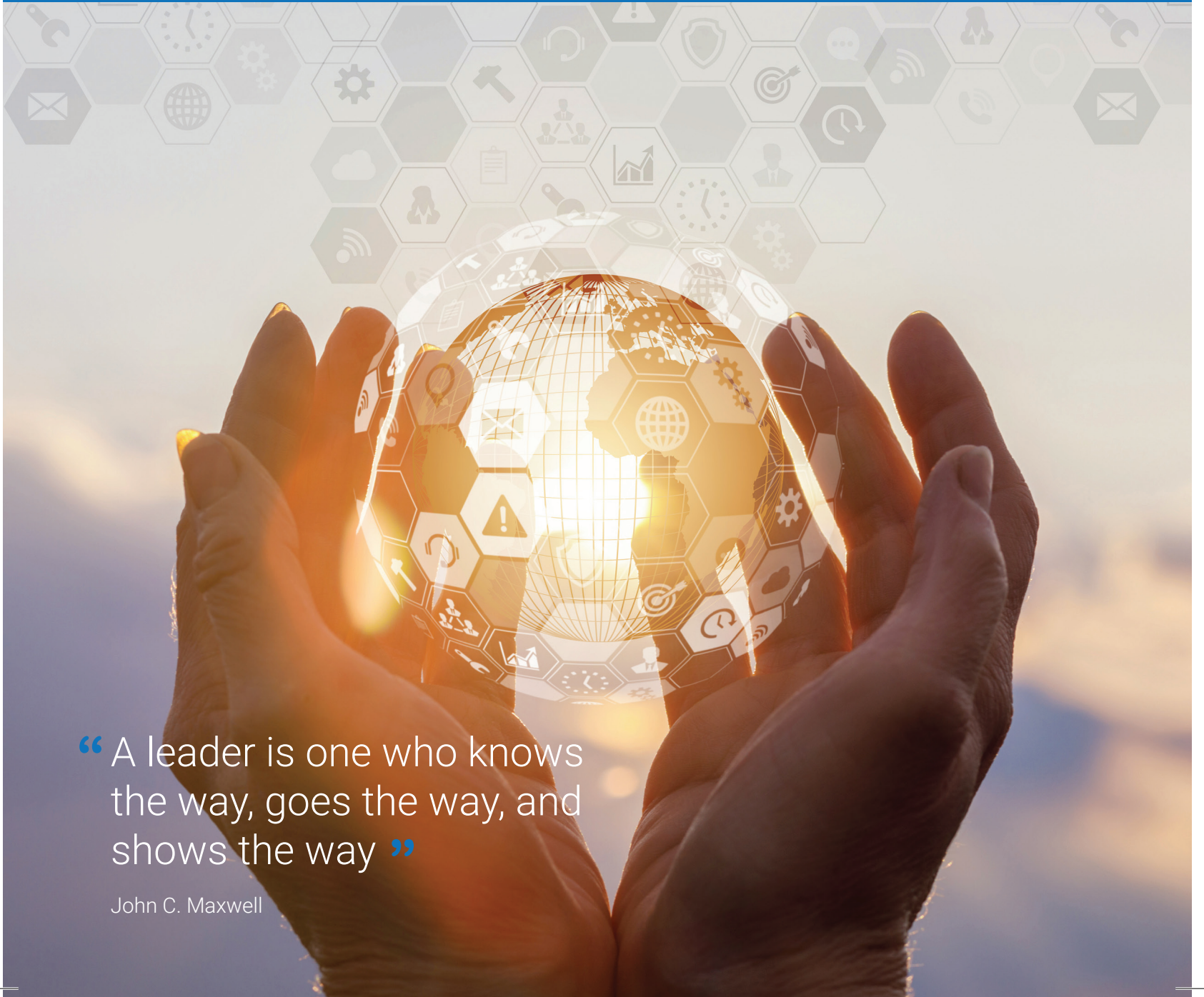


Self Development Guide

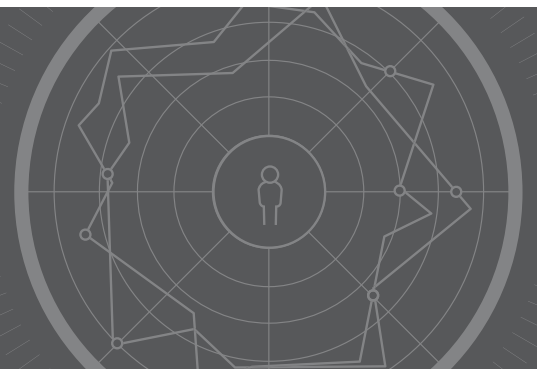
Creating a visible shift in safety performance and leadership



“ A leader is one who knows the way, goes the way, and shows the way ”

John C. Maxwell

Welcome Letter



Dear Safety Leader,

Being a great safety leader is a massive challenge. Leaders have so many demands expected of them; deliver cost savings, increase production, increase quality, innovate, and oh yeah while you're at it, make sure that no-one gets hurt....

When leaders and their teams somehow successfully manage all these demands and indeed no one gets hurt, it often goes somewhat unnoticed. When an injury or tragic event is prevented from happening, it's usually invisible by virtue that it never actually happened.

The point is, when safety goes well it can sometimes be taken for granted as a given, but when safety goes horribly wrong, it can be a nightmare that changes things for the worse for everyone involved.

For over a decade my role was to provide Critical Incident Response counselling to the many family and workmates of people who had been killed at work. I will forever be changed by this experience and often think of the loved ones, children, colleagues and mates whose lives changed forever on those fateful days.

This gut-wrenching work fuelled my commitment to do whatever I could to prevent workplace injuries and deaths. So, I've spent the last decade working across a vast array of industries and types of organisations, formed a comprehensive team of industry professionals, and secured the backing of a leading Australian University to create the Integral Safety Assessment (ISA 360).

The ISA 360 provides scientific analysis of your safety leadership capability and will give you insights that will unlock your full safety leadership potential. Your confidential results will help you understand where to focus your leadership development efforts to get the most value out of it and this is where the ISA 360 Self Development Guide comes in.

Congratulations on coming this far in your safety leadership journey and I sincerely believe that the ISA 360 will give you the tools to strike the most effective balance of all the demands placed on you as a leader. After all, many lives are counting on you each and every minute of every day.

A handwritten signature in black ink, appearing to read 'Ash Hunt'.

Enjoy!

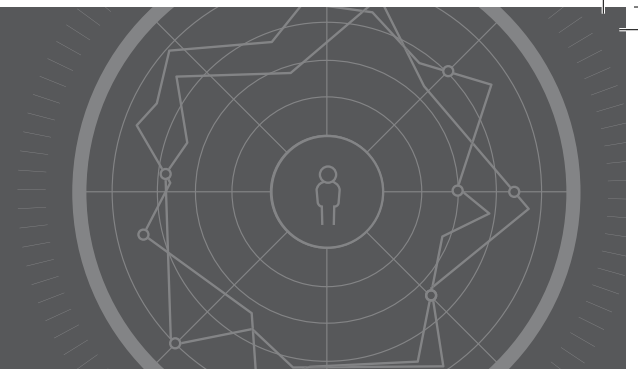
Ash Hunt

Director

Datadrivesinsight.com

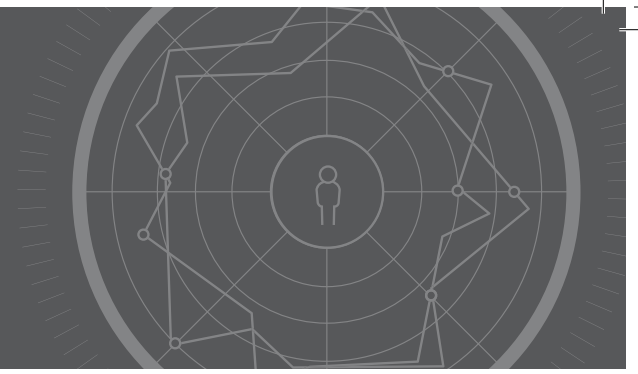
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Introduction

WHAT IS SAFETY LEADERSHIP?

*“He who knows others is wise; he who knows himself is enlightened.”
Lao-tzu, Chinese philosopher*

What is Safety Leadership?

If leadership is defined as one’s ability to inspire others to achieve sustainable results, then Safety Leadership could be defined as **one’s ability to inspire everyone to look after their own safety and the safety of others.**

This is not a formal leadership role. It’s a calling to the humanity within us. It’s a calling from the families and loved ones of all of those around us ... and ours. It’s a calling from our future selves.

Safety is our most important value because it underpins the potential of all others.

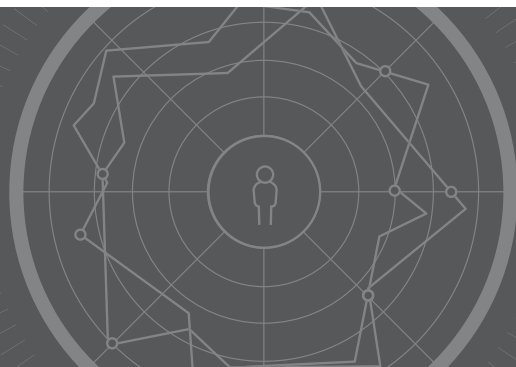
So, what does it take to be an effective Safety Leader?

Through experience, thought leadership, and considerable industry research we now know that there are four key capability areas, or ingredients, to high-performing safety leadership. We’ve described those capability areas as **Purposeful, Curious, Caring** and **Connecting**. These will show up in many different ways and speak to the way we view the world and the way we behave as individuals and also as part of a larger group.



If we walk past smoke, we could reasonably assume that a fire will result. Most things aren’t as obvious, but the concept is the same. If the condition is in some way, potentially unsafe, then we can reasonably assume the result will be a safety incident. Whether that incident results in a near miss, minor injury, reportable injury, lost time injury or a fatality, it is the condition which set the scene.

An effective Safety Leader will be constantly on the lookout for how to make the conditions safer and committed to inspiring others to do the same. Those conditions may be physical, and they may also be emotional. They’ll be curious as to how that has come about and why others may not have noticed it. Because of their commitment, it will be intolerable for them not to take action to make the condition(s) safer; immediately and more sustainably into the future. Because they genuinely care about others, even people they don’t know, they’ll find a way to ensure that the learning is shared with others throughout the business (and even beyond).



ABOUT THE SELF DEVELOPMENT GUIDE

This guide was developed for safety leaders in any industry and works in conjunction with your ISA 360 Feedback Report. It was developed as a practical toolkit to help you strengthen areas for improvement through understanding of contemporary leadership practice and theory and through practical activities that help you to focus on making improvement where it's desired.

You will get the most from this guide by taking time to read and work with the activities, talking to others about what you have read or learnt and making commitments that enable you to move towards your desired results.

The 'My Personal Development Plan' page is designed to be detached from the booklet and displayed somewhere that helps keep you on track.

