FORGOOD

Behavioural science FORGOOD - building trust, resilience and better customer outcomes

Introducing…

Dr Tom Reader

Dr Tom Reader is a psychologist, and expert on organisational culture. He directs the MSc in Organisational and Social Psychology and leads the Culture and Risk Research Unit.

Tom's research investigates how organisations and teams build resilient cultures in which people are good at managing risk, learning from feedback, and innovating when the unexpected happens. Focussing on domains such as healthcare, finance, energy, and aviation, the aim of his research is to generate insights and practical tools that can help organisations prevent harmful failures and adapt to disruption and change. Increasingly, Tom's work explores how psychological science and AI can be harnessed to better understand, assess, and improve the culture of organisations

Tom's academic background is in Human Factors psychology, and how the design of social and cognitive systems in organisations cause or prevent errors and catastrophic accidents in safety-critical industries.

Since we last met…

Website and members area

https://lse-forgood.webflow.io/

Use cases and studies – in progress

GAABS annual conference

Adapting tools and services

The FORGOOD Framework

A 'Mindspace' for navigating ethical dilemmas

An evaluation framework for the private sector

Fairness	Does the intervention **treat** its **target fairly**? Are **cohorts** of the target community **treated differently?** Does it **attempt** to **fairly manage conflicts of interest** between targets, beneficiaries and other relevant stakeholders?	Yes/ No - Mitigation
Openness	Is the behavioural intervention **disclosed** or **evident to** the **target**? Are disclosures **clear and proportionate**?	
Respect	Does the behavioural intervention **respect** the **target's autonomy, dignity, freedom of choice** and **privacy** within the **context** of their **relationship with the corporation**?	
Goals	Does the behavioural intervention **seek** to **improve outcomes** for targets, beneficiaries and/or other relevant stakeholders of the company? Are there different goals?	
Opinions	Does the behavioural intervention **pass the ' front page test'** of public opinion? Has the intervention been assessed by an **independent perspective**?	
Options	How do **financial** and **non-financial cost/benefit assessments compare** to other options? Is an intervention the best way, on balance, of achieving the objective?	Quantify & Compare
Delegation	Does the company have the **regulatory right** and **ability** to **implement** the **intervention**?	

Lades, L. K., & Delaney, L. (2019). Nudge FORGOOD. *Behavioural Public Policy*, 1–20. https://doi.org/10.1017/bpp.2019.53

LSE Psychological and Behavioural Science

Using NLP to study culture and complaints

FORGOOD

Dr Tom Reader | t.w.reader@lse.ac.uk

(1/2)
Using NLP and AI to study culture

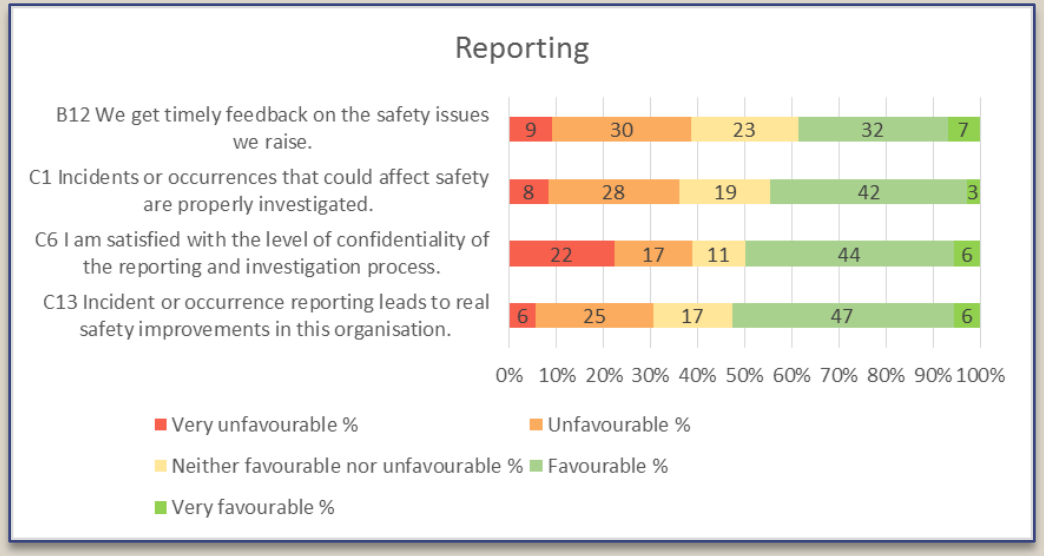
Discussion:
How is culture measured in your organisation?

Culture measurement

- **Traditionally we study safety culture through self-report**
  - Psychometrically validated staff surveys
  - Interviews
  - Focus groups

Survey staff

Examine trends



Recommendations

Safety culture improvement plan:

- *Improving feedback*: Ensure feedback on safety investigations is provided promptly
- *Implementation*: Recommendations from safety investigations should be implemented in 90 days
- *Leadership*: decision-makers encourage incident reporting
- *Reporting fatigue*: staff must see the outcomes from their incident reports

Interpret findings

Safety culture measurement

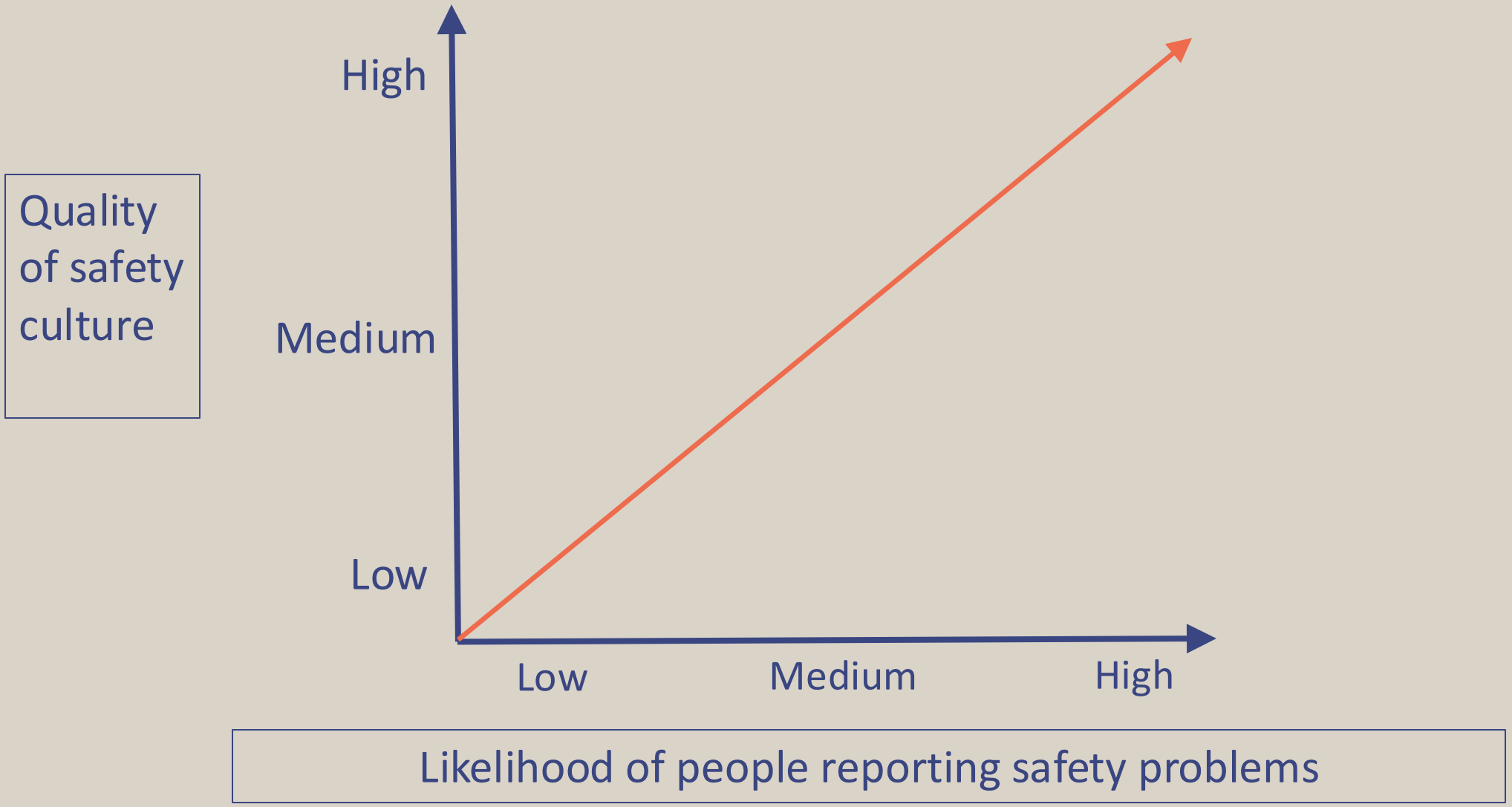
- **Traditionally we study safety culture through self-report**
  - Psychometrically validated staff surveys
  - Interviews
  - Focus groups

