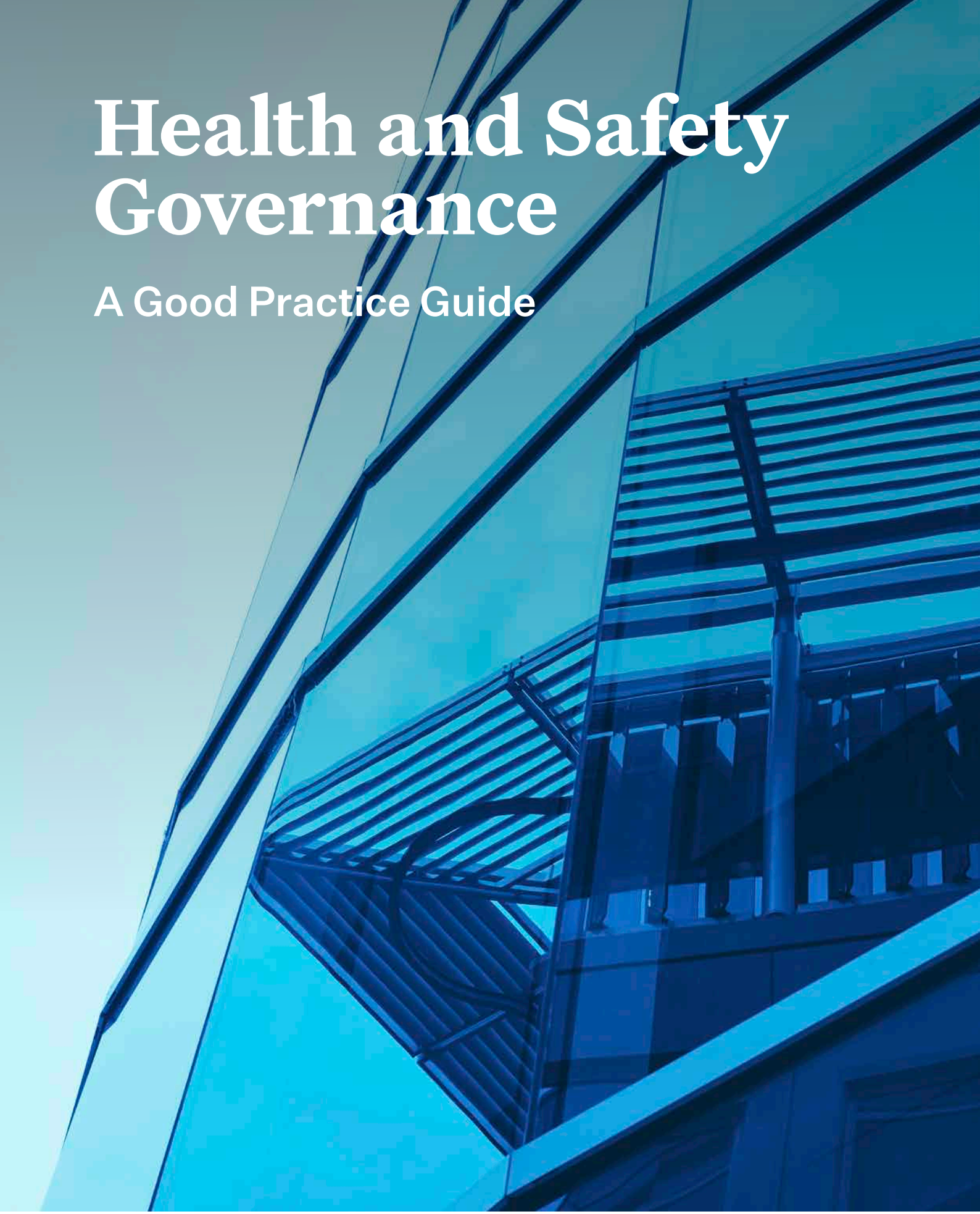
Health and Safety Governance

A Good Practice Guide



Institute of DIRECTORS NEW ZEALAND

WORKSAFE NEW ZEALAND | MAHI HAUMARU AOTEAROA

This guide has been prepared by the Institute of Directors (IoD) in New Zealand in association with WorkSafe New Zealand, the Business Leaders Health and Safety Forum and the General Manager Safety Forum.

The IoD and WorkSafe would like to thank those members of the governance community that provided input and advice through workshops, interviews and reviews, and acknowledge the authors of the report, members of the steering group and members of the Better Governance Project Team for their dedication and expertise, in particular:

Chris Jones – Steering Group Chair, representing the GM Safety Forum

Francois Barton – Steering Group, representing the Business Leaders' Health and Safety Forum

Craig Marriott – Lead Author and Expert Advisor

Mike Cosman – Expert Advisor, and representing the IoD

Greg Lazzaro – Expert Advisor

Stephanie Coutts – Project Manager, Better Governance

Contents

Foreword

The Health and Safety at Work Act 2015 introduced new obligations on "officers" of companies and other organisations. Directors were advised to be risk averse in ensuring they did not incur the substantial penalties that they could not insure against. This made sense in the context of the Pike River disaster and other problems with health and safety practice that the independent Taskforce on Workplace Health and Safety found in its report from April 2013. They suggested that:

"...those in governance roles assume a due diligence duty to be held by directors and people (e.g. chief executives) who participate in decision-making. We believe strongly that directors' duties in relation to workplace health and safety should be as strong as other fiduciary duties."[1]

These changes aimed to address a gap in New Zealand's health and safety at work system. The previous Institute of Directors of New Zealand (IoD) and WorkSafe Health and Safety Governance Guide ("the Blue Book") was published to help directors follow and achieve the vision the Independent Taskforce created for better health and safety at work outcomes.

The new legislation, with officer duties, expected to deliver the significant decrease in workplace injuries and fatalities that other countries achieved with new workplace health and safety legislation. For example, a 2011 report from the United Kingdom showed that over 10 years "the rate of fatal injuries to workers has fallen by 38 per cent between 1999/2000 and 2009/10".[2]

Despite the new legislation and our effort to support improved health and safety governance practice in New Zealand and the penalties involved, workplace deaths and injuries in New Zealand have remained high.

This needs to change with a new approach.

The Better Health and Safety Governance Project has been our starting point. We contributed to this with our partners the Business Leaders Health and Safety Forum and the General Manager Safety Forum and funding from WorkSafe.

This forms the basis for this new Health and Safety Governance Guide. It's based on good practice governance, the role and mindset of directors, and the tools that will help directors more effectively support better health and safety at work outcomes.

I hope that this helps directors and boards to more effectively support management to deliver better health and safety at work outcomes.

Ngā mihi

Kirsten (KP) Patterson
Chief Executive – Institute of Directors

1 The Report of the Independent Taskforce on Workplace Health and Safety: *He Korowai Whakaruruhau:* Executive Report, April 2013 (see: Executive report of the Independent Taskforce on Workplace Health & Safety - He Korowai Whakaruruhau (mbie.govt.nz)), page 20

2 Löfstedt, R. E. (2011), Reclaiming health and safety for all: An independent review of health and safety legislation (see: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/66790/lofstedt-report.pdf)

As Chair of WorkSafe New Zealand, I am pleased to introduce this guidance to support a better understanding of what good governance looks like in practice, particularly as it relates to work health and safety.

WorkSafe is pleased to have supported a guide developed by industry, for industry. As the primary work health and safety regulator, WorkSafe's role is to influence businesses, with the support and involvement of workers, to carry out their responsibilities to ensure work is healthy and safe. Endorsing this resource is a great example of how we can exercise that influence to empower others to take action.

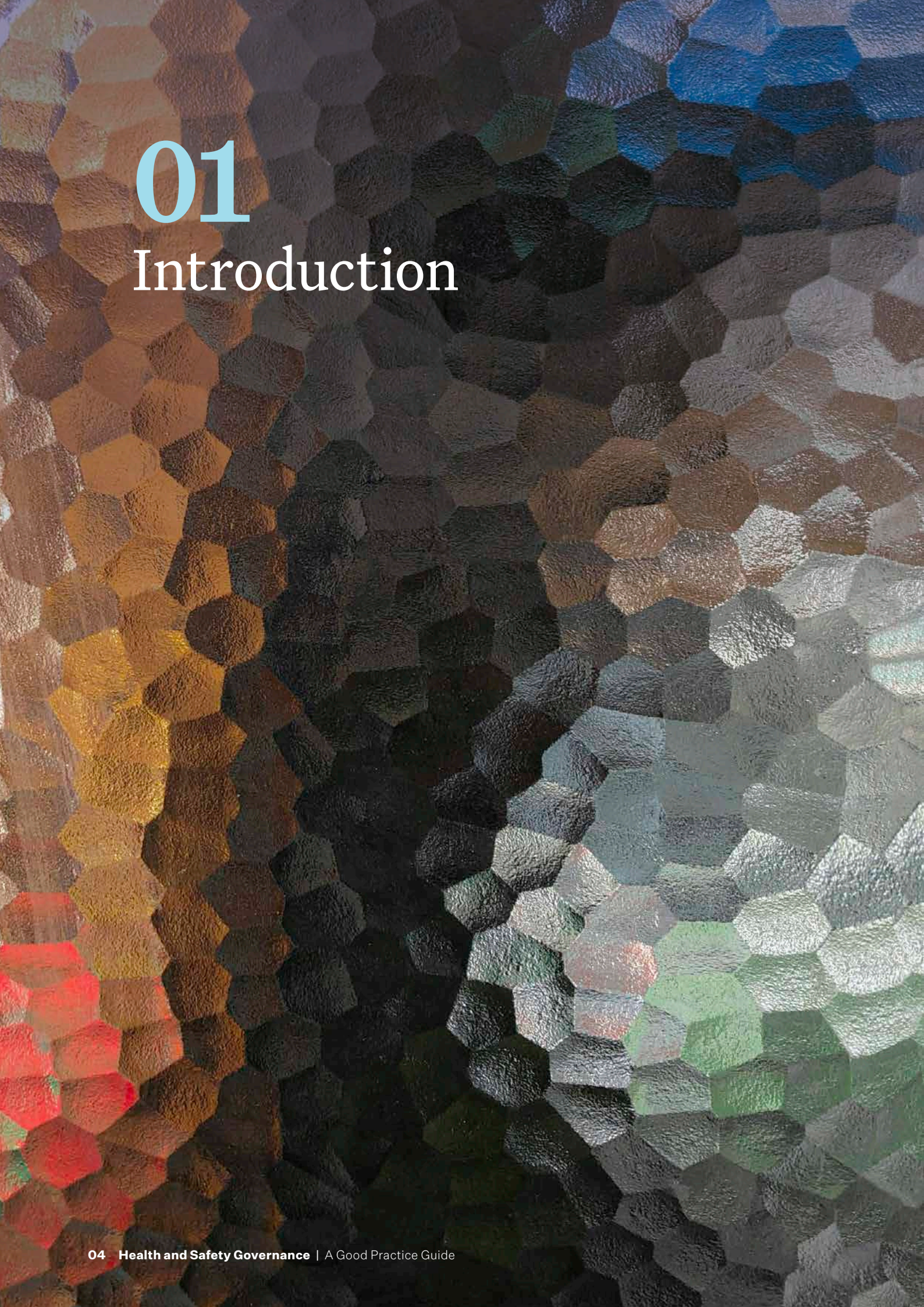
Businesses best know their workplace, their risks, and how to manage them. In developing this guide, the Institute of Directors, together with the Business Leaders Health and Safety Forum and the General Manager Safety Forum, drew on their collective expertise and knowledge to present information for those in governance roles in a way that a government regulator could not.

This resource goes beyond typical guidance focused on legal obligations under the Health and Safety at Work Act 2015. Instead, it also embeds the officer duty within wider good governance practice, by describing practical ways in which officers can approach their role that will help achieve the outcomes intended by the law. WorkSafe encourages officers to take those extra practical steps.

I am confident that this guide will help those in governance roles to do better to promote and embed work health and safety across businesses in Aotearoa.

Ngā mihi

Jennifer Kerr
Chair – WorkSafe New Zealand



01 Introduction

→ Health and safety thinking is now more work-focussed and takes more account of the complexity and variability of workplaces.

Effective governance has a key role to play in helping organisations deliver better performance and outcomes. This includes good health and safety outcomes.

Health and safety governance is not materially different from any other type of governance in terms of the approach taken, the roles of governance and management and the fundamental drivers of good governance. It does, however, focus on specific aspects of an organisation's operations and their effects. This requires a sound knowledge of health and safety concepts, practices, terminology and approaches, with clear understanding of responsibilities and accountabilities.

In 2015 the Health and Safety at Work Act (HSWA) was introduced to strengthen the regulatory framework and help drive better health and safety performance. While significant effort has been expended, and widespread improvements made, this has not had the intended effect in terms of a sustained reduction in the number of workers dying, being seriously hurt, or suffering severe health effects in New Zealand workplaces. This includes groups more likely to suffer harm at work, such as Māori and Pasifika workers, migrant workers, workers with disabilities and those with low literacy levels or for whom English is not their first language.

HSWA included obligations on 'officers' carrying out governance activities. While the fundamentals of governance have not changed significantly since 2015, there has been a global evolution in the way health and safety is viewed and managed. This has moved from a compliance-focused, rules-based approach to one that is more noticeably focussed on productive work and takes more account of the complexity and variability of workplaces. This approach acknowledges that systems and rules cannot predict and cater for all eventualities and that trained and competent workers need to be supported to safely manage activities, and adapt to changes in real time. This is not a wholesale shift that abandons the need for compliance, but one that demands a more appropriate balance.

This guide reframes health and safety governance to reflect the latest thinking and research in health and safety. It helps officers better understand how to make sense of the complexities of work and work organisation to enable improved decision making at a governance level. It is based on the vision and principles detailed by the Better Governance Project.[3]

3 Better Governance Project, a review of health and safety governance in New Zealand carried out in 2022/23 by the Institute of Directors, the Business Leaders' Health and Safety Forum and the General Manager Safety Forum, supported by WorkSafe NZ.

Purpose and scope

The primary purpose of this guide is to provide advice to officers on how to deliver better health and safety governance with a view to creating better performance outcomes. In doing so, it considers the specific legal obligations that are in place but goes beyond them to view health and safety in its broader context.

To achieve this, the guide:

- Lays out the fundamentals of health and safety governance.
- Provides a vision for good health and safety governance and a behavioural framework for officers and other leaders to support the vision.
- Outlines a set of health and safety governance principles.
- Offers questions for officers to ask and examples of good answers to look for.

→ Readers should seek independent advice as necessary regarding their own specific legal obligations under HSWA.

The guide has been designed to be flexible so that the information is of use to anyone in a governance role in any type of organisational structure of any size. It also acknowledges the role of management and health and safety leads supporting this approach and provides guidance on their roles.

This guide has been drafted by the IoD in New Zealand in association with WorkSafe New Zealand, the Business Leaders Health and Safety Forum and the General Manager Safety Forum. It replaces the *2016 Health and Safety Guide: Good Governance for Directors*.

How to navigate the guide

There is a wide range of experience, capability and resource availability within the governance sector in New Zealand. To account for this, this document is supported by a separate 'quick guide'. The quick guide describes basic actions that will provide a foundational level of governance if implemented. It is intended to be used as a first step in the governance journey as well as acting as a short refresher to the full guide. This full guide describes a more detailed and comprehensive approach to governance.

Following a discussion about what governance is all about, the guide provides sets of questions to ask both your organisation and yourself. These are supported by examples of good answers and are broken down into:

- Fundamental systems and processes to have in place.
- What you should do to carry out good governance.
- How you should go about doing it.

