry are available to users and decision-makers who use them to continuously improve risk controls. - Records and documents are comprehensive in scope and include all relevant features to assist in managing H&S risks, or they are readily available from third-parties through transparent communication. - The procedures and standards facilitate learning lessons and sharing information beyond the industry enabling continuous improvement.	**Culture** The importance of maintaining and growing corporate knowledge to deliver continuous improvement is embedded in all levels of the organisation's culture. - Records are effectively used to drive continuous improvement in risk control.
Predictable	- Comprehensive records, including shared industry records, of risk-related processes and standards, decisions and information are available to users and decision-makers, who use them effectively to develop and review risk controls. - The organisation's records and decision-making are shared with industry and the organisation uses industry data in its own decision-making and reviews, and this is effective in developing cross-industry best practice.	**Culture** There is a culture of making decisions based on corporate knowledge. - All records have periods of retention assigned to them. - Systems are in place for capturing and retaining corporate knowledge.

Standardised

- Records of risk-related processes and standards, decisions and information are readily available and utilised consistently by decision-makers.
- The procedures and standards look beyond internal records to support and draw on shared industry knowledge in decision-making.
- The organisation's records and decision making are shared with industry and the organisation uses industry data in its own decision-making and reviews, and this is effective in developing cross-industry best practice.
- Documented information contains appropriate identification and description, format, status, review and approval.

Culture
All employees understand why corporate knowledge is important and work with the organisational processes to develop and maintain it.

- Record keeping includes sharing relevant records during collaborative working.
- Records are kept of important information and decisions that are likely to be valuable in the future.

Managed

- There are some records of information on important risk controls, but the records are inconsistent and not used effectively by decision-makers.
- Procedures are used for managing some record keeping, document control and knowledge management, but are inconsistent in use across the organisation.
- There are records of processes and standards for main risks which are used to inform decisions, but are used inconsistently across the organisation.
- Records are created, maintained and updated by appropriate competent individuals.

Culture
There are pockets of information retention by individuals or parts of the organisation, but the importance of developing and retaining corporate knowledge is not widely understood or valued.

Ad-hoc

- There are few or no written records.
- Procedures to identify and manage record keeping, document and knowledge management do not exist or are weak.
- Any decisions made are frequently only based on an individual's knowledge.
- The organisation is unable to use records to demonstrate that risk management was considered in decision-making.
- There is no sharing of information on decision-making.

Culture
There is no evidence of corporate knowledge, only individual's memory.

RSSB products relevant to organising for control and communication:

- **Safety Culture Toolkit:** one-stop-shop for safety culture assessment, improvement and good practice exchange.
- **Annual Safety Performance Report:** a review of safety trends for passengers, workforce and the public.
- **LHSBR Quarterly Monitoring Report:** a summary of implementation actions in the LHSBR priority areas.
- **RED programme:** a series of briefing tools on a range of safety issues for the workforce. Some include dramatic reconstructions of incidents.
- **Right Track:** a newspaper for front line rail industry workers with news and guidance on safety issues. Published three times a year.

OC

OP   Securing co-operation, competence and development of employees at all levels

Purpose

- To find out whether the organisation has employees (including volunteers) with the competencies (knowledge, skills, experience and abilities) needed to perform effectively, efficiently and safely.
- To see if the organisation's recruitment, selection, training and development policies focus, as far as possible, on meeting the organisation's health and safety (H&S) objectives.
- To prove how much the organisation consults its employees at all levels to make sure that knowledge and experience are shared, and H&S becomes 'everybody's business'.

Introductory notes

Employee (including volunteer) involvement and engagement supports risk control by:

- Drawing on their experience and learning so that the health and safety management system (SMS), risk assessments and risk controls are practical and reality-based and;
- Encouraging 'ownership' of H&S policies and procedures.

It makes sure the organisation as a whole, and people working in it, benefit from good H&S performance. Sharing knowledge and experience means that H&S becomes 'everybody's business'.

Organisations need an effective system for managing competence to help make sure that their employees and volunteers have the appropriate skills. Making sure that workers, supervisors, managers and directors have and keep, the appropriate skills, helps assure those members of staff make safe decisions and carry out their work safely, reducing the risks to themselves and to other people.

Securing co-operation and competence ensures:

- **OP1 Worker involvement and internal co-operation** - employees / volunteers, trade unions and their representatives are actively consulted and engaged in making the business safe and healthy; and
- **OP2 Competence management system** - the organisation is capable of effectively managing OHS by having sufficient employees with the requisite competences at all levels.

By law, all employees in Great Britain must be consulted on, not just told about, health and safety (H&S) issues in the workplace that affect them. There are two sets of general regulations under which a duty holder must consult the workforce about H&S:

- The Safety Representatives and Safety Committees Regulations 1977 and;
- The Health and Safety (Consultation with Employees) Regulations 1996.

These regulations build on sections 2(6) and 2(7) of the Health and Safety at Work etc. Act 1974 and encourage employers and employees to work together to:

- Develop, maintain and promote measures for protecting H&S at work and;
- Check the effectiveness of those measures.

Successful organisations often go further than the law specifies and actively encourages and supports consultation done in different ways. Effective organisations will actively involve the workforce and their trade unions to encourage them to use their knowledge and experience and build commitment to achieving shared objectives.

OP 1

Excellence

- The organisation makes full use of its employees' potential and actively involves them to develop.
- The organisation involves employees at all levels, to gather ideas for improvement, puts these into practice and provides feedback.
- Employees feel empowered to use their knowledge and experience to propose or champion ideas which support continuous improvement.
- Employees show a commitment to exceeding those goals by following existing processes and indicating where they can be improved.

Culture
There is a culture of shared values trust, openness and empowerment.

- Collaborative working is recognised as an important way for the organisation to obtain and share ways of continually improving management of risk.
- Employees are motivated to deliver the organisation's objectives and demonstrate a consistent understanding of how this is achieved.

Predictable

- The organisation regularly consults its workforce in a range of ways, such as through surveys, workshops, meetings with managers and safety tours.
- The organisation has a process of seeking to involve employees at all levels of the organisation, and there is a clear structure through which it can communicate this.
- Employees show that they understand how they contribute to achieving the organisation's goals. That understanding is consistent with the organisation's relevant policies and vision of the senior team.

Culture
Employees believe their views will be listened to and acted upon during times of change.

- Employees understand the need for change and confirm that they are consulted on how changes are introduced.
- Leaders take responsibility for supporting the establishment and functioning of H&S committees.
- There is consultation during periods of change and employees believe they can have a say in the way the organisation develops, through collaborative projects.

Standardised	• The organisation has a way of making sure that employees are consulted on H&S matters. • The organisation has established, implemented and maintained processes for employee consultation and participation at all levels in H&S matters. • Employees understand how they contribute to the H&S of the organisation. • Employees feel able to make decisions within a goal-setting framework. The organisation provides the mechanisms, time, training and resources necessary for consultation and participation.	**Culture** Employees share the organisation's goals and vision, there are effective arrangements for consulting and participating; and their views will be listened to and acted upon. • The same systematic approach to involvement and consultation is applied during collaborative and organisation-only working.
Managed	• There is some consultation on H&S matters, but it is not carried out in a systematic way, or it does not involve all employees and is only done broadly to comply with legislation. • There is a process for involving staff and consulting but it is not adopted consistently, frequently it is only with limited sectors of the workforce. Non-members of trades unions may not be included. • People in similar roles apply standards in the same way. • Involvement of individuals in collaborative project decision-making is inconsistent and depends on the individuals involved.	**Culture** Employees feel that some managers will listen and act on their views, but there is no consistency in the organisation. The organisations goals and vision are generally known about, but not widely understood and respected. • Employees understand that they are responsible for their own H&S and that of colleagues, but this is not consistent across the organisation.
Ad-hoc	• There is little or no consultation. • There is no process for involving employee in H&S matters. • Employees do not understand how they contribute to their own H&S and to the safety of the people that they work with. • There is little or no involvement of workers from collaborative organisations in decision-making during projects.	**Culture** Employees feel that senior managers have no interest in their ideas and they do not share a commitment to the organisations goals. • No standards are defined, so none are implemented.

