EHS Today

Safety and Performance Excellence

▸ *with* Terry L. Mathis

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In February 2012, Terry Mathis began contributing to *EHS Today*'s Managing Safety column. Readers demanded more columns from Terry, and he began contributing monthly. Soon, the safety management column belonged to Terry and the Safety and Performance Excellence column was born.

This baker's dozen (plus one) of Terry's 2015-16 Safety and Performance Excellence columns offer a roadmap of the right things to do to create safety excellence at your company. It's not an easy journey, as Terry points out, but it is a valuable one.

Terry L. Mathis is the founder and CEO of ProAct Safety, an international safety and performance excellence firm. He is known for his dynamic writing and presentations in the fields of behavioral and cultural safety, leadership and operational performance.

Terry is a veteran of over 1,600 safety, culture and performance improvement projects in 39 countries and 21 languages, and has personally assisted organizations such as Georgia-Pacific, AstraZeneca, Wrigley, ALCOA and many others to achieve excellence.

EHS Today has listed Terry four consecutive times as one of "The 50 People Who Most Influenced EHS." SlipNOT's safety blog claims he "sets a new standard for safety success in the corporate world." Terry has presented over 40 webinars and podcasts, co-authored two books, published more than 45 articles and spoken at hundreds of private and public events.

▶ ***A list of upcoming events can be found at proactsafety.com/events.***

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When Organizations Outgrow Their Safety Programs

Whether your organization is growing internally or through mergers or acquisitions, shifting direction or simply experiencing the world-wide change of generations, you might be outgrowing your current safety capacity.

Many safety programs have become stagnant during a period of relatively good results and have dulled their sense of vulnerability. The need for strategic change in safety is ambushing many organizations in today's climate. The best time to make adjustments is before your current programs create the possibility for catastrophic accidents.

Many organizations have enjoyed the luxury of experienced workforces over the past two or three decades. These well-seasoned workers have developed a keen awareness of workplace dangers and often have developed a culture of looking out for each other. New workers could be introduced into this culture with relatively little onboarding and be assimilated quickly and safely.

Certainly, some bad practices get passed along in such a system, but the good usually outweighs the bad. In such a reality, training and onboarding often atrophy and become ineffective. The outcomes don't point to the deficiencies because the culture prevents the negative consequences of weak formaltraining by providing good on-the-job training and a support system of experienced fellow workers.

But what happens when the experienced workforce is diluted with too many new hires, or the most experienced workers begin to retire in large numbers? New employees often get thrown into the workplace with inadequate training and weak, or lacking, support systems. Safety professionals find they need to spend much more time in the workplace to correct performance problems.When they can no longer manage critical safety issues with the inexperienced masses, accident rates begin to climb and the safety staff goes into fire-fighting mode reacting to accidents. Accidentinvestigations take an increasingly large percentage of the safety staff's time. Corrective actions also begin to take longer and the remaining time often is confiscated by organizational leaders who begin to question why the failure rate is growing.

Many organizations fail to realize in a timely manner that changing workforces require changingsafety efforts. When the realization finally comes, the reaction often is simply to do more rather than to address the problem strategically. New programs are initiated with little regard to how they fit in with existing programs and with few metrics to truly test their effectiveness or efficiency.

This programmatic approach has created a marketplace for safety programs. Almost every consultant and training company can provide something more for organizations to do and price them according to the urgency to improve results. Ironically, most of these programs produce Hawthorne Effect results, which make them look good in the short-term. When an

organization adopts a new program and the lagging indicators respond in a timely manner, leaders often declare the problem solved and move on to other priorities. Unfortunately, a programmatic approach to safety almost always fails in the long run.

Vision Statement

The alternative to this approach is to rethink the overall safety strategy. It is ironic that organizationsthat have a strategic approach to almost every aspect of business don't all have a true safety strategy. Strategy begins with a view of what desired success looks like. Some call this a vision statement.

It is important to envision the organization's personal best rather than some abstract view of perfection. Many vision statements are so perfectionistic they actually demotivate workers. It also is critical to define success in terms of performance, not just results. Remember that "Zero Accidents" and "Everyone Goes Home Safe" are goals and not strategies. What performance will produce those results, and how can you repeat it next year?

Once strategic thinking begins, old paradigms and heritage practices don't necessarily dominate the approach to success. Strategic thinking opens new possibilities that programmatic thinking tends to ignore. Who should set the safety strategy? Who should make it happen in the workplace? What training will be necessary? What criteria should be used to screen candidates for new positions? What communication will create focus? What metrics will give workers motivational insight into successful performance? What kind of safety leadership and management is needed, and should it be embedded into the organization or be a separate, stand-alone department? What kind of safety culture will sustain the desired performance long-term? What kind of engagement opportunities do workers need to form this desired culture?

Once a strategy begins to emerge, it may be necessary to assess the current status of the safety culture and determine what factors influence it. Many argue that assessments should precede strategy development, but often an assessment identifies problem areas, causing the strategy sessions to digress into problemsolving sessions (gap closure) rather than true strategy development. When strategy comes first, it more often defines success- rather than just avoids failure. Such strategies tend to be proactive and preventative, rather than simply reactionary.

Once the strategy is determined and the current status assessed, it may be time to look for programs that were avoided earlier. Now programs can be fit into the strategic framework rather than simply aiming new efforts at old problems. Many organizations find that refining existing programs is more effective than adopting new ones. Always remember to manage the perception of change and not overwhelm the workforce. A modification of an existing program can appear less daunting than starting over with something new. Even new programs can be postured as the next logical step in a progression rather than a new start from a dead end.

Leaders always should be in touch with the evolution of their organizations and realize changes in the workforce necessitate changes in safety efforts. Leaders who stay in touch and avoid the "more is better" mentality tend to think about safety strategically. Strategy is the purview of leaders and they should take the lead in safety, as they do in any key priority or value in the organization. Such strategies utilize help from safety professionals without delegating safety entirely.

The Complacency Dilemma

Is complacency the problem, or is the issue more complex than that?

There seems to be an upward trend in several industries to list "complacency" as a contributory cause on accident investigation reports. Many perception surveys now ask workers if they have become complacent when doing repetitious jobs and if complacency is considered an undesirable characteristic of a safety culture. Although this attention to complacency is deserved, the standard solutions to improve it fall short of success in almost all instances. Complacency is a state of mind, which is not necessarily the only influence on safety choices or behaviors.

When was the last time you were complacent about wearing seatbelts? When did you just stop paying attention to them because they didn't seem that important or you were distracted by other things? The answer is probably never. You either have formed the habit of using seatbelts or you have not. If you have formed the habit, you automatically buckle the belt, regardless of your complacency, sense of vulnerability or other distractions or priorities. If you have not formed the habit, you may buckle up only when you are concentrating on the need for such precautions (or not at all).

About half of the accidents we review that are attributed to complacency involve risks that can be avoided with simple precautions. Most simple precautions can become habitual with practice and reinforcement. Once they become habitual, they are all but exempt from complacency, distraction or other common problems. Just as many children are taught and reminded to look both ways before crossing the street, workers can be taught and reminded to take the precautions that most often impact accidents and near misses in their particular site or industry.

Root-cause analysis actually is a contributing cause to the complacency dilemma. Most organizations have not realized that root-cause analysis is geared toward machines and circuits rather than human beings. Human behavior almost always is more complex than the model of contributory and root cause describes. When workers get tired or distracted and are injured, their condition tends to be described as complacent, and that condition tends to get listed as a contributory or root cause of the accident. Such simple, linear thinking usually is inaccurate and ineffective at preventing future accidents.

Root-cause methodology also is flawed. The idea that five is the magic number down a causal chain has been disproved again and again. That you have reached a root cause when you run out of data and cannot answer the next-level "why" question equally is erroneous. The more appropriate question to ask is, "When workers become complacent, what precautions do they most often fail to take?" The answer to this question will reveal the habits that need more focus and to be reinforced in the safety culture.

A behavioral Pareto analysis of accidents and near misses can be a real eye opener. The key to such an analysis is to determine not what caused the accident, but the behavior that could have prevented or lessened the severity of the accident. If the preventive behavior is complex and highly cognitive, then forming

habits might not be the answer. However, if the preventive behavior is simple and rote, forming habits around these behaviors can be the solution.

Habitual behaviors continue to occur regularly in spite of complacency or other mental states. If these habitual behaviors impact the majority of accidents, then habits solve the safety problem. Remember the stages we went through to get drivers to use seatbelts in cars? We raised awareness, sold people on the wisdom of seatbelt use, punished them for not wearing it and put devices in all cars that noisily reminded us until we buckled up. In the end, we did not change the mindset nearly as much as the habit. Most drivers use seatbelts because they are in the habit of using them, not because of some elaborate strategy to overcome complacency.

Admittedly, not all complacency results in risks that can be addressed by forming habits. We want workers buckling seatbelts, using the right tools and equipment and using good body mechanics automatically without reliance on conscious thought. We don't want workers at nuclear power plants refueling nuclear reactors that way.

Certain tasks require great planning and meticulous, conscious thought to carry out safely. Such tasks should not be addressed with cultural habit forming. However, in our experience, these complex tasks compose half or less of all risks attributed to complacency in most industries. In a few organizations, such tasks are negligible or non-existent.