- **But this approach has limitations:**
  - Partial view on safety
  - Top-down
  - Less reliable as safety culture worsens
  - Fixed questions
  - Averages, not specifics


YES, I AGREE IT'S EASY TO SPEAK UP
NO, YOU CAN'T SAY ANYTHING HERE (but should I say this?)
CULTURE SURVEY
CULTURE SURVEY


It looks like we are in the middle for 'Speaking Up'
CULTURE REPORT
CULTURE REPORT

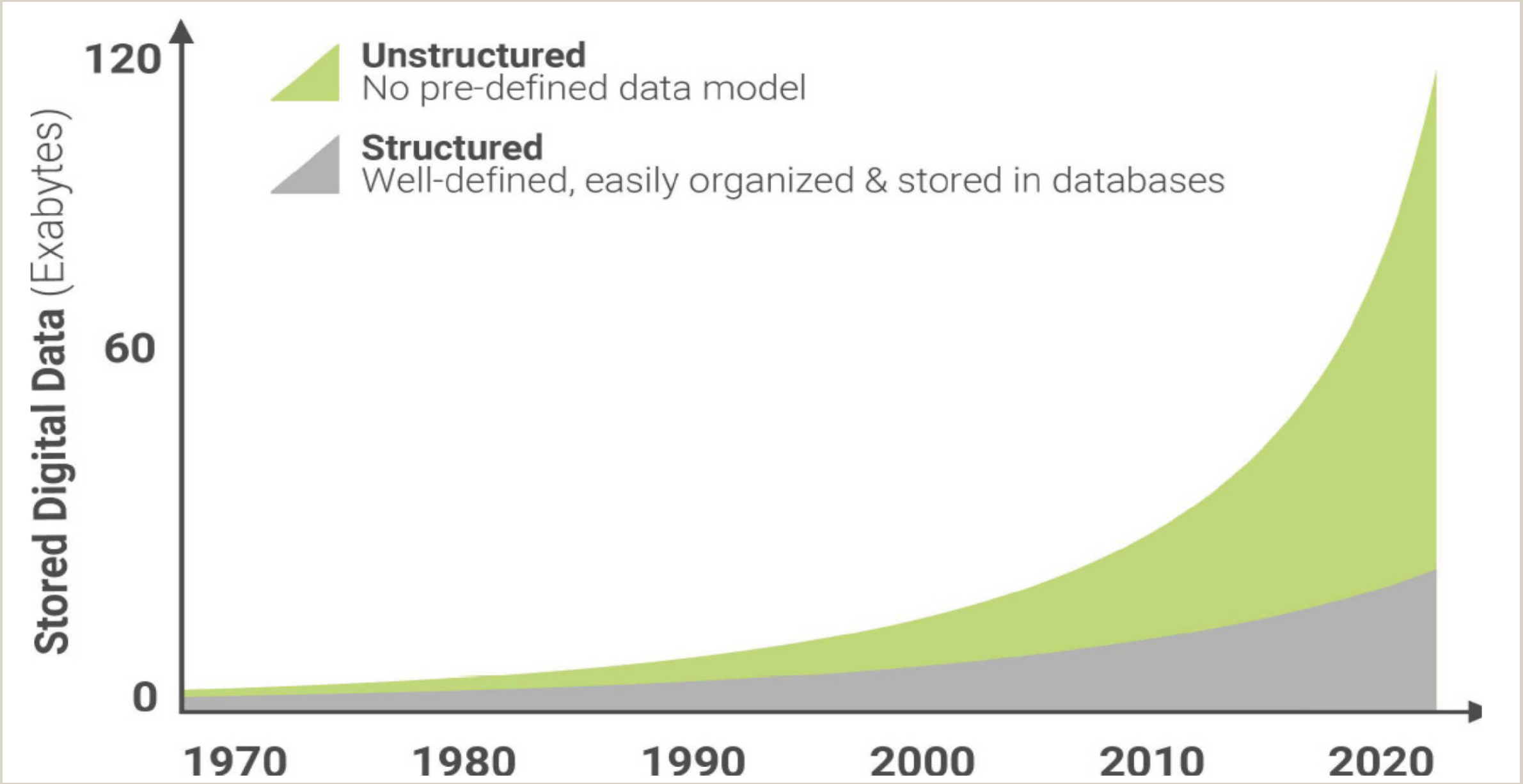
Responses to surveys can be mixed indicators



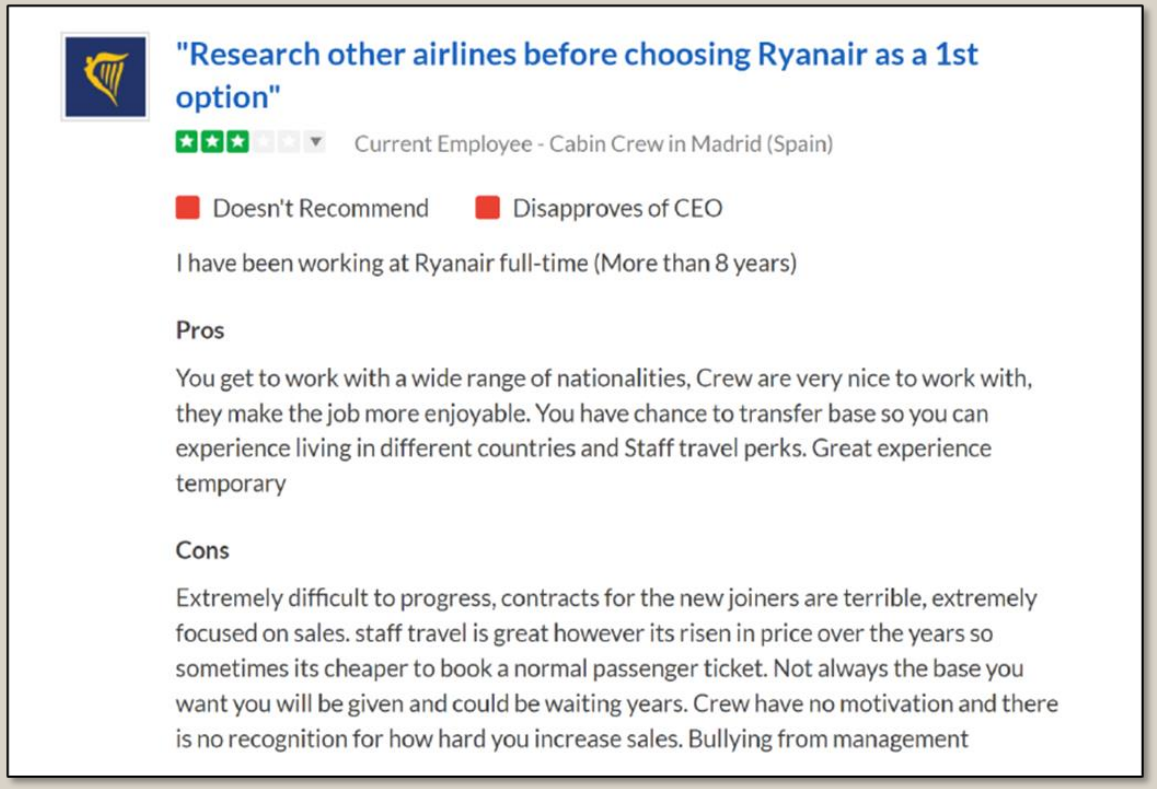

SURVEY
CULTURE REPORT
SNAPSHOT vs. STORY
UNSAFE CONDITIONS
PRESSURE


PSYCHOLOGICAL SAFETY
LEADERSHIP VISIBILITY
WORKLOAD
INCIDENT REPORTING
TEAMWORK
LEARNING FROM ERRORS
STAFF ENGAGEMENT
SPEAKING UP
PROCEDURAL FAIRNESS