OP 1

OP 2 — Competence management system (CMS)

The organisation is capable of managing health and safety (H&S) effectively by having sufficient employees (including volunteers) with the appropriate competences at all levels.

An organisation needs to maintain an adequate organisational capability for H&S, including:

- Having the right number of people, in the right place, at the right time with the right competence;
- Ensuring recruitment, training and development systems are able to anticipate and cater for retirements and resignations, especially when there is an ageing workforce and / or a potential skills shortages and;
- Understanding the minimum human resource needs to maintain safe operation and particularly to ensure effective risk control during times of organisational change.

A CMS should secure the competence of all those who have roles, responsibilities, authority and accountabilities, within the organisation's health and safety management system (SMS), at all levels of the organisation. This includes directors, senior, middle and junior managers, supervisors and front-line workers and volunteers.

Regulation 13 of the Management of Health and Safety at Work Regulations 1999 (MHSWR) requires consideration of people's capabilities as regards H&S when appointing them. Regulation 24 of The Railways and Other Guided Transport Systems (Safety) Regulations 2006 (ROGS) requires companies to have a system in place for ensuring that staff who carry out safety-critical work are competent and fit to do so.

Excellence

- The organisation looks to improve and test its employee competence by using innovative and technological solutions.
- The organisation considers innovative technological solutions, addressing human factors issues, to continuously improve risk control and resilience.
- The right people are always in the right place at the right time and there is in-built resilience with some employees competent in both current and next roles.
- The CMS is subject to regular monitor, audit and review to ensure that risk controls are continuously improving.
- The organisation uses employee involvement to gather ideas for improvement and puts them into practice.

Culture

The organisation makes full use of its employees' potential and actively involves them through shared values and a culture of trust, openness and empowerment.

- The CMS clearly considers operational competences related to safety-critical work, referencing relevant legislation where necessary (e.g. ROGS).
- There is a clear and well defined link between the CMS and the need to maintain necessary organisational capability.

Guidance and further reading:

- RSP1 - Developing and maintaining staff competence: ORR 2016

Predictable	• There is a comprehensive CMS based on thorough risk assessments of tasks and includes policies on recruitment, selection and training in-line with identified objectives. • There are a range of processes in place to manage organisational competence including succession and resilience planning. Changes to roles are planned. • Employees have required competencies to ensure effective risk control when undertaking safety-critical tasks, including when their role may change. • Appropriate priority is given to managing competence by sharing resources.	**Culture** Employees believe they have a role to play in the CMS and routinely act to support and develop themselves and colleagues. • Changes in the risk profile routinely trigger a review of the CMS. • The CMS is proactive and predictive in identifying emerging operational risks associated with safety critical employees and activities.
Standardised	• The organisation has an effective CMS in place. This covers the competencies needed to meet the business's objectives and manage risks; and includes both technical and non-technical skills. • There is a process which consistently ensures that the appropriate skills, knowledge and experience are included in the CMS and this leads to effective control of identified and emerging risks. • The organisation provides individuals with the skills, knowledge and experience required and makes full use of the competencies of its employees.	**Culture** The value of the CMS is understood by all employees and there is a consistent belief that it will provide them with the necessary competencies to undertake tasks safely and manage risks competently. Employees accept ownership of their own competence and its development. • Risk controls repeatedly identify the skills, knowledge and experience needed by individuals to manage the risk.
Managed	• There is a CMS, which is linked to the risk profile, but it is inconsistently applied and does not apply to all staff. • There are policies on recruitment, selection and training, but they do not always link to the risk profile, or are not in -line with the business objectives. • Training is provided as and when training needs are identified locally. The right people, may not be in the right place, at the right time, to manage the risks.	**Culture** Employees believe that the competence management system is important for H&S, but effectiveness varies depending on the managers implementing it. • Risk controls identify the skills, knowledge and experience needed by individuals to manage the risk, but not consistently across the organisation.
Ad-hoc	• There is no evidence of any clear approach to managing competence or the system is inappropriate for the risks to be controlled by people. • Employees may have the competencies they need, but there are no arrangements to check this.	**Culture** Employees do not believe they are provided with the necessary information, instruction and training to undertake their roles, which may result in them deviating from procedures and ineffective risk control.

RSSB products relevant to
securing co-operation, competence and development of employees at all levels:

- **Safety Culture Toolkit:** one-stop-shop for safety culture assessment, improvement and good practice exchange.
- **Taking Safe Decisions:** the industry-agreed framework for safety decision making on our railways. How to account for safety and the principles to apply.

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OP

Planning and implementing risk controls through co-ordinated management arrangements

Purpose

To make sure that the organisation has risk controls, that enable it to operate safely.

Introductory notes

Safe operation is based on the adequate control of risk. The health and safety management system (SMS) needs to set out how decisions are made for the control of risks to ensure legal compliance is achieved in a structured, efficient and effective way. This includes strategy-making, planning and processes for the control of risk.

The criteria in this section include:

- **PI1 Risk assessment and management** - there are adequate, appropriate and proportionate methods for identifying hazards and assessing risks as a basis of effective control of health and safety (H&S) risk in the organisation.
- **PI2 Objective / target setting** - suitable objectives and targets support the motivation of employees in the pursuit of H&S strategies, plans and the implementation of risk controls.
- **PI3 Workload planning** - effective workload planning ensures that the right resources with the right skills are in place at the right time to deliver safe and healthy operation.
- **RCS1 Safe systems of work (including safety-critical work)** - appropriate safe systems of work (SSOW) are developed and implemented for high hazard, safety-critical work to safeguard both those carrying out the work, the integrity of the assets involved and others H&S.
- **RCS2 Management of assets** - assets are managed to ensure that they remain in good condition, and can continue to operate reliably within their design parameters.
- **RCS3 Change management, (operational, process, organisational and engineering)** - effective change management ensures that the quantity, frequency and nature of change, (to assets, process or organisation), does not adversely affect H&S management and risk control.
- **RCS4 Control of contractors and suppliers** - selection and control of contractors secures risk control compatible with organisational standards and expectations.
- **RCS5 Emergency planning** - effective emergency planning ensures the mitigation of risk and consequences in foreseeable emergency scenarios.

PI1   Risk assessment and management

There are adequate, appropriate and proportionate methods for identifying hazards and assessing risks as a basis of effective control of health and safety (H&S) risk in the organisation.

Proportionate, appropriate hazard identification, risk assessment methods, and the design of risk controls are a necessary basis for effective risk management. This includes arrangements which:

- Consider personal as well as process / system risks;
- Are based on the reality of the way work is done and engage employees, (or volunteers) and / or their representatives;
- Recognise the impact of ageing, stretched and fragile assets;
- Recognise the impact of interfaces, shared risks and involve business partners;
- Apply human factors knowledge about behaviour and consider both H&S risks; and
- Consider both the risks of performing work and the impact of that work on other risk controls.

PI 1

Excellence

- Risk assessment is used to drive continual improvement in the risk profile of the organisation.
- The organisation strives for continuous improvement in risk assessment processes looking at alternative techniques, which challenge the effectiveness of risk controls, by working with other organisations in their own and other industry sectors.
- The organisation maintains an external view to identify effective risk controls from other organisations and other industry sectors.
- The organisation's adoption of new and novel techniques in risk management has led to significant risk reductions.

Culture
Employees at all levels seek to learn from others and readily share their knowledge and experience, knowing that this will lead to improved risk control, within their own organisation and collaborating partners.

- The organisation is recognised as an industry-leader in risk management.
- The organisation leads cross-industry risk reduction programmes.
- Appropriate risk assessment processes are used to make strategic choices related to the totality of the rail infrastructure.

Predictable

- Risk assessments are integrated throughout the organisation to make sure there is a systematic approach to risk control, even during periods of change.
- The approach to risk management is embedded and applied consistently throughout the organisation and enables effective collaboration with stakeholders.
- The risk assessment review cycle is prioritised on a risk-basis.
- Risk management principles are intelligently applied at all levels.

Culture
Risk assessments, including removing risk at its source, are part of the culture of the organisation; "Risk assessment is how we do things round here".

