Dimensions of Safety
Guidance Document

Version 1.2

April 2013

1. Introduction

The intention of this document is to provide an overview to the background, development, application and content of the Dimensions Of Safety (DOS) tool. The DOS tool has been developed and launched for the Rail Industry as a way of interrogating Safety Culture across six specific Dimensions. It enables consistent and collaborative measurement and action planning for improvement with its innovative use of Intervention Suggestions.

It is important to note that not all Dimensions may relevant to all organisations; as such, it informs a mature approach to measurement and assurance. DOS moves away from traditional scoring and status reports and focuses on action or intervention planning for improvement.

The use of DOS or similar Safety Culture Measurement tools has been included in the Network Rail Standards, specified below, embedding this progressive measurement approach in the Network Rail Assurance and Licensing processes;

   NR/L2/CPR/302 (Core Requirements) compliance date September 2011
   NR/L3/INI/CP0073 (Licensing Requirements) compliance date March 2012

This document provides context and guidance in the use of the DOS tool and is part of Network Rail's commitment to improving Safety Culture within the Rail Industry.

The tool can be used at team, project, programme and functional levels. It is suggested that this document be read in conjunction with the tool itself.

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2. The Context for the Dimensions and Factors

The initiative started in 2009 with the Project Safety Leadership Group (PSLG); suggesting that "Safety Culture" could be delineated into distinct parts or Dimensions. These Dimensions are areas of an organisation that directly affect safety, how it is managed and how it is "lived", as follows;

1. Leadership
2. Technologies
3. Outputs
4. Workforce
5. Companies
6. Processes and Systems

During 2010 and again in 2013, this work was built upon by a pan-industry working group, which included the companies listed below and consultation from the Office of the Rail Regulator (ORR) and other parts of Network Rail;

- Carillion Plc.
- SES Holdings

- Buckingham Group
- Morgan Sindall

- Balfour Beatty
- Bam Nuttall

- Keltbray
- Invensys Rail

- Colas Rail
- TXM Plant

- Babcock International
- Murphy Group

- Hydrex
- Volker Rail

3. The Dimensions and Factors

In order to develop these six Dimensions into something that may identify and measure a Safety Culture; the working group identified four factors for each dimension;

Leadership	Workforce
Level of Investment in Safety.	Activity Risk Assessment.
Engagement of Senior, Middle and Supervisory Management in Safety Programme.	Competence Management (task and individual).
Safety Tours.	Safety Action Groups.
Leadership Communications.	Cultural / Climate Surveys.
Technologies	**Companies**
Training.	Safety Culture Management.
Usability.	Audit.
Innovation.	Sustainability.
Safety in Design.	Non-Conformance Report (NCR) Management.
Outputs	**Processes and Systems**
Bench Marking Supply Chain.	Process Improvement.
Implementation of Continuous Improvement.	Near Miss and Close Call Reporting.
Balanced Score Card.	Contract / Tender Process.
Welfare.	Risk Management.

Using the Safety Culture measurement approach supported by the Health and Safety Executive (HSE) and recognised by the Office of the Rail Regulator; (ORR) the working group developed descriptions of each level of maturity - per factor.

Finally; detailed intervention plan suggestions were written for each factor's maturity level. Whilst these are suggestions, they provide guidance and support for an organisation, team, and project or programme to evolve from level to level. These are context specific and were developed to engage and support improvements.

The full detail regarding the maturity descriptions and intervention suggestions a may be viewed in full in Appendix 1 of this document and also in the admin portion of the tool itself.

4. A Journey in Safety Culture Improvement

It is important to note that improving or evolving through the Safety Culture maturity levels is the result of a committed journey or continuous effort.

It is important to note that the journeys from one stage to another differ greatly across the levels of maturity. For example, in the 'Leadership' dimension, for the factor 'Level of Investment In Safety', the journey from level 2 (Reactive) to level 3 (Calculative) could look like this;

- Encourage Safety Action Groups to meet regularly - support them with management commitment

- Feedback from managers on progress made and regular attendance by managers at these meetings

- Review Behaviour Based Safety programmes

Whereas the journey for a Level 4 (Proactive) organisation to reach a Level 5 (Generative) looks like this:

- Engage your Supply Chain with your Behavioural Based Safety Programme and share

- Include designers, engineers etc. in behavioural safety programme

- Introduce co-ordinated Safety Action Groups at all levels of the organisation.

