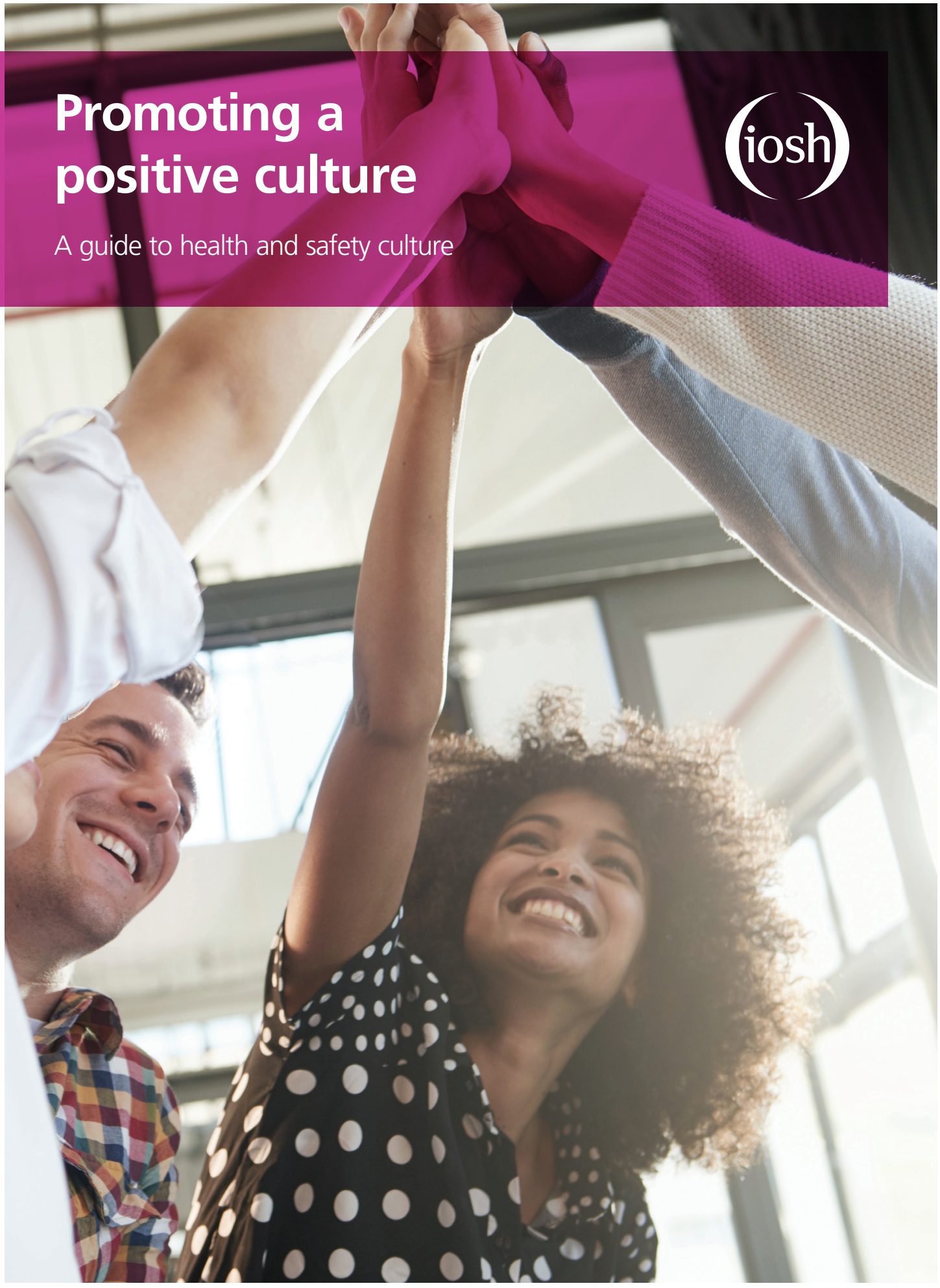
Promoting a positive culture

A guide to health and safety culture



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Promoting a positive culture – a guide to health and safety culture

This guide provides an overview of the principles of a positive safety culture and looks at improving safety culture and behaviour through leadership and worker involvement. It provides some indicators of a positive safety culture and outlines ways of improving safety culture, as well as describing some of the elements needed to develop a positive culture.