Growth of new data creates opportunities for culture



Examples (1)



"Research other airlines before choosing Ryanair as a 1st option"

Current Employee - Cabin Crew in Madrid (Spain)

Doesn't Recommend Disapproves of CEO

I have been working at Ryanair full-time (More than 8 years)

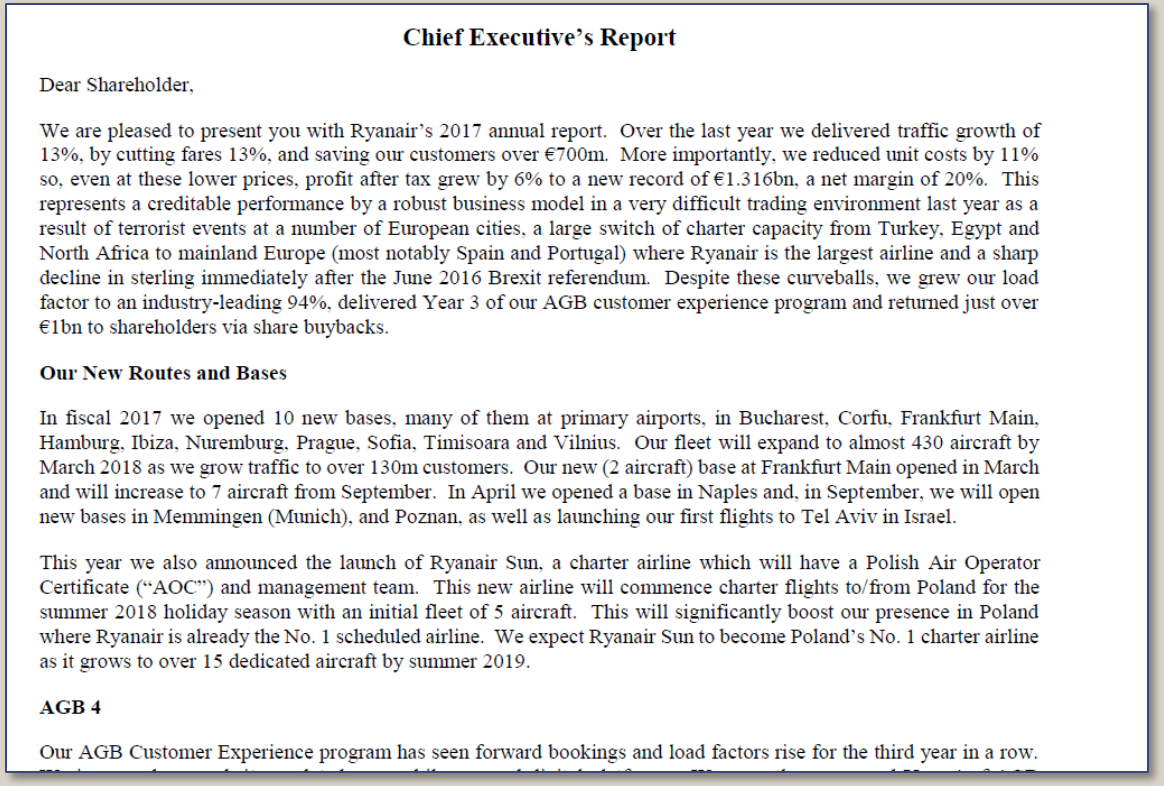
Pros

You get to work with a wide range of nationalities, Crew are very nice to work with, they make the job more enjoyable. You have chance to transfer base so you can experience living in different countries and Staff travel perks. Great experience temporary

Cons

Extremely difficult to progress, contracts for the new joiners are terrible, extremely focused on sales. staff travel is great however its risen in price over the years so sometimes its cheaper to book a normal passenger ticket. Not always the base you want you will be given and could be waiting years. Crew have no motivation and there is no recognition for how hard you increase sales. Bullying from management

Employee feedback



Chief Executive's Report

Dear Shareholder,

We are pleased to present you with Ryanair's 2017 annual report. Over the last year we delivered traffic growth of 13%, by cutting fares 13%, and saving our customers over €700m. More importantly, we reduced unit costs by 11% so, even at these lower prices, profit after tax grew by 6% to a new record of €1.316bn, a net margin of 20%. This represents a creditable performance by a robust business model in a very difficult trading environment last year as a result of terrorist events at a number of European cities, a large switch of charter capacity from Turkey, Egypt and North Africa to mainland Europe (most notably Spain and Portugal) where Ryanair is the largest airline and a sharp decline in sterling immediately after the June 2016 Brexit referendum. Despite these curveballs, we grew our load factor to an industry-leading 94%, delivered Year 3 of our AGB customer experience program and returned just over €1bn to shareholders via share buybacks.

Our New Routes and Bases

In fiscal 2017 we opened 10 new bases, many of them at primary airports, in Bucharest, Corfu, Frankfurt Main, Hamburg, Ibiza, Nuremburg, Prague, Sofia, Timisoara and Vilnius. Our fleet will expand to almost 430 aircraft by March 2018 as we grow traffic to over 130m customers. Our new (2 aircraft) base at Frankfurt Main opened in March and will increase to 7 aircraft from September. In April we opened a base in Naples and, in September, we will open new bases in Memmingen (Munich), and Poznan, as well as launching our first flights to Tel Aviv in Israel.

This year we also announced the launch of Ryanair Sun, a charter airline which will have a Polish Air Operator Certificate ("AOC") and management team. This new airline will commence charter flights to/from Poland for the summer 2018 holiday season with an initial fleet of 5 aircraft. This will significantly boost our presence in Poland where Ryanair is already the No. 1 scheduled airline. We expect Ryanair Sun to become Poland's No. 1 charter airline as it grows to over 15 dedicated aircraft by summer 2019.

AGB 4

Our AGB Customer Experience program has seen forward bookings and load factors rise for the third year in a row.

Organisational reports

Examples (2)

Flight 230 (1969)

PIC: Well, looks like our altimeters were ***within reason***
COP: Yeah
PIC: Yeah, ***I like that altimeter***
COP: Boy, you know it - reads right about the middle marker there
PIC: Yeah
COP: I always watch that radio altimeter
[Sound of PIC whistling]
PIC: ***I go by this one on a field like this close one***
COP: Yeah
PIC: There's too many valleys here
PIC: Ask him - John, ask him if he's got his lights turned all the way up
COP: Have you got the lights turned all the way up?
TWR: Sure do, uh, a little fog, right off the end there [...]
COP: ***Everything's good*** *[...]*
COP: Watch it! [Sound of impact]

Natural speech

Important information is buried under ideas and questions that should unfold during the meeting, not before it.

Our Meeting Tomorrow

Good afternoon, Kurt.

Thank you very much for agreeing to meet with m[illegible]y. I know that we're both busy, so perhaps we can combine a couple of future meetings into this one.

