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HEALTH AND SAFETY EXECUTIVE

The HSE Board

RESOURCE ALLOCATION - PROPOSALS FOR FUNDAMENTAL PRINCIPLES TO UNDERPIN DECISION MAKING

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Cleared by Kate Timms on 25 June 2003

Issue

1. Proposals for some fundamental principles, assumptions and factors to assist in making future resource allocation decisions.

Timing

2. Routine, but connected work on strategy development and planning for 2004+ are currently in progress.

Recommendation

3. The Board is asked to:

   a) agree the proposed principles and assumptions to direct HSE's future resource allocation process (paragraphs 8 - 11);

   b) decide whether it wishes further work to be undertaken on defining 'harm' and trying to establish measures of harm at this time (paragraph 13);

   c) endorse the use of the 'checklist' of relevant factors at Annex 1, subject to further testing and refinement, to help decide on work priorities (paragraphs 17 – 19); and

d) **discuss the circumstances in which it would want to apply the emerging resource allocation model.**

Background

4. The Resource Allocation (RA) project was commissioned under HSE's Change Programme, initially to provide a set of principles to assist in future resource allocation decisions. This paper provides part of the output of that project, namely some fundamental principles, key assumptions and a checklist of factors that need to be considered and taken into account when deciding on priorities for our resources.

5. The other part of the RA project, which proposes a new approach to resource allocation for HSE, will be presented at the Board meeting on 3 September. This new approach is a synthesis of ideas originating in the RA project and related workstreams currently being pursued elsewhere in HSE, including that by PEFD for the next planning round. It is based around HSE's activities being modelled on a 'core + programme' approach, with programmes being underpinned by new programme management arrangements currently being developed.

6. There will be a number of practical challenges in applying the principles and factors. In particular, that it will invariably always be a process requiring 'best judgement' to be exercised at a corporate level on some difficult issues, rather than being a wholly or largely evidence-led process. However, over time, the evidence base on which such judgements are exercised is expected to improve. Nonetheless, even in the short term, applying the principles will mean the outcomes of and the reasons behind the decisions being made can be articulated more clearly and be founded on a more robust process than at present. This will contribute to greater transparency to our stakeholders of our decision making process.

7. This paper's proposals support the Board's desire to move to a more top down corporate approach to resource allocation. They also assist in underpinning the proposals being formulated by PEFD for the planning arrangements for 2004+ (Board paper B/45/03).

PROPOSALS

Principles and Assumptions

8. The guiding principles need to assist in making robust decisions and hence underpin the resource allocation process. During consultation it was largely agreed that, in the interest of simplicity, the number of principles should be as few as possible.

9. The consensus view is that the following three principles are the most important and their adoption and implementation (particularly the first) would pose sufficient challenge to HSE and introduce a higher degree of rigour than at present:

- *Principle 1- Resource allocation decisions will be based on the concept of HSE maximising the impact we have on reducing harm*

- *Principle 2 - Resource allocation flows from the HSC/E strategy, the strategic plan and the priorities set out in it*

- *Principle 3 - Ensuring HSE meets its (publicly stated) key targets is the highest priority and resources will follow accordingly*

10. As well as the three principles above, there are four assumptions which have either previously been agreed by senior management or are necessary to take the application of the principles forward. These are set out for formal endorsement.

11. The underpinning assumptions are that:

- *Assumption 1- Harm is to be defined widely, encompassing:*

    - *health and safety risks to workers and members of the public from work activities; and*
    - *public and societal concerns.*

  Comment - The balance and relative importance between these two separate facets of 'harm' will vary depending on the circumstances. Also, there may be occasions when additional facets of harm (eg relating to HSE's delivery capabilities and public confidence in it as a regulatory body) that may need to be taken into account on particular issues.

- *Assumption 2 - The starting point for resource allocation decisions will be to focus first on the outcomes we wish to achieve and then to determine whether these outcomes are deliverable.*

  Comment - When considering their deliverability, we need to consider if we can afford the mix of activities they represent and overall whether they provide an acceptably balanced work portfolio. This will naturally entail an iterative process. This approach is a change from the current position of a largely bottom up planning methodology combined with trying to maximise what we can achieve for any particular financial settlement.

- *Assumption 3 – All of our activities must be open to rigorous challenge on their continuation at current funding levels or at all.*

  Comment - When deciding whether or not activities should be discontinued or cut back, all relevant factors must be taken into account

- *Assumption 4 - The underpinning rationale and methodology for resource allocation should be independent of any particular financial settlement.*

  Comment - But this assumption is constrained because resource allocation must be made within current Treasury rules eg specifying how income generated and non-income generated funding streams may be allocated.

12. ***Question: does the Board agree to these three principles and four assumptions directing HSE's future resource allocation process?***

13. Some important challenges to HSE will arise from the adoption of these principles and underlying assumptions:

- agreeing on a common definition of the term 'harm' and the factors which contribute to it;

- whether it is possible to find measures of harm which allow comparison to be made between different types (eg health vs safety, chronic vs acute) and also between the various industry sectors (eg high hazard, low probability events vs low (medium) hazard, high frequency events); and

- how we determine the contribution to impact on harm of our (individual) activities and functions which, in sum, determine the overall effectiveness of our work.