The guide includes case studies as examples of how safety cultures can be improved and what can be achieved with a positive safety culture.

This guide refers to UK law, statistics and examples. The general principles and advice apply outside the UK, but if you're reading this in a non-UK context, you should be aware of possible differences and may need to use data from your own country.

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Our materials are reviewed at least once every three years. This document was last reviewed and revised in **May 2015**.

Contents

1 Overview

It's now generally recognised that health and safety management should embrace – in a holistic way – the interactions between the working environment, equipment, systems and procedures, and the people in the organisation.

Effective risk management depends partly on the behaviour of individuals in an organisation. A significant number of accidents can be traced to unsafe behaviours. Poorly designed equipment or operations, poor systems and poor working conditions can all encourage unsafe behaviours, but these behaviours are not inevitable. An organisation's attitudes and values regarding safe working are important factors that influence its approach to work and ultimately its health and safety performance. Put another way, it's not enough to provide safe equipment, systems and procedures if the culture doesn't encourage healthy and safe working.

Safety culture has been defined[1] as consisting of shared values (what is important) and beliefs (how things work) that interact with an organisation's structure and control systems to produce behavioural standards (the way we do things round here). A poor health and safety culture is likely to lead to weaknesses due to problems at the person–work interface – perhaps because of poor training or communication.

A poor culture encourages an atmosphere where not complying with safe working practices is acceptable, and it doesn't help the organisation to take effective action to solve health and safety problems. Quite often, organisations that have a poor safety culture can have the same underlying attitude to all process and procedures. This can result in poor product quality and financial control as well as poor health and safety.[2]

The challenge is how to have a positive influence on an organisation's health and safety culture. It's hard to change the attitudes and beliefs of a workforce by direct persuasion, but by acting safely workers can start to think safely.[3] This belief has led to the development of 'behavioural safety' approaches. Remember that culture often develops slowly, and that fundamental change requires time.

Health and safety professionals must aim to apply current thinking in a practical way to achieve healthier and safer working environments. This IOSH guide offers some pointers to healthier and safer working by describing some aspects of a good health and safety culture and suggesting some steps that you and your organisation can take to improve it.

Although many of the references in this guide concentrate on 'safety' rather than 'health' cultures, the lessons are equally applicable to issues of workplace health. Indeed, because the links between poor workplace practices and resulting ill health can be less clear and enforceable than those relating to poor safety conditions and resulting injuries, the cultural issues linked to work-related health are arguably even more important than those affecting workplace safety.