- Removing risk at its source is part of a consistent approach and is reflected in the organisation's policies.
- There is evidence of participation in cross-industry risk reduction programmes.

Guidance and further reading:

- EU Common Safety Method for risk evaluation and assessment; Guidance on the application of Commission Regulation (EU) 402/2013: ORR

Standardised	• The organisation has clear policies on using risk assessments. The organisation's risk profile has been established. There is clear understanding of what risks will be tolerated. • Risk management of system / process risks, as well as individual risk, is used in a consistent way in different parts of the organisation using quantitative and qualitative techniques proportionate to the risk profile. • Control measures in place are those that have been identified by risk assessment. • The effectiveness of control measures for both H&S risks are evaluated and proportionate corrective action is taken.	**Culture** Employees understand the purpose of risk assessment, they are actively involved and see the value of risk assessment in controlling hazards and ensuring their H&S. • The organisation makes effective use of the risk control hierarchy (General principles of prevention from MHSWR 1999, Schedule 1) and there is evidence that some risks have been eliminated at source. • There is evidence of collaboration with other organisations, where the control of a risk requires action by more than one party.
Managed	• Risk assessments are completed, but there is a lack of consistency on how risk assessments are conducted, with some managers doing better than others. • There is a process for risk assessment, but it is not applied consistently across the organisation. • There is some coordination of risk control, but focus is on operational risks and not the complete risk profile. • The organisation uses a range of risk assessment techniques, but not always appropriately to the risk profile. • Control measures within an activity do not always include the measures identified by the risk assessment. • Health risk controls rely on lower level controls from the hierarchy such as personal protective equipment (PPE) and training.	**Culture** Managers recognise that risk assessment is their responsibility, but they frequently use risk assessment to demonstrate that controls already in place are adequate, or to justify not doing more. There is some involvement of employees in the risk assessment process and some understanding by employees as to why it is important. • There is evidence that the organisation co-operates with other organisations to identify and control shared risks, but not consistently.
Ad-hoc	• Risk assessments are not completed or used to develop effective risk controls relevant to the hazards associated with the organisation's operations. • There is no process to identify the risk profile associated with the organisation, or to develop and review risk controls. • Risk assessments are inappropriate for their intended use. • Health risks are not considered by the organisation. • The hierarchy of risk control is poorly used and there is over-reliance on use of information, instruction and training.	**Culture** There is widespread evidence that the risk control hierarchy is not understood by employees at many levels in the organisation. Managers / supervisors think it is someone else's job to carry out risk assessments. Employees see risk assessment as a bureaucratic process getting in the way of them doing their job. • No evidence of collaboration over the improved control of shared risks.

PI2   Objective / target setting

Suitable objectives and targets support the motivation of employees in the pursuit of health and safety (H&S) strategies, plans and the implementation of risk controls.

H&S objectives need to be 'specific, measurable, and agreed with those who deliver them, realistic and to a suitable timescale' (SMART). Both short and long-term objectives should be set and prioritised alongside wider organisation objectives.

Objectives at different levels or parts of an organisation, should be aligned so they support the overall objectives of the organisation's H&S policy. Personal targets can also be agreed with individuals to help ensure the objectives are met.

Objectives and targets are a means of providing motivation and incentives and a basis of rewarding success for good risk control. They should be set carefully to avoid:

- Conflicts with other business objectives and;
- Perverse behaviours leading to unintended consequences such as under reporting of incidents, or activity to control one risk to the detriment of another.

An **objective** is defined as the desired end point.

A **target** is a measurable step taken towards achievement of an objective.

Excellence	• The management of performance is measured against that of others, within and outside the rail industry, to drive continual improvement. • There is a commitment to continuous improvement backed by performance targets for managers and board members. • Achievement or non-achievement is recorded and used to help with continual improvement. • Performance objectives are challenging and reviewed to demonstrate continuous improvement in H&S achievements.	**Culture** Organisations can demonstrate a coherent cascade of objectives against delivery of continual improvement, in a balanced suite of performance objectives, such that they create an evident culture of continual improvement through the use of process, plant and people development. • Mutual performance standards are set for collaborative relationships and these are recognised to drive continuous improvement.
Predictable	• Objectives are SMART, prioritised and in line with each other to support the overall policy. • The health and safety management system (SMS) makes sure that targets are set and achievement is measured. • The organisation plans to achieve H&S objectives and these plans determine; what will be done; what resources are required; who is responsible, when it will be completed; how the results will be evaluated and how actions will be completed.	**Culture** The organisation incentivises the delivery of objectives, but does not fully understand if the objectives have made a substantial change to the capability of the organisation to deliver sustained H&S control. • The importance of performance targets for H&S is recognised and achievements rewarded. • Systems are in place to follow up on non-achievement.

Standardised	• H&S performance targets and objectives are set. • Attempts are made to achieve SMART objectives and to prioritise objectives and targets and bring them in-line with each other. • Systems are in place to follow up on achievement. • Achievement of objectives is not well aligned to the review process.	**Culture** Individuals expect to be held accountable to fair, clear and achievable objectives. • Objectives include performance standards for collaboration internally and with external organisations, such as contractors, etc..
Managed	• There are objectives. Some may be SMART and prioritised, but team and individual objectives within different parts of the organisation are not aligned and do not always support the objectives of the organisation's overall policies. • Personal targets are not related to the objectives of the organisation's overall policies. • Failure to meet targets or objectives is tolerated. • No consistent application of standards of any performance standards that do exist.	**Culture** The organisation does not have a consistent approach to the setting of objectives. This results in an incoherent cross organisation approach with conflicting priorities. • The organisation does not have a consistent approach to the setting of objectives for collaborative situations. This results in an incoherent inter-organisational approach with conflicting priorities.
Ad-hoc	• There are few or no H&S targets set for the organisation. • Any targets which do exist are not SMART or prioritised or aligned to the risk profile. • No clear idea of performance of individuals involved in the SMS. • No effective application of standards for setting performance targets. • No performance targets set for collaborative ventures or joint-risk management with contractors, other operators, etc..	**Culture** The assumption is that individuals must be delivering if the organisation is still operating but there is no evidence to back this up.

PI 2

PI3   Workload planning

Effective workload planning ensures that the right resources, with the right skills (with the right equipment) are in place, at the right time, to deliver safe and healthy operation.

Good planning will significantly improve the way an organisation manages health and safety (H&S) by making sure there are the right resources to carry out tasks. This will lead to effective risk control and efficient working.

Planning should be realistic drawing on human factors, to ensure that work demands do not exceed human capabilities.

Excellence

- The organisation looks beyond its organisational boundaries for factors which may impact on its workload planning.
- The organisation collaborates with others to achieve continuous improvement in planning systems of all collaborating parties.
- The workload planning system supports a healthy lifestyle for the individual balanced against delivering the organisation's objectives, efficiently.
- The organisation actively seeks out best practice in managing workloads and implements ideas that enable continuous improvement in risk management.

Culture
Employees at all levels feel they are able to influence their own work plan, have active involvement in planning additional work and that there is a healthy balance between their needs and those of the organisation.

- Active pursuit of best practice which is implemented even when planning the workloads of collaborative teams.

Predictable

- The planning system includes regular reviews of workload and resources, both within the organisation and the supply chain.
- When major projects and changes occur, the workload planning system is designed to ensure that nobody is overloaded with work.
- The fatigue management system is part of a comprehensive health and safety management system (SMS) and applied to all staff at all levels of the organisation.
- Even when there is extra work or changes, nobody becomes overloaded with work.

Culture
Employees actively support managers over workload planning and resource management and feel that their ideas and concerns are valued and will be acted upon.

- Standards reviewed following changes to workloads or tasks.
- Effective workload planning system includes changes to workloads, or task content, including collaborative project teams.

PI 3

Standardised

- A planning system is in place to make sure that tasks are given to the correct person and can be completed on time.
- The organisation determines; what will be done; what resources are required; who is responsible and when it will be completed.
- The resource management system captures work and travel hours to be recorded to identify / monitor excessive hours worked.
- The fatigue management system considers activity, workload, environment and travel, but is principally focused on operational employees.
- The organisation determines and provides the resources needed for the establishment, maintenance and continual improvement of the SMS.