Each question set is provided as a single table to make it easy to refer to.

It also includes appendices with further examples of good practice and other useful information that also support the quick guide.

The guide mainly describes approaches where formal governance is in place, such as a board of directors. Many organisations do not have this in place but the principles and approaches still apply, although they may require some changes to suit the local context.

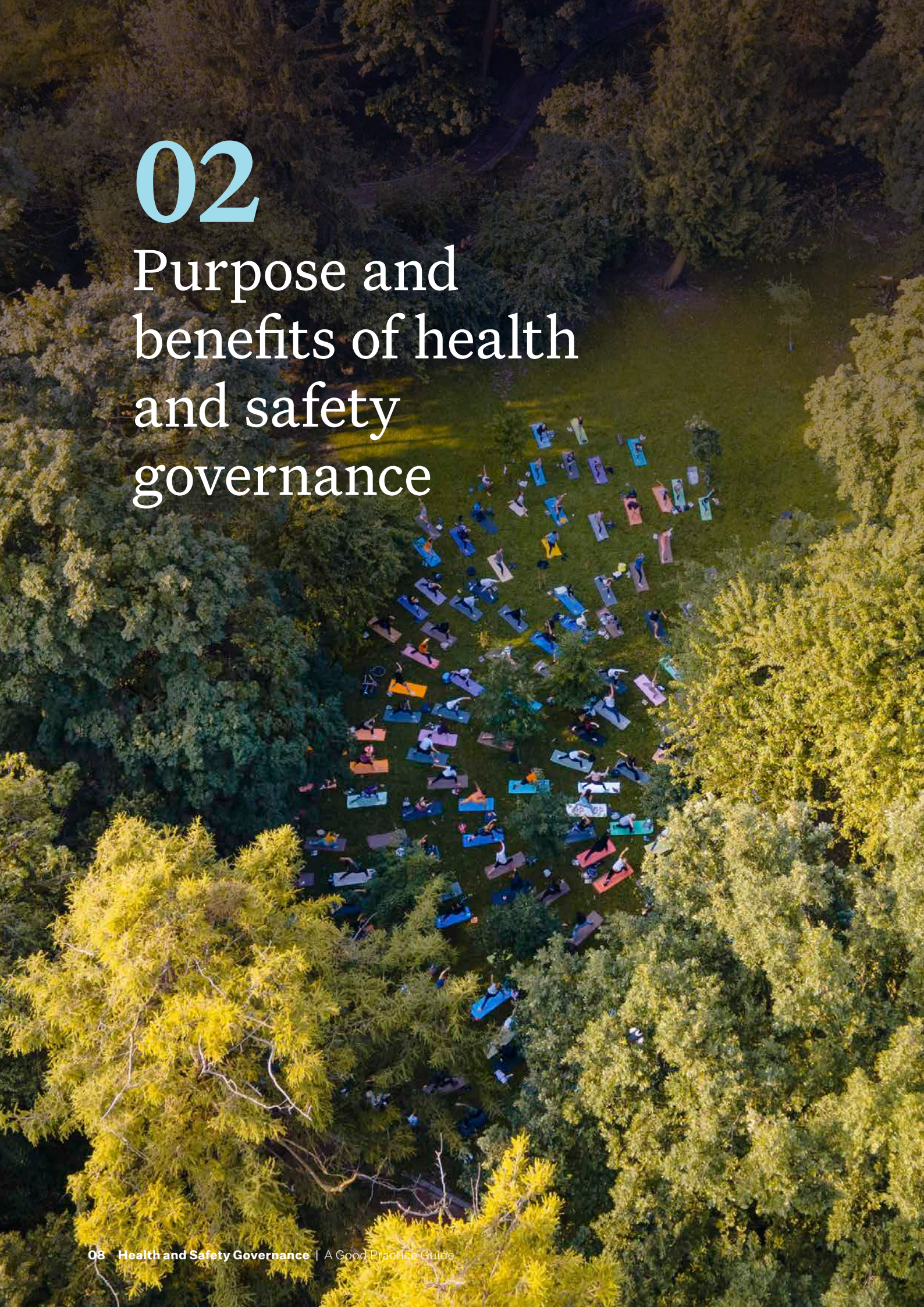
A note about wellbeing

This guide talks about health and safety risks. This includes risks with the potential to cause both physical and mental harm in the short or long-term. 'Wellbeing' is more typically used to describe a broader sense of good health (physical and mental), a strong sense of purpose, and a positive sense of being and is complementary to the risk management focus of health and safety. HSWA places obligations relevant to health and safety and does not mention wellbeing.

Wellbeing is a challenging area due to the intersection of causes and effects from work and home life. A key component in the work contribution to better wellbeing is developing and sustaining a positive and supportive working environment, both in terms of working culture and provision of adequate training, resources and good work design. Governance plays an important role in establishing the framework through which these can be delivered, and making sure it is applied with cultural and emotional intelligence to create an environment that is inclusive and welcoming for all. This is woven into the vision and principles laid out in the guide. If these are implemented as recommended, they will provide a solid foundation for better wellbeing.

02

Purpose and benefits of health and safety governance



Governance is:

- Seeing the bigger picture.
- Taking the longer-term view.
- Working on the business, rather than in the business.
- Noses in; fingers out.
- Doing the right things, rather than doing things right.

Governance is the 'bigger picture' part of running your organisation. It includes all the activities associated with making sure that things are stable, well-managed and heading in the right direction. This involves taking a well-informed view of the wider environment that you operate in; understanding your staff, customers and other stakeholders and creating a strategy to continue to perform in the longer term. Then checking regularly to make sure that management operates in a way to support that strategy.

Governance also leads the ethical and legal aspects of operation. The way in which you govern sets the tone for the organisation and has a big impact on your working environment, your reputation and ensuring fairness, honesty and legal compliance.

There is no single definition of governance, but a widely used one is defined in the landmark Cadbury report as 'the system by which companies are directed and controlled.'[4]

While governance often conjures images of formal boardrooms and financial markets, all organisations carry out governance no matter how they are structured or how big or small they are. There are, of course, legal compliance requirements and other necessary parts of governance, but any time you step back from detailed operational matters to think about the future, how well you are performing or what new areas you could explore, you are taking governance action. Without doing this, you run the risk of being unprepared for the future and impacting your performance.

There are many different functions and tasks involved in running an organisation and governance considers all of them. Financial, legal, operations, marketing, people, technology, and other areas all feed into governance considerations. This includes health and safety. All these areas are interlinked and, though each requires its own expertise and knowledge, they must be thought about together. You can't meet your health and safety goals if they don't align with your operations strategy or if things are not financially stable.

Governance activities that are key to health and safety include:

- Setting the vision and strategy for health and safety.
- Mapping the health and safety risk profile.
- Defining your risk appetite/tolerance.
- Oversight of relationships with related parties.
- Agreeing health and safety objectives and the required resources and priorities.
- Establishing the framework for monitoring and reviewing performance.
- Assuring yourself that critical health and safety systems, controls and processes are known about, understood and being applied effectively.

4 *Report of the Committee on the Financial Aspects of Corporate Governance UK (1992)*, better known as the Cadbury Report.

Good governance increases the likelihood of good health and safety outcomes for your workers and anyone else that may be affected by your activities. As well as making sure that they go home healthy and safe, there are several other benefits that arise from good health and safety performance:

- Supporting broader environmental, social and governance (ESG) expectations from investors and communities.
- Enhanced standing among potential workers, customers, suppliers, partners and investors as a result of a good reputation for a commitment to health and safety.
- Workers participating positively in other aspects of the organisation.
- Decreased worker absence and turnover.
- Reduced business costs, for example, a reduction in ACC levies or insurance costs.
- Potentially increased economic returns. A report from the International Social Security Association found a return on prevention ratio of 2.22.[5]

A note on the use of metrics.

Traditionally, organisations often counted the number of injuries to decide how safe their work was. This has followed through into governance reporting, with most reports focusing on accident rates, such as total recordable injury frequency rates (TRIFR) and lost time injury frequency rates (LTIFR). But people can escape unhurt from very unsafe activities, so the lack of an accident does not provide much insight into how safe the work was. Research[6] has also shown that such measures can be random, non-predictive and not helpful as a measure of health and safety.

→ Focus should move away from counting accidents to monitoring positive contributors to health and safety.

Focus on health and safety performance, and related governance reporting, should centre on those areas that genuinely contribute to safer outcomes, such as providing enough resources, designing work well, training people, testing key health and safety controls and so on. These contributors are discussed in more detail later in this guide.

You should consider your reporting systems and move away from measures like TRIFR and LTIFR to those that are more insightful. Further information on reporting is provided in Appendix 2.

5 The Return on Prevention: Calculating the costs and benefits of investments in occupational safety and health in companies; International Social Security Association (ISSA), Geneva, 2011.

03 Health and safety governance ecosystem

The obligation to keep workers and other people safe lies with those organisations that can influence or control work, workers and workplaces that could harm someone. This is known as the Primary Duty of Care. Part of governance is ensuring that the organisation is discharging this primary duty and any other obligations. Although the person conducting a business or undertaking (PCBU) has this duty, officers should positively influence how the PCBU goes about meeting it, by exercising due diligence.

People responsible for governance activities have the influence, control and authority to make decisions that impact the whole organisation. In the health and safety context, these are known as officers, a term defined in HSWA. Officers have specific legal obligations. Good governance practices are broader than just these obligations but include them. Officers cannot carry out their role in isolation from other parts of the organisation and the key components in the health and safety governance ecosystem are the officers, the senior management and the health and safety professionals that provide specialist advice. Specialist advice can also come from external experts where a topic is particularly complex or unusual, where additional independence is beneficial or where there is no internal resource available.

Working together across this ecosystem allows health and safety matters to be integrated into the organisation's strategy and effectively embedded into its day-to-day operations.

Broader ecosystem factors include working with supply chains and partners, regulators and the expectations of wider society. These should also be considered when carrying out governance activities.

Officers

Officers are defined as:

- Company directors.
- Partners in a partnership and general partners in a limited partnership.
- A person who holds a position comparable to a director in a body corporate or unincorporated body (e.g. members of boards of Crown entities, school trustees, board or committee members for iwi trusts, or community or not-for-profit organisations).
- People who hold positions that enable them to significantly influence the management of the business or undertaking (e.g. CEOs).

Officers set the organisational vision and strategy for health and safety and approve the health and safety policy and other key policies. They may also set a charter outlining how they will approach health and safety governance and leadership. Once a strategy is in place, they set objectives for management to achieve and ensure the resources are made available to deliver them.

Having established these foundations, their role is then to monitor the performance of the organisation. To achieve this, they receive and review performance reports and establish suitable assurance

activities – such as audits and reviews into areas of high risk or of particular interest or concern. This requires a knowledge of what good practice should look like and being curious and asking insightful questions about performance.

This ongoing monitoring is a legal obligation in the HSWA. An officer must exercise due diligence to make sure that the PCBU is managing its risks and other activities effectively so that it meets its legal obligations.

Due diligence is defined in section 44(4) of HSWA as including taking reasonable steps to:

- Acquire and keep up to date knowledge of health and safety matters.
- Gain an understanding of the operations carried out by the organisation, and the hazards and risks generally associated with those operations.
- Ensure the PCBU has, and uses, appropriate resources and processes to eliminate or minimise those risks.
- Ensure the PCBU has appropriate processes for receiving and considering information about incidents, hazards and risks, and for responding to that information in a timely way.
- Ensure there are processes for complying with any duty, and that these are implemented.
- Verify that these resources and processes are in place and being used.

Officers must exercise the care, diligence, and skill that a 'reasonable officer' would exercise in the same circumstances. What is considered reasonable will depend on the circumstances, including the nature of the business or undertaking, and the officer's role and responsibilities. For example, what is reasonable for a newly appointed officer may be different to that of an officer who is the Chair of the Board Health and Safety Committee.

All officers may seek health and safety advice from experts or others within their organisation. Where they choose to rely on this advice, the reliance must be reasonable.[7] Officers should obtain enough health and safety knowledge to ask the right questions of the right people and to obtain credible information. This may involve external experts.

Due diligence is an obligation on individual officers. It is not the responsibility of the PCBU and it is not a collective responsibility. It places a duty on individuals whose decisions significantly influence the activities of a PCBU, therefore influencing whether the PCBU meets its duties. However, the PCBU's duties and the officer's due diligence duty operate independently. If a PCBU fails to meet any of its duties it does not necessarily mean that the directors or other officers have failed to exercise due diligence. Conversely, a director

7 Companies Act (1993), s138 (and s44 of HSWA for officers other than company directors)

or other officer may fail to discharge their due diligence duties even where the PCBU has not failed in its duties. This might happen if there is no demonstrable governance of health and safety occurring, for example.

Note that elected members of local authorities and community boards, trustees or members of school boards (other than the Principal) and volunteer officers cannot be prosecuted for failing to discharge their officer duty.

Management

Management's role is to ensure that the organisation is managed so that the health and safety strategy and objectives are achieved. To do this they set targets that support progress towards objectives, incorporate these into management practices and allocate resources to achieve them (within the overall budget approved by the board). They collate insights and reports to inform the officers of progress and any challenges arising. This must involve worker participation to ensure that the approaches taken, and the information reported, reflects the reality of work on the front line.

Health and safety leads

The health and safety lead's role is to bring technical specialism to the governance process. This includes:

- Implementing a health and safety management system that guides leaders and workers on practices that make positive health and safety outcomes more likely.
- Keeping up to date with health and safety concepts and ideas.
- Structuring the reports to give genuine insights.
- Ensuring the data underpinning the reports is robust, relevant and targeted towards the right areas of high risk.
- Providing health and safety advice to both management and officers.

Health and safety advice can come from external specialists as well as an internal team. This may be the case where an organisation is too small to carry its own expertise; when the advice required is of a specialist nature that may not be available internally or where fresh eyes or an independent view are of value. There is a range of options from specialists with strong field experience, to those experienced at governance and strategic levels. Officers cannot delegate their obligations, but they can delegate specific tasks to others to help them meet them, such as by seeking advice from an external specialist. An officer's reliance on advice must still be reasonable, so officers should ensure that there are processes in place that allow them to be satisfied that any advice they receive is reliable. Seeking demonstrably capable and credible advice is key to this.

The use of external versus internal advice should always balance the value of the new perspective with the level of understanding of the local context.

Managing Dual Roles

Senior managers may also carry the officer responsibilities where there are no independent or non-executive directors such as in smaller businesses or many government departments. Even with a dedicated board, chief executives fall within the officer definition and other senior leaders may potentially do so.

In these instances, executives that wear both hats should make a deliberate effort to separate their governance activities from their management ones. This may involve:

- Setting aside time dedicated to governance.
- Having a clearly defined set of governance activities.
- Bringing in an independent person to provide advice and/or challenge for governance discussions.

Key relationships are summarised in the figure on the next page for a typical company with a formal board of directors. To optimise health and safety governance and achieve better outcomes, all components of this governance ecosystem need to be aligned and work effectively together, including formal worker representation as well as more informal worker engagement processes. This is explored in the next section of the guide.

