RM³ 2019

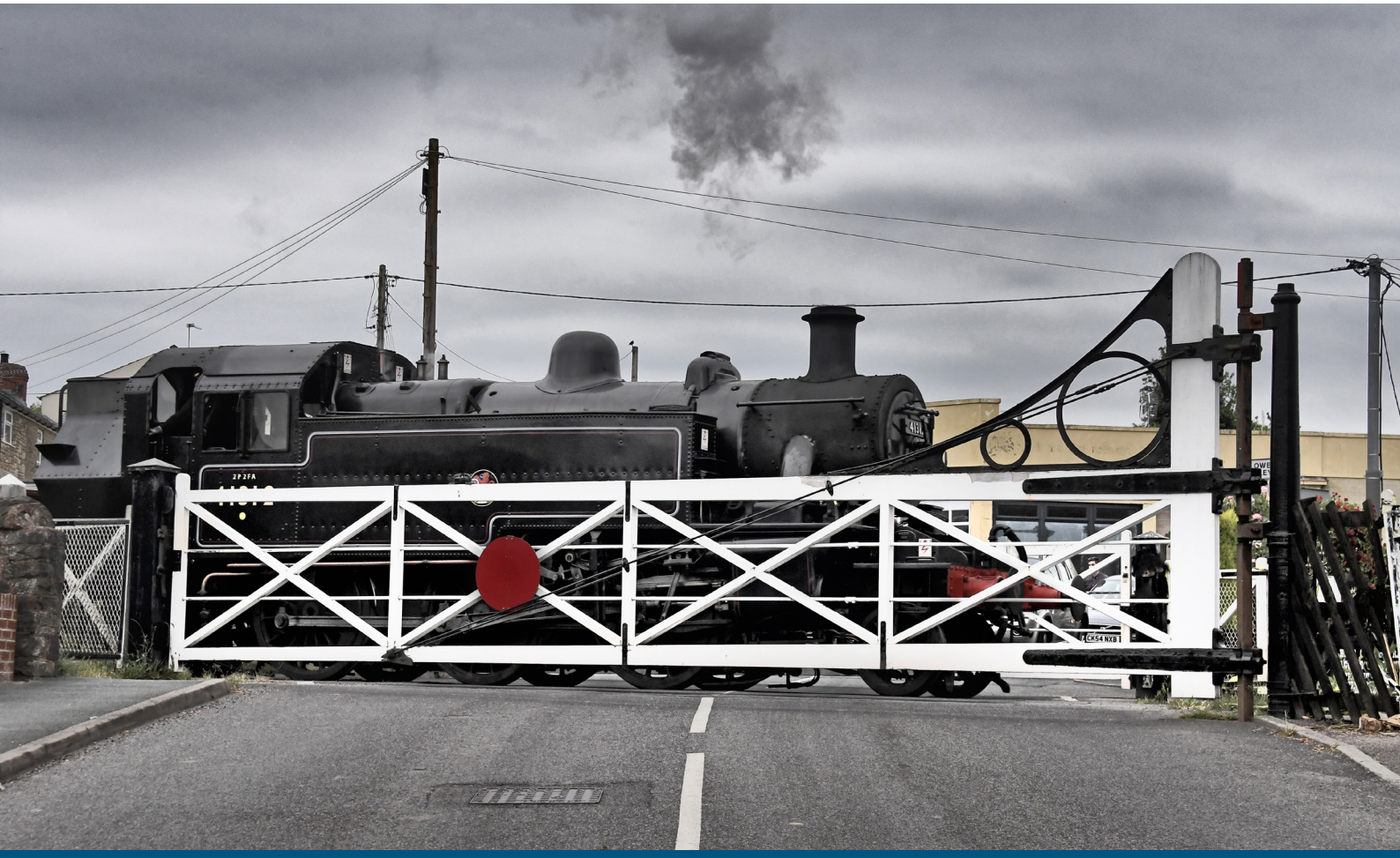
OFFICE OF RAIL AND ROAD

The Risk Management Maturity Model

Topic set 1

Heritage Railways

Version 1 2021



RM^3 *2019*
The Risk Management Maturity Model

Topic set 1

Heritage Railways

Published 2021

For more information contact us at rm3@orr.gov.uk or visit our website: orr.gov.uk

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Introduction

What is the purpose of the Risk Management Maturity Model (RM^3) 2019 Topic Set 1 Heritage Railways?

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

- identify and assess risks properly
- control them effectively, and
- comply with the law.

Relevant legal provisions for minor and heritage railways[1] include:

- The Health and Safety at Work etc. Act 1974 (HSWA 1974) and the Regulations made under it that cover how certain risks should be controlled, including the Management of Health and Safety at Work Regulations 1999 (MHSWR 1999).
- The Railway and Other Guided Transport Systems (Safety) Regulations 2006 (ROGS).

ROGS gives railway organisations duties to develop a safety management system (SMS) that meets certain requirements, adapted to the size and nature of the railway. ORR's website provides further information, including A Guide to ROGS[2]. To achieve and sustain excellence in H&S culture and risk control, we believe that railway organisations must have in place an excellent SMS.

To compliment the ROGS requirements, RM^3 provides criteria for measuring management capability against five maturity levels across criteria we have identified as essential areas of an SMS. The criteria identify the steps to evaluate a company's progress through five levels of maturity, from ad-hoc to excellent[3]. ORR and organisations can use the criteria to understand their management capability in several business-critical areas.

Topic Set 1 for Heritage Railways assumes that the organisation has a legally compliant safety management system in place; and focuses on developing the management capability of that system.
Topic Set 1 is not intended to be a compliance tool, but rather a tool to help develop management maturity.

1 Minor and heritage Railways that ORR has excluded from the mainline railway requirements of ROGS
2 ROGS: www.orr.gov.uk/guidance-compliance/rail/health-safety/laws/rogs
3 For more information on the purpose of RM^3 2019, excellence in health and safety management systems, and criteria development refer to RM^3 2019.

Why we have developed RM^3 2019 Topic Set 1 for Heritage Railways?

RM^3 is relevant to the minor and heritage railway sector and is a useful tool to help both ORR and the railways themselves consider safety management system capability, identify areas for development, and provide a benchmark for year-on-year comparisons.

We recognise that smaller organisations or those just starting out on the RM^3 journey may find some of the criteria and descriptors inaccessible, or not obviously relevant to them. To help heritage railways we have developed, with input from key stakeholders, the RM^3 2019 Topic Set 1 for Heritage Railways.

Topic Set 1 provides more focused RM^3 descriptors over a much smaller and more readily applicable set of criteria than the 26 found in the full RM^3 2019. The intent is to provide descriptors that reflect the heritage sector's particular operating characteristics and risk profile. We believe this makes the RM^3 approach more accessible and meaningful as a tool for those responsible for implementing, analysing and improving heritage railway safety management. Users should find that the additional examples of heritage-centred evidence make it easier to determine maturity levels in their organisation.

Topic Set 1 contains 10 particularly applicable elements of RM^3 2019, tailored to the heritage sector. Users can of course supplement the 10 Topic Set criteria with others from RM^3 2019, if they believe this will help their development, or better reflect their risk profile. Furthermore, the heritage Topic Set has been designed to offer an uncomplicated, simple way for organisations to identify what they can do to improve their management maturity. Selected guidance and further reading suggestions are provided.