Some of our clients have observed how nuclear power plants operate and tried to use them as a model. The main attraction was to strictly define procedures and reduce decision-making in the workplace that often results in human error, leading to accidents. If your business is not labor-intensive, this approach may work. However, most organizations require frequent interventions, often calling for the laborers to make workplace decisions. Such decisions are difficult to control through rigid guidelines or procedures. In such cases, worker competence and judgment becomes more critical than written procedures, and the forming of basic safe work habits has a significant impact on such decisions. Overall safety performance is impacted by common practice, and common practice is impacted by worker safety habits.

In the end, safety solutions can be divided into conditional and behavioral. The behaviors can be divided into two categories as well: simple, repetitive behaviors and complex, cognitive behaviors. Root-cause analysis has great value in the conditional part of safety. Machines and circuits malfunction for a reason, which must be traced to its source to keep it from recurring. Human beings are more complex. When people "malfunction," we need to decide whether better habits or better thinking is needed. Forgetting that habits are part of the issue makes safety seem much more complicated than it has to be.

Safety and Motivation

When you think about your organization's safety efforts, does the thought motivate or de-motivate you?

Does safety motivate you or de-motivate you? This is a question I often ask in workshops and am amazed how demotivating most safety programs are perceived to the workforce. Leaders constantly ask how they can get workers more engaged in safety efforts and form the kind of culture that will sustain excellent safety performance. A partial answer to this question is to make safety more motivating.

Motivation currently is not a hot topic in most businesses. Over-marketing of reward and incentive programs and the swarm of books on the subject during the past two decades dulled its appeal. The basic idea of motivation as some kind of hyperactive energy boost to employees was unrealistic and largely replaced by the concept of identifying and controlling the factors that influence workplace performance. The books about motivation evolved into books about influence and the new goal is to align and shape performance rather than supercharge it.

Whether you attempt to control what you call motivators or influences, successfully doing so should elicit a degree of enthusiasm from workers. If it does not, the program and overall effort of safety is swimming against the current of culture. In such cases, safety efforts tend to be minimal and grudging. Workers practice a degree of safety to avoid negative consequences or labeling, not to help the organization achieve true excellence. The safety culture is one of compliance, not collaboration. Even if hands and feet move, the hearts and minds of workers are not engaged. Safety has a "have to" rather than a "want to" culture and all the potential altruism is stifled.

Slow Creep of De-Motivators

Interestingly, most leaders do not de-motivate safety efforts deliberately. They simply allow de-motivators to creep into their management style and communication. Workers begin to receive negative messages, which build up over time and defeat motivation. Some leaders simply don't view motivation as a part of their job description and therefore, don't try. Others fail to realize that many employees come to work motivated, and all that's needed is to quit beating it out of them before they leave. When I ask workers to give me specific instances in which they felt most de-motivated, I regularly get the following three answers:

First, workers feel de-motivated when they feel separated from leaders. This happens when they don't receive timely, detailed information or have regular contact with leaders. Many organizations grow too big or scattered for leaders to have periodic face time with workers, but motivational leaders make use of new technologies to make that contact happen. Leaders can get busy and lose track of how often they communicate with workers, or simply not make such contact a priority.

One leader was recognized for the successful performance of a safety team that had been formed to address a specific safety concern. He asked the team what he could give them as a reward and they only asked for information about the company. He stated in some awe that he did not realize how hungry workers were for meaningful communication.

The second most mentioned de-motivator is about control. Workers who feel manipulated or micro-managed have difficulty remaining motivated.

Control and trust are perceived as inversely proportional. Too much control is interpreted as a lack of trust in workers to do the right thing and to do it safely. Over control also can be demeaning. Step-by-step oversight is what parents give to small children, not what good leaders give to trusted workers.

Recent studies have touted autonomy as one of the greatest motivators for workers whose jobs require any degree of cognitive tasks. Control removes autonomy and destroys the great motivational potential it can provide. Again, most leaders are not deliberately trying to de-motivate; they simply are trying to exercise control. They don't realize that less control actually can be more if workers take initiative and require less oversight to produce better performance. In fact, enlightened leaders report that a motivated and autonomous workforce is the pinnacle of control.

The third most-mentioned de-motivator closely is related to the first two. It is when input from the workforce is ignored. In some instances, worker input isn't ignored; there is just no channel to collect it in the first place. Some leaders don't elicit or accept input from workers. In other instances, the suggestion box or other mechanism for gathering worker ideas and suggestions becomes a symbol of insincerity. It is black hole into which genuine suggestions go and from which nothing ever returns.

W. Edwards Deming said that the greatest expertise in an organization was found in the people most intimately involved in the work; that almost always is the worker. Certainly, safety experts need to ensure compliance with regulatory agencies, and leaders and managers should ensure adherence to company policy and intent, but workers should be involved in the tactics of safe work. Where workers cannot give input or where their input is not utilized, theory and practice begin to separate. Workers view new safety rules and guidelines as impractical and not in touch with the reality of the workplace. Dangers are known to workers, but not addressed by leaders until they produce accidents. Ignoring worker input drives many reactive safety practices and blocks the best path to meaningful proactivity.

Motivation is not the main goal of a safety program, but it is a tool without which the highest levels of excellent safety performance are not possible. De-motivated workers give grudging compliance but not willing cooperation. Overly controlled workers comply but don't excel. Worker input through suggestions is a remarkable pool of improvement possibility that will be untapped if motivation is lacking. Improving motivation for safety may be as simple as regular communication, increased autonomy and letting the folks who do the work tell you how it could be done safer.

Safety Culture and Social Media

Soon, social media will be tapped as a resource to build safety cultures.

American culture heavily is impacted by social media. Cultures once formed around the workplace, school, church or other places where people gathered to build relationships. Today, people get together and form cultures in cyberspace. It is just a matter of time until these cyber cultures are tapped as a resource to build organizational and safety cultures.

Organizations that have been challenged by their own logistics now have a way to connect previously disconnected workers and to form safety cultures via social media. Already, Facebook and LinkedIn have invited companies to form their own groups online. Many companies have used the Internet to distribute safety manuals and guidelines to their scattered workforces via shared, restricted-access web sites. Adding opportunities for their workers to chat with each other and share ideas, experiences and best practices is a logical extension of Internet and cell phone usage.

Although logistically challenged organizations will be among the first to use social media, other organizations without logistical problems will follow in close order. We often joke about people sitting across a table texting each other rather than speaking. However, this joke is becoming the new reality. We are becoming more and more users of social media and texting, and less and less users of interpersonal conversation. Recognizing this reality is the first step toward forming company and safety cultures via social media.

Sharing in Real Time

Sharing everyday experiences and ideas in real time is a great lure to participation for workers. The ability to immediately communicate accident-investigation findings or even to have a safety stand down via everyone's smart phones could prove invaluable. Immediate access (without travel) to another employee with greater expertise could improve JSAs and other forms of pre-job planning.

The fact is, workers already communicate with some of their fellow employees via social media. Groups of friends, family members at work and neighbors who also are work associates "friend" each other and regularly communicate. An organization easily can create an online work community to facilitate the connection of these groups. Several types of social media already facilitate multiple groupings of contacts such as family and friends. Adding business associates is a simple next step, for which the technology already exists.

Organizations already are experimenting with the use of social media to enhance safety in their cultures. The ones that were quickly successful had three commonalities in their approaches.

First, they started with a beta group to prove the concept before expanding it to broader groups or organization-wide. The small groups

were selected to be representative of organizational sub-cultures that already existed and had some degree of commonality and communication already. The problems encountered in each group were solved before expanding the cyber community to more members. Complex organizations selected more than one beta group, if they felt they were needed, to be a cross-section sampling of the overall organization.

Second, the group members' experiences were monitored through surveys and focus group interviews to test the progress and analyze challenges. Overall usage of the media also was tracked to see what percentage of participants used the media, how often and for how long. Length of comments and strings of dialogue also were measured to see if they were growing.

Third, successful organizations made sure everyone had the same access to social media by providing the same types of smart phones to everyone in the groups and making sure everyone had adequate access and instructions for using the site. Help desks commonly were provided for the users of the beta site through internal IT departments and help features were available through the social media programs used.

Advantages of Social Media

The organizations with successful beta groups began to expand the site offerings to larger groups in their organization. They were pleased with the beta groups and reported several perceived advantages provided by social media. The most common were:

- Interpersonal communication among workers drastically increased and barriers to talking to each other about safety issues seemed to disappear. Perceptions of the importance and contribution of fellow workers grew in relation to increased knowledge of what others were thinking and how they reacted to organizational issues. Perceptions of teamwork and looking out for each other in safety reached new heights.
- Communication of safety data improved. Accident and near-miss reports reached everyone via posts and were discussed among workers on the same social media. The testing of knowledge about recent events indicated much greater awareness of details and significance. Lessons learned from incidents more widely were known among workers. Communication of safety data greatly was enhanced and workers preferred getting the communication by social media rather than by more traditional communication methods.
- Perceptions of organizational leaders responding to safety suggestions changed radically. Workers felt leaders were more in touch with workplace issues and were listening to workers more openly. The need for formal suggestions was replaced by an ongoing dialogue between workers and leaders.
- Organizations with logistical challenges felt they finally were giving workers opportunities to network with each other and share best practices. The yearly meetings of limited numbers gave way to larger groups being able to get together daily.