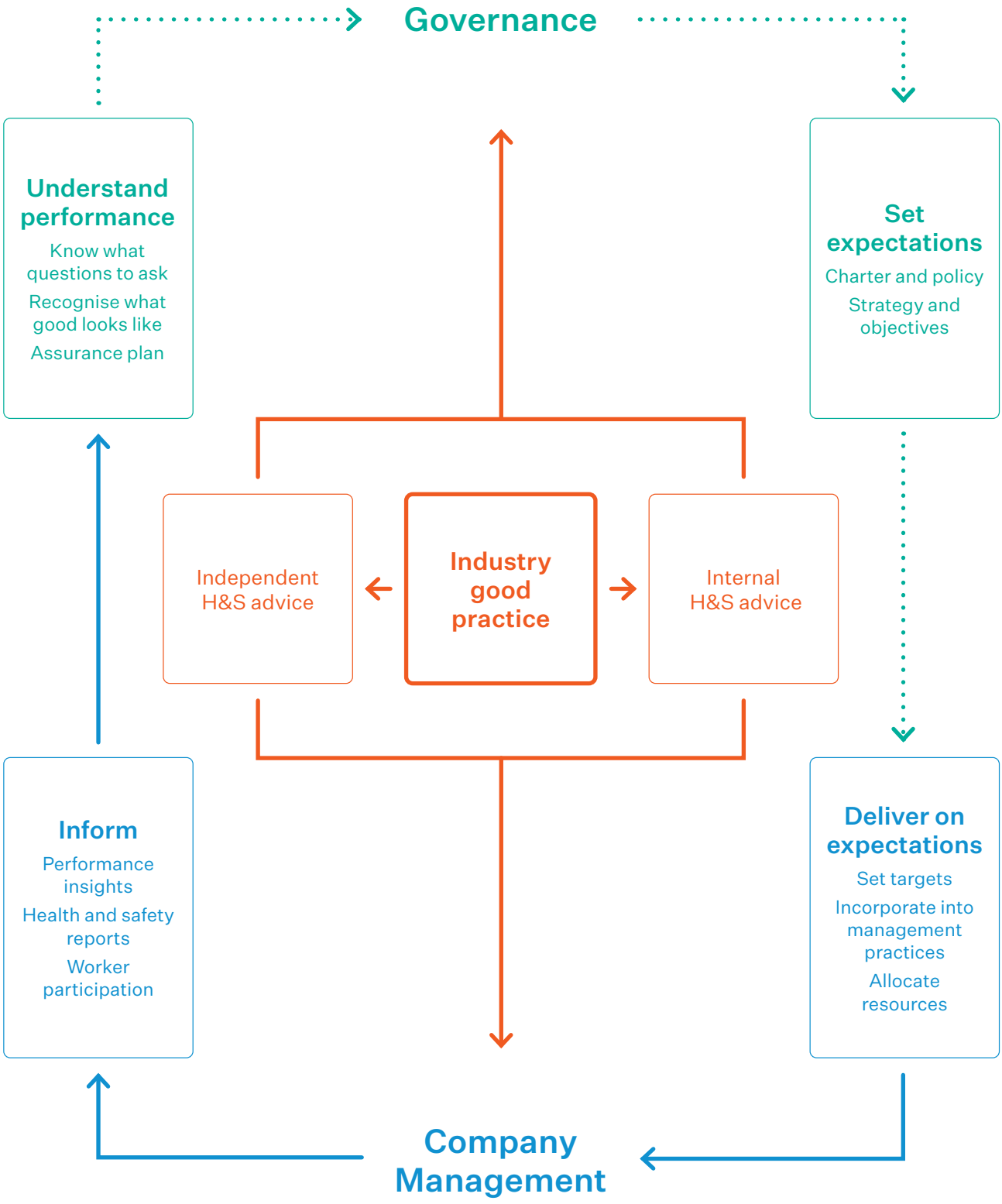
Understanding Your Own Ecosystem

In some instances, the relationships between officers and PCBUs can become more complex. This happens, for example, when there are multiple PCBUs that have very strong connections between them that can result in some overlaps. Some examples include:

- Organisations where a single group owns multiple PCBUs. Each PCBU should have its own governance structure, but they may all use a single, central management system.
- Foreign-owned organisations where the local PCBU has corporate systems established under overseas legislation.
- Co-operatives or franchises where PCBUs are independently owned, but certain policies are set centrally.
- Where one PCBU invests in another and places an employee there as a Board member. That employee is now an officer with personal obligations but is discharging that duty for an employer that controls their time.
- Joint ventures between different PCBUs, particularly where these may be unincorporated.

In some of the examples above, decisions are potentially being made within a different PCBU, by different officers, that impact your activities. Officers should clearly define where responsibilities lie between the different parties and what the process is for ratifying decisions where required and managing concerns that arise. This will be unique to the particular arrangement and expert legal advice may be beneficial.

Governance Ecosystem



04

Developing better health and safety governance

→ Health and safety is a positive outcome of work going well.

Health and safety is not a separate 'thing' that you can easily see or point to, but there are many things that you can see that support it as part of routine work, such as:

- Having trained and capable people.
- Having enough resources to work with.
- Carefully planned jobs.
- Taking into account where you have workers at higher risk of injury or illness.

A healthy and safe outcome is therefore more likely where work has been well planned and delivered. In this way health and safety can be viewed as a positive outcome of work going well. Governance should focus on making sure it is as easy as possible to deliver good work, by the right resources being available and used. This involves 'hard' factors such as availability of resources, tools and systems and 'softer' considerations like a supportive working environment and a strong culture and set of values.

In doing this, the quality of your health and safety governance reveals itself through the conversations that occur between officers, management and other stakeholders.

A vision for good health and safety governance is:

Capable leaders integrating health and safety into curious and courageous governance discussions and decisions, that are context-rich and demonstrate care for workers.

To achieve this, all parties must understand and agree on what they are trying to achieve. It is important to set a clear basis for health and safety governance and recognise what good looks like.

What to focus on

To put this structure in place and to make it work as well as it can to achieve this vision, there are some key areas where your effort should be focused:

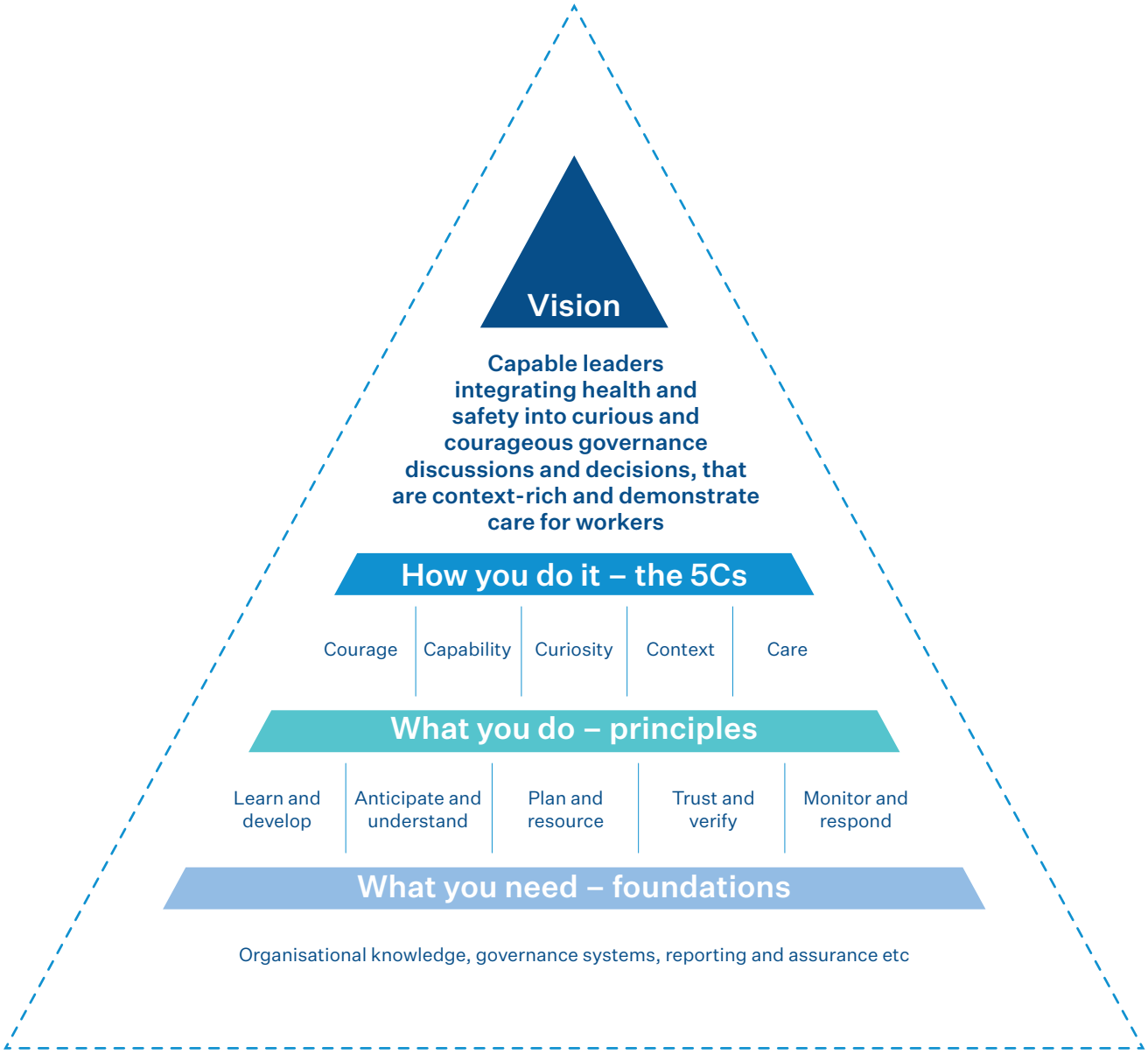
***What you need*. Put the foundations in place** – make sure that the basic systems and building blocks are there to support governance work.

***What you do*. Undertake the right activities** – carry out tasks that support the core principles of better health and safety governance. Specific activities will vary widely across different industries and governance structures. Five principles have been developed to provide guidance on what these should cover that can be applied to any situation. These are:

- Learn and develop.
- Anticipate and understand.
- Plan and resource.
- Trust and verify.
- Monitor and respond.

Basing activities on these core principles helps everyone understand the intent of activities they carry out so officers, management and health and safety leads can be aligned on their role.

How you do it. **Adopt the right mindset to take a supportive personal approach** – carry out your governance role in a way that encourages better performance. The 5Cs – courage, capability, curiosity, context and care – describe key governance behaviours that encourage open and fruitful discussions.



Each of these is described in the following sections, together with examples of good practice that you should be looking for and suggested questions for officers.

05 What you need – foundations

The foundation systems and practices provide a solid baseline. This makes sure that activities don't get forgotten about and are built into routine systems. This helps free up time to focus on the most important risks and discussions. You should review your organisation to make sure that these are in place or take steps to develop them if not. Once in place, you should review them regularly to make sure that they are effective, that they are still fit for purpose and that everybody is familiar with the processes being used.

What	Detail	Good Practice
Set expectations Define the role of officers and executives in owning and prioritising health and safety within this organisation.	Be clear that good health and safety performance will only come about when officers and executives suitably prioritise it. Ensure that ownership of health and safety risks and their management sits with officers and with management, not with health and safety teams or health and safety representatives.	• Clear roles and responsibilities are defined for health and safety at executive and governance level. • Board charters, or terms of reference, include ownership and expected activities. • Processes include escalation protocols so it is clear what needs to be brought to the attention of governance.
New officer induction Clearly lay out what happens when a new officer starts and who is responsible for it.	Make sure they know key basics such as: • What the organisation does. • Who the key people are. • Worker demographics including any groups that may be at higher risk of injury or illness. • What other organisations you work with or rely on. • What the key health and safety issues are and how they're managed. • What their due diligence obligations are as officers and the reasonable steps that can be taken to fulfil them in this organisation.	• The agenda and content are consistent but regularly reviewed so that information stays current. • Face to face wherever possible. • Includes initial site visits. • Health and safety content focuses on critical risks; key current or emerging issues and progress towards achieving the health and safety strategy.

What	Detail	Good Practice
Governance processes Define how your routine governance operates through charters and clear terms of reference.	These should include: • Setting your health and safety vision, policy, strategy and objectives. • How often governance meetings occur. • How many board members there are. • What the governance structure is – e.g. whether health and safety is a full board discussion or via a committee. • What the programme of work and key governance activities and approvals are. • What reports and other information the board routinely sees. • What the board's role is in non-routine situations – emergencies and major events.	• The health and safety policy is unique and meaningful for your organisation, including values as well as activities. • Governance structures ensure clear separation from management, but with well understood communication and escalation protocols in place. • An annual governance programme supports both officer knowledge (site visits, development sessions etc) and assurance activities (audits, deep dives, reviews). • There is no right or wrong about whether the health and safety discussion is via a committee or the full board, but the benefits of each are explored and discussed to inform your decision. • Objectives link clearly to the strategy and describe what success looks like. Targets support these objectives and avoid simply setting a number against routine metrics, as people will manage to targets rather than doing what is most appropriate for performance improvement. • See Appendix 2 for a good practice board report example.

What	Detail	Good Practice
Competence framework Ensure that the board has, or has access to, the right health and safety capability and experience.	Define the health and safety skills and experience mix that is needed at a governance level and assess how that is met by the current team. Consider adding to or changing the mix of people involved if there is a significant shortfall. Enable access to competent independent advice to supplement your internal capability and to provide assurance where required.	• A skills matrix defines the required capability across the governance team. The current officers' experience is compared against this, any gaps identified, and a plan developed to close those gaps. This may be via recruitment, or through the retention of expert external advisors. • Recruitment of future officers is done with a view to maintaining the skills balance and/or closing known gaps. • Specialist external resources are used where appropriate (e.g. a health and safety specialist rather than a generalist auditor). • Cultural aspects are included, such as understanding of te ao Māori.
Continuous improvement Enable the improvement of governance as the board matures.	Include regular self-reviews that consider how well your governance processes are working. Consider: • How well the board works as a team. • How open is the relationship with the CEO and management team? • Are you happy with the quality of information received and have you defined what is required? • How you keep abreast of good practice. • How effectively you call out issues or concerns.	• Self-reviews are carried out on a routine basis, using feedback from management and others within the organisation (use the supporting self-review process). • An independent third party carries out formal reviews, with resources such as the Institute of Directors' suite of board review tools. • Reviews include a discussion on whether officer obligations under HSWA are being met.

What	Detail	Good Practice
Assurance Gain confidence in the effectiveness of systems through objective checks and reviews.	Have a structured assurance programme to make sure you have comprehensive information from multiple sources to know what performance is like. Include: • Internal and external audits. • Inspections and site visits. • Reports on specific topics – e.g. deep dives into management of critical risks.	• Assurance programmes combine a range of internal audits, inspections and reviews with external, independent audits. They are carefully planned so that high risk areas are reviewed more frequently and more deeply but balanced to ensure coverage across all areas. Structured approaches such as the standard three lines of assurance model help ensure good coverage of assurance. • Plans are based on a clear and well-articulated risk profile, giving a good understanding of where effort should be focused. • All component parts of the health and safety management system are reviewed at least once over a 2-3 year cycle. This is done via a standard approach such as SafePlus, or ISO45001 audits, or can be bespoke for the specific PCBU's needs. • Audits and reviews are viewed as positive opportunities to improve – embracing findings to enable improvement. They avoid pass/fail structures as these discourage learning by encouraging people to present the most positive perspective to the auditor/assessor in order to pass. • Improvement actions are risk ranked and tracked to completion with a due date that is sensible for the action being carried out and agreed with the actionee. Standard completion targets are avoided but agreed dates are adhered to. • Independent perspectives bring a lot of value, but independence may be outweighed by local knowledge, and these are balanced in developing review programmes • The value of an audit is heavily dependent on the quality of the auditor so officers should take a keen interest in the assurance plan and who is involved.
Records Keep good records of governance activities in relation to health and safety management.	Include: • Meeting minutes. • Decision logs. • Activities carried out e.g. – site visits. • Records of your own activities as an officer, such as health and safety training received.	• Actions raised in meetings are clearly linked to discussions recorded in the minutes so the context can be fully understood and are phrased such that the requirement is clear and unambiguous. Officers set their expectations for what they wish to see in response to an action at the time it is raised to avoid unnecessary or misjudged work. • Minutes demonstrate the level of interest and challenge being shown by officers. Draft minutes are reviewed carefully, and any inaccuracies rectified. Actions assigned to or by officers are clearly tracked through to close out. Personal notes and annotations on reviewed papers are retained by Officers to enable review of historical discussions and consistency.