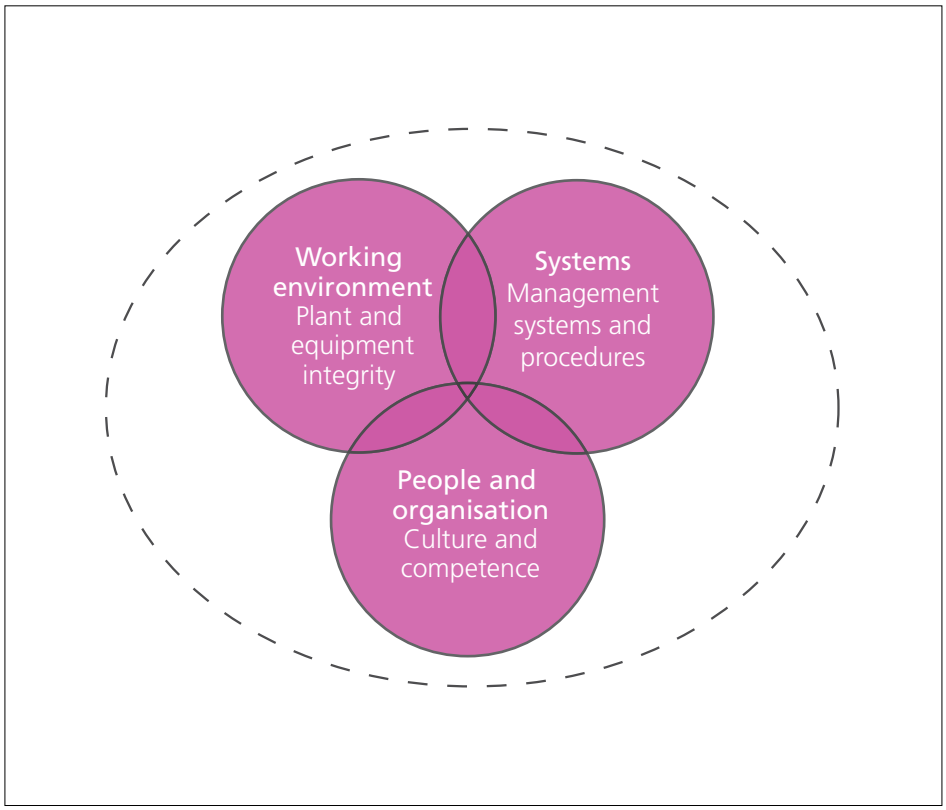

Figure 1: Health and safety risk management: managing the risks associated with interactions between the working environment, the management systems, the organisation and its people

2 Towards a positive health and safety culture

A culture is a way of doing things that is shared, taught or copied. Everyone in a particular culture tends to do things in a similar way, which they would consider to be the norm. Therefore, an organisation's safety culture consists of its shared working practices, its tendency to accept or tolerate risk, how it controls hazards and how it deals with accidents and near misses.[3,4] Safety culture can also be described as a combination of how people feel about safety (the safety climate), what they actually do and the policies and procedures the organisation has.[5]

A positive safety culture has three key elements:[6]

- working practices and rules for effectively controlling hazards
- a positive attitude towards risk management and compliance with the control processes
- the capacity to learn from accidents, near misses and safety performance indicators and bring about continual improvement.

An organisation can develop standard safe working practices that comply with the law and best practice. It can also create a positive attitude to compliance by making sure that senior managers lead from the front on this. But for these two elements to work effectively, the organisation needs to learn from what's happening in the workplace. Only by being aware of and analysing accidents and near misses is it possible to develop suitable improvements to safe working practices.

Organisations also need credible and honest safety inspections and reports so that managers know where they need to concentrate their efforts. It's important to include near misses in this analysis, as many organisations have levels of reported injuries and ill health that are too low to be used as a basis for an improvement plan.

A prerequisite for a positive safety culture is good information. In order for the information to flow, the workforce needs to be willing to participate and be prepared to report their mistakes, near misses and accidents.

This willingness will depend on how the organisation investigates incidents and how it handles blame. A blame culture – one that looks to blame and punish people when things go wrong – will encourage very little reporting. On the other hand, a completely no-blame culture – one that allows all mistakes or errors to go unpunished, including those that are reckless or negligent – is not really feasible either, and probably won't be acceptable to the organisation or to individual workers.

Therefore, the best safety culture will be based on a fair allocation of responsibility.[7] In this kind of culture, all but the most reckless health and safety failures can be reported without fear of retribution. You should encourage or even reward reporting. For this to happen, you'll need to draw a clear line between acceptable and unacceptable, reckless behaviour. It's important that if you do have to attribute blame, this doesn't undermine the reporting culture. In order to be transparent about attributing blame, some organisations use a substitution test[8] to help decide whether an incident was due to unacceptable or reckless behaviour.

In a substitution test, a small group of employees who weren't involved in the incident are given information about the incident and what led up to it, and are asked to discuss it. If this group of people decide that they'd have done the same as the person involved in the incident, this may indicate that it's not appropriate to allocate blame. It may be better to look at redesigning a process or giving staff more training. On the other hand, if the test group decides that they'd have done things differently, you may need to consider whether what happened was a deliberate or negligent act, and whether some sort of blame or punishment is appropriate.

