Guidance – Safety Culture
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1 About safety culture

Safety culture is defined as *the attitude, beliefs, perceptions and values that employees share in relation to safety in the workplace*.[1] It guides the way people behave in the workplace and shapes decisions people make, their priorities and actions.

A poor safety culture has been clearly implicated as a causal factor in several large-scale organisational accidents in Australia and overseas. As a significant system component safety culture can, and should, be managed in practical, proactive ways to promote safety outcomes.

The Bus Safety Culture assessment model is designed to make objective decisions about the safety culture and maturity of bus operators. It is based on well-established safety maturity models used in other industries.

The model is made up of the following elements:

1. Management and leadership
2. Just culture
3. Information flow (reporting/feedback loop)
4. Learning culture
5. Staff involvement

2 Safety culture elements in detail

2.1 Management and leadership

The management and leadership element focusses on how managers/owners of bus companies behave with respect to safety. It considers the degree to which:

• consistent, clear and strong safety messages are communicated (safety message)

• managers/owners lead by example and their actions support the organisations' safety message, even under difficult or non-routine situations (actions support safety message)

• safe behaviour, discussion about safety, safety being everyone's responsibility and not cutting corners is encouraged (encouragement)

• managers are visible and have regular interaction with front line/operational staff (visibility)

• adequate time and resources are devoted to safety (time and resource commitment)

• management/owner decision making prioritises safety over performance (production), and risk and safety decisions are made at the proper level by appropriately qualified people (decisions)

• safety issues are actively addressed through a process of continuous improvement and there is action to identify and address safety issues (actions)

• systems such as audit, other policies and procedures are clear, comprehensive, understood by all levels of the organisation and actively 'lived' (that is, systems are used and used effectively). Safety has a high priority (systems).

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[1] Cox, S. & Cox, T. (1991). The structure of employee attitudes to safety - a European example. *Work and Stress, 5, 93 - 106.*

2.2 Just culture

A just culture can be described as *"An atmosphere of trust in which people are encouraged (even rewarded) for providing essential safety-related information, but in which they are also clear about where the line must be drawn between acceptable and unacceptable behaviour"*[2].

The just culture element focusses on how leaders of bus companies see incidents and accidents. It considers the degree to which:

- incidents are seen as a result of front line staff/operational staff errors for which they are solely responsible versus systems failures which staff have inherited (blame)

- operational staff trust that they won't be unfairly penalised if they report incidents or raise issues, management are approachable (trust)

- proper analysis, using fair and just processes to allocate fault (fault allocation process)

- there are clear procedures and a clear distinction between acceptable and unacceptable behaviour, and disciplinary actions taken to manage unsafe behaviour are fair and consistent (disciplinary process).

2.3 Information flow and feedback

The information flow and feedback element focusses on how leaders of bus companies organise this in relation to safety issues. It considers the degree to which:

- operational staff and other stakeholders are encouraged to report safety issues (for example hazards, concerns, near-misses, incidents) and believe that they will be taken seriously. There are systems for anonymous reporting and all are encouraged to use them (reporting behaviour)

- there are systems in place such as audits, hazard and incident reporting (audit and reporting systems)

- processes are known and understood by management and staff, are easy and straightforward to use for reporting and are used to facilitate continuous improvement (continuous improvement)

- operational staff are kept informed of safety issues relevant to them, they are given feedback about safety concerns they raise (feedback)

- communication flows up and down the organisation and across divisions (communication flow).

2.4 Learning culture

A learning culture is one where people actively seek to learn from incidents and near misses to continually improve safety outcomes[3]. The learning culture element focusses on if and how leaders of bus companies learn from failure. It considers the degree to which:

- organisations monitor and evaluate changes and new systems and have a continuous improvement focus (internal monitoring and evaluation)

- systemic analysis of incidents and accidents is undertaken including identifying root causes and monitoring patterns and trends (systemic analysis)

- the organisation looks outside to identify good safety practices/benchmarking (external monitoring)

- positive performance indicators as well as negative performance indicators, successes are shared across the organisation and celebrated (safety measurement).