Regarding the potential, um, Potentiality Report, I know that we're in the high-level planning stages, which leaves a lot of room for ideation. However, it would be ideal to firm up a deadline for our first draft; I'm thinking July 31 by 5pm PST. If you have a preference for which day you would prefer (Monday, Tuesday, Wednesday, Thursday or Friday), or if there are days that will absolutely not work, please let me know as soon as possible and I will adjust my schedule and expectations accordingly. In the meantime, please let us know if you me to bring along any materials for the meeting - ideally, I'd like the details by tomorrow afternoon. I'm happy t[illegible]pay for lu

Good reports have a letter of endorsement, table of contents, introductio[illegible]r individual potential, analysis of community potential, how the competencie[illegible]nc

I think that our meeting should also focus on some ideas for the report, which we've already discussed. Our ideas to explore human potential, how people get promoted, and framing our competencies as "advancement abilities" are, I believe, the strongest options that we'll be considering. If you have other ideas to bring to the table please let me know.

Would Meat and Bread be the best place to meet? Here is a map to the location: https://maps.google.ca/maps?q=Meat+and+Bread+Vancouver&ll=49.283484,-123.109274&spn=0.007293,0.021136&oe=utf-8&client=firefox-a&fb=1&gl=ca&hq=Meat+and+Bread&hnear=0x548673f143a94fb3:0xbb9196ea9b81f38b,Vancouver,+BC&cid=0,0,5974644075226205790&t=m&z=16&iwloc=A. Let me know what you think.

Thank you again, buddy pal awesome guy. I'm looking forward to this awesome collaboration.

Sans Serif | Send | Saved

This superfluous sentence adds no value to Kurt

Email keeps going, and going, and going...

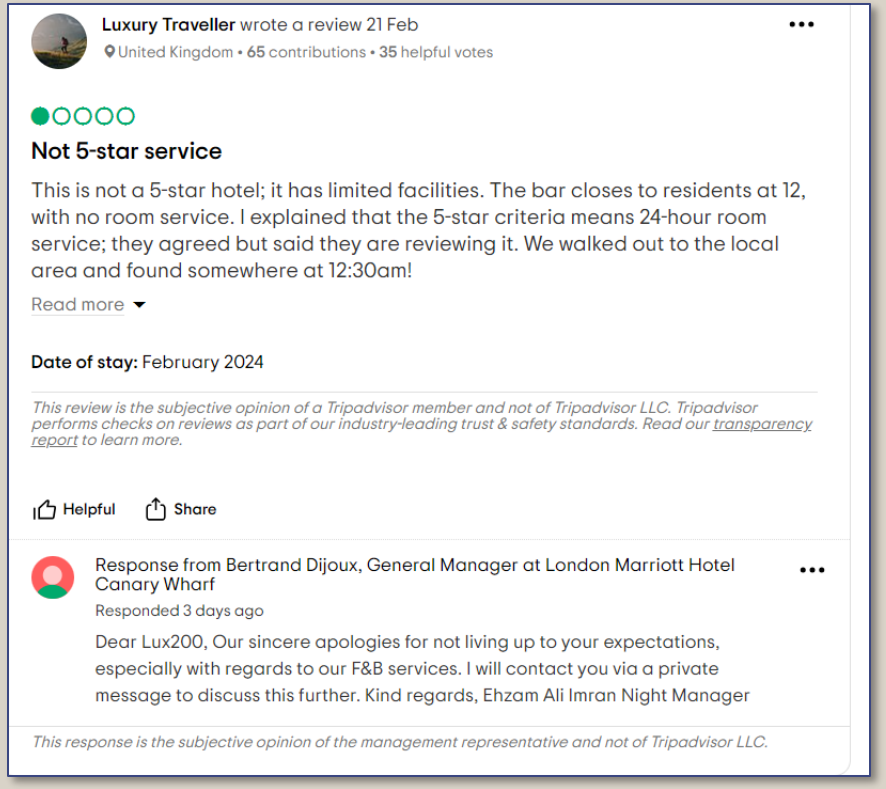
Long, big, ugly, distracting hyperlink

Written communication

Examples (3)

"We are writing to you to complain about the care given to our mother....she twice visited A&E in pain from an severe and ongoing sickness. The doctors examined her, and diagnosed a gastric bug. They ignored our concerns that she was getting progressively weaker. We visited a third time, five days later, where mum was diagnosed as having a hernia blocking her bowel. We feel the first doctors should have detected the hernia and acted on her deterioration. The hernia could have been detected through a more thorough examination, before her health had deteriorated to the point where she was too weak to undergo the operation (which result in kidney failure and death)"

Complaints



Responses to complaints

Enter AI…

- **Enables analysis of large text data:**
  - Beyond human comprehension
  - ‘Scores’ text for concepts

- **Three main approaches:**
  - ‘Bag of words’
  - ‘Word embeddings’
  - ‘Large language models

- **How can we use these approaches to study culture?**

What does taking a language-based approach to culture mean?

- **Focus is on communication rather than shared norms**
  - Culture is conceptualised in terms of what people say and do
  - Measured through text that reveal values and norms

- **Very different to surveys**
  - Bottom-up and top-down analysis
  - Less artificial
  - Not about averages

Employee textual feedback

- **Employees often report workplace experiences**
  - Social media
  - Employee surveys
  - Exit interviews
  - Professional website forums
  - Incident reports

- **Vast data: millions of words**
  - Sharp-end descriptions of culture
  - Cultural actions: e.g., speaking-up

Demonstration

Validity of this approach?

EUROPEAN JOURNAL OF WORK AND ORGANIZATIONAL PSYCHOLOGY
2024, VOL. 33, NO. 6, 855–867
https://doi.org/10.1080/1359432X.2024.2398181

Routledge
Taylor & Francis Group

Target pressure and corporate scandals: a natural language processing investigation of how organizational culture underlies institutional failures

Tom W. Reader[a] and Alex Gillespie[a,b]

[a]Department of Psychological and Behavioural Science, London School of Economics, London, UK; [b]Department of Psychology, Oslo New University College, Oslo, Norway

ABSTRACT

An organizational culture of pressurizing employees to achieve unrealistic goals ("target pressure") is often suggested to foster the misconduct and risk-taking that causes institutional failures (corporate scandals, accidents). To conceptualize and investigate this, we gathered anonymous employee online reviews about working in 218 companies (71,830 reviews, containing 4,356,105 words) and developed a natural language processing algorithm to measure the salience of norms for target pressure within the employee reviews. Using this measure, we surfaced and qualitatively analysed sentences in which employees discussed target pressure, and quantitatively tested whether companies with a high target pressure culture (in which target pressure was especially salient in collective thinking) were at greater risk of experiencing a corporate scandal. Our hypothesis was supported. Qualitative analysis found that high target pressure cultures are characterized by norms for three inter-linking elements: *overly ambitious targets* that are beyond the capability and control of employees, *highly consequential targets* that generate strain, and *expediency in achieving targets*, which encourages an "ends justify the means" mentality. Combined, these elements may increase the likelihood of institutional failures by promoting, incentivizing, and normalizing deviant or risky behaviour (i.e. to achieve targets), and implicitly de-prioritizing the importance of safe and ethical conduct.

ARTICLE HISTORY
Received 10 August 2023
Accepted 23 August 2024

KEYWORDS
Organizational culture; institutional failure; natural language processing; risk; target pressure

A culture of pressurizing staff to achieve unrealistic or risky goals ("target pressure") is frequently identified as a causal factor in major institutional failures. For instance, in the Wells Fargo cross-selling scandal, the pressure to meet unrealistic sales targets led bank staff to create millions of false customer accounts (Tayan, 2019), and in the BP Deepwater Horizon oil rig explosion, pressure to establish oil production contributed to errors in risk management (Reader & O'Connor, 2014). Broadly, it has been theorized that excessive target pressure in organizations – for instance, from managers setting infeasible yet punitive or lucrative targets – tacitly or directly encourages and normalizes deviant behaviour, undermines values for safety and ethics, and thereby increases the likelihood of an accident or corporate scandal (Entwistle & Doering, 2023; Ordóñez et al., 2009).

