Business Leaders' Health & Safety Forum

ZERO HARM WORKPLACES

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Learning from success

Understanding why things go right can help CEOs build safe, healthy businesses

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www.zeroharm.org.nz

Safety-II – a radical new approach to leading health and safety

Traditionally, health and safety has been about eliminating unwanted outcomes, such as injuries, incidents, and illnesses.

This goal of ensuring a state where as few things as possible go wrong has been labelled Safety-I*.

Safety-I allows organisations two main avenues to improve health and safety:

- Learning from what has gone wrong – usually through accident investigations
- Constraining performance to prevent unwanted deviations – e.g. using risk assessments to determine the probability of things going wrong again.

To prevent accidents, organisations put in place or improve barriers that separate people and processes from danger.

People, with their autonomy and capacity for creativity, are from this perspective primarily seen as a liability or a hazard.

But Safety-I doesn't and can't explain why things go right most of the time.

This perspective also locks organisations into a reactive safety management mode, and a drive for ever-increasing compliance. As a consequence, organisations pursuing Safety-I are likely to generate a negative culture around safety, and create solutions in which people are seen as a problem to control.

*The concepts of Safety-I and Safety-II were created by Professor Emeritus Erik Hollnagel. See more about Erik at *www.erikhollnagel.com* or read his book *Safety and Safety II – The past and future of safety management*, Ashgate Publishing.

Harnessing the power of what goes right

To avoid creating a negative culture around safety, organisations can focus on enabling as many things as possible to go right. This perspective has been labelled Safety-II.

Safety-II not only changes the definition of safety, it changes how safety is understood and practised. While Safety-I focuses on managing constraints and deviations, Safety II encourages organisations to focus on understanding *what helps and hinders performance*.

Things go right because people adapt and adjust their performance to changes, inefficiencies, and surprises in the workplace. To enable more things to go right, organisations can invest in the capacity of people and processes to achieve desired outcomes.

People, with their capacity to adapt and learn, are in this perspective viewed as a critical resource for organisations to harness in order to both understand how work gets done, and so they can develop solutions to improve performance.

Need to understand how normal work happens

Safety-II requires an interest in how normal work occurs. That is, how tools, resources and strategies enable people to achieve outcomes across varying conditions – and the conditions and constraints that make this difficult.

From this perspective, organisations can learn and improve from any event/outcome, not just incidents and injuries.

When a Safety-II lens is applied to incident investigations the goal is to explain *how the process normally goes right*. This enables organisations to understand how the capacity to handle demands was limited, rather than focussing on seeking out the defences that failed.

Safety I vs Safety II

Safety I	Safety II
The system is safe	The system is not safe in itself
Accidents happen because of unsafe acts/rare deviations from plan	Accidents happen when resources are not enough to deal with the demands
Variability is a threat	Variability is inevitable
People are a liability	Only people can adapt, accommodate, absorb, and respond to emerging threats
Procedural compliance is mandatory	Success comes from people being able to adapt successfully
How can we change people?	How can people be supported to adapt successfully?

Safety-II – putting it into practice

3 steps CEOs can take to apply a Safety II approach in their businesses

1 Understand normal work

Don't wait for something bad to happen to learn and improve. Rather, try to understand what's actually happening when nothing out of the ordinary seems to take place.

Organisations can find out more about what helps and hinders performance by asking employees questions like:

- What day last month was work (performance) the best? What happened that day?
- Tell me about a time when your work was difficult?
- What are you most dependent on to be successful in your work? What happens when that resource isn't available in the way you need?
- If you had $50,000 (or other sum) to make this a better place to work, how would you invest it?

Organisations that use Safety-II practices integrate questions like these into various information gathering mechanisms, like focus groups, end of day debriefs, or executive site visits. Responses are analysed and fed into improvement programmes.

2 Dampen sources of variability

Equipped with information about sensitivities, dependencies and frustrations, organisations can invest in boosting resources and methods to better match conditions.

Examples of how organisations can dampen variability include:

- Reorganising stores to have more frequently used material closer to the checkout area
- Improving lighting so people can see rocks, signage and other vehicles on the road
- Having dedicated rest areas and making work areas more predictable
- Installing rain/shade covers to even out the effect of weather/ temperature
- Installing a barcode scanner to keep track of tools
- Some organisations have even developed measures of performance variability, e.g. measuring the ratio between planned and reactive work.

3 Increase capacity to handle variability

Some challenges can't be eliminated. Heavy things need to be lifted, and tedious and repetitive tasks need to be carried out over and over again. However, organisations can invest in the capacity to deal with variability by:

- Supporting the development of expertise and autonomy
- Having leaders and frontline employees co-generate solutions
- Making clear what resources are available for people if they need help
- Reducing unnecessary bureaucracy/ increasing clarity of purpose.

Some organisations have invested in site improvement teams to increase local capacity. These teams consist of 5 – 8 frontline employees who, together with a senior manager (not the direct supervisor), develop ideas and solutions that can improve their capacity to deliver. The ideas are analysed from a cost-benefit perspective and implemented after approval.

Other organisations have started decluttering initiatives, asking their employees:

- What is the most stupid thing you have to do around here?
- What procedures don't really support your work?

The take-outs

- Safety-II can be defined as a state in which as many things as possible go right.
- Translating Safety-II into practice requires organisations to understand the qualities of the activities that normally produce desired outcomes, across varying conditions.
- Equipped with this knowledge, organisations can invest to either dampen sources of variability (that make work difficult) or boost the capacity of people to deal with variability that can't be eliminated.

This booklet summarises a presentation given at the Forum's October 2016 CEO Summit by Daniel Hummerdal. Daniel is Director of Safety Innovation at Art of Work and is recognised as a leading safety thinker and practitioner. He is also the founder of *www.safetydifferently.com*.

Leaders make a difference

The Business Leaders' Health and Safety Forum inspires and supports its members to become more effective leaders of health and safety. The Forum has more than 290 members, who are CEOs or Managing Directors of significant New Zealand companies and companies operating in high risk environments.

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How leaders can learn from normal work – and use what they learn to improve performance

Many leaders conduct site visits where they talk directly to workers. These conversations can be an opportunity to learn what happens during a normal working day, and to use that information to ensure workers have what they need to succeed.

Why talk to workers about normal work?	How to do it	What to capture from the conversation	What to do with the information you get
• Things go right much more often than they go wrong • We miss huge learning and improvement opportunities by only focusing on incidents • Normal work provides a rich environment to learn from • By understanding normal work, we can better identify **what helps and hinders performance.**	When talking to workers remember to: • Be the learner not the expert • Be curious and open to new perspectives • Avoid *why* questions – they tend to make people defensive • Ask open questions that draw out a story. Listen for comments about how their work is helped or hindered by: • Equipment • Work conditions/environment • Strategy/procedures/processes • Training/capability.	**Good practice:** → Keep, spread and enhance. New ways of working that people have come up with that are safe and productive. **Dependencies:** → Invest to ensure required resources are available. What do people need or rely on to be able to do their jobs safely and productively. **Sensitivities:** → Push up the line for improved planning so people don't have to deal with it on the day. Unexpected things or surprises that people need to adapt to. **Frustrations:** → Fix, or disrupt the practice. People need things they can't get – so they are forced to adapt and use 'work-arounds'.	

This table is informed by a presentation given by Daniel Hummerdal from Art of Work in October 2016. To watch a summary of this presentation visit: **www.zeroharm.org.nz/workers**