December 2001

Practical Safety Improvements for Small Firms

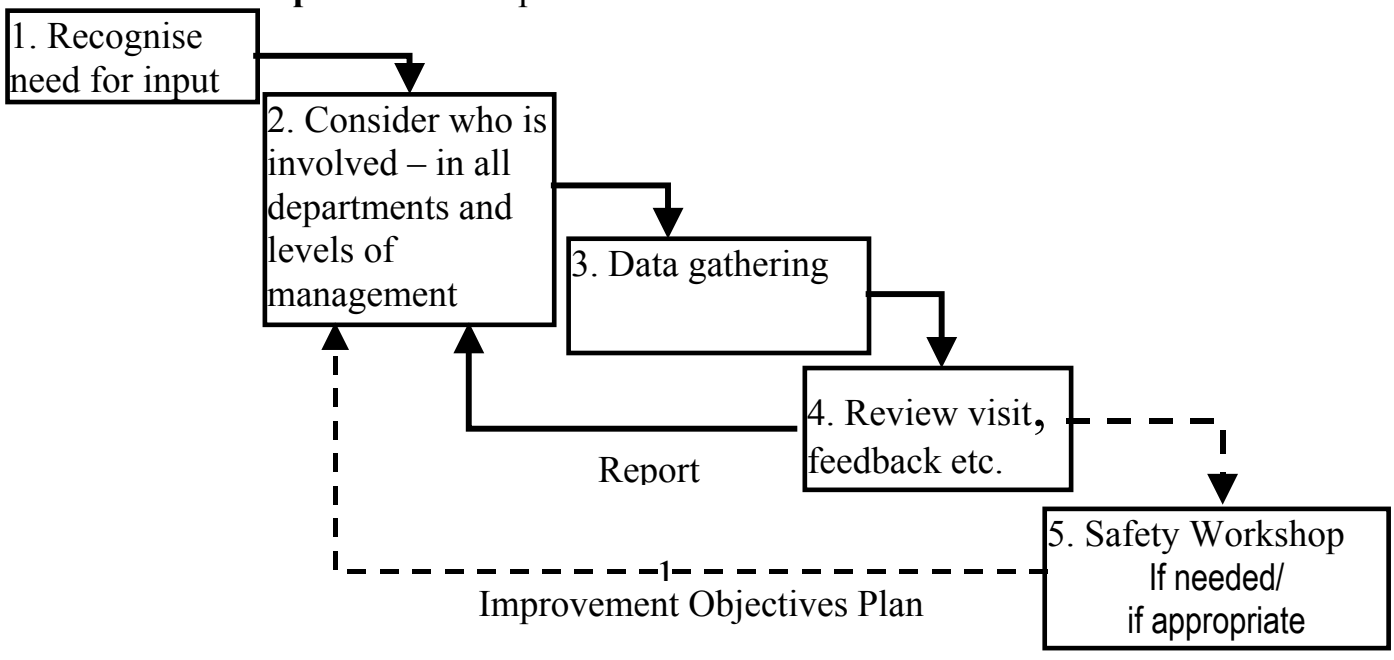
- Presentation by George Allcock, Group Safety Adviser, GKN plc.

George launched his presentation with the surprising assertion that large firms are often just like small firms in their day-to-day operations. It's just that the various parts are collected together under the same corporate umbrella, giving them common management systems and resources, which gives them the 'big' image. The basis for monitoring the safety performance of the corporate body then becomes like looking at auditing many small businesses. George added that it is no use doing any 'audit' unless the managers of that unit acts proactively on the recommendations. The secret to achieving this is to adopt a 'persuasive' approach to presenting findings. It is often best to focus on improvements in order to find common ground with senior managers to get a positive response from them. The whole process then becomes like another 'opportunity' to make improvements, although George the detailed approach should be obviously tailored to the individual SME situation..

In order to reinforce the proactive stance of this process, the company avoided use of the word ***'Audit'*** and, instead, preferred to use the term ***'Review'.*** Each review was prepared for by the issue of a '**Pre-visit questionnaire**' designed to focus minds on the key topics and to assist with the provision of factual evidence on the following headings, known as ***"Enablers"***, leading to ***"Excellence"***: -

- Management system, policy & responsibilities
- Strategy, objectives and plans
- Safety committee
- Health and safety training
- Risk assessment/job safety analysis
- Accident investigation
- Inspections and audits