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[2] *A Roadmap to Just Culture: Enhancing the Safety Environment* Global Aviation Information Network Working Group E, Flight Ops, ATC Ops Safety Information Sharing, First Edition, September 2004

[3] Reason (1997) *Managing the Risks of Organisational Accidents,* Ashgate Farnham UK.

2.5 Staff and stakeholder involvement

The staff and stakeholder element focusses on if and how leaders of bus companies involve key stakeholders in safety improvement. It considers the degree to which:

- staff and stakeholders are meaningfully involved in the development of changes and new initiatives, risk assessments, the development of policies, systems and procedures and safety improvements (stakeholder involvement in changes)

- all staff and stakeholders are encouraged to communicate about safety issues and share and learn from each other's experiences (communication)

- innovative ideas are encouraged and staff is empowered to implement them (innovation).

3 Element descriptors

3.1 Management and leadership

	Reactive	Calculative	Proactive
Safety message	Safety message is non-existent. Safety is not a high priority. Assumed that if you have done the right thing everything will be fine.	If you follow the procedures the system and workers should be safe. Safety is a high priority.	Safety is equal to production.
Actions support safety message	Managers/owners send the message that workers need to take responsibility for being safe.	Managers/owners send the message that following the rules will keep workers safe. Focus on individual responsibility.	Managers lead by example and their actions support the safety message even under difficult or non-routine situations. Individuals' minds are harnessed to fulfil goals through a culture of conscious inquiry.
Encouragement	Reports of problems are not welcome and reporters are punished.	There are systems in place to record issues and staff are encouraged to reporting issues.	Enthusiastic communication between workforce and management. They are encouraged to speak up, think outside the box and to act as fully conscious participants in a great cooperative enterprise.
Visibility	Managers not available and not approachable and/or are very busy doing other important things. Little opportunity for face to face communication with managers.	Managers are available and generally approachable. Management generally listens.	Management has high visibility and there is regular interaction with front line/operational staff and customers. No threshold between management and workforce. All participate/share activities.
Time and resource commitment	No resources are invested in the identification of problems or areas of good practice.	Resources are invested in improvements as per the management system protocols.	The organisation is flexible in terms of the ability to reconfigure its structure, goals and resources in the face of a dynamic and demanding task environment.
Decision-making	Production is always more important than safety.	Budget is available to address issues.	Safety prioritised over production, and workforce has a lot of freedom for innovation.
Actions	If any auditing occurs it lacks structure and there is no or little response to what is discovered. It is assumed everything is alright until management is forced to accept that it is not.	Prompt action generally taken to address the issue. Longer-term solutions were planned and implemented if required.	Staff and managers will do whatever is required to ensure information is shared and actions taken.

	Reactive	Calculative	Proactive
Systems	Any protocols, policies or systems are there to meet the minimum statutory requirements and are not used, reviewed or updated. No long term management of the issue.	Systems, such as audit, other policies and procedures, used are generally understood by all levels of the organisation	What is known in one part of the system is communicated to the rest. Those in the system consider it their duty to inform others of potential danger/improvement. Feedback loops are closed, as no special safety meetings required.

3.2 Just culture

	Reactive	Calculative	Proactive
Blame	Incidents and accidents are seen as a result of operational staff or customer errors for which they are solely responsible.	The apportioning of blame rests on whether rules were followed.	Incidents and accidents are seen as the outcomes of systems failures until otherwise identified.
Trust	Operational staff know that they will not be treated fairly in the aftermath of incidents and accidents. There is little trust in the organisation between staff, management, customers and other stakeholders.	There is trust in the organisation between staff, management, customers and other stakeholders as long as the rules are followed.	Operational staff know that they will be treated fairly in the aftermath of incidents and accidents and will often report their own incidents and accidents.
Fault allocation	Staff know that they will bear the brunt of fault and will be unfairly penalised if they report incidents or raise issues.	Proper analysis to identify systemic failures so that learning can occur rather than apportioning blame.	Staff know that they will not be penalised if they report incidents or raise issues.
Disciplinary process	The process appears random and at the discretion of management. When disciplinary action is taken, the process is determined by the organisation's reaction to the events rather than a planned process.	There is a process for disciplinary action. While reporters of issues feel it is alright to report it feels procedural rather than an important aspect of organisational culture.	Where disciplinary action may be required, there are clear procedures and a clear distinction between acceptable and unacceptable behaviour, and actions taken to manage unsafe behaviour are fair and consistent.