Topic Set 1 has been developed so that there should be consistency in the assessed level, irrespective of whether the full RM^3 2019 or Topic Set 1 criteria are used. This means that as an organisation matures, it can adopt RM^3 2019 in full without adversely impacting on the usefulness of previous assessments. To assist in this process, figure numbers and topic reference codes are transferred unchanged from the RM^3 2019 document. This ensures that common references are used whether an organisation is using the Topic Set or the full RM^3 2019 document.

Who should use RM^3 2019 Topic Set 1 for Heritage Railways?

We want heritage railways to embrace RM^3 and to use it as a tool to help them continuously improve their health and safety management system capability. We believe Topic Set 1 will help to achieve those improvements.

We recommend that larger heritage railways that also operate on the mainline, or which routinely transfer rail traffic through a mainline interface, consider using the full version of RM^3 2019. That said, the heritage Topic Set could form part of the route to achieving this, by first introducing RM^3 to such a railway.

Excellence in health and safety management systems (SMS)

Excellence is not a theory, it relates to what an organisation does, how the organisation does it, the results it gets, and the confidence that these results will be repeated. An excellent organisation not only meets its legal obligations, but goes beyond these in its pursuit of excellence. RM^3 has adopted the framework set out in the Health and Safety Executive's (HSE) publication 'Successful Health and Safety Management' (HSG 65), shown in Figure 1, which is the most widely adopted model of successful health and safety management within the UK.

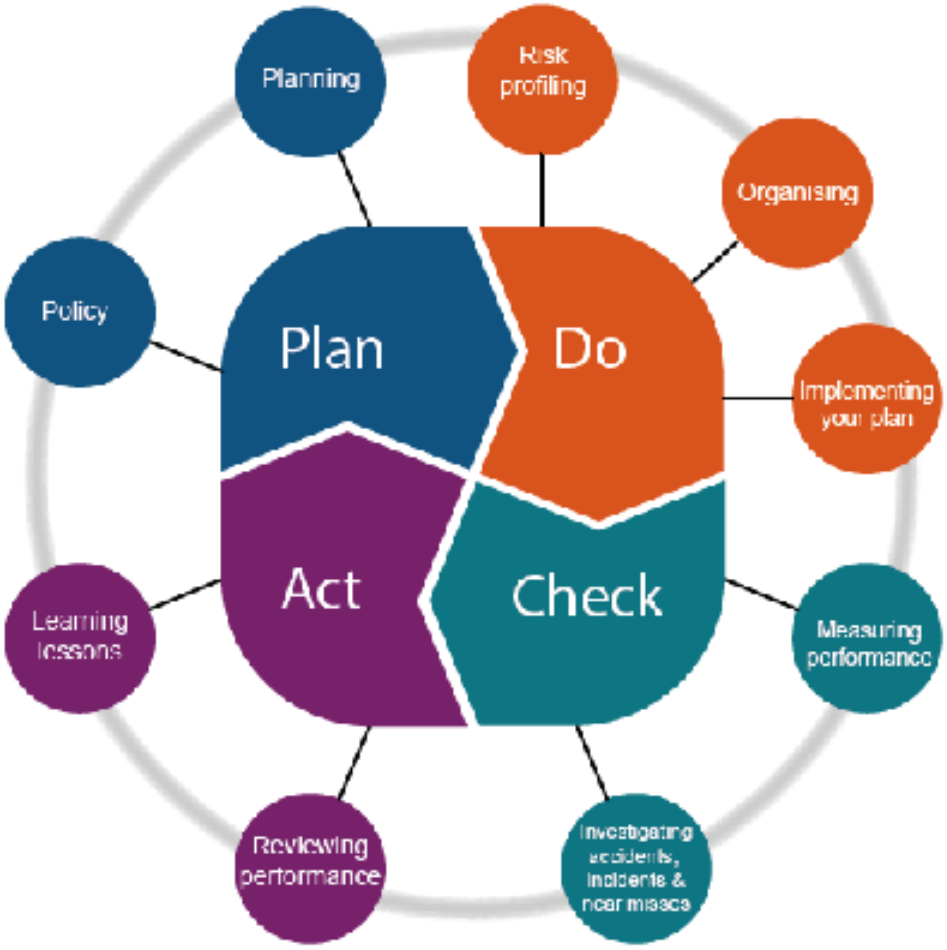


Figure 1 The Plan, Do, Check, Act cycle (HSG65 2013)

Using this approach allows organisations to manage their operations using a systems process, that is in line with other management systems standards, such as ISO 9001: 2015 (Quality) and ISO 14001: 2015 (Environmental). The move towards the 'Plan Do Check Act' approach achieves a balance between the systems and behavioural / cultural aspects of management.

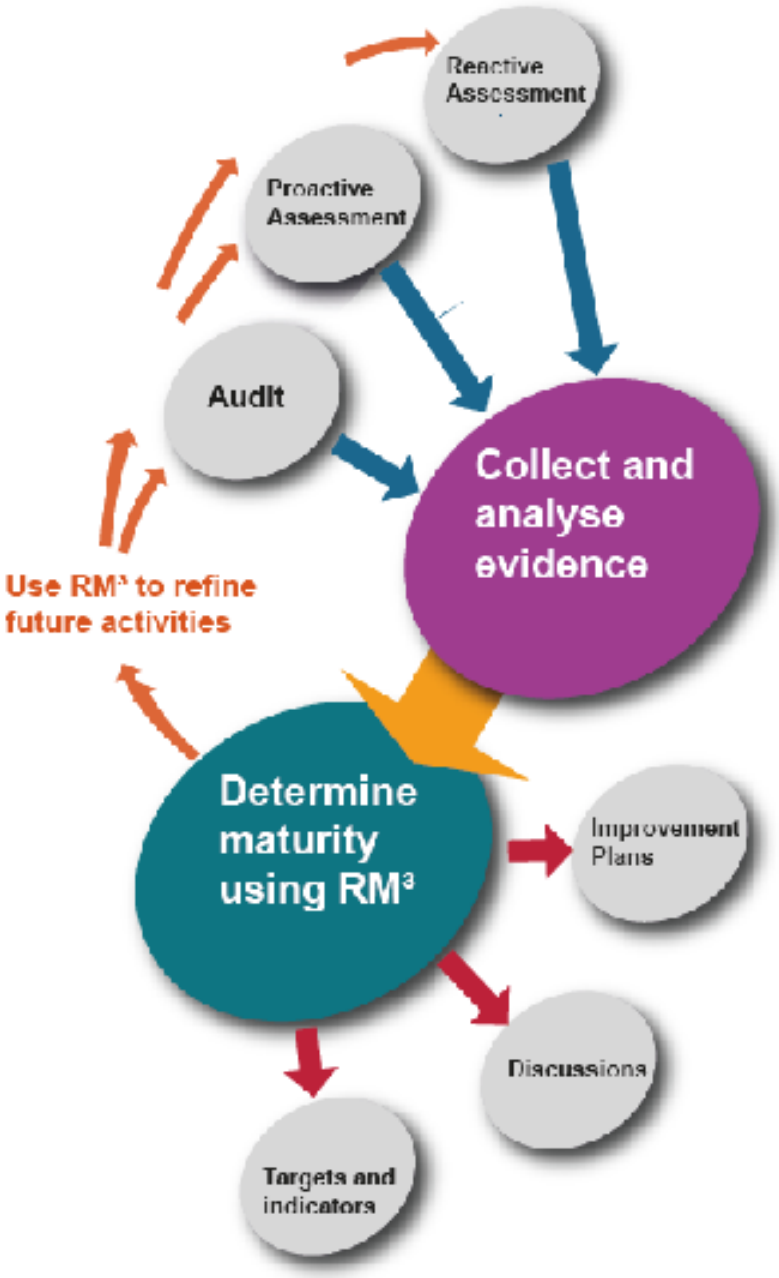
Further information

RM^3 2019 provides further information on how RM^3 can help an organisation understand if their SMS can deliver excellence in risk control, and how ORR developed the criteria.

