PRIME

Platform of Rail Infrastructure Managers in Europe

Safety Culture subgroup update

June 2017

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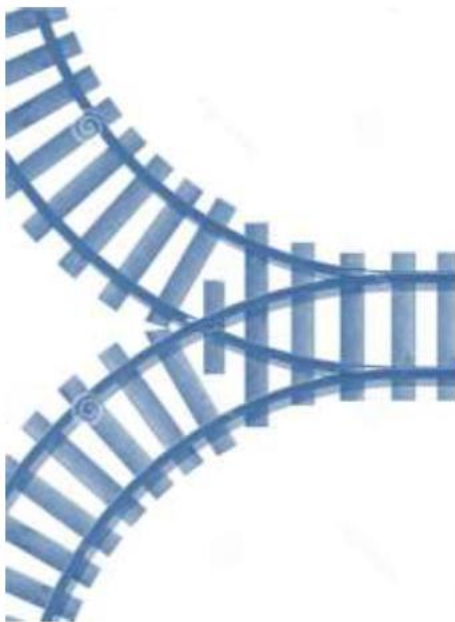
Network Rail



TWINNING PROGRAMME

'Enhancing the cooperation between Railway Infrastructure Managers for better safety management'

Twinning visits

Group	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct
1: CFR; Network rail, Infrabel, HZI			CFR to NR	NR to CFR	NR to Infrabel				
			Infrabel to NR	HZI to Infrabel					
			CFR to HZI						
2: Trafikverket, PLK, ADIF				ADIF/PKL to Trafikverket				Trafikverket, ADIF to PLK	Trafikverket PLK to ADIF
3: RFI, SNCF		RFI to SNCF							
		SNCF to RFI							
4: OBB, ProRail, Irish Rail	OBB, ProRail to Irish Rail			Irish Rail, ProRail to OBB	Irish rail, OBB to ProRail				

Final conference December 2017

Learnings so far

The organisations feel that significant benefits will be derived from the exchange and acquisition of different approaches and best practice applied to the Safety Management System.

The cooperation between Belfour Beatty and Irish Rail is a role model for joint work in terms of safety

Learning from near misses starts with a simple/easy reporting system like an app (the main contractor in Ireland has this).

The safety department has a clear role in the safety culture,

Safety Culture KPIs-self score

Model for safety conversations

Result of discussion in PRIME subgroup June/November 2016. To be used for assessment of the maturity level of the organizations taking part in the twinning program

Maturity level	1	2	3	4	5
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"
Planning of safety conversation	None	Unplanned, ad hoc, on the spot	Structured planning by safety staff	Structured planning with more flexibility	Less explicit planning
Support – instructions/ training	No drive, no interest	Basic instructions for managers ("do that")	Competences defined, specific training in place	Part of company's competence management	People trained for open discussion
Support - documents	None	No fixed use of documents	Fixed checklists and procedures. Part of SMS	Toolkit available in SMS, flexible use - context based	Any document can be used, also outside SMS
Operation - who performs conversations?	Nobody/unclear	Manager-worker	Staff-manager Manager-worker	Everybody, in all processes related to safety	Everybody, also across company borders
Performance evaluation & improvement	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	No explicit measurement, more trust: learning is standard

Score 3.4

Twinning score

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Total: 4.1 – We consider that more detailed information is needed for a more realistic assessment