Foundational questions

Much of governance is about being curious and asking good questions. Questions relating directly to governance principles and the 5Cs are included later, but the following questions provide a basis that is applicable across all areas of governance.

Processes

- **What have we got?** E.g. Does the process we have in place meet expectations of good practice?
- **Does it work?** E.g. Is the process able to achieve what it is supposed to, is it effectively applied and how do we know that?
- **Is it enough?** E.g. Are there any gaps in our processes?

Information

- **So what?** E.g. What insights into performance effectiveness are being provided?
- **Is it meaningful?** E.g. Is the information robust, honest and representative?
- **What now?** E.g. What is the next step if something is of concern, or is particularly good?

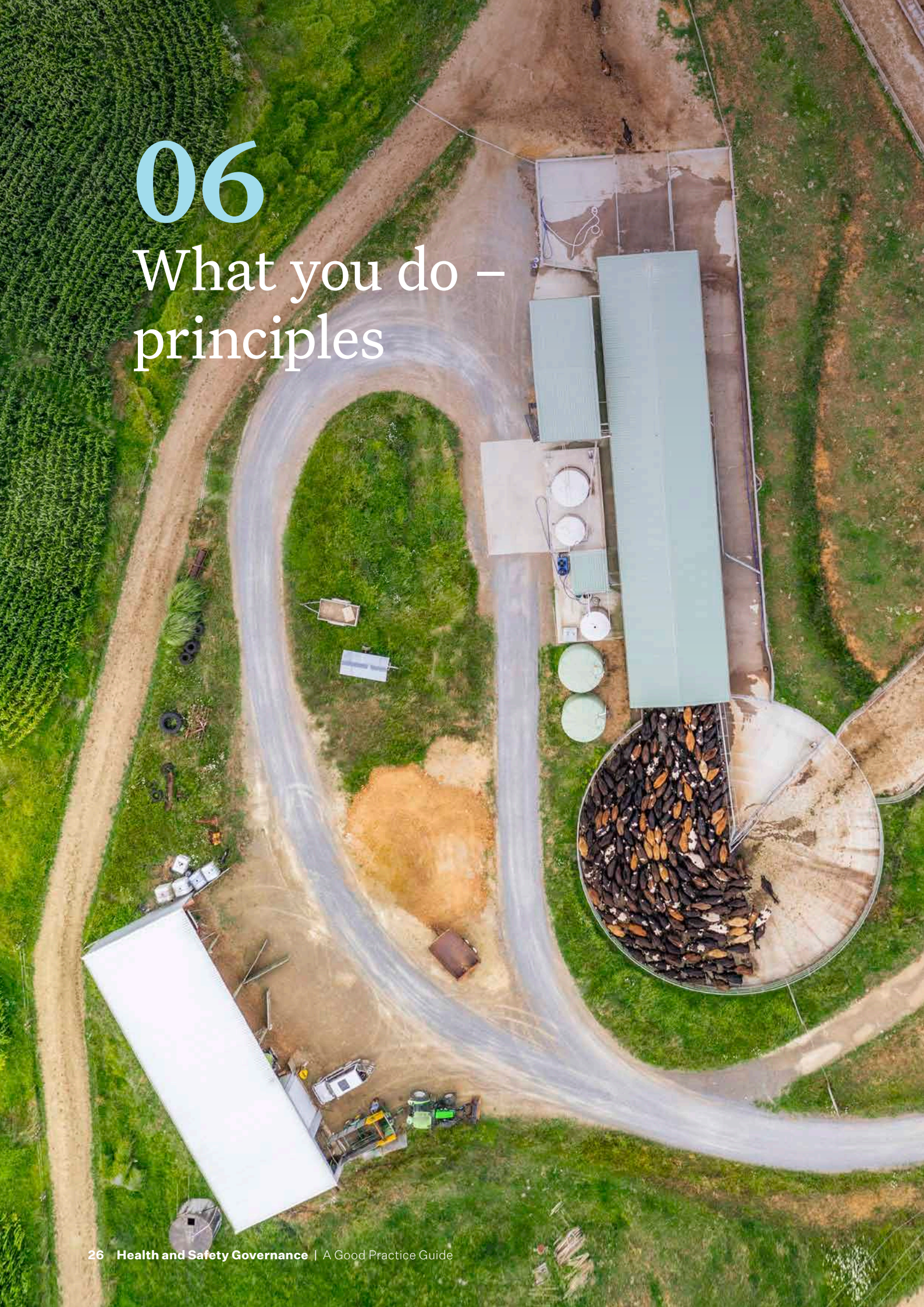
The fundamental questions that underpin all health and safety governance are:

Does this give reassurance that health and safety risks are being adequately managed? If not, what more information is required to give reassurance? If there is a shortfall, what is the plan to address it?

Foundational questions example

Information presented	Governance questions
This month we had five health and safety audits. Three on contractors, one internal audit and one re-certification audit. Re-certification was achieved.	• How do we select which contractors to audit and how often? • Is five more or fewer than we had planned for the month? • Were there any significant findings? If so, what are the action plans? • What do these findings tell us about the degree to which our critical health and safety systems are known about, understood, and being applied as intended? • What does certification achieve for us? • Re-certification is an achievement – what are we doing to celebrate it and to share lessons from the process?

06 What you do – principles



→ While the principles take into account officers' HSWA obligations, officers should always satisfy themselves that they are doing what is required under HSWA.

The wide range of industries, governance types, organisation sizes, commercial structures, workforce demographics and other factors mean that there can be no definitive, one-size-fits-all way to carry out health and safety governance that will always be effective. These principles provide an underlying basis that can be interpreted in a way that makes sense for your context, while keeping activities anchored to a good practice base. Adopting these provides an opportunity for all key stakeholders to agree a clear approach to health and safety governance.

They combine good practice in governance, leadership and health and safety and take into account due diligence obligations. In this way officers, management and health and safety leads can be confident their requirements are aligned, minimising the potential for conflicting views on the best way to progress. Each principle is shown here through the different lenses of officers, management and health and safety leads to provide guidance in their role in supporting it collectively. Suggested questions are provided for officers to reassure themselves that systems are in place and are effective, together with some descriptions of good practice to help understand what a good answer to those questions will look like.

Back to contents

Principle – Learn and develop

We recognise that ongoing learning and development is vital and a requirement of our role

Actively learning and developing our knowledge is important to us. This includes knowledge about:

- Leading health and safety governance practice.
- Effective risk management and assurance.
- How people work, behave and make decisions.
- The importance of local context and how systems and circumstances drive behaviour, including trade-offs and workarounds.

We recognise that our systems, policies and procedures do not always accurately reflect the realities of normal work. People necessarily innovate at work to meet objectives, and to remain healthy and safe while under conflicting pressures.

We know that people's decisions make sense to them at the time they are made. We avoid using hindsight to judge past decisions and actions, even where they may have contributed to an actual or potential incident. Instead, we seek to learn more about why the incident happened, to support the continuous improvement of our systems, policies and procedures.

Roles

Officer

Spend time within the organisation to learn about its activities, the risks faced and the reality of work as it is done in practice.

Make sure you have enough knowledge and understanding to make informed decisions that consider the real context in which work is carried out. Continue to develop that knowledge over time.

Management

Enable officer development through providing access for site visits that are meaningful and not 'stage-managed'.

Provide reporting that is open and transparent, providing insight into challenges, conflicts and constraints faced by workers.

Health and safety lead

Provide specialist advice and information to support officer learning, such as deep dives into critical risks and up to date health and safety thinking.

Ensure incident investigations focus on learning and improving rather than blame and punishment.

Questions to ask and what good practice looks like

Is there a planned programme of learning in place for officers?

A learning programme delivered at a practical pace/frequency so all officers can attend. Input comes from a combination of external expert advisors who provide training on broader governance topics and in-house people who can provide intimate knowledge of the organisation. Both can be supported by further reading and on-line training.

Topics rotate through critical risk information, health and safety knowledge and site visits.

The training programme is planned over a one- or two-year delivery period to provide comprehensive coverage of all required topics, taking into account the existing knowledge and experience of the officers. Other senior managers are exposed to the same material so that there is consistency in understanding and application.

Feedback loops are in place between officers and health and safety teams to assess quality of information and understanding.

Note: officers on multiple boards may receive some of this professional development elsewhere so those aspects common to all organisations need not be repeated

Questions to ask and what good practice looks like

How do officers get regular feedback on the practical reality of how work is normally done?	Officers undertake regular site visits to learn from workers about their typical activities. Where possible these are planned with people and locations that are related to recent or upcoming topics of interest to put those into context. Visits are limited to one or two officers at a time to enable good discussions and to avoid pressure on workers. Workers understand these are opportunities for officers to learn, not that they are being inspected. Routine reporting includes feedback narrative from workers (positive and negative). Workers, health and safety representatives and key partner organisations are invited to governance discussions to provide direct feedback to officers.
Are incidents investigated in a way that generates genuine learning and avoids blame?	Incident investigations are focused on learning and improving to prevent future incidents. Investigation processes are used that understand the complexity of external pressures, environmental factors and local variability. They take a broad system view, considering how they happened rather than who was involved. They recognise that incidents can arise from unknown and unanticipated combination of events. People feel comfortable in sharing information because they know the process is supportive of better future outcomes. Governance reporting and discussions about incidents and investigations is centred on those events with higher potential for harm so follow up can be prioritised. Recommendations made can provide improvements in areas much broader than the specific event under review. Clear expectations are set with partner organisations about information sharing and roles and responsibilities in complex investigations
Do officers clearly understand the PCBU's risks and how it is managing them and other obligations?	Risks, especially critical risks, are clearly articulated by the PCBU and shared with the officers. Discussions are held outlining what controls are in place to manage those risks and how their effectiveness is tested. Workforce demographics and the increased risk exposure of vulnerable groups are routinely considered in risk management. Regular deep dives are held with officers providing more insight into risk management.

Case Study – Learn and develop

Department of Corrections

The Department of Corrections developed a health and safety learning programme covering topics and activities for officers to complete. An innovative scoring system not only tracked completion rates, but incorporated multipliers based on the quality of feedback received after the event. This gave an incentive for thoughtful and considered engagement and helped reduce the risk of quantity at the expense of quality that can often happen when completion targets are used.

Back to contents

Principle – Anticipate and understand

We anticipate the impacts of change, and understand that a range of different scenarios may arise from it

Our operating environments are constantly changing. This includes change as a result of external factors. It also includes change as a result of the strategic decisions we make for our organisation and its people, and the decisions that influence our partners. We recognise that health and safety governance is about the here and now, but also about anticipating and understanding:

- how change will affect our future work, and our work with partners.
- a range of different scenarios that may occur and need to be considered and planned for.

All change has the potential to impact health and safety, often slowly and invisibly.

Change can influence the behaviours and decisions of our workers and those of our partners. It can result in trade-offs and workarounds that may increase risk. We anticipate this.

When setting and supporting the strategic direction of our organisation, we seek to identify and understand what has the potential to go wrong. We also seek to understand how prepared we are for a range of different scenarios, especially those with potentially significant or catastrophic consequences, even when their likelihood may be low.

We use this understanding to support better work design, and better work.

Roles

Officer

Actively enquire about potential health and safety impacts of strategic decisions being made at the governance level.

Be curious about broader organisational goals, activities and pressures that don't immediately seem related to health and safety (e.g., financial performance, productivity, workloads, etc). Seek to understand if improvements in these areas are being achieved at the expense of your safety margin (even if not consciously so).

Management

Regularly report on movements and changes within your broader operating environment to bring them to the attention of officers.

Build health and safety considerations into all strategic and change management processes so that potential impacts can be considered.

Clearly articulate what attributes and resources are required to make work successful.

Health and safety lead

Ensure your health and safety strategy aligns with the broader business strategy.

Upskill in non- health and safety aspects of operations to better understand the broader environment and identify health and safety impacts arising from non- health and safety decisions.

Questions to ask and what good practice looks like

How do organisational change processes consider health and safety?	Organisational change processes include risk assessments based on proposed changes to people, structures, skills mix, training, assets and other areas that may impact on health and safety. Where risks are confirmed, change does not progress without a suitable mitigation plan in place. Plans align with the risk severity – the higher the risk, the more rigour should be applied. Health and safety is considered as early as possible within the change process – e.g. during mergers and acquisitions, or through health and safety in design processes, taking the opportunity to design out (eliminate or substitute) risks where possible. Workers are consulted about the potential impacts of, and the best solutions for, change.
What future health and safety impacts might there be based on our strategy and how can we manage them?	Strategic plans include clear assessment of risks associated with their implementation. Where risks are significant, alternative strategies are explored to remove the risk prior to developing mitigation plans. Strategic goals relating to productivity, financial performance, etc are carefully considered to see if they can inadvertently cause health and safety to be compromised, even where leaders are genuinely committed to good health and safety management. Where change involves activities outside of the normal scope of work (e.g. an acquisition of a different business), external advice and resource is sought from people with the right expertise.
How do we know what makes work successful and have we thought about what might interfere with that?	Feedback loops are in place to learn from normal and successful work as well as incidents, with direct worker involvement. These identify the factors that create successful work. Reduction in, or challenge to, these resources and attributes is managed as a risk in its own right.

Case Study – Anticipate and understand

Link Alliance

The Project Alliance Board represents the client, three principal construction contractors and three principal designers on the Auckland City Rail Link project. It implemented a six-monthly deep-dive review examining the changing risk profile of the project, considering how it would be impacted as the project moved through different phases. Discussion was centred on critical risks, whether they would be increasing or decreasing and what resources, systems and approaches were planned to mitigate those risks. They also reviewed the monitoring and assurance processes that would be used to verify effectiveness of controls, giving a clear understanding of the plans in place to protect workers.

Back to contents

Principle – Plan and resource

We plan for dynamic, messy work, and recognise that positive health and safety outcomes require people and resources to cope with that complexity

We understand that planning, people and the provision of effective and efficient resources, are crucial to designing and doing healthy and safe work.

Through direct feedback from workers and other sources, we invest in understanding what is needed for work to go well under expected and unexpected circumstances.

Recognising that work is dynamic and messy, our plans acknowledge complexity in developing solutions.

We ensure that our people and our partners have the knowledge and skills, and tools and equipment to be healthy and safe at work, with feedback loops ensuring they have the resources they need. This enables capacity to be developed and a safety margin to be created.

Roles

Officer

Ensure approval is given for sufficient resources to allow enough flex and capacity to manage surprises, because this is often when health and safety incidents happen.

Be open to discussions acknowledging complexity, realising that there are often no simple solutions to challenges arising.

Management

Deploy resources in a way that retains some margin where possible – avoiding pursuing efficiency at the expense of capacity. Plan for the unexpected as a matter of course.

Make sure there are channels available for direct feedback about capacity to deliver good work.

Health and safety lead

Work across the organisation to identify pressures that might cause health and safety to be sacrificed (time, productivity, budget, expertise, etc), then use influence to direct resources and build capacity and redundancy into those areas.

Regularly check planning processes and feedback loops to make sure they are effective.