Using the criteria

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

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



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

Figure 4 illustrates the type of information and the collection methods available to assessors in determining an organisation's maturity levels.

A non-exhaustive list of evidence sources is attached at appendix 4.

Reactive assessment includes:

- Workplace violations and errors
- Incidents
- Failures to deliver performance objectives
- Complaints

Proactive assessment includes:

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

Audit includes:

- Top down SMS reviews
- Corrective action monitoring
- Internal and external scrutiny

Figure 4 Information sources and collections methods

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

RM^3 assessments of the SMS may focus on a limited number of risk controls and track them up through the levels of the organisation.

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

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

Assessors should use the evidence gathered to inform their opinion of the organisation's management arrangements against the RM³ criteria. As the volume of evidence increases, there should be greater clarity over where an organisation's maturity lies. Assessors should use their judgement when deciding which criteria and evidence to use. Figure 5 illustrates the evidence factors assessors should consider when deciding which evidence to use.

Figure 5 Evidence factors

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

Collating findings

When collating findings, assessors should critically review their evidence against the evidence factors (see figure 5 above) to determine the weight placed upon that evidence when determining a maturity level.

For areas that heritage railways are assessing, a maturity level should be determined and the most frequently occurring assessment level will then be the maturity level recorded for each criteria.

This will build up a picture of the health and safety management maturity of the organisation. This naturally leads to identification of strengths and areas for improvement. The assessment is likely to be most valuable if it is done by department rather than try to evaluate the organisation as a whole. It is the discussion between assessor and department on how to further improve, based on the ten criteria that provides the most value.

Determining how the SMS works in practice to manage risk in the organisation is more important than how it appears on paper. The assessment should focus on the day-to-day application of the SMS and the gaps that exist between "what we say we do" and "what is actually done". From this, plans should be developed, agreed and owned so developing a culture of continuous improvement.

A method for collating organisational culture assessments is included in Appendix 2 of this document (and Criterion OC6 of the full RM^3 2019 version (amended 2020)).

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

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

The Risk Management Maturity Model (RM³) Topic Set 1 for Heritage Railways criteria

Health and safety policy, leadership and board governance	SP1 Leadership SP3 Board governance SP4 Written health and safety management system	SP
Organising for control and communication	OC7 Record keeping, document control and knowledge management	OC
Securing co-operation, competence and development of staff at all levels	OP2 Competence management system	OP
Planning and implementing risk controls through co-ordinated management arrangements	PI1 Risk assessment and management RCS2 Management of assets RCS3 Change management (operational, process, organisational and engineering)	PI & RCS
Monitoring, audit and review	MRA2 Audit MRA3 Incident investigation	MRA

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SP Health and safety policy, leadership and board governance

Purpose:

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

Introductory notes

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

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

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

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

The Heritage Railways Topic Set criteria in this section include:

- **SP1 - Leadership** from the top which provides consistent example and inspiration for leaders at all levels of the organisation;
- **SP3 - Board governance** - effective at providing clear direction, leadership and oversight for health and safety – setting 'the tone from the top'; and
- **SP4 - A written safety management system** designed to control all H&S risks which arise as a consequence of the business activities.

SP 1 Leadership

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

- The attitudes and decisions of senior managers aligning with the H&S policy and culture;
- Identifying and promoting the styles of leadership and management practices at all levels, which best support a positive H&S culture;
- Promoting effective collaboration and engagement of all staff and business partners to achieve continuous improvement on H&S;
- Aligning the leaders in all parts of the organisation around the common H&S purpose, strategies and goals;
- Assessing H&S leadership and management behaviour to improve the control of risk and;
- Setting standards and expectations to help the organisation achieve its goals and strategies for improving health, safety and performance.

Excellence

- Outstanding leadership is displayed at all levels of the organisation, by directors, managers, department heads and front line staff.
- There is ample and consistent evidence of all the following:
  - Honesty and integrity;
  - Competence over confidence;
  - The ability to inspire others;
  - Commitment and passion;
  - Good communications;
  - Decision-making capabilities;
  - Accountability;
  - Delegation and empowerment;
  - Creativity and innovation;
  - Empathy;
  - Visibility of leaders

Culture
All leaders recognise they have an obligation to foster an atmosphere where people do not fear and find it easy to speak up and share when they have made mistakes rather than covering up errors.

- Leadership is part of a carefully planned structure and does not happen by accident.
- The organisation acts as one powerful, totally coordinated team with high levels of trust.
- There are training courses on leadership and opportunities for encouraging and to develop qualities in the next generation.

Predictable

- Leaders at all levels maintain attention on their significant risks and quality of implementation of the control measures.
- Leaders' actions show they are committed to improving safety performance.
- Appointment to leadership positions are mainly based on merit, attitude and competence.
- There are good levels of communication, coordination and collaboration at and between leadership levels and staff.

Culture
Leaders take responsibility for developing, leading and promoting a positive atmosphere that values staff and encourages safe working and an awareness of risk.

- Everyone pulls together in times of stress or difficulty.
- Some efforts are made to develop the next generation of leaders.

Standardised	• Staff who demonstrate leadership qualities are usually willing to accept responsibility and so tend to settle into leadership roles. • Leadership is seen to be about having personal qualities and confidence in self and others. • Leaders challenge unsafe behaviour. • Standards of discipline are generally good, and departments speak, share information and cooperate with each other to improve safety.	**Culture** Leadership is still largely viewed as a directors and senior management role. • Non-technical skills (such as communication, decision making, team working) are viewed as important and staff receive appropriate training.
Managed	• The organisation is heavily reliant on a few key individuals who are considered natural leaders. • There is not always planned or documented consistency or collaboration between individuals and the various departments and groups. • Rules are generally followed, but not always to the letter if there is a simpler, quicker alternative. • Leaders accept deviation and non-compliance.	**Culture** Leadership is viewed solely as a directors and senior management role.
Ad-hoc	• The role of leaders and managers is to tell staff what to do. • Individuals are blamed and disciplined when things go wrong. • Leaders set no health and safety priorities • There is no effort to allocate time or resource to health and safety organisation. • Nothing gets done until it goes wrong.	**Culture** Staff consider there is little effective leadership in health and safety and it is left to those undertaking tasks to manage their own and visitors' health and safety. • Staff are expected to get on with their tasks and not question.

Suggested guidance and further reading:

- INDG 417 'Leading Health and Safety at Work': HSE
- HGR-M0101 The Duties and Roles of Boards of Directors and Chairmen; HRA

SP 3 Board governance

An effective board provides clear direction, leadership and oversight for health and safety (H&S). It sets the 'tone from the top' and help achieve long term viability. An effective Board is:

- Setting direction by defining H&S policies, vision, strategies, goals, values and culture;
- Defining the arrangements to manage risk and monitor effectiveness;
- Ensuring appropriate resources for controlling H&S risk are provided
- Leading by example to promote a leadership style which supports appropriate H&S culture;
- Delegating to management through organisational structures and SMS.

Smaller heritage railways may not have a complex board structure. It is likely all will have persons fulfilling the functions of key corporate roles required by company/charity law: e.g. chairperson, director, trustee. Organisations should take into account the 12 'Tablets of Governance' detailed in Appendix 1 when developing their maturity.