One way of identifying where you may need to improve your organisation's health and safety culture is to assess your current safety climate.* Safety climate surveys describe an organisation's culture using factors such as:

- the degree of leadership in health and safety and the commitment to healthy and safe working that is demonstrated by senior managers (eg visibility and close contact with the 'shop floor')
- how much employees know and communicate about health and safety, how committed they are, and how reliably they attend health and safety training sessions
- the extent to which different levels of the workforce are involved in the health and safety improvement process
- the responsibility which employees show for their own and other people's health and safety
- the degree of tolerance of risk-taking behaviour
- how well good health and safety performance is measured and reinforced
- the arrangements for periodic reviews of health and safety culture and for implementing improvement plans.

* The distinction between 'climate' and 'culture' is significant. The former embraces perceptions, attitudes and beliefs about risk and safety, is typically measured using questionnaires, and provides a 'snapshot' of the current state of safety. The latter is more complex and long-lasting, and reflects more fundamental values.[9]

By looking at these factors, it's possible to build a picture of an organisation and understand how it can improve its health and safety culture.

You can also judge health and safety climate by using questionnaires.[10] Where possible, you should use this kind of self-reported information alongside observations of behaviour and data gathered in workshops and focus groups, as these provide the richer picture which is needed to understand the underlying reasons behind behaviours. You can then use the outputs of these assessments to:

- raise awareness of health and safety
- judge the organisation's current attitudes towards health and safety
- pinpoint areas that need attention
- assess whether the organisation is ready for a behavioural safety programme
- provide a baseline that you can measure progress against.

Safety climate surveys have been carried out in a number of industries, including offshore[11] and nuclear.[12] The UK government has produced a generic Health and Safety Climate Survey Tool.[13]

If you're planning to assess your organisation's safety culture, you should also always ask the opinion of the employees.[12] The action plan that follows can be focused on organisational changes, training programmes or behavioural safety, and the survey will help organisations to target resources where they are needed (see case studies on pages 06, 07, 09 and 10).

Health and safety culture change is not achieved quickly, and plans to improve an existing culture should take into account that it will have evolved over a long period. A culture change programme is also very unlikely to succeed unless senior managers are committed to leading the change. If you try to change a culture too quickly, you may just generate resistance to it. It's true that the direction of a culture often comes from senior managers, but it's important not to overlook influential people on the 'shop floor'. These can be key people to engage in improving a safety culture. You might even be able to persuade them to become safety champions.

An important ingredient of plans to promote a positive health and safety culture is 'organisational learning' – the process of involving staff who learn to change their ways of thinking and acting as a result of sharing experience and addressing shared problems. Mutual trust and confidence between managers and workers are needed for a strong health and safety culture to develop, and it's vital that managers at all levels accept that health and safety is a line management responsibility.

A review of behaviour modification programmes has shown that change programmes which succeed at one location can fail at another.[15] The factors that increase or decrease the chance of success have been identified and can be linked to the existing culture of the organisation. There's a 'maturity' model for culture[16] that can help you choose and implement the right behavioural interventions for your organisation. Figure 2 shows the five stages of this model.

