ASK BETTER QUESTIONS

5 FOUNDATIONAL HEALTH, SAFETY & WELL-BEING PRINCIPLES

That Every Board Member Should Know

By

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WHY YOU NEED TO READ THIS ...

Whether or not you're an experienced non executive director, there are certain principles and concepts that you should be comfortable with when it comes to leading health, safety and well-being. Without this foundational understanding, you might be asking the wrong questions of your executives and/or health and safety professional and therefore driving the wrong behaviour and giving your board a false sense of security that the board is effective in its monitoring of non-financial risks.

For example, if you've ever said any one of the following statements, even if you've only said it to yourself, "safety is about rules", "why can't people just follow the rules?", "how can we control that one person who is obviously breaking the rules?" or "we generally have a good safety culture, but everyone has a few bad apples", then this guide is going to help you feel less frustrated and more inspired to use your influence as a means to drive positive health, safety and well-being outcomes in your organization.

With that said, I'm not going to lie to you, you might very well get frustrated reading what I'm about to tell you and think to yourself, "this woman has no idea what she's talking about!" And I'll be the first to say "I get it" - you're not the first and you won't be the last!

But all I ask from you is that you bring an open mind when reading this guide because what I'm going to tell you might be a paradigm shift for you and these types of shifts make people feel a bit uncomfortable. Indeed, it can be hard to accept that our mental models might be out-of-date and even more difficult to accept that we might be part of 'the problem'. We don't know what we don't know, right?

I will say this, I've worked with many non-executive directors and if any of the principles / concepts that we go through in this guide are new to you or challenge your way of thinking - you are not alone!

It's a paradigm shift for a reason.

So I encourage you to not tear up this document when you feel your perspective is being challenged or when you feel uncomfortable. That is exactly the time to push forward and stay curious because if you want to lead with heart and make a positive impact on the health, happiness and resilience of those in your organization then you need to lead by example.

The health, safety and well-being principles / concepts that we will go through in this guide will serve you well in your board career for years to come. They will build a foundation for you to ask better questions and challenge your own thinking as well as those in your boardroom and beyond.

Ok, let's get started!

1 SAFETY IS NOT DEFINED BY THE ABSENCE OF FAILURE

It's What Happens When It's Present

Safety is a term that is used and recognised by almost everyone, but because we immediately recognise it and find it meaningful, we take for granted that others do the same and therefore rarely bother to define it more precisely (Hollnagel, E., et al., 2015). However, people can think about safety very differently and not even realise this when they're talking amongst themselves.

So here's some food for thought … when you think about safety, what's the first thing that comes to your mind?

I bet in some part of your definition or frame of reference you've made a link between safety and the prevention of harm. For example, when someone is getting on a plane we commonly say, "have a safe flight" and of course we implicitly mean, "I hope you get to your destination without an accident or at the very least, in the same condition you left". Another common perception of safety is that it's the management of risk to an acceptable or 'reasonable' level.

The problem with these interpretations of safety is that they have traditionally contributed to an over reliance on the absence of negative events as a means of determining what is safe, and what isn't and these assumptions start to inform our biases and our decision-making around future safety.

Take an airline for example, if they haven't experienced a crash or a significant event, we often perceive them to be safe. No doubt you've said to yourself at some point in your life, "I've done this a million times before, and nothing bad has ever happened".

And while you might think it sounds logical to think of 'safety' as the absence of negative events because we don't want people to be hurt, and if they're not hurt, then they are safe. However, this mindset inextricably positions safety as a mechanism for avoiding things that go wrong and that therefore becomes the focus of our resources and energy. The problem with this mindset is that we prevent ourselves from appreciating or wanting to understand how things go right, which happens 99% of the time.

Let me explain.

How often do you think things go wrong in your organisation, compared to how often they go right? That's not a trick question. You don't have to be a statistician to know that things go right a heck of a lot more often than they go wrong - otherwise you'd probably be out of business.

In fact, research has found that the statistical probability of failure is 1 out of 10,000, meaning that one can expect things to go right 9,999 times out of 10,000. If that's the case, why are we focusing most of our efforts to create safety on the absence of failure when failure is only 1% of our work.

If we want to understand how our business succeeds every day, we can't just look at situations where safety wasn't present.

Figure 1: Relation between event probability and ease of perception

Adapted from Hollnagel, E., Wears, R.L. & Braithwaite, J., Safety-I to Safety-II: A White Paper, 2015

Adapted from Hollnagel, E., Wears, R.L. & Braithwaite, J., Safety-I to Safety-II: A White Paper, 2015

This is not to suggest that you don't try to prevent harm to those in your organization or other stakeholders, but how your board goes about preventing harm makes all the difference.