These ideas only scratch the surface of what social media potentially could do for safety culture. Use and experience will teach the rest over time. Technology changes as quickly as our ability to use it and that will open even more opportunities. Security of data certainly will be an issue, as it already is with all Internet and broadcast media, but we certainly will run a race with hackers and cyber-crooks to stay ahead of their thievery.

Society, in general, is becoming a social media society. Savvy safety professionals will get together with their CIOs, IT departments and with the growing group of cooperative providers to look ahead and explore the opportunities to use this world-changing social media to their advantage.

Fear: The Enemy of Safety Excellence

It is ironic that organizations encourage risk taking and develop a tolerance for failure in pursuits such as marketing and new-product development, but have a completely different view of safety.

Certainly, no one wants to fail at safety. Safety failures can be catastrophic and costly. But when the fear of failure becomes the primary driver of safety efforts, the results often are self-limiting.

The fear-driven safety program tends to steer organizations to take steps directly aimed at avoiding failure. The definition of success becomes "to fail less." Goals are based on negative steps, such as avoiding risks, and the metrics are failure metrics. Blame and punishment often are attached to failures and the lack of failure is rewarded without regard to the performance that led to it.

Luck is rewarded the same as safe performance, as there is nothing to distinguish between the two. Lagging indicators guide efforts and key performance indicators either are not developed, are ignored or are viewed as "soft" metrics. The proverbial "wag the dog" is in full effect and the focus on results makes the processes and performance that actually produce the results disappear into the background.

Management's fear of safety failure can lead to other self-limiting approaches. Safety, which should be a strategic job of management, often is delegated to safety "specialists," who are expected to lead the effort to fail less. Executives and senior managers often separate their duties from safety and also may allow lower-level managers and supervisors to do the same.

Business and safety are managed as two separate priorities and may compete for resources, time and worker attention. It becomes a dichotomy in the minds of workers, who often ask which is most important each day. The fear of safety failure keeps the business leader's attention until the fear of business failure becomes greater. Safety based on fear never becomes a value because its priority changes when one fear outweighs another.

Fear of Failure: Contagious

Leaders whose primary goal is to avoid failure often try to convey their fear to the workforce. They hypothesize that if workers also fear failure, it might align efforts to fail less. Guidelines center on avoidance and management style focuses on negative consequences to emphasize these goals. In this mindset, proactivity in safety means making rules and procedures that minimize failures. The goal is compliance rather than excellence.

The safety professionals become the safety police and workers begin to develop avoidance behaviors. There are only three possible consequences of safety for workers:

1. Getting injured
2. Getting caught in non-compliance, or
3. Getting away without consequence.

Great safety performance is not rewarded more than mediocre performance if neither result in consequences. Excellence is never better than "good enough."

When incentives are attached to the lack of failure, the outcome can be disastrous.

OSHA has realized that rewarding a lack of injuries can result in non-reporting rather than improved performance and has moved against such incentive programs. Still, many organizations celebrate lagging-indicator milestones without reinforcing the effort that produced the result. Workers who contributed to the improvements receive no more recognition than workers who took risks but were not caught or injured.

The implied definition of safety success as not getting injured continues to mislead workers into thinking that any performance or practice that doesn't produce an injury or punishment must be safe. If the result of performance is less failure, the performance is, formally or informally, approved and reinforced by the organization.

The delegating of safety by organizational leaders is not just an abdication of a basic duty, it is a means of creating a scapegoat for potential failure. If the leader can produce a profit, even at the cost of accidents, the leader succeeds in production and the failure belongs to the safety professional.

When this occurs, the interconnections between production and safety are not addressed. The holistic thinking around "safe production" is undermined by the assertion that each is a separate aspect of work with different leaders and different priorities. Safety gets lip service and production gets rewarded. Productive workers get raises and promotions, and safe workers who are less productive get criticized and corrected. The boss gets bonuses when production is good and the safety manager gets replaced when safety pays the price for that production.

Managing by fear of failure promotes lagging indicators as the ultimate metric of safety. All programs and efforts are measured by their impact on failure rates and the cost of failures. The cause-and-effect relationship of programs to results is assumed rather than measured, and every effort either passes or fails the lagging-indicator test. Program or process efficiencies are not considered in management decisions because there are few or no metrics to gauge and understand them.

Programs that could have impact with a little more time or effort may be scrapped as failures without having a chance to succeed. New programs and processes get practiced too long before being evaluated because it takes longer to develop meaningful lagging indicators. New efforts that are ineffective can be disguised by other factors that improve lagging indicators or simply by a normal variation of results that corresponds to the programs. Measuring effectiveness of new safety efforts by the impact they have on lagging indicators often ignores important other factors and data trends.

Is More Better?

Defining success as the lack of failure also drives the "more is better" mentality in safety. When failure rates are unacceptable, the organization decides it needs to do more. Programs are implemented on top of other programs in an array of accountability that can be more confusing than focused.

Safety activities are measured by volume rather than value: Unproductive activities are perpetuated and added to, rather than eliminated, and replaced with higher-value activities. Most organizations don't need to do more in safety; they need to do better.

The most-excellent safety cultures have a healthy sense of vulnerability to accidents, but their motivation comes from a quest for success, not the fear of failure. Success is defined and worked toward. Failure is the lack of success, not the opposite. Fear is not the driver, nor the tool of success. It is the enemy.

The Customers of Safety

More and more, organizations are realizing that workers are not a safety problem to be controlled, but the customers of their safety efforts. When the needs of the customer are not met, tragedies become possible.

April 28th was a national day of mourning in Canada for those who have been killed on the job. The promotional posters read: "Reflect, Remember, Resolve, Prevent." At 11 a.m., all participants observed a moment of silence for those who lost their lives and their families that were left behind. At the organizational safety conference in St. John, New Brunswick, they showed a video depicting the story of one man who was seriously injured on the job and how the owner of the company realized he had not done all he could to prevent the incident. The video had a genuine tone of regret, but no clear call to action other than to try harder.

More and more, organizations are realizing that workers are not a safety problem to be controlled, but the customers of their safety efforts. When the needs of the customer are not met, tragedies become possible. Still, many organizations base their efforts on required, regulatory restrictions and minimizing legal exposure rather than on the needs of the workers.

Tragedies such as catastrophic injuries and fatalities continue to be the wakeup call that communicates workers don't have all they need to do their jobs safely. In many cases, reactive safety still tends to produce more effective safety efforts than proactive efforts. Organizations turn the crank on the box of traditional safety programs even after the music has ceased to play.

Do the Research

So, how do we get out of this mindset and meet the safety needs of workers? The answer lies in adopting some marketing and market research practices for safety efforts. Products and services often are developed to meet a consumer need. Market research has been done to determine what the need is and if the proposed product or service will meet the need.

We need to do such research among workers in safety. They should to be asked what they need to do their job safely in terms of training, assistance, tools and equipment, procedures and, most importantly, time. Regular tabulations of workers' perceptions of need should direct the efforts of the safety department as well as feed valuable information to training, procurement, engineering and supervision. The increased percentage of worker needs met should become a KPI for the safety department that is reported to management and leadership along with lagging indicators.

Realizing that workers may not know what they need, the organization should use outside expertise and benchmarking to determine what other things might improve safety that workers are not aware of. In marketing, "Blue Ocean" refers to new products and services that create whole new markets. Steve Jobs said, "No one knew they needed an iPhone until I invented one."

There may be any number of innovations in safety that could benefit workers in particular

organizations. Savvy organizations have explorers with an "ear to the ground" through safety publications, trade shows, new product announcements and other media who include organizational leaders as well as safety professionals. These groups of explorers are on the lookout for anything that potentially could help their workers do their jobs more safely.

However, it seldom is sufficient to simply measure the market and respond. The true meeting of needs should be strategic, not just tactical. This means that safety market research should be shared with organizational leaders who compile the data into a strategy for safety that matches and compliments the business strategy.

The safety strategy clearly should define the plan for winning the war against accidents by arming the workers with the best equipment and a clear battle plan. Progress periodically needs to be measured and the strategy adjusted when needed. If the business strategy competes with, rather than compliments, the safety strategy, safety almost surely will lose the battle. Safety and productivity should not become dichotomous for workers. The ideas of safety and productivity should meet in an overarching strategy to achieve "safe production" of products and/or services. When the battle plan is clear, the effort of everyone involved is aligned and effective.

Limitations

Such a strategic approach to safety creates some limitations as well. Off-the-shelf programs, processes and training modules often are insufficient to meet needs and create alignment with strategy. More customization may be needed, which may challenge existing approaches to training and worker engagement.

Computer-based training (CBT) modules used for annual refresher training may need to be modified. Classroom training may need to be better aligned, and the use of outside training companies may not work as well. However, while these are challenges, they also are opportunities. In reality, most safety training, especially CBTs, don't meet worker needs and largely are a waste of time other than to meet minimal compliance requirements.

The workers already are taking time for these activities. The cost of worker time away from work usually is greater than the cost of delivering the training through various media. Making the training modules more effective in meeting worker needs ultimately is a low-cost approach with a great potential ROI based on accident reduction.