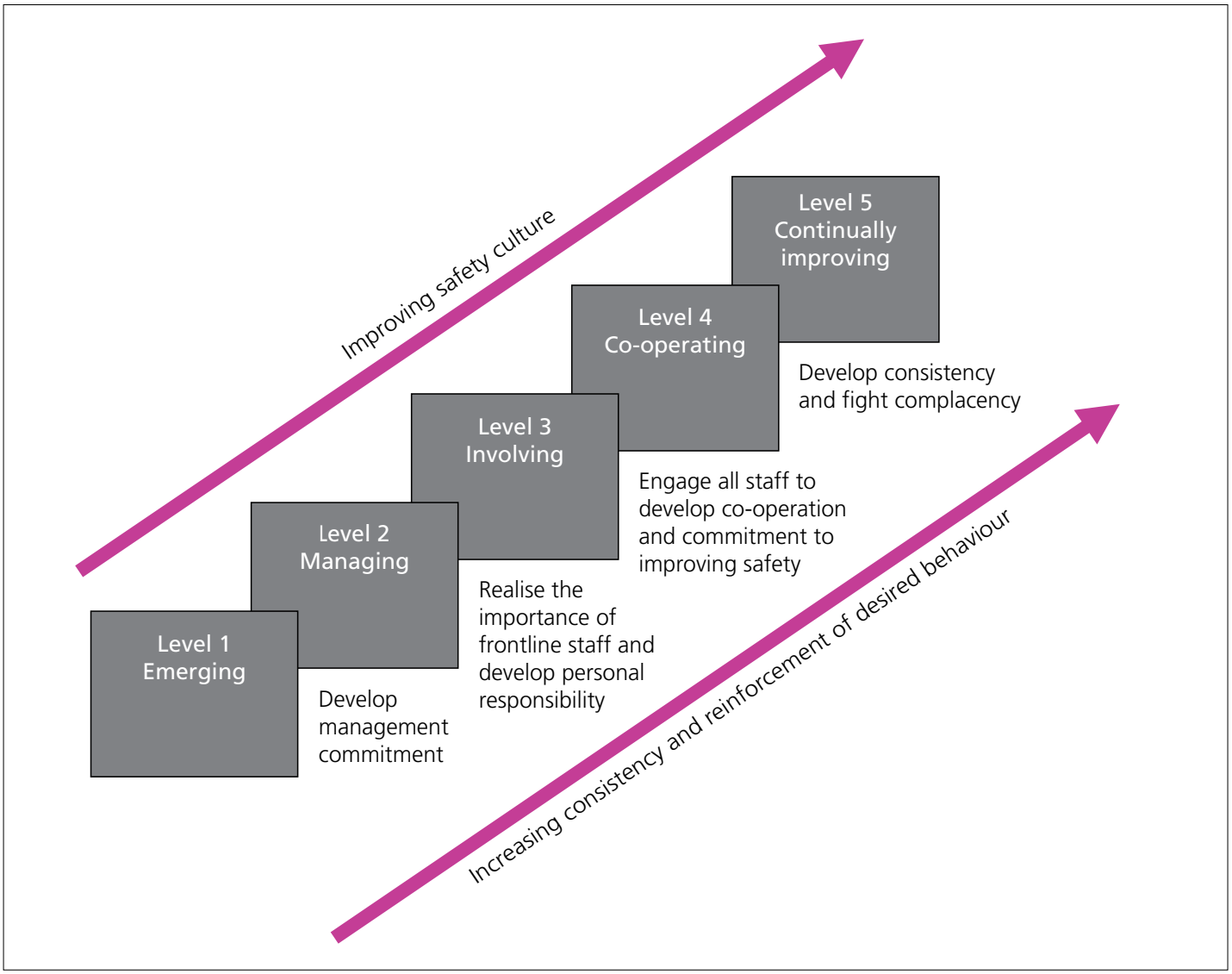

Figure 2: Safety Culture Maturity® model. © The Keil Centre 2001
Safety Culture Maturity is a registered trademark of The Keil Centre Ltd

Case study 1

Using the Health and Safety Climate Survey Tool

The Health and Safety Executive (HSE) contacted three organisations that had used its generic Health and Safety Climate Survey Tool (CST) to obtain feedback. A nuclear fuels manufacturer reported that, in order to obtain a higher response rate, it had:

- programmed the work to make sure the schedule was achievable and it could report the results quickly
- publicised what it was doing and why, and set targets for response rates
- encouraged employees to complete the survey in work time and sent a letter with the CST reminding employees why it was being used
- guaranteed that responses would be treated anonymously and individual respondents wouldn't be identified
- gave respondents envelopes addressed to the contractor carrying out the data analysis, again to ensure anonymity
- created safety events to reinforce the reason for the CST and issued the survey immediately afterwards.

The company reported that the CST was extremely helpful in identifying gaps in health and safety arrangements and/or risk control, and that it had responded to these.

