Senior leadership programmes
Bronze – one day

Session 1: Welcome, introductions, exploration of our safety responsibility as leaders. Introduction to the key issues and factors which we will link together during the day: major accidents; latent conditions; trigger events; culture and leadership.

Session 2: Major and fatal accidents: Multiple causal factors/system failures. Illustrate by reference to examples of organisational accidents (e.g., Piper Alpha, Texas City, Deepwater Horizon, Dupont – Belle, Virginia, your organisation). Video clips to explore latent conditions. Link to Reason's layers of protection model/bow-tie.
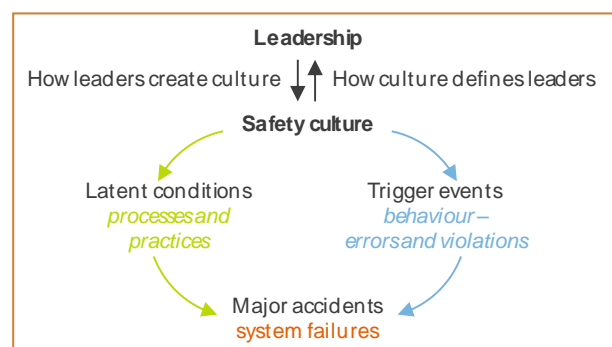
Objective

Changing the way leaders think about safety

Changing the safety culture of the organisation

Sustainable risk reduction

Practice opportunities

Session 3: The role of culture: definition of culture (embedded norms and practices); its role in contributing to fatal accidents; different types of safety culture (ref. Baker Panel and Longford); two-triangle model to distinguish personal safety culture v process safety culture.

Session 4: Attributes of a resilient safety culture: Informed, mindful, learning, fair, respectful. Origins of research (Reason/Hudson, commissioned by Shell into cultural resilience in high-hazard industries). Exploration/assessment of strength of these attributes within your organisation.

Session 5: Leadership Impact: Exploration of how leaders' observed behaviour, tacit rewards and site interactions (including leaders' conversations on site) can engage the front-line and influence safety culture. Discussion/scenarios based on real organisational examples.

Session 6: Identification of pit falls in holding safety conversations, applying on practical principles from psychology and neuroscience. To have a full understanding of how we 'show up' as leaders when holding conversations in the business and the true impact of culture.

Session 7: Putting it into practice: How can we apply today's learning to making a difference in relation to safety culture? What actions are necessary – collectively and individually? How do we measure, monitor and sustain improvements in a way that leads to a continuous reduction of risk?

Session 8: Summary, next steps and close.

Leadership

How leaders create culture ↕ How culture defines leaders

Safety culture

Latent conditions
processes and practices

Trigger events
behaviour – errors and violations

Major accidents
system failures

Senior leadership programmes
Silver – two day

Session 1: Welcome, introductions, exploration of our safety responsibility as leaders. Introduction to the key issues and factors which we will link together during the day: major accidents; latent conditions; trigger events; culture and leadership.

Session 2: Major and fatal accidents: Multiple causal factors/system failures. Illustrate by reference to examples of organisational accidents (e.g., Piper Alpha, Texas City, Deepwater Horizon, Dupont – Belle, Virginia, your organisation). Video clips to explore latent conditions. Link to Reason's layers of protection model/bow-tie.

Session 3: Degradation of norms: How culture can allow degradation of norms (e.g., NASA Challenger, Herald of Free Enterprise). The phenomenon of Groupthink and how it can impact norms. The potential for degradation of norms and Groupthink in your organisations' operations.

Session 4: The role of culture: definition of culture (embedded norms and practices); its role in contributing to fatal accidents; different types of safety culture (ref. Baker Panel and Longford); two-triangle model to distinguish personal safety culture v process safety culture.

Session 5: Attributes of a resilient safety culture: Informed, mindful, learning, fair, respectful. Origins of research (Reason/Hudson, commissioned by Shell into cultural resilience in high-hazard industries). Exploration/assessment of strength of these attributes within your operations.

Session 6: Cultural impact on both latent conditions and on human error (trigger events). How culture is shaped by leadership response to human error. Taxonomy of human error – mistakes and violations. Illustrate via Chemical Safety Board video examples relevant to you.

Session 7: Your organisations Leadership Impact: Exploration of how leaders' observed behaviour, tacit rewards and site interactions (including leaders' conversations on site) can engage the front-line and influence safety culture. Discussion/scenarios based on real examples.

Session 8: Practice opportunities.

Session 9: Identification of pit falls in holding safety conversations, applying 9 practical principles from psychology and neuroscience. To have a full understanding of how we 'show up' as leaders when holding conversations in the business and the true impact of culture.

Session 10: How to address human errors and violations, reduce barriers to reporting and gaining commitment to safe behaviours and practice.

Session 11: Putting it into practice: How can we apply today's learning to making a difference in relation to safety culture? What actions are necessary – collectively and individually? How do we measure, monitor and sustain improvements in a way that leads to a continuous reduction of risk?

Session 12: Summary, next steps and close.