Worker engagement opportunities, such as behavior-based safety (BBS) observations and steering teams, also may need to be assessed against the safety strategy. While engagement is a noble goal, many such programs are viewed by workers as unnecessary and unproductive busy work, and can actually create resentment rather than engagement. This is not true of all such programs.

Many BBS and other processes are viewed by workers as extremely valuable in accident prevention and should be continued. Others may need some revisions. But, again, the determining factor should be whether or not the programs are meeting the needs of workers and helping them do their jobs more safely.

When organizational leaders and safety managers realize that the true challenge is not compliance or legal exposure, but meeting the needs of the workers through effective safety efforts, it may be possible for the Canadians to quit mourning, and the world to quit regretting, and for everyone to take safety to a new level of excellence.

The New Safety Strategy: Quit Preventing Accidents and Start Creating Value

If your safety programs and strategy were a product, would your employees buy it?

If you charged a membership fee to participate in your safety programs, how many of your workers would voluntarily pay? The answer to this question is a glimpse into the perceived value of your safety efforts.

Too many safety programs view the worker as a problem that must be controlled. EHS professionals try to control workers through imposing rules and procedures, modifying their behavior, dictating the formation of their safety culture and attempting to get them engaged. But what if we viewed the workers as the customers of safety and tried to add value to their efforts by providing resources and programs that met or exceeded their safety needs?

The first step in this direction is to change the vision of the safety initiative from a compliance problem to a customer opportunity. Rather than trying to control and limit workers, the new safety strategy would be to market to them.

Marketing begins with research to determine customer wants, needs and possibilities. Most traditional safety efforts focus on organizational needs and how to get workers to meet them. The new safety strategy begins with analyzing what workers need in order to perform their jobs safely, rather than telling them what the organization expects of them. Once needs are determined, the organization can better align itself to meet those needs and identify influences that conflict with worker safety performance.

Targeting Shared Value

Once the vision of the worker is changed from problem to client, safety can begin to target the creation of shared value. In business strategy, shared value is defined as social value plus economic value. This marriage of values answers the "what's-in-it-for-me" question for both the worker and the organization. The organization avoids all the economic and social costs of accidents, and the worker avoids both the pain and expense of work-related injury and can be motivated by involvement in this important effort. Shared value also forms the foundation for safety culture excellence by uniting the goals of workers and leaders. The "us vs. them" mentality of traditional safety is replaced with "all-of-us vs. the problem."

The strategy of safety changes its focus from preventing accidents to creating value. At first glance, this sounds like a dangerous distraction from the goal of safety rather than advanced thinking. But when the new strategy begins to take shape, organizations realize safety always has been accomplished by effort rather than subtraction.

When the strategy defines which efforts add value rather than what risk-taking needs to be eliminated, the risk-taking systematically gets replaced by proactive effort. In the minds of workers, safety becomes something you do

rather than something you avoid. The effort is visible, whereas the lack of accidents or even the avoidance of risks is less obvious. The lack of accidents becomes the result of very specific activities, which can be replicated next month and next year. The luck element in safety, which also can result in a short-term lack of accidents, no longer clouds the picture nor creates a false illusion of success.

As the strategy changes the goals of safety from stopping risks to starting value-add activities, there is another benefit. The tools to stop human behavior (policing, punishment and blame, etc.), while sometimes effective, potentially have a negative impact on relationships and culture. Organizational efforts to eliminate risk-taking behavior are fraught with such negative side effects: Trust levels often are low, making it difficult to create collaborative efforts. Avoidance behaviors abound, and motivation is stifled by the overall tone of avoiding failure rather than achieving success.

The tools to start specific human behavior, on the other hand, are builders of strong relationships and culture. Coaching and positive reinforcement bring workers together in their efforts and motivates the culture with positive scorekeeping and celebrations of success. Managers and supervisors can move from safety cop to coach, from enemy to ally.

Measuring the addition of value potentially is a discrete and insightful leading indicator of accidents, and is a positive vs. a negative metric, a measure of winning rather than losing less. Dozens of KPIs can be developed to measure value-add and these can be compared to the impact on lagging indicators to test overall effectiveness. The organization begins to measure what it wants and works to attain success rather than measuring what it does not want and working to avoid failure.

Aligning Safety and Business

A value-add approach necessitates meaningful alignment between the safety strategy and the business strategy. All too often, these two strategies compete with each other for attention and priority when they could synergize to accomplish common additions of value. Organizations that have made the effort to align these strategies have discovered that, very often, good safety is good business and that a good business is a safe business. Safety professionals must become business professionals who specialize in safety, and business leaders must take the lead in developing safety excellence strategies as they do in other strategic aspects of operational excellence.

As efforts to add value to safety mature, another opportunity appears on the horizon. Competitive business strategists have realized there is an alternative to competing for the market share of a given product or service. This alternative is to go to the "blue ocean" and create a whole new product or service that exceeds customer needs and generates new marketplaces.

Steve Jobs said that no one knew they needed and iPhone until he made one. Your safety efforts to add value can become transformational when you develop new products or processes that workers may not realize they need until you roll them out.

This realization can energize safety efforts and turn them into innovative pursuits rather than the same dull efforts to lower failure rates. The leading edge of safety is the development of a safety strategy that seeks to add value rather than control, looks for innovations to add transformational potential for value and finally realizes that eliminating accidents is the byproduct of adding value and not the direct task at hand.

The Four Core Components of Safety Excellence

Organizations that have basic safety programs in place usually take one of two paths: either they turn their attention away from safety to other priorities, thinking their safety performance is adequate, or they turn their attention to true safety excellence.

Unfortunately, many companies that seek excellence simply try to do better at the basics. They do not realize the thinking and programs that got the organization from bad to good in safety will not take it from good to excellent. The organizations with the most excellent safety performance have added four core components to their safety efforts.

Strategy – While basic safety programs are adequate in the beginning, a true safety strategy is necessary to achieve the next level of excellent performance. Strategies can align thinking and fit among programs. Alignment and fit are the basic building blocks of organizational excellence.

It takes every person and every program working in the same direction with the same end goals in mind to accomplish exceptional results. Who manages safety and how they do it must be strategically decided and reinforced. How safety is communicated and motivated must match the management style. Safety meetings and training cannot be a mismatched or outsourced conglomeration of conflicting messages.

Compliance must become a minimum standard, not the ultimate goal. Accident prevention must be recognized as the outcome of excellence, not the primary target. Strategy is how to win, not just how "not to lose."

Assessment – Many of our clients initially have argued that assessment should precede strategy. However, we have found that a strategy based on an assessment tends to fill gaps rather than be a true strategy. Once a strategy is developed, an organizational assessment can identify the best opportunities to create alignment and fit with the strategy, rather than simply identifying perceived gaps between reality and some artificial ideal of perfection.

Assessment is difficult in organizations with trust issues. If employees are hesitant to point out issues for fear of the consequences, outside help may be necessary to truly assess the current status. Some organizations think they can overcome trust issues simply by using a perception survey that is filled out individually by each worker. While such surveys do provide a degree of anonymity, they don't allow for following up on the details of the issues that have been identified. This must be done in interviews or focus groups where the trust levels again become critical. Also, perception surveys only are one of several areas of assessment that are necessary to truly understand where an organization and its culture are in the progression toward safety excellence.

Perceptions are limited by two primary factors: accuracy and completeness. The fact is, perceptions can be completely different from reality. Workers' perceptions that their safety training is adequate might be completely re-

futed by testing their knowledge on critical safety issues. Workers might perceive their greatest risk as burns when the accident data suggests trips and falls are far more common.

Also, workers don't know what they don't know. Testing their perceptions of anything in which their knowledge is limited creates relatively useless data. Accurately determining the current status is a necessary step toward more excellent performance.

Coaching – Excellence is not simply the result of great leadership; it is the result of leading great people. People become great through coaching. For an organization to move from good to great, coaching must become a skill that's regular use is expected and reinforced at every level of leadership. Performance coaching should be an integral part of the organizational training curriculum and refresher/follow-up training should be held regularly. It should be in the job description of every leader and a top item on their performance appraisal. It should be discussed in every leadership meeting and coaching best practices should be shared.

The continuous improvement of the performance of direct reports should be the primary goal of every leader and should become the standard by which their own performance is judged. Specific safety improvement targets should be selected in every work group and should be the focus of the coaching efforts. Every day, specific safety improvements should be visible and expected. This improvement should become the primary driver of safety, replacing the lagging indicators which should approach zero as the improvement efforts bear fruit.

Engagement – Aligning workers and coaching them is a good start toward getting them engaged in safety, but more is needed. Workers need opportunities to be involved in the work of safety in a meaningful way.

Well-designed and executed behavior-based safety (BBS) processes are one example of how this can be achieved. If workers are included in the design of the process, and learn through discovery which behaviors can have the greatest impact on accidental injuries, they develop a sense of ownership for this part of safety. If they can be involved in meaningful observations, then this interaction between workers becomes an extension of the safety coaching performed by leadership.

When this happens, all interactions between workers and leaders or workers and other workers are aligned, and the two programs are fit for purpose and they support the safety strategy. Organizations with good safety strategies readily can select the process with the best fit and avoid the less-than-effective safety programs.