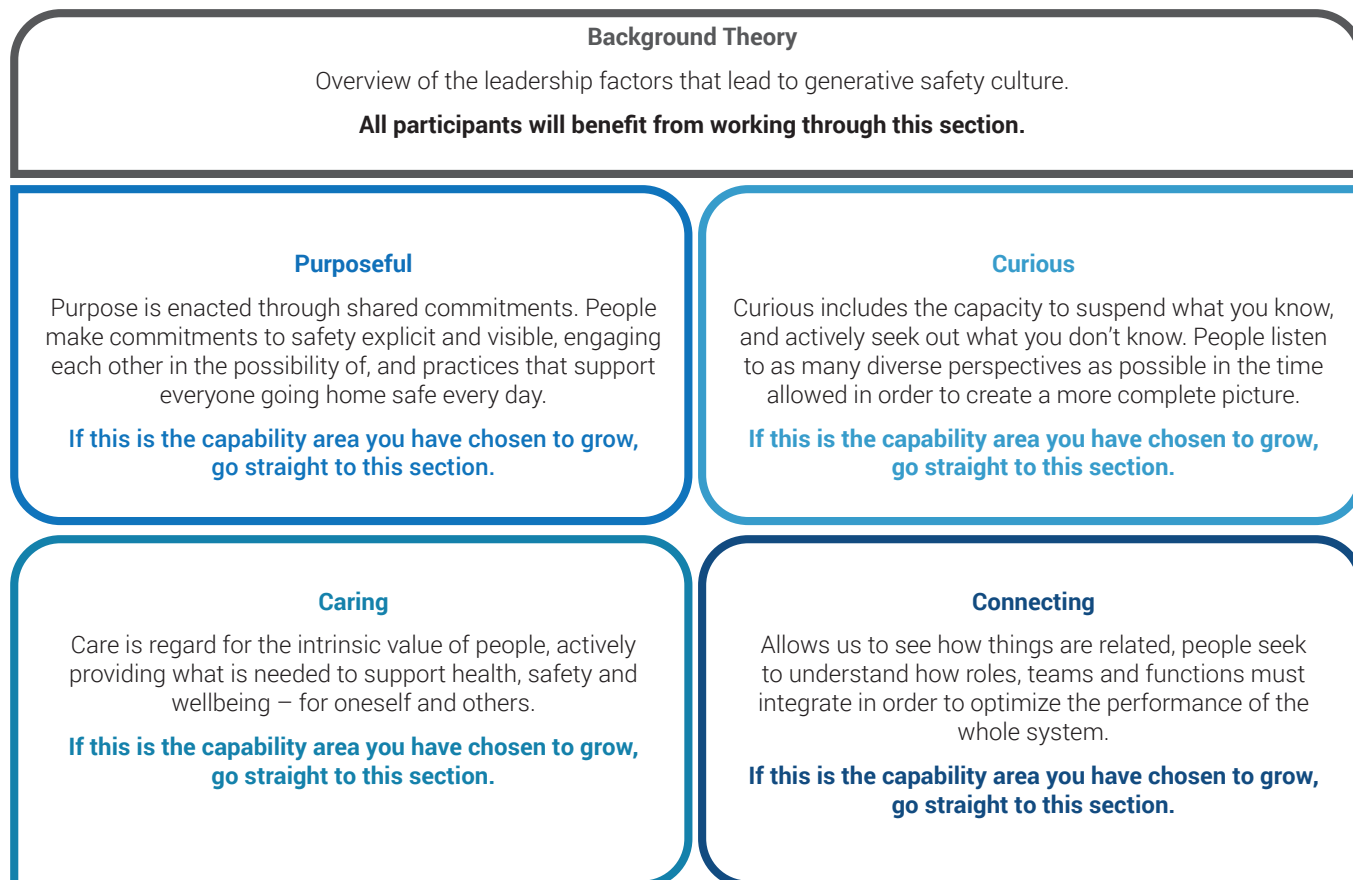
HOW TO USE THE SELF DEVELOPMENT GUIDE

This guide is comprehensive (and quite large) but has been designed as a universal resource, so knowing how to use it can ensure that the size of the guide is not overwhelming or a barrier to you achieving your desired growth.

This guide has been structured to allow you to focus on the capability area(s) most relevant to you. Once you have reviewed the results of your ISA 360 Feedback Report and decided on which of the four capability areas you are going to focus on you can go straight to that section of the development guide.

You can use only the section of the guide relevant to your chosen capability area initially and use the rest of the guide later for your own development or as a resource to assist you in developing your team over time.

The structure of the guide is as follows:



HOW TO COMPLETE THE DEVELOPMENT PLAN

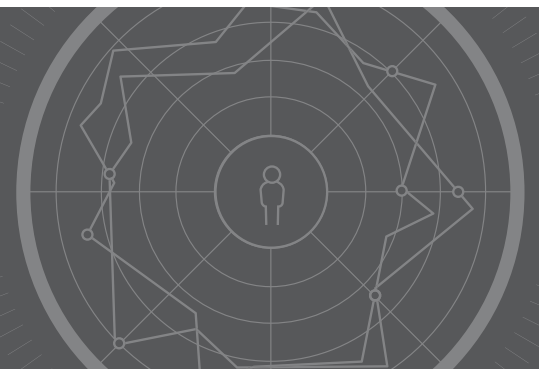
The next section 'Personal Development Plan' is intended to be where you can record in one place

- **What** you want to work on
- **Why** you want to work on it
- **How** you will make a change/what you commit to

Firstly, transfer the relevant information from your ISA 360. Then go to the relevant Safety Leadership Capability Area: Purposeful, Curious, Caring or Connecting to work through some activities. Once you have completed these activities, record actions and commitments in your development plan.

The development plan is located at page 25.

Background Theory: Safety Culture and Leadership



INTRODUCTION

Our understanding of safety has and continues to evolve.

Over time, the theories and practice of **safety management have evolved** to address the changing landscape of work.

In the early days, the focus of safety was on establishing regulations and governing institutions to ensure **working conditions** were fair, reasonable and safe for workers. Over time, the emphasis shifted between the focus on **individual behaviour** on the one hand and working conditions and the system design on the other.

Generally, through each progression, safety performance improved up to a point and then levelled off, soon followed by another shift in focus and more incremental progress.

If we stand back and look at the development of safety practice over time, we see that **each progression represented a partial truth, a piece of the safety puzzle, which is valid but not the whole story**. Our intent is to bring together the best of what has been done over the history of safety into an **integrated view**.

Creation of assessments that represent the best of safety practices.

The **ISA 360 and IASC** assessments reflect our commitment to represent the best of safety practice, and to use assessment itself as a way to help people reflect on where they are at in their safety journey and so that they can design where to go next.

These safety assessments reflect our understanding of the most current thinking in safety research and practice while at the same time appreciating the contributions of the past.

The original research that led to the development of these tools was based on a discovery of the common threads that linked divergent safety practices together. Two of those threads were the important roles of **Safety Leadership and Culture**.

Culture and leadership are the catalysts and glue.

We found that whether safety practice focused on individual contributions to safety performance or the process (or systemic) factors, both culture and leadership were key.

They were the catalysts and glue that both moved the needle forward and held the course steady.

Since safety performance emerges from a healthy system, our approach puts emphasis on creating a **Generative Safety Culture**.

Generative Safety Culture is not an end state, or a state of perfection where things don't go wrong, but is a way of working together, learning, being curious and purposeful, and continually getting better at detecting and addressing hazards. More will be said about this in the pages to come.

Because **leaders** have a crucial influence on safety performance, we provide specific feedback to leaders at all levels so they can learn to **create the conditions that lead to a Generative Safety Culture**.

Safety Culture and Leadership are important levers that can be used to improve performance in safety while also ensuring that people are engaged and happy in their work.

In summary, our approach is **integral**, which means that it is important to recognize the many contributions that have been made to safety and include the best of them as we continue forward.

Our **focus on leadership and culture** is a broad and inclusive one that integrates these views.

BRIEF HISTORY OF SAFETY APPROACHES & PHILOSOPHIES

We want to include those lessons that still have value in our current practice.

Safety has come a long way over the past 100+ years or more. In earlier times, a significant price for humankind's major accomplishments was measured by the large number of lives lost, limbs taken, and the well-being sacrificed. For many centuries, this loss was assumed to be inevitable, a cost of doing business, so-to-speak.

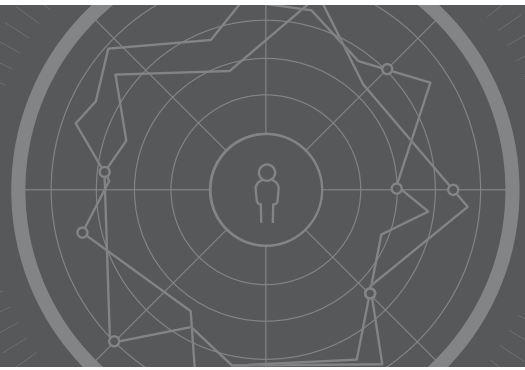
At many points along the way, people realized that we could do better, that through the invention of some new technology, method, or a shift in mind-set, we could reduce the unnecessary suffering, perhaps even eliminate it. It is useful to review these improvements to ensure we go forward with those lessons in mind.

We have included a simplified overview of the major safety developments and key learnings. We identify seven waves of development that have origins at a particular time, but that overlap and converge throughout the decades. The seven are:

- Regulatory
- Scientific Management
- Behaviour-Based / Human Factors
- Systems & Complexity
- Safety Management
- Safety Culture
- Resilience Engineering

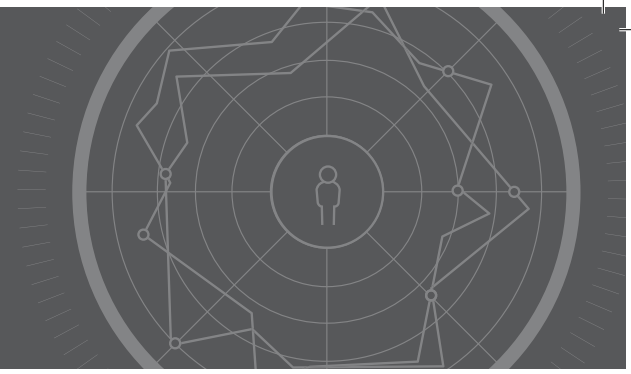
The following table highlights the key elements for each of the seven waves of development: the problem addressed at the time it emerged, key areas of focus, the result of it both good and bad, and the main lesson we want to retain from it.

Table of Safety Developments



	Problem Addressed	Key Focus Areas	Results	Take Away
Regulatory (1900+)	Workers had very little protection in high-risk work environments Major losses of life and well-being.	<ul style="list-style-type: none"> Creation of Governing bodies Work standards created with penalties enforced 	<p><u>Positive</u></p> <ul style="list-style-type: none"> Significant improvements in safety <p><u>Unintended</u></p> <ul style="list-style-type: none"> Corruption Violations are hidden 	A good regulatory environment holds businesses to account
Scientific Management (1910s+)	The cause of accidents and their resolution had never been studied systematically, so the rules could be arbitrary and unfair	<ul style="list-style-type: none"> Use of scientific method to study the patterns and causes of accidents Application of general approach and process of improvement 	<p><u>Positive</u></p> <ul style="list-style-type: none"> General improvements across broad categories of work <p><u>Unintended</u></p> <ul style="list-style-type: none"> People were treated as "cogs" in the machine, dehumanized 	A science-based approach to safety is necessary to weed out safety myths
Behaviour Based Safety/Human Factors (1930s+)	A large degree of variability in individual behaviour is seen as a major cause of accidents	<ul style="list-style-type: none"> Study the primary causes of accidents and use reinforcement to change behaviour Understanding the limits of humans and redesigning systems accordingly Application of psychology to safety 	<p><u>Positive</u></p> <ul style="list-style-type: none"> Better understanding of the human role in safety <p><u>Unintended</u></p> <ul style="list-style-type: none"> Too much focus on individual behaviour and human factors as the cause of accidents 	Understanding of the strengths and limits of human cognition and resulting behaviour
Systems & Complexity (1950s+)	Engineered systems become more complex and difficult to control by traditional means	<ul style="list-style-type: none"> Application of systems theory to engineered systems Understanding that accidents can result from system design and the interactions between system elements Studies of high performing organisations in high risk situations (HROs) 	<p><u>Positive</u></p> <ul style="list-style-type: none"> A broader understanding of how accidents can happen, beyond individual behaviour <p><u>Unintended</u></p> <ul style="list-style-type: none"> Underemphasis on the role of individual beliefs, values, behaviour 	Safety is a property that emerges from the system's design

Problem Addressed	Key Focus Areas	Results	Take Away
<p>Safety Management (1990s+)</p> <p>The fragmentation of safety into specialised and competing views makes it difficult to determine what practical approach to use</p>	<ul style="list-style-type: none"> • Safety Management Systems provide a comprehensive approach to organizing the safety function • Focus on the organisation balances an overfocus on the sharp end • Focus on risk and the management of risk 	<p><u>Positive</u></p> <ul style="list-style-type: none"> • Many organizations implement comprehensive safety systems and use them to monitor and improve <p><u>Unintended</u></p> <ul style="list-style-type: none"> • Safety largely become a “paper” exercise and companies believe the SMS will keep them safe 	<p>Importance of organizing the elements of safety into a management system that can be tracked, measured and improved</p>
<p>Safety Culture (2000s+)</p> <p>Large and catastrophic accidents around the world suggest that even the best safety management is insufficient. There is a hidden source of behaviour that drives performance</p>	<ul style="list-style-type: none"> • A shift from a purely mechanical view of safety to a more human one that includes values, beliefs and basic assumptions • Further focus on the organisational factors that drive behaviour • Emphasis on the role of leadership as a key influence on safety behaviour 	<p><u>Positive</u></p> <ul style="list-style-type: none"> • The human element in safety is brought to the foreground as both an individual and collective phenomenon <p><u>Unintended</u></p> <ul style="list-style-type: none"> • Safety Culture is often not well defined, and can sometimes be seen as the answer to everything 	<p>With safety, you can get everything right but culture trumps everything else. Safety culture is the intangible regulator of safety, risk, and resilient performance</p>
<p>Resilience Engineering (2010s+)</p> <p>Safety improvement has plateaued, and much of safety thinking and practice is based on a mechanistic worldview, therefore focuses heavily on individual human behaviour as the cause and remedy for poor safety performance</p>	<ul style="list-style-type: none"> • New principles for safety are formulated based on a living systems view • The causes of safety, either good or bad, are thrown into question • A new focus on design of safe (resilient) systems is highlighted 	<p><u>Positive</u></p> <ul style="list-style-type: none"> • Humans are seen as the source of innovation, improvisation, safe and resilient systems <p><u>Negative</u></p> <ul style="list-style-type: none"> • Sometimes viewed as making other ways of thinking about safety wrong 	<p>Resilient systems learn to adapt to changing situations, and the best humans can do is to learn how to nudge them toward a desired state (versus command and control)</p>



AN INTEGRAL APPROACH: PERSONAL AND PROCESS SAFETY (COMPLEX SYSTEMS)

Integral: A model that identifies personal, behavioural, cultural and systems views. And helps us remember the importance of the subjective/interior view alongside the objective/ exterior view.