This '**Process Map**' is used to explain how it would be handled: -



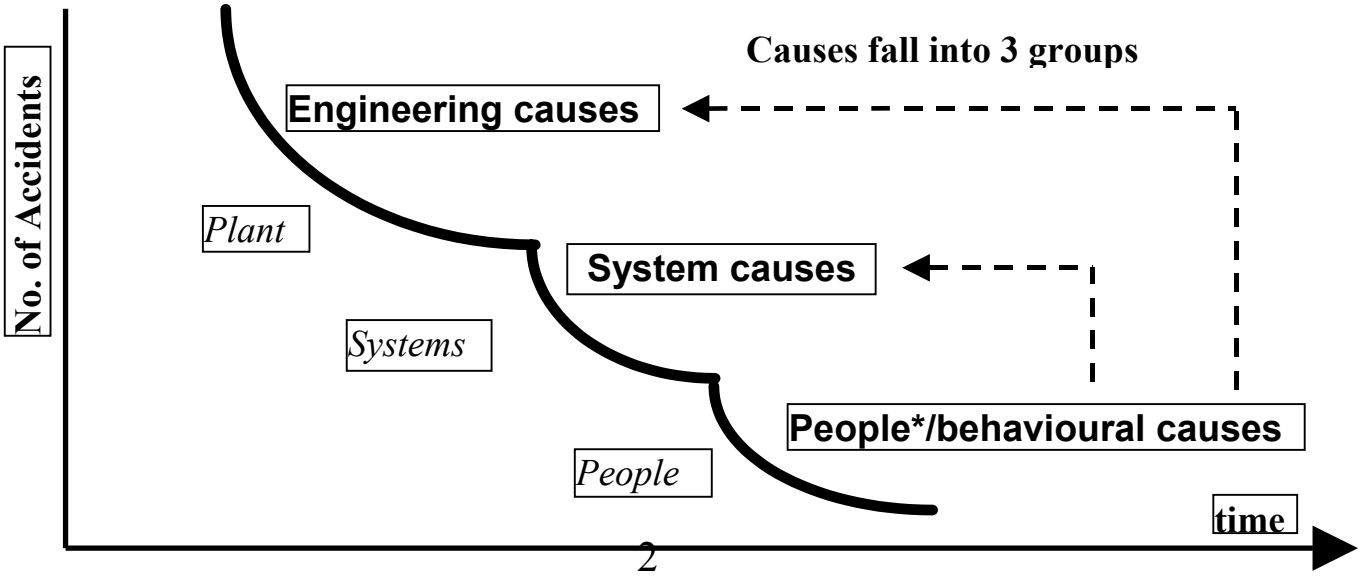
These key elements and overall strategy form a model for all small firms to follow, with a few modifications to allow for scale. In the pre-visit questionnaire it is important not to be too detailed, or searching, as a heavy implementation programme can easily overload the management resources. The Data Gathering phase is typically done on a plant tour and one of the easiest ways of capturing information is to use a digital camera. George commented that this method is also one of the best ways of conveying feedback on the findings and is probably one of the biggest single improvements in investigating techniques over recent years!

A typical review of current safety arrangements, systems, performance & objectives may cover such topics as : -

1. Policy, arrangements, leadership and ownership
2. People - involvement, teamworking, training & induction
3. Current performance, trends, benchmarking
4. Accident investigation & analysis
5. Audit process (es) & results - internal & external
6. Continuous improvement - examples, programme, culture
7. Visual management techniques & communication*
8. Main hazards, hazard analysis/risk assessment(s)
9. Housekeeping, orderliness & tidiness*
10. Improvement objectives, targets and plans

Evidence under these headings would be collected during the plant tour. Depending on the nature and seriousness of the findings, it may/may not be advisable to hold a workshop session after the plant tour. This should involve those persons likely to be affected by the feedback ond those who may be able to contribute to the follow up actions and improvements. Again, depending on the situation, the workshops can be general in nature or be specialist and may be attended by external experts.

Although all theses headings are important, George added, probably one of the most crucial is **'leadership'**. If managers fail to accept ownership for the whole process then it will be almosyt impossible to achieve the necessary improvements.



This Chart shows how **Causes of Accidents** show a tendency to fall into three natural groups. There is also a natural inclination for management to address problems in these groups in order of Plant, Systems and People because the underlying causes in the first two are easier to identify and address. The People/Behavioural causes are always more difficult to solve and that is why they are usually the last to be tackled in any accident prevention programme. It is people in all roles and at all levels (with their behaviours, actions, failures to act, wrong decisions etc) - not just shop floor workers who cause accidents, so it is important to involve everyone in the solution**.** There is a link, of course, between the behavioural elements and the other two, so the ultimate solution is to include all three in any programme – hence Items 1 – 10 in the list above.