Excellence

- The board demonstrates all 12 'Tablets of Governance' (See Appendix 1).
- The organisation has in place a vision, purpose and long term strategy, to which there is total buy-in by organisation board, management and staff.
- There is transparency and clear lines of accountability for the board to the owners and/or members.
- There is excellent organisational discipline and culture.
- The board, is generally seen by most staff to exhibit fairness and justice, when making sensitive and difficult decisions.

Culture
The board promotes a culture of continuous improvement, challenging managers and supervisors to improve, supporting that with examples of good practice from both outside and the wider rail industry, that have the capability to be implemented in a way that adds value to the organisation.

- Corporate social responsibility is demonstrated by using measures such as BITC's Responsible Business Tracker, a Community Mark or similar.
- The board demonstrates diversity across a range of expertise, opinion, age and background.

Predictable

- The board, demonstrates, to a reasonable level, the 12 'Tablets of Governance'.
- The organisation has in place a vision, purpose and long term strategy.
- The board ensures all policies are reviewed at an appropriate interval determined by the board and they are updated on the outcomes.
- There is reasonable transparency and clear lines of accountability for the board to the owners and/or members.
- There is good organisational discipline.
- The board reviews proactive monitoring information (e.g. delivery of training and maintenance programmes) and reactive information (e.g. accident, near miss sickness data).
- The board initiates periodic audits of effectiveness of the management structure and risk controls.

Culture
There is a culture of most people doing the right things in the right way at the right time.

The board seeks balanced indicators of safety assurance and has mechanisms in place to demonstrate the integrity of the organisation's assurance regime. The board demonstrates a systematic approach to identifying and understanding risk and sets clear tolerances and expectations.

- The board has independent and effective non - executive directors and the minutes of board meetings will demonstrate their level of engagement, investigation and questioning
- The board demonstrates some diversity across a range of expertise, opinion, age and background.

Standardised	• The board effectively governs the organisation. • The board takes its responsibilities seriously. • The board sets out to work in the best way possible, with the resources available. • The board routinely review the risk register, and use it to inform Board decisions. • The board has access to a good level of technical and railway expertise for decision making.	**Culture** The role of the board and managers in managing H&S is clear and the expectation of risk tolerance is communicated. • The board recognises that improvements are necessary and has plans in place to address this.
Managed	• The board is well intentioned and can demonstrate how it believes it has the best interests of the organisation at heart. • The board has access to some, but not all the levels of expertise it would like to be effective. • There is a risk register in place. • H&S performance is considered reactively, rather than proactively. • The board routinely reviews reactive safety performance indicators (e.g. accident / near miss / sickness rates. • The board communicates when it needs to, but does not always welcome challenge.	**Culture** Some, but not all parts of the organisation, believe that the board managers and supervisors are interested in H&S. • Succession planning for new directors has proved difficult. • Most of the board's efforts are directed to immediate operational priorities, rather than a focus on longer term developments
Ad-hoc	• Trustee and director roles are seen as positions of status and remote from the ordinary running of the railway, with only a limited overseeing role and to approve decisions. • Power and control reside with individuals or ad hoc committees and groups.	**Culture** Throughout the organisation, individuals are either not confident or do not know that the board, managers and supervisors are interested in H&S.

Suggested guidance and further reading:

- INDG 417 'Leading Health and Safety at Work': HSE
- HGR-M0101 The Duties and Roles of Boards of Directors and Chairmen; HRA

SP 4 Written health & safety management system (SMS)

A written health and safety management system (SMS) describes how the organisation intends to systematically manage the safety risks associated with running a railway. This includes setting out how the organisation ensures that the risks associated with railway operation, engineering, and maintenance activities are managed in a coordinated way as a system to achieve safety.

The safety management system is not a single document. It is a suite of documents, policies and procedures that, when correctly implemented, work together in a consistent manner to deliver a safe railway.

The SMS should:

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

Excellence

- The organisation's SMS is adaptable and responsive to change.
- The SMS is capable of accommodating emerging risks and reasonably foreseeable developments in:
  - Legislation;
  - Best practice (such as HSG 65);
  - Technology;
  - Social;
  - Environmental and;
  - Political influences
- The SMS is an integral part of the overall management system.

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

- The SMS is seen as the means to demonstrate a commitment to measuring and improving organisational culture.
- Everyone on the railway has received training on the SMS and is regularly updated.

Predictable

- People understand the risks associated with their role, and are able to describe and implement the prescribed control measures.
- Visiting staff and contractors are able to adhere to the same standard.
- Everyone in the organisation can explain their role, how the SMS affects them, and know where to find information and guidance or processes.
- Standards are reviewed, to ensure that the SMS uses and delivers up to date standards of risk control.

Culture
There is a collaborative approach across the organisation in implementation and reviews of the health and safety management system.

- The SMS describes how performance is measured, to check controls are working, and standards are being implemented.

Standardised

- The written SMS meets the elements laid down in relevant regulations and standards, such as HRA's guidance note on safety management systems, as a minimum.
- The written SMS contains clear references to supporting documents that describe control measures.
- Each document within or referenced from the written SMS has its own author / owner and it is approved and authorised as being fit for its intended purpose.
- The SMS reflects clearly the systems in place to manage risk effectively.

Culture
There is a clear understanding at all levels and across the railway of how the SMS sets out to control risks and to what standard.

- The SMS is communicated to staff and others who work with the railway or share risks e.g. connecting infrastructure managers and operators).

Managed

- There is a process in place within the organisation to produce and maintain a legally compliant SMS.
- The SMS says what the organisation does about railway safety.
- The SMS reflects the 'PLAN DO CHECK ACT' principle in describing how safety is managed on the railway.
- Relevant parts of the SMS are communicated to staff and;
- Not everyone does what the SMS says in all parts of the organisation.

Culture
The SMS is understood by most staff as an important and integral part of how safety and risk are managed.

Culture
The SMS is seen as unimportant or is poorly understood.

Suggested guidance and further reading:

- A Guide to ROGS; ORR
- HSG 65 Managing for Health and Safety; HSE
- HGR-A0017 Safety Management Systems; HRA

OC Organising for control and communication

Purpose

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

Introductory notes

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

Control is the foundation of a positive health and safety culture.

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

Communication is often a challenge to organisations.

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

The Heritage Railways Topic Set criteria in this section include:

- **OC7 Record keeping, document control and knowledge management-** suitable information is collected, stored and is readily retrievable to support H&S decision-making and, effective and reliable control of risk at all levels.

OC 7 Record-keeping, document control and knowledge management

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

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

This includes information, such as:

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

The SMS needs to identify key information, and the processes for updating, storing, and retrieving the information. This ensures that those persons who need to make informed decisions have ready access to the information. It also ensures that the experience and learning of those who are leaving the organisation is not lost.

Excellence	• The organisation has a centralised and comprehensive system for all records and documents. • There are active systems in place to capture data and corporate knowledge. • Paper records are scanned and made into electronic (soft) copies where appropriate. • The system is easily accessible on line to appropriate and approved users. • The organisation subscribes to industry wide information systems and readily shares its own information.	**Culture** The importance of maintaining and growing corporate knowledge to deliver continuous improvement is embedded in all levels of the organisation's culture. • Data and information are regularly published in an understandable format that can be used to drive continuous improvement.
Predictable	• The organisation has a comprehensive document and record system with a central index made up of a mix of electronic and paper-based records. • Records include details of all risk related processes and controls, standards, and outputs from those processes (e.g. inspection records, maintenance records). • Systems are in place for capturing and retaining corporate knowledge.	**Culture** There is a culture of making decisions based on corporate knowledge. • Corporate knowledge is used to inform decisions.