Some or all of these four core components can and often do become a part of initial, basic safety efforts. If they already are in place, they should be used and not replaced. However, organizations with the most excellent safety performance tend to adopt all four of these and strive to make them work together with synergy and harmony. It is important not to wait until you have the perfect plan to get started. Excellence is a process that grows from sincere intent and effort and from having all the core components in place to enable success.

Questioning the Key Pieces of Safety Strategy

The best performers in safety realize more of the same is not the answer.

Sadly, more corporate safety initiatives are based on history than on strategy. The old adage, "We have always done it this way," is used to justify existing efforts and hide the need for seeking better methods.

Most organizations continue to manage safety the way they always have until the lagging indicators send them a wake-up call. Then, most respond by finding scapegoats or by adding more effort, rather than thoroughly examining their existing efforts. Thus, flawed or lacking safety strategies are perpetuated indefinitely.

More and more, organizations don't need to add to their safety efforts, but rather need to strategically improve the quality and effectiveness of their existing efforts. A good way to examine your existing safety strategy is to ask yourself some basic questions:

Basic Question No. 1: Have you created a shared vision of what safety excellence looks like? If you ask any worker at any level to describe the desired state of safety, will you get accurate and similar answers? Is the answer the cliché "lack of accidents," or does it describe what makes the accidents go away?

Follow-up Questions: Is this the best vision to direct the efforts of your workforce? Is it clear and does it describe the role of each individual? Does it truly direct safety efforts in the desired direction? Can you think of a better vision or better ways to effectively communicate and reinforce it?

Basic Question No. 2: What is the priority or value of safety compared to other priorities? Priorities change, but values do not. Is safety a changeable or unchangeable issue in your organization? Does the perception of safety among managers match the perception by workers? Are workers clear on how to make situational decisions when safety and production compete? Many organizations tell workers they have the right to stop work if they deem it unsafe, but not all workers would do so and not all feel confident they know the real criteria for making such a decision.

Follow-up Questions: Is your communicated priority or value of safety the best one to guide your workers' decisions in the workplace? Can you think of a better or clearer way to state the importance of safety that will result in better workplace decisions?

Basic Question No. 3: Who manages safety? Is it the member or members of the safety department, or is it the same people who manage production? Does everyone manage safety? To what extent do you expect workers to manage their own personal safety, and what training and resources do you give them to enable them to do so?

Follow-up Questions: Is this the best way to manage safety? If you rely on safety professionals to manage safety, do you have enough of them to do so effectively? Does this form of management create unity of purpose, or does it cause a conflict between safety and production in the minds of workers? Is this the best set of people to manage safety? Could others manage safety more effectively or efficiently? What training would they need to do so?

Basic Question No. 4: What is the desired style of safety management? This is a question many organizations have failed to ask or answer. Should safety managers be controllers, collaborators, coaches, parental figures, safety police or simply subject matter experts and resources? How well-aligned in the desired style of management are all the managers of safety?

Follow-up Questions: Is this the best safety management style for your organization? How well do your workers respond to it? Is it producing the desired results? Can you think of a better management style to help you accomplish your desired state of safety excellence?

Basic Question No. 5: How is safety com-

municated? What do you communicate? What media do you use? How often do you communicate? Do you check for receipt of message? Does safety communication create alignment of knowledge and decision-making guidelines? Are lessons learned from past accidents and near misses effectively shared and acted upon?

Follow-up Questions: Is your current practice the best way to communicate safety? Have you measured its effectiveness or workers' perceptions of its effectiveness? Can you think of better ways to communicate safety?

Basic Question No. 6: Are your safety programs fit for your purpose? If you have added outside safety training programs, behavioral initiatives, VPPPA applications or other off-the-shelf programs to your safety program, are they creating synergy or anarchy? Do they align well with each other or do they have competing efforts or conflicting terminology?

Follow-up questions: Are these the best programs to help you accomplish your goals? Are there better programs, or would you be better without these programs?

Basic Question No. 7: Are your safety metrics effective? Are you still managing safety with strictly lagging indicators, or have you developed more prescriptive and predictive metrics? Do safety managers feel in control of the factors that determine safety outcomes? Can they produce excellent results and repeat them next year? Do you have metrics that are meaningful and directive for your workers?

Follow-up Questions: Are your current safety metrics allowing you to understand and manage safety effectively? Can you think of or develop more effective and useful metrics?

These seven basic questions not only are the ones that impact safety strategy, but they are crucial to success and often not asked. Pursuing safety in the same traditional ways almost certainly will produce similar or diminishing results, and almost is incapable of producing meaningful improvement that leads to world-class safety excellence.

The best performers in safety realize more of the same is not the answer. They also learn that simply adding more programs and processes will not help if the basic structure is not strategically aligned. In the end, the development of a strategy to achieve true safety excellence requires an honest self-assessment, which begins with asking and answering the right questions.

Assessment: The Second Component of Safety Excellence

Strategy defines the ending point of your road to safety excellence through the creation of a vision of success, and assessment determines the starting point by specifically determining the current status.

Last month's column suggested strategy as the first element of safety excellence. Many argue that assessment should precede strategy, but experience has suggested that a strategy based on assessment rather than strategic vision tends to be a gap filler rather than a true strategy.

That said, it is critical to determine the current status in order to map the road to excellence. Determining the shortest distance between two points requires determining the exact location of those two points. Strategy defines the ending point through the creation of a vision of success, and assessment determines the starting point by specifically determining the current status.

If a safety strategy includes improving safety culture, an assessment should include measuring key cultural elements. Unfortunately, many leaders have been convinced that a simple perception survey is a sufficient metric for culture. It is not! While perceptions are an important artifact of culture, they are by no means a complete description.

Also, most perception measurement tools are fraught with potential problems that can skew the data. Among these problems are the following:

Administration – If participants are asked to fill out a paper survey or sit at a computer to respond, several factors come into play. If participants are not given sufficient time to complete the questions or are being watched or checked up on by supervisors or are not convinced that their completed forms are confidential, they may be guarded in their responses.

Timing – If perceptions are measured near in time to other events such as downsizings, union contract negotiations, significant disciplinary actions or announcements of new policies and procedures, these factors can skew the perceptions being measured.

Terminology – Many off-the-shelf perception surveys have generic language that cannot be changed. For example, if the form asks about "supervisors" when workers use terms such as "foremen" or "team leads," it may cause a degree of confusion that can impact results.

Specific Programs – Generic surveys don't allow the inclusion of information about specific or new programs that may be important to safety efforts. Knowing how workers perceive these programs can be important information that is missed.

Benchmarking – Some surveys statistically validate their results with other responders in the same industry and with a similar level of maturity in safety programs and results, but many simply report how the organization's responses compared to everyone else who completed the survey. Percentage or quartile rankings are meaningless when compared to undefined groups.

Perceptions Versus Reality

Even if you avoid these common problems by measuring perceptions, you will not know the accuracy of the perceptions from a survey alone. Whoever said that perception is reality had a very narrow view of reality. Perceptions fall into two categories: accurate and inaccurate. Just because your workers perceive something and generally agree doesn't make it so.

In fact, inaccurate perceptions of safety issues can result in the misdirection of safety efforts. When workers focus on issues of little consequence and ignore more impactful issues, their efforts don't produce efficient results.

So, what is needed to measure the accuracy of perceptions? This requires a comparison of reality to perceptions. For example, if workers perceive the most common type of accident in their facility is a trip or fall, does the accident data validate or contradict this? If workers perceive receiving adequate information on accidents occurring at other sites, does the overall data indicate lessons are learned and similar accidents are prevented, or that the same type of accidents regularly repeat at different sites? If workers perceive their safety training is good or adequate, do accident reports regularly indicate a lack of knowledge as a contributing factor to the accident?

In addition to comparing perceptions to reality, it is important to compare perceptions to strategy. If you strategically target improved teamwork in safety, do workers perceive that is happening or not? If you strategically target a type of management style in safety, do workers perceive their boss to be demonstrating that style of management or another type? If you strategically target more effective safety communication, do workers perceive it is working and can they remember and repeat the important messages communicated? This kind of comparison is another example of why strategy should precede assessment. It also is a reason for using customized rather than off-the-shelf assessment instruments in order to accurately target the most important perceptions to measure for comparisons to reality and strategy.

Frequency of Assessments

The frequency with which assessments are made also is vitally important. Like any metric used for management, assessment data needs to be timely.

Managers who cannot measure their progress toward strategic goals often tend to "work in the dark," hoping the next measurement will show progress. Also, visible progress toward strategic goals has been shown to be highly motivational. When workers see regular progress reports, their efforts are more meaningful and better targeted. Efforts that are not producing desired results are identified earlier and wasted time and resources are redirected. Few organizations assess their cultures or programs frequently enough to maintain momentum and manage the change efficiently. Expensive generic perception surveys can make such frequent measurement cost prohibitive.

Assessments also can be done too often, although that rarely happens. Workers can tire of constant questioning and measuring and become almost immune to the process. More often, organizations perform assessments and fail to respond to what workers have told them or fail to communicate how and when they have responded. When the results of an assessment have not been shared or acted upon, workers are less willing to actively and willingly participate in another.