14. ***Question: does the Board wish for more specific work to be undertaken on defining 'harm' and trying to establish measures of it at this time?***

15. One of the biggest hurdles facing us presently is the limited amount of available evidence on impact of our activities. Put simply, we do not have robust evidence demonstrating the cause and effect relationship of HSE's (and Local Authority) actions on changing the health and safety system (or dutyholders performance). That is, of course, presupposing that it is in fact possible to obtain such information in the first place. This confirms that any resource allocation decisions made must be on a 'best judgement' basis, often in the absence of hard 'scientific' evidence.

16. However, HSE is taking work forward on this issue to increase our evidence base. We introduced a framework for gathering evidence through impact evaluation studies in 2002, with DDs having a rolling programme of self identified work. With an increased emphasis on the effective use of resources to maximise impact, HSE will need to continue and perhaps increase the amount of effort - in the short term - it is expending in the area of evaluation. This may also require a greater degree of central direction on which activities should be evaluated to fill our knowledge gaps.

Comparing impact on reducing harm

17. When considering the impact on reducing harm of current or proposed future activities, HSE will need some commonly agreed assessment (criteria or) factors to use when reaching its decisions. An initial list of such factors is attached as Annex 1.

18. The intention is that these be used as a common 'checklist' to ensure that all areas of harm are considered and those most relevant are explicitly identified. The importance and scale of the separate contributory factors can then be judged. A specific comparison between the outcomes from using the checklist for different topics or risks should help in the process of reaching a structured decision on resource allocation.

19. Annex 1 is offered as a starting point to assist in decision making. It has, so far, had some small scale testing for applicability on a limited number of topics to prove the concept. It will need further refinement (to ensure all relevant factors are captured) and testing to prove its wider applicability and robustness.

20. ***Question: is the Board content to endorse the use of the checklist subject to some further testing and refinement?***

Question: at what level of decision making should this checklist be applied?

Consultation

21. Colleagues in RI, NSD, FOD, HID, PEFD, RPU, SID, OPD, Sols Office and Policy have been consulted over these proposals.

Financial/Resource Implications for HSE

22. Resources to progress the work if agreed will come from existing resources.

Action

23. The Board is asked to agree to the recommendations as at paragraph 3.

Contact

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Relevant factors to consider when deciding on priorities — Annex 1

Nature of harm

- Known vs unknown (old vs new/novel, evidence base, extent of underpinning by S & T knowledge, level of certainty)
- Primary effects (impact on eg QUALY)
    - Acute vs chronic (latency)
    - Temporary vs permanent effect (when exposed)
    - Recoverability/adaptability with consequence
    - Injury vs ill health
- Second order effects
    - shelter/evacuation, recovery/remediation costs
    - damage to fabric of society loss of trust in regulator
- Credible worst case event(s)
- Single event vs multiple event (eg multiple single / single multiple fatalities)
- Benefits brought from exposure to risk
- Permanent vs temporary existence
- Complexity
- Effects on future generations
- ‘Playing with nature’

Population

- Voluntary vs involuntary exposure
- Size potentially exposed
- Individual vs societal
- Vulnerability
    - Age, gender, socio- economic group etc
- Composition
    - workers vs MOPs
    - occupations
    - degree of coherence/similarity
- permanent vs temporary workers
- continuing exposure vs infrequent
- duration of exposure
- Frequency of events
- location
- population trends and land use policy eg brown site development

Statutory obligations on HSE to act

- UK (specify)
- European (incl HRA)
- International conventions
- ‘Binding’ agreements – eg judicial review, public inquiries

‘Market’ (eg sector(s))

- Stability
- Coherence (homogeneous?)
- track record – experience of hazards
- Accident/ill health performance
- existing HSE penetration/influence
- level of existing regulatory control
- other regulators and law involved (positive or negative)
- employment patterns
- ease of reach
- existence & effectiveness of intermediaries
- regulatory stability

maturity of sector from regulatory perspective

Modifying factors

Ethical, economic and social considerations:

Societal concern

- Perception of risk vs actual level of risk
- Degree of trust in regulator (incl track record)
- Social amplification (by media)

Uncertainty/relevance of taking a precautionary approach

Financial constraints on HSE

Political pressure (and ministerial/parliament instruction)

Stakeholder interests/pressures/expectations

HSE’s business risks

- institutional risk attenuation (our own blind spots)
- consequences of not doing
- contribution of issue to HSC/E strategy/plans
- vulnerability if goes wrong, delivery failure
- costs of preparing, maintaining and enhancing contingency and disaster recovery plans.
- impact on reputation
- level of assurance of current regulatory regime

Evidence of HSE/LA impact & effectiveness

- Activity types eg
    - Inspection vs investigation
    - Legislation vs guidance etc
- Policy vs operations
- How enduring are changes from intervention
- Scope/ability to intervene/make a difference

Implementation practicalities of proposed actions

Financial constraints

- Treasury rules
- Actual settlement