Each of the waves of development in safety improvement provides a partial solution which is based on what was missing in safety performance at the time it emerged. Some of these ideas and practices continued on in isolation from other developments, some of them merged or integrated with others, and some lost appeal. There were many others that are not listed in the table above.

An integral approach to safety aims to include as many of these perspectives as possible but to also keep the approach as **simple as possible**.

The 4-quadrant model, shown below, is a useful way to think about these partial, and real perspectives that have been important to safety's evolution. The 4-quadrant model (K Wilber) identifies personal, behavioural, cultural and systems views, and also helps us remember the importance of the subjective/interior view alongside the objective/exterior view.

It has been our experience that safety is often reduced to the technical, objective, and structural (visible) elements while forgetting the non-technical, qualitative, and personal (invisible) elements.

INTEGRAL MODEL

	PERSONAL (INVISIBLE)	PROCESS (VISIBLE)
INDIVIDUAL	Individual attitudes and beliefs	Individual behaviours
ORGANISATION	Organisational Culture	Organisational systems, policies and processes

Learning grew as perspectives altered back and forth from personal to process safety

The history of safety can be viewed as a swinging back and forth between the personal view of safety and the systems view, with each movement reflecting a more nuanced and integrated perspective.

For example, the behaviorist view in the 1930s was quite blind to the nature of the system and the system view of the 1940s was unconcerned with individual behaviour.

However, the resilient systems view of current times reflects a more comprehensive view that includes both. At the same time, the qualitative view of safety (the left side of the integral model) is often left out of the story completely.

We used the integral perspective to remind us of the need to include personal, process and systems views as safety progresses.

This perspective was provided in greater detail in R. Strycker's 2011 Paper. ¹

GENERATIVE SAFETY CULTURE

Information flow and what leaders preoccupy themselves with as signals to safety culture.

Our approach to culture identifies specific aspects of culture that are connected to high performance in general and to extraordinary performance in safety in particular. Our research has shown that a specific cultural pattern, when present, enables both **team performance and extraordinary safety**.

Identified by Westrum more than 20 years ago, Generative Safety Culture has been supported by researchers and practitioners around the world. The characteristics of a Generative (Safety) Culture are closely aligned with studies in High Reliability Organisations (Weick & Suttcliff), Safety Culture Maturity (Parker & Hudson), and an Informed Culture (Reason).

These studies were integrated into a set of advanced safety practices by Strycker¹, and later synthesized into a set of factors that define Generative Safety Culture by Datadrivesinsight.com.

Generative Culture was first identified by noticing **how groups of people relate to the flow of information** in their work environment. Groups that support the free flow of information have established qualities that lead to higher performance, better coordination, high trust and good communication, many of the qualities that we now associate with psychological safety.

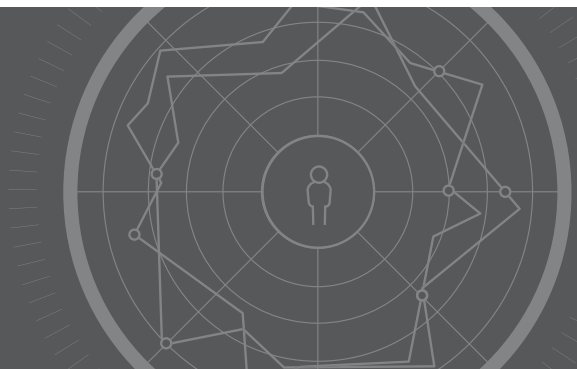
By observing how groups deal with information, especially safety specific information, we find a key indicator that regulates and enables good safety performance.

The insight about information flow led to the development of a culture typology which identified three dominant types: Detrimental, Bureaucratic, and Generative (Westrum²). The features of these types are shown in the following table.

A primary determinant of these types is what **leaders preoccupy themselves** with: power, rules, or purpose. This focus will eventually result in a climate where people and teams orient their work in ways that are more or less productive, more or less risk aware, and more or less safe. Although culture type is not the only determinant of safety performance, it is a key one.

¹ Looking For A 21st Century Solution for Safety Performance: Integrating Personal and Process Safety Rick Strycker, JMJ Associates February 2011

² A Typology of Organisational Cultures, R Westrum, Qual Saf Health Care 2004;13(Suppl II):ii22–ii27. doi: 10.1136/qshc.2003.009522



TYPOLOGIES OF CULTURE

Detrimental	Bureaucratic	Generative
<p>Power Oriented</p> <p>Characterised by low cooperation, blame, hiding incidents. Information is often withheld for personal gain. It is not safe to speak up, especially if doing so might be embarrassing.</p> <p>Messengers are shot, responsibilities are shirked. When things go wrong, a scapegoat is found and punished. There is no real learning from failure.</p>	<p>Rule Oriented</p> <p>Focused on positions, hierarchy, span of control. Responsibilities are compartmentalised by departments that seek to preserve their own existence and power. Information must flow through standard channels or procedures, in order to preserve status quo.</p> <p>Messengers are neglected, responsibilities are narrowed. When things go wrong, there is a process to produce retribution. Learning is institutional.</p>	<p>Purpose Oriented</p> <p>The hallmarks are good information flow, high cooperation and trust, bridging across teams, and conscious inquiry. Psychological safety creates openness, curiosity, care, and systemic learning.</p> <p>There is awareness of the importance of getting the right information to the right people, in the right form at the right time.</p> <p>When things go wrong, people look for a systemic cause and for systemic solutions, a recognition of the interrelated parts of the organisation. Messengers are trained.</p>

From these definitions we see that only a **Generative Culture** can be understood as a **genuine safety culture**. Both Detrimental and Bureaucratic cultures are seen as detrimental to safety, but to different degrees.

The Detrimental culture is seen as individual safety focussed where a person's desire to stay (physically, mentally, socially and psychologically) safe may inadvertently put the safety of others at risk.

For example, not speaking up when a hazard is spotted in order to not be seen to challenge a teammate, leaves that teammate exposed to risk – is less safe.

Bureaucratic culture is seen as having certain characteristics that reduce safety and some that are more supportive.

For example, "best practices" might be stored in the information system that is collated or developed by a particular function. If the nature of that work lends itself to a 'police state,' the culture will be less open to information sharing. However, if that work is done with a customer focus in mind, it can be supportive of the free flow of information and better coordination.

For this reason, we see the **Bureaucratic Culture as having two poles**, one that tends toward Detrimental and one that tends toward Generative. This is a point of leverage for developing toward a high performing safety culture.

FACTORS OF GENERATIVE CULTURE

The Generative Culture type is like a garden and needs to be cultivated and cared for.

Our approach includes the use of four factors that support and develop a Generative Culture, factors that can apply to individual leaders, teams, or groups of people working toward common goals.

Our research has shown that these four factors have a positive impact on how you and the people around you perform.

The four factors often develop at different rates, and these practices can be operating to achieve different safety cultures depending on the development of that practice. For example, one individual may demonstrate “Purposeful” at a level that may be working towards a Generative Safety Culture, they might also be demonstrating “Curious” at a level that will achieve a Bureaucratic Safety Culture.

In addition to our definitions of each factor, we provide a QR Code to a video that explores elements of this factor and is intended to help grow your understanding of them.

PURPOSEFUL

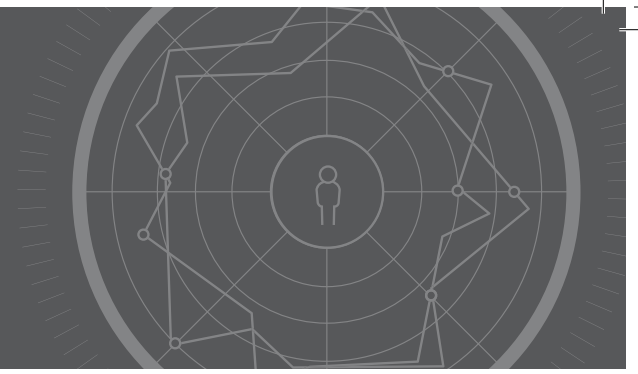
- Purposefulness provides practical guidance and orientation to a person, team or organisation, indicating the direction of change. When people know why they are doing a project or task, they can self-correct when they get off course. Purpose is enacted through shared commitments.
- People make commitments to safety explicit and visible, engaging each other in the possibility of, and practices that support everyone going home safe every day. When integrity is broken, it is restored by returning to commitment and rebuilding trust. Leaders engage others to be purposeful, committed, and continuously learning how to improve safe performance.



CARING

- Care is regard for the intrinsic value of people, actively providing what is needed to support health, safety and wellbeing. Care is personal, connecting with others based on understanding of how it is and what is needed from their perspective. Regard for others creates an environment where people respect each other and build trust and willingness to say what is true.
- Caring springs from care for oneself, ensuring one has the capacities and energy to provide real help. It balances a focus on building strengths with a compassionate drive to address gaps in performance and realise potential.





CURIOUS

- Curiosity creates openness to learning how things actually happen in order to improve safe performance. It includes the capacity to suspend what you know, and actively seek out what you don't know.
- Openness means that people are slow to make judgments or to blame people when things go wrong. Inquiry is kept open as long as possible in order to fully understand what happened and to generate lasting change.
- People listen to as many diverse perspectives as possible in the time allowed in order to create a more complete picture.



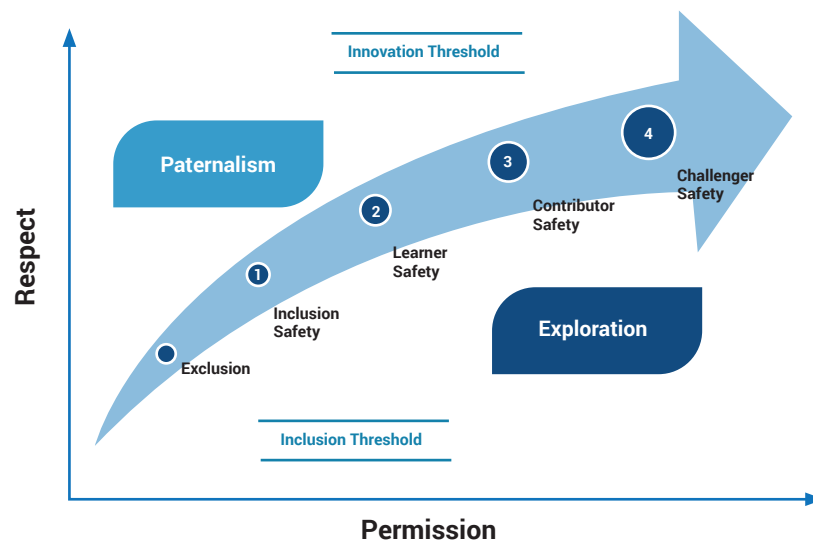
CONNECTING

- Allows us to see how things are related, people seek to understand how roles, teams and functions must integrate to optimise the performance of the whole system.
- Connecting is increased when people work together to create models of how the system works and then continually updated as new information is revealed. There is a concerted effort to understand how people close to the work understand the work, updating systems to match how work is actually done.
- There is work on the right things at the right time with the right people. There is use of highly intentional and focused approaches that leads to operational discipline and maximises the use of all resources to achieve the purpose.



PSYCHOLOGICAL SAFETY

Although the idea of psychological safety is built into the factors, it is also helpful to feature it separately. In her work on team performance, Amy Edmondson³ suggested that team learning was a key factor in team performance and that learning was dependent upon an environment that supported mutual respect, trust, personal risk taking—an environment she labelled “psychological safety”.



