

Pro-Active Safety Culture – The role of human behaviour and six essential habits for a world class safety culture.

by Tim Marsh

Have you ever offered anyone any ‘advice’ unsolicited and had the response “yes please!”? Have you ever even seen or heard of such a response? Even when the advice in question would prove really useful? No, neither have I, and it is difficult to overestimate how *contrary* people can be. The worst way to get them to change is to *tell* people to change. However, if they decide *themselves* that they want to change, then things can be very different. The *person* factor is absolutely vital when we consider the practicalities of moving beyond a compliant to a pro-active safety culture.

Parker and Hudson Safety Culture Model

The Parker and Hudson model is as follows:-

- *Pathological (i.e. anarchy)*
- *Re-Active*
- *Calculative (i.e. compliant)*
- *Pro-Active*
- *Generative (i.e. embodying a ‘healthy paranoia’)*

I favour this model, as nine times out of ten clients who approach us, describe themselves as ‘compliant but suffering from the plateau effect’ and wanting to ‘actively push on from here’. That is, they have moved beyond ‘reactive’ and have good systems, procedures, training and inductions in place and they also have a set of files guaranteed to deliver a certificate or two for the wall in reception. Despite this, they know that the descriptions in the neat files and the reality can differ, and that their safety performance has hit a plateau and has been like that for some time.

The organisations in question can easily identify that they need to ‘do something’ about the fact that 90% or more of accidents seem to have a key *human* element. Deciding what to do to push through this plateau is the harder part.

A request that has definitely increased as the global economy has begun to suffer is ‘Can we have a magic safety culture bullet please?’ The answer is ‘No’. Increased effort and attention can only take you so far. Changing underlying attitudes and values is very difficult, as anyone who has ever debated politics, sport or religion knows. A practical illustration of this would be, that just as a new football manager is held to deliver 6 points more from the first five games in charge before performance drifts back to the previous standard... so it is with safety. You *can* get close to 100% motivation (or “110% Brian” in football terms!) for a while, but this simply is not sustainable. Martin O’Neil at Aston Villa would be a good example. Villa enjoyed an excellent start to last season then they tailed off in results somewhat as the honeymoon effect abated, but now, because of the sensible *changes* he has made at the club, they are beginning to build performance levels slowly and finished 7th in the league in 2008. (Not sure I quite understand this allusion??)

This simply reflects a universal truth – you cannot improve performance in the medium to long term without *changing* something and this will nearly always involve changing behaviour.

The six sets of behaviour required to develop a world class safety culture are:

- Analysis (before blame)
- Lead Measurement
- Workforce Ownership
- (Effective) Communication
- Modelling Safety
- Challenging Unsafe Acts

1 Analysis before blame. Perhaps the key element of James Reason's "Just Culture" is that an unsafe act needs to be properly *analysed* for its root cause before *any* blame is apportioned. This is because frequently, even if the safe way is possible, it will be slow, uncomfortable or inconvenient in some way and the classic 'antecedent; behaviour; consequence' or 'ABC' model needs to be applied.

This model basically says that often it is the consequences that drive behaviour more than triggers and though some consequences can be very serious; they can be very weak if delayed, uncertain and negative (lung cancer and heart disease for example) and very strong if soon, certain and positive (a cigarette or rich food for example). A variation on this is 'why' analysis - the practice of looking at any near miss report and asking 'why?' 'He was clumsy, or 'she made a mistake' often is not the end of the analysis. It is probably a symptom of an underlying problem rather than a direct cause.

I once visited a management team on site where the first thing that happened was the safety manager jumped on a chair to turn on the air conditioning. The MD groaned and said 'oh no John what's this Tim chap going to think of that?' but actually I found that I wasn't judging the *individual* at all – instead what I was thinking was 'what a stupid place to have the air conditioning controls ... 8ft in the air... someone really needs to get an electrician in or this will keep happening...'. As the ABC model explains so clearly, if the safe way is slow, uncomfortable or inconvenient, then the temptation is to cut the corner and as Stephen Fry says 'what I do with temptation is yield to it straight away – it saves on the faffing about".