Culture
Employees feel that resources and workload are aligned and reasonable. They are comfortable to challenge managers about additional tasks, particularly when related to safety critical activities. Employees accurately record the hours they work including travelling for work.

- Standards identified and used effectively.
- Effective use of systematic workload planning, leading to effective risk management, including collaborative work teams.

Managed

- Workloads vary, but some thought has been given to allocating tasks in a way that aims to reduce overloading.
- There is a process to identify and prioritise safety-critical tasks, but workloads are not reviewed to manage areas of overloading.
- There is a simple process of looking at hours and shift patterns to manage workload-related health issues.
- Safety-critical tasks are mostly completed effectively.
- There is some monitoring of workloads, but people still become overloaded, leading to failures in risk control.

Culture
Employees recognise the importance of safety-critical tasks. There is some challenge of managers by employees where there is inadequate resource. Managers accept that working excessive hours is just part of the job and will tend to under report the hours they work.

- Standards to reduce fatigue identified, but used inconsistently.
- Inconsistent application of workload planning to collaborative projects dependent on individuals not systems.

Ad-hoc

- There is little or no control of workloads.
- There is no effective process for managing workloads.
- There is evidence that poor performance in carrying out tasks is due to not enough time being given and tasks which are critical to safety not being prioritised properly.
- Some people are overloaded, while others are lightly loaded.
- No standards identified and used.

Culture
There is a culture of accepting tasks that are allocated, without challenging, even if this results in becoming overloaded and non-completion of tasks. Managers think it is acceptable to employee to work excessive hours.

- No effective workload planning for collaborative work.

RCS 1 Safe systems of work (SSOW) including safety critical work

Appropriate safe systems of work (SSOW) are developed and implemented for high hazard, safety-critical work, to safeguard both those carrying out the work, or affected by it, and the integrity of the assets involved.

The focus of this element is to evaluate an organisation's ability to identify risks relating to specific tasks and put appropriate controls in place to protect the health and safety (H&S) of those carrying out and affected by those tasks.

Excellence

- There is a commitment to continually improve SSOW by, for example, benchmarking within and outside of the rail industry.
- The SSOW have the best possible blend of processes, plant and people to achieve excellent results, delivered efficiently and safely.
- The SSOW are shared with industry and are recognised as excellent by outside organisations.

Culture
The culture is one where everyone across the organisation is actively seeking improvement, identifying, deploying and sharing best practice from all relevant sources.

- Consistent use and continual improvement of shared SSOW and active sharing of good practice, for example at conferences.

Predictable

- The SSOW are used to both implement risk controls and get feedback on how adequate they are.
- Changes to the SSOW are checked carefully and are well-managed. They produce the result that was predicted and planned for, before the change was made.
- Standards are maintained even after changes to SSOW. Consistency is clearly evident across departments and projects.

Culture
The culture involves a mature and integrated approach, with a carefully managed library of SSOW based on robust risk assessments.

- Extensive consultation is carried out with those using and those affected by the SSOW. Shared SSOW are subjected to the same processes as the organisation's own ones.

Standardised

- There is a clear, consistent approach to developing and putting in place SSOW that use effective risk management.
- The tasks, including ones critical to H&S, are clearly understood and can be repeated across sites and shifts.
- Standards are applied consistently across the organisation in the management of SSOW.
- Collaborating parties consistently use shared SSOW.

Culture
The culture of risk management is mature, effectively using and improving existing safe SSOW.

Managed	• SSOW are in place, but there are clear differences in how they are applied across the organisation.	**Culture** The culture is to use what is available for a specific task or area, but in isolation, not learning from elsewhere or sharing good practice.
	• The SSOW are sometimes less than adequate because the procedures cause mistakes, or are not effective in achieving the intended result.	
	• There is inconsistent compliance with standards across departments and areas of work.	
	• SSOW are not used consistently between collaborating parties.	
Ad-hoc	• The SSOW actually used are not the same as the written procedures.	**Culture** The culture is reactive, using SSOW inconsistently and not communicating the requirements using a systematic approach.
	• The SSOW do not take account of risk, and tasks that are critical to H&S are not always identified and prioritised.	
	• No or only weak evidence of application of standards.	
	• SSOW are not co-ordinated with those of collaborators.	

RCS 2   Management of assets

Assets are managed to ensure that they remain in good condition and can continue to operate reliably within design parameters.

Successful management of assets involves:

- Identifying the assets the organisation owns and manages and;
- Having systems in place to make sure that assets remain in a good condition and capable of operating reliably within design parameters.

Suitable predictive maintenance techniques should be employed where appropriate. The condition and life expectancy of assets should be factored into maintenance and renewal decisions. Asset condition and life expectancy should be factored into enhancement project thinking to ensure that a balance is struck between safety, performance and efficiency in investment decisions.

Excellence

- Information on work history type and cost, condition and performance are recorded at asset component level.
- Systematic and fully optimised data collection programme is in place with supporting metadata.
- There is evidence of an effective pro-active and predictive maintenance regime across the organisation.
- Enterprise-level guidelines and standards are in place with best practices incorporated from other industries.

Culture
There is a demonstrable alignment between asset management objectives, systems and individual responsibilities at all levels and across the organisation.

- There is clear evidence of searching for best practice in asset management and condition monitoring as part of the drive to continuous improvement.

Predictable

- A reliable register of physical, financial and risk attributes are recorded in a system with data analysis and reporting functionality.
- Systemic and documented data collection processes are in place.
- The organisation has successfully implemented a condition-based, preventative maintenance regime that is effective.
- There is a governance plan in place which is continuously reviewed and updated to incorporate learning from the organisation's asset management activities.

Culture
The organisation is structured to support effective asset management and the importance of this is understood by everyone. There is a consistent approach to asset management across the organisation.

- Changes to frequencies or content of examinations are communicated to collaborator organisations to ensure that joint assets are correctly maintained.
- Audit is used by all parties in collaborative activities, individually and jointly.

Standardised

- The data held by the organisation is sufficient to support prioritisation of asset management programmes (criticality).
- Asset hierarchy, identification and attribute systems are documented and appropriate metadata is held.
- Maintenance is conducted against a periodic maintenance plan, which is in the most part achieved.
- There are standards in place for each asset type.
- Joint assets are part of the asset management system.

Culture
The organisation's leadership own and visibly support the asset management programme. There is an awareness at all levels of the organisation of the importance of asset management in managing system safety.

Managed

- Asset management is inconsistent across the organisation.
- Basic physical information for assets is held in a spreadsheet or other simple system, but is typically based on broad assumptions, or it is incomplete.
- There is evidence of a generally reactive approach to maintenance across the organisation. Where maintenance is planned, there is widespread evidence of backlog.
- The standards in place in the organisation are generally those defined by the original equipment manufacturer (OEM) / asset vendors.

Culture
Asset management functions are carried out by small groups. Roles reflect asset management requirements. Understanding of the importance of asset management is typically limited to individuals directly involved.

- Some joint assets are included in the asset management system, but no consistency.

Ad-hoc

- There is a general awareness of the need to manage assets to maintain their integrity and to hold an asset register.
- Asset information is held in multiple formats.
- Equipment is repaired when it fails. There is little evidence of planned preventative maintenance (PPM).
- There are no defined standards for asset management.

Culture
There is little recognition that asset management is important.

- Shared assets are not maintained proactively.

Effective change management is proactive and secures the quantity, frequency and nature of change, (to assets, operation, process or organisation), does not adversely affect health and safety (H&S) management and risk control.

All individual changes need to be managed to prevent adverse impact on the SMS) and control of risk. This includes risk arising from the process of change itself, as well as the new end-state. Appropriate methods of risk assessment should be employed where appropriate.

The total amount and pace of change should be managed to ensure the collective impact does not adversely affect safety performance.

Excellence

- There is an understanding that change can affect other aspects of an organisation's business or other organisations with shared accountabilities this leads to business risk being linked with H&S risk during and as a result of any change.
- All employees are fully conversant with the change management process and there is no need for a dedicated change management team, changes lead towards continuous improvement.
- Changes which are implemented, only ever reduce the organisation's overall risk profile and seek continuous improvement.