Safety Culture KPIs

Metric description		Level 1	Level 2	Level 3	Level 4:	Level 5:
The organisations ability/desire to proactively look and manage safety risk throughout the organisation	Learning	Risk managed only post serious incident Investigations discover obvious cause only- Often from regulators Serious accidents blamed on individuals no root cause analysis	Investigations of all safety incidents- Outputs rarely used for safety improvement. Learning only as a reaction to major problems	Initial reporting of safety issues pre accident but learning from close calls doesn't drive improvement. Numbers driven- information over-load and seen as an additional load rather than useful information	Starting to adopt a risk based approach. Starting to look at organisational failure. Root cause analysis. Trends and them[illegible] captured	Close call number have reduced because close calls are mainly around behaviours- close call challenges current thinking and planning at all levels in the organisation
The maturity of a system within the business to record, analyses and feedback information on reported safety issues through the business	Process	No close call in place. Investigations reactive	Reporting system available-Education on system use not outputs Targets for reporting quantitative only. Close calls only made by most staff through management instruction	Development of a process to support the learning from the system eg managers responsible in the busiess for review and close out of calls including feedback- howvere at this stage this is not fully effective. Close calls 'encouraged' by target setting	System available [illegible]d feedback provided. Still some st[illegible] suspicion about value of system[illegible] Some quality data not just quant[illegible]. Feedback regular and asked for by [illegible]porter. System understood and used. [illegible]ain operators and wider industry involved too	Close calls used to improve processes and reduce risk and information from close call shared and used for industry improvement. Close call information is owned by all business, front-line, corporate an leadership an thus impacts on decision making. reporters are part of the safety solutions.
The ownership of safety learning as indicated by business wide leadership of safety data collecting, analysis and learning for improvement	Leadership	Focus on commercial safety. Safety seen as a front-line issue only. No fair culture (or equivalent process) thus no consistency of approach or consequences Leaders interested in safety when it affects performance	Leaders need development to champion close calls- extra responsibility seen as an extra load. Rare Feedback to reporters. Main responsibility seen only at front-line leadership thus limiting systemic learning	A drive from management to do close calls but little support to use for improvement- target driven. Poor quality of feedback to staff who report. Close call made by all staff including senior leaders	Management [illegible]terest in close calls throughout the busine[illegible] Engaged and use data for their decisi[illegible] making. Investigations inclusive a[illegible] fair. Monitoring of interventions	Culture of trust and confidence of learning system which includes close calls system. Data used to understand issues, themes, and risks and all staff see safety as their responsibility to both report and resolve- leaders enable this by listening, questioning and demonstrating use of close calls in their decision making
		No priority	Must do	Want to do	Lead	Inspire
The driver to create and use a proactive learning/close call system	Who owns	External regulatory pressure to investigate incidents/close calls/near misses	Owned by safety professionals- little reporting in rest of the business. Investigations only by safety team. Someone else should fix issues	Senior leadership recognise a need to change and to look at safety reporting as a whole business process but see the accountability as that of the safety teams only. A process is created to record close call data in a wider context	Close calls owned by senior leadership/board. Data regularly interrogated in senior meetings. All startin[illegible] to use a risk- based approach- reporting unsafe conditions and acts. Behaviour of others and self regularly close called.	Owned by everyone- proud to be part of it- safe behaviour part of company DNA. Awareness of information from close calls high throughout business- with a desire to use it to create safety improvement. Process owned locally. Fair culture truly in place
The maturity of data analysis as part of a proactive learning/close call reporting system	Measurement	Measurement is many of accidents rather than near misses or pre-cursor data Reporting as a tick box- seen as an annoying and not valuable management requirement.	Some engagement with process but different measurement across business- and still seen as big numbers best- poor closure. Extra load on investigations seen as negative.	An increasing value experienced in availability of data and not just from m[illegible] targets. Local initi[illegible] demonstrate the [illegible] of reporting. Sharing across business from preventative learning is starting	KPIs on clos[illegible] include not just numbers but outcomes too. 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. Investigation of all safety risks increases both safety learning and improved safety ownership throughout the business.
The outcomes from reporting	Outcomes	No real outcomes	Lots of data	Some thematic data o[illegible] serious risks- some learning	Thematic and some pre-cursor data- understanding and mitigating of root causes	Predictive data used to prevent incidents- learning and few repeat incidents- all control safety risk

Score: 3.4

Twinning Score

Metric description		Level 1	Level 2	Level 3	Level 4:	Level 5:
The organisations ability/desire to proactively look and manage safety risk throughout the organisation	Learning	Risk managed only post serious incident Investigations discover obvious cause only-Often from regulators Serious accidents blamed on individuals no root cause analysis	Investigations of all safety incidents- Outputs rarely used for safety improvement. Learning only as a reaction to major problems	Initial reporting of safety issues pre accident but learning from close calls doesn't drive improvement. Numbers driven- information over-load and seen as an additional load rather than useful information	Starting to adopt a risk based approach. Starting to look at organisational failure. Root cause analysis. Trends and themes captured	Close call number have reduced because close calls are mainly around behaviours- close call challenges current thinking and planning at all levels in the organisation
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Total: 3.7 – We consider that more detailed information is needed for a more realistic assessment

Any Questions?