Safety culture

Francis Inquiry Conference

The King’s Fund, 27th February 2013

Rhona Flin
Industrial Psychology Research Centre
University of Aberdeen
Francis Inquiry 2010: culture

- ...such a culture has played a significant part in the development of the problems to be seen in this Trust. This culture is characterised by introspection, lack of insight or sufficient self-criticism, rejection of external criticism, reliance on external praise and, above all, fear. I found evidence of the negative impact of fear, particularly of losing a job, from top to bottom of this organisation. Regrettably, some of the causes of that fear have arrived at the door of the Trust from elsewhere in the NHS organisation in the form of financial pressures and fiercely promoted targets.

- 136. Such a culture does not develop overnight but is a symptom of a long-standing lack of positive and effective direction at all levels. This is not something that it is possible to change overnight either, but will require determined and inspirational leadership over a sustained period of time from within the Trust.

- Vol 1, p184
The staff surveys continually gave signs of substantial staff dissatisfaction with the way the Trust was run. Trust management reacted to this with various action plans, but dissatisfaction persisted, albeit not always in response to the same questions. Such surveys were not of as much assistance as they might have been because of the delay before the results became available, but they could and should have indicated to the wider system that all was not well on a persistent basis. That the results caused no very significant external reaction could be due to inattention, but it is more likely due to the lack of importance accorded to this source of information. 2.370
Nimrod Review (Haddon-Cave)

‘A failure of leadership, culture and priorities’

Chapter 27  New Safety Culture  
[for military aviation]

• Engaged safety culture =
  • reporting culture
  • just culture
  • flexible culture
  • learning culture
  • questioning culture (Reason, 1997)

• Role of leadership from the top
Deepwater Horizon (2010)

‘It is also critical that companies implement and maintain a top-down safety culture.’
(Report to the President, Jan 2011 ch 4)
Deepwater safety culture

A survey of the Transocean crew regarding “safety management and safety culture” on the Deepwater Horizon conducted just a few weeks before the accident hints at the organisational roots of the problem.

The reviewers found Deepwater Horizon “relatively strong in many of the core aspects of safety management.” But there were also weaknesses. Some 46 percent of crew members surveyed felt that some of the workforce feared reprisals for reporting unsafe situations, and 15 percent felt that there were not always enough people available to carry out work safely. (chp8)
Organisational safety

Technical Factors

Accident Causation

Human Factors

= 

Culture/Leader Behaviour + 

Worker Behaviour
What is safety culture?

Term introduced following Chernobyl accident in nuclear industry (1986)

- The necessary framework that prioritises safety within the organisation which is the responsibility of the management hierarchy

- The attitude of staff at all levels in responding to and benefiting from the framework
Defining safety culture

The Health and Safety Executive in the UK defines the safety culture of an organisation as ‘the product of individual and group values, attitudes, and perceptions, competencies, and patterns of behaviour that determine the commitment to, and the style and proficiency of, an organisation’s health and safety management’.

‘doing the right thing even when no one is watching.’ (Dept Health, 2000, ch. 8)
Safety culture and behaviour

• Worksites with more positive safety culture show lower accident rates

• Workers who perceive their supervisors/ managers to be more committed to safety engage in more safety-related behaviours and fewer risk taking behaviours

• Motivational mechanism linking culture to behaviour – expectations/ rewards linked to behaviour of managers/ supervisors (Zohar, 2002)

( Landy & Conte 2006)
Cultural antibodies to safe behaviour

Bristol Royal Infirmary Inquiry
– Powerful motives for keeping quiet – especially junior doctors and nurses
– Need for ‘a culture of openness’
– This calls for ‘significant leadership’

• Safety still struggling to be on the agenda.
• Strong leadership needed. Kennedy 2006
Is the culture reinforcing or toxic for safe behaviours?

Unit culture

Worker behaviour
Training crew resource management skills - UK operating theatre teams (2009)

• Investigators noted that “considerable cultural resistance to adoption was encountered, particularly among medical staff”.

Organisational factors associated with a safety culture (HSE, 1999)

• Senior management commitment
• Management style
• Visible management
• Good communication between all levels of employee [management action]
• A balance of health and safety and production goals [management prioritisation]
‘As congressional hearings on the Deepwater Horizon disaster kick off today, lawmakers are likely to get a tangle of finger-pointing from the corporate leaders whose companies are being sued for negligence in connection with the disaster’ Houston Chronicle, May 10 2010.

“When you became CEO of BP, you promised to focus "like a laser on safe and reliable operations."”

"I clearly am the ultimate power...“
"We have begun to change the culture."
"It is a thing that I talk about every time I talk internally or externally."
"I wasn't part of the decision-making process... I wasn't involved in any of the decision making... I simply was not involved in the decision-making process”
Managerial resilience skills (Flin, 2006)

- Situation awareness
  - ‘mindfulness’
  - detection and recognition of threats
  - Cf. Shell: ‘Chronic Unease’/ Attention to weak signals
- Decision making
  - balancing competing pressures
  - ability to make ‘sacrificial decisions’ (Woods)
- Assertiveness
  - speaking up
  - challenging the leader
- But needs a supportive organisational culture
Human factors approach

• Focus on behaviours that contribute to safe and efficient performance
• Situation awareness, decision making, leadership, teamwork
• Used in aviation – CRM/ non-technical skills
• Recurrent training linked to current safety issues
• Now being adopted in other industries + some domains of healthcare e.g. surgery
We are independent, impartial, and work in a voluntary capacity...

Our vision is to engender human factors thinking in the hearts and minds of all healthcare staff and stakeholders. From board to ward and beyond...

Established by Bromiley in 2007
DH Human Factors Reference Group

- Established in 2010 under chairmanship of Sir Stephen Moss.
- Role of human factors in NHS, especially in training and incident investigation
- Interim Report to Professor Sir Bruce Keogh 2012
- Proposed HF actions to ‘shift the culture’
r.flin@abdn.ac.uk

- www.abdn.ac.uk/iprc