Culture
Employees feel that all changes which are implemented have an overall positive effect upon themselves and the organisation.

- The organisation actively seeks improvements to standards of change management to drive continuous improvement.
- The organisation actively seeks collaborators to assist in driving continuous improvement in management of change.
- There is a clear review process in place that analyses the effectiveness of changes as and when they take place.

Predictable

- The change process requires a review to be carried out after a change, which is structured to consider the wider implications of the change including the effect the change has had on the culture of the organisation.
- There is an efficient and effective change management process, which considers the wider impact of change including the impact on other organisations.
- All changes are well managed and their risks well controlled.
- Organisational standards for management of change exist and are uniformly applied.

Culture
The importance of involving employees in the change process is recognised to bring benefits and those employees are actively involved, because they understand the importance of managing change and the role they play in that organisation.

- Effective control of change extends to cross-organisational change involving collaborators and includes effective information transfer post-change on H&S performance.

Standardised	• There is an efficient approach to managing any process, technical, operational or organisational changes, engaging staff in the process. • There is a structured approach to change, involving a number of steps and a defined process in the management system. • There is a consistent approach to risk assessment and risk control after a change is made. • Organisational standards for management of change exist and are uniformly applied.	**Culture** Employees recognise the importance of effective change management, but still feel that changes are often implemented without proper consideration of the impact on their safety and/or health. • Standards include clear processes for managing changes involving collaborators and these are applied. • Risk assessments consider human performance.
Managed	• The importance of change management is understood and there is some degree of control over all types of change or inconsistent types of control over different types of change (technical, operational, organisational). • There is a process for managing change, but it is either not used consistently, or it is not effective at managing the risks following a change. • Some changes are made without their risks being controlled. • Some departments have standards for change management, but not all, and even those that exist are inconsistently applied.	**Culture** Some employees recognise the importance of a systematic approach to change, but this is inconsistent and depends on the individual's experience. • Inconsistent involvement of collaborator organisations in the management of changes, depending on individuals involved not systematic process.
Ad-hoc	• There is little or no control of change and changes are made without effective consideration of their risks or their wider impacts. • There is no process or system for making changes, which leads to risks not being identified or controlled following a change. • The risks associated with a change are not identified and so are not controlled. • No organisational standards for managing change exist, so none are applied.	**Culture** Employees feel that the effect of change on their safety and/or health is not considered. • There is little or no involvement of collaborator organisations in managing change, even to shared processes or risks.

Organisations need to effectively manage the health and safety (H&S) of their contractors and suppliers and those affected by their activities, wherever those activities are carried out.

Maintaining a sound intelligent customer capability is essential, to ensure the organisation retains understanding and knowledge of the products or services being supplied by the range of contractors.

Some key features of effective contractor / supplier control are:

- Selection (including resources, equipment, knowledge and experience);
- Co-ordination between clients, contractors and sub-contractors (i.e. who does what, when and how);
- Induction to site rules, procedures, hazards and emergency arrangements;
- Supervision (by whom - including on-the-job and checks of completed work);
- Competence of contractors (e.g. consider the role of the client and the contractor's management);
- Assessment of new hazards introduced by the activities of contractors – which could be direct (e.g. in the case of asbestos removal), or indirect (e.g. caused by undetected, latent faults left behind when a contractor completes work) and;
- Review of the contractor selection and management system.

Excellence

- The contractor supply chain seamlessly delivers all of the organisation's objectives.
- Effective processes exists for pre-qualification, selection, induction, management and post-contract review of contractors. These processes are under continual review and improvement.
- The contractor's / supplier's main H&S activities are in line with the organisation's.
- The process is consistently applied and measured for effectiveness. There is evidence of formal audit, and of measurable continuous improvement delivering tangible benefits.

Culture
A culture of openness and mutual trust and respect exists in which the boundary between contractor and organisation is seamless, and values and objectives are shared.

- The contractor / supplier collaborates seamlessly with the organisation and customer, all parties operate inter-dependently for mutual benefit. Evidence of transparent and effective two-way communication.
- The organisation maintains an intelligent customer capability for contractor selection, control and management.

Predictable

- There is a systematic approach to contractor / supplier control.
- Effective pre-qualification arrangements take a balanced approach, considering H&S performance. Effective processes exist for the ongoing management of contractors at all stages of the relationship.
- There is a clear understanding of responsibility at all stages of the contract. Good working relationships between client and all contractors, are delivered through effective interface arrangements.

Culture
A culture exists in which communication is open and honest. The integration between contractor / supplier and the organisation is strengthened through collaboration and sharing of objectives.

- Performance measures and post-contract reviews help guide decisions on the choice of contractors for further work.
- The contractor / supplier collaborates effectively with the organisation. Evidence of effective two-way communication.

Standardised

- The importance of contractor control is recognised and this is reflected in the organisation's relevant policy and process, but measurement of the effectiveness of the process may be lacking.
- There is robust evidence of induction and communication with contractors.
- Contractors are closely aligned with the customers expectations.
- The contractor's performance is monitored during the contract, and appropriate performance measures are used effectively to track achievement.

Culture
A culture exists in which communication is open and honest. The contractor and organisation are still distinct, but there is some evidence of collaboration and sharing of objectives.

- Comprehensive processes exists to ensure that contractors are chosen on their ability to complete work safely and to a satisfactory standard, and managed effectively following appointment.

Managed

- Some elements of a risk control system are in place for contractor control, but there is no systematic process from selection through to post-contract review.
- There is some evidence of induction of and communication with contractors.
- Contractors are broadly aligned with the customers expectations.
- There is some evidence of a managed process in the initial selection, monitoring, and post-contract review, but application may be inconsistent.

Culture
A 'contractual' culture exists in which communication is open and honest but the contractor / supplier and organisation are clearly separated.

- The key elements of the contractor relationship are managed through formal processes.
- The contractor is loosely managed by the organisation, but operates mostly as an independent entity.

Ad-hoc

- Contractors and suppliers are appointed when needed, but when selected there are few considerations other than cost.
- There is no formal process for managing contractors / suppliers, monitoring their performance or review of the completed contract.
- There is little evidence of integration of contractors / suppliers with the organisation, and consequently a lack of shared objectives and values.

Culture
An 'us and them' culture exists. The contractor / supplier is blamed for operational failings. The organisation is blamed by the contractor / supplier for lack of information / management.

- There is little consideration of the responsibilities for risk control when deciding how to do the work.

RCS 5   Emergency planning

Effective emergency planning ensures the mitigation of risk and consequences in foreseeable emergency scenarios.

The overall aim of emergency planning is to make sure that appropriate measures will be used when and where necessary to prevent or reduce the harmful effects of major accidents.

Excellence

- The organisation proactively looks outward when planning emergency response to identify and use good practice in a spirit of continuous improvement.
- Emergency response arrangements are in place and reflect good practice from both within and outside the rail industry.
- Lessons from published reports are included in procedure reviews and incorporated into revised emergency procedures.
- The organisation actively seeks to find and share more effective ways of dealing with emergencies.

Culture
Culture of striving for continual improvement in response to all emergencies.

- Information sharing is fully collaborative both with direct collaborating organisations and others with relevant information and / or experience.

Predictable

- Emergency responses are developed and reviewed in response to developing risks and emergency scenarios.
- Feedback from exercise 'wash-ups' is taken into account when procedures are reviewed to make sure emergency responses remain up to date and effective.
- The full suite of emergency arrangements have been assessed so that appropriate risk reduction strategies are evident should they be realised. Feedback from exercise 'wash-ups' is taken into account when procedures are reviewed to make sure emergency responses remain up to date and effective.

Culture
Culture of making the best possible response if an emergency occurs.

- Changes to the emergency response procedures are based on evidence from experience and demonstrably lead to improvements.
- Collaborative organisations are fully involved in wash-up sessions including reviews of procedures.