For example, the company:

- devised a training programme for supervisors after the CST showed that they weren't clear about their role in health and safety issues
- established teams to review instructions and procedures after the CST helped to identify that these were too technical and not appropriate. Work teams participated in safety-related activities and a sense of pride was created when simplified procedures were accepted and used as a template across the site. These teams also perceived managers as being committed to working together to improve safety and also that action was being taken as a result of the CST
- set up a site-wide 'learning from experience' database, which helped to communicate lessons learned from near misses or other safety-related activities
- committed itself to continuing to respond to issues raised by the CST
- reviewed the near-miss reporting system to ensure consistency across the site. The new system encouraged employees to report near misses in a 'no-blame' context and to take action as a result. Near misses are now regularly discussed at safety improvement team meetings.

Source: Evaluating the effectiveness of the Health and Safety Executive's Health and Safety Climate Survey Tool[17]

Case study 2

CHEP – a win–win situation

CHEP is the global leader in pallet and container pooling solutions, operating in 46 countries. It handles over 3 million equipment movements every day, and serves 345,000 customers. CHEP offers pallet and container supply chain logistics for the consumer goods, fresh produce, meat, home improvement, beverage, raw materials, petrochemical and automotive industries. Across Europe, it employs 2,800 people, with 1,500 in 12 sites in the UK and Ireland.

Around six years ago, CHEP UK's approach to health and safety in a sector heavily dependent on manual work was less formal. As Hugh Kempton, Health and Safety Manager at CHEP and an IOSH member, explains: "We thought we were doing OK, but when we benchmarked the company against others in the industry we realised that we shouldn't be complacent." Lost-time incidents were running at about 30 a year, and near-miss reporting wasn't even on the radar.

The starting point for CHEP UK was an initiative introduced by its Australian parent company, Brambles, known as the 'Zero harm journey'. The challenge was to turn the scheme into a practical, workable tool for European operations.

The company quickly realised that the new initiative had to genuinely involve workers on the ground if it was to be successful. It was also important to make it clear that the initiative was here to stay, and that it wasn't just a 'flash in the pan'.

The team started by focusing on frontline statistics – lost-time incidents. Hugh and his colleagues introduced a new standard operating procedure across all European sites and worked hard to make sure that all incidents were reviewed, and that the root causes were identified, with clear close-outs. Before the new scheme was launched, the company had a tendency to accept incidents at face value, but under the 'Zero harm' regime, each one was investigated properly and where things didn't seem right, they were challenged. One side effect was that 'mischievous claims' were brought firmly under control. In five years, lost-time incidents in UK and Ireland operations went from an average 30 a year to just one a year.

The team turned its attention to the next level down, in terms of severity: 'modified duty' and 'medical treatment' incidents. This was followed by a new action plan for near misses. Five years ago, reported near misses were at zero. Now they are in the thousands, not because more are happening, but because operational teams understand that by reporting what's happened, they can help managers to help them prevent things going wrong again.

Better communication was vital too. Sharing information on incidents, close-outs and corrective actions across Europe meant that improvements came thick and fast. The attitude was, plant to plant, 'This won't happen on my patch.'

The programme has seen culture improvements across the board. Absenteeism at the company was above the industry average, at between 5.5 and 7 per cent. Now it's around 2 per cent. This alone has delivered obvious savings, with a cut in the bill for drafting in temporary workers to cover absent staff. Motivation is far healthier too. Earlier this year, CHEP introduced 'kaizen', the Japanese continuous improvement philosophy, and has seen thousands of ideas coming in.

Hugh Kempton puts the initiative's success down to consistent controls, and changing the culture gradually, taking things one step at a time and making sure that new developments are bedded in before moving on to the next one. "Great buy-in at shop floor level is essential, as is senior support. Our Vice-President at the time completely supported the programme and banged the drum at European level. He took away the barriers."

Hugh Kempton estimates that cash savings have run well into hundreds of thousands of pounds. The initiative has had a positive impact on areas beyond health and safety, including "massively improved" retention, motivation, productivity and quality. The cost of implementing the programme has been minimal – there was no budget allocated, with the team expected to finance it from plant operations budgets.