Standardised	• The organisation has a basic document and record system with a central index made up of a mix of electronic and paper-based records. • Records include details of most risk related processes and controls, standards and outputs from those processes (e.g. inspection records, maintenance records). • Records are kept of important information and decisions. These are readily available and used by decision-makers to control risk.	**Culture** All staff understand why corporate knowledge is important and work with the organisational processes to develop and maintain it. • There are basic systems in place for capturing and retaining corporate knowledge, so individual memory is rarely relied upon.
Managed	• Records are created, maintained and updated by individuals or departments; but may not be widely available to the organisation. • Information and records are not readily shared between departments, and there is no centralised index. • There are only a limited number of documents shared e.g. the rule book. • Individual memory and expertise are used to fill in gaps of recorded corporate knowledge.	**Culture** There are pockets of information retention by individuals or parts of the organisation, but the importance of developing and retaining corporate knowledge is not widely understood or valued.
Ad-hoc	• There are few or no corporate documents that describe how safety is maintained or achieved. • Reliance is placed primarily on the memory and knowledge of a few key individuals. • Procedures to identify and manage record keeping, document and knowledge management, do not exist or are weak. • The organisation is unable to use written records to demonstrate that risk management was considered in decision-making.	**Culture** There is no evidence of corporate knowledge, only individuals' memory.

Suggested guidance and further reading:

- HGR-M0110; The Care of Key Corporate Documentation; HRA

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

Purpose

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

Introductory notes

Staff involvement and engagement supports risk control by:

- drawing on their experience and learning so that the SMS, risk assessments and risk controls are practical and reality-based; and
- encouraging 'ownership' of H&S policies and procedures.

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

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

The Heritage Railways Topic Set criteria in this section include:

- **OP2 Competence management system** - the organisation is capable of effectively managing health and safety by having sufficient employees with the requisite competences at all levels.

OP 2 Competence management system (CMS)

A key component in ensuring an organisation is capable of managing health and safety (H&S) effectively is by having sufficient staff with the appropriate competencies at all levels.

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

- Having the right number of people, in the right place, at the right time with the right competence;
- Ensuring recruitment, training and development systems are able to anticipate and cater for staff leaving, especially when there is an ageing workforce and / or a potential skills shortages and;
- Understanding the minimum number of staff needed to maintain safe operations and particularly to ensure effective risk control during times of change – technical, operational, and organisation.

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

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

Excellence

- The organisation has a fully operational and developed CMS.
- All individuals are clear about the performance that is expected of them.
- All individuals, including senior managers, have received appropriate training, development and assessment.
- The competence of individuals is maintained or improved over time.
- Training and development are provided to create a level of competence for the individual or team, to enable them to undertake the designated operations.

Culture
The organisation makes full use of its staff potential and actively involves them through shared values and an atmosphere of trust, openness and empowerment.

- The CMS is subject to regular monitor, audit and review, to ensure that risk controls are continuously improving.

Predictable

- The organisation has an appropriate CMS based on thorough risk assessments of tasks.
- The CMS includes policies on recruitment, selection and training in line with identified objectives.
- There are processes in place to manage competence, including succession and resilience planning.

Culture
Staff believe they have a role to play in the CMS and routinely act to support and develop themselves and others.

<table>
<tr>
<td>Standardised</td>
<td>

The organisation has an effective CMS in place that takes into account relevant guidance (such as ORR's document and HRA Guidance note HGR-A0012 "Management of Safety Critical Work").
Risk controls identify the skills, knowledge and experience needed by individuals to implement them, across all safety critical tasks.
All individuals carrying out safety critical work have been assessed as being competent and fit.
There is an accurate and current written record of every individual's competence and fitness that is available for inspection.

</td>
<td>
Culture
The value of the CMS is understood by all staff and there is a consistent belief that it will provide them with the necessary competencies to undertake tasks safely and manage risks competently. Staff accept ownership of their own competence and its development.

There are arrangements in place for monitoring the competence and fitness of individuals.

</td>
</tr>
<tr>
<td>Managed</td>
<td>

There is a basic documented CMS in place.
Most safety critical roles and persons who occupy those roles have been identified.
Most risk controls identify the skills, knowledge and experience i.e. functional competency, needed by individuals but these are not always consistently applied in all departments.

</td>
<td>
Culture
Staff believe that the competence management system is important for H&S but effectiveness varies depending on the managers implementing it.
</td>
</tr>
<tr>
<td>Ad-hoc</td>
<td>

There is no competence management system in place.
Staff have the necessary competencies they need, but there are no formal arrangements to define what is required, record what competencies are held and to regularly check competence.
Individual managers are left to make their own judgements, as to the competence needed by their teams.

</td>
<td>
Culture
Staff do not believe they are provided with the necessary information, instruction and training to undertake their roles, which may result in them deviating from procedures and ineffective risk control
</td>
</tr>
</table>

Suggested guidance and further reading:

- RSP 1; Developing and maintaining staff competence; ORR
- RSP 4; Safety Critical Tasks – Clarification of ROGS Regulations Requirements; ORR
- HGA-P0005; Fitness Assessment for Safety Critical Workers; HRA
- HGR-A0012; Management of Safety Critical Work; HRA
- HGR-A0050; Competence Management Systems; HRA

PI & RCS Planning and implementing risk controls through co-ordinated management arrangements

Purpose

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

Introductory notes

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

The Heritage Railways Topic Set criteria in this section include:

- **PI1 Risk assessment and management** - there are adequate, appropriate and proportionate methods for identifying hazards and assessing risks as a basis of effective control of H&S risk in the business.
- **RCS2 Management of assets** - assets are managed to ensure that they remain in good condition, and can continue to operate reliably within their design parameters.
- **RCS3 Change management (operational, process, organisational and engineering)** - effective change management ensures that the quantity, frequency and nature of change (to assets, process or organisation), does not adversely affect H&S management and risk control

PI1 Risk assessment and management

Adequate, appropriate and proportionate methods for identifying hazards and assessing risks are the foundation of effective control of health and safety (H&S) risk in the organisation.

Proportionate and appropriate hazard identification and risk assessment methods are the first step in designing risk controls that are necessary for effective risk management. This includes arrangements which:

- Consider staff as well as process / system risks;
- Are based on the reality of the way that staff undertake the work, and actively seek the input of staff and / or their representatives;
- Recognise the impact of ageing, stretched and fragile assets;
- Recognise the impact of interfaces, shared risks and involve business partners;
- Apply human factors knowledge about behaviour and consider both safety and health risks;
- Consider both the risks of performing work and the impact of that work on other risk controls.

Excellence	• Risk management is embedded in the organisation's culture. • Detailed and comprehensive risk registers are maintained for both business and operational risk, including emergency preparedness. • All risks identified are allocated to an owner. • Risk registers are actively reviewed and managed to close out and mitigate risk. • The organisation actively engages with the wider industry.	**Culture** Staff seek to learn from others and readily share their knowledge and experience, knowing that this will lead to improved risk control, both within their own and other partner organisations.
Predictable	• There are written risk assessments for all significant risks. • Risk assessments are integrated throughout the organisation. • There is a systematic approach to risk control and it is applied consistently throughout the organisation. • Risk registers are maintained for both business and operational risk and are regularly reviewed.	**Culture** Risk assessments, including removing risk at its source, are part of the culture of the organisation; "Risk assessment is how we do things round here". • The organisation participates with wider industry (e.g. HRA, RSSB) on safety risk control matters.