Psychological safety is a condition in which you feel (1) included, (2) safe to learn, (3) safe to contribute, and (4) safe to challenge the status quo— all without fear of being embarrassed, marginalised, or punished in some way⁴.

This term has grown in popularity over recent years and for a good reason. It is missing in many work environments and that absence makes work both miserable and unproductive. The relationship between psychological safety in a team environment and a team’s safety performance is significant.

Our view is that psychological safety is a key characteristic of a Generative Culture and so we have embedded these features into the four factors.

It is also an **outcome** of the development of the four factors and a good measure of a team’s working environment so we include it in our assessment of culture to indicate how well leaders and teams are progressing in their journey toward high performance.

³ Psychological Safety and Learning Behavior in Work Teams Author(s): Amy Edmondson Source: Administrative Science Quarterly, Vol. 44, No. 2 (Jun., 1999), pp. 350-383/

⁴ <https://www.leaderfactor.com/4-stages-of-psychological-safety>

WHAT THE ASSESSMENTS MEASURE

OVERVIEW

The culture and leadership assessments developed by Datadrivesinsight.com enable insights for the individual, team and organisation into their current strengths and opportunities for growth in relation to the four factors that create generative safety cultures.

There are two assessments that enable insight.

ISA 360

An individual 360 assessment designed for leaders at all levels and an Executive 360 for those with strategic roles at Executive levels.

The assessment is completed by the Individual (self) as well as the line manager, peers and direct reports to provide insights into strengths and potential blind spots.

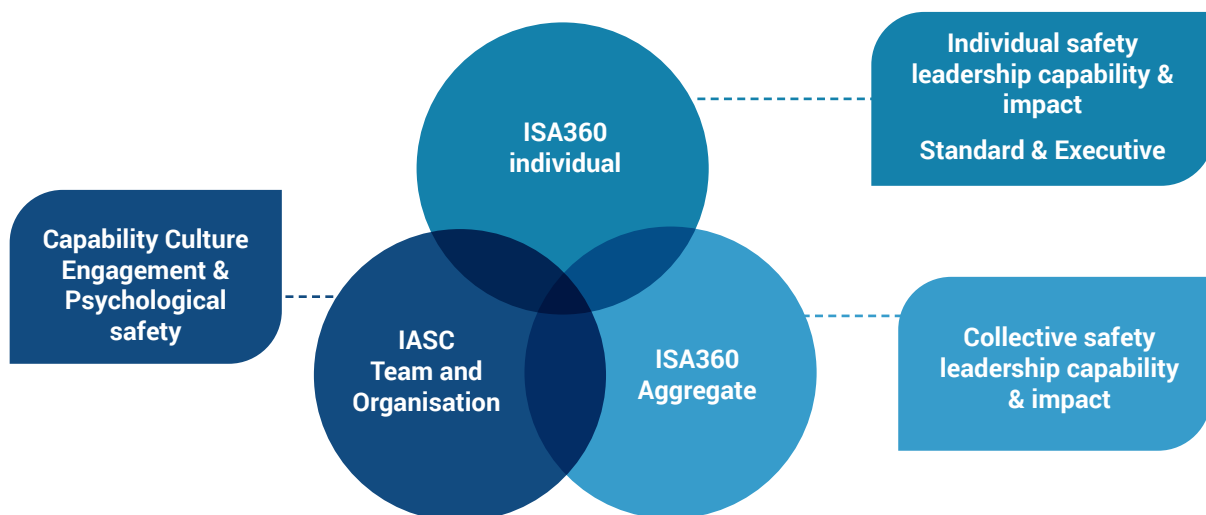
IASC

A team-based assessment designed for teams in any industry. The team or group is usually defined as the collection of people that have work in common and must rely on each other and coordinate amongst themselves to get things done. This approach is a practical way to assess safety culture (at the team level), it is also a primary location where safety improvements will have the most impact.

The assessment can be completed by the team members, leaders and interfacing teams.

Both assessments can be aggregated to create a collective view:

- Of individuals, a group of leaders for example, to help identify collective growth and development needs and develop tactics to meet these needs, through leadership programs for example.
- Of teams to get holistic view of the organisation or multiple teams.



WHAT ISA360 MEASURES

ISA 360 is a valid and reliable measure of a leader's strengths and growth areas across the four factors - enabling a leader to get feedback and a chance to see blind spots.

It also measures the current impact of the leader in regard to team engagement and psychological safety.

This is summarised below:



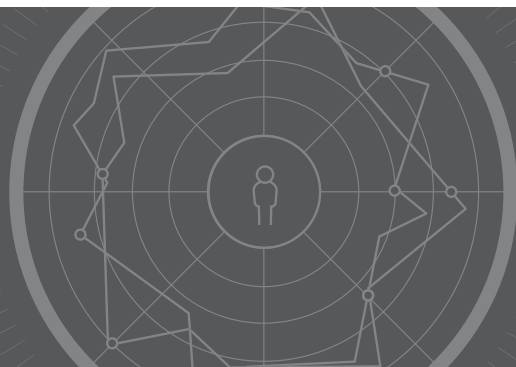
Our research has shown that the four factors have a significant impact on how staff feel.

What would it mean to you if your leadership capability enabled staff that felt:

- ✓ 41% more valued
- ✓ 59% more listened to
- ✓ 57% more likely to share their ideas and concerns
- ✓ 58% less avoidant of safety issues
- ✓ 63% more confident that changes would result in improved processes

What would it mean to you knowing that leaders who actively engaged in transformation activities could create;

- ✓ 17% more staff, that felt safe to stop the job if unsafe?
 - ✓ 34% more staff, who had confidence in safety processes?
 - ✓ 15% more staff, who felt empowered?
-



WHAT IASC MEASURES

This culture assessment tool supports people and organisations who are committed to significantly improving safety performance. Our approach recognizes the importance of safety culture in achieving extraordinary performance and sustaining it over time.

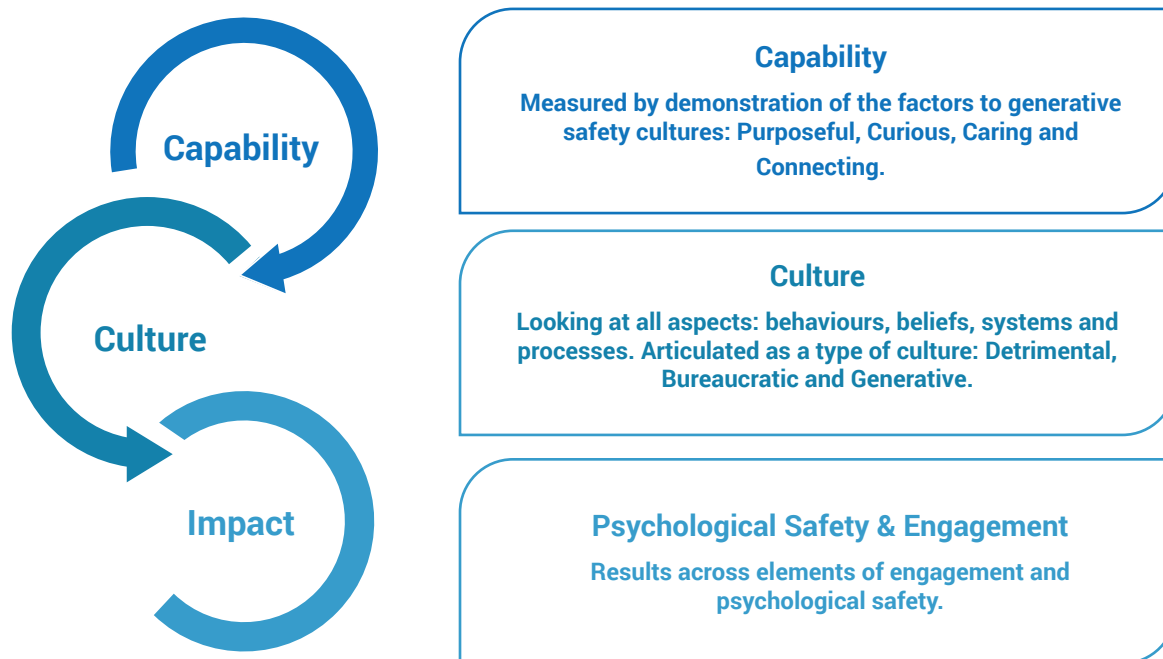
Our approach to cultural assessment is designed to identify specific and actionable areas of improvement. The assessment process is meant to be a beginning point of change, not a panacea. Culture is complex, meaning that it cannot be reduced to simple set of formulas or prescriptions. It is best understood through inquiry, investigation, and multiple meaningful conversations.

An organisation will likely have many different sub-cultures that when taken together, create a patterned and predictable response to challenges and opportunities.

When we talk about changing a culture, we are always aware that many of these routine patterns are essential to the ongoing success of the group so it is important to consider what is preserved along with what must be changed.

Therefore, the IASC team assessment tool helps to reveal both what is working and what is missing, enabling levers for change to be identified and explored.

Three key areas are measured; capability, culture and impact, including engagement and psychological safety. A high-level view is provided below:



What about knowing that if your team could increase its generative culture it can create results like:

- ✓ 79% decrease in TRIFR;
- ✓ 43% decrease in SIFR;
- ✓ 60% reduction in vehicle collisions;
- ✓ 10% increase in productivity while maintaining all maintenance schedules and targets
- ✓ 84% positive response to colleagues ability to display 'genuine care'.

The Transformation Model

This development guide is a little different to others you may have used. It is designed to increase your technical knowledge or understanding of safety leadership techniques AND to also expand your understanding of yourself. Most leadership training programs focus on technical knowledge or more effective management 'actions' to achieve a better result. From a personal/process safety perspective, this would be emphasising process safety. While this is important, this development guide also invites you go deeper to examine your views, beliefs and values that also impact on your leadership performance.

This transformational approach to leadership is summarised in the following **VIEW – ACTION – RESULTS** model that you will see regularly throughout this guide.



To truly transform as a leader, you need to explore both components of the model (VIEWS + ACTIONS). This guide is designed to do both.

Why? Our views, beliefs, values or perceptions influence our behaviour and actions, which have an impact on the results or outcomes we get. It's these beliefs that enable us to achieve our personal definitions of successful and fulfilled lives.

Some commonly held beliefs within organisations include:

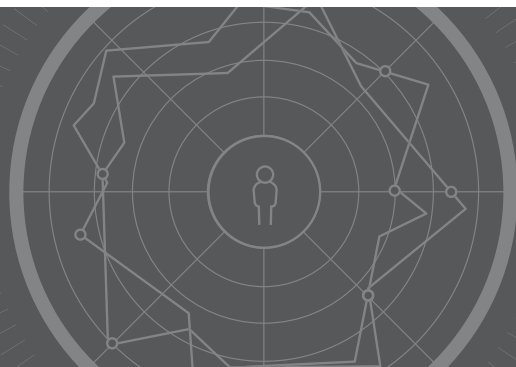
- "Our safety procedures will keep us safe"
- "Productivity is more important than following the rules"
- "Safety paperwork will keep us safe – as long as everyone completes them"

No one sets out in the morning to put other people's lives at risk. However, sometimes we can unintentionally cause an impact on safety that is difficult to see. This is **the intent/impact gap** and common for us all in our daily lives.

For example, a safety leader might think he is doing a great job by *encouraging everyone to fill out all their paperwork and making sure to discipline those who haven't filled the paperwork in correctly.*

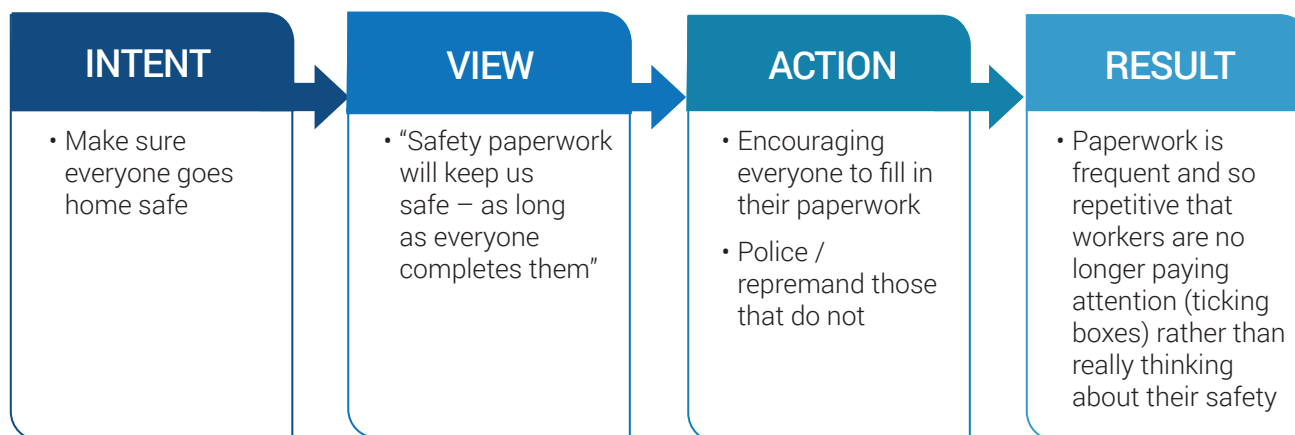
The unintended impact might be that the paperwork is so frequent and so repetitive that workers are no longer paying attention, they are just ticking boxes so they can get back to work, rather than really thinking about their safety. The forms become a perceived obstacle to productivity, rather than a tool to keep them safe and be efficient.