Source: IOSH Li£e Savings campaign – www.iosh.co.uk/lifesavings

The maturity model mentioned above can be combined with the principles of total quality management to build a safety culture change process (see Figure 3), based on:

- assessing the current level of maturity
- developing a plan to move to the next level
- implementing the plan
- monitoring the implementation
- re-assessing the level of maturity to evaluate success and identify more actions.

Information from health and safety climate surveys and structured interviews can be used to identify the current level of health and safety maturity, and can then help in choosing an appropriate intervention, such as a health and safety leadership or behaviour modification programme. There's guidance on appropriate interventions in 'Changing minds',[18] along with learning points from several behavioural initiatives.

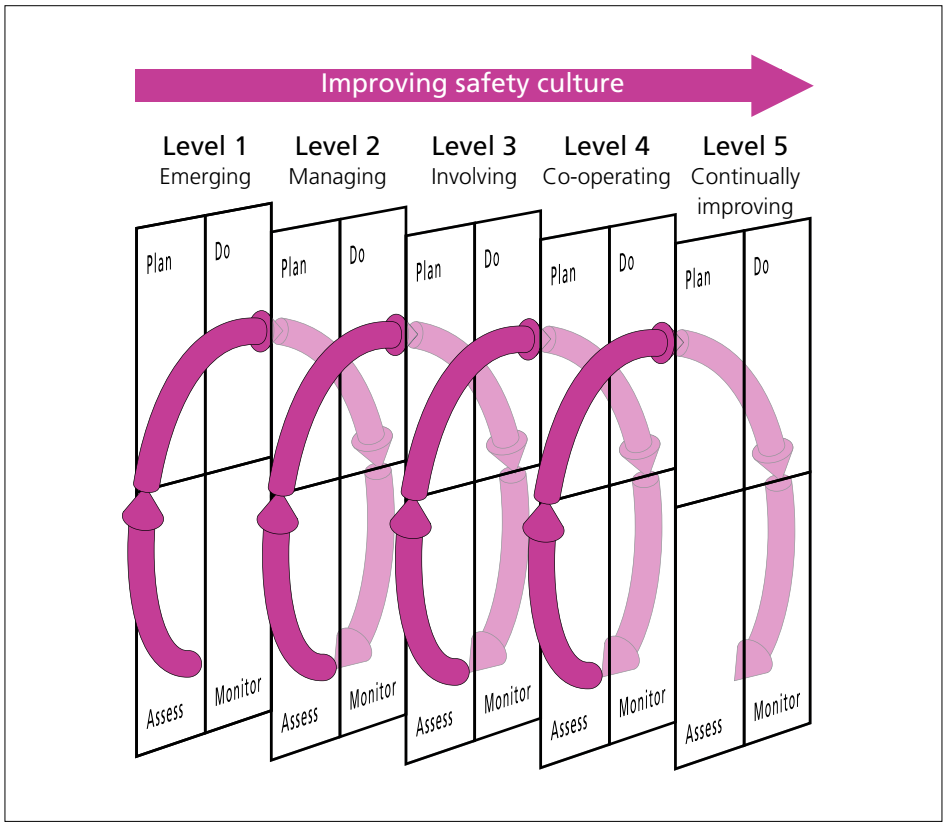

Figure 3: Safety culture change process
Source: Changing minds[18]

3 IOSH guidance

IOSH believes that health and safety professionals need to recognise that a good health and safety culture is an important part of improving the health and safety performance of the organisations they advise. They also need to appreciate the characteristics and benefits of a sound health and safety culture (see case studies on pages 06, 07, 10 and below). Establishing open reporting of incidents, near misses and concerns, coupled with the concept of 'fair blame', is crucial to achieving a positive culture.

Regularly measuring the health and safety climate of your organisation can yield useful results, allowing you to target resources appropriately. Such climate surveys aren't a substitute for other performance measures and audits, but are a useful complement.