Questions to ask and what good practice looks like

What direct routes do we have for feedback from workers about how well work is being completed?	Multiple formal feedback routes to management exist including health and safety committees; post-project or after-action reviews and feedback processes learning from normal work. Direct feedback is received at a governance level from site visits and from the invitation to governance meetings extended to health and safety representatives, health and safety committee chairs, union representatives and other workers – including workers from contractors and partner organisations. These routes are supported by an environment that encourages open discussion, taking account of the cultural context so that everyone feels able to contribute.
What resources do we have to support critical risk management and provide sufficient advice and support?	Officers set management a clear expectation that risk management efforts need to be weighted towards those risks with the greatest potential consequences, even if their likelihood is low or rare, ensuring critical controls are resourced as a high priority so that they are available and reliable. Resources required to support delivery of the overall health and safety strategy are clearly defined, well understood and maintained in place, such as IT systems, maintenance programmes, capability needs.
How do we resource workers to help them deal with both expected and unexpected situations?	Planning processes include contingency plans that that can be easily put into place when needed. Supplementary resources are kept available via flexible deployment or alternative sources (such as contractors or equipment hire suppliers) where it is not practical to always carry them. The potential for their need is regularly assessed.
How do we manage work that is complex with unpredictable outcomes?	New ways to manage complex work are tested via controlled experiments to understand how effective different solutions may be. Different scenarios are explored, and controls put in to manage those considered most likely to arise. Regular reviews and checks are carried out during work to identify emergent issues and a diverse range of views is sought on possible approaches.

Back to contents

Principle – Trust and verify

We trust our people and partners to give advice and implement the decisions we make; we verify that those things happen, and that our critical systems and controls work

We take, and trust, the advice we receive from our management, workers, partners and technical experts. This is because we select advisors who are demonstrably reliable and competent. We choose people and partners that will support us to enable healthy and safe work. We also trust them to implement the decisions we make, and our systems, policies and processes, but verify that this is the case.

Our verification processes are proactive, and we apply a curious scepticism that responds constructively to what we learn. They give us insights into the degree to which our systems, policies and processes are known about, understood, and working effectively. Through these processes we also seek to identify that we have the people, systems, resources and other factors needed to maintain our 'safety margin'.

We use our verification processes to understand where normal work varies from work-as-designed. We want to know whether this variation is innovation that still achieves healthy and safe work, or drift that may be unintentionally increasing risk. Knowing this helps us harness opportunities to build organisational resilience, and healthy and safe work.

Roles

Officer

Continually seek confirmation of the accuracy and robustness of information received and ensure that it demonstrates that systems are effective in achieving a clearly understood aim.

Maintain a helicopter view that enables you to have sight of the whole of the health and safety risks and systems, whilst ensuring you probe deeply into individual areas when seeking assurance.

Management

Implement robust processes for verification that are multi-layered and comprehensive, covering all aspects of operations, but retaining a clear focus on critical risks.

'Fear the green and embrace the red' in performance reports to create an environment where openness and challenge are the norm.

Health and safety lead

Focus assurance effort on critical risks and on understanding variability – with approaches to share and grow innovative variation, while dampening at-risk variation.

Questions to ask and what good practice looks like

Do we know what our critical and catastrophic risks are and the key controls and critical systems used to manage them?	Critical risks are well defined and the controls in place to manage them are well understood. Those controls that provide most of the risk mitigation are identified and specific assurance plans put in place that proactively demonstrate controls are effective in practice.
Has an appropriate process been used to identify these controls and what have we benchmarked against?	Risks have been reviewed using a systematic process that considers whether the controls are sufficient to reduce risks so far as is reasonably practicable. This covers all areas where the risk exists, including supply chain activities. The process is suitable for the size of risk presented (e.g. bow tie analysis for higher risks). Outcomes are double checked against other organisations doing similar work with similar risks, while recognising that local context will impact on the type of controls used.
How effective are those controls and what is that effectiveness based on – are they known about, understood and being applied as expected?	Controls are effective as demonstrated by a three-layer process in defined assurance plans, showing how well they are known about, understood and applied. Firstly, regular proof testing is carried out at point of use by those who manage the risk operationally. Secondly, higher level reviews are undertaken periodically to ensure the proof-testing process is working and that underlying inputs are in place, such as training, maintenance routines and plans for when the controls fail or are unavailable. Any shortfalls identified are subject to appropriately prioritised corrective action. Thirdly, system audits review the whole approach for effectiveness.
Where do we look to find out where work varies from what was intended?	Regular feedback is sought from workers and their representatives to understand where work varies from what was planned, how well this variability was managed and whether it makes it harder to implement key controls. Such variation is assessed to understand if it is helpful and innovative, in which case it is shared more widely, or if it appears to increase risk, in which case the causes of the variability are investigated to reduce them.

Back to contents

Principle – Monitor and respond

We monitor our work, seeking and welcoming genuine insights into our risks, and respond in a way that encourages honesty and transparency

We monitor our organisation's work, including our work done with others, and the changes we make to it. We want to understand:

- how effective our governance, and strategic direction and decisions are in keeping people healthy and safe.
- where our people or resources might be, or might be becoming, compromised, particularly any groups of workers at higher risk of injury or illness.
- where health and safety margins may be being borrowed against for other organisational goals.
- how our critical systems and controls are working to support healthy and safe work.

Recognising the dynamic and messy nature of work, we know that indicators can never provide a complete or accurate picture of risk and look for narrative as well as numbers. Recognising health and safety as an outcome of work going well under expected and unexpected circumstances, we base the selection of indicators we monitor, and the reports we receive, around the curious discussions we want to have about the delivery of work. Seeking genuine insights, we use indicators as prompts for further exploration. We look for patterns, anomalies, weak signals and gaps in our knowledge and understanding. We look for hidden issues when everything seems positive.

Honesty and transparency are vital to our culture, organisational resilience, and healthy and safe work. We respond to risk and harm in a way that shows we encourage reporting. We want people to be comfortable sharing information and insights early and completely.

We acknowledge personal bias and avoid using hindsight to judge past decisions in our response to reporting and when an incident happens. We do not accept reports that blame 'human error', our workers, or those of our partners. We constructively challenge reports that do not help us identify weaknesses in our systems, policies and processes.

Roles

Officer

Insist on information that is insightful and contributes to better decision making.

Seek to understand the factors that underpin delivering safer outcomes through curious discussions, setting an expectation that incident findings focus on systems and pressures, goal conflicts etc, rather than individual workers.

Respond constructively to bad news and be wary when receiving only positive reports.

Management

Provide reports that include narrative as well as data to provide rounded, context-rich insights. Be fully transparent so officers can gain a full picture.

Create a working environment of openness so that issues can be raised and dealt with.

Health and safety lead

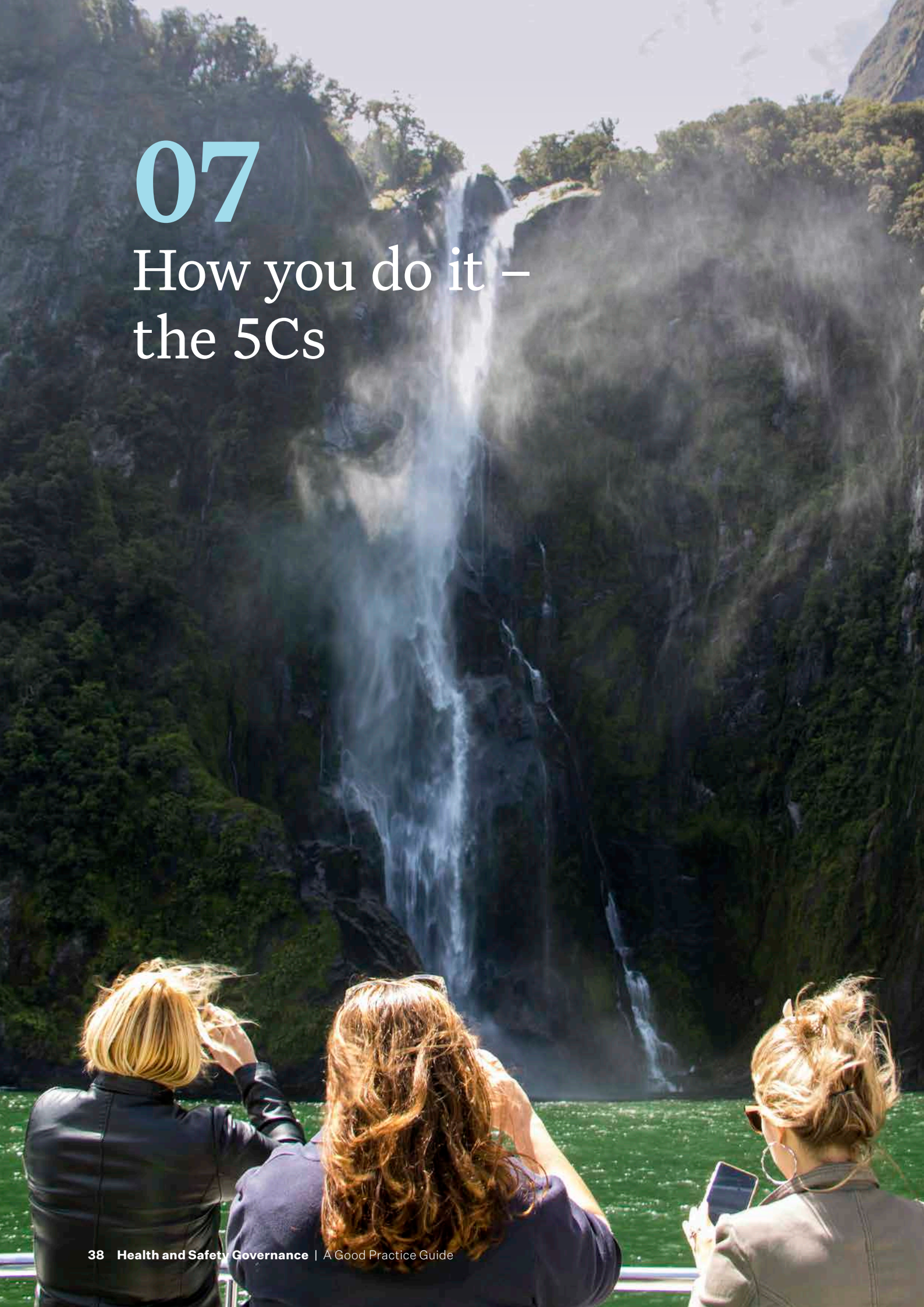
Provide suitable information that pre-empts and answers obvious questions to allow probing rather than clarifying questions.

Provide reports that are succinct, while comprehensive, with a focus on significant issues. Clearly articulate the purpose and intent of the various metrics and how knowledge of them contributes to better performance.

Questions to ask and what good practice looks like

Do our reports give us genuine insight rather than just numbers?	Reports include narrative as well as metrics to provide more context. Data are presented with context, such as trends and progress against plans, rather than raw numbers. All information is provided with statements explaining why it is important and what relevance it has to health and safety performance. Reports assist officers in meeting due diligence obligations by providing context and system information that enables genuine understanding rather than just accident rates.
Are we focusing on significant issues and avoiding trivia?	There is a clear focus on critical risk. Escalation processes are well-defined so that significant issues are raised to officers in a timely fashion. Where lower risk information is provided for overall background, it is summarised to avoid overload.
How do we react when people report bad news? Does it encourage future reporting? Are we curiously sceptical if our indicators are always green?	We avoid blaming people or taking knee-jerk reactions to information. We recognise that people's actions are rarely malicious, and that the decisions people make are normally the ones that seemed most sensible for achieving their work goals safely at the time they made them (and without the benefit of hindsight). Dashboards are viewed as a starting point for enquiry rather than a decision-making tool. Incidents raised are viewed as opportunities to learn, understand and prevent recurrence.

Processes, systems and structures will not be fully effective unless they are supported by officers acting in the right way to create the right working environment. Within organisations where governance is less formal (most obviously smaller businesses), the way the officer carries out their role becomes even more significant.



07
How you do it – the 5Cs

The 5Cs are the component parts of achieving the health and safety governance vision. ***Capable*** *leaders integrating health and safety into* ***curious*** *and* ***courageous*** *governance discussions and decisions, that are* ***context****-rich and demonstrate* ***care*** *for workers.*

Each of the 5Cs is presented with a *set of questions* to pose for self-reflection. While these questions are individual in nature, the 5Cs represent the approach to be taken by all the governance team and the questions can also be used to hold each other accountable for governance activity. The environment created by this behavioural approach applies not only to the immediate team, but also spreads further within the broader organisation. It is important not only to do the right things, but for this to be transparent and visible. Without visibility, it will not have the same effect on the broader environment, so officers should consider how their behaviour manifests itself in ways that are clearly visible to others – while ensuring that it remains genuine and sincere and not done purely for perception reasons.

Officers should also recognise that their perspective can be very different to that of the people within their organisations and messages and behaviour may be received and interpreted differently from how they are intended.

Back to contents

The 5Cs

1 Courage

We acknowledge that we don't have all the answers and have the courage to admit when we don't know.

We challenge ourselves and others – ensuring an environment of honesty, transparency, learning and improvement – by responding constructively to information in a way that encourages this.

- *What do I do to create a constructive environment for those bringing us information?*
- *When was the last time I said, "I don't know" or "I don't understand"?*
- *Do I speak up if I hold a different view to the rest of the group?*
- *Do I actively encourage people to air different perspectives and advocate for diversity of input, particularly from groups most at risk of injury or illness?*
- *When I am challenged, do I respond to this in a constructive manner and seek to understand, then improve?*
- *Am I comfortable displaying vulnerability or is that seen as a sign of weakness?*

2 Capability

We continuously develop our health and safety knowledge and capability to a level appropriate for our governance role.

To achieve this, we seek and welcome:

- continuing professional development to build capability
- diverse, reliable and competent advice from others
- insights and feedback, including from our partners
- a worker perspective to better understand normal work.

- *What personal development in health and safety have I had in the last few months? Is that enough? Do I have a future development plan?*
- *Do I genuinely understand enough about what makes good health and safety happen?*
- *Who have I listened to outside of my immediate governance contacts for greater understanding of work?*
- *Have I discussed capability/experience with fellow officers to make sure we have the right mix of skills and knowledge?*

3 Curiosity

We are curious about the realities of how our organisation's work is prioritised, planned, resourced, completed and experienced, and are constructively sceptical of continuous positive reporting.

We seek meaningful insights to understand:

- how normal work is done by our people and our partners and the challenges they face when work varies from what was anticipated
- the impact and unintended consequence of our discussions and decisions on healthy and safe work, including decisions that may not appear to be health and safety-related at first glance
- if our systems, policies and processes are working effectively

- *Do I accept the reports presented by management or do I follow up with curiosity to understand more, probing beneath the surface to make sure systems are effective and that organisational culture is supportive?*
- *Do I know what our people really think? How do I hear their authentic voice, especially those that may be reluctant to speak up?*
- *Do I think about health and safety implications in relation to our core business processes such as procurement, competence management, asset management, business planning, mergers and acquisitions, incentive schemes, goal setting etc?*
- *Do I ask questions that I genuinely don't know the answer to, rather than asking to confirm existing beliefs?*

4 Context

To better understand the internal and external factors that affect our work and our organisation, we continuously:

- horizon scan, to understand what's coming up that may have an impact
- seek insights into the broader environments in which we operate and understanding of where our decisions may impact others' health and safety
- build an understanding of which are our most important risks and the effectiveness of our controls
- build and maintain strong and diverse relationships and networks.