So the question is, how should we think about 'safety' to better lead by example?

This may be a paradigm shift for some, but safety is not defined as an absence of negatives, but by what happens when it's present.

Safety is not about ensuring that "as few things as possible go wrong", it's about looking at how we can ensure that "as many things as possible go right". Despite their crucial importance, understanding why things go right most of the time usually receives little attention.

If you want to support things going right, we need to look at the attributes of resilient teams and organizations, because resilient organizations focus on identifying and enhancing the positive capabilities of people and the organization to allow each of them to adapt effectively and safely under all the organizational and human pressures that they're faced with day-in-day-out.

Resilient organizations create ways to increase the capacity of the organization to accommodate change, conflict and disturbance without failure.

Safety is therefore about creating resilience.

See the difference in mindset? If we think positively, we are more likely to invest in the positive capabilities of our people and our organisation.

One of the most important questions you can ask yourself in all of our decision making is, "How can our board make it as easy as possible for people to do their job the right way?". If we support people in making their job easy, we can trust in their human nature to want the "right way" to be the safest and healthiest way.

Which brings us to the 2nd Foundational Principle

2 THINGS GO WRONG & THINGS GO RIGHT

For the Same Reasons

We often associate things going right with people following the procedure or doing what they're told - "follow the rules and we'll all be fine".

But the reality is, it's not that things went right today because rules were followed. By the same token, when we experience an incident, it's very likely that the way work was conducted on that day was not unique.

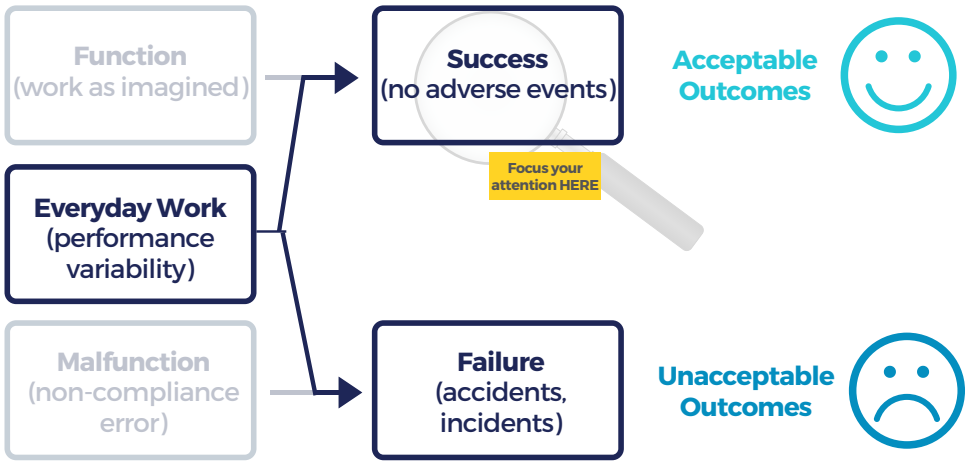
When systems perform reliably it's because people are flexible and adaptive (this is an attribute of resilient teams and organizations), rather than because the systems are perfectly thought out and designed and that work is done exactly as it was written in a procedure or plan.

Adjustments and variability are both normal and necessary for a complex system to operate effectively and efficiently, indeed they're the reason for success, but also for failure.

This is why people are essential to the system, because it's the people in your organization that must make these adjustments and manage everyday performance variability; therefore, people and performance variability are the source of both success and unfortunately failure.

The byproduct of this is that we come to an understanding that incidents can happen "even from perfectly 'normal' relationships, where nothing (not even a part) is broken", we can appreciate that our systems can be operating correctly or as intended and that can be the source of both success and failure.

Figure 2: Performance variability is the reasons things go right and things go wrong