It may sound strange but the reason we hold onto some of our views or beliefs, despite us not getting the result we intended, is that there are **perceived benefits** to having these views or beliefs. Things that help make us feel safe, maintain peace in relationships, or get things done. On the flip side, there are also **costs** for having these views and beliefs - unintended impacts to us and others, and our relationships.



INTENT-IMPACT EXAMPLE

Let's explore this further. How might the intent to 'make sure everyone goes home safe' occur if a view or belief is that 'Safety paperwork will keep us safe – as long as everyone completes them'.



SO WHAT COULD SOME OF THE PERCEIVED BENEFITS OF THIS VIEW BE?

PERCEIVED BENEFIT	...AND WHAT IS THE BENEFIT OF THAT?	...AND WHAT IS THE BENEFIT OF THAT?
<i>I've covered my 'ass' if something goes wrong</i>	<i>I can't get in trouble</i>	<i>I feel safe</i>
<i>I'm praised by OSH and other areas of the business for completing forms</i>	<i>I'm seen as a good worker</i>	<i>I keep my job</i>

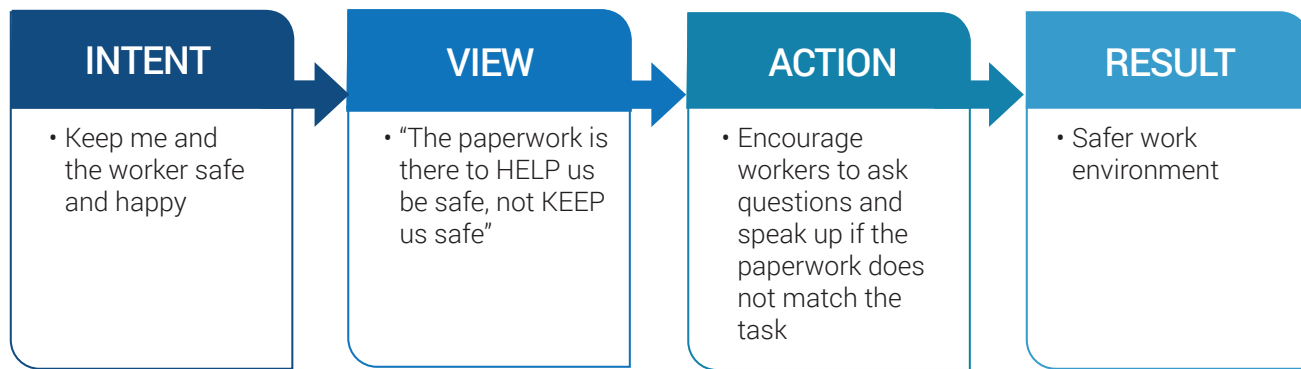
AND WHAT ARE THE POTENTIAL COSTS?

COST	...AND WHAT IS THE COST OF THAT?	...AND WHAT IS THE COST OF THAT?
<i>Workers aren't paying attention, just ticking boxes</i>	<i>They aren't thinking about their safety</i>	<i>Unsafe work conditions</i>
<i>I'm not aware of any gaps or improvements that are needed</i>	<i>Missed opportunities</i>	<i>Our business suffers</i>

So, you can see that the **impact** of our actions based on a certain **belief** can create a gap between our intentions and the results we get. The good news is that we have control over our beliefs and views. This means as part of the development work, you will get a chance to explore your current views as well as potential alternative, more constructive views that can give you a different outcome.

OK, SO WHAT VIEW MAY BE MORE CONSTRUCTIVE TO ACHIEVING THE ORIGINAL INTENT?

How about:



SO WHAT COULD SOME OF THE BENEFITS OF THIS NEW VIEW BE?

BENEFIT	AND WHAT'S THE BENEFIT OF THAT?	AND WHAT'S THE BENEFIT OF THAT?
More safe work practices	Improved safety performance of my area	Recognised by colleagues, management, clients
We all go home safely	I can enjoy other areas of my life	Happier overall

While the benefits are significantly greater, every alternative view also comes with challenges for you to overcome as a leader. These challenges are significantly less than the costs that you might experience with a less constructive view. It is important to recognise these challenges too.

SO, WHAT ARE SOME OF THE CHALLENGES OF THIS VIEW?

CHALLENGES	AND WHAT'S THE CHALLENGE OF THAT?	AND WHAT'S THE CHALLENGE OF THAT?
Have to create a trusting environment for workers to speak up	Having to spend more time in the field with my team	Will have to prioritise
When I notice the paperwork does not match the task, I'll need to influence a change	Speaking up and being heard by managers/decision makers	Takes perseverance to effectively influence change

To get the most out of this approach, be as open and honest with yourself as possible, particularly about the costs of your current, less constructive views. Be courageous and challenge yourself with compassion. Explore and try out new views and reflect on what you learn from trying these out. We didn't learn to walk in one try, so remember you have whatever is required to make the change you want to see, don't give up.

My Personal Development Plan



NAME:

MY ROLE:

MY PASSION:

MY AMBITION:

BEING CLEAR ABOUT MY STRENGTHS AND AREAS FOR IMPROVEMENT

TOP 5 STRENGTHS	TOP 5 AREAS FOR IMPROVEMENT

MY DEBRIEF WAS ON:

KEY LEARNINGS ABOUT MYSELF:

THE CAPABILITY AREAS I WILL FOCUS ON ARE (TICK):

Purposeful

Caring

Curious

Connecting



ACTIVITY

GETTING CLEAR ON HOW I WILL MAKE A CHANGE

MY COMMITMENTS

Now that you have an idea of what capability area you want to focus on, go to that section and complete the reading and activities that are relevant. These will help you to increase your awareness of what 'good' looks like, what areas of focus may be helpful to you and therefore enable you to make a commitment/action to improve this area.

Once you have done these, record all your commitments here:

I AM COMMITTED TO:	BY (DATE)

I will keep myself accountable by sharing and asking for support from:

We will do this by:

I will know I have made a change by:



Purposeful



Purposeful

Purposefulness provides practical guidance and orientation to a person, team or organisation, indicating the direction of change. When people know why they are doing a project or task, they can self-correct when they get off course. Purpose is enacted through shared commitments. People make commitments to safety explicit and visible, engaging each other in the possibility of, and practices that support everyone going home safe every day. When integrity is broken, it is restored by returning to commitment, rebuilding trust. Leaders engage others to be purposeful, committed, and continuously learning how to improve safe performance.

Purpose provides practical guidance to a person, team or organization, and sets the direction of change. In a generative culture, people know why they are here, why they are doing the project or task, and can self correct when they get off course.

Purpose is enacted through commitments. Generative leaders make commitments to safety explicit and visible, engaging others in work where people go home safe every day. When integrity is broken, it is restored by keeping one's word, and rebuilding trust.

Leaders engage others to be purposeful, committed, and continuously learning how to improve safe performance.

Personal Commitment & Integrity



ACTIVITY

CONNECTING WITH SAFETY

“For safety is not a gadget but a state of mind” Eleanor Everet⁵

Sometimes we get so caught up in ‘doing’ that we don’t spend a lot of time thinking about the big picture. So much effort can go into ‘doing things safely’ that we can neglect the bigger picture. Why is safety important to you? Let’s explore this further.

Just imagine you were injured/hurt at work. What would this look like? I.e. what might happen to you at work that would cause you to become hurt?

What would this mean for your work life? Think about your role, your responsibilities, your team, production, the business strategy, your colleagues, how others might be impacted etc?

What would this mean for your home life? Think about your loved ones, what you might miss out on, financial implications, changes to your routine, how others might be impacted etc.

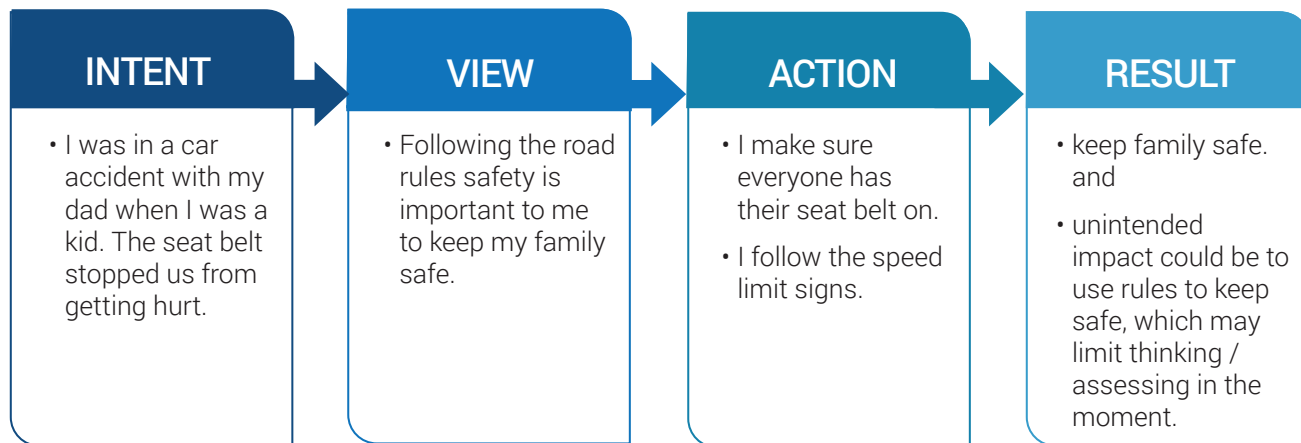
How likely is this hypothetical scenario? I.e. how likely is it that you will get hurt at work? How do you feel after exploring this scenario?

⁵ <https://www.quotery.com/authors/eleanor-everet>

It might sound strange, but not only do we have relationships with people, we also have relationships to topics such as safety. Our relationship with safety is formed through our experiences. Starting at home we learn from our parents and family members, then as we get older we are influenced by friends, community and workplaces. We start to form views that are often unconscious to us, for example, if we have never been involved in a car accident or witnessed a 'near-miss' we might have a view that 'it's safe to text and drive, as long as I don't look down for too long.' This will be a very different view to someone who has been involved in an accident caused by texting while driving.

These views then influence our actions and behaviours, what we say or do, or don't say or do. This of course impacts the results we get in life and safety.

Here is an example:



ACTIVITY

What people, experiences and values have influenced your view and connection to safety? Reflect on these here;

MY VALUES I.E. WHAT IS IMPORTANT TO YOU?	PEOPLE WHO HAVE INFLUENCED ME	EXPERIENCES OR STORIES THAT HAVE INFLUENCED ME
<i>e.g. family, health</i>	<i>e.g. my Dad, my boss</i>	<i>e.g. the time</i>



How would you describe your 'why safety is important to me?'

As a result of the above, on a scale of 0-10, how would you rate your current relationship with safety?



What is a +1 action you could take to shift your relationship along the scale?

MY RELATIONSHIP WITH SAFETY

Each person as a member of a team, has an impact on the culture and performance of that team. Take some time to answer these questions below

How would you rate your current relationship to safety?

Circle the answer that is most accurate for you.

