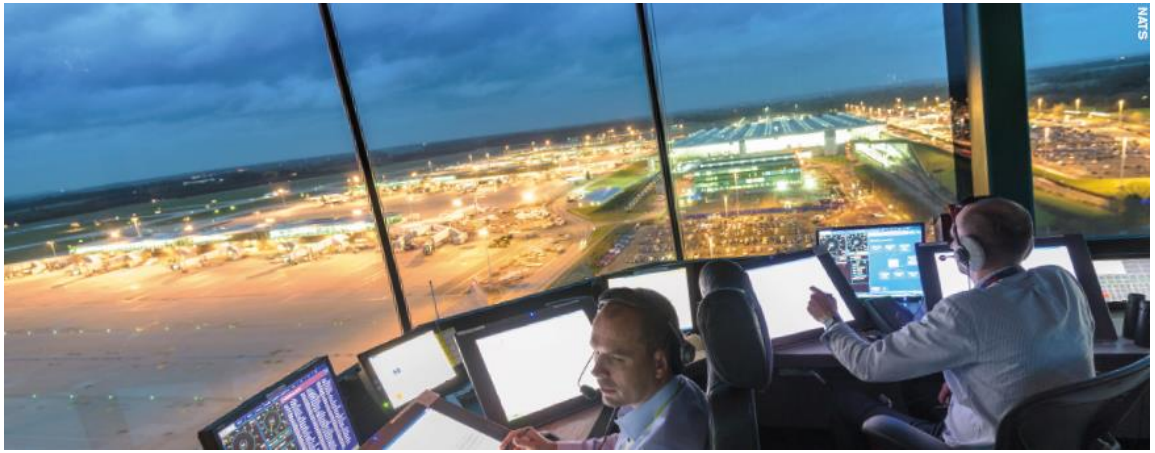
SMS Interfaces - A Human Factors Perspective

Achieving Peak Safety Performance: Listening and Learning



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Introduction

Organisations need to be confident that they are hearing all the safety concerns and observations of their workforce.

They also need the assurance they are learning and improving.

The RAeS Human Factors Group: Engineering set out to find a way to check if organisations are truly *listening and learning*.

This presentation looks at that work *and* its applicability to looking at the interfaces between organisations.

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Credit

The HFG:E project team consisted of:

- Stephen Bramfitt-Reid (Rolls-Royce)
- Colleen Butler (Health and Safety Laboratory)
- Andy Evans (Aerossurance)
- Doug Owen (The Schumacher Institute)
- Tania Wilson (Virgin Atlantic Airways)

All work in the public domain:

- *Aerospace* March 2017 (p26-29)
- https://www.aerosociety.com/news/achieving-peak-safety-performance-listening-and-learning/

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What We *Could* Have Done

We *could* have designed an audit or survey. Downsides:

- **These tend to look for compliance with pre-conceived practices**
- **They don't tend to encourage innovation**
- **They tend to focus on processes and procedures**

Plus they encourage senior executives to rely *on others* to assess *their* organisation.

We *could* have concentrated on performance indicators and data gathering. Downsides:

- **Common, consistent SPIs often very high level**
- **The quantitative doesn't address the qualitative well**

Being More Human Centred

Our approach:

- **10 performance based questions for self-reflection**
- **Backed by 42 ‘considerations’ for guidance**

Q2 How does your organisation react to ‘bad news’?

A strong safety culture is one in which everyone, especially senior executives, are ready and willing to hear bad news. In such an organisation no one denies an ugly or inconvenient truth, shoots the messenger or mistrusts the reporter's intent. Stay open minded and non-judgemental, listen for understanding and opportunities for improvement. Consider:

- Do you welcome bad news as an opportunity to improve or as a way to identify who is at fault?
- Do managers go to see for themselves and talk to the right people before acting?
- Are managers open and inquisitive, willing to listen, learn and change?
- In your organisation, is it normal to aspire to be a leader that nurtures, enhances, enables and empowers?

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Three Themes

1. **Identifying warning signs *and* opportunities**
2. **Analysing those signs and suggestions**
3. **Taking action:**
    - **Learning,**
    - **Improving and**
    - **Leadership**

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Interfaces with Other Organisations or "Partners"

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Identifying Warning Signs and Opportunities

Q1 How do you know that employees are confident to confide their concerns, report occurrences, reveal human performance issues and suggest improvements

Are *your partners* confident to confide in you? Is your organisation trusted? Evidence?

See also Q2…

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Identifying Warning Signs and Opportunities

Q2 How does your organisation react to ‘bad news’?

Do you automatically do ‘special’ audits?

Will a contract extension be less likely?

Do you terminate contracts?

Or do you recognise honesty and trust as essential for a long-term relationship?

Identifying Warning Signs and Opportunities

Q3 How do you ensure that it is easy for employees to raise concerns, report occurrences, reveal human performance issues and suggest improvements?

How do you know *your partners* people are able to do these too and does this get to you?

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Analysing the Significance of Warning Signs and Suggestions

Q4 How do you ensure that your organisation appropriately analyses its safety data?

Is relevant data from *your partners* considered?

Do you appropriately share data?

Analysing the Significance of Warning Signs and Suggestions

Q5 How deeply does your organisation consider what prevented ‘near-misses’ from becoming accidents?

Are relevant ‘near misses’ involving *your partners* considered too?