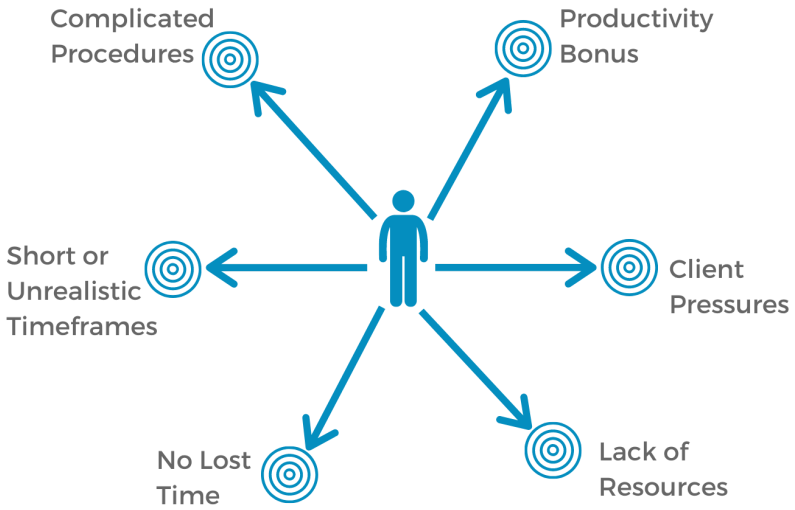
Hollnagel, E., Wears, R.L. & Braithwaite, J., Safety-I to Safety-II: A White Paper, 2015

Therefore, trying to achieve safety by constraining people's ability to make performance adjustments and manage all the day-to-day variability by putting in more policies and procedures or more rules will inevitably affect their ability to achieve desired outcomes as well as being counterproductive (Hollnagel, E., et al., 2015).

This is a paradigm shift - it takes us away from looking for "bad apples" or a person to blame and instead has us look at the structure of the system that is influencing patterns of behaviour; this is part of systems thinking and is essential to understanding how people in complex systems get work done.

The key is to focus your attention more on understanding the characteristics of everyday performance variability – where are things being adjusted, or where might things need to be adjusted, in order to achieve our outcomes or goals?

Figure 3: Everyday performance variability



Remember *Principle #1 - Safety is not defined at the absence of failure, but by what happens when it's present*, "how can our board make it as easy as possible for people to do their job the right way?".

Look to understand how people in your organisation achieve safe and healthy work everyday amongst all the constraints? How does your board influence those constraints?

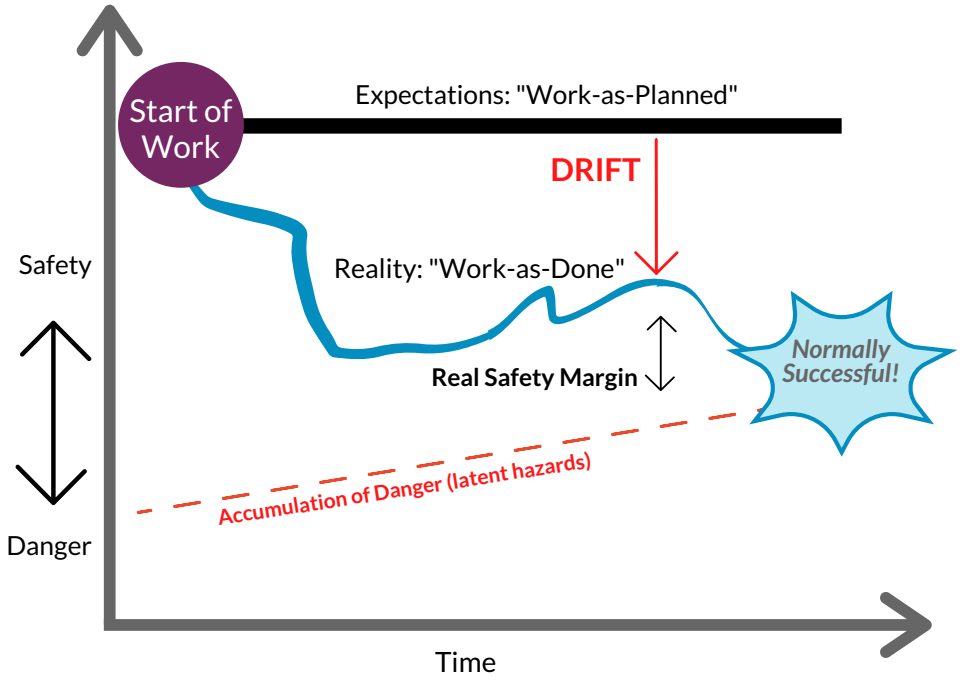
To appreciate these questions, you need to remember Principle #3

3 WORK IS RARELY DONE *As Planned*

If we want to understand how things go right most of the time, we need to understand how work actually gets done, not how we imagine the work will be done.

You might have heard the terms “Work-as-Imagined” or “Work-as-Planned” vs “Work-as-Done”. Work-as-Planned is an idealised view of our work environment that disregards the inherent complexity in our work - how people adjust their tasks or activities to match the constantly changing conditions of work and the world in which they work.