Standardised

- The organisation has appropriate risk assessment procedures and policies in place and maintains a risk register.
- The organisation uses the principles of hierarchy of control measures when assessing the risks.
- Control measures in place have been identified by risk assessment.
- The effectiveness of control measures to manage safety and health risks are evaluated, and proportionate corrective action is taken.

Culture
Staff understand the purpose of risk assessment. They are actively involved and see the value of risk assessment to control hazards and ensuring their H&S.

- The organisation makes effective use of the risk control hierarchy (General principles of prevention from MHSWR 1999, Schedule 1) and there is evidence that some risks have been eliminated at source.
- There is evidence of collaboration with other organisations, where the control of a risk requires action by more than one party

Managed

- There is a process for risk assessment, but it is not always applied consistently across the organisation.
- Hazards are recognised and control measures developed, but there is a lack of consistency in how this is done and recorded.
- Safety measures used to perform an activity do not always include the measures identified by the risk assessment.
- There is some co-ordination of risk control, but the focus is on operational risks and not the complete business risk profile.

Culture
Managers recognise that risk assessment is their responsibility, but they frequently use risk assessment to demonstrate that controls already in place are adequate, or to justify not doing more.

There is some involvement of staff in the risk assessment process and some understanding as to why it is important.

Ad-hoc

- Hazards are not identified and considered as part of identifying, developing, and examining control measures.
- Managers and supervisors think it is someone else's job to carry out risk assessments.
- Staff often see risk assessment as a bureaucratic process, which gets in the way of them doing their job.
- Risk assessments are inappropriate for their intended use.

Culture
There is widespread evidence that the risk control hierarchy is not understood by staff.

Managers and supervisors think it is someone else's job to carry out risk assessments. Some staff see risk assessment as a bureaucratic process which gets in the way of carrying out tasks.

Suggested guidance and further reading:

- HGR-A0011; Risk Assessment; HRA

RCS 2 Management of assets

An organisation should manage their assets (such as locomotives, carriages, infrastructure, and property) to ensure that they remain in good condition and can continue to operate reliably within design parameters.

Successful management of assets involves:

- Identifying and recording (OC7) the assets the organisation owns and manages and;
- Having systems in place to make sure that assets remain in a good condition and capable of operating reliably within design parameters.

Suitable predictive maintenance techniques should be employed where appropriate to ensure that maintenance work takes place before an unsafe condition occurs. The condition and life expectancy of assets should be factored into maintenance and renewal decisions. Asset condition and life expectancy should also be factored into decisions that aim to enhance the railway's capability or scale of operation to ensure that a balance is struck between safety, performance and efficiency. There is the potential for significant risk if the organisation increases the scale of its operation if it does not have the capability to maintain that increased operation to ensure continued safety.

Excellence	• Full register and condition of all assets including locomotives, rolling stock, infrastructure and property, linked to the collections policy. • Regular monitoring, updating and review of asset registers. • Prioritised and fully costed programme of repairs and renewal. Funding identified or in place, with no significant backlog of work to key assets. • Available capability to undertake all planned work or manage contractors. • There is an effective pro- active and predictive maintenance regime across all assets.	**Culture** There is a demonstrable alignment between asset management objectives, systems and individual responsibilities at all levels and across the organisation.
Predictable	• Basic register and condition of all assets including locomotives, rolling stock, infrastructure and property, linked to the collections policy or equivalent. • Costed programme of repairs and renewal in place. Priorities set based on risk and need across all railway functions, some backlog of work to key assets. • Available capability to undertake prioritised work or manage contractors. • The organisation has a successful condition-based, preventative maintenance regime.	**Culture** The organisation is structured to support effective asset management and the importance of this is understood by everyone. There is a consistent approach to asset management across all aspects of the organisation.

Standardised	• The information held by the organisation is sufficient to support prioritisation of basic repair and renewal programmes. • Maintenance is conducted against a periodic maintenance plan, which is in the most part achieved. • There are standards in place for each asset type.	**Culture** The organisation's leadership owns and visibly supports the asset management programme. There is an awareness at all levels of the organisation of the importance of asset management in managing system safety
Managed	• Basic information for assets is held in a spreadsheet or other simple system, but is typically based on broad assumptions, or it is incomplete. • There is a generally reactive approach to maintenance and renewal across the railway.	**Culture** Asset management functions are carried out by small groups. Roles reflect asset management requirements. Understanding of the importance of asset management is typically limited to individuals directly involved.
Ad-hoc	• There is a policy of 'make do and mend' when it can be fitted and afforded. Little evidence of planned preventative maintenance. • Individuals or groups often dictate priority of overhauls, repairs and renewals. These priorities are not based on recognised standards. • There is no documented evidence to demonstrate that asset condition is being measured or managed.	**Culture** There is little recognition that asset management is important.

RCS 3 Change management, (operational, process, organisational and engineering)

Effective change management ensures that the quantity, frequency and nature of change, (to assets, process or organisation), does not adversely affect H&S management and risk control.

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

Excellence

- There is a comprehensive change management process, which considers the wider impact of all types of change.
- There is an understanding that change can affect other aspects of an organisation's business. This leads to organisational risk being linked with H&S risk during and as a result of any change.
- All staff are familiar with and understand the change management process. Changes lead towards continuous improvement.
- Changes which are implemented only ever reduce the organisation's overall risk profile.

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

- There is a clear review process in place that assesses the effectiveness of changes as and when they take place.

Predictable

- There is an effective change management process, which considers the wider impact of change.
- The change process includes a post-change review which considers the wider implications of the change including the effect the change has had on the culture of the organisation
- All changes are well managed and their risks well controlled.

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

- Organisational standards for management of change exist and are uniformly applied.

Standardised

- There is a structured approach to managing any process, technical, operational or organisational change, involving a number of steps. It is a defined process in the management system.
- Staff are engaged in the change process.
- There is an effective process for managing change and it is consistently applied.
- There is a documented system to risk assessment and risk control after a change is made.
- Management of change standards exist and are uniformly applied.

Culture
Staff recognise the importance of effective change management, but still feel that changes are often implemented without proper consideration of the impact on their safety and/or health.

- Risk assessments include human factors.

Managed

- There is a process for managing change but it is either not used consistently, or it is not effective at managing the risks following a change.
- The importance of change management is understood.
- There is some control over all types of change; or there is inconsistent control of different types of change (technical, operational, organisational)

Culture
Some staff recognise the importance of a systematic approach to change, but this is inconsistent and depends on the individual's experience.

- Some changes are made without their risks being controlled.
- Some departments have standards for change management, but not all. Even those that exist are inconsistently applied.

Ad-hoc

- There are no organisational standards for managing change
- There is little or no control of change and changes are made without effective consideration of their risks or their wider impacts.
- There is no process or system for making changes, which leads to risks not being identified or controlled following a change.
- The risks associated with a change are not identified and so are not controlled.

Culture
Staff feel that the effect of change on their safety and/or health is not considered.

MRA Monitoring, audit and review

Purpose

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

Introductory notes

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

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

Audit - an audit checks that the organisation is doing what it says it will do. It should be supported by regular reviews to make sure that the organisation's business objectives are correct. This means that the organisation is checking to confirm that *what it thinks it is doing* is actually *what it is doing*; and that this aligns with *what they should be doing*. Audit can be undertaken internally by the organisation (1st Party), or externally by customers/suppliers (2nd party) or independent organisation (3rd party).