5. Suggestions for use

The tool itself is dynamic and lends itself to workshop discussion and use within the scales suggested.

The following approaches have proven most successful over the last 12 months;

i) 360 Review Workshop Outline
Using DOS to baseline alliance or partnership culture at the beginning of the relationship.

1. Identify central collation for the DOS returns.
2. Identify a cross section of staff involved; including Leadership, Management and Direct Reports from each company. Approximately 15 – 20 individuals provide a good sample set.
3. Arrange a half-day/one-day workshop.
4. Email the tool and this document to attendees two weeks before the workshop requesting each individual to complete the tool on behalf of their own organisation/function and return it within one week to the central co-ordination point.
5. The week before the workshop, collate the results and average the results. It is recommended to round down for fairness and visibility.
6. During the workshop, discuss the general principles involved with DOS, and reiterate the action plan will be owned by the Alliance or Partnership.
7. Present the combined results.
8. Discuss the general principles involved and record any areas of DOS that are irrelevant i.e. if a Labour Supplier is present, action planning under Technology may seem less relevant than Workforce.
9. Using the self populating intervention plan sheet and other ideas in the room, pull together the action plan that will be managed and monitored over the next 12 months.

Note: Should the Alliance or Partnership be in effect for less than 12 months, agree at the workshop which actions will be taken forward and when they will be reviewed.

ii) Culture Workshop

Using DOS to baseline understanding of what Safety Culture includes, what the current Safety Culture is and where improvements may be made for Organisation, Team, Programme or Function.

1. Identify central collation for the DOS returns

2. Identify a cross section of staff involved; including Leadership, Management and Direct Reports. Approximately 15 – 20 individuals provides a good sample set.

3. Arrange a half-day/one-day workshop.

4. Email the tool and this document to attendees two weeks before the workshop requesting each individual to complete the tool based on their perception and experience and return it within one week to the central co-ordination point.

5. The week before the workshop, collate the results and average the results. It is recommended to round down for fairness and visibility.

6. During the workshop, discuss the general principles involved with DOS, and reiterate the action plan that results will be owned by the group.

7. Present the combined results.

8. Discuss the general principles involved and record any areas of DOS that are irrelevant or may need altering to be directly relevant.

9. Using the self-populating intervention plan sheet and other ideas in the room, pull together the action plan that will be managed and monitored.

iii). **Further suggested applications for DOS:**

1. May be used as part of the Network Rail Licence review process.

2. May be used as a compliment to the RM3 tool. Whilst the RM3 tool measures process maturity, the DOS tool assesses organisational behavioural maturity.

3. It is a versatile tool, which can be used to assess individual companies, teams, projects, business units etc., or benchmark with others. This may be used to help promote organisational learning.
4. To objectively challenge during a conversation.
5. Follow-on workshops; It is a live tool, which should not just be used as a one off. It is not aimed at being a quick win but to help plan and guide a change journey.
6. It may be used when creating a new team or project to assess where you are and where you want to get to; as a team-building or discussion exercise to challenge perceptions in an objective manner.
7. It provides an objective way to identify where to target resources for maximum benefits or improvements.
8. It provides a reality check as it can be used to identify gaps in perceptions across groups or between management.
9. It may be used as a gap analysis across companies, projects/teams etc.
10. To measure culture and action plan in relation to the Network Rail 10 Point Management Plan.
11. To define your cultural goals, help set targets and objectives for change across the dimensions in order to achieve this.
12. Inform, guide or provide structure for annual SHEQ/H&S plan.
13. To change and/or verify board-level perceptions of where the board think the company is versus where management's perceptions, in an objective manner.