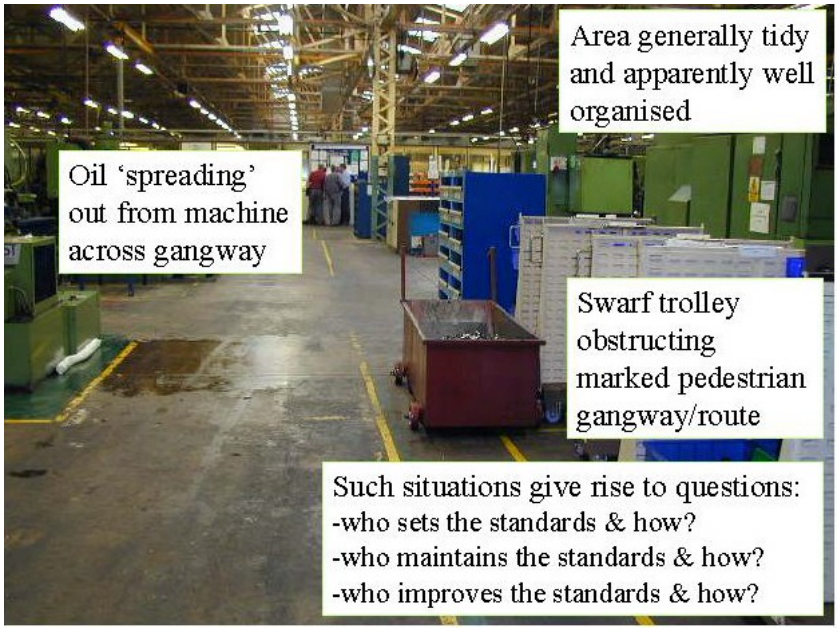
George commented that one of the simplest ***initial*** indicators of safety performance was Housekeeping because it signified that many other fundamental tasks were probably receiving their proper attention. Because these management tasks also had an impact on **Quality** it reinforced its link with **Safety.** Another indicator of good safety management was whether a firm had a viable plan in operation. Very often managers believe that they have but when asked for the evidenc, they are unable tp provide practical evidence of systems in action.

At the end of the review a report has to be compiled to achieve improvements. GKN produce these in Microsoft Powerpoint, so as to encourage others to pass on the message in an easily presentable form and without having to waste too much time in the process! This is usually done to people at all levels in the firm – a manager who cannot find time to release a person for about 20 minutes will probably not take the trouble to make changes, anyway!

It is very useful to use SWOT analysis to produce an assessment like the one below.

Strengths	**Weaknesses**
➢ Team spirit & openness ➢ Loss Prevention corrective action approach ➢ Safety structure/system ➢ Visual displays/H&S notice boards ➢ Loss Prevention approach/committee	➢ Follow up of actions (e.g. audit photos) ➢ Intervention by line managers & others
Opportunities	**Threats**
➢ Prioritised action plans (avoid overload) ➢ Increased focus on action/intervention ➢ Further use of visual information including photos ‘before’ and ‘after’ ➢ Simplification/standardisation of forms & displays in cells ➢ Learning/sharing e.g. floors/oil leaks ➢ Increased employee/safety rep. involvement ➢ Improved housekeeping/5s	➢ Initiative/systems overload ➢ High severity - low frequency accidents from: • fork lift trucks/vehicles machinery access & intervention (dealing with problems, maintenance, setting etc) • contractors activities

It is most powerful when it is used in discussions between managers and workers at diferent levels in the firm. It is an excellent way of giving a safety committee some real work to get its teeth into! It is also very useful to project photographs from the Review Report of the site visits to get a vigorous, informed discussion going!. The one below is a typical example with 'good' (an encouragement to 'desirable' behaviour) and 'critical' comments against the image: -



During the site visit and afterwards, during the analysis of the photographs, it is important to make a **"critical examination"** of each scenario.

- **What** - is the problem and what other situations and activities including 'hidden' activities exist?
- **Why** - did/does it exist/occur?
- **Who** - should see such situations and take action?
- **How** - can we prevent these and other poor situations & activities occurring in the first place?
- **When** - should we take action?
- **What** - is the problem and what other situations and activities, including 'hidden' activities, exist?
- **Why** - did/does it exist/occur?
- **Who** - should see such situations and take action?
- **How** - can we prevent these and other poor situations & activities occurring in the first place?