Standardised	• Potential emergencies arising from tasks are identified as part of risk assessments. • Control measures, including training and resources, are in place to deal with emergencies. • The organisation determines and provides the resources needed to support the emergency planning arrangements. • The organisation recognises that emergency planning is a critical part of the business and is applying the appropriate standards.	**Culture** The culture is to recognise and plan for effective emergency responses. • Joint emergency response exercises take place with other organisations involved in a task. Roles in emergency response are clear and understood.
Managed	• The organisation realises that emergency responses are an important part of a risk control system. • Major emergencies that could arise are identified and there are some plans in place to deal with them. • Emergency responses are the responsibility of departments or divisions of the organisation. • The organisation applies basic requirements to the plans for major emergencies that could arise.	**Culture** Emergency responses are developed locally and owned by individual departments or sites, rather than being jointly developed and co-ordinated. • Emergency procedures requiring multi-agency response are recognised, but there is no structured planning of responses required.
Ad-hoc	• There is no organised identification of possible emergencies and how to respond if they arise. • The organisation relies on the emergency services to deal with all aspects of an emergency. • The organisation does not consider the risks or the consequences of possible emergencies on the business or its workforce. • The organisation does not apply standards to support emergency planning or arrangements.	**Culture** The culture is that there is a recognition that major emergencies could occur, but no planning is undertaken to deal with specific ones; a generic emergency response is thought to be enough. • There is no consideration of the need for co-ordinated responses with other organisations in the event of major incidents requiring joint responses.

RSSB products relevant to
planning and implementing risk controls through co-ordinated management arrangements:

- **Annual Safety Performance Report:** a review of safety trends for passengers, workforce and the public.
- **Close Call:** to record and manage conditions and behaviours that, under different circumstances, could have led to injury or harm.
- **The Safety Risk Model:** access to a network-wide risk profile. Use the outputs to understand your own risk profile, make risk assessments and investment decisions.
- **Safety Risk Model Profile Tool**
- **Measuring Safety Performance Guidance:** to help you identify the best safety performance indicators to monitor for your key risks.
- **Leading Health and Safety on Britain's Railway (LHSBR):** Looks at 12 priority risk areas, a framework for the collaborative improvement of health and safety risk management.
- **LHSBR Quarterly Monitoring Report:** a summary of implementation actions in the LHSBR priority areas.
- **Taking Safe Decisions:** the industry-agreed framework for safety decision making on our railways. How to account for safety and the principles to apply.
- **Common Safety Method for Risk Assessment and Evaluation:** Six CSM RA Rail Industry Guidance Notes (including GEGN8646).
- **Rail Industry Supplier Qualification Scheme:** single point of entry for buyers of products and services for the rail industry.
- **Safety Management Intelligence System:** for the collection, sharing and analysis of safety incident data.

MRA   Monitoring, audit and review

Purpose

The aim is to make sure that risk controls are in place, working correctly and achieving the organisation's objectives.

Introductory notes

Organisations need to measure, audit and review the implementation and effectiveness of all parts of the SMS. This is the basis of feedback, learning and continuous improvement.

Monitoring - organisations need to measure the effectiveness of risk controls to make sure that risk controls are identified and work in practice. Safe systems of work (SSOW) must be monitored to make sure they are appropriate and are actually being followed. Systems for monitoring, auditing and reviewing performance should be in place to make sure that the health and safety management system (SMS) is working correctly.

Audit - an audit checks that the organisation is doing what it says it will do. It should be supported by regular reviews to make sure that the organisation's business objectives are correct.

Review - the review should also check that the arrangements put in place to meet the business objectives are working as intended.

Monitoring, audit and review form a feedback loop within the overall SMS, and are an essential part of programmes for continual improvement and achieving excellence.

The criteria in this section include:
- **MRA1 - Proactive monitoring arrangements** - proportionate, targeted monitoring before an accident or incident to provide feedback on the implementation of strategies and plans, and the effectiveness of the SMS arrangements essential to motivate and reward success in risk control.
- **MRA2 - Audit** - Independent, systematic audits check that risk-control systems and management arrangements within the SMS are effective.
- **MRA3 - Incident investigation** – proportionate investigation of accidents, incidents and near misses is essential to learn from adverse events.
- **MRA4 - Management review -** review at appropriate levels to ensure that policies, strategies and plans remain appropriate and effective in the face of feedback from monitoring, investigations and audit findings.
- **MRA5 - Corrective action** - Corrective action through change management programmes secure the proportionate, prioritised close out of actions arising from monitoring, investigations, audits and reviews.

MRA

Proportionate, targeted monitoring before an accident or incident to provide feedback on the implementation of strategies and plans, and the effectiveness of the health and safety management system (SMS) arrangements essential to motivate and reward success in risk control.

Monitoring provides managers with confidence that risk control measures identified in risk assessment are in place and working as intended to control risk before something goes wrong. This includes hardware controls, work systems and practices controlling risks. For example, train dispatch arrangements at the platform train interface (PTI), or maintenance procedures for relief valves in process industries.

Monitoring should be proportionate to the hazards / risk and include:
- **Critical systems** (those relied upon to prevent a serious risk outcome being realised);
- **Vulnerabilities** - those systems with a tendency to degrade over time, (such as controls with a large human input, for example train dispatch and valve maintenance, and those for which current performance is not being implemented well and;
- Sampling cultural characteristics.

and a mixture of:
- **Activity / process** measures (doing something, e.g. number of valves maintained); and
- **Outcome** measures result (for example number of valves passing examination).

Suitable analysis of the results of monitoring assists in identifying common underlying issues and systemic problems. Choosing the correct monitors is important; "measure what is important, don't make important what you can measure" [1].

Excellence

- Active steps are taken to identify, evaluate and utilise novel ways of monitoring to achieve continuous improvement in risk control.
- Managers actively participate in industry-wide and cross-industry groups to improve risk control monitoring techniques e.g. remote condition monitoring.
- The organisation is an early adopter of new standards relating to monitoring and recognised as an 'early complier' organisation.
- The organisation has closely linked outcome and activity indicators which demonstrate risk controls are optimised.

Culture
Monitoring is understood to be a key part of assurance and component of continuous improvement.

- The organisation is known for mature relationships with collaborators who strive to work again with the organisation as they are assured that risks will be controlled.
- Across the organisation monitoring activities are recognised as vital in improving risk control.
- The monitoring arrangement address proportionately and appropriately all the processes and systems within the SMS to ensure their implementation, adequacy and effectiveness.

Guidance and further reading:
- HSG 254 'Setting Performance Measures in the Process Industries'
- RSSB guidance 'Measuring Safety Performance'.
- EU Common Safety Method for monitoring,

1 Robert McNamara, U.S. Defence Secretary at the time of Operation Rolling Thunder.

Predictable	• Change processes ensure that risk-based monitoring is in place following a change. • Managers and supervisors are well-trained and have the necessary resources, and there is evidence of challenge of SSOW (see RCS1). • Monitoring remains key to understanding risk control, even in times of change. • Monitoring is reviewed to ensure continuing compliance with standards.	**Culture** Monitoring of risk controls is part of the way risk is managed, including during periods of change. • The outcomes of monitoring are shared with collaborators to ensure mutual assurance of the effectiveness of risk controls.
Standardised	• There is a systematic approach to monitoring, based on published guidance. • Monitoring flows from the risk assessment, and all risk controls are monitored in a systematic way across the organisation. • The organisation has established, implemented and maintained processes for monitoring, measurement, analysis and performance evaluation. Including, the extent to which legal and other requirements are fulfilled, progress towards achievement of H&S objectives, the effectiveness of operational and other controls. These systems apply to collaborative working too.	**Culture** The importance of monitoring risk controls is understood and the right things are measured, giving assurance of the effectiveness of risk controls. Monitoring provides feedback and positive motivation / reward. • Management receive information from monitoring activities that allows them to have assurance that key risk controls are in place and working as intended. • Monitoring is compliant with the requirements of CSM for Monitoring or ISO 45001:2018.
Managed	• Some risk controls are monitored, but there is no systematic approach to monitoring. • Monitoring is not a systematic process, records of monitoring activities are not co-ordinated and there is evidence that adverse outcomes are not actioned. • There are inconsistencies between different areas of the business in the way monitoring is done and the action taken in response to the outcomes of monitoring.	**Culture** Some monitoring is undertaken, but it is not risk-based and any assurance obtained from it is purely by chance. • Most people in the organisation understand the need to monitor risk controls. • Some risk controls for collaborative working are monitored but there is no systematic approach to monitoring.
Ad-hoc	• There is little or no monitoring, so little understanding of whether risk controls are in place or are working effectively. • There is no evidence that risk controls are monitored. • There is little or no data analysis done to inform the organisation that monitoring is needed to ensure that risk controls are in place and effective.	**Culture** There is little or no evidence of understanding why risk controls must be monitored. • Little or no monitoring of risk controls needed for collaborative working.