Appendix 1

The Dimensions and Factors

Leadership	Pathological (Emerging)	Reactive (Managing)	Calculative (Involving)	Proactive (Co-Operating)	Generative (Embedded)
Level of Investment in Safety.	- Investment limited to provision of basic PPE and legislative minimum requirements. - Leadership visibility on safety is limited to reacting when incidents occur.	- Management are interested in improving basic safety provisions. - Improvements in safety provisions are made only in response to accidents and incidents.	- Management understand the benefits of involving the Workforce in Safety Initiatives and provide visible support. - There is evidence of engaging with the front-line workforce as a way of seeking improvements required.	- Programmes are implemented and management provide consistent, visible leadership at events including financial support as a result of workforce input. - Management controlled issues are resolved consistently and closed out within timescales.	- All levels within the organisation understand their impact on Safety - Safety programmes are communicated and maintained to schedule with measurement and scorecard tools in place.
Engagement of Senior, Middle and Supervisory Management in Safety Programme.	- Supervisory management engagement limited to reacting to incidents. - Middle management focus is on safety reporting data. - Senior Management function is limited to receiving safety reports rather than on analysis, learning and resolution. -Staff understands their right to stop the job but this is rarely or never done.	- Rectifications or changes to Safety programmes are only made in response to Safety incidents. - There is Management awareness of the need to equally weight Safety and productivity when measuring performance. - Staff have asked to stop the job based on Safety grounds but this has previously resulted in pressure from Management to rescind this or the requestor has not been invited	- All levels of Management are involved willingly in safety meetings. - Visible communications from Senior Managers on safety messages. - Pockets of usage of safety coaches from workforce/supervision. -Work has been stopped on safety grounds by frontline staff, which was supported by management. Client supportive although this is based on facts rather	- All levels receive training on Behaviour Based Safety. - All communications related to safety are backed up by action planning and proactive interventions. - Consistent use of safety coaches from workforce/supervision with support in place. -Management and frontline staff have both stopped work and supported those who requested it. Investigation carried out into how it could have been managed better.	- All levels proactively involve themselves in Safety events and meetings. - Safety coaches are actively engaged throughout the organisation. - Learning programmes are implemented consistently with focus on Sustainability. -No hesitation to stop the job based on Safety. If request is made, this is fully supported by staff and client. -Learning is carried out by joint Management and

		back to work again if contractor.	than open communication.		staff to understand reasons and how the system can be improved both on site and as a Safety mechanism.
Safety Tours.	- In line with Network Rail guidelines, conduct a minimum of 6 Safety tours per year. - Focus is on finding fault and completing the form. -Minimal communications with safety/staff representatives; based on fulfilment of legal minimum requirements.	- Management conduct more than the minimum number of safety tours as part of a performance target. - There is some focus on using a Safety Tour to find opportunities for improvement. - Communications with safety/staff representatives is two ways but focussed on what is wrong on site and looking for someone to blame.	- Performance targets and Safety tours are used to show commitment and support to the Workforce. - Action planning includes behavioural drivers and forms the focus of the Safety Tour. - Style of tour is more instructional and process orientated. - Communications with Safety/staff representatives is two way and based on mutual agreement of what could be done better.	- Clear communication of management commitment and active participation at all levels of staff in the safety tour. - Style of the safety tour is conversational and focuses on listening, followed by action. - All parties are ask open questions and take responsibility for what is going right or wrong on site. Communications based on genuine interest for people, work and on reaching a consensus on what more can be done.	-Safety Tours are considered Business as Usual practice and used as a communication tool. - Open discussion of Safety related concerns and successes is / are evident. - Open and transparent communications with full mutual trust established. - Mutually pushing forward to improve work for all.
Leadership Communications.	- There is a disconnect between Safety Policy communications and actions taken. - Communications to workforce/supply chain is minimal and inconsistent; and no feedback is sought from them.	- Communication strategy under development to identify the best methods to communicate. - The safety vision of the business is clearly displayed. - Communications to	- Clearly defined communication strategy based on feedback and requirements. - Leadership messages are delivered in a meaningful and honest manner. - Monitoring of	- Clearly defined communication strategy, which is a live process open to improvement based on feedback. - Leadership actively responds to the workforce/supply chain in a constructive and timely	- All employees are engaged in contributing to achieving the safety vision of the business. - Communications actively include stakeholders with their staff, cross functionally and within Industry.

	- Safety Forums are held as a one-way communication tool.	workforce/supply chain is limited to what must be done and not why it must be done	consistency of cascaded messages	manner.	