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

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

The Heritage Railways Topic Set criteria in this section include:

- **MRA2 - Audit** - Independent, systematic audits check that risk control systems and management arrangements within the SMS are effective.
- **MRA3 - Incident investigation** – proportionate investigation of accidents, incidents and near misses is essential to learn from adverse events.

MRA 2 Audit

Independent, systematic audits help ensure that risk control systems and management arrangements within the health and safety management system (SMS) are effective. Audits also form one of the basic elements of a SMS required by ROGS.

An audit is an independent, systematic check of risk control systems and management arrangements to check that the organisation *is doing what it thinks it is doing*; and that this is *what it should be doing*. Audit can be undertaken internally by the organisation (1st Party), or externally by customers/suppliers (2nd party) or independent organisation (3rd party).

Auditing is recognised as a key part of the SMS in ISO45001:2018. Audit processes are described in more detail in BS EN ISO19011; 'Guidelines For Auditing Management Systems'.

A proportionate, targeted risk based audit programme should be devised and implemented to provide the directors, trustees and general managers with adequate assurance about the 'health' of the SMS and the sustainability of safety performance.

Excellence	• Audit actions help the organisation continually improve the management of risk by referring to examples of best practice elsewhere in the rail and other sectors. • Peer-to-peer reviews with other comparable organisations, are routinely included in the audit approach. • The audit process provides a high level of assurance across the organisation. • The audit process drives continuous improvement, through feeding back into the organisation's H&S management plans.	**Culture** The organisation strives to identify best practice in business risk management to inform the audit programme.
Predictable	• There is a co-ordinated, effective and up-to-date audit programme undertaken by qualified auditors. • Auditors keep their competencies up to-date through practice and Continuing Professional Development (CPD) activities.	**Culture** Audit is understood to be an essential part of development of processes and procedures contributing to improvement in risk management.
Standardised	• The audit programmes cover critical activities. • There is an up-to-date audit programme in place, indicating how it is prioritised on the basis of risk. • Audit is generally understood as an essential part of the risk management process. • Staff are prepared to engage with the audit programme. • Audit results are accepted, and there is evidence they are acted upon.	**Culture** The value of audit is understood at all levels in the organisation and there is a culture that the challenges and recommendations are positive influences.

Managed	• There is some auditing, but there is no co-ordinated audit plan. • The audit plan is not always proportionate to the risk profile of the organisation, or implemented consistently. • Some departments / processes are audited, but not all. • The role of audit is not widely understood across the organisation. • Audit is often perceived defensively and negatively. • Some audit findings are acted upon.	**Culture** The value of audit is inconsistently understood, and challenges are often taken personally resulting in conflict between auditors and auditees.
Ad-hoc	• Auditing is limited to the annual accounts.	**Culture** There is little or no understanding of the value of auditing health and safety arrangements. Audit is is seen as a chore.

Suggested guidance and further reading:

- HGR-A0018; Safety Audits; HRA

MRA 3 Incident investigation

Proportionate investigation of accidents, incidents and near misses is essential to learn from adverse events. Investigation also offers opportunities to review the adequacy of the SMS and identify areas for improvement, for example in its design or in how it is implemented.

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

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

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

Excellence

- There is a 'just' organisational culture where all staff freely participate in the investigation, openly and honestly.
- Incident investigation is seen by everyone as an opportunity to deliver continuous improvement and managers respond fairly.
- Relevant investigation outcomes are routinely shared within and outside of the organisation.

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

Predictable

- The range of incidents investigated includes, where appropriate:
  - Non-compliance;
  - Non-conformance;
  - Near miss/hit reports and;
  - H&S complaints or disruptions to work and where expected outcomes are not achieved.
- Investigations and recommendations are generally accepted as important ways of improving risk management.

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

Standardised

- The defined management arrangements for when and how investigations are carried out are followed consistently across the organisation.
- Investigations are carried out after a near miss or near hit and after H&S incidents.
- Investigations identify all the reasons relevant to the cause and provide an explanation as to how the incident occurred, and what allowed it to happen.
- The underlying causes of an incident are identified and investigated.

Culture
There is a general understanding of the importance of good quality investigations into a range of occurrences generating recommendations that improve systematic control of risks.

- Recommendations aim to improve safety by reducing the likelihood and/or consequences of recurrence; and addressing the underlying issues and deficiencies identified by the investigation.

Managed	• The organisation has guidance on what type of incident should be investigated and the detail of investigation required. • The level of detail of the investigation is related to the potential (or actual) consequences and likelihood of the incident. • The range of incidents investigated is limited to accidents. • Only immediate causes are identified. • Staff encouraged to report incidents and near misses as an opportunity for the organisation to learn.	**Culture** The culture is to accept inconsistencies in investigations and superficial recommendations, which do not improve risk management. • Recommendations are limited to preventing the same thing happening again, and do not identify areas for wider improvement.
Ad-hoc	• There is no evidence of effective investigations, and the culture of the organisation is to find someone to blame • Investigations focus on the actions of the individual, with little or no indication that the adequacy of systems and risk controls were considered. • Staff may not feel safe to speak up and therefore tend to cover up genuine errors.	**Culture** Evidence of a blame culture when something happens.

Suggested guidance and further reading:

- HSG245; Investigating accidents and incidents; HSE
- HGR-A0555; Incident Investigation; HRA

Appendix 1

The 12 'Tablets of Governance'

Purpose

The 12 'Tablets of Governance' describe what proportionate governance and leadership look and feel like.

- **Preparedness**

  Each Director shows up to meetings totally prepared for their role.

- **Doing the right thing**

  Directors individually and collectively will always strive to do the right thing in the right way for the right reasons and at the right time.

- **Faith**

  Directors will retain faith that they will prevail in the end regardless of difficulties and at the same time confront the brutal facts of the current reality, whatever that might be.

- **Alignment**

  Directors must always have full alignment between the core purposes and values [which the Board should define/refer to here]. The Board makes sure that these values underpin all its decisions and railway's activities.

  What it is they must excel at – [to be stated]; what is it they cannot fail at – [to be stated]; what makes Directors think they are delivering – [to be stated]; and how do they keep delivering – [to be stated].

- **Bottom line of Governance**

  Our base line is [Board to state here], the UK Corporate Governance Code , and if a charity the Charity Commission Charity Governance Code ; or and other relevant codes. Further information is also available at the HRA Guidance note on the duties of Board Directors & Chairs .

  Directors will comply with all legal, regulatory and recognised good practice requirements. All Directors will have read and understood all relevant documents and update themselves with individual continuous professional development and board wide training.

  The four basic tasks of the Board are:

  - Establishing and maintaining vision, mission, and values
  - Deciding strategy and structure
  - Delegating the authority to manage to monitor and evaluate performance
  - Communicating with its members and all internal and external stakeholders

- **Roles and responsibilities**

  Each Director will have specific roles, responsibilities and standards of ethics and behaviours; and these will be written down and available to all. Directors can never tolerate carelessness, incapacity, and neglect; they are forever accountable for what they do and what they fail to do. Both individually and collectively. Directors will never compromise their responsibilities. They will never take anything for granted. Directors will never be found short in their knowledge and in their skills.