3.3 Information flow and feedback

	Reactive	Calculative	Proactive
Reporting behaviour	Operational staff and other stakeholders are discouraged from reporting safety issues, for example, hazards, concerns, near-misses, incidents.	The systems in place encourage operational staff and other stakeholders to report safety issues, for example, hazards, concerns, near-misses, incidents. They believe that they will be taken seriously. Systems for anonymous reporting exist and all are encouraged to use them.	Management and staff in generative organisations go looking for problems and report them.
Audit and reporting systems	There are no, few or incomplete systems in place such as audits, hazard and incident reporting. Where systems are in place they are used reactively in response to events. Staff and management may not know and understand systems for reporting.	The systems in place, such as audits, hazard and incident reporting, are known and understood by management and staff. The focus is on the system rather than on the benefits derived.	The systems in place, such as audits, hazard and incident reporting, are known and understood by management and staff and are easy and straightforward to use for reporting.
Continuous improvement	Information is not used for improvement unless forced by circumstances or an external authority.	Information gathered is used to facilitate continuous improvement.	Systems encourage continuous improvement.
Feedback	Operational staff may not be kept informed of safety issues relevant to them, or given feedback about safety concerns that they raise. If feedback is received it is often not systematised and often ad-hoc.	Operational staff are kept informed of safety issues relevant to them and they are given feedback about safety concerns they raise.	Operational staff are kept informed of safety issues relevant to them and are given feedback about safety concerns they raise. There is a check to ensure that the message was received.
Communication flow	The organisation is characterised by very poor communication flow up and down the organisation and across divisions. Information about issues generally does not go beyond the people involved.	Good communication flow up and down the organisation and across divisions. Information is disseminated across the organisation as per procedure rather than need.	Everyone has access to the key safety learning and information.

3.4 Learning culture

	Reactive	Calculative	Proactive
Internal monitoring and evaluation	Organisation does not monitor and evaluate changes or new systems.	The organisation informally or partially monitors and evaluates changes, new systems.	The organisation systematically monitors and evaluates changes, new systems and has a continuous improvement focus.
Systemic analysis	Systemic analysis of incidents and accidents, identification of root causes, monitoring patterns and trends does not occur and is not considered important unless something occurs or is forced on the organisation.	Systemic analysis for incidents and accidents, identification of root causes, monitoring patterns and trends. The organisation knows what its key hazards are. However this is by the book and novel analyses do not occur.	Systemic analysis for incidents and accidents, identifying root causes, monitoring patterns and trends., The organisation knows what its key hazards are and is inventive, open and wide ranging in its pursuit of hazards.
External monitoring	Looking outside own organisation does not occur and is not considered important.	Minimal looking outside the organisation as it is assumed the procedures cover everything that is required.	Always looking outside own organisation for ways to continuously improve.
Safety measurement	Positive performance indicators do not exist or are in disrepair. Negative performance indicators are used to determine success.	The organisation seeks positive performance indicators as well as negative performance indicators.	The organisation seeks positive performance indicators as well as negative performance indicators. Successes are shared across the organisation and celebrated.

3.5 Staff and stakeholder involvement

	Reactive	Calculative	Proactive
Stakeholder involvement in changes	Staff and stakeholders are not involved in the development of changes and new initiatives or risk assessments unless forced to be.	Staff and stakeholders are sometimes or informally involved in the development of changes, initiatives, risk assessments, the development of policies, systems and procedures and to safety improvements.	Staff and stakeholders are meaningfully involved in the development of changes, initiatives, risk assessments and, the development of policies, systems, procedures and to safety improvements.
Communication	Staff and stakeholders are discouraged from communicating about safety issues and sharing and learning from each other's experiences.	Staff and stakeholders are encouraged to communicate about safety issues.	All staff and stakeholders are encouraged to communicate about safety issues and share and learn from each other's experiences.
Innovation	Innovative ideas are discouraged and staff fear implementing anything not directted by management.	Innovative ideas are considered but can only be implemented by management.	Innovative ideas are encouraged and staff is empowered to implement them.