Figure 4: Work-as-Planned vs Work-as-Done and the presence of "drift"



Adapted from Dekker, S. (2007) *The Field Guide to Understanding Human Error*

The theoretical and practical roots of Work-as-Planned stem from the theory of scientific management, which suggested that a breakdown of our work or tasks and activities into “parts” (i.e. people, policies, procedures, equipment) could be used to improve work efficiency. This of course led to the factory production line. The assumption was that Work-as-Planned was a necessary and sufficient basis for understanding how work gets done, or Work-as-Done.

Work-as-Planned is based on the premise that the system in which we work is fairly decomposable and that all the parts in the system are working together in a linear fashion (i.e. task A, causes task B, which causes task C, and so on.). Consequently, this meant that adverse outcomes (i.e. incidents/accidents) could be understood by looking at the components or parts in the system to find out what has failed or malfunctioned or who made a bad decision - this is what we do when we search for a root cause.

Work-as-Planned sees performance variability as undesirable and something to be controlled and that to improve safety outcomes we need to plan our work better and provide more instruction, rules and training.

These beliefs have founded one of the dominant paradigms in our boardrooms concerning how work is done and the way our organization or the system functions; that is, work is done in a linear fashion and performance variability should be controlled or eliminated where possible.

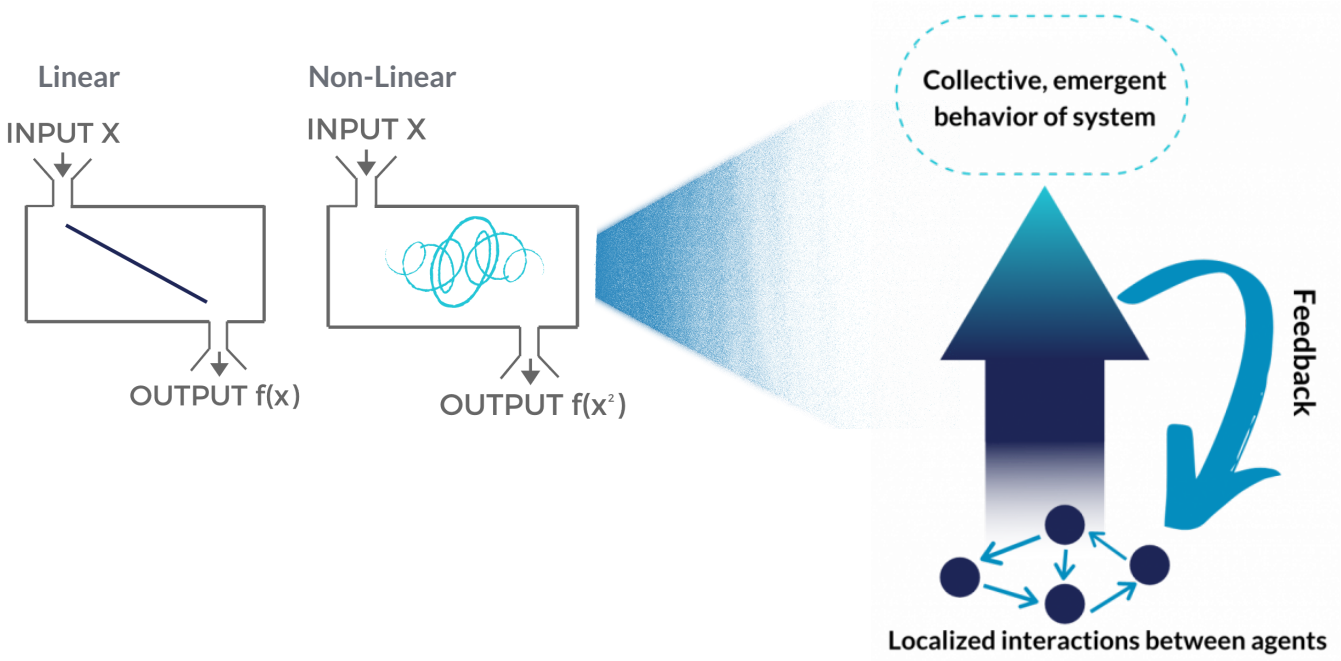
This is of course is at odds with *Principle #2 - Things go wrong and things go right for the same reasons*, because performance variability is necessary for a complex system to function; that is, for our work to get done and still meet the organisation's goals.