Technologies	Pathological (Emerging)	Reactive (Managing)	Calculative (Involving)	Proactive (Co-Operating)	Generative (Embedded)
Training.	- Basic minimum technical training. - Training is task based and delivered in a paper based or PowerPoint based style. - Focus is on qualifying for competence / role.	- Training requirements are understood and designed with consideration to learning styles and delivery requirements. - It is task based training which is completed / rolled out before technology or rule changes are implemented.	- Inclusion of behavioural training is delivered as part of task specific training. - Observable outcome training methodology is used. - The availability of refresher training is clearly communicated and requirements are continuously assessed.	- New methods of training delivery explored and exploited. - Behaviour Based Safety is integrated into all training packages identified as relevant and as stand-alone packages. - Continuous validation and verification of learning requirements.	- Learning is packaged and communicated into the Supply Chain and shared with Industry. - Training design and delivery is fully integrated with Close Call, Near Miss and Accident Investigation processes as part of Continuous Improvement.
Usability.	- Only Budget dictates what technology can be used; not requirements or suitability for purpose.	- Usability of the technology is only explored as a result of incident investigation.	- User Acceptance Testing in design and procurement of new Technology is done in response to competition in the market and client / customer requests. - Current practice is reviewed to identify the benefits of using new Technology.	- Both the client and workforce are invited to review and feedback on the Usability of new Technology. - Alternative technological solutions are investigated to improve safety arrangements.	- Commitment to Continuous Improvement in design and procurement of new Technology. - Revisiting User Acceptance Testing results and learning from them in new design. - Knowledge, findings and experiences are with Supply chain and Industry.
Innovation.	- Innovation is limited to legal or client drivers. - Product acceptance testing is completed within timescales, as required.	- Implementation of Safety related innovation is limited by cost implications. - Innovations are implemented as a result of competition in the market rather than as an effort to improve	- Innovation schemes or programmes are in place. - Cost benefit analyses are done to represent long-term advantages of innovating.	- Sustainability of technology is included in strategy / business approach. - Open channel of communication / feedback from those that use the product, service etc. - Recommendations from feedback are picked up and	- Leads Industry in terms of innovating and implementing with new safety related technology. - Learning in regard to innovation is shared in external forums or similar in order to contribute to Industry development.

		Safety.		integrated holistically.	
Safety in Design.	- End user requirements included in design of assets and equipment in a reactive manner i.e. in response to client request. - Reviews of designs are focussed on technical compliance.	- In addition to CDM minimum compliance, design changes are implemented in response to client / customer requirements. - Design Risk Management is focused on producing a Risk Assessment as a design deliverable. - Safety risks included on drawings.	- Regular design review meetings, which include construction, maintenance and end users. - Red and green lists used by designers. - Constructability HAZOPs are embedded in the design process. - Safety and environmental risks included on drawings.	- Design risk log is reviewed by line management. - Staff proactively provide feedback on equipment/asset design and is included in new product design or acceptance. - Consistent quality in each design.	- Usability of the finished product is integrated with the design process. - Consistent delivery of quality designs that fully encompass feedback and learning from experience. - Standard design is consistently challenged and improved upon.

Outputs	Pathological (Emerging)	Reactive (Managing)	Calculative (Involving)	Proactive (Co-Operating)	Generative (Embedded)
Bench Marking Supply Chain.	- No benchmarking in place.	- Benchmarking in place with plans for consistent usage being designed.	- Supply Chain benchmarked with primary focus on costs and process adherence. - Management engagement in the process with planning for improvement as evidenced by action plans in place and being monitored.	- Supply Chain benchmarked on costs, process and safety, with full management engagement from company management and Supply Chain management. - Action planning identified with commitment to Continuous Improvement.	- Supply Chain benchmarked on costs, process and safety, with full engagement from internal and external management. - Action planning identified as a result with commitment to Continuous Improvement with close out within timescales identified.
Implementation of Continuous Improvement.	- Continuous Improvement process in place as per ISO 9001. - Activities to improve are identified without consultation with the workforce. - Implementation of improvements is inconsistent. - Lack of integration with the Lessons Learned process.	- Data collated as required by ISO 9001. - The focus is as a reactive process where learning is primarily focussed on negative events and not looking for proactive learning opportunities. - Only lagging indicators used to measure progress.	- Data collated cross functionally and with full consultation with the Workforce. - Two distinct approaches exist - proactive (leading) and reactive (lagging). - Measurements lead to action planning with consistent and sustainable implementation.	- Data volunteered and collated as a business-as-usual activity. - Consistent and embedded use of a workable system for data collection and learning that has proactive and reactive balanced measures. - This system is used across the company.	- Continuous Improvement processes include all functional areas with action planning; regularly measured for effectiveness. - There is a very low level of repeat issues as the Lessons Learned are implemented consistently internally and externally.
Balanced Score Card.	- There may be several Score Cards in place offering different factors for measurement. - Inconsistent usage. - The factors measured and scored do not hold equal weighting.	- Score Cards are under review to identify how the factors may be measured with equal priority / weighting. - Measurement is done with reactive (lagging) indicators only.	- A single, balanced score card ibis used consistently across business. - 10% of score is based on positive (leading, proactive) safety indicators.	- Consistent balanced scorecard used across business. - 20% of scorecard is based on positive (leading, proactive) safety indicators. - Feedback on the relevance of the factors measured is	- The balanced scorecard includes consistent internal and external measurement. - 30% of scorecard is based on positive (leading, proactive) safety indicators.