While target pressure is often an implicit part of cultural models that aim to explain why institutional failures occur, for instance, as part of the theory on safety culture (Guldenmund, 2000) and ethical culture (Kaptein, 2011), the psychology literature lacks (a) a nomological conceptualization of target pressure as a cultural construct and process, and (b) the systematic investigation of its proposed relationship with institutional failures. Addressing these gaps would advance theory and evidence on how target pressure manifests in organizations, better account for the role of organizational culture in institutional failures, and potentially lead to the development of measures to indicate when organizations have fostered cultural norms that increase the risk of an incident. Accordingly, in the current study, we conceptualize and investigate the nature of a "high target pressure culture" – in which the norms for target pressure are highly salient to the members of the organization – and the mechanisms underlying it, and explore its relationship with institutional failures.

We build upon recent advances in the use of unstructured textual data and natural language processing (NLP)[1] to measure organizational culture (Pandey & Pandey, 2019), and analyse anonymous employee online reviews that describe experiences of working in major European firms. Research has suggested that such unobtrusive and unstructured textual data are valuable because they can generate unvarnished insights into organizational culture, and NLP is increasingly used to develop quantitative indicators from textual data on the degree to which certain norms are prominent and shared within an organization (e.g., around target pressure) and to surface high-relevance textual statements that qualitatively show how norms manifest and shape behaviour in workplace environments (Hald et al., 2024; Reader et al., 2020). Taking a mixed-methods approach to address two research questions, we developed an NLP algorithm to indicate whether an organization has developed a high target pressure culture, and used the algorithm to (a) qualitatively conceptualize how a high target pressure culture manifests and shapes behaviour within

CONTACT Tom W. Reader t.w.reader@lse.ac.uk

DOI: 10.1111/risa.14002

ORIGINAL ARTICLE

Online patient feedback as a safety valve: An automated language analysis of unnoticed and unresolved safety incidents

Alex Gillespie[1,2] | **Tom W. Reader**[1]

[1]Department of Psychological & Behavioural Science, London School of Economics, London, UK

[2]Department of Psychology, Oslo New University College, Oslo, Norway

Correspondence
Alex Gillespie, Department of Psychological & Behavioural Science, London School of Economics, Houghton Street, London, WC2A 2AE, UK.
Email: a.t.gillespie@lse.ac.uk

Abstract

Safety reporting systems are widely used in healthcare to identify risks to patient safety. But, their effectiveness is undermined if staff do not notice or report incidents. Patients, however, might observe and report these overlooked incidents because they experience the consequences, are highly motivated, and independent of the organization. Online patient feedback may be especially valuable because it is a channel of reporting that allows patients to report without fear of consequence (e.g., anonymously). Harnessing this potential is challenging because online feedback is unstructured and lacks demonstrable validity and added value. Accordingly, we developed an automated language analysis method for measuring the likelihood of patient-reported safety incidents in online patient feedback. Feedback from patients and families (n = 146,685, words = 22,191,427, years = 2013–2019) about acute NHS trusts (hospital conglomerates; n = 134) in England were analyzed. The automated measure had good precision (0.69) and excellent recall (0.98) in identifying incidents; was independent of staff-reported incidents ($r = -0.04$ to 0.19); and was associated with hospital-level mortality rates (z = 3.87; $p < 0.001$). The identified safety incidents were often reported as unnoticed (89%) or unresolved (21%), suggesting that patients use online platforms to give visibility to safety concerns they believe have been missed or ignored. Online stakeholder feedback is akin to a safety valve; being independent and unconstrained it provides an outlet for reporting safety issues that may have been unnoticed or unresolved within formal channels.

KEYWORDS
incident-reporting, natural language processing, online feedback, patient safety

1 | INTRODUCTION

Approximately 10% of hospital patients experience an adverse event during treatment (unintended harm due to errors), such as exacerbating resource pressure, harm, and even mortality (Lane et al., 2021; Makary & Daniel, 2016; National Academies of Sciences & Medicine, 2018; Vincent et al., 2001; World Health Organization, 2017). To reduce adverse events, healthcare organizations have invested in safety reporting systems for staff to report observations or involvement in safety incidents (adverse events and near misses) in order to identify and mitigate emerging risks (Barach & Small, 2000; Vincent et al., 2017). However, the success of these reporting systems in reducing adverse events has been limited due to inconsistencies in staff recognizing and reporting incidents (Shojania & Thomas, 2013; Stavropoulou et al., 2015).

Patient and family reports of care submitted to healthcare review websites (henceforth "online patient feedback") can augment risk management in hospitals (Greaves et al., 2013; Griffiths & Leaver, 2017). Specifically, we propose that online feedback is especially valuable for monitoring unnoticed and unresolved safety incidents. To this end, we introduce and validate an automated language analysis

Discussion:

What forms of data do you have in your organisation that could be used to study culture?

(2/2)
Using NLP and AI to study complaints

Complaints

- **The value of complaints**
  - From the sharp-end
  - Outside the organisation
  - Less pressure to distort
  - Unsolicited, reveals events not averages

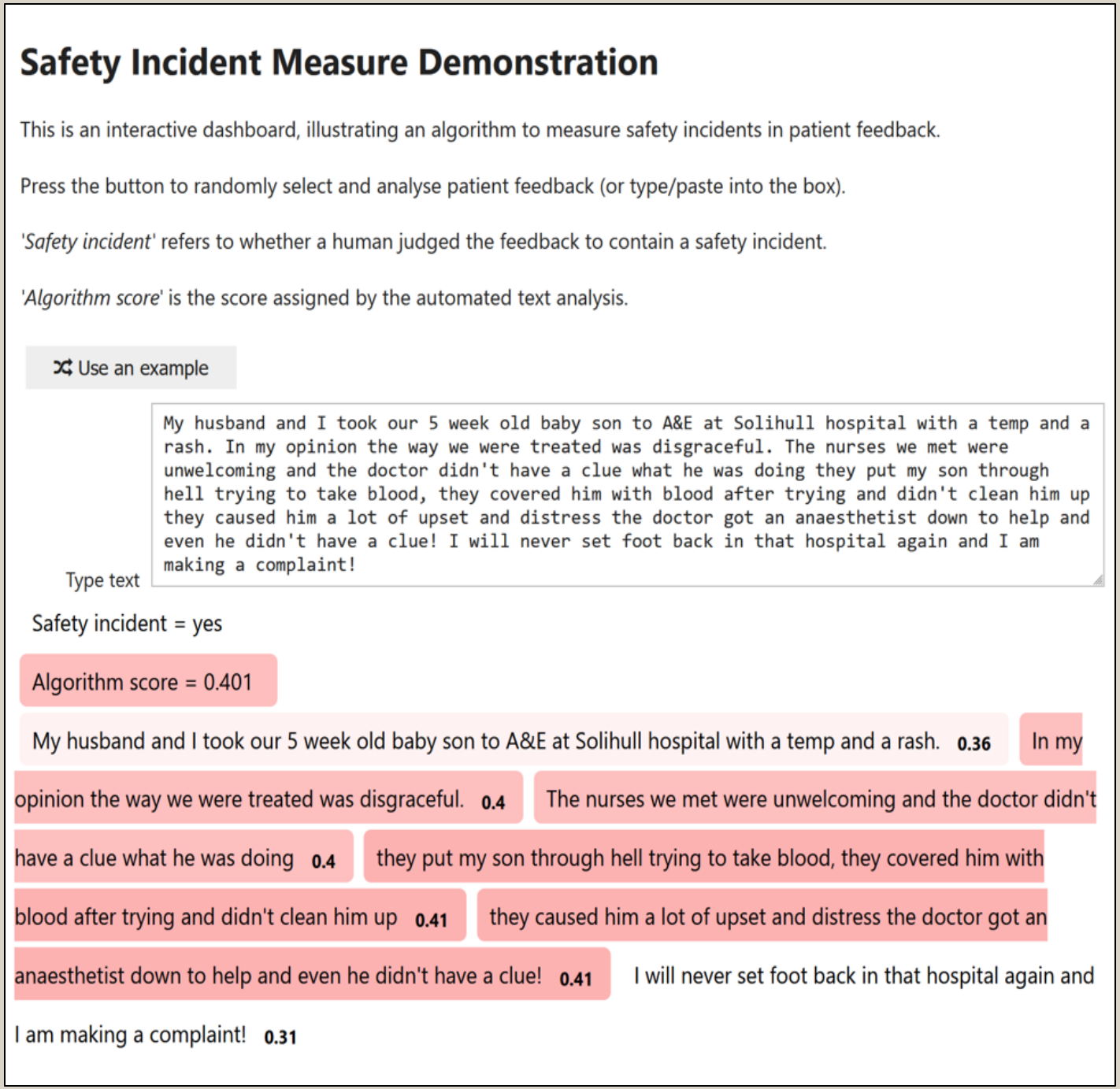
- **Report on problems in organisational functioning**
  - For example: medical errors, poor attitudes, bad communication, unsafe practice (Reader & Gillespie, 2021)

- **Provide an external view on culture**

Discussion:
How do you analyse complaints in your organisation?