As outlined above in Figure 2, performance variability includes the outcomes of addressing goal conflict, which all of us do on a daily if not hourly basis, whether that's at work or at home. For example, we all have to make various trade-offs; such as being efficient versus being thorough, forgoing coaching and leadership activities to meet production targets or incentives, or choosing to deal with the mountain of work that we need to get done, over our health and physical exercise. Performance variability is also created when we're working with limited resources (which is for many of us, is most of the time), and performance variability happens amongst a web of relationships that exist inside and outside our organisation that inform our priorities.

As such, performance variability is the essence of Work-as-Done.

With that said, in today's inherently complex organisations the majority of our work is not done in a linear fashion, it's more circular in nature, and dynamic, where outcomes emerge rather than strict causality.

Figure 5: Emergence informs the system's behaviour



The presence of emergence is not that something happens 'magically', but that it happens in a way that cannot be explained using the principles of decomposition and causality. In the case of emergence, the observed (final) outcomes, or Work-as-Done are of course observable or 'real', but it's not necessarily clear what brought them about. The outcomes may, for instance, be due to transient phenomena or conditions that only existed at a particular point in time and space.

For example, we cannot ignore that outcomes will be influenced by someone experiencing a headache at work, or the breakup of a marriage, or the celebration of an event or local politics that were antagonistic that day or because departments were arguing over resource allocations. This is our reality.

It's easy for us to appreciate these factors or situations may influence how work gets done, but when something goes wrong our default is to break apart things and look for broken parts or bad decisions, instead of accepting that outcomes can emerge, and more often than not they do, and we can't always explain why. So don't let failure determine whether things are safe or unsafe because the reality is, adverse outcomes (incidents/accidents) are more often due to a combination of known performance variability that is usually disconnected from safety (Hollnagel, E., et al., 2015).

Accepting the idea of emergence and the circular nature of work instead of linear thinking and decomposition means that you accept that performance variability is necessary for the system to function.

So what does that mean from a safety perspective? And how can we create safe outcomes with all this performance variability?

The answer goes back to *Principle #1 - Safety is not defined at the absence of failure, it's what happens when it's present.* As such, don't put all your focus into how the organisation can avoid failure, because inevitably that will create more control and more control will not help prevent failure, but it will most certainly prevent success because you will take away the human element of managing the variability which is necessary.

Rather focus on understanding Work-as-Done by asking "why things go right most of the time (or why has nothing gone wrong)?" and then try to make sure that this happens again, because it's a safe bet that something that goes wrong will have gone right many times before - and will go right many times again in the future. Try to get a feel for the constraints or trade offs that people have to make that might compromise safe work. Again, "how can our board make it as easy as possible for people to do their job the right way?".

Ok, let's switch direction and look to mental healthh.

4 IMPROVING MENTAL HEALTH OUTCOMES *Is Multifaceted*

In most global jurisdictions, providing a psychologically safe and healthy workplace is a legal requirement; that is, you have a duty to ensure there is no harm to the mental health of your employees, customers or others like the public or those in your supply chain who may be impacted by your product or service, and in many jurisdictions this duty extends to your contractors.

But to ensure your duty is fulfilled, it's important to know that over the last 20 years, there have been significant developments in both law and various scientific disciplines as to what mental health is and isn't.

So let's start with a clear definition. First and foremost, we need to see and treat the term "mental health" as a positive state of being.

In fact, we are all on a mental health spectrum and therefore have the potential to fluctuate from healthy or flourishing on the right to moderate mental health or languishing in the middle where our life feels quite hollow and empty, where we don't fit the criteria of mental illness but we're definitely not functioning as well as we could be. And some of us may unfortunately venture over to the far left where we feel very unwell and this is where we may be susceptible to developing a mental disorder or experiencing mental ill-health.

Figure 6: Mental health spectrum

Adapted from Centre for Mental Health, UK; The United States Marine Corps Department of Psychiatry; YouthSmart, Canada; The Department of National Defense, Canada.

The World Health Organization has defined HEALTH as:

> *A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.*

The reference to 'well-being' here is important because it demonstrates that your duty should extend to not only preventing mental ill-health, but to ensure that through company operations you're not harming people's ability to flourish (we'll talk more about flourishing under *Principle #6: To Flourish is to Feel Food & Function Well*).

