Direction is key!

What most organizations overlook in their journey towards safety excellence.

This week, NewView Consulting and Tapora had the opportunity to participate in a two-day Swedish Human Factors Network seminar on the topic of effective Team Resource Management. Two very interesting days included a wide array of topics and sharing experiences from aviation, energy sector, marine, and military.

On the first day, we also had the opportunity to present our take on the importance of Safety Leadership in creating safe and effective teams and, not least, why many organizations experience problems in this respect.

In the last 15-20 years, many large organizations in high-risk industries have engaged in ambitious journeys towards zero accidents or becoming incident & injury free. Formulating this as a target can in itself become problematic. However, this is not the topic of this article and can be mitigated by moving away from outcome-centered targets toward ethical and moral aspirations.

The much larger problem, which we have observed on numerous occasions, is the following: At first, the case for change is obvious. The organization wants to improve significantly on safety and to achieve this, all levels and branches need to become committed to this journey. Hence, vast energy is invested in engaging the organization to partake in this commitment. Provided top management credibly espouses and demonstrates such values; this step is usually also successful.

However, this is exactly where the seed is planted for the succeeding problems. The newly generated commitment is expected to manifest in a substantial achievement (i.e., improved safety performance). In the absence of proper guidance on what direction this commitment should take, the risk is that hundreds of committed yet unguided missiles have been created instead of the unified constructive movement one had hoped for.

Consequently, some positive steps are nullified by counterproductive opposite currents. Without deeper substance, many organizations default towards pedestrian symbolic rituals such as invoking handrail-holding mandates, seeing coffee cups as an unacceptable risk, and insisting on the superiority of reverse parking. Further downstream, the problem intensifies when top management, after some time, begins to express dissatisfaction with the lack of progress on their ambitious safety targets. As it has been expressed by a top executive: "Is someone not getting the message?"

Now let us pause here for a second and analyze what has happened here. Edgar Schein, in his extensive work and research on organizational culture, has provided a useful model on cultural layers. (Fig1.)

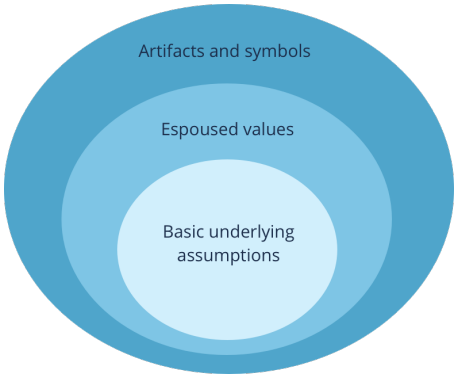

Fig 1: Schein's model of cultural layers.

This model distinguishes between an outer layer of artifacts and symbols corresponding to all the directly perceivable elements communicated daily. The idea is that what is enacted on this surface level is driven by people's values. Hence, it makes sense to address safety commitment on this level and create a sense of urgency, importance, and personal ownership for the subject. As described earlier, most safety campaigns or programs address this value-based and then move directly toward the artifact level.

In doing so, a fundamental step is omitted. As Schein's model illustrates, there is a deeper core level of underlying assumptions that are left unaddressed. Exactly at this fundamental level, two completely opposite assumptions about "how the world works" implicitly and subconsciously inform how the newly created commitment will be enacted.

The key to successful transformation lies exactly in addressing this dilemma. A constructive, unified movement toward improvement can be created by making these opposing worldviews visible and building the necessary buy-in and consensus to abandon one of them and be consciously directed by the other.

So, what are these opposing worldviews? In the safety literature, they have been outlined as the difference between 1st stories and 2nd stories of failure (David Woods), the old view and the new view on human error (Sidney Dekker), or the individual vs. the systems perspective of organizations.

In brief, these views can be summed up as the following:

The individual perspective is built on the assumption that "my system is basically safe". The system would work flawlessly if it were not for the erratic behavior of individuals. Consequentially the system needs to be protected against such agents, which positions people as a problem to be solved or controlled.

The systems perspective holds the exact opposite view. The system is inherently flawed as it harbors multiple problems, such as production pressures, resource constraints, goal conflicts, and uncertainties. Still, organizations produce safe and effective outcomes most of

the time precisely because of the resourcefulness of the people within the system. This means people are seen as a resource to harness rather than a problem to control.

It becomes evident that any commitment to safety is enacted dramatically differently, depending on which worldview it is based upon.

To address this dichotomy, we have thoroughly laid out the three-step CDA process for leadership training: **Commitment – Direction – Achievement**. It is based on our cumulative experience in safety culture work creation of learning environments in conjunction with the operational translation of essential models from safety science.

Since we are dealing with fundamental assumptions, which often have developed over the years, if not decades, it is rarely sufficient to state the difference between the views and expect everybody's immediate buy-in. Experience shows this can be achieved through workshops, where contrasting views are explored through case studies, dilemma discussions, and gameplay.

Here tangible insights are gained on the repertoire of actions and their consequences on the organization, which result from applying either an individual- or a systems view.

One example of what this looks like in practice was demonstrated at the Swedish Human Factors Network Conference. It combines the classic "Falling Tower Game" alongside safety dilemma cards to create small group discussions. Discussions evolve around the described safety problems and their potential relevance for own work domains.

Fig 2: The Falling Tower Game

This process, in conjunction with the content of the cards, already creates a rich basis for subsequent reflections and discussions. Usually, despite all the group's best efforts, one of the towers falls over towards the end of the session. As this corresponds to an accident, the question becomes, who or what made the tower fall? Was it the last person who touched the final block? Or was this person merely the recipient of a system of system, which had been heading for failure for some time?

This exercise provides fertile ground for fruitful discussions on rule-following as well as reactions to failure. Further, it constitutes the basis for introducing Erik Hollnagel's "Sharp End- Blunt End Model". (Fig3). This model illustrates how visible accidents usually happen at the sharp end of an organization, where people work with hazardous processes. The model emphasizes that such accidents do not occur in a vacuum. On the contrary, they result as a

systematic by-product of what happens further upstream in the organization. This is illustrated by the reach that each organizational layer has down to the sharp end.

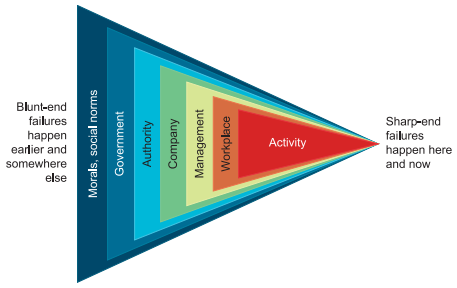

Fig 3: Sharp End – Blunt End

Recognizing and buying into this perspective opens completely new ways to engage. Rather than an increased emphasis on controlling work more rigorously, the discussions can evolve around how management and upstream workplace layers can create conditions that make safe outcomes more likely.

We were happy that this approach was well received amongst the Swedish Human Factors Network experts.

So, **Direction is Key**. If you are curious to hear more about our CDA leadership training, please contact:

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