1. When driving, I eat food or drink coffee or other beverages?

1 = never

2 = occasionally

3 = frequently

2. When driving or stopped at traffic lights, I make calls, text, check emails or calendar appointments?

1 = never

2 = occasionally

3 = frequently

3. When I cross an intersection as a pedestrian, I only cross when the "Green Man" is flashing?

1 = always

2 = occasionally

3 = rarely

4. When I'm given a job to do that I'm unsure about, I just push ahead and work it out?

1 = never

2 = occasionally

3 = frequently

5. Before commencing a job, I thoroughly read all safety materials relevant to the job?

1 = always

2 = occasionally

3 = never

6. When I do work around my house or garden, I use PPE (personal protective equipment)?

1 = frequently

2 = occasionally

3 = never

7. When I notice someone from a different "crew" to mine doing something "less safe", I talk to the person about it.

1 = every time

2 = occasionally

3 = rarely

8. When I'm heading off on a long drive or holiday, I make sure that I give some thought to my fatigue levels.

1 = always

2 = occasionally

3 = never

9. When using chemicals around the house (eg: pool, garden, cleaning) I make sure my family aren't in harms way?

1 = always

2 = occasionally

3 = rarely

10. If I'm asked to do a job that I worry is unsafe, I stop the job and report it.

1 = always

2 = occasionally

3 = rarely

NOW, PLEASE ADD UP YOUR SCORES:

TOTAL SCORE



My Relationship to Safety Score:

- If you scored 10 to 14 points, you have an extraordinary relationship with Safety.
- If you scored 15 to 22 points, you have an ordinary relationship with Safety.
- If you scored 23 to 30 points, you have an insufficient relationship to Safety (it is not going to happen to me!)

PERSONAL REFLECTION

What thoughts has this simple assessment raised for you?

Is your current level of 'relationship' to yours/others safety sufficient to generate the results you want?

What ideas have you got about improving your 'relationship' with safety?



LINK TO YOUR PERSONAL DEVELOPMENT PLAN
What did you learn?
What have you decided to work on?
Add your actions to your Personal Development Plan.

STAYING CONNECTED – ASLEEP AT THE WHEEL

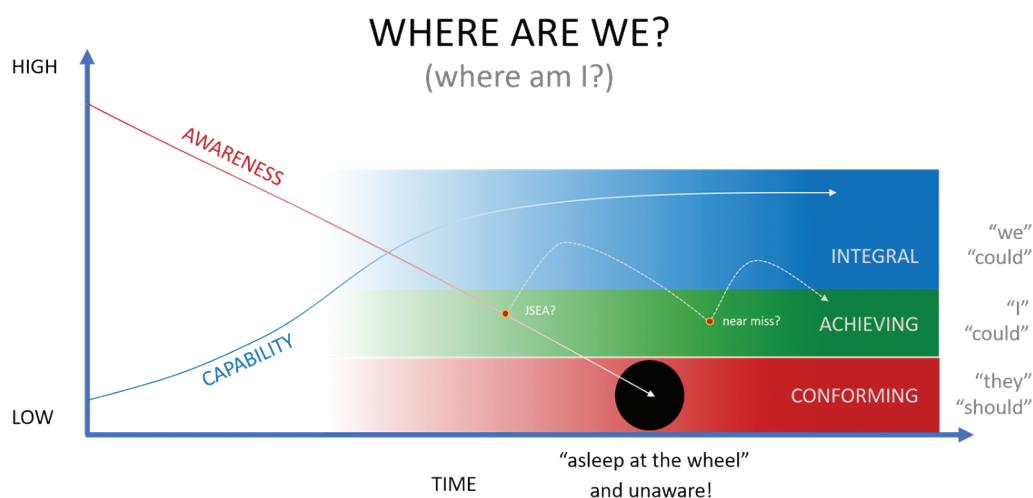


Risk can be defined as a situation involving exposure to danger. Assessing risk generally has two elements; consequence (severity of e.g. extreme, high, low) and likelihood (possible, probably, likely, etc.). By considering these two elements we can increase the visibility and understanding of a risk and therefore improve our decision making.

Risk perception is the subjective judgement that people make about the characteristics and severity of a risk. This is based on our different experiences and skills; hence we all have different risk perceptions. The person who does professional car racing on the weekend will have a different risk perception of driving than a learner driver.

Our perception of risk is influenced by two elements; competence (skills and knowledge) and time (experience). Using the graph below and the driving example; when a new driver first starts, they have low competency or skill in driving and their awareness of risk is high. They are at high risk.

On the other hand, someone who has been driving for a long time can become normed to the risks – so their awareness reduces. This is called complacency. This may sound like “I’ve been doing this for years; I know what I am doing”. Ever arrived at work and realise that you don’t even remember leaving home? We kind of go on ‘autopilot’. Another way of viewing this is that we are essentially ‘asleep at the wheel’.



The real risk with complacency, is that we are unaware that we are complacent, and it takes an event (a near miss or incident) to wake us up.

In the workplace this could be a routine check-up or inspection, something you do every day. Interestingly, the longer you’ve been doing something, the more ‘at risk’ you are of being ‘asleep at the wheel’ and not even realise it.

The challenge for everyone, and particularly those leading people, is to help them be in the Integral (blue) zone, in the diagram above. This is where we match our high capability with high awareness, of what we’re doing and why we’re doing it. It’s natural for our risk perception to decline and so we’re all vulnerable to becoming ‘asleep at the wheel’. That’s why we need each other.



Some examples may be:

- Use processes and systems to help keep awareness at constructive level e.g. 'step backs' or safe job planning
- Use training to keep capability increasing and as opportunities to see risks in a different way
- Encourage staff mentoring to have experienced and new staff working together so that experience can be shared and help manage the anxiety of new staff. New staff could even share with the experienced staff a different/fresh perspective on the risks
- Engage a variety of people in incident reviews to get different perspectives on risks and solutions
- Share lessons learnt, rather than each of us having to learn the hard way
- Reminding each other, in handover meetings, why it's important that we're aware of the risks
- Adding a safety 'thought of the day' to the staff notice board



ACTIVITY

Note: if you have trouble doing this activity on your own, consider working with a colleague or friend.

Reflect on a time where you were essentially 'asleep at the wheel'. What was the situation? What contributed to that experience? If you were sharing this story with friends what would you say?

Imagine this happened to someone close to you. How would you coach them to find ways to prevent this occurring again and be in the 'Integral' zone? What questions would you ask?

What did you learn for yourself in the act of coaching this person?





LINK TO YOUR PERSONAL DEVELOPMENT PLAN

What did you learn?

What have you decided to work on?

Add your actions to your Personal Development Plan.

DEMONSTRATING INTEGRITY

Integrity means doing what you say you'll do, or ensuring your actions are consistent with your words. It means being consistent, reliable, honest, authentic and leading others with both heart and mind.

Authenticity is behaviour that conveys to others that you are being "real" with them. In other words, that you are not hiding behind roles or facades, and that you are being open and honest within appropriate boundaries. Essentially, it is making sure you are not coming across as a "phoney".

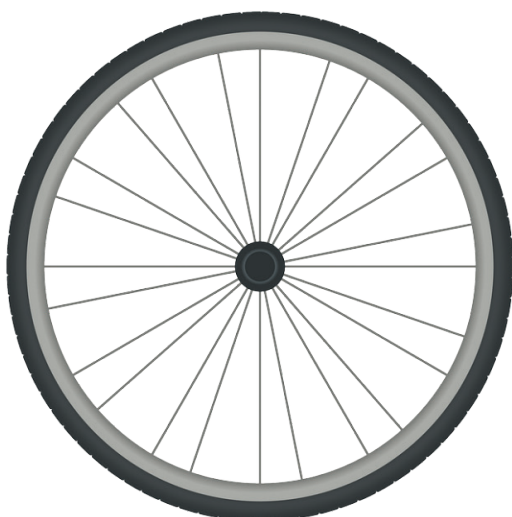
It is conveyed by:

- Talking appropriately about yourself.
- Responding naturally.
- Sharing feelings appropriately.
- Verbal behaviour consistent with non-verbal behaviour.
- Not being defensive.
- Not pretending to be someone or something you are not.
- Being honest and up front with people
- Sharing your real feelings or thoughts in a caring and assertive manner.
- Not saying things you don't believe simply because you think other people would want to hear them.

WHEEL OF INTEGRITY

Integrity is like a bicycle wheel.

When all spokes are intact and undamaged, the wheel rim has perfect structural integrity. All the right characteristic foundations are in place to support high performance. It can perform at its optimal functioning capacity.



However, like a broken promise, if one spoke is damaged, the structural integrity of the whole wheel is weakened.

Over time, if this spoke is not repaired, the wheel loses its shape, its performance is affected, and the weakness is visible.

While we may have good intentions, occasionally we break promises or commitments. One broken spoke won't harm the wheel's performance unless they go unfixed. The important thing is to repair the spoke and restore the structural integrity of the wheel.



ACTIVITY

Reflect on a time you broke a promise or didn't follow through on a commitment to yourself. For example, a new healthy eating plan or exercise regime. How did you feel? What did you do? How did you try to 'fix' the situation?

Often, we try to repair a broken promise through generating excuses, reasons, justifications, explanations, or blaming others. However, this approach is costly because the integrity of your relationship with the other person remains damaged.

Where a broken promise is left unrepaired or unresolved, this baggage from the past can live on into our future. One way to resolve this is using the Completion Sequence, below (The Three Laws of Performance, Zaffron & Logan, 2009).

THE COMPLETION SEQUENCE

When looking at your issue from above, is there anyone involved in the situation with which you feel distance or where you sense that something is 'off', but you just can't put your finger on it? What you're seeing is an **incompletion** – something that lives in your future due to baggage from the past.

The Completion Sequence is a future-based communication process you can use to repair and restore the structural integrity of a relationship. Particularly when things are left 'unsaid' or feel incomplete after a broken agreement or miscommunication.

1. Start a conversation with the person with whom you need to resolve something.

- Create a scenario or frame the situation in such a way that resolving the issue is of benefit to the issue. Speak about the benefits or positive outcomes.
- E.g. "I'd like to discuss something which, if resolved, will make our working relationship much stronger, improve the team morale and increase our effectiveness and performance overall."

2. Address what happened.

- Let them know your perspective on the situation and take responsibility for all parts (e.g. what decisions you made, what you did or didn't do in the situation concerning the relationship between you and the other person). Because you harboured and held onto it, you have to take responsibility for the diminishment of the relationship. It may even be to such an extent that you ask to be forgiven for what happened.
- E.g. "I acknowledge and take responsibility for this."

3. Take whatever action is necessary.

- Apologise or give up your excuses or old stories. When we give something up, forgive or are forgiven, a new space opens up. E.g. "Today I decide to give up the grudge I've been holding onto for all these years and move forward."

In this space, a new future can be created. Both of you can move forward and learn from this situation so that it will be less likely to occur again.



LINK TO YOUR PERSONAL DEVELOPMENT PLAN

What did you learn?

What have you decided to work on?

Add your actions to your Personal Development Plan.

LEADING WITH VULNERABILITY

Following on from the topic above, Integrity, you will notice that to have integrity requires us to be vulnerable. Vulnerability here does not mean being weak or submissive. To the contrary, it implies the courage to be yourself. It means replacing “professional distance and cool” with uncertainty, risk, and emotional exposure⁶

As leaders and employees, we are often taught to keep a distance and project a certain image. An image of confidence, competence and authority. However, research shows that onlookers subconsciously register lack of authenticity, which in turn impacts a leader’s perceived trustworthiness. Why? Because nobody knows everything and the moment we pretend we do, others lose confidence in our integrity. Conversely, the moment we demonstrate authenticity, others feel we’re more worthy of their trust (and so do we).



Find out more on vulnerability by watching the video below by Brene Brown

Link: <https://qrs.ly/d59ya17>

Or scan the QR code to the left

Trust, authenticity and vulnerability are cornerstones to building high performing teams and strong working relationships. It also creates an environment where others feel safe and comfortable discussing their own hesitations, vulnerabilities and concerns which may result in preventing an unsafe act.

How can a leader demonstrate their vulnerability and increase trust and relationships in the workplace?

Here’s what you, as a leader, can do to unmask your vulnerabilities in the workplace.⁷

1. Confront self-doubts.

Just because you’re a person of high power in your company doesn’t mean you never doubt yourself. Sure, you might appear confident, and that might have been what landed you the position in the first place. But no one is free of worry or reservation at all times.

2. Confide in your team.

While you want to set a good example for your workers, you can’t be perfect. In fact, concealing your imperfections will only give your team unrealistic expectations. Sharing your struggles is a great way to encourage sharing vulnerabilities and learnings. It also allows your peers and employees to see a more personal side of you, that will strengthen your bond with them. Additionally, confiding in others will show that you trust them and value their feedback and support.

⁶ <https://hbr.org/2014/12/what-bosses-gain-by-being-vulnerable>

⁷ <https://www.businessnewsdaily.com/10680-unmasking-vulnerabilities-leadership.html>

What is something you could do today, to increase your vulnerability in the workplace, to have a positive impact on safety?