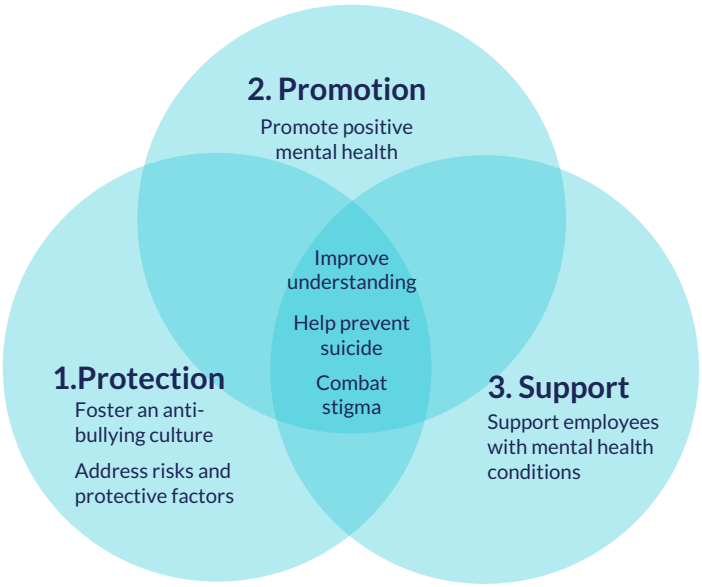
Much like what we've talked about above in terms of safety not being defined as the absence of negatives (i.e. injury), but as the presence of something, so too is mental health.

With that said, a psychologically safe and healthy workplace is a workplace that promotes workers' psychological well-being, where leaders ACTIVELY work to prevent mental ill-health, not just ensure that harm doesn't exist, and where possible IMPROVE workers' mental well-being.

Managing and governing mental health should focus on our organisational capacity to treat human beings in such a way that they become more, rather than less than what they were at the point of their employment.

That's why any mental health plan or psychological health and safety management system should take a holistic approach by focussing on three strategic pillars:

Figure 7: Three strategic pillars to psychological health and safety



Adapted from *Beyond Blue and Heads Up*

#1 Prevent & Protect employees from hazards and risks to their psychological health and safety.

This is where we identify the key hazards that are or can cause people distress.There are a few hazards that are broadly applied to any workplace; such as harassment and bullying, but we also need to identify those hazards that are specific to our workplace that may cause distress.

For example, in 2019, in a world first, a judge ruled that Australian newspaper company, The Age, was responsible for one of their journalist's post-traumatic stress disorder, otherwise known as PTSD, because the company had failed to provide a safe workplace.

Like many journalists, for decades she had attended the scenes of more than 30 murders while employed by the newspaper. As a crime reporter, she was frequently among the first on the scene for serious crimes, injuries and deaths of which she was required to investigate and report on. She even reported on gangland-related crimes, and as a result found herself on the receiving end of threatening phone calls.

She covered Supreme Court cases, suicides, fatal car accidents, and natural disasters including the Black Saturday bushfires in Victoria Australia where towns were wiped out and 173 people perished, with over half of them (113) dying trapped in their homes.

As a result of her workplace, she developed symptoms of depression and anxiety. Her legal team argued that the repeated exposure to traumatic events led to the deterioration of her mental health which significantly affected her sleep and personality to the extent that she sought medical treatment. The reference to sleep and personality is just as important to note as is her depression and anxiety. These are both the mental and physical results of the impact organisations can have on people's ability to flourish.

The answre is not that The Age should have no employee reporting on these events, that's part of the business model, but there no strategies offered to her to prevent further trauma when she repeatedly asked to be transferred from "first on the scene" reporting due to experiencing mental ill-health.

Indeed, instead of protecting her mental health, the company had her cover supreme court cases where there was still trauma related events to report on. The Age also never offered support mechanisms during her employment or when she suffered mental ill-health, which we'll take a look at below under Pillar #3.

#2 Promote activities and intervention initiatives that support psychological health and combat the stigma.

This pillar will include positive things that your organisation does to improve workers' mental well-being, raise awareness of mental health or increase people's resilience. This would include your workplace pilates, yoga and meditation / mindset programs as a starter and it includes awareness events like those that many organisations host for R U Ok? Day, a day in Australia that's focussed on mental health awareness and prevention of suicide.

But it also includes a strategic focus on well-being - see *Principle #5: To Flourish is to Feel Good & Function Well.*

#3 Provide Resolution or Support services for those employees who are suffering from mental distress or illness.

This is where your employee assistance program would sit and other support mechanisms that assist employees in managing their own mental health. These mechanisms are often confidential and available to employees to use at their leisure.

This pillar also includes the structure and flexibility you have in place to support people to take time off when they're distressed (i.e. sick or some companies have implemented a 'mental health day'), or to work from home if they have a mental illness and they simply have days where they just can't physically make it into work. They don't necessarily want or need more sick days, because those run out at some point and that's stressful in itself. What people with a mental illness often need is flexibility and empathy. They need their manager to understand that they're struggling, but given time, compassion and flexibilty, they will be back and able to contribute.