- *Do I keep up to date with the external factors in our industry that are influencing H&S? What's changing? How can we influence them?*
- *Do I understand the day-to-day pressures of our front-line workers and how organisational decisions affect them?*
- *Do I know what may cause internal conflict with health and safety outcomes in areas such as work planning, priorities and resourcing?*
- *Do I understand the demographics of our workforce and the particular needs of different groups? Have I asked them what may help improve health and safety?*
- *Who is in our ecosystem that our PCBU has overlapping duties with? How have we considered those?*
- *When did I last step back and consider the broader operating environment?*
- *What external voices have we invited into our discussions?*

5 Care

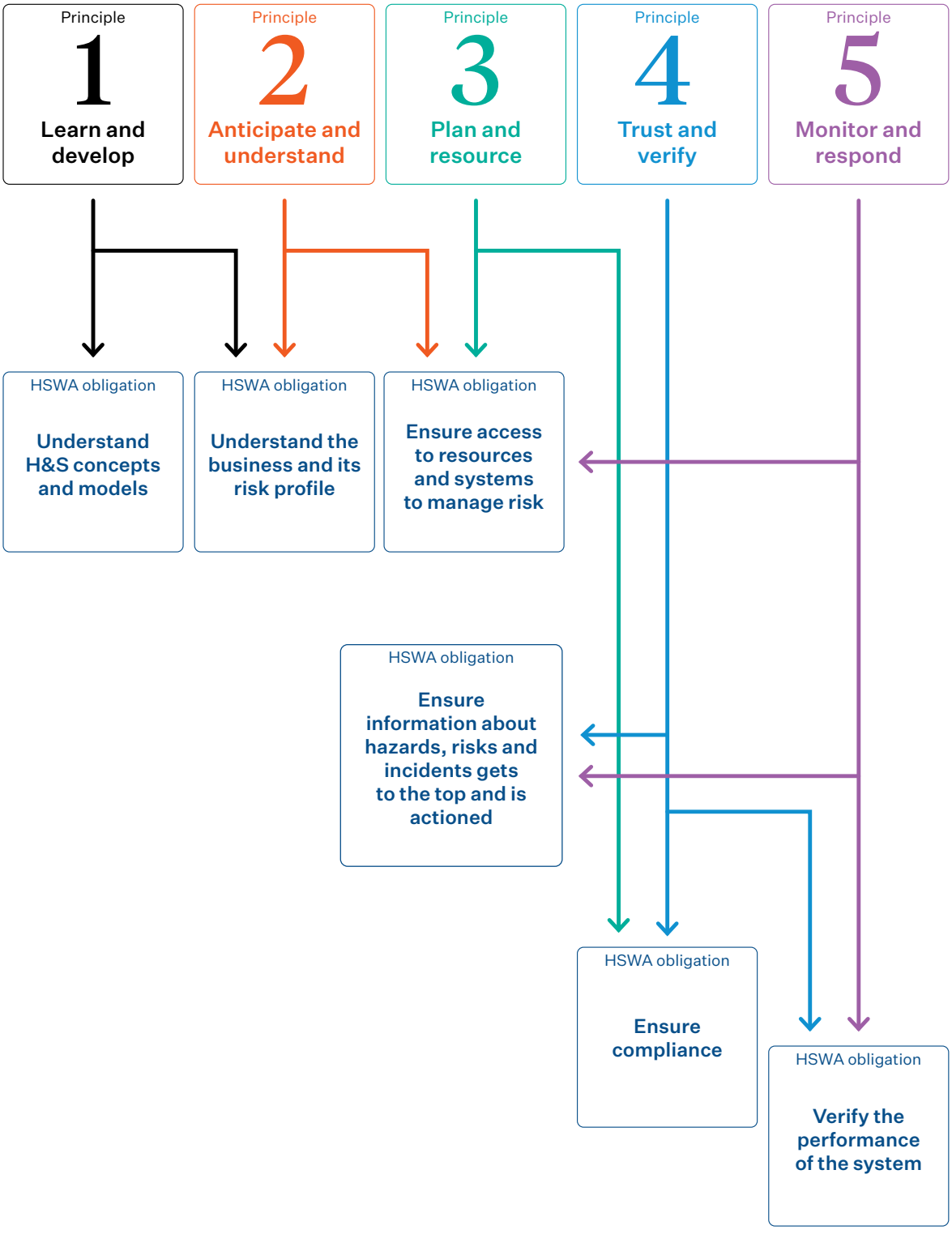
We understand that people are our greatest asset, and work to create an environment of trust where everyone can honestly and safely contribute to health and safety discussions throughout our organisation.

Our health and safety governance approach is driven by our ethical responsibility to support the wellbeing of our people and those of our partners.

- *How do I express my concern for our people in a way that is genuine, culturally appropriate and likely to be believed?*
- *How do I demonstrate that health and safety must be a core value of the organisation and that health and safety cannot be sacrificed for productivity and performance?*
- *How is my concern for our people's health and safety, and equitable outcomes for all workers, reflected in my actions?*
- *When responding to events do our leaders, culture and systems put people at the centre of things?*
- *Do I know how we treat injured workers and get them back to work? Do I know what our people think about the process?*

Mapping principles onto due diligence obligations

The principles described above are designed for performing governance well to achieve better health and safety performance. They take formal obligations in HSWA into account, but do not follow it directly in terms of structure. The diagram below shows how adherence to the principles maps to formal obligations. By delivering well against the principles, obligations should be met, but officers should always satisfy themselves that they are doing what is required and review performance directly against HSWA obligations.



08
Appendices

Appendix 1 – Personas

Governance personas

→ This appendix provides an example of a persona for the 'commercial – formal board' governance sector. It is followed by a brief 'how to' guide for creating other personas.

The use of personas provides an easily understandable context-specific description for governance activities.

A persona provides a lens through which governance can be viewed to help understand how it works in practice. It is not an example of how governance should be done but explores some issues in a particular context to give some insight into the sorts of things to consider. By connecting the governance to a relatable person, it makes it easier to imagine the type of issues that may be present.

There are several different governance 'sectors' in operation within New Zealand. Each has distinctive characteristics that provide specific governance challenges. Understanding and articulating these clearly can help implement effective strategies.

Some common types are:

- Commercial – formal board
- Commercial – advisory board
- Small and medium enterprises (SMEs) (defined in New Zealand as <20 employees)
- Co-operatives
- Franchises
- Partnerships
- Iwi owned
- Family owned
- Government departments
- Joint ventures and alliances
- Crown entities
- Local government
- Educational establishments
- Not for profit organisations
- Volunteer clubs and societies

Organisations may wish to develop their own persona to clarify their approach. Where relevant sector advisory bodies are in place, these may wish to develop personas on behalf of their members to provide additional governance guidance. With the ever-changing and developing nature of work, sectors can be more nuanced than this, but almost any organisation can be summarised as a combination of the following three key factors:

Organisation type	Governance Type	Ownership model
Commercial business	Professional board	Private owners/shareholders
Educational establishment	Advisory panel	Publicly held
Government department	Volunteer board	Partnership
Joint ventures and alliances	Elected members	Iwi owned
Crown entity	Executive-led governance	Local/central government
Local authority	Iwi/community	Co-operative
Not for profit/social enterprise		Member owned
Volunteer club/society		Franchised Family owned

Health and Safety Governance Persona – Commercial Business, Formal Board

"My name is Rebecca. I'm a professional director with roles on three boards. I have a background in strategy and HR within large corporates in energy and infrastructure construction, so I understand high-risk activity but don't have hands-on detailed knowledge."

The PCBU is a privately-held commercial business operating with a formally appointed board with two major shareholders and three independent directors.

Governance structure	"We have a board H&S committee because that gives us more time to discuss the issues. But we worried that we all have H&S obligations and didn't want to leave people out of those discussions, so all directors are members of the committee. That's different to my other boards where H&S is part of the Risk Committee agenda, but it's what works for each context, guess. Those businesses have lower H&S risks than this one, so it makes sense. We have an independent H&S expert who joins us as we don't have that in our current skills mix. It's something we will include when we next recruit a new director."
Our context	"There is a really clear distinction between governance and management when you have a formal board. This helps clarify roles. But we are part of a bigger group and sometimes they insist we do things a certain way. We also have a lot of partners and contractors that we work closely with. These issues blur the line on responsibilities a bit, so we spend a lot of time discussing who does what across those interfaces and making sure, whatever happens, were comfortable it's been thought through properly."
Main concerns	"I worry that we're a little bit distant from the work. We only meet six times a year and it's a complex business. How can I be sure I know enough about what is going on to make good decisions? Sometimes the shareholders try to push things through a bit too quickly. As an independent, I have to challenge them on that, which can be difficult to do in a constructive way, but I'd be failing in my role if I didn't do it."
How we know it's working	"I talk to my peers in similar businesses and we compare notes on how we do things. It can be a bit of an eye-opener, but that goes in both directions. We do some things well and some not so much. Other than that, it's about really delving into the information we're seeing and letting the business know what we need. Board reports used to be a whole pile of metrics and information but not a lot of insight. You'd get lost in the data and not be able to draw any real conclusions. We've now got much shorter reports, but they focus on the most important areas and include a lot more assurance information."

Creating your own persona

Personas can be useful as examples for a range of officers. An industry association may wish to prepare one (or more) that considers some of their key issues. They can also be developed by individual officers or by governance teams to help them provide context based on their own unique circumstances, skill sets and experience. Alternatively, simply use the main headings as a high-level exploration of your current position.

To develop a persona, use the example provided here to give some structure, but this can easily be added to or changed to suit your requirements.

First, create an identity that is realistic and representative of the type of background people may have within the area you are considering. This can be instructive in itself. If there is a very wide range of backgrounds, you may have to do more than one. If it's very easy, consider whether that is indicative of a lack of diverse perspectives or the necessary range of experience.

Then, putting yourself in the shoes of that individual, consider their interaction with each of the four areas given – structure, context, concerns and how it's working. Brief examples of each below show how these can vary for different governance types.

	Co-operative – director	SME – owner/operator
Governance structure	Each co-operative member is a separately owned PCBU. The co-op has a formal board that meets every six weeks. Our CEO is a member representative on that board. Our business has an advisory board that meets monthly.	Once a month I spend half a day thinking about bigger picture stuff. I have a list of things laid out to keep me on track and not to get dragged into operational details. I have a business coach who I discuss things with, but no specialist health and safety input.
Our context	It's really hard to understand where the responsibilities lie when each business is its own PCBU and the co-op is also a PCBU, but the officers of individual businesses also 'double hat' as the officers of the co-op. We have started to map the influence and control that each governance group has so that we can draw some clearer lines.	The business is growing, and we are working out what that means in terms of more formal systems. We are a close-knit crew and have been able to do most things informally up to now.
Main concerns	Is there anything that is going to fall through the gaps between the different PCBUs? How do we challenge the main co-op if we don't think what they're proposing is good enough?	How do I know the systems I'm putting in place are meeting my obligations as we grow? Should I invest in a health and safety advisor or rely on a contractor? And what are the key things for them to focus on?
How we know it's working	We have a lot of feedback from our workers about what works well, with really strong and engaged health and safety committees. They also share their ideas and experiences with other member businesses and that is really helpful, so we understand the industry expectations.	It's all word of mouth and discussions at the moment, as well as customer feedback. I'm slightly worried that this will be harder to sustain going forward as the business grows.

Back to contents

Appendix 2 – Example board report

It is not ideal to rely on heavily summarised information to understand a topic as complex and diverse as health and safety performance. However, the reality of governance means that such summaries are inevitable. It is crucial, therefore, that board reports focus on the right areas and provide useful insights to act as a starting point for curious inquiry. Board reports are all about the board gaining understanding of what is happening in health and safety, how well the organisation is progressing towards its objectives and confirming that it is meeting its legal obligations.

The core principles of such a report are outlined here, together with the types of information that may be useful to include. These are combined to provide an example. It is important that reports align with the risks and objectives of your organisation, so this is not intended to be a standard report to copy, rather it shows what the various components might look like when combined.

Risks change, as does the level of confidence in delivery, so some things that are worth tracking now may not be in a year's time. Re-assess the value and validity of your reporting on a regular basis.

Boards often use these reports to attempt to benchmark performance against other, similar organisations. There are so many differences in risk profile and data collection processes between even organisations of the same size in the same sector, that benchmarking outcome metrics can produce very misleading results. Benchmarking is more effectively undertaken against processes rather than outcomes. For example, rather than compare lost days due to injury, compare the quality and effectiveness of return-to-work programmes. This provides insight and learning about good practices and supports improvements.

Fundamentals

- Design your report taking into account your health and safety vision and strategic objectives.
- Not everything is measurable – include narrative as well as data.
- Provide insight without information overload – balance depth with brevity.
- Focus on the most important issues – avoid trivia.
- Consider effectiveness of completed items, not simply their delivery – quality over quantity.
- Look to understand improvements over time – examine direction of travel rather than hitting targets.
- Ensure you hear about the reality of work as done – incorporate direct worker feedback.
- Always be mindful of unintended consequences of setting targets – "When a measure becomes a target, it ceases to be a good measure" (Goodhart's Law).

Topics to include

Some or all of the following may be useful to include. These may overlap or combine depending on what you are trying to understand.

Performance	How well is the organisation doing in meeting its objectives? This may include health and safety plan progress, timely completion of action items or meeting competence requirements for workers. This is likely to be the most similar to traditional, metric-led reports.
Assurance/ verification	What is our assurance programme telling us? What areas have we checked, inspected and audited? What were the findings and how significant were they? What are we doing about those findings?
Risks	What does our risk profile look like? This should focus on critical risks and how effectively these are controlled. Where there is a particular area of interest or concern, this might be separated out and monitored more closely, for example disproportionate impacts on certain groups of workers.
Relationships	What are our most important relationships and how healthy are these? This may include where there are overlapping duties or where particular suppliers, partners or clients might impact on risks.
Resources	Are we providing sufficient resources and are they matched to the need? This may include people, equipment or processes to enable work.
Due diligence performance	Information about the officers' completed and planned activities to allow self-reflection on governance performance.

Example indicators

The indicators shown here are typical ones that can be developed as both narrative and numerical information. These are broad indicators across the whole organisation and its operations. More detailed indicator sets can be developed against specific risks for use in deep dives, or for focus on specific areas of concern and many other indicators are available and in use across different sectors.

Performance	Assurance	Risks	Relationships	Resources	Due diligence
Incidents by potential harm	Assurance findings – number and criticality of findings	Site critical control verifications completed	Worker improvement feedback opportunities realised	Staff turnover and vacancy rates	Leadership learning visits completed
Progress against health and safety plan	Completion against programme for assurance	Percentage of fully effective critical controls	Net promoter score survey results	Succession planning for health and safety critical roles	Completion against officer activity programme
Health and safety action completion	Actions in response to findings	Incidents related to critical risks	Normal operations learning teams held	Proportion of work completed by contractors	Independent governance review findings
Percentage of workers assessed as fully competent	Quality of assurance activities delivered	Variation from written procedures – as risk or innovation	Overlapping PCBU management reviews completed	Corrective vs preventative maintenance completed	Feedback on quality of officer interactions
Sick leave rates	Emerging issues	Residual risk against risk tolerance	External stakeholder feedback	Percentage of overall spend dedicated to health and safety	

← Back to contents

Demo Co Board: Health and Safety Report Q1

Action: For discussion

Performance

Q1 has seen good progress against our improvement plan with a range of staff and contractors involved in reviewing the Bow Tie for one of our critical risks and the launch of our new worker engagement structure and training programme.

One item is off track – the introduction of our new IT system – due to delays by the developer making changes agreed late last year. We now expect to soft launch this in the next quarter.