Not convinced vulnerability is for you.



Have a read of the article at this link to bust some myths about vulnerability.
Link: [The-Strength-of-Vulnerable-Leaders](#)
Or scan the QR code to the left

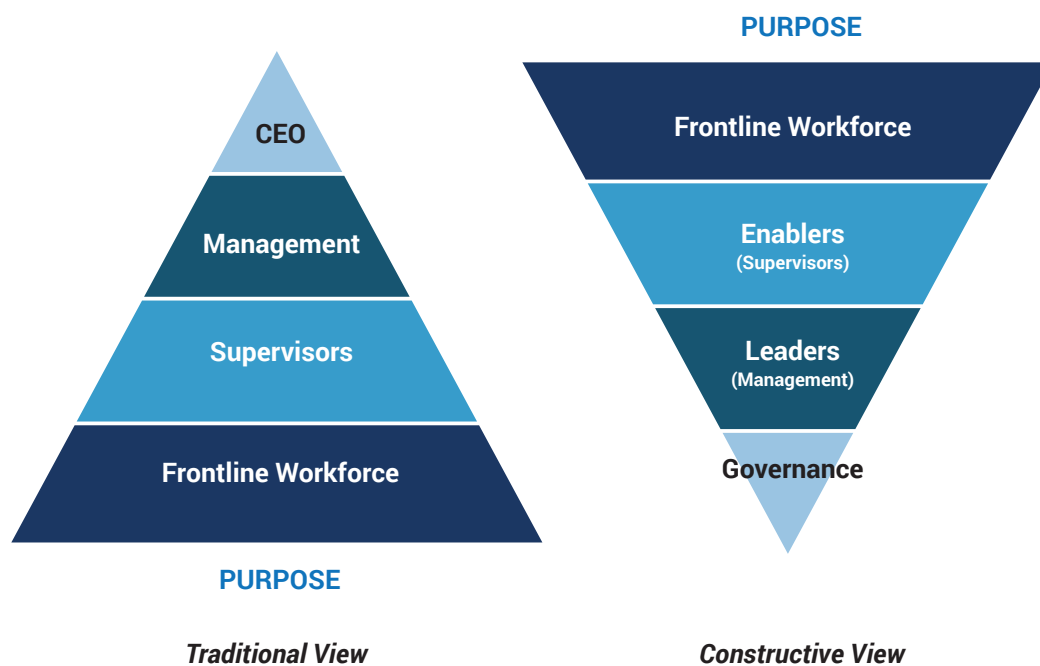


LINK TO YOUR PERSONAL DEVELOPMENT PLAN
What did you learn?
What have you decided to work on?
Add your actions to your Personal Development Plan.

LEADING WITH A CONNECTION TO PURPOSE & INTENT

The common way we think about an organisation is through its structure; with frontline workforce at the bottom of the pyramid, interacting with customers and with layers of leaders and managers above them. This visual often represents to frontline workforce that they have a lot of 'bosses above them to answer to' and who're more important. In fact, it is the frontline workforce who is closest to the organisation's purpose and the objective of everyone else in the organisation is to help them to do that most effectively. A more constructive way to view this is through the following "Constructive View" diagram; where we place the organisation's purpose at the top, as this is what's most important.

The frontline workforce is delivering on that purpose and requires the support of the organisation and its leaders to do so safely and effectively. When people view the organisation like this, everyone's attitude changes. The very nature of what we each do and how we see ourselves changes.



Naturally, this relates more to mindset, than to anything else. It's a shift in the invisible. Where it becomes visible is in communication and behaviour. The "traditional view" creates a sense of division between "the workers" and "management" which widens as they lose respect for each other. Rather than treating the workforce as the least important, with the "constructive view" the rest of the organisation treats the workforce as vitally important. Accountability is to enable the workforce to deliver the purpose. The workforce naturally respect and appreciate the rest of the organisation. Communication is two way and often considerably less formal. It's probably not hard to imagine how the constructive alternative produces a far more effective and higher performing organisation. Why? Because everyone is focussed on working together to serve the greater purpose. That's integral.

When leaders have this view of the organisation and their role, to be in support of their team rather than in control of, it creates a new dynamic that enables an Integral culture and high performance.

This focus on purpose and intent is at the heart of 'Greatness' - which shares an insight into leadership from the point of view of Captain David Marquet (a nuclear submarine commander) and is based on his book 'Turn the Ship Around'. It's all about leaders 'giving control' not taking control and allowing staff / team members to feel inspired, empowering decision-making down the line so people have the responsibility and authority to rise to the occasion.



Hear Captain Marquet talk about giving control
Link: [Greatness](#)
Or scan the QR code to the left

This perspective is also aligned with the concept of servant leadership.

“The servant-leader is servant first... It begins with the natural feeling that one wants to serve, to serve first. A servant-leader focuses primarily on the growth and well-being of people and the communities to which they belong. While traditional leadership generally involves the accumulation and exercise of power, by one at the “top of the pyramid,” servant leadership is different. The servant-leader shares power, puts the needs of others first and helps people develop and perform as highly as possible.”⁹

According to Larry C. Spears, former president of the Robert K. Greenleaf Centre for Servant Leadership, these are the 10 most important characteristics of servant leaders.¹⁰ Once you’ve decided to prioritise other people’s needs over your own in the long term, you can work on developing your skills in each area. Let’s look at how you can do this.

1. Listening

You’ll serve people better when you make a deep commitment to listening intently to them and understanding what they’re saying. To improve your listening skills, give people your full attention, take notice of their body language, avoid interrupting them before they’ve finished speaking, and give feedback on what they say.

2. Empathy

Servant leaders strive to understand other people’s intentions and perspectives. You can be more empathetic by putting aside your viewpoint temporarily, valuing others’ perspectives, and approaching situations with an open mind.

3. Healing

This characteristic relates to the emotional health and “wholeness” of people and involves supporting them both physically and mentally.

First, make sure that your people have the knowledge, support and resources they need to do their jobs effectively, and that they have a healthy workplace. Then take steps to help them be happy and engaged in their roles.

4. Self-Awareness

Self-awareness is the ability to look at yourself, think deeply about your emotions and behaviour, and consider how they affect the people around you and align with your values.

You can become more self-aware by knowing your strengths and weaknesses and asking for other people’s feedback on them. Also, learn to manage your emotions, so that you consider how your actions and behaviour might affect others.

⁹ <https://hbr.org/2014/12/what-bosses-gain-by-being-vulnerable>

¹⁰ <https://www.businessnewsdaily.com/10680-unmasking-vulnerabilities-leadership.html>



5. Persuasion

Servant leaders use persuasion – rather than their authority – to encourage people to take action. They do so by understanding the person's own values and motivations to be able to align the goals. They also aim to build consensus in groups, so that everyone supports decisions.

6. Conceptualisation – connect with purpose and intent

This characteristic relates to your ability to “dream great dreams,” so that you look beyond day-to-day realities to the bigger picture.

If you're a senior leader in your company, work through and develop a robust organisational strategy. Then, whatever level you're at, create mission and vision statements for your team, and make it clear how people's roles tie in with your team's and organisation's long-term objectives. Also, develop long-term focus so that you stay motivated to achieve your more distant goals, without getting distracted.

7. Foresight

Foresight is when you can predict what's likely to happen in the future by learning from past experiences, identifying what's happening now, and understanding the consequences of your decisions.

You can use tools such as SWOT Analysis and PEST Analysis to think about your current situation and environment, while Scenario Analysis helps you understand how the future could play out.

Also, learn to trust your intuition – if your instinct is telling you that something is wrong, listen to it!

8. Stewardship

Stewardship is about taking responsibility for the actions and performance of your team and being accountable for the role team members play in your organisation.

Whether you're a formal leader or not, you have a responsibility for the things that happen in your company. Take time to think about your own values, as well as those of your organisation, so that you know what you will and won't stand for. Also, lead by example by demonstrating the values and behaviours that you want to see in others, and have the confidence/courage to stand up to people when they act in a way that isn't aligned with them.

9. Commitment to the Growth of People

Servant leaders are committed to the personal and professional development of everyone on their teams. To develop your people, make sure that you seek to understand their developmental needs and give them the skills they need to do their jobs effectively. Also, find out what their personal goals are, and see if you can give them projects or additional responsibilities that will help them achieve these.

There is great personal reward for leaders in assisting team members achieve at and beyond their ambitions.

10. Building Community

The last characteristic is to do with building a sense of community within your organisation.

You can do this by providing opportunities for people to interact with one another across the company. For instance, you could organise social events such as team lunches and barbecues, design your workspace to encourage people to chat informally away from their desks, and dedicate the first few minutes of meetings to non-work-related conversations.

Encourage people to take responsibility for their work and remind them how what they do contributes to the success and overall objectives of the organisation.

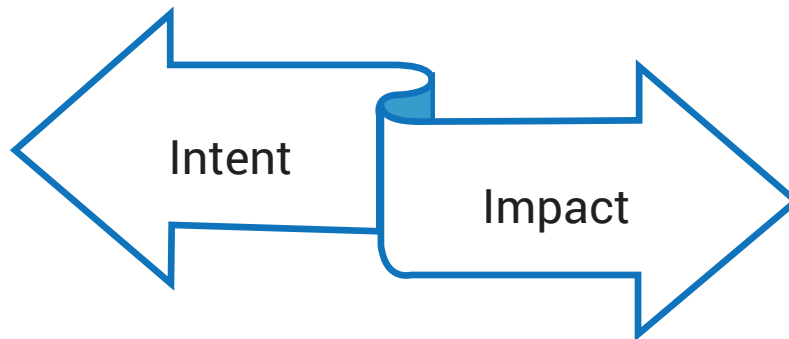


ACTIVITY

IS YOUR COMMITMENT VISIBLE?

Often there can be a gap between an intent and the impact of our actions, practices, processes, engagements, etc. when working on safety related challenges. For example, a leader might be personally committed and engaged with an organisation's safety vision (intention) but be so busy they don't spend the time sharing their commitment with others (impact).

The gap is what causes the potential for dissatisfaction or unintended consequences in behaviour, culture and practices with the way safety is practiced. This is in part because often when we are talking about safety in the workplace, we talk about the issue, the ideas, the problems, not our intentions and values.



How do you share how your views and intentions with your colleagues, employees and others? How would you describe your commitment to safety? Include why it's important to you, what experience shaped this?

How do you intend to lead your team in a way that supports them to deliver their work safely, effectively and efficiently? i.e. how would you like others to describe your leadership style?



How is this connected to the organisation purpose?

What new actions and behaviours will you exhibit to help your commitment and intent be more visible to others?



LINK TO YOUR PERSONAL DEVELOPMENT PLAN

What did you learn?

What have you decided to work on?

Add your actions to your Personal Development Plan.

ENGAGE OTHERS IN COMMITMENT

How, as a safety leader do you engage others in their commitment to safety? Effective leaders not only have a visible personal commitment to safety, they also actively engage others in the organisations and their own commitment to safety.

What does an effective leader do to engage others?

- ✓ Communicates the reasoning behind safety
- ✓ Acknowledges behaviours that are aligned with safety
- ✓ Encourages staff to report unsafe acts, hazards, and risks
- ✓ Works with the team to find a solution when someone speaks up about a safety concern
- ✓ Acknowledges staff members for reporting unsafe circumstances

Some of the concepts that are related to the above are:

1. How we experience our work and people plays out in language (e.g. More safe/both/and)
2. Psychological safety
3. Player or victim (hand/gravity, above the line? Escalator)
4. Leader as a learner and coach (to bring out issues, find solutions, get it from those with knowledge)

LANGUAGE

The definition of language here is in the broadest sense. It includes not only spoken and written communication but also body language, facial expressions, tone of voice, pictures, drawings, music and how people dress, and any other actions that have symbolic intent.¹¹

Also, understanding that whenever you say something, other communication is carried along with it. We call this the unsaid but communicated. The unsaid but communicated includes assumptions, expectations, disappointments, resentments, regrets, interpretations, significance and issues that occur as dangerous.¹²

What does this have to do with engaging others in commitment to safety?

For all safety leaders its understanding that what you say and don't say is communicated when interacting in the workplace.