Many of the organizations with excellent performance in safety attribute their success in part to the development of an overarching strategy for safety and regular assessments to monitor and direct their progress toward their strategic goals. The old safety practices of simply trying to fail less and measure progress with lagging indicators quickly is being replaced with strategic thinking and proactive leading indicators.

Imitation Can Be Suicide

No two cultures are identical and any approach that does not recognize the differences risks limiting success or creating abject failure.

I have been flooded the past few weeks with articles, webinars and workshops that claim to present all you need to know about behavior-based safety (BBS). My first thought is that 1,000-word articles, one-hour webinars or even one-day workshops are inadequate for such a subject. The commonality of all these is the authors and presenters generally are people who successfully have implemented a BBS process… ONCE!

As a BBS consultant for almost three decades, with well over 1,000 site implementations and many more training sessions for internal consultants, I firmly can avow that what works at one site does not necessarily work at another. Certainly, there are some common core components, but the details of how these components are put into practice is absolutely critical to success. It is not so much a choice among options as a fitting of the options to the site culture.

The limitation of most practitioners and consultants is they want to create success by imitating another success. It seems logical; what has worked in the past will work again in the future. The problem is successful implementations of BBS or any other process is not about the past and the future. It is about this culture and that culture. No two cultures are identical and any approach that does not recognize the differences risks limiting success or creating abject failure.

First let's look at the core components all or almost all BBS approaches have in common:

- **An implementer –** This most often is an external or internal consultant with some experience or credentials related to BBS.
- **A sponsor or facilitator** – This most often is either a senior site safety professional or a line manager.
- **A process leadership person or group –** This can be the facilitator, but more often is a team or committee.
- **A list of safety-related behaviors –** This list is the target of the observations and directs the focus of the observers.
- **An observation strategy –** This is a plan of how many observations to perform monthly and how to distribute them among the site population.
- **Some analysis or utilization of observation data –** Many, but not all, processes include some review or analysis of the data gathered by the observers.
- **Process metrics –** These are measurements of the process activities that indicate how well the effort is going.

Now, let's look at the options for how each of these core components can be turned into process activities and how to select options to fit the site culture:

The implementer – The choice between an outsider (external consultant) or an insider (internal consultant) should be a matter of whether the population respects process knowledge more than knowledge of the culture. At some sites, you aren't an expert if you are "just one of us." At others, unless you are "one of us," you

don't really understand us and what we do.

The sponsor – Sponsorship of any process can determine success or failure. The individual's reputation with the workers, past history of successes or failures or simply the level of the sponsor in the organization greatly can impact implementation of the process.

The process leadership – Some processes have a single person as the leader. Since this approach has proven problematic when the leader leaves and also has failed to create the desired buy-in and ownership, most processes use a team or committee as leaders. The makeup of the team varies from all management and supervisors to all workers and all combinations in between. Site leadership style and employee turnover are among the most common deciding factors in selecting process leaders. The size of the team or committee also varies according to what is required to represent the range of jobs and simply maintaining critical mass in the face of turnover.

The behavior list – Targeting the right behaviors and the right number of behaviors absolutely is crucial to success. Changing the wrong behaviors will not prevent accidents. Working on too many at a time can keep behavioral change from happening or from being sustainable long term. Also, trying to stop unsafe behaviors is more problematic than trying to start safe behaviors.

The observation strategy – The goal of observations is to give feedback that can change behaviors and, sometimes, to gather data on behavioral change. The number of observations and the distribution of observations among the population will determine the level of success. The nature of the interaction between observer and worker also will impact the amount and rate of behavioral change. Confrontation between observers and workers often results in reaction and resistance rather than cooperation and a coaching transformation. The observation strategy is where the BBS process either gets traction or begins to spin its wheels.

Analysis and utilization of observation data – The use of observation data ranges from counting the number of observations performed to sophisticated analysis of workplace and cultural factors influencing the targeted behaviors. Although some argue it is the interchange between observer and worker that most impacts behavioral change, ignoring this data seems to demoralize observers and hurt the effectiveness of observer interactions. Also, good, actionable data should not be ignored when the organization already has paid to gather it.

Process metrics – I already mentioned some people count the number of observations performed. Some also calculate this number as a percentage of a targeted number of observations. The correlation between the number of observations and accident recordable rate reductions has been established at a number of sites, especially in the early months of a new BBS process. However, in later months and years, the number of observations becomes much less important than using the data from the observations. Many measure participation of leaders and observers as an indicator of support for the process as well.

Although these issues may seem simple and straightforward, the devil is in the details and the possibility of failure quickly increases when you simply copy a process from another site. Carefully consider the potential consequences of jumping into something as complex as BBS with simplistic thinking and limited experience.

The Generational Cliff

If baby boomers are the majority of your workforce, there might be a generational cliff in your future.

America has an aging workforce. The last of the baby boomers will be retiring within a few years and a new generation of workers will take their place. In many industries, this transition will be smooth, with few problems. In others, the transition will be more problematic. Safety will be the area of performance in which the problems will become the most critical.

A defining difference between smooth and problematic transitions is the spread and average tenure of the workforce. Some industries have a history of steady hiring and onboarding of new employees. They have hired and retired workers every year and the tenure is evenly spread across the entire workforce. These organizations will see the boomers go as just another normal turnover event. The average tenure of the workforce will not dramatically change.

In other industries and organizations, the baby boomers are the majority of the workforce. They all were hired many years ago over a narrow range of years and their attrition rates were nearly zero. No new workers were hired for many years since there were no openings other than through business growth or expansion. The only new hires came on board just a few years ago when the first of the older workers began to retire, and the average tenure of these new workers is a few years or less. In many cases, more than half the workforce will retire and within a few years the average tenure of the workforce will drop by as much as 15-25 years.

The problems will not come from reducing average employee age, but from dramatic reductions in employee experience. In industries with significant workplace dangers, this lack of experience often will result in increased accident frequency or severity. The new workers will find themselves in unfamiliar situations and will not have more experienced associates to consult. Decisions made from limited knowledge also can compromise the integrity of the workplace and increase risks for other employees who work there. Processes and procedures can become less strictly observed as inexperienced workers struggle to master all the aspects of their jobs.

Steps to Avoid the Cliff

If organizations see the generational cliff in their future, there are steps they can take to minimize the damage it will do. The more quickly the problem is identified, the more time there will be to take these steps. Unfortunately, some organizations already have waited too long and will struggle to address their issues.

The first step is to capture the expertise of the departing workers. Many jobs don't have adequate descriptions. Often, job descriptions simply are a list of responsibilities and do not elaborate on how each responsibility should be accomplished. Very few job descriptions include roles and desired results along with lists of responsibilities, which makes them less than descriptive enough to paint an adequate picture of ideal performance for a new employee.

Mature employees should be asked to complete their job descriptions as soon as possible before their retirement. They should consult with their immediate supervisor to finalize the description and then forward it up the organizational structure for review and coordination with other job descriptions.

Pair new workers with experienced workers when possible. Certainly, if new workers can be paired up with older, more experienced workers for an adequate time period to truly be mentored and trained, this is ideal. However, many organizations have waited until it's too late and the ratio of new workers to highly experienced workers no longer makes such an

arrangement possible.

Also, many organizations have downsized, making it difficult to pair employees on the job and still get the work done. In these companies, even when older workers are still active, they are so busy that they don't have the time or opportunity to pass along their career knowledge to the newer hands.

Emphasize training. The inability to effectively mentor new employees puts an additional burden on training and onboarding processes. Many organizations heavily have relied on experienced workers to train new hires, and have minimized their formal training and new-employee orientations. When on-the-job training no longer is viable, formal training needs to be much more robust and complete.

Rather than simply providing an introduction and overview to the job to be supplemented by workplace experience and mentoring, training needs to resemble trade school classes in which students are both educated and trained to perform work tasks in the classroom and the workplace with instructor oversight and feedback. Many organizations lack the resources to design and deliver such training without a significant investment.

Check with local resources. Community colleges have stepped in, where invited, to provide such training for specific jobs in a number of industries. Many organizations provide equipment or other resources to the community colleges to enable them to provide such training and hire successful graduates as they complete the programs.

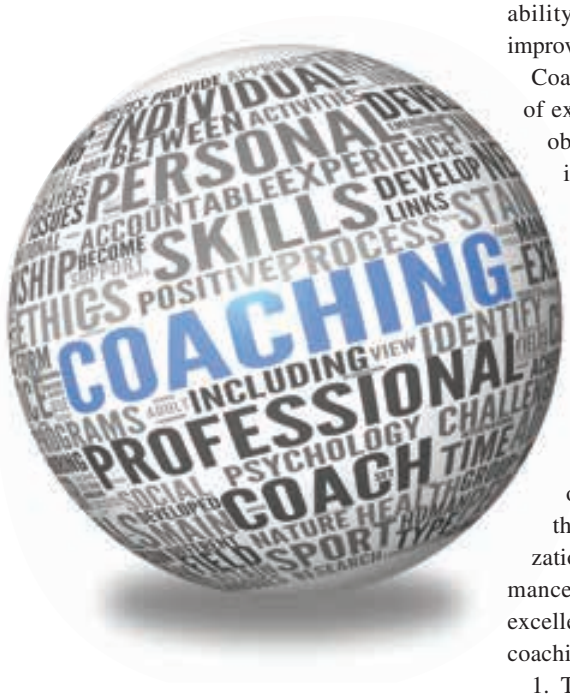
As the workforce becomes more and more inexperienced, such arrangements are going to become more necessary and valuable. However, these programs take time to implement and time for students to complete. Organizations are going to need to project staffing requirements further and further into the future in order to stay on top of changing requirements.