High potential events (rated major and catastrophic) are trending upwards although our assessment is that this is due to improvements in the reporting culture (following the roll out of our 'Just Culture Foundations') and an increase in activity level now that the Hamilton plant is back up to full capacity.

Assurance

Our insurers have just completed a fire audit of the Ashburton site and identified improvements in how we manage the dust explosion risk there including the need to replace some electrical equipment with explosion protected items. This work will be programmed into the mid-winter shut, with some temporary controls in place to mitigate the risk until replacements are made.

Several learning reviews were carried out this quarter with some common themes arising (see 'Resources' below). Feedback from workers has been very positive and several other items have been prioritised for review on their recommendations.

Risks

New Workplace Exposure Standards for silica will be challenging to meet in some parts of the business without significant investment in new tools and local exhaust ventilation systems. A CAPEX proposal will be presented to the Investment Committee once we have evaluated the options and obtained quotations.

In Q2 we anticipate commissioning the new fleet of fork trucks in the distribution centre. These have a range of health and safety and environmental enhancements from our current plant including fingerprint driver ID, smart AI sensing technology to detect collision risks and automatically slow the truck, geofenced speed control to ensure our speed limits are adhered to and telematics to enable reporting of shock loads and other issues. They also have the capability to be operated autonomously should we decide to move to a fully 'dark' warehouse and remove all pedestrians from the cold store. This would eliminate moving plant hazards in that area and is currently being risk assessed.

Relationships

We have taken legal advice on the status of our Joint Venture which suggests that both parties will have joint and several liability under HSWA for the business. We are developing a Memorandum of Understanding with our partners to ensure clarity of expectation about roles and responsibilities and in future will include lead and lag data from the JV as a separate line item in our health and safety dashboard.

Our latest net promoter score survey was undertaken last month. Results are being collated and will be included in the next report, together with a selection of verbatim comments from the optional extra questions.

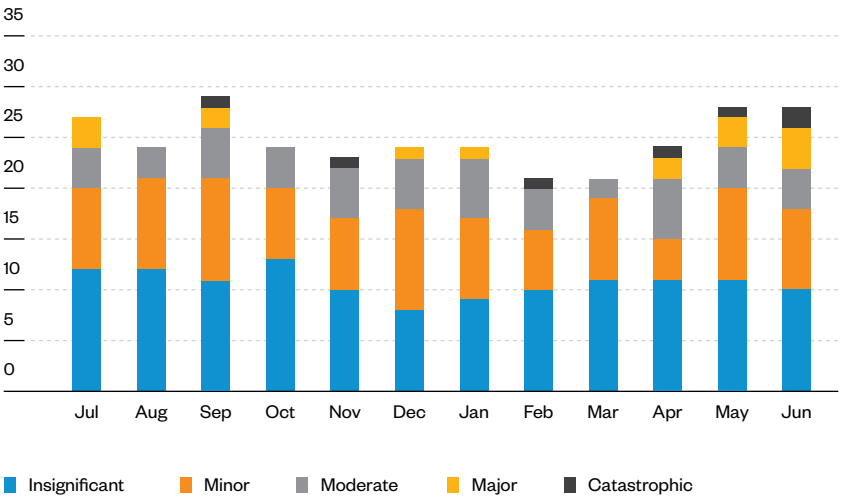
Resources

Common themes from our learning reviews suggest that events are occurring when circumstances change but our teams did not review the impact these would have on how we carried out non-routine work. This has been particularly apparent due to the need to use labour hire and contractors to fill gaps in the maintenance team and some equipment breakdowns. We have managed to make a number of permanent hires and have introduced a new inventory management process to ensure adequate spare parts are available for key machines.

Q1 – Insights

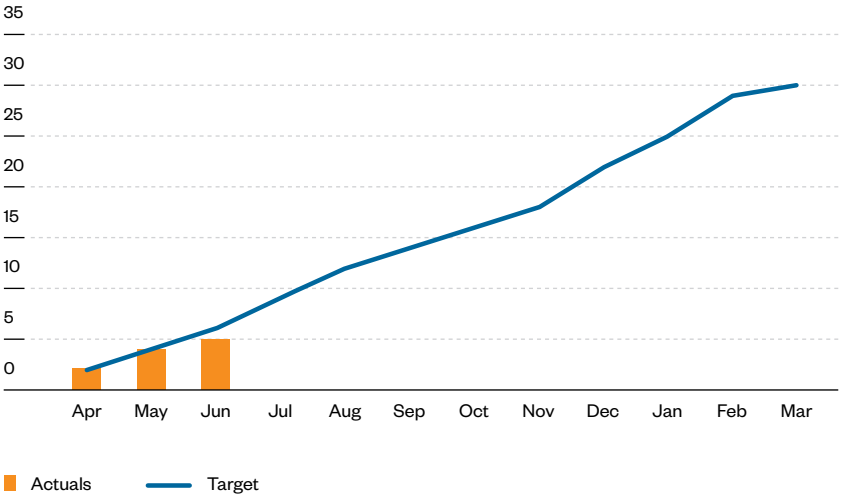
Performance

Incidents by Potential



High potential incidents in Q1 were primarily related to vehicle/ people interactions in warehouses. The new forklift trucks being introduced should improve management of this risk. Others were road transport near misses (see deep dive information).

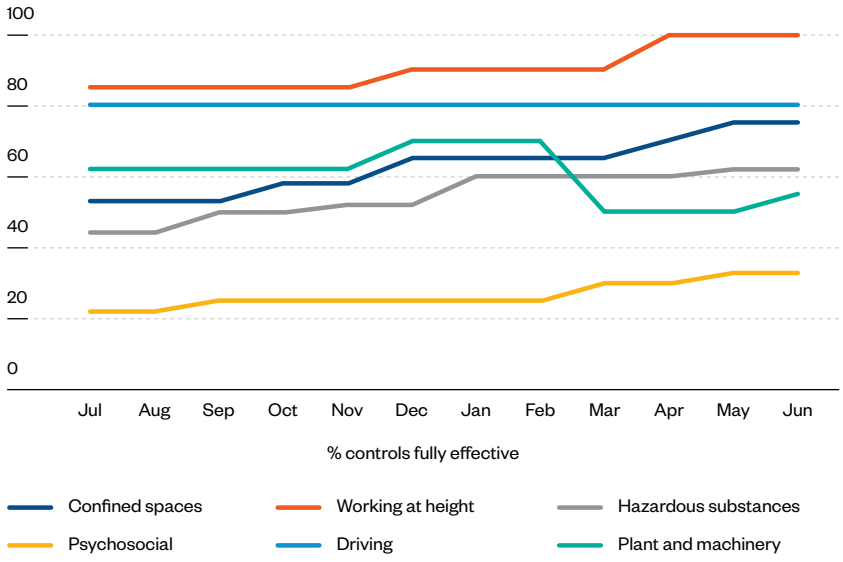
H&S Improvement Plan Progress



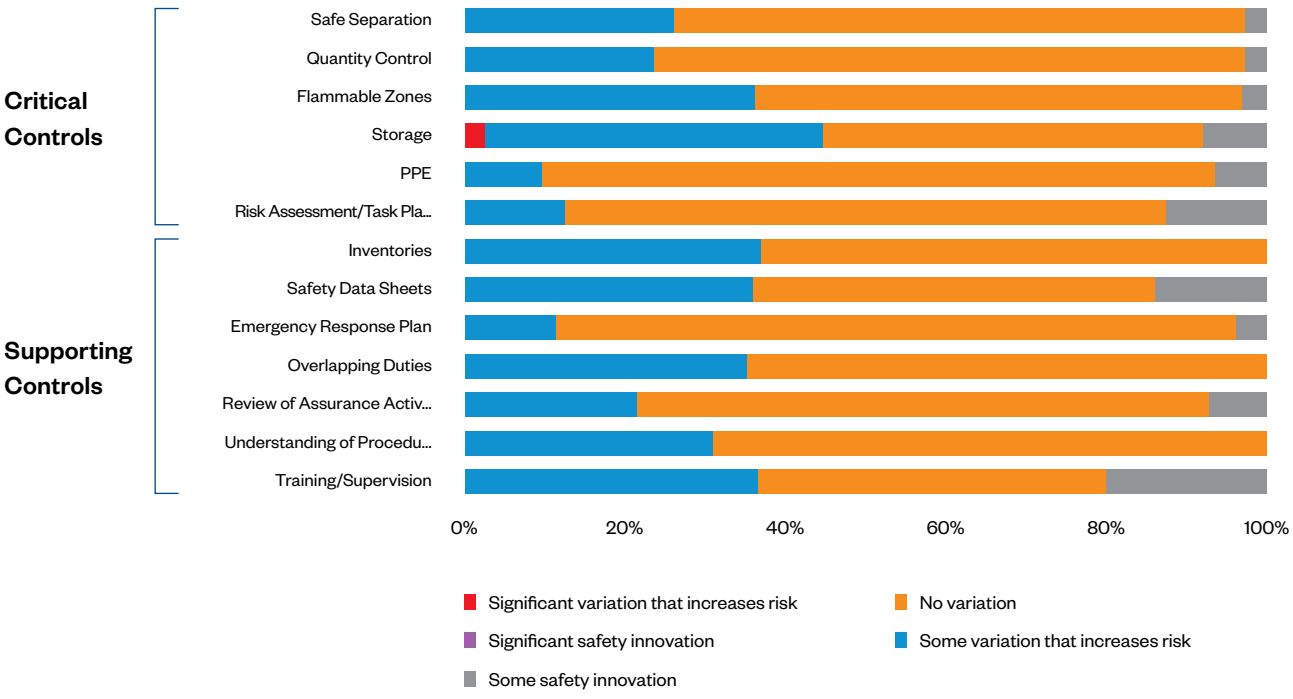
This year's H&S plan has started well. The overdue item is the new IT system (see main text). Several projects have started ahead of schedule and should see some programme gains by mid-year, but the overall target remains a stretch given there are two resource-heavy projects in Q3.

Risk Management

Critical Risk Control Effectiveness (%)

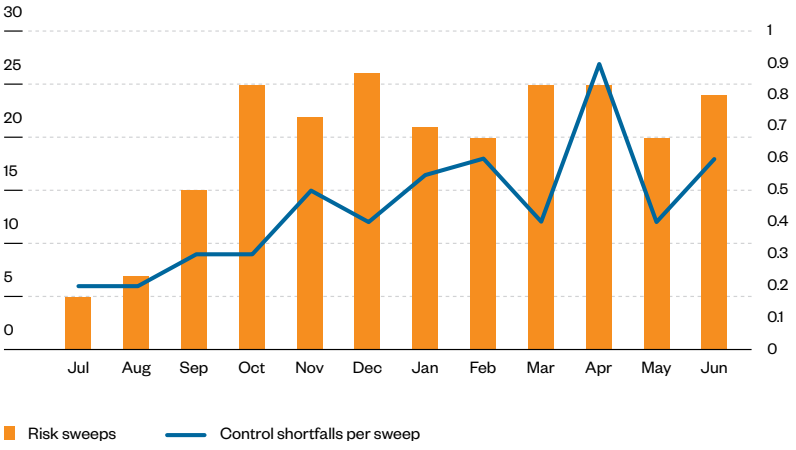


Progress on psychosocial risks continues to progress slowly. Improvements being made are across a wide range of work design factors, requiring significant consultation. While this is disappointing it is important to do this just once and take the time do it well.



This is a new measure this quarter. Identified variations that increase risk will be actioned via the critical control effectiveness action plan. Identified innovations feed into the continuous improvement programme.

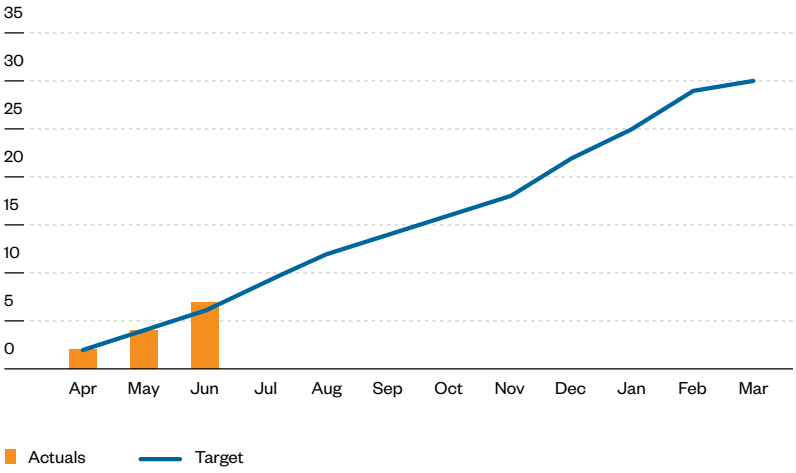
Critical Risk Sweeps



The sweep in April saw a peak level of shortfalls due to a number of machinery guarding issues in a workshop. These have been rectified and other workshops brought forward in the programme (to be carried out next quarter).

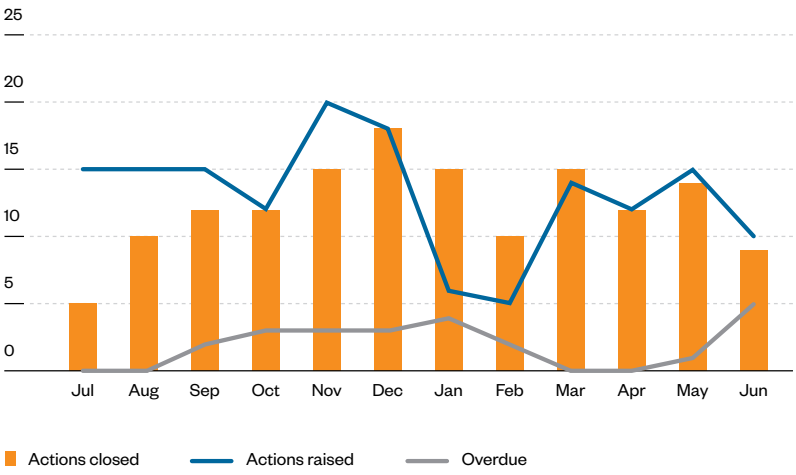
Learning and Improvement

Assurance Completion



The assurance plan is slightly ahead of target due to better auditor availability than expected. No significant findings were found during formal audit, although a number of recommendations have arisen from learning reviews.

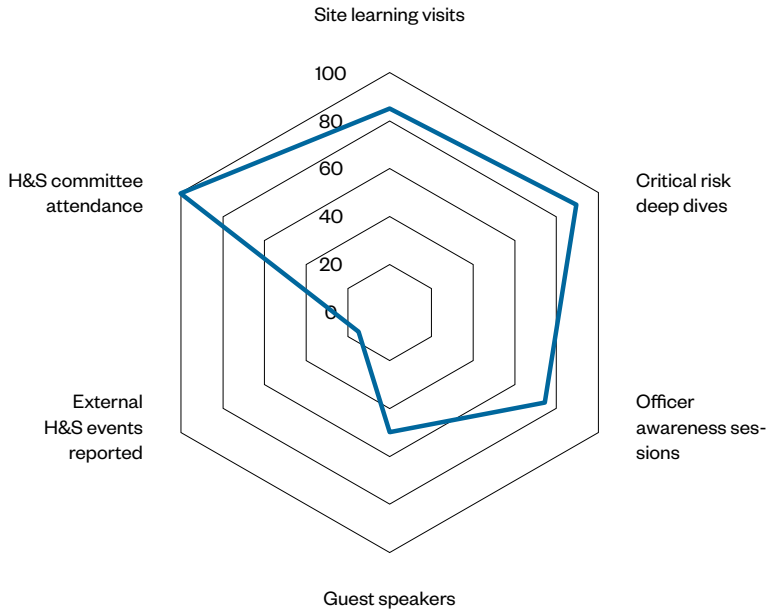
Action Status



After a concerted effort at the end of last FY to complete all actions on time, overdue actions have increased again. Significant emphasis has been placed on setting realistic due dates when actions are first raised.