	- Higher weighting may be given to productivity, delivery or cost efficiencies.		- All management levels engaged and communicate the importance of consistent use and measurement.	requested / invited by management.	- Factors measured are regularly reviewed for effectiveness and relevance.
Welfare.	- Basic compliance to Legislation, CDM and Industry Standards. - 'Shell' of welfare in place but not used as designed. - Reality and Strategy of Welfare facilities does not match; concerns raised by staff.	- PPE provision is on a 'One size fits all' basis i.e. one size of work gloves provided. - Management involvement in Occupational Health and Wellness provision and measurement indicators is as a result of Industry pressure rather than in response to staff concerns.	- Reality and Strategy of Welfare facilities match - Feedback mechanisms are used to capture successes, improvements and confirm usability of PPE. - Fatigue management, stress awareness and Occupational Health programmes are in place for direct staff.	- Occupational Health and Wellness programme in place for direct staff e.g. wellness campaigns, and subsidised health initiatives. - Level of take-up is monitored and plans are in place to pro-actively raise awareness and engagement with all direct staff.	- Occupational Health and Wellness campaigns covers staff, their families and supply chain partners. - Monitor the uptake of offers and from analysis run campaigns to engage all. - Occupational Health and Wellness Programme is proactive in identifying risks and preventing harm. - Information campaigns include the Supply Chain.

Workforce	Pathological (Emerging)	Reactive (Managing)	Calculative (Involving)	Proactive (Co-Operating)	Generative (Embedded)
Activity Risk Assessment.	- Task Risk Assessments are sufficient for the risk involved and in compliance with legislative requirements. - Are high level and generic.	- Specific Risk Assessment performed. - The Risk Assessment process is disjointed without fully interlinking Activity, Design, Environment etc. risks. - Minimal engagement and involvement from workforce.	- The workforce is invited to engage in Risk Assessment process. - Task specific Risk Assessments are focussed on both high-risk task and site specific Risks. - Process is open to query, challenge and feedback.	- All levels of staff are proactively involved with the process. - The process is regularly reviewed and adaptable and implements changes. - Full integration with the briefing process including the opportunity to sense check and question content.	- Various analysis techniques i.e. ETA, FTA are in use. - Full integration with Lessons Learned, design and planning processes to support Continuous Improvement and reduction of risk.
Competence Management (task and individual).	- Competency records exist. - Competency needs are identified. - Focus is on skills and knowledge and not attitude or behaviour.	- Competencies and training needs are identified. - Competency assessments identify gaps and opportunities to develop individuals. - Competency training is delivered to include skills, knowledge, attitude and behaviour.	- Initial use of job profiling and behavioural markers in order to employ and develop the best people for the role or task. - Job descriptions include behavioural attributes. - Competency matrix is under development for all roles in the organisation.	- Implementation plans for behavioural components for all competencies including capability for trainers, assessors and verifiers. - Competency matrix for all roles is used proactively with 360-degree involvement.	- Competency Matrix includes Risk Assessment and Behaviour Based Safety and leadership. - Fully integration with performance Review and 1:1. - Training and competency requirements include behaviour-based improvements.