When they occur at an interface do you look at them jointly and constructively?

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Analysing the Significance of Warning Signs and Suggestions

Q6 How can your organisation get more safety insight out of the corporate data it collects?

Can you get more insight by sharing data?

Do you make the most of the data you do get?

Do you jointly analyse the data with *your partners*?

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Analysing the Significance of Warning Signs and Suggestions

Q7 How well do you monitor your top risks with Safety Performance Indicators (SPIs)?

Are you using data from *your partners* in your SPIs?

Do you benchmark your SPIs with *your partners*?

Do your SPIs give good early warning on issues with *your partners*?

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Analysing the Significance of Warning Signs and Suggestions

Q8 How confident are you that your organisation has accurately identified your top risks?

How confident are you that *your partners* have accurately identified *their* top risks?

How do those affect you?

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Taking Action: Learning, Improving and Leadership

Q9 How do you ensure learning and improvement is achieved across your organisation?

And does that learning and improvement happen with *your partners* too?

Are you truly collaborative on safety?

Or do you see that as sensitive IPR?

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Taking Action: Learning, Improving and Leadership

Q10 How can you behave to clearly demonstrate you are an authentic safety leader who promotes trust in your organisation?

…and with *your partners*?

Do you encourage *your partners* to develop their safety leadership skills?

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Conclusion

The RAeS HFG:E believe that reflecting on these 10 questions will:

- **Give insight on becoming better at listening and learning**
- **Enhance your safety performance.**

We recommend revisiting the 10 questions periodically on your journey to peak safety performance.

It's vital to remain constantly vigilant of the reality across your organisation and *your partners*.

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Questions

Achieving peak safety performance: listening and learning

Organisations need to be confident that they are hearing all the safety concerns and observations of their workforce. They also need the assurance that their safety decisions are being actioned. The RAeS **HUMAN FACTORS GROUP: ENGINEERING (HFG:E)**[1] set out to find out a way to check if organisations are truly listening and learning.

Accountable managers and senior executives are increasingly reliant on their organisation's Safety Management System (SMS) to help them make sound safety decisions and to implement their decisions. As part of a move to Performance Based Regulation (PBR), the UK Civil Aviation Authority now also has 'conversations' with accountable managers on their organisation's risks and safety performance.

Organisations that aspire to peak safety performance need a heightened awareness of two things: the warning signs of impending threats and their opportunities to improve. They need a reliable organisational ability to 'listen' for warning signs and opportunities, analyse their significance, learn and crucially, to promptly act on that learning. To do this effectively they must engage everyone in their organisation, meaning that effective leadership is vital too.

[1] The HFGE project team consisted of Stephen Bearfield-Ritt (Rolls-Royce), Colleen Butler (Health and Safety Laboratory), Andy Evans (Aerossurance), Doug Owen (The Schumacher Institute) and Tania Wilson (Virgin Atlantic Airways).

They say 'safety is no accident' but, as commercial aviation accidents become rarer, having had no recent accidents does not mean an organisation is 'safe'. So how can accountable managers and senior executives prove to themselves that they have listening and learning organisations? The RAeS HFG:E set out to answer this question.

The traditional approach would have been to deconstruct the components of ideal SMS (typically from a regulatory requirement or an industry standard for SMS), create a checklist and do an audit. During that audit one might even grade the maturity of the components as present, suitable, operating and effective (for example). While this conventional approach has value, it also has three limitations. Firstly, it is structured around compliance with pre-determined practices. Secondly, it doesn't actively encourage innovatively creating future best practices. Thirdly it focuses on processes and procedures yet, as highlighted in the Haddon-Cave Nimrod Review, people make safety, not just processes and paper.

Are you getting a true picture of your organisation's operations and threats? Do your people trust the reporting and investigation processes, enabling them to be open and honest? Are they motivated to continually suggest improvements? Consider:

- How much time do your managers and supervisors spend with their people, talking about safety and encouraging a dialogue?
- How do you know that your people understand their responsibility for safety?
- How do you show you are committed to a just culture and how confident are you that this commitment is understood by your people?
- How well do you maintain trust through your investigation process? Are your HR policies and processes aligned with your safety policy? Are investigations primarily aimed at systemic improvement?
- Does your SMS capture the general feeling of your people on safety matters?

> THEY SAY 'SAFETY IS NO ACCIDENT' BUT, AS COMMERCIAL AVIATION ACCIDE… BECOM… HAVING … NO RECENT ACCIDENTS DOES NOT MEAN AN ORGANISATION IS 'SAFE'

The RAeS HFG took a different approach. They chose to develop ten performance-based questions, organised in three themes, to prompt reflective thought. As well as self-reflection, they can be used as discussion topics in safety meetings and workshops, or as part of safety leadership coaching.

Identifying the warning signs and opportunities:

Q1 How do you know that employees are confident to confide their concerns, report occurrences, reveal human performance issues and suggest improvements?

Q2 How does your organisation react to 'bad news'?

A strong safety culture is one in which everyone, especially senior executives, are ready and willing to hear bad news. In such an organisation no one denies an ugly or inconvenient truth, shoots the messenger or mistrusts the reporter's intent. Stay open-minded and non-judgemental, listen for understanding and opportunities for improvement. Consider:

- Do you welcome bad news as an opportunity to improve or as a way to identify who is at fault?
- Do managers go to see for themselves and talk to the right people before acting?

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