A perfect segway to our fifth and final health, safety and well-being foundational principle.

5 TO FLOURISH IS TO *Feel Good + Function Well*

The realm of positive psychology was officially recognised as a new domain of psychology in 1998 when Martin Seligman chose it as the theme for his term as president of the American Psychological Association. He is considered one of the founding fathers of positive psychology and his view, as well as many other eminent psychology practitioners, was that psychology had more often than not emphasised the shortcomings of individuals compared to their potential. Another example of where we tend to focus on the negatives, over the positives.

As an example, in clinical psychology research, any studies around emotions and the impact they have on our well-being were focussed primarily on fear, anger and sadness, not on the effect that positive emotions could have on our well-being; such as experiencing joy, serenity, happiness or gratitude.

Positive psychology still applies a scientific method, but it simply studies different topics to clinical psychology and asks slightly different questions, such as "what works?" rather than "what doesn't?" or "what is right with this person?" rather than "what is wrong?".

Are you seeing a theme here?

Just like "safety" and "health", we are encourage to move beyond preventing adverse outcomes or measuring negatives, and instead focus on promoting the positive aspects of health, safety and well-being and supporting people in being healthy, happy and resilient or flourishing.

Flourishing is where our life feels complete and fulfilling; we are happy and satisfied; we tend to see our lives as having a purpose; we accomplish meaningful and worthwhile tasks; we have a sense of personal growth in the sense that we are always growing, evolving, and changing; and we have a sense of autonomy and an internal locus of control, we chose our fate in life instead of being victims of fate.

Simply put, flourishing is about feeling good and functioning well.

The World Health Organisation has defined WELL-BEING as:

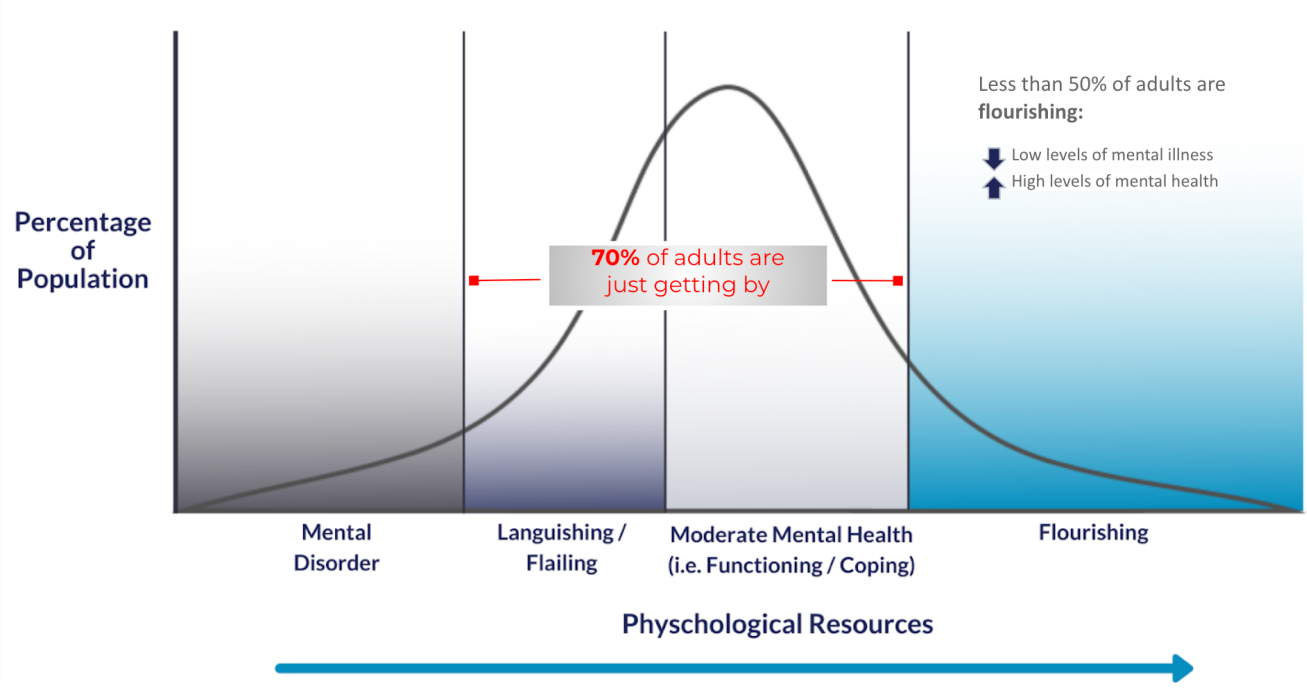
> *A state in which the individual realises his or her own abilities, can cope with normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her own community.*

Think about the employee who suffered PTSD at The Age newspaper. Not only did her employer cause her to suffer a mental illness, but they diminished her ability to make a contribution to her community. She certainly didn't feel good or function well.