Safety Action Groups.	- Specific forums or meetings taking place within the business on a minimum basis and in compliance with the law - Led by management as they see at as a legal obligation rather than as a forum for improvement or communication.	- Safety Action Groups are seen as a communication tool and are Management led. - Feedback is led by Management resulting in little action planning for improvement. - Workforce is in attendance but not fully engaged with the process.	- Safety Action Groups have consistent attendance, led by workforce with management engagement and support. - Outputs captured as actions in minutes and published. - Actions closed and recorded as such.	- Outputs from the Safety Action Groups are measured, managed and maintained by the Workforce. - Excellence communicated internally. - Process for escalation and cascading of key safety messages are visibly in place driving changes within the business.	- The Workforce has autonomy and is empowered by Senior Management to implement plans or changes identified by Safety Action Groups. - The communications, innovation and feedback processes are integrated with Safety Action Group.
Cultural / Climate Surveys.	- Email and paper responses are only methods available. - 20% max response rate - mostly anonymous. - The context is not communicated to the Workforce. - No evidence of local ownership or action planning.	- Multiple methods of response available (i.e. paper, internet, 'phone). - 30% max response rate - mostly anonymous. - Effort is made to communicate the context to the Workforce. - Activities and actions are identified without cascade or close out plans.	- Cross-functional and role specific surveys used. - 40% response rate - more than 1/2 are anonymous. - Clear context is communicated to workforce. - Actions identified are cascaded through the organisation, without follow up to confirm completion.	- Behaviours and personal responsibility are included. - 60% max response rate - less that 1/2 anonymous. - Ownership within functions to encourage participation. - Actions identified are cascaded through the organisation, with follow up.	- 80% average response rate - over 3/4 have named responses. - Findings communicated through the business. - All actions are reviewed for effectiveness. - Employees are engaged with the process and actively encourage others to participate.

Companies	Pathological (Emerging)	Reactive (Managing)	Calculative (Involving)	Proactive (Co-Operating)	Generative (Embedded)
Safety Culture Management.	- Initial interest from Senior Management based on external influence. - Understanding of current Safety Culture is limited to Safety professionals.	- Safety Culture development programme is underway. - Scorecards and other tools are used to identify current Safety Culture. - Engagement with workforce in terms of a response rate is low and scepticism is evident.	- Management have a tangible plan for improving Safety Culture. - This primarily focuses on improving behaviour at the Frontline. - Action plans are put in place with a majority of actions closed out within the timescales.	- Management have a holistic plan for improving Safety Culture. - Focus is on improving the behaviour of all. - Action plans are closed out within timescales stated. - Full integration with Continuous Improvement, feedback and communication processes.	- Improvement plans include the organisation and supply chain. - Measurement tools used identify Safety Culture improvement strategically. - Frontline workforces do not feel a conflict between safety and delivery.
Audit.	- Internal Audit process makes very limited or no reference to behaviours. - Action planning for improvement is in response to External Audit findings only.	- Internal audit process includes some aspects or focus on behaviours. - External and Internal Audit processes are not aligned. - Action planning for improvement is as a result of both Internal and External Audit.	- Internal Audit process specifically includes Frontline behaviours. - Clear communication provided by Management to workforce. - Internal and External Audit processes are aligned evident by the same criteria in use.	- Audit process specifically includes behaviours at all levels of the organisation. - The internal Audit process is as robust as the External one. - Issues are identified and resolved consistently internally. - Excellent communication of findings.	- Internal Audit process is more robust that External processes. - Internal Audit identifies and resolves all issues in advance of External intervention. - All findings communicated to remove recurrence or repeat of issue.

Sustainability.	- Focus is on Environmental Sustainability due to contract considerations. - Compliance to Industry or legal requirements. -No interest in sustainability apart from Sustainability/Environment Manager.	- Sustainable working policies have been adopted in response to client pressure for commercial reasons. - Focus is broadly Social, Environmental and Economic as a holistic sustainability policy. -Sustainability has mainly environmental meaning to Frontline Staff.	- Sustainability policy includes; Environment - natural resources, stewardship, Social - community, ethics and worker's rights, Economic - efficiency, growth, research and development. - Development of leading KPI measurements. -Management run awareness campaigns focussed on engaging Frontline staff with Sustainability messages.	=- Clear communication and leadership from Management of the Sustainability Policy. - Active measuring and monitoring of activities and achievements using Learning and lagging indicators. - Inclusion of Sustainable working on the Balanced Scorecard.	=- Full product and service reviews to determine which should be phased out of use. - Sustainability policy is fully integrated e.g. with Continuous Improvement. - Engaging and motivating Workforce to adopt Sustainable attitudes to working practices.
Non-Conformance Report (NCR) Management.	- Majority of NCRs remain open without resolution. - Internal Audit processes are not integrated with NCR reporting systems.	- Majority of NCRs have action plans - many remaining open. - Internal Audit processes include NCR management	- All NCRs have actions plans, 50% are closed within agreed timescales. - Data used and some trend analysis is done, results not used to mitigate future events. - Full integration with Internal Audit. - Clear internal communication of Best Practice.	- All NCRs have actions plans, 50 to 75% are closed within agreed timescales. - Data used and trend analysis is done, also resulting in action planning and mitigation against future events. - Visible management engagement at all levels.	- All NCRs have actions plans, 75 to 100% are closed within agreed timescales. - Trend analysis is done to mitigate against future events. - Visible workforce engagement at all levels.