IOSH recommends that employers should:

- find out what their managers and employees actually believe about health and safety, and make clear what's expected of them in terms of health and safety values, beliefs, attitudes and practices
- consider the most appropriate interventions to address any differences between expectations and reality in the organisation's health and safety culture. Organisations need to find the right balance between decree, prescription, 'organisational learning' and joint goal-setting, as well as acknowledging the time that it's likely to take to achieve measurable and permanent change in the health and safety culture
- take account of the influence of health and safety cultural factors when assessing the effectiveness of their health and safety management arrangements.[19] This is particularly important when auditing formal health and safety management systems – the system may look robust on paper, but it's what actually happens in practice that determines health and safety results.[20]

Case study 3

Partnership working to improve health and safety culture

In a drive to reduce the number of workplace injuries, illnesses and unsafe behaviours, a gas utilities group incorporated its health and safety strategy into the overall business management plan. As well as establishing a 'partnership approach' involving employees and safety representatives, the company:

- updated staff each month on issues and improvements using photos and videos
- made sure that a manager and safety representative investigated lost-time injuries on the day of the incident, and that any lessons learned were quickly communicated to staff
- defined the role and responsibilities of line managers and supported them through a staff performance review process and safety management training
- set up a hotline for staff to make it easier for them to report incidents and hazards
- included health and safety on the agenda of all management meetings, and held frequent meetings between safety advisers, safety representatives and managers
- involved safety representatives in joint meetings, communications, training, investigations and inspections
- made sure that directors supported the scheme through good communication, attending management meetings and meeting staff members.

Major expenses invested in the process included £2.5 million for a 'safety charity challenge', where donations were made to charity when employees spotted and eliminated workplace hazards. The company also spent £600,000 on safety management and behaviour training. As a result, the company saw:

- an improved safety culture – including ownership at all levels, with commitment and competence to improve
- a reduction in accidents, incidents and injuries of over 80 per cent; lost-time injuries reduced from 35.5 per 1,000 staff to 6.6 over five years
- improved incident investigation and procedures to help prevent incidents happening again
- increased reporting and resolution of hazards and near misses
- a saving of around £4.5 million over four years through reduced lost-time injury rates, including costs from lost production, investigation and civil claims
- staff develop their health and safety leadership skills, which are transferable to other business performance areas
- a boost to staff morale and pride as a result of acknowledging their performance
- an improved reputation with stakeholders.

Source: HSE case study – www.hse.gov.uk/business/casestudy/transco.htm

Case study 4

Health and safety training and communicating information

A company in the electricity, gas and water industry described how it was training managers through 'Safe and unsafe act' (SUSA) discussions, facilitated by external consultants. One health and safety manager outlined how training line managers was backed up by basic behavioural safety training for staff:

"All our managers are trained in the SUSA technique now… But we're also putting every single one of our operators through a mini-SUSA… as well, so they can start to understand what… the manager is talking about when he's got this little blue book out and he starts to talk to them."

Another organisation also reported employing outside consultants. This company wanted external help to introduce a behavioural safety approach as a way to change culture. A senior manager from a construction company said:

"We're dealing with a company at the moment… and they have a different approach to health and safety. Rather than a policing aspect, it is changing culture, where they've done a lot of work on oil rigs, and had a lot of success where if something has gone wrong, you go out and meet people on the job and rather than giving them a bashing if they're doing something wrong, finding out why they're doing wrong. It's basically a different approach, so we're actively dealing with [outside consultants] at the moment, who are specialists in that sort of field. So it's culture-based, trying to get a step change in culture."

A different approach to behavioural safety was demonstrated by a medium-sized manufacturing company. This example highlights how a focus on behavioural safety techniques doesn't necessarily require expensive external consultants. The company described its process of staff observation by in-house assessors – trained in behavioural safety – to identify 'unsafe behaviours' before they become 'unsafe acts':

"We've been running the behavioural safety process now since 2000… The reason why is that our health and safety performance went through a little bit of a shaky patch for a year or two and we realised that you can have procedures and systems but you also need to be doing other things. And the processes are very proactive – you're actually watching people doing jobs and giving feedback. So, you're watching them do things before there's any chance of getting hurt, really. If you think about accident investigation and near-miss reporting, they're things that you do after the event. The observations of behaviour are while people are doing tasks normally."

Source: The impact of health and safety management on organisations and their staff[21]

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