They will also recognise other roles need to be fulfilled to make an effective Board: someone who looks to the stars; a stickler for procedure and detail; someone grounded in practicality; the devil's advocate; the sensitive, touchy feely one; someone to give alternative views and a different perspective; the ice cold logical view; and someone to always provide the moral compass.

- **Planning for the best and worst**

  The rules / constitution / governance documents / policies and strategies will be regularly reviewed (e.g. annually). Their purpose should include setting targets and objectives for success and intervention, and describe and reference arrangements designed to guide the organisation through any foreseeable conflict, crisis, and disaster. Directors must never forget every organisation is vulnerable, no matter how big or small, strong or weak, and whatever stage of development. Directors must always prepare and plan for their succession.

- **Leadership and teamwork**

  Directors will strive to act as a team, respecting and utilising the abilities of others whilst realising they are working towards a common goal. Success depends on the efforts of all. Directors must be disciplined to follow, as well as to lead, knowing that they must master themselves before they can master their task.

- **Making the best decisions**

  The Board working as one, not individuals, make the best decisions. Directors must have the courage and integrity to challenge how things are done: not settling for the status quo. The Board should confront and overcome complexity, incomplete information, the consequences of being wrong, and the human element. Decisions must be based on truth and reality – what is actually done versus what should be done in accordance with the standard. Where possible, Directors should seek alternative perspectives, question their objectivity, be paranoid to biases, and be open to new information. No decision can be absolutely right or wrong, but it must be the best they can make.

- **Vigilance**

  Directors must be always attentive to the dangers and risks to the business, never accepting success as a substitute for the rigour in everything they do. Directors must share information willingly and openly even when it is challenging and discomforting for them. Directors will continually keep asking why, looking behind the incident reports for underlying factors. Why something happened? Why something didn't happen? And the How it happened. Acknowledge that small errors that aren't caught and corrected can lead to bigger failures.

- **Communication**

  Directors must listen closely and carefully when colleagues, staff, members, volunteers, customers and stakeholders talk. What they say and what they don't say. What do Directors need to do, to find out more? Whenever possible record everything in writing to reduce risk of misinterpretation and confusion. It will be the only record on which future actions and learning can be based. Whenever possible double check what Directors think they have communicated has been understood, always use language that is simple, inclusive, and understandable. Be prepared that Directors themselves are the communication problem.

- **Final Tablet**

  Constantly guard against a Board where good people are leaving, power is concentrated and exercised by the chair; and key appointments go to a select few. Be aware of the risk created by telling rather than consulting; key decisions being made by small select groups; and popular projects winning over essential projects.

Appendix 2

Organisational Culture

RM^3 2019 takes a new approach to determining the level of safety culture maturity across an organisation. As organisational culture is a key enabler to successful health and safety management, it is featured in every level of maturity in all criteria. The Heritage Railways Topic Set does not include OC6 as one of the 10 elements RM³ 2019. It does however include typical evidence of actions, beliefs, and behaviours held by workers for every level of maturity for the elements included. This allows organisations to gauge safety culture maturity level in that area and the scale of challenge in introducing change as necessary.

How to use the culture 'call-outs' in each criteria:

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

For all Criteria contained in Topic Set 1 for Heritage Railways:

- Use the culture ‘call-out’, in the same way as the other bullets, to determine a maturity level for the criteria. Apply the same evidence factors of **Quality, Quantity, Currency** and **Consistency**.
- The culture maturity level may be different to the assessed level you determine (which should be based on the modal average). If the culture maturity level is the same or higher than your assessed level, this will probably mean that there is an understanding, commitment and willingness, which will support continuous improvement. Where the culture level is lower than the assessed level you determine, progression to higher levels of maturity may be more challenging.

Using RM^3 2019 to assess organisational culture

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

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

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

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

Testing organisational culture and RM^3

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

1. By routinely gathering informal information about the H&S culture during monitoring, inspections, investigations and other dealings with staff, interfacing organisations and the supply chain. For instance, workers on site during a routine preventive inspection may comment that performance pressures sometimes take priority over risk controls. In this case, as well as investigating the allegation, the background should be recorded to build up a picture of the organisation's H&S culture.
2. Organisations can conduct H&S culture or safety climate assessments using techniques and toolkits, such as the RSSB's Safety Culture toolkit. These assessments can provide useful information on the current safety culture, and provide information and views about leadership, communications, learning culture, employee involvement and attitudes towards blame.
3. RM^3 is not intended to be a substitute for other safety culture assessment tools, but in this version there are highlighted 'culture call-outs' against every level of maturity in all criteria. The 'call-outs' suggest typical actions, beliefs and behaviours held by employees, at all levels, suggesting the culture of the organisation.

Appendix 3

Glossary

CMS	Competence Management System
HSWA	Health and Safety at Work etc. Act 1974
HSE	Health and Safety Executive
MHSWR	Management of Health and Safety At Work Regulations 1999
ORR	Office of Rail and Road
PTW	Permit to Work
RM3	Risk Management Maturity Model
ROGS	Railways and other Guided Transport Systems (Safety) Regulations 2006
RSSB	Rail Safety and Standards Board
SMS	Health and Safety Management System
SSOW	Safe systems of work
Staff	Includes workers, supervisors, managers, paid employees, and volunteers, whether members of the railway or visiting

Appendix 4

Evidence Sources

So what is evidence?

Evidence in its simple form is the information that you gather from your meetings, inspections, tests, reviews, monitoring activity and audits. You are probably already gathering much of this as part of your day-to-day work. This evidence supports your SMS and will consist of **Policies** at the top giving direction, **Processes** which help to structure and manage the task, and **Procedures** to deliver the task. Sources of evidence will include:

- **H&S management action plans** – Objectives on what you want to improve / mitigate, with targets to indicate achievement towards them;
- **Standards** - Infrastructure inspection and maintenance requirements; traction & rolling stock maintenance, refurbishment requirements; arrangements to review and update
- **Competence management system** - competency training, induction and refresher records and process to manage and maintain currency;
- **Maintenance records** - railway and site infrastructure, rolling stock and permanent way;
- **Statutory inspection and testing** - boiler inspections, thorough examinations, A, B & C examinations;
- **Safety inspection** - a regular, planned activity with assessment against a statutory, standard or in house requirement, usually in a checklist for ease of completion. These can be applied to the Premises (workplace and site), People (behaviours and working methods), Procedures (SSOW, PTW or method statements) and Plant (equipment, machinery). The frequency of inspection can vary from a daily pre-user check to an annual boiler inspection.
- **Workplace inspection** - workshops, buildings, common areas incl. paths and walkways;
- **Hazard survey** - identify hazards in activities, equipment and premises and what risk you bring onto premises;
- **Risk assessment** - activities, equipment and premises / workplace and their review;
- **Communications and provision of information** – safety briefings, publishing board minutes, operational notices, alerts or toolbox talks, use of noticeboards;
- **Control of contractors** – management of contractors on site, their briefing and due diligence checks of their method statements, SSOW and PTW system;
- **Emergency arrangements** – testing of plans /exercises, emergency service liaison;
- **Staff Consultation** - workforce safety committee with minutes;
- **Investigation** - accidents, incidents and near misses incl. joint investigation with Trade Unions;
- **Official documents** - records, certificates, licences, log books, meeting minutes (inc record of actions / decisions), registers, inc asset and corporate risk;
- **Document control** – version control, document approval, publishing and access.
- **Audit** – internal or external, with reports, actions tracked through to completion.
- **Management Review** – minutes, registers, actions plans,
- **Evidence from Interview**;
- **Monitoring evidence** - from verification of activities through observation;

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