Processes and Systems	Pathological (Emerging)	Reactive (Managing)	Calculative (Involving)	Proactive (Co-Operating)	Generative (Embedded)
Process Improvement.	- Reactive process improvement led by Industry changes to standards.	- Reactive process improvement led by Industry changes to standards, the changing expectations from external bodies and results of external auditing.	- Proactive process improvement led by internal auditing and reviews. - Action planning and change management processes support implementing sustainable change. - Clear management engagement. - Workforce is consulted as part of Continuous Improvement.	- Clear action planning. - Commitment from management and clear communication internally. - Results of process / system changes reviewed. - Workforce is fully engaged in reviews. - Feedback is actively invited on improvements implemented - internally.	- Clear action planning and change management in consistent use. - Commitment from all levels in the organisation. - Feedback is actively invited on improvements implemented - internally and externally.
Near Miss and Close Call Reporting.	- Near miss and Close Call reporting system in place. - Management encourage it, action planning is not yet taking place. - Low levels of reporting compared to Industry trends. - Awareness of Worksafe procedure and requirements, no usage.	- Action planning has begun, however using these, as a management tool is not yet done. - Reporting levels are inconsistent and trends cannot be identified. - Awareness of Worksafe procedure and requirements with some success and positive reaction. - Near Miss/Close Call reported and entered into system sporadically and inconsistently.	- Management engagement is evidenced by an increase in Near Miss and Close Call Reports. - Action planning is consistently carried out. - Worksafe procedures and requirements in consistent use. - Success is evidenced by a reduction in identical events. - Data inputted into system by all levels of staff. - Factual feedback provided to all levels of staff.	- Change is managed and implemented in response to valid work safe invocations, monitoring of types of work safe invocations. - Improvement made as a result of reporting. - Management support the use of the Worksafe procedure. - All staff feels confident entering data into reporting system. - Feedback given to all staff of analysis and follow-up/rectification put in place based on reports.	- Clear and consistent downward trend in recurrent near miss and close calls reported. - Organisation held up as leading near miss and close call reporting and demonstrated by benchmarking results. - Reporting system consistently used and feedback, analysis, learning and rectifications shared with staff and supply chain.

Contract / Tender Process.	- HSE aspects of contracts not formally built into all aspects of Contract and Tender process. - Little evidence of business developing this holistic EHS approach. - Requirements are client led.	- Some formal inclusion of HSE requirements in all aspects of Contract and Tender process. - Requirements are client and business led. - Development of specific lagging EHS KPIs to measure performance.	- Formal inclusion of HSE requirements in all aspects of Contract and Tender process. - Lessons learned are incorporated in the next cycle of Contract and Tender activities. - Specific lagging HSE KPIs used to measure performance.	- Consistent application of HSE requirements. - Specific leading and lagging EHS KPIs used to actively measure performance. - Full integration with all Continuous Improvement and audit processes to enable consistency of internal and external measurement.	- Validation and verification processes are detailed and include delivery of "customer quality expectations". - Qualitative record is maintained of all aspects of internal and external Contract and Tender Processes as part of Continuous Improvement.
Risk Management.	- Risk registers are reviewed reactively when issues arise. - The mitigation plan in place to manage risk is not clearly communicated or maintained regularly. - Workforce not actively engaged in risk mitigation by management.	- Risk registers are reviewed and updated with detailed mitigation plans. - Focus is on process-related risk. - Risk management is perceived as the responsibility of Management. - Workforce is engaged in Risk Management at the invitation of Management.	- Risk registers and mitigation plans are regularly reviewed and updated proactively. - All business risk processes are integrated. - Clear leadership from management. - Workforce is engaged by Management and participating in reviews.	- Behavioural risks are identified and fully integrated in risk management processes. - Workforce is actively engaged and participating in reviews. - Lessons Learned processes are fully integrated with Risk Management approaches.	- Risk management and mitigation planning is fully integrated with Business processes including; Innovation, Safety by Design, Lessons Learned, Continuous Improvement. - The feedback mechanisms for the workforce include risk reporting.