Officer Due Diligence Activities

Due diligence activities % against plan



All programmed sessions have been held with reduced scores due to people's unavailability to attend. External H&S events is very low, but several of the directors are attending the IoD safety governance course next quarter, which will see some recovery.

Next quarter officer activities and *site visit opportunities*

July	Guest speaker topic – complexity *Te Kuiti site mental health week*
August	H&S Committe meeting *New forklift implementation*
September	New H&S IT system presentation *New packaging line commissioning*

Worker Feedback

Feedback for the latest round of site visits was much better than previously. This suggests the training completed in March was successful. Workers gave the following direct feedback:

- X was really interested in what we were doing and open to feedback.
- Would have been nice to have a little more time for decent conversation, but thanks for the opportunity.
- Last time we had one of these, they were checking all our paperwork – it felt like a test. This time we were able to talk about the important risks.

Critical Risk Deep Dive – Mobile plant

Risk	Description	People Exposed	Controls
Mobile plant	The risk of impact and crushing injuries to people due to: • uncontrolled interaction with mobile plant on facilities • vehicle accident e.g. rollover Includes vehicles on sites but not general road driving (see Critical risk – driving).	Staff, contractors and site visitors	**Critical controls** One way traffic flows Physical segregation Barriers Traffic management plans Roll cages Seatbelts **Other controls** Speed limits Signage Use of spotters Manoeuvring indication – alarms, cameras etc
Gaps/ Improvement/ Progress	Five sites have been reconfigured for one way flow, three are underway and programmed for completion in the next three months. New forklift truck implementation imminent. A recent audit identified several gaps in traffic management plans. None are high risk, but suitable actions have been put in place to close them. These were mostly administrative – for example, out of date plans or plans with no review cycle – but the key finding is that plans are not being used routinely as they are too long, not always clear and not readily available on site. A project is underway to design a robust and clear working version (especially for visiting drivers) that details those key risks and controls that need immediate attention during operations.		
Key incidents	Given the number of plant movements across our sites, incident numbers are relatively low. There have been two high potential near misses that involved reversing delivery vehicles – both are on sites that have now had reversing eliminated through one way traffic flow redesign. One crash occurred between two forklifts at the Tauranga depot. This was during a very busy period pre-Christmas. An extra truck was hired to cope with demand, but it did not have the same movement indicators as our normal fleet and so the other driver was unaware of it at the time. Several other factors contributed including reduced access due to extra inventory stacks. A pre-work operational review with drivers and pickers has been scheduled ahead of the next busy seasonal run to review options to better manage the surge period.		

Current overall assurance level	**Medium**	**Overall assurance level next quarter**	**High**

Back to contents

Appendix 3 – Achieving equity in health and safety outcomes

There are clearly identifiable groups that have worse outcomes in health and safety, being more likely to be injured at work. For example, Māori and Pasifika workers have higher rates of injury with Māori kaimahi more likely to experience injury requiring a week away from work at a rate of 25-33% more than non-Māori (based on WorkSafe statistics). Similar groups that may be at greater risk include migrant workers, workers with a different first language, workers with a disability, young workers and older workers.

Governance has a key role to play in ensuring equitable outcomes for these groups. The considerations below supplement those in the main guide. Consider these for your organisation and understand how they may be implemented by using the principles and 5Cs discussed in the main guide.

Representation in Governance

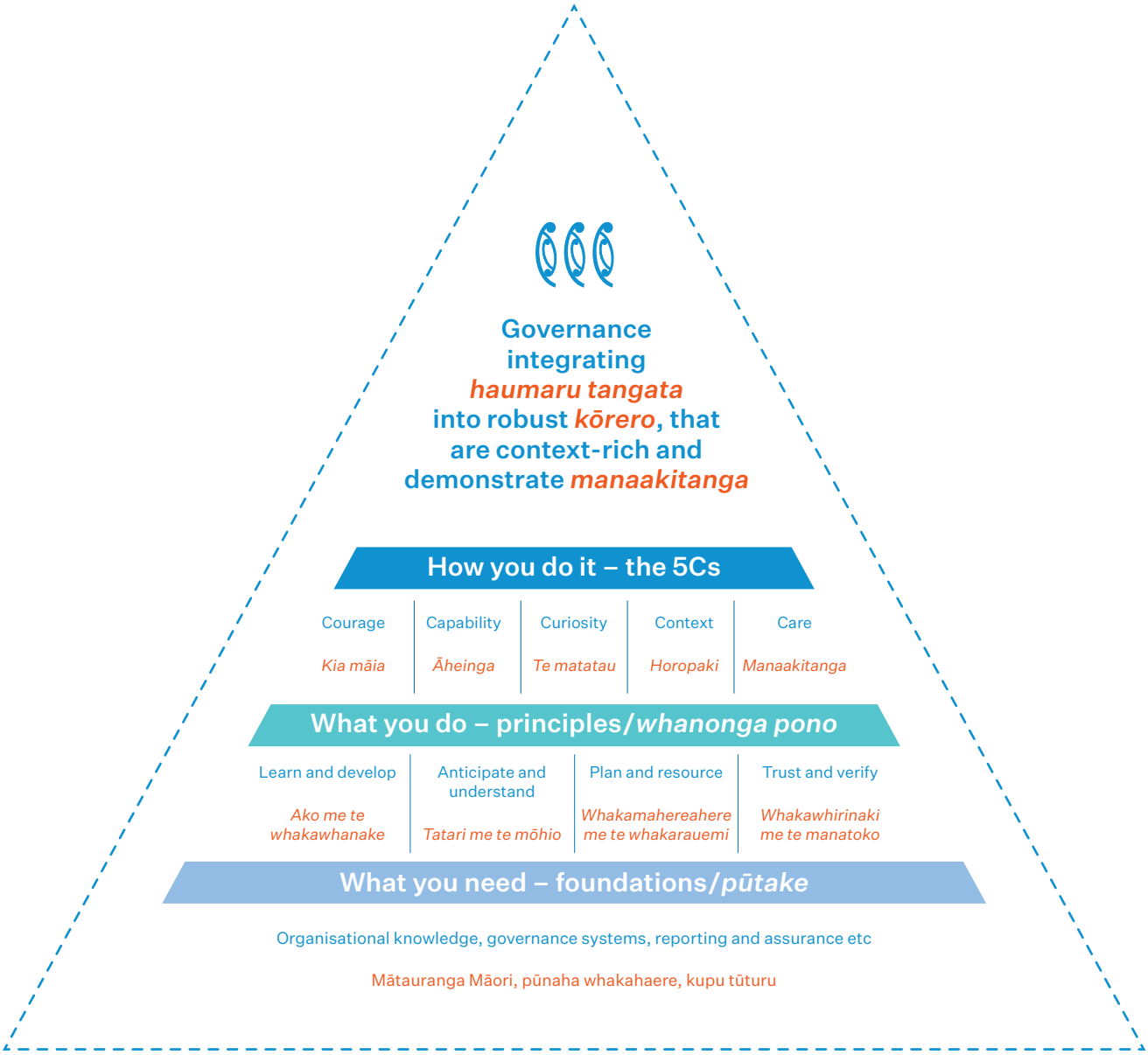
Ensure all voices can be heard.

What		Detail
Diversity of members	Appoint directors with the right balance of skills and experience	Diversity is vital to enable understanding and encourage robust debate and constructive challenge. Where it is not possible to be fully representative, bring in people with the experience to represent relevant groups
Board dynamics	Create an environment of trust and openness with good communication and consultation with wider stakeholders such as owners or beneficiaries	All aspects of how the board operates should be designed to create the right culture and encourage robust kōrero leading to consensus decision making, so that all groups can provide input
Demographics	Understand the people that make up your organisation and recognise where they may be at higher risk	Where necessary, implement additional controls and monitoring. Consider how to adapt the working environment to make it more inclusive, easier for people to be involved and culturally appropriate to gain genuine feedback

Language

Consider where there are different languages being used and work to limit the barriers that this creates. This improves communication that assists in health and safety (and other) outcomes and also normalises the use of different languages. This makes people feel more accepted and involved in the organisation.

For example, the terms used in this governance guide in te reo:



What		Detail
Language	Consider the range of languages spoken when designing communication	Where appropriate: • Consider language classes • Provide information in multiple languages • Provide translators • Use pictures/videos rather than words in instructions

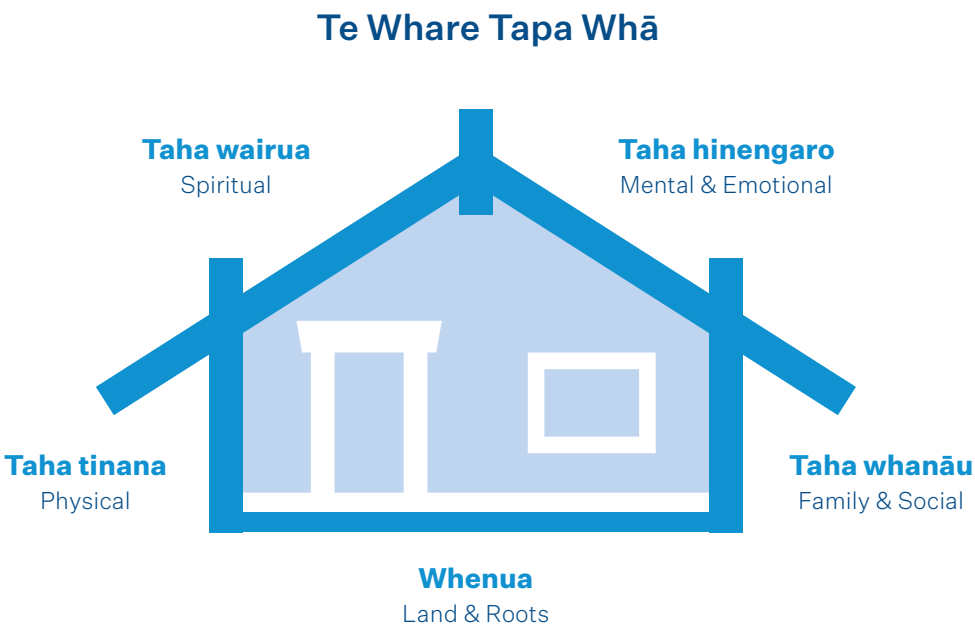
Culture

Cultural backgrounds have powerful influences on people's approach and behaviours. Some cultures are traditionally very hierarchical and others take a more consensus view of the world. It is important to be sensitive to the cultural landscape in your organisation and design work and processes to take this into account.

What		Detail
Feedback	Consider cultural norms in feedback processes to enable greater understanding	Recognise that different cultures respond in different ways – simply telling people they can speak up is not enough. Design formal feedback process to account for cultural variety.
Awareness	Enable different cultures to better understand each other	Consider: • Awareness training for managers and supervisors • Story-telling and sharing to celebrate different cultures • Cross-cultural events to provide insight

The use of different cultural artifacts can aid understanding, provide insight and draw on different cultures to help everyone. For example, for many Māori and non-Māori organisations 'Te Whare Tapa Whā', a model developed by Sir Mason Durie, provides a useful framework for looking more holistically at wellbeing. It includes the four pou or pillars:

- **taha hinengaro** – mental health and emotions
- **taha wairua** – spiritual health
- **taha tinana** – physical health
- **taha whānau** – whānau as the epicentre of one's wellbeing



Te Whare Tapa Whā model of hauora

Wellbeing can be challenging to traditional governance thinking due to the intersection of causes and effects from work and home life. Taking a holistic approach using Te Whare Tapa Whā as part of applying an iwi Māori governance lens that incorporates tikanga principles and takes into account the aspirations of whānau, hapū and iwi along with cultural considerations, may be more attuned to te ao Māori in context.

Accessibility

Different groups may encounter difficulties in accessing information or physical assets or locations. Consider arrangements to maximise access.

What		Detail
Access to information	Consider those with different accessibility needs	Consider additional literacy and numeracy support for workers Use pictures/videos rather than words in instructions Consider aids to information access, such as: • Braille • Hearing loops • Voice activation, reading aloud or visual aids for IT systems
Physical access	Enable easy access to locations and assets	Ensure accessible facilities for workers to be fully involved at work in meetings, informal areas and individual workspaces.

Nā to rourou, nā taku rourou, ka ora ai te iwi

With your food basket and my food basket, the people will thrive

Back to contents

Glossary

5Cs	Defined in this guide as the five core behaviours that support good governance: • Courage • Capability • Curiosity • Context • Care
Catastrophic Risk	Risks that have the potential for very large consequences, such as multiple fatalities or significant impacts over a large area.
Critical Risk	Risks that have been defined as those that are most significant for an organisation, in terms of their potential impact. Typically defined as potentially fatal consequences.
Due diligence	The investigation and exercise of care that an officer is expected to carry out to ensure their PCBU is complying with its health and safety duties. Formally defined in Section 44 of HSWA as including (but not limited to): (a) to acquire, and keep up to date, knowledge of work health and safety matters; and (b) to gain an understanding of the nature of the operations of the business or undertaking of the PCBU and generally of the hazards and risks associated with those operations; and (c) to ensure that the PCBU has available for use, and uses, appropriate resources and processes to eliminate or minimise risks to health and safety from work carried out as part of the conduct of the business or undertaking; and (d) to ensure that the PCBU has appropriate processes for receiving and considering information regarding incidents, hazards, and risks and for responding in a timely way to that information; and (e) to ensure that the PCBU has, and implements, processes for complying with any duty or obligation of the PCBU under this Act; and (f) to verify the provision and use of the resources and processes referred to in paragraphs (c) to (e).
Governance Principles	Five principles defined in this guide as the core components of activities associated with H&S governance: • Learn and develop. • Anticipate and understand. • Plan and resource. • Trust and verify. • Monitor and respond.
Health and Safety Lead	The most senior person with direct responsibility for execution of health and safety matters within an organisation.
HSWA	Health and Safety at Work Act 2015
IoD	Institute of Directors

ISO 45001	The International Standards Organisation standard for health and safety management systems
LTIFR	Lost time injury frequency rate
Management	Used in this guide as the executive or senior team responsible for execution of policies set by the board (or equivalent). Typically, the Chief Executive and their direct reports.
Officer	A role formally defined in HSWA to define those individuals with senior responsibility for health and safety. This includes: • Company directors. • Partners in a partnership and general partners in a limited partnership. • A person who holds a position comparable to a director in a body corporate or unincorporated body (e.g. members of Boards of Crown entities, school trustees, Board or Committee members for iwi trusts, or community or not-for-profit organisations). • People who hold positions that enable them to significantly influence the management of the business or undertaking (e.g. CEOs).
PCBU	A person conducting a business or undertaking. In most cases this refers to the organisation that is carrying out the work.
Risk	A combination of the likelihood of something going wrong and the potential severity of its consequence.
SafePlus	An assessment tool designed and supported by WorkSafe and ACC to enable PCBUs to assess their health and safety systems.
TRIFR	Total recordable injury frequency rate
Weak signals	Subtle signs or indications of something that may be lost in noise without careful consideration. These tend to become apparent with hindsight following a failure, but are difficult to identify ahead of that event.

Institute of DIRECTORS NEW ZEALAND

WORKSAFE NEW ZEALAND | MAHI HAUMARU AOTEAROA