Even if organizations manage to capture expertise and upgrade job training, this alone may not ensure that the new workers can perform their jobs safely.

Even this retiring generation of workers had a lot more accidents early in their careers than in the later years. They learned safety through experience and interaction with experienced workers just as they learned their job skills. Certainly safety programs and efforts have become more sophisticated over the past few decades, but so has the safety knowledge of this aging workforce. It remains to be seen if organizations adequately will address the pending loss of expertise due to the generational cliff and if, in doing so, they will also capture the safety knowledge that is retiring at an alarming rate.

Coaching: The Third Component of Safety Excellence

Coaching is the preferred management style of excellent organizations and preferred observation style of truly excellent behavior-based safety processes.



In August 2015, I wrote about the four components of safety excellence. In the past few months I addressed the first two components: strategy and assessment. This month's column addresses the third component of safety excellence: coaching.

Coaching is the process by which one person helps another person improve performance. The results of individual coaching greatly are multiplied when a whole organization coaches. Each performer has help from everyone of higher ability or position, and the whole population improves its performance.

Coaching is the preferred management style of excellent organizations and the preferred observation style of truly excellent behavior-based safety processes. Lesser organizations pursue command-and-control styles and confrontational observations, which tend to view the worker as the problem to be controlled rather than the solution to be used. When safety systems seek to control workers, they tend to peak when they achieve a level of grudging compliance.

Coaching seeks to create willing cooperation among workers as they pursue their own personal bests. When the organization seeks to use and maximize the performance of its workers rather than to control it, excellence becomes possible. Most successful coaching models have four commonalities:

1. They set specific improvement targets rather than working on everything at once.
2. They seek to start desirable practices rather than stop undesirable ones.
3. They use feedback for positive reinforcement and to determine influences on performance.
4. They develop action plans to change influences on performance to align them with desired goals.

Coaching to improve overall performance has severe limitations. It can be overwhelming to both the coach and the performer. It tends to involve personal opinions rather than objective, measurable facts and therefore can become confrontational rather than helpful. The alternative is to set specific improvement targets and coach toward them.

Targeted improvement can create focus and alignment toward specific goals. Opinions give way to factual observation of improvement. Progress becomes measurable and meaningful. Success motivates more success.

Our average client is working on one to four targeted improvements at a time. These targets usually are identified through a Pareto analysis of previous accident and near-miss data. This means they are improvements with high potential impact on lagging indicators. Workers can see over time how their own improved performance translates into overall organizational improvement. As coaching becomes the management and observation style, improvement becomes the symbol of success.

"Less Bad" Is Not Good

It is critical improvement targets be stated as safe practices to be started vs. bad practices to be stopped. Improvement should not be described as "less bad."

Behavioral tools used to start behaviors fit the coaching model much better than the tools to stop behaviors. The starting tools also tend to strengthen relationships and culture, whereas the stopping tools tend to weaken them. Whether it is a manager or supervisor coaching a worker or a fellow worker doing behavioral observations, the goal should be to get better rather than to be less bad.

When improvement goals are set as taking certain precautions or following particular safety steps, the measurement of such goals can be accomplished by observation, and the results stated as a percent of success. As success is achieved in behavioral performance, it becomes motivational to workers who see themselves winning the game of safety.

If the goal of coaching is to improve performance, the coaching feedback given should

support that goal. Unfortunately, most feedback in safety is confrontational, i.e. pointing out what a worker is doing unsafely. This form of fault finding seldom results in meaningful or lasting change. We have begun to realize over the past decade that people do things for a reason. If we don't know the reason, we don't truly understand the behavior. If we fail to understand what is influencing current behavior, we will likely fail to establish a sustaining environment for a new behavior.

It is imperative feedback take two approaches. If we set an improvement target and observe the worker doing what we have targeted, we must give positive reinforcement. Positive reinforcement simply is pointing out the positive behavior and encouraging the worker to continue it. If the worker is not doing the targeted improvement, we must find out why. Discovering the reason is more important than confrontation, criticism or even attempting to force a change of behavior on the spot. Such forced changes almost always are temporary at best.

If the coaches, whether they are supervisors or peer observers, do their job of finding out why targeted behaviors are not happening, then this last step is fairly straight forward.

Action Plans to Change Influences

If we know what is influencing workers to do other than our targeted improvements, we must develop action plans to change these influences. These plans can take several approaches: they can attempt to remove influences to take risks, add influences to take targeted precautions or a combination of the two.

The influences fall into two categories. The first is internal influences such as simply forgetting, disagreeing with the targeted change or falling back into old habitual behaviors. Action plans can include training to convince workers of the wisdom of the change, or simply reminders that help workers stay aware until they can change habits. The second is external influences in the workplace or culture. These may require physical changes, changes in common practice or new procedures. It is important to measure and monitor the impact of action plans to ensure they actually result in behavioral change and that the behavioral change produces an improvement in lagging indicators.

Organizational excellence in performance is not just about leadership and direction; it is about followership by workers who continuously improve. Only a coaching model of management and behavioral observations can produce and sustain such improvement. Organizations that fail to coach will find workers only perform well when directly supervised. Behavior-based safety programs that fail to coach find that reducing the number of observations quickly lowers the percentage of safe behaviors. Both of these problems are solved when organizations adopt this coaching model as their official management and observation style.

Engagement: The Fourth Component of Safety Excellence

The quantity and quality of employee engagement will determine the level of effort needed to move an organization toward excellent performance.

In previous articles, I labeled the first three components of safety excellence as strategy, assessment and coaching. The fourth element is both an extension and implementation of the first three.

Astute leaders and safety professionals quickly realize it is the workers, and not just themselves, that must achieve excellence. There needs to be a strategy to help workers achieve excellence, an assessment of their current performance levels and coaching to help them improve from that current level. But ultimately, the quantity and quality of employee engagement will determine the level of effort needed to move an organization toward excellent performance. Engagement begins in the development of the first three elements.

Strategy: Organizational leaders should develop a strategy to engage employees in safety. This strategy should begin with a vision of what excellent engagement would look like. What beliefs, perceptions and values would engaged employees ideally have? What opportunities should employees at all levels have to actively participate in meaningful safety activities? What input should be sought from employees to help design safety efforts? How much input will it take to develop a sense of ownership in safety efforts from employees? Once these questions are answered, a plan of action can be developed to make it happen over time. Like a military strategy wins a war one battle at a time, a worker engagement strategy should be executed one step at a time. It is critical to not do too much at once.

Assessment: Once the desired state of engagement is defined and envisioned, the organization should assess the current state of engagement and all safety programs and processes that influence workers. The findings of such an assessment might necessitate changes or adjustments in strategy, but this does not mean that assessment should precede strategy. We have found that organizations that assess first tend to develop gap closers at current levels rather than true strategies to achieve excellence. It is important to envision the desired state before assessing the current state. If good engagement opportunities already exist, they can be used and possibly expanded or supplemented. If current programs to foster engagement are not producing results, they can be modified or abandoned.

Coaching: Knowing the desired state and contrasting it with the current state helps define the targets needed to coach workers. Specific improvement targets are key to effective coaching. Asking supervisors, managers or peers to coach workers toward some nebulous and poorly defined goal of safety usually is ineffective and frustrating. Such untargeted coaching actually can damage relationships and the safety culture rather than improve it. Once safety improvement targets are established, everyone asked to coach in the strategy for engagement should be trained in effective coaching techniques. Very few leaders have received any formal training in performance coaching. Developing these skills is important, but so is the alignment of efforts among the organizational culture.

Engagement: Armed with a strategy, an assessment and coaching ability targeted toward

high-impact improvement potential, the organization is ready to achieve greater levels of engagement. The strategy should have outlined what good engagement looks like (i.e. what attitudes, perceptions, values and behaviors embody this engagement). The assessment should have revealed to what extent workers already have these desired qualities of engagement and which ones need to be started or enhanced.

The specific areas that need to be addressed should have become improvement targets, and coaches should have been focused on these targets during and after their coaching training. Good coaches will positively reinforce these factors when they see them and ask why these factors are lacking when they observe the absence of them. The knowledge of what is influencing these attitudes, perceptions, values and behaviors should be used to facilitate the development of these factors of engagement.

Attitudes are resistant to direct efforts to change them. They largely are based on personal experience and peer influence. They also can be influenced by official communication from organizational media or leaders, but only if the trust levels between workers and the organization are high. Changing attitudes will take time and usually is best accomplished by a combination of good communication and sharing of experiences that reinforce the desired attitude. Treating workers with respect also is a critical factor in changing attitudes.

Perceptions are based on personal experience but also on available information. More and better information potentially can change perceptions. Changing the workplace realities that create personal experience also can change perceptions, but usually over a longer period of time. While improvement efforts will change workplace realities, most organizations increase communication of information to enhance perception changes and don't rely on organizational changes alone.