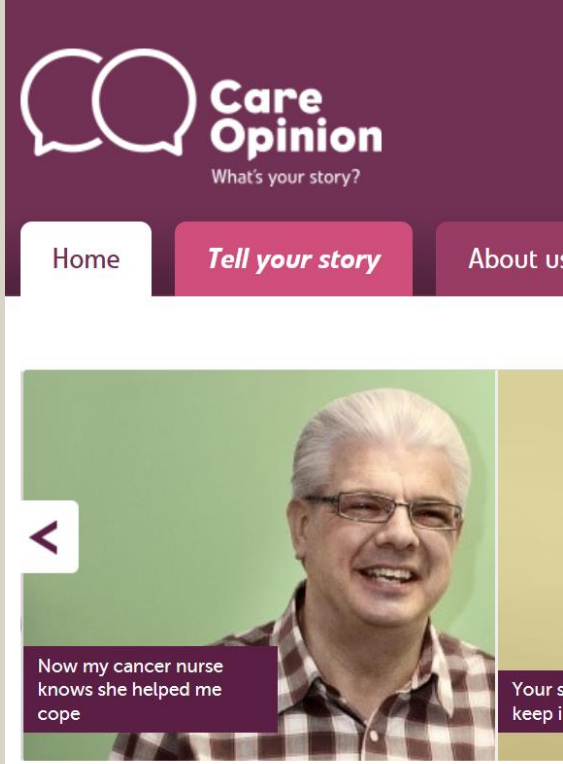
AI-algorithm

- Scores textual data from patients and families in complaints
- Measures every sentence in terms of relation to safety incidents
- Every story sent to a hospital is scored
- Hospitals are scored in terms of how much patient complaints focus on issues about safety culture



Empirical Study

- Care Opinion (established 2007)
- Online feedback platform for patients and their relatives
- Aim to improve healthcare in UK
- ‘Stories’ posted are unsolicited and qualitative
- ‘Responses’ are posted by staff
- **700k stories and 15k staff listening**



Marsh, C., Peacock, R., Sheard, L., Hughes, L., & Lawton, R. (2019). Patient experience feedback in UK hospitals: What types are available and what are their potential roles in quality improvement (QI)? *Health Expectations*, *22*(3), 317–326.