Studies have shown that we live in a world where less than 50% of adults are flourishing, where they have low levels of mental illness and high levels of mental health. And a growing body of research suggests that when it comes to our well-being, 70% of us report that we actually spend most of our time somewhere between 'functioning' and 'flailing'. In other words, instead of flourishing, most of us are just getting by.

The goal of positive psychology is therefore to increase the amount of flourishing in life, so that we're all moving just that little bit more to the right on the mental health spectrum.

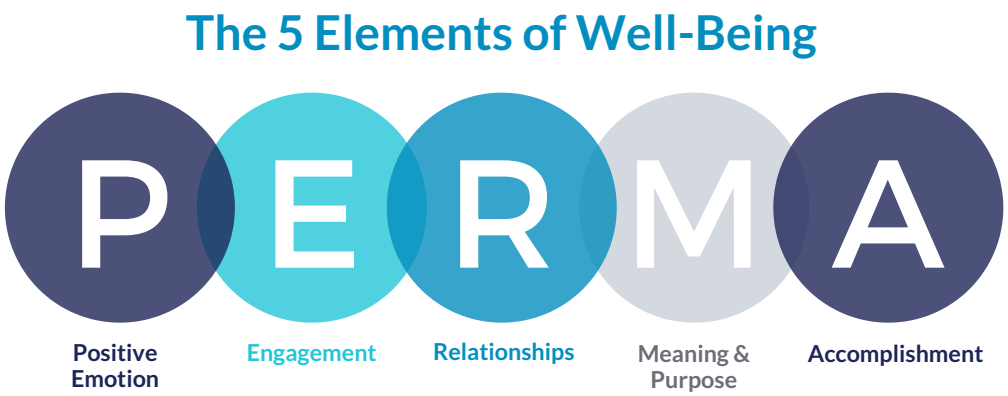
Figure 8: Mental health spectrum and the goal of positive psychology



Adapted from Well-being Institute, University of Cambridge, 2011

Using the science of positive psychology, Seligman developed a well-being framework that takes well-being from a concept and gives us five measurable elements that count toward flourishing and greater resilience. It's called the PERMA well-being model.

Figure 9: 5 Elements of the PERMA well-being model



Adapted from Seligman, M.

#1 Positive Emotions

This includes emotions like happiness, joy and gratitude and the incredible emotional and chemical benefits they bring to our brain and our heart.

#2 Engagement

This is where we're employing our strengths and virtues so that we're operating at our peak performance and through this, we're fully absorbed in that space - this is called a state of "flow".

#3 Positive Relationships

These are relationships where we feel connected to others in a meaningful way. Do we feel seen and heard? Do we feel like someone cares about whether we're here on this planet or not? And do we feel that we have people in our lives who we can rely on in a crisis or who we can discuss important life decisions with or other private matters?

#4 Meaning and Purpose

This is where we experience a sense of belonging to something or serving a bigger purpose.

#5 Accomplishment or Achievement

We have an intrinsic motivation to achieve things, or to have a level of mastery or competence.

No one element in the PERMA well-being model defines well-being, but each contributes to it. Indeed, each of the elements in the model link together, they support each other, even amplify each other.

For example, feeling good about a new board role or other achievements, feels even better when we celebrate with people we're close to. Feeling connected to others and having positive relationships can also give our life purpose and meaning and it's why when we don't feel connected to others, we are at a much greater risk of depression and suicide.

Understanding where and how your board influences these elements and therefore the well-being of those in the organisation is important, so too is how and where your board can utilise these elements to improve the well-being of those in the organisation, but also those on the board.

What Next?

To help you take these principles and use them to inform your boardroom decision-making, I've collated five of my favorite videos / blog posts for your viewing and reading pleasure.

Enjoy!

#1 Injury Classifications - Moving Away from Lost Time Injuries

#2 Process Safety, the Black Swan of Safety

#3 Investing in Mental Health is a Healthy Investment - Part 1 of a 3-Part Series

#4 4 Director Health & Safety Governance Myths [free download available]

#5 The Cost of Unfairness in Your Workplace

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