Objective

Changing the way leaders think about safety

Changing the safety culture of the organisation

Sustainable risk reduction

Interacting with others to change safety behaviours

Practice opportunities

Improving control of risk

Senior leadership programmes
Gold – 2 day

The course will comprise one day of classroom training and one day skill development, either in the classroom or out in an actual operation or project. This program will equip executive leaders with the knowledge, capability and skills to ascertain, to verify and to improve the organisations safety, reliability, effectiveness and operational culture.

Objective

Understand the importance and impact of human judgement in relation to risk

Explore and examine the concept of risk intelligence as an aid to improving human judgement

Critically re-evaluate and improve our risk management processes

Day 1

Day 1 provides a respectful, yet challenging and exploratory journey, involving case studies and drawing on participants' knowledge and experience. It aims to challenge existing mental models, to provide powerful insights that have a strong relevance and application for driving the safety culture and performance.

Session 1: Introduction: Assessments of how an uncertain future, and the associated risks and opportunities, are influenced by many factors, and these shape our decisions and judgement, often unwittingly. The introduction outlines a model through which these factors are subsequently explored, along with an overview of participants' perceptions of their own risk management processes.

Session 2: Defining Risk: We take a more forensic look at the language and definitions of risk and the limitations that we unwittingly embed in our formal risk assessment processes. The problem with probability; emotional and cognitive considerations. Communicating subjective assessments of risk; the limitations of language. The impact of uncertainty and the consequence of our mental bias towards causality. The implications for risk management processes and the communication of risk.

Session 3: Thinking, Cognition and Risk: the model of rational decision making and its shortcomings. Intuitive and rational thinking (S1/S2) – key features of the brain and its implications, including the role of emotions in making judgements. Self-awareness and understanding of the way we think and how we reach judgements is crucial to our risk intelligence. The brains heuristics produce systematic errors and biases that affect our interpretation and judgement. Risk intelligence means building awareness and understanding of important systematic errors and biases in order to compensate for them. How are these accommodated in participant's existing risk management processes?

Session 4: Alertness to cues and information: detecting cues and processing information is central to situation awareness and decision-making. Underlying subconscious mechanisms help us make sense of a vast bombardment of cues and data from the environment. However, they can also lead to systematic errors and biases in the information we draw on for our decision making. We consider several such biases and then look at their implications for risk intelligence and judgement within the context of the risk management process.
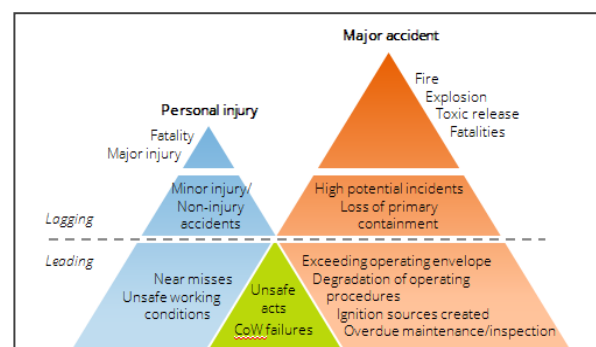

Session 5: Group dynamics and risk: Most work-related decisions, and certainly those which have significant implications for risk, are often made in the context of a team or group. We look at

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phenomenon associated with group dynamics that adversely impact risk intelligence and judgement. How are these dealt with in your own organisation?

Session 6: Organisational culture and risk: While we can build our own competency, it is easy to forget that our behaviour can be powerfully driven by the culture of the organisation. The missing link in understanding how to balance risk and reward successfully in decision-making is the organisations culture. If we, as the result of group influence, or as the product of organisational culture are risk-blind, then our risk management processes can be relatively easily defeated. What is the impact of your organisation culture?

Session 7: Leadership presence and intervention: This session equips leaders with insights and tools to build their self-awareness and skills in conducting site visits and in engaging the workforce in safety improvement. Building on the constructs covered during the day, this session rings them together in a practical 'how-to' approach to the conduct of site visits, inspections and conversations.

Day 2

Day 2 provides a stimulating and supportive environment for developing the skills and habits to apply to senior leaders' intent and have the necessary impact on the thinking and behaviour of others, and ultimately on the operating culture.

Communication and interaction tends to be shaped by the pre-existing relationship between the participants or the authority relationship between them. People try to manage the interaction and the information they give and receive to maintain the status quo of the relationship (Robert T Craig, 2007). This can lead to self perpetuating patterns of interaction that get in the way of effective communication and interaction.

Through **small group role plays with peer to peer coaching, or coached practice in the field**, new patterns of interaction and conversation are developed that extend the behavioural variety of participants, equipping them to further develop their leadership effectiveness in developing safety in a complex socio-technical system that is constantly adapting to multiple objectives, changing priorities and conditions, situational differences and new information.

It culminates in a facilitated **peer to peer conversation** on how to incorporate your organisations 'conversations with intent' into ongoing practice and management review, integrated as a part of the ongoing performance management process ; that is, not something additional or extra, but rather something that helps them do their normal day to day job better and achieve their objectives.

Depending on the number of attendees 1 or 2 actors/coaches support the delivery of day 2. Following the programme, there would be 2 coaching sessions for each individual in order to support their conversation practice and ongoing development.

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