MRA 2   Audit

Independent, systematic audits check that risk-control systems and management arrangements within the health and safety management system (SMS) are effective.

An audit is an independent, systematic check of risk-control systems and management arrangements to make sure that business objectives are being met. An audit can be an internal audit (first party, conducted by the organisation) or an external audit (second or third party, conducted on behalf of the organisation).

Auditing is recognised as a key part of SMS in ISO45001:2018.

Audit processes are described in more detail in BS EN ISO19011; 'Guidelines For Auditing Management Systems'. Auditing relies on a number of principles that are set out in the guidance.

A proportionate, targeted audit programme should be devised and implemented to provide the board with adequate assurance about the 'health' of the SMS and the sustainability of safety performance.

Excellence

- Audit actions identify ways to continuously improve management of risk in the organisation by referring to examples of excellence in the rail or other sectors.
- Identification of innovative solutions that improve risk management is encouraged in audit reporting and actions.
- Audit and completion of actions arising is understood to be a driver of continuous improvement.
- Auditors are competent to make effective challenge and encouraged to identify and deliver findings which drive continuous improvement.

Culture
The organisation strives to identify best practice in business risk management to inform the audit programme.

- Peer-to-peer reviews with other comparable organisations are routinely included in the audit approach.
- The audit process provides a high level of assurance across the organisation.

Predictable

- Post-change audits are carried out as part of the verification of change process.
- The audit programme includes consideration of new processes and procedures.
- Audit of processes that have been changed is understood to be an important part of the change process.
- Audit is used by all parties in collaborative activities Individually and jointly.
- Audit findings are recognised as important indicators of successful changes.

Culture
Audit is understood to be an essential part of development of processes and procedures contributing to improvement in risk management.

- Auditors keep their competencies up-to-date through practice and Continuing Professional Development (CPD) activities.

Standardised	• There is evidence of a co-ordinated, effective and up to date audit programme. • The organisation can show that audits are completed by competent auditors. • Audit is understood as an essential part of the risk management process and staff readily engage with the audit programme. • Audit results are accepted, acted upon and tracked through to completion. • Audit programmes are adequately resourced.	**Culture** The value of audit is understood at all levels in the organisation and there is a culture that the challenges and recommendations are positive influences. • Collaborative activities are included in the audit programme.
Managed	• There is some auditing, but there is no coordinated audit plan. The audit plan is not proportionate to the risk profile of the organisation or implemented consistently. • Some departments / processes are audited, but not all. • The role of audit is not understood consistently in the organisation. Audit is perceived defensively and negatively. • Some findings are acted upon dependent on the individuals involved. There are some competent auditors, but no system in place to ensure that they carry out the audits.	**Culture** The value of audit is inconsistently understood and challenges are often taken personally, resulting in conflict between auditors and auditees. • Some collaborative activities are subject to audit, but there is no consistency.
Ad-hoc	• There is little or no evidence of any audits being carried out. • Audits that are carried out are not planned or prioritised and the findings are not acted upon. • The value of audit is not understood, or audits are only completed to satisfy a requirement. • There is no auditing of collaborative / joint working.	**Culture** There is little or no understanding of the value of auditing, which is seen as a chore. • There is no oversight of audit to ensure corrective actions and recommendations are acted on. There is little or no evidence that the organisation can demonstrate that persons undertaking audits are competent.

Proportionate investigation of accidents, incidents and near misses is essential to learn from adverse events

Accidents, incidents and near misses provide stark learning opportunities. It is important events from all sources are reported. An open and just culture is necessary to support an effective system.

It is not usually feasible to investigate all events; an appropriate system of selection is often necessary – usually prioritising high hazard events, i.e. those with severe actual injury or those with potential for serious injury.

Investigations need to be proportionate getting to underlying causes and concluding with practical lessons for improvement and learning. Suitable analysis of events and investigation findings assists in identifying common underlying issues and systemic problems.

Excellence

- The organisation actively seeks to implement findings from external investigations to support continuous improvement.
- Managers and board members have objectives to review reports of external investigations from the rail and other sectors to identify opportunities for continuous improvement.
- Relevant investigation outcomes are routinely shared within and outside of the organisation.
- Board members and managers are active in promoting and supporting the development of techniques and training for investigations.

Culture
There is a 'just' organisational culture where all employees freely participate in the investigation, openly and honestly. Incident investigation is seen by all employees as an opportunity to deliver continuous improvement and managers respond fairly.

- Collaborative working incidents are investigated to learn lessons that aid continuous improvement.

Predictable

- The quality of investigation produces recommendations that can be applied both within and outside the organisation.
- The range of incidents investigated includes, where appropriate, non-compliance, non-conformance, near miss / hit reports and health and safety (H&S) complaints or disruptions to work and where expected outcomes are not achieved.
- Investigations produce recommendations which can be applied across the organisation and relevance outside the organisation is routinely considered as is the impact of the recommendations on risk management.

Culture
Investigations and recommendations arising from them, are generally accepted as important ways of improving risk management.

- Employee representatives including, where appropriate, trades union safety representatives are actively involved in investigations.
- The effects of recommendations from investigations on risk control in collaborative working, are themselves reviewed to demonstrate improvements in risk control.

Standardised	• The defined management arrangements for when and how investigations are carried out are followed consistently across the organisation. • The underlying causes of an incident are identified and investigated. Investigations are also carried out after a near miss or near hit and H&S complaints. • The investigation team selected is proportionate to the type and severity of the matter under investigation. Employee representatives participate in the investigation. • There are systems in place to ensure that the competence of investigators is maintained.	**Culture** There is a general understanding of the importance of good quality investigations into a range of occurrences generating recommendations that improve systematic control of risks. • The investigation procedures include collaborative working and the need to investigate reports of non-compliance, non-conformance, near miss / hit reports and H&S complaints. • Human factors and human performance are considered as part of the investigation and the training for investigators.
Managed	• Incidents are investigated, but only where the organisation's guidance directs. The investigation process followed is not proportionate to the risk. • Frequently, only immediate causes are identified and investigated. • The range of incidents investigated is limited to accidents. Recommendations are limited to preventing the same thing happening again. They do not identify areas for wider improvement.	**Culture** The culture is to accept inconsistencies in investigations and superficial recommendations which do not improve risk management. • Investigations are carried out only by safety professionals or managers, who are not independent of the incident. • Inconsistent use of investigations during collaborations. • Confidential incident reporting is embedded in the investigation process (see Annex 1).
Ad-hoc	• There is no evidence of effective investigations, and the culture of the organisation is to find someone to blame. • Employees do not believe it safe to speak up and therefore tend to cover up genuine errors. • The organisation focuses on the actions of the individuals, rather than looking to challenge the adequacy of systems and risk controls. • No training in investigation techniques, no independent investigators.	**Culture** Evidence of a blame culture when something happens. • No joint investigations of incidents during collaborative ventures.

MRA 4   Management review

Management reviews check to ensure that policies, strategies and plans remain appropriate and effective in the face of feedback from monitoring, investigations and audit findings.

Reviewing safety performance takes a 'big picture' overview of the patterns of evidence arising from all forms on monitoring, investigation and audit to decide whether the overall approach, policies, resources, priorities, improvement targets and the SMS remain relevant and appropriate in pursuing the safety vision and strategy and cultural development.

Excellence

- Board reviews are carried out routinely as planned and result in suggestions for continuous improvement of risk management performance.
- The board and senior management reviews bring about demonstrable continuous improvement and confirm the strategic direction or lead to changes.
- There is clear evidence that the outputs of management reviews are shared to improve processes or shape positive behaviours.
- Reviews are informed by corrective actions, monitoring and measuring results, audit results and consultation and participation of employees and, if appropriate trades unions.