Descriptives

Hospitals = 134

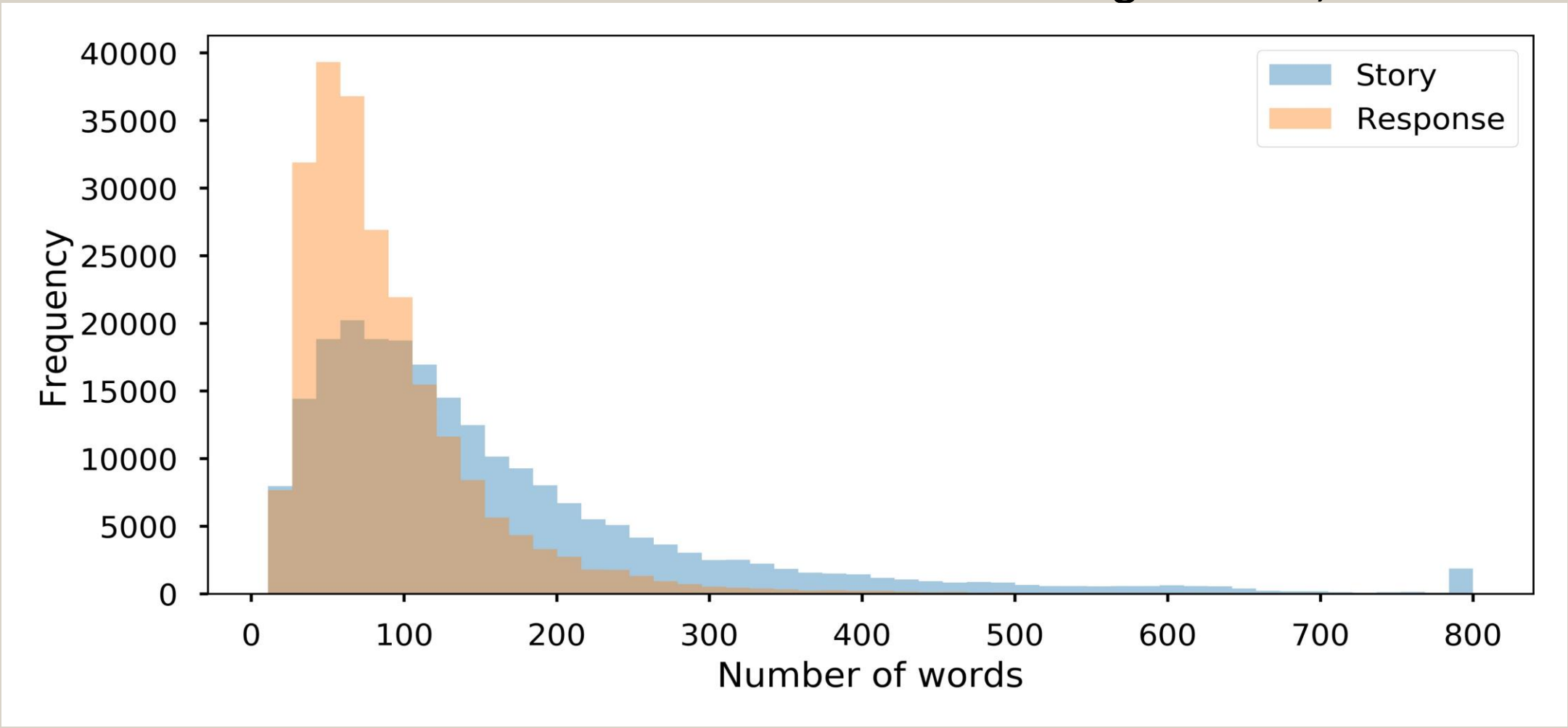
Stories = 146,000

Years = 2013 - 2019

Total words = 22,191,427

Story mean words: 158

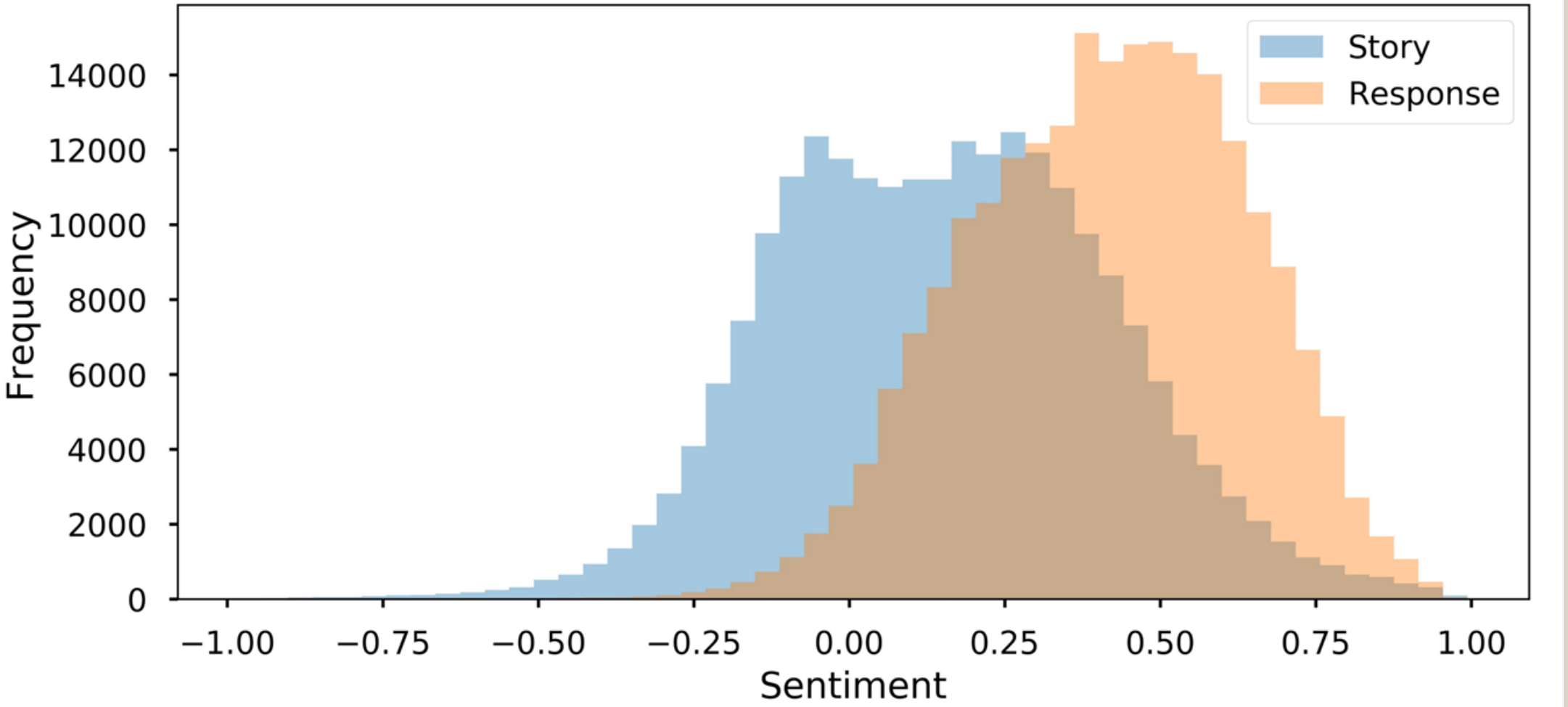
Range: 1 to 3,894 words



Descriptives

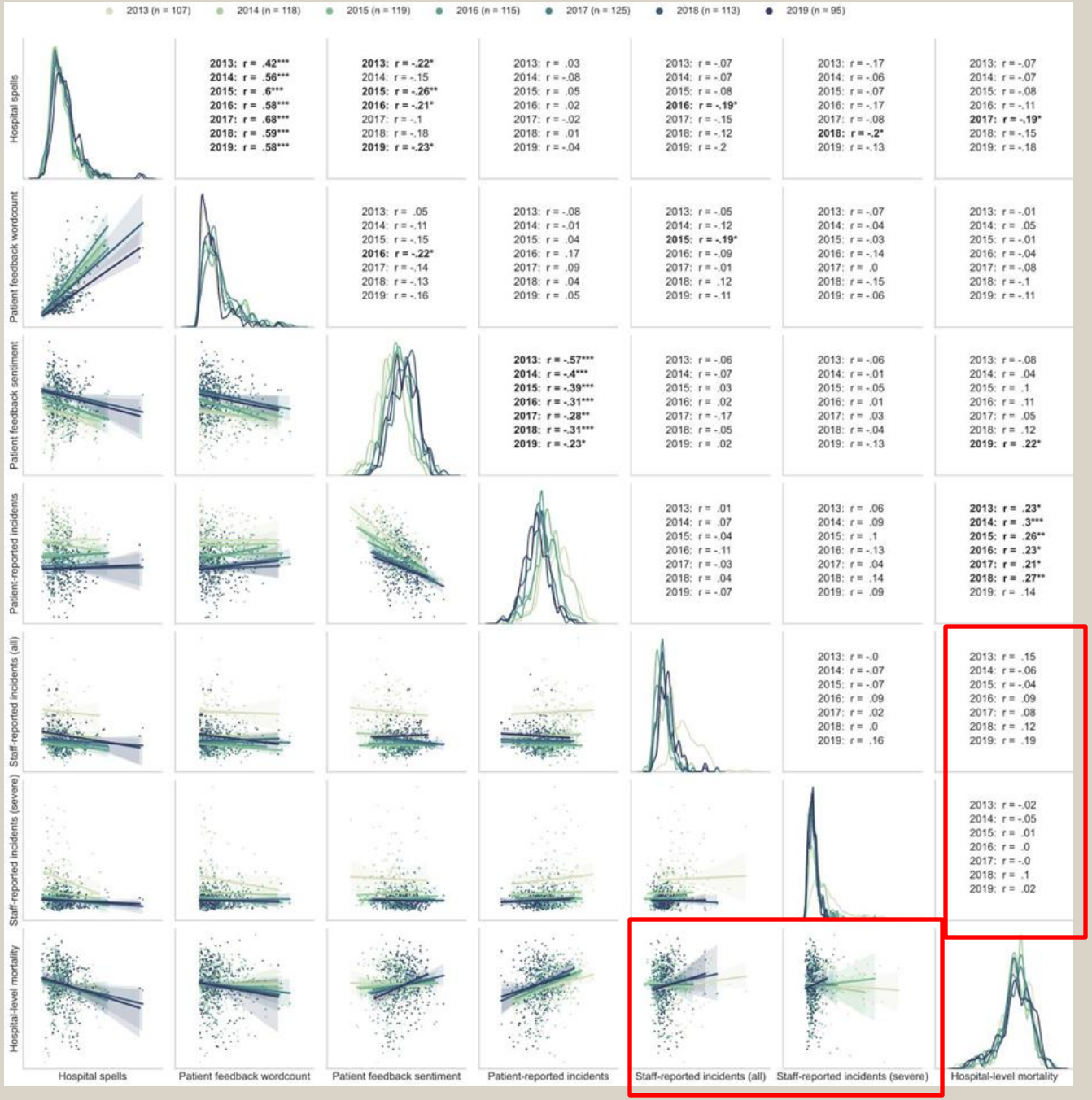
Stories have bimodal sentiment, with negative & positive peaks

Responses have a positive sentiment skew



High-scoring hospitals had more safety incidents

- “I raised concerns that the beta blockers were causing me to feel faint and confused [reporting possible adverse reaction to medication]”;
- “I said...I thought my wife had a blood clot [voicing concerns over a misdiagnosed chest infection]”;
- “she showed the video of her knee popping out, he [the doctor] immediately said that her knee had been fitted with the wrong sized spacer” [helping a doctor identify a medical error].
- “I asked ‘why the hell had these stones been missed on both the ultra sound and MRI scans’ [addressing poor safety standards]”;
- “Our frustration with Mum’s lack of care continued...my stepfather and I challenged the ward manager about how the ward was being run [on monitoring patients)”;
- “to our horror we discovered she had been taking tablets prescribed for [someone else] and demanded the right ones [after a series of medication problems]”.



