PRIME
Platform of Rail Infrastructure Managers in Europe

Safety Culture Sub-group 17th November 2016

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On behalf of sub-group chair

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Safety culture sub-group

Given 3 actions:

1) What could be used to measure safety culture across Europe?

These should deliver both measurement and if developed an improved safety culture

Proposal to use:

- Safety conversations- and how they improve decision making
- Safety learning from incidents and close calls

2) Tools to develop safety culture

3) Share experiences and best practise on how to develop safety culture (delivered through twinning)

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Draft maturity measures for safety conversations

Model for safety conversations

Result of discussion in PRIME subgroup June 2016. To be used to measure the maturity level of the organizations taking part in the twinning program

Culture maturity	Level 1: pathological	Level 2: reactive	Level 3: calculative	Level 4: proactive	Level 5: generative
Learning	Little/none	Basic	Regular, organized	Continuous, standard	In the DNA
Process	None	Unstructured	Structured, organized by safety staff	Structured, with more flexibility	Less structure needed, conversations led by everyone
Leadership on safety conversations	Not visible. Other things go first	Involvement after an incident. For the sake of the process. Focus on what went wrong. Closed/one way communication - no questions	Planned and fixed involvement. Focus on what others can learn. Instrumental approach	Real engagement. Actively checking what is learned, sharing lessons learned in teams. More challenging.	Also focus on own learning. Use of story telling to motivate others. Sharing lessons learned industry wide
Leaders...	*"give no priority"*	*"must do"*	*"want to"*	*"lead"*	*"inspire"*
Who performs conversations?	Nobody/unclear	Manager-worker	Staff-manager Manager-worker	Everybody, in all processes related to safety	Everybody, also across company borders
Measurement of safety conversations	Poor/none	Unstructured, main focus on quantity	Organized, system in place. Use of checklists: "have you done it?". Focus on quantity	Organized, focus on quality: "have you done the right things?". Also checking follow-up	Less measurement, more trust: learning is in the DNA

Draft Model for learning from investigations/close calls

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Colu	Level 1 : pathological	Level 2 :Reactive	Level 3: Calculative	Level 4: Proactive	Level 5: Generative
Learning	Investigations discover obvious cause only. Serious accidents blamed on individuals no root cause analysis	Education of system not outputs Outputs rareky used for safety improvement. Learning only as a reaction to problems	Learning from close calls doesn't drive improvement. Discipline most likely outcome	Starting to adopt a risk based approach. Starting to look at organisational failure. Root cause analysis. Trends and themes captured	Close calls are mainly around behaviours- close call challenges
Process	No close call in place. Investigations reactive	Targets for reporting quantitative on. Just starting to promote reporting Close call as a paper ssytem	No managed process for close call.	System available and feedback provided. Still some staff suspicion about value of system. Quality data not just quantity. Feedback regular and asked for by reporter. System understood and used. Tics and wider industry involved too	Close calls used to improve processes and reduce risk
Leadership	Focus on commercial safety. No consistency of approach or consequences Leaders interested in safety when it affects peformacne	Leaders need development to champion close calls	No feedback to staff who report. Reactive learning	Management interest in close calls. Engaged and use data for their decision making. Investigations inclusive. Monitoring of interventions	Culture of trust and confidence on system
	No priority	Must do	Want to do	Lead	inspire
Who owns	External regulatory pressure to investigate incidents/close calls	Owned by safety professionals- little reportingin the busienss. Investigations only by safety team. Someone else shold fix issues	Limited SL understanding or support. Only owned by safety team. Unsafe conditions are for someone else to fix	Close calls owned by board. All starting to use a risk-based approach- reporting unsafe conditions and acts. Behaviour of others and self regularly close called. Awareness of information from close calls high throughout business. Process owned locally. Fair culture truly in place	Owned by everyone- proud to be part of it- safe behaviour part of company DNA
Measurement	Reporting as a tick box. Different measurement across business	Numbers driven by quantity not quality	Low levels of reporting- staff don't value it. Investigations still focus on front-line	KPIs on close call exist. Investigations look at control measures including human error. Leading KPIs for close calls. Equal emphasis on high risk close calls as on incidents	Open data sharing in industry. Fewer close calls as unsafe behaviour not tolerated

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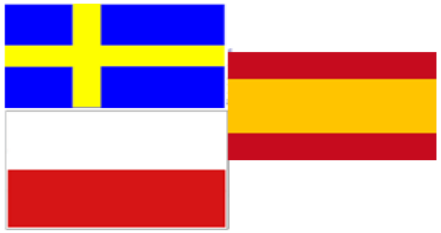
Twinning- funded by European Commission

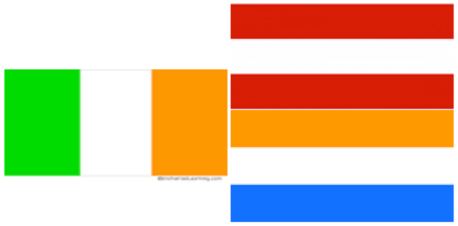
12 European countries involved- each visiting and receiving at least one country

Group One: Network Rail (UK), CFR (Romania), Infrabel (Belgium) and HZI (Croatia)

Group Four: RFI (Italy) and SNCF (France)



Group Two: Trafikverket (Sweden), PLK (Poland) and ADIF (Spain)



Group Three: Netherlands (Prorail), OBB (Austria) and Irish Rail (Ireland)

Post visit reports

Learning shared at a conference at end on twinning year

Draft outline of a visit

Focus area	Possible questions
Senior leaders	**How do senior leaders impact, enable or block safety- how do they role** model safety **behaviour?**
Data	**How is data used to enable understanding of safety and to help manage safety culture?**
Investigations and learning	**What processes are in place to make investigations about learning and improvement? Is there a fair/just culture process or equivalent?**
Front-line staff	**How are front-line staff involved and engaged with safety? How effective and the safety processes and procedures at front-line?**
Industry partners	**What processes are in place to make investigations about learning and improvement? Is there a fair/just culture process or equivalent?**
Others	**These might include training departments within the organisation, Human-resources, cross-industry competency management (eg sentinel), National investigation body**

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Chairing the safety culture sub-group

Network Rail UK

ProRail Netherlands

The main focus of the work of the PRIME sub-group for safety culture for 2017 will be the delivery of the safety twinning programme and the trailing of the draft maturity measures within the visits. Network Rail is the coordinator for the twinning consortium and therefore as any other chair would be nominal due to twinning focus for work it has been agreed to change chair AFTER the twinning is complete.

PRORAIL will take over the chair at this point