Culture
The organisational culture encourages suggestions for improvement and these routinely trigger management reviews.

- Reviews are carried out collaboratively with other organisations, using shared evidence and strategies, and measures of good and bad performance with the purpose of continuous improvement.

Predictable

- Management reviews systematically include learning lessons from events in other organisations and other industries.
- There is a process to review lessons learnt from other organisations, including reviewing the output from confidential reporting services (see Annex 1).
- Management reviews include measures of the outcome of changes.
- Reviews of the outcomes of changes are compliant with the relevant requirements of recognised management system standards and guidance e.g. ISO45001:2018 Clause 9.3.

Culture
Widespread belief that management reviews result in changes which are effective in controlling H&S risks.

- Changes resulting from collaborative working are included in board reviews of outcomes.

Standardised	• Management automatically uses findings from monitoring and audits to review the organisation's performance and make changes where necessary. • Reviews are also triggered following events in addition to planned cyclical reviews. • Recommendations from reviews are clearly allocated, tracked and show that the wider implications are considered to ensure continuing suitability, adequacy and effectiveness. • Management reviews are compliant with the relevant requirements of recognised management system standards and guidance e.g. BS ISO45001:2018 Clause 9.3.	**Culture** Good communications of outcomes from board reviews and actions arising leads to culture where all believe that the organisation cares about risk management and that individuals can and do contribute to it. • Management reviews for collaborative working are compliant with the relevant requirements of recognised management system standards and guidance e.g. BS ISO45001:2018 Clause 9.3.
Managed	• Management reviews are carried out but do not always align with the organisational risk profile and strategies. • Reviews of the organisation's health and safety management system (SMS) are only undertaken at planned intervals. • Management reviews are limited to simple data such as outcomes and status of actions from previous management reviews. • Inconsistent application of standards to some reviews of some areas of the organisation.	**Culture** Some understanding and support for the board role in setting and reviewing safety performance, but it is inconsistent.
Ad-hoc	• There is no analysis of the findings of monitoring and audits by senior management. • Achievement of risk management objectives is not reviewed. • Management are not able to demonstrate that the SMS has delivered the intended objectives. • No effective application of management system standards relating to management review, e.g. BS ISO45001:2018 Clause A9.3.	**Culture** No or little understanding, at any level, of the importance of senior level review to ensure that risk management objectives are delivered. Culture of believing that the board do not care about safety or safety risk management. • No effective review of objectives relating to collaborative working arrangements.

MRA 5   Corrective action

Corrective action and change management programmes secure the proportionate, prioritised close out of actions arising from monitoring, investigations, audits and reviews.

Excellence

- The organisation monitors reports from the rail and other industries to identify and implement corrective actions that improve risk management.
- The board and senior managers can provide evidence on how corrective action has supported continuous improvement.
- Corrective actions are sought and shared from national and international organisations.
- There is a highly effective systematic approach and demonstrable improvements to risk management.

Culture
Individuals can and do identify actions from outside the organisation which improve risk management within the organisation.

- Effective collaboration ensures that corrective actions are shared and adopted by organisations with shared or similar risks.

Predictable

- Corrective actions are linked to objectives set out in the H&S management system to deliver the greatest benefit possible.
- The board and senior managers actively support and resource the delivery of corrective actions.
- Corrective actions are considered as part of the change management process.
- Corrective actions are verified and validated proportionately to ensure effective risk control.

Culture
Reviews following change are recognised as opportunities to implement improvements to risk management in the organisation.

Standardised

- Underlying causes are routinely identified and corrective actions are appropriate to the potential risk.
- The right people are tasked with owning actions to ensure effective implementation.
- Corrective action will be at any level of the SMS and all actions are tracked to closure.
- Corrective actions are actioned in a timely fashion that is proportionate to the risk addressed by the action.

Culture
Individuals understand the importance of completing corrective actions and the organisation can demonstrate a learning culture.

- System for addressing corrective actions includes those affecting or arising from collaborative ventures.

Managed	• Corrective actions address only the immediate causes or those which are quick and simple to implement and rarely address underlying causes. • Actions are owned, but not always by the individual best placed to implement them effectively. • There is some tracking of corrective action to completion by senior managers, but not consistently. • Corrective actions are not prioritised consistently on the basis of risk. • Inconsistent sharing of lessons learned during collaborative ventures.	**Culture** Inconsistent completion of corrective actions. Completion depends on individuals involved and not system driven.
Ad-hoc	• Monitoring, audits and reviews result in little or no change, either because none are carried out or they are not followed up. • No systematic process for ensuring corrective actions are completed. • The organisation does not know if lessons are being learned from incidents and cannot demonstrate continuous improvement or a learning culture. • No application of legal or other standards. • No sharing of lessons learned with collaborators.	**Culture** Culture of acceptance of non-completion of corrective actions.

RSSB products relevant to monitoring, audit and review:

- **Annual Safety Performance Report:** a review of safety trends for passengers, workforce and the public.
- **Close Call:** to record and manage conditions and behaviours that, under different circumstances, could have led to injury or harm.
- **Common Safety Method for Monitoring:** guidance on how to complete the CSM monitoring process.
- **Accident Investigation Training:** standard, advanced and refresher training courses for incident investigators working to RIS-3119.
- **Human Factors Awareness Course for Incident Investigators:** for people involved in undertaking incident and accident investigations in the rail industry.
- **Safety Management Intelligence System:** for the collection, sharing and analysis of safety incident data.

RSSB Disclaimer and Intellectual Property Statement

The Risk Management Maturity Model (RM^3) has been developed by ORR in collaboration with the rail industry. RM^3 is freely available for readers to access and use, however, to ensure the Model is fully understood, the Rail Standards and Safety Board ("RSSB") has granted readers access to relevant Standards, that would normally be restricted to member-only viewing.

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Glossary

CMM	Capability Maturity Model
CMS	Competence Management System
CPD	Continuing Professional Development
CSM	Common Safety Method (of the EU)
EU	European Union
HSWA	Health and Safety at Work etc. Act 1974
H&S	Health and Safety
HSE	Health and Safety Executive
IOSH	Institution of Occupational Safety and Health
MHSWR	Management of Health and Safety At Work Regulations 1999
NED	Non-Executive Director
OEM	Original Equipment Manufacturer
LNER	London North Eastern Railway Limited
PDCA	Plan-Do-Check-Act Cycle
PPE	Personal Protective Equipment
RDG	Rail Delivery Group
ROGS	Railways and other Guided Transport Systems (Safety) Regulations 2006
RSSB	Rail Safety and Standards Board
SMART	Specific, Measurable, Achievable, Realistic and Time-bound
SMS	Health and Safety Management System
SSOW	Safe Systems of Work

Annex 1

The role of independent confidential reporting

The use of an independent confidential reporting service is an enabler of many aspects of the cultural excellence we are looking for. Leaders who genuinely welcome intelligence about their operations, 'work as done', and transparently use it, are effectively fulfilling the need for pro-active monitoring. Effective internal reporting systems which encourage people to speak up, set alongside a confidential reporting channel which people know they can use if they don't feel able to raise their voices internally, maximise the opportunity for leaders to capture this leading-indicator intelligence and act before an incident. This holds true during periods of stability when unsafe practices can creep in and during periods of change when feedback on unintended or unanticipated impacts of change is critical.

The confidential reporting service provided by CIRAS supports collaboration on two fronts. Enabling third party confidential reporting across contractual boundaries helps surface concerns that may otherwise remain hidden due to unclear reporting routes or fear of jeopardising commercial relationships. Active participation in the CIRAS membership community enables sharing of learning from reports and corrective actions taken, together with in-sector and cross-sector good practice on the topics raised by reporters.

To take well informed decisions, executive leaders and boards need access to transparent information on health, well-being and safety performance which is tested against independent sources of intelligence. Use of the data that CIRAS provides on the trends in topics reported confidentially, and of the reasons why people say they are reporting confidentially, provides independent insight into safety culture as felt on the ground, and an organisation's effectiveness at listening to and responding to concerns. CIRAS also delivers a degree of assurance that reported performance is genuine, by providing an outlet if safety targets have a negative impact on reporting culture.