The question we are asking is "How good are our systems, arrangements, tools and techniques for identifying & managing risks and achieving continuous improvement?"
In looking for the root cause(s) of these elements it is important to ask the simple question ***"Why?"*** *5 times*

- ***Why?*** *- e.g. sub-standard acts/conditions?*
- ***Why?*** *- e.g. preceding events?*

- ***Why?*** *- e.g. equipment or control failures?*
- ***Why?*** *- e.g. system failures?*
- ***Why?*** *- e.g. management failures?*

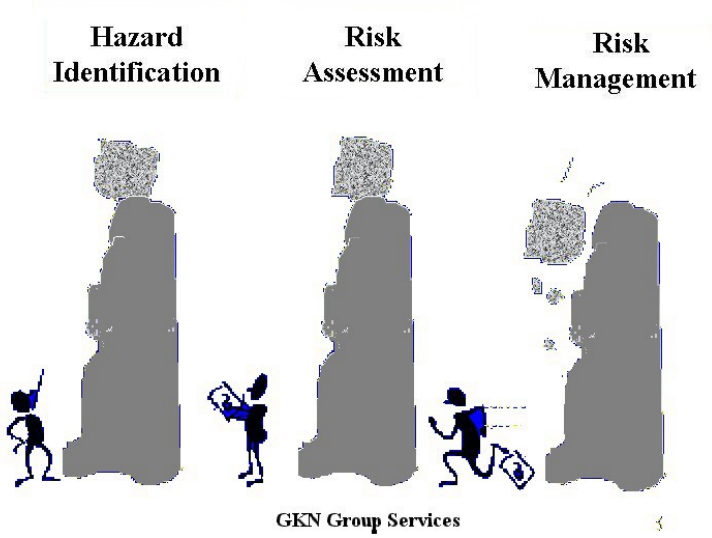
Finally, you should ask/consider ***"which of the above you have responsibility for or can/should influence?"***

"The value of photographs for focussing minds and stimulating responses cannot be overestimated", George added. Attaching a photograph to an emailed query multiplies the probability of a swift, meaningful reply, many times over. Photographs on notice boards are also a powerful, continuing reminder of localised problem areas. Another worthwhile initiative for noticeboards is to post up a blank paper with the caption**"Opportunity for Improvement"**

These issues are also closely linked to **Quality,** as well as Safety and most Managers worth their salaries should readily take an interest in any benefits to be gained from such an association. These can be highlighted by running a **"Loss Prevention Health and Safety Workshop"** immediately after a site visit. In addition to the photographs in any formal presentation for the development of new ideas, photographs are an excellent substitute for hand-written notes to prompt the reviewer – and they are a lot less obtrusive!

George went on to say that one visual aid he had used with great success to stimulate ideas at these sessions was **"The rock".**

This diagram concisely contrasts the crucial definitions and stages to be identified in the risk management cycle. The precise answer provided by this process is not always important but, at least it provokes discussion and action. Many managers, and quite a few safety professionals too, fail to identify these elements and, as a result, often do a less than adequate job!



But the key elements for the small firms are the ten items listed earlier – " Typical Review Topics". And, contrary to the customary trait of the blame resting with people closest to the problem, if the review does not end in the Management court, then the review probably has not been thorough enough. A poor performer would probably warrant a follow-up visit after six months – with serious issues neding immediate action. Timescales were not imposed as it was preferred for managers to work at their own pace and integrate improvements into their own action programmes.

George finished his presentation by quoting advice about the GKN process being like a "A journey to Safety and Excellence".

> "Safety, like business excellence, is a journey – not so important where you are now but that you are heading in the **right direction and with the necessary speed**. Like any long and continuous journey, small steady steps are often best."

Members' Questions

Brian Greaney of Safety Training and Advisory Service asked the sensitive question of how how it was possible to raise different departments and/or small firms to ther same standard? George replied that it was useful to harness their differences as well as their similarities to drive improvements. It was essential to use 'positive' factors as much as possible but, in certain circumstances, the threat of dismissal often made underperforming managers carry out a rapid self-reappraisal! Howevr, sanctions are not a good long term answer as it indicates that there is something wrong with the company culture.

Peter Greenwood of Timet UK Ltd. Commented that 'bottom line' results were probably a good motivator. George commented that reduction in Accident costs had a direct contribution and needed many times their value in increased turnover to balance out their effect. This was readily accepted in GKN and the benefits did not need justifying repeatedly. George added that "Revitalising Health and safety" mention the effect of accidents on insurance premiums.

David Hughes, Vice-Chairman remarked that safety improvements were very often financially driven and cited a recent case where insurance assessors' questions had been extremely searching and had threatened managers most effectively! George added that added that costs were not always the best motivator, the implication being that the moral and legal factors had their part to play in getting employers to ptotect their empoyees health and safety.

As time was pressing, the Chairman brought the meeting to a close and asked the members to thank George, in the normal way, for a very informative presentation.