4 TSV audit questions

TSV's audit checklist contains the things that auditors will consider and discuss during the audit process to allow them complete an assessment of operators' safety cultures. An extract from the checklist is below.

4.1 Element 1 - Management and leadership

Safety message
Do leaders communicate safety messages consistently, clearly and strongly?

Do leaders lead by example and do their actions support the organisations safety message, even under difficult or non-routine situations?

Encouragement
Do leaders promote safe behaviour? Do leaders discuss safety and make it clear that everyone is responsible for safety?

Do leaders discourage cutting corners?

Visibility
Are leaders visible? Do they regularly interact with staff?

Time and resource commitment
Do leaders commit adequate time and resources to safety?

Decisions
Does leader decision making prioritise safety over performance? Are risk and safety decisions made at the proper level by appropriately qualified people?

Actions
Are safety issues actively addressed through a process of continuous improvement? Is action is taken to identify and address safety issues?

Systems
Are safety relevant procedures clear and comprehensive? Are they understood by all levels of the organisation and actively lived? Are the systems are used and used effectively?

4.2 Element 2 - Just culture

Blame
Rather than blaming staff, do leaders look for system failures when errors occur?

Trust
Do operational staff members trust that they won't be unfairly penalised if they report incidents or raise issues?

Fault allocation process
Are failures captured with the aim of learning from them?

Disciplinary process
Where disciplinary action may be needed are there clear procedures?

Is there a clear distinction between acceptable and unacceptable behaviour?

Are actions taken to manage unsafe behaviour fair and consistent?

4.3 Element 3 - Information flow and feedback

Reporting behaviour
Do leaders encourage staff and stakeholders to report safety issues, for example, hazards, concerns, near-misses, incidents? Do reporters believe that they will be taken seriously? Is there a system for anonymous reporting and are staff members encouraged to use it?

Audit and reporting systems
If there are systems in place, such as audits, hazard and incident reporting, are they known and understand by leaders and staff? Are they easy and straightforward to use?

Continuous improvement
Are reporting systems used to facilitate continuous improvement? Is information gathered used to facilitate continuous improvement?

Feedback
Do leaders keep staff members informed of safety issues relevant to them? Are staff members given feedback about safety concerns that they raise?

Communication flow
Is there an effective communication flow up and down the organisation and across divisions?

4.4 Element 4 - Learning culture

Internal monitoring and evaluation
Do leaders monitor and evaluate changes, new systems, etc.? Is there focus on continuous improvement?

Systemic analysis
Are incidents and accidents analysed systemically, are root causes identified? Are trends and patterns monitored? Does the organisation know what its key hazards are?

External monitoring
Do leaders look outside own organisation, proactively looking for ways to continuously improve?

Safety measurement
Does the organisation have positive performance indicators as well as negative performance indicators? Are successes celebrated and shared across the organisation?

4.5 Element 5 - Staff and stakeholder involvement

Stakeholder involvement in changes
Do leaders meaningfully involve staff and stakeholders in the development of changes and initiatives (for example, risk assessments, the development of policies, systems and procedures and safety improvements)?

Communication
Do leaders encourage staff and stakeholders to communicate about safety issues and share and learn from each other's experiences?

Innovation
Do leaders encourage innovative ideas and are staff empowered to implement them?

5 Audit conduct

It is understood that some elements within our safety culture assessment may be new concepts to the bus industry. The safety culture component of safety audits is therefore deliberately consultative and educative. Our aim is to enhance operator awareness of the facets of a good safety culture and enable them to adopt a process of continuous improvement.

Where to get more information

Transport Safety Victoria

121 Exhibition Street
Melbourne Victoria, 3000

PO Box 2797
Melbourne Victoria, 3001

T. 1800 223 022
F. (03) 9655 6611

E. information@transportsafety.vic.gov.au
W. www.transportsafety.vic.gov.au