2 Lead Measurement. Lead measures are measures that actively predict events rather than measure what has happened. Lost time incidents being a classic *lagging* measure, where companies may note an increase on previous years' figures and *react* to that. Lead measures on the other hand seek to *actively* predict whether headline figures are likely to improve.

As it happens, many "lead" indicators that focus on training and risk assessment completion are by definition mostly measuring *compliance*. They also beg questions such as: How appropriate was the training? How good was the training and how was it followed up?

However, *behavioural* lead indicators are definitely *pro-active*. If twice as many people are lifting correctly and holding the handrail descending stairs, then half as many should suffer bad backs and falls.

If the behavioural items are well written, clearly defined and an appropriate sample strategy used then lead indicators deliver the benefit of "*if we can measure it we can manage it*" - because we can pro-actively identify areas of risk and whether interventions are working. Interestingly, lead indicators deliver the benefits of "*what gets measured gets done*" regardless of the quality of the data. The assessor will need to be seen to be observing with a clipboard when it is *busy* for that issue to be perceived as genuinely important.

The biggest **problem** we see is organisations which collect data from badly defined lead indicators; These organisations simply end up analysing pie charts that tell them (*inaccurately*) how safe the organisation is when it is nice and quiet.

3 Workforce ownership. A high level of **ownership** of the safety process by the people who are most at risk is required. After all they nearly always know *exactly* what happens in the middle of busy day, why – and what needs to be done to stop it. Ownership is about *actively* making choices and isn't just about a quick consultation of a pre-made decision with the usual suspects. Scottish football fans *choose* to put their best foot forward abroad.

In many respects ownership and consultation look similar. However, this is not the case, and they deliver vastly different results in practice. The biggest **problem** I see in this area is organisations making decisions that are routinely ratified in a quick and meaningless consultation with the 'usual suspects' or perhaps by a handful of hand picked keen employees who tend to - *atypically* - act very

safely at all times anyway. A symptom of this are the numerous conversations over coffee among workers saying “it’s obvious that wouldn’t work... if they’d asked me I’d have told them ... I did try to mention it but no-one listened“.

4 Effective communication. Of course *all* organisations communicate about safety, but it is how well and how often, that makes the difference. Naturally, all behavioural models will stress that good communications involve high levels of praise and (a key expression used by the famous “one minute manager”) “catching people doing something right” applies. However, it might also include well-delivered and high impact weekly briefings as well as demonstrating that health and safety issues raised by staff will be taken seriously and acted upon – not just filed in a draw. To help achieve this many organisations have started to train all managers and supervisors in presentation, active listening, feedback and coaching skills. Bill McFarlan’s book “Drop the Pink Elephant” (Capstone, 2004) covers much of this ground in a very accessible way.

5 & 6 Modelling safety and challenging unsafe acts. The best organisations understand that if a safety leader sees and fails to challenge an unsafe act, then they condone it, and that if they are *ever* seen to act unsafely themselves, they undermine the whole safety process. There simply is not room in a pro-active culture for managers to take the odd short cut and turn the occasional blind eye. Obviously, these are challenges all organisations face; to address this, many organisations develop check-sheets and hazard spotting dvd’s to remind their supervisors of the *everyday* behaviours that cause the majority of accidents. For example on an oil platform, 50% of all Lost Time Incidents are caused by failing to hold the handrail and slipping on the stairs.

In conclusion

The best organisations are pro-actively addressing day-to-day behavioural issues by training supervisors and managers in practical people skills and getting the workforce as actively involved in the day to day management of safety as they can. These organisations are seeking to win the hearts and minds of the workers, not just by inspirational ‘vision’ statements and speeches, but also by treating them as adults; they are assuming that a person cutting a corner usually has *at least* a half sensible reason for doing what they did. Pro-active organisations understand that people don’t put themselves at risk because they are inherently lazy or stupid – but because they are human!