Values fall into two categories: universal values and situational values. Universal values apply in all situations. Situational values apply only in certain instances where multiple priorities might conflict. Organizations tend to espouse both types of values and assume workers will adopt them. Organizational values don't automatically become personal values. Organizations consistently must demonstrate values over time to get worker buy-in and to influence them to make personal decisions according to those values.

Behaviors are affected by all these factors as well as workplace conditions, leadership styles, culture and numerous other influences. Changing behaviors within a workplace culture is best accomplished from within the culture rather than through outside influences. Many processes have been developed in the safety community to systematically accomplish behavioral changes.

Organizations can improve safety performance through a number of programs and processes. However, the highest levels of excellence tend to happen when workers truly are engaged in safety efforts. Enhancing employee engagement is not a simple, one-step process. It must begin at the strategic level and follow a path that is systematic and tenacious. Engagement is not impossible, nor is it utopian. Many fine organizations have achieved it and reaped the huge benefits it brings.

Inside Strategy:
Value Creation from within Your Organization

Shawn M. Galloway & Terry L. Mathis

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Introduction

A new focus

Prediction is very difficult, especially about the future.

—Attributed to Nobel Prize winner in physics, Niels Bohr

Every book we've read on strategy has focused on external strategy: competition with rivals in business, or overcoming the enemy on the battlefield.

This book is different.

We take strategic thinking and give it a new focus of attention: inside your organization. This doesn't mean how to fight interdepartmental turf wars; quite the opposite. Inside Strategy is aimed at aligned continual performance improvement. This is an iterative process. Success breeds success. As people within your organization come to see not just the trees but the whole forest, choices and behaviors at every level become more effective.

Strategy and internal value creation are not well understood. We authors see companies simply aiming programs at problems instead of developing strategy. Strategy goes beyond problem solving. Strategic thinking is an ongoing process, a way of being and behaving. When strategy isn't understood, it's ignored. Out of sight is out of mind. Ignoring strategy leaves you rudderless. You paddle around in circles. If all your attention goes into just staying afloat, you can't think ahead. People who need strategic thinking the most are often the very people who ignore it. They spend all their time ricocheting from one emergency to another.

We're all familiar with the concept of return on investment, but what about return on attention? Priorities result from decisions. "No time for strategy" is a poor decision. Attention needs to be reallocated to thinking ahead. When short-term behaviors are misaligned with long-term vision, you're continually surprised by events. And some of these can be painful, if not outright dangerous.

Not paying attention to strategy is expensive. Each year organizations waste millions of dollars in time, resources, and effort. In our consulting practice we continue to see confusion; misunderstanding of strategy, real problems not addressed, misdirected effort, lack of personnel alignment, directionless short term fixes, forgettable training, over complexity, poor communication, cookie-cutter programs in place of strategic thinking, muddled motivation, poor incentives, not understanding what an existing organizational culture will tolerate or accept, misinterpretation of data, and attention to results without a clear understanding of how they came about. And these are just a few of the unproductive situations we encounter in our work.

But most of all we see a lack of focus on generating and measuring ongoing contribution to value throughout the organization. And, as you've probably guessed, contribution to value is the central theme of this book.

Strategic thinking can create value at just about every level of organizations. Today, managers and lineworkers have increasing discretionary effort. They need a reason to guide and believe in what they choose to do. The best you can hope for with an alienated workforce is grudging compliance. No organization can afford disaffected workers. But influence hearts and minds and hands and feet will follow. People need to be involved in decisions that affect them because projects tend to fail at the beginning, not at the end. Get the thinking right and implementation becomes relevant, easier, faster, and often cheaper.

Inside strategy is not a recipe book. There are no sure-fire tips that will suit every situation because you and your organization are unique. Instead we offer you a series of structured questions in Part II aimed at ongoing value creation. You can think of this as a checklist. This book is not so much what to do, but how to think about what to do. We wrote this book to stimulate your own thinking.

Finding your way

We've divided the book into three parts. Part I, Foundations, is an overview of important concepts; strategy, questioning, beliefs, and value. Part II, Framework is a set of ten strategic performanceimproving questions. Part III, Living Strategy, is how to sustain continual performance improvement.

Inside strategy's goal is first to understand and define effective strategy, then to focus it inside the company. The purpose is to improve performance and uncover previously hidden value from the resources already in place. In our previous books we've written extensively on the topic of safety and its relationship to culture. Safety done right is an example of inside strategy. But strategic thinking for performance improvement has many applications beyond safety. This book arms you with a framework of questions and ideas with which to define and measure effective value-producing behavior. This framework generates behaviors (things people actually do) that lead to results.

In Chapter 1 we ask the question: What is strategy? We take a look from diverse perspectives. We show limitations of planning and advantages of strategy.

A strategist needs to think ahead, be aware of current conditions, and imagine how small changes can lead to big effects. You'll learn how strategists from Sun Tzu in ancient China to a Greek naval strategist some 3,000 years ago thought about strategy. Why are these relevant?

Organizational perspectives today have their roots in strategic thinking of statesmen and military commanders. Strategy only started to become widely recognized in non-military organizations during the 1960s. Outside strategy looks toward possible choices of action in an ever changing external environment. Awareness and anticipation matter. Emerging social needs, new sources of profit, competitors, changing political realities and markets, regulations, and innovations are just a few influences upon outward-facing strategies. Michael Porter, a leading authority on competitive strategy, wrote, "Strategy is the creation of a unique and valuable position involving a different set of activities."

By contrast, inside strategy is a framework of choices organizations make to determine and deliver value. Inside and outside strategies are part of a whole. Behavior is dependent on what you want to achieve. Yet it's surprising how often this seemingly obvious idea can be forgotten. When conditions change you need to question if your approach still makes sense. If the company is about to merge, be sold off, or expand, this will influence a definition of value. And that in turn will determine desirable behavior. Value is context dependent. Yet searching for value from within organizations – by asking the right questions – isn't always a natural strategic impulse. But competition is.

In the late 1960's, Bruce Henderson of the Boston Consulting Group (BCG) divided his company into three units so they could compete against each other.2 Henderson had been reading Charles Darwin and became enthusiastic about the idea of survival of the fittest. Henderson believed that competition among his red, blue, and green units would result in ever higher performance for the whole company. The blue unit headed by Bill Bain beat the other two. It did so by a wide margin and went on to form its own company. Bain and Company became BCG's biggest competitor for years to come. Be careful what you wish for.

Peter Drucker got it right when he asserted that culture eats strategy for breakfast. Strategy emerges from culture, not the other way around. Imposing a strategy without understanding the culture is asking for rejection.

A common impulse is to identify what's been successful, and do more of it – only faster. If you're successful, and you wear brown shoes on Fridays, that doesn't mean that wearing brown shoes on Fridays caused you to be successful. We see confusion between cause and correlation. Asking questions helps sort out the difference.

In Chapter 2 we ask the question: Why ask why? Strategic thinking generates questions. An organization, company, business unit, team, or individual needs responses to four overarching questions: What do you want to happen? Why do you want it to happen? How are you going to make it happen? How will you know you were successful? These questions are relevant at each level of your organization.

Questions are at the core of inside strategy. No one wants to look foolish. Yet "dumb questions" can have huge value. We like questions so much that this book contains over 500 of them. Questions sharpen awareness by helping you know what to look for. Answers frequently change. Fundamental questions remain the same. Some cultures are more open to questions than others. Your answers will vary with your unique changing circumstances. With wide-ranging stories from our own experience and research, you'll see how performance improvement generates value.

In Chapter 3 we investigate belief, motivation, and rewards. Belief drives behavior. Behavior builds (or destroys) confidence. And confidence is an integral part of mastery. But confidence doesn't happen by itself. It comes through achievement.

Like Russian dolls that fit inside each other, cultures contain subcultures. Companies, teams, and individuals operate from belief systems. Culture determines what's acceptable and what's not. Some believe that risk taking is necessary as the only way to do something new. Other cultures punish anything seen to be varying from the norm. It's important to understand organizational beliefs and beliefs about change in particular. For this reason we try to minimize perception of change when implementing strategic initiatives. If you want to change behavior, you'll need to find out which beliefs are active. Actions speak louder than words. You can recognize beliefs through observable behavior.

Chapter 4 looks at value. We make a distinction between values, those moral principles people align themselves with, and value, something that makes life better in a way that's aligned with strategic purpose. Value is always either being created or destroyed. Value destruction comes from efficiency in the wrong context. Continual value creation generates long-term success. Value is the driving force of strategic effort.

Part II, Framework, is ten short chapters, each addressing one vital strategic question in an iterative process. Every question is integral to a holistic approach to performance improvement. The ancient Greek philosopher Heraclitus wrote that you can't step into the same river twice. A framework is like the banks of the river guiding flow. The river itself is your whole system, dynamic and in constant flux. Your strategy is informed by data. The data you find will influence your decision to keep moving within the river banks, or consider alternatives.

Part III, Living Strategy, is aimed at sustaining value creation within your company. If you're short on time right now, go straight to chapter 14. However, you'll get more value from reading this book in progression.

Voltaire, an eighteenth-century philosopher and wit, said something to the effect that, if you want to speak with me, first define your terms. So, let's now turn to the question: What is strategy?