Findings (1)

Staff-reported incidents

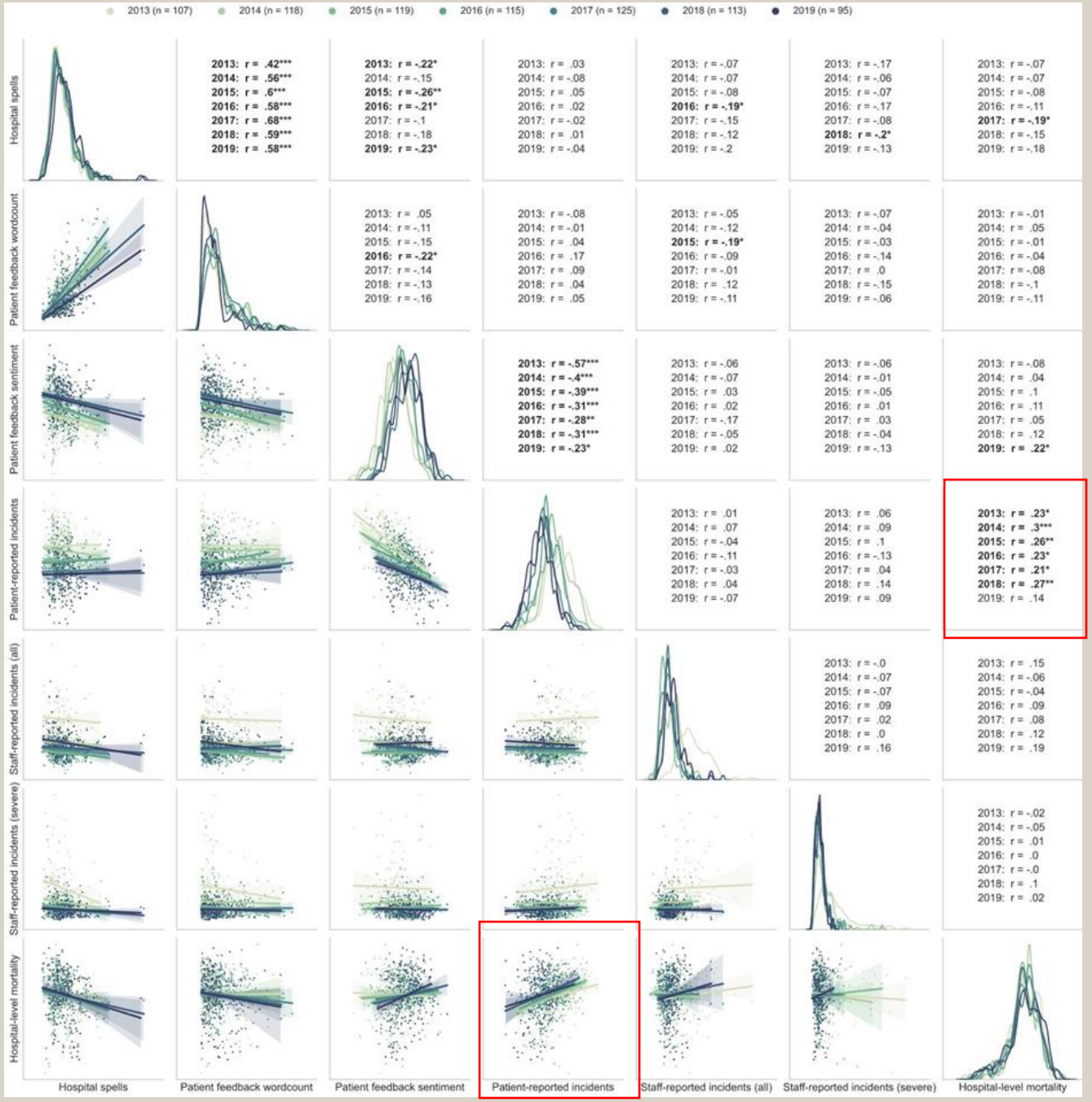
Obtrusive, internally reported

No association with hospital mortality rates

(for any year 2013-2019)

Gillespie, A., & Reader, T. W. (2023). Online patient feedback as a safety valve: An automated language analysis of unnoticed and unresolved safety incidents. Risk analysis, 43(7), 1463-1477.

Findings (2)



Patient-reported incidents

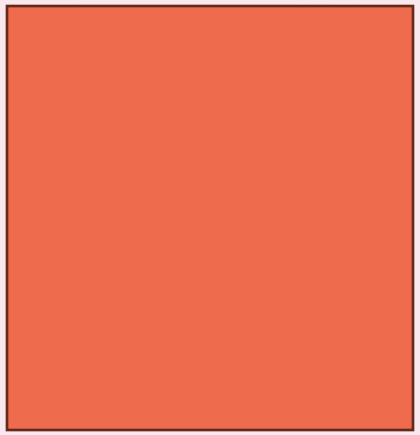
Unobtrusive, externally reported

Strong association with hospital mortality rates

(for every year 2013-2018)

Gillespie, A., & Reader, T. W. (2023). Online patient feedback as a safety valve: An automated language analysis of unnoticed and unresolved safety incidents. Risk analysis, 43(7), 1463-1477.

ward 4. My family have been relying on accurate information about OUR MOTHER when we call. However twice in less than a week we have been given information about other patients. This is from two different wards, two different members of staff and two incorrect patients confidential information being passed on. this has been highly distressing to our family. To add insult to injury, when I sent an E-mail of complaint within their closed system there has been no response!



Thank you char11e I can acknowledge receipt of your concerns and advise that you will be contacted by my team today. Providing information via telephone is limited and there is a protocol in place to ensure that there are no breaches of confidentiality. If a relative lives a distance away we can set up a password to ensure the correct information is provided to the right person.

The ward is awful. My Dad is in there now and is in a shocking state. Unshaven, sitting in dirty clothes, has been given the wrong food, as he is coeliac. We had to wait over 1 hour yesterday to speak to someone in charge. It's not as if the hospital is around the corner we have to drive from the Isle of

Thank you for your feedback. I am very sorry that you are dissatisfied with your Dad's care, this must be very worrying for you.

Have you spoken to the Senior Sister or Senior Charge Nurse to let them know of your concerns. I know from experience that they would be really keen to know of your concerns as it will give them an opportunity to try and resolve things.

Conclusions

- Complaints provide an alternative lens on culture:
  - They report on incidents and problems hidden or missed by organisations
  - Validated against outcomes
  - Can be used as an early warning system
  - Become especially important when there is a poor culture
  - Are usually the first ‘canary in the coalmine’

Discussion:
Potential to use NLP on complaints in your organistion?

Breakout Groups – 15 mins

Tackle a live challenge in groups

Come back ready to share

Debrief

Four experiential workshops in ethical behavioural science

FORMAT

- Specialist topic
- Practical workshop
- Research & use cases
- Q&A

Quarterly FORGOOD for deep dive community workshops

Oct '24	Feb '24	June '25	Sept '25
• FORGOOD framework	• AI, ethics & behavioural science	• NLP tools for complaints analysis	• De-sludging

Network of academics and professionals, with access to a curated content hub*

*supported by subject matter experts on behavioural science in AI and organizational psychology

Conclusion and next steps

One Action

What has resonated today? What one action will you take into your work tomorrow?

What application does this

Feedback

I liked...

I wish...

Future topics of interest

What's next?

Prctical application

Increasing profile

Building community of practice

*For a limited time, we are offering a **12-month** rolling membership at **£7.5k** per institution, with terms reviewed annually.*

Contact us at info@forgoodframework.com to find out more.

FORGOOD** is supported by **LSE Consulting** and **LSE Innovation & Impact

The team

*The **FORGOOD** team at LSE are supported by a wider group of subject matter experts who share professional knowledge and provide advisory support. LSE's research and teaching span the full breadth of the social sciences, from economics, politics, and law to sociology, anthropology, behavioural science, accounting, finance, and communication.*

Professor Liam Delaney | Co-Founder of FORGOOD

***Professor Liam Delaney** leads on the scientific insights curated for the FORGOOD community. He co-developed the FORGOOD Framework with Professor Leonhard Lades, heads the Department of Psychological and Behavioural Science at LSE and is a leading expert in the ethical foundations of behavioural public policy.*

Annabel Gillard | Co-Founder of FORGOOD

***Annabel Gillard** leads relationship development with the FORGOOD community. She has two decades of experience in asset management and is a key figure in shaping ethical business practices. She serves on the advisory council of the Institute of Business Ethics and Blueprint for better business, and co-founded CFA UK's ethics committee.*

Bishin Ho | Co-Founder of FORGOOD

***Bishin Ho** leads on the structure and delivery of the FORGOOD proposition. She is a finance strategist with over 15 years of experience. She specialises in applying behavioural science to corporate challenges, particularly in the age of new technology.*