Some examples could be:

- When you visit an operational site where PPE/HiVis (safety clothing/equipment) is the norm for the workforce – what do you wear? Do you add a HiVis vest over your suit or wear the same PPE attire as the workforce? What are you communicating in each situation?
- When sharing changes to a process, procedure or practice – how do you communicate this? Do you talk about how head office has changed the way you do something or talk about what has changed and why? What's the difference and why is it important?
- When trying to find out about an incident do you question with curiosity, seeking just to understand, or do you question with intent to support a preconceived perception? What are the likely different outcomes and what message does it send to the team?

How many conversations have you been a part of where the group talked about production or safety, finding efficiencies or making it safer? Have you noticed that in general people tend to use the language of we can either do this OR that? That we unconsciously put two needs into competition with each other, rather than connecting them. The consequence of this is we:

- Risk sending mixed signals about what is 'more important', which can create cynicism and confusion amongst the workforce.
- Put groups of people at odds with each other – making one right or wrong if they perceive they have competing needs e.g. safety team and finance team.
- Create a belief that it's not worth putting ideas forward to improve safety, or report hazards, or stop a job if its unsafe.
- Limit problem solving and creativity – when you consider all the needs and expectations and ask a team to find a way to meet all of them you have a greater chance of doing so and tapping into the full capability of the team.

¹¹ The Three Laws of Performance, S Zaffron, D Logan 2009, Jossey0Bass, chapter 2, pg38

¹² The Three Laws of Performance, S Zaffron, D Logan 2009, Jossey0Bass, chapter 2, pg39



“Or” thinking and language reflects a scarcity mind-set. For example, forcing a choice between short-term sales targets and building long term potential is scarcity thinking.¹³

Using different language is a simple way to take all needs into consideration – using both/and.

The Power of AND

‘And’ subtly reframes whatever topic is on the table.

For example, imagine that a direct report asks for permission to work from home two days a week. If you respond, “I understand your desire, but I need to ensure coverage in the office,” there is an implied denial of the request. An alternate reply of “...and I need to ensure coverage” is an invitation to mutually solve a problem. The shift of one word acknowledges each person’s interests as legitimate and recognises that there are issues to be resolved. It creates an environment for positive dialogue.¹⁴

‘And’ thinking embraces abundance thinking. You don’t have to choose between to be tough on standards and enthusiastic about people. The most fulfilling leadership experiences occur when performance expectations are extremely high, and people care deeply for each other.¹⁵



ACTIVITY

When have you noticed that you use both/and or either/or?

What did you notice happened in each situation?

How can you use more both/and into the way your team helps keep each other safe?

¹³ <https://leadershipfreak.blog/2011/08/23/a-ceo-of-campbells-explains-the-power-of-and/>

¹⁴ <https://www.strategy-business.com/blog/The-Power-of-And?gko=0b8af>

¹⁵ <https://leadershipfreak.blog/2011/08/23/a-ceo-of-campbells-explains-the-power-of-and/>

The power of 'Safe' and 'MORE Safe'

As with the previous distinction, the use of language 'safe vs. not safe' can create:

- Tension between two or more parties who have different views on what 'safe' is
- Limits problem solving and creativity and creates 'fixed' positions
- Complacency because we think something is 'safe' so we can switch off
- Compliance based thinking – contributing to a conforming safety culture

All of which limits our ability to influence safety practices and performance. When we think about it, everything we do can be made 'MORE SAFE.' Using 'more safe' language invites others to continually look out for ways to do it better and be on the lookout for risks.



Do we all give permission to our workmates to tap us on the shoulder and have a “more safe” conversation? So what might we need to do so that our intent of helping someone is understood, rather than it becoming an adversarial conflict? Coaching conversations enable this to happen.

Coaching conversations engage others and demonstrate your own commitment. These three questions are a great way to increase your knowledge of the work your team does from their perspective, give them a chance to reflect on the tasks at hand and create an opportunity to see possible ways to make work (even) more safe.

Imagine you are on site and the team are about to begin a job or are part way through the job...

SAFE VS. NOT SAFE LANGUAGE (ORDINARY)	MORE SAFE LANGUAGE (EXTRA-ORDINARY)
1. <i>What are you working on?</i>	1. <i>Can you walk me through the task you are doing?</i>
2. <i>Is it safe?</i>	2. <i>What are all the things that are keeping you and others safe while getting the job done well?</i>
3. <i>Do you need anything from me?</i>	3. <i>Just suppose we had unlimited resources, what would make it more safe and effective? Let's come up with a list.</i>

The conversation on the left often results in one word or very limited responses from the workforce. The conversation on the right is more likely to generate a quality discussion.



ACTIVITY

Have a coaching conversation using 'more safe' language. What did you notice? What information or 'gold' became present that may not have emerged in ordinary conversations?

COMMUNICATING YOUR COMMITMENT – THE WHY OF SAFETY

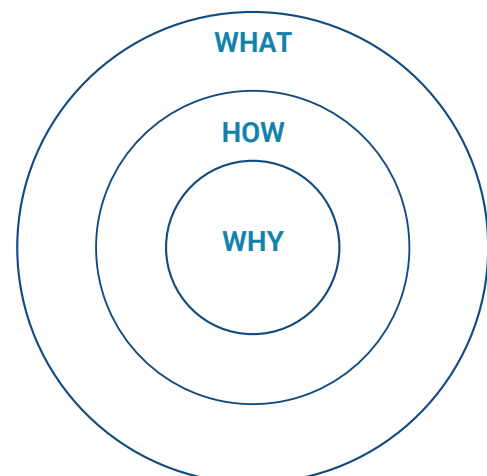
Most conversations at work are about the 'what' e.g. tasks, actions, conversations, information. Highly effective leaders are able to engage others in the vision through clearly articulating the connection between 'what' the team is doing and 'why' they are doing it i.e. the organisational goal/vision.

Simon Sinek uses Apple as an example of an organisation who clearly distinguishes and articulates the difference between WHY, HOW and WHAT. Watch the following video to see how powerfully communicating the WHY can be to engage others.



Watch Simon Sinek explain the power of communicating the WHY.
Link: [Power of Why \(TED TALK, Simon Sinek\)](#)
Or scan the QR code to the left

This section has included activities that were designed to stimulate your thinking about your 'WHY' and to assist you in communicating this with others. Use this opportunity now to consolidate your thinking and identify your **WHY, HOW and WHAT**. This will assist you in communicating your commitment with others which will go a long way to engage others in the vision.





ACTIVITY

What is your WHY? I.e. WHY is safety important to you and what are you committed to achieving when it comes to safety?

HOW are you going to achieve this?

WHAT do you and others need to do to achieve this?

CREATING AN ENVIRONMENT FOR LEARNING

At the beginning of this section, we mentioned that effective safety leaders engage others in commitment to safety by acknowledging behaviours that are aligned with safety, acknowledging staff members for speaking up and reporting unsafe circumstances and encouraging staff to report hazards and concerns. In other words, an effective safety leader creates a safe environment for all staff to have a voice.

Psychological Safety

In Simon Sinek's TED talk on Why Great Leaders Make You Feel Safe, Simon shows that leaders who makes their employees feel secure, draw their teams into a circle of trust. In this environment, everyone has each other's back



Watch this great Ted Talk as Simon Sinek explains why good leaders make you feel safe

Link: <https://youtu.be/lmyZMtPVodo> (Simon Sinek - Safe)

Or scan the QR code to the left



ACTIVITY

Who would you consider to be in your 'circle of trust'?

How do you know that you can trust these people? What do they do (or not do) that makes you feel safe?



Watch this video to explore what this means and consider where you are in your style and thinking.
Link: <https://conscious.is/video/are-you-taking-100-responsibility>
Or scan the QR code to the left

How can you show your team that you 'have their back'? How can you build their trust for you?

ACCOUNTABILITY

Accountability is the obligation of an individual or organization to account for its activities, accept responsibility for them, and to disclose the results in a transparent manner¹⁶.

As a safety leader, how do you demonstrate accountability? Are you able to take 100% responsibility?



Watch this video to explore what this means and consider where you are in your style and thinking.
Link: <https://conscious.is/video/are-you-taking-100-responsibility>
Or scan the QR code to the left

¹⁶ Read more: <http://www.businessdictionary.com/definition/accountability.html>



ACTIVITY

From the video, what was the key insight for you?

Can you connect with a time you;

Identified a pattern of behaviour that limited you taking 100% responsibility and affected an outcome?

Created a story that influenced how you behaved, or your actions that impacted performance?

Contributed to the 'drama' that affected others in the team?

LOCUS OF CONTROL

Locus of Control as a principle was originated by Julian Rotter in 1954. It considers the tendency of people to believe that *control* resides internally within them, or externally, with others or the situation.



Read this article on the need for a sense of control
Link: <http://changingminds.org/explanations/needs/control.htm>
Or scan the QR code to the left

Note that, like other preferences, this is a spectrum. Some people have a wholly internal or external locus of control, but many will have some balance of both views, perhaps varying with each situation. For example, some may be more internal at home but more external at work.

Internal People with a high internal locus of control believe in their own ability to control themselves and influence the world around them. They see their future as being in their own hands and that their own choices lead to success or failure.

Rotter (1990) describes the internal locus of control as:

'The degree to which persons expect that a reinforcement or an outcome of their behaviour is contingent on their own behaviour or personal characteristics'

Their belief in their ability to change things may well make them more confident and they will hence seek information that will help them influence people and situations. They will also likely be more motivated and success oriented. These beliefs may even lead them to be more politically active.

They are more likely to have **expectancy shifts**, where a sequence of similar events are expected to have different outcomes. They tend to be more specific, generalising less and considering each situation as unique.

A challenge of an internal locus of control is that, in accepting responsibility, the person could fall into the trap of being blamed for failures. Alternatively, they could view failure as a necessary ingredient for success. People with an internal locus of control can also be considered **PLAYERS** as they have psychological power over their situation.

External People with a high external locus of control believe that control over events and what other people do is outside them, and that they personally have little or no control over such things. They may even believe that others have control over them and that they can do nothing but obey.

For example, "because the weather is bad, I have no choice but to be in a bad mood because my plans for the day are ruined." People with an external locus of control can also be considered **VICTIMS** because they are psychologically powerless.

Rotter (1990) describes the external locus of control as:

'The degree to which persons expect that the reinforcement or outcome is a function of chance, luck, or fate, is under the control of powerful others, or is simply unpredictable.'

With such beliefs, people with an external locus of control tend to be fatalistic, seeing things as happening to them and that there is little, they can do about it. This tends to make them more passive and accepting. When they succeed, they are more likely to attribute this to luck than their own efforts.

They are less likely to have expectancy shifts, seeing similar events as likely to have similar outcomes. they hence step back from events, assuming they cannot make a difference.

Do you have an internal or external locus of control?



Watch this video to understand the difference between player/victim
Link: <https://www.youtube.com/watch?v=xXdN5kMioRQ>
Or scan the QR code to the left



ACTIVITY

Think about a situation that you didn't feel great about. Examples might be when a change was introduced, a new process or way of doing something, or when an incident occurred or when someone provided feedback to you.

Example: I reversed my work vehicle into the roller door of the tool shed.

What was your first reaction? This is likely to be an 'external locus of control' reaction.

Example: I felt annoyed and embarrassed, I thought about how the reversing sensor must not be working, the signage wasn't clear, there should be a bollard there to protect the door. I reported the incident and wrote the cause as faulty reversing sensor.

I felt.....

I thought.....

What I did or said was.....



What was the impact of the external focus? Consider impact on self and on others.

WHAT WERE THE BENEFITS FOR YOU OF HAVING THIS VIEW?	WHAT WERE THE COSTS FOR YOU AND OTHERS OF HAVING THIS VIEW?

Example: Benefits: I saved face, I didn't have to fix anything.

Costs: lost opportunity for learning, to keep others safe, prevent repeat incident, loss of respect from people who thought I wasn't taking responsibility.

After your initial reaction, what did you do to shift to an internal locus of control?

Example: Reflected on the incident - As I was writing up the report, I realised I should have checked behind me before getting into the car.

What else could you do? How could you build on what you already do?

Example: Take a step back in the moment and be curious.

What are the payoffs of an internal locus of control?

Example: respect from others, demonstrate safety leadership, improve safety practice.

WORKING WITH THE TEAM TO FIND A SOLUTION

Consensus Framework - INOCC

INOCC is a framework that can be used to achieve consensus or 'win/win' outcomes when different parties are committed to generating options to find one that best meets the needs of each member of the group.

The following INOCC framework can be used as a step-by-step guide for reaching a consensus decision that best meets the needs of all parties. It can also be used as the framework for meetings that need to recognise a range of needs from different people. The framework accounts for the **I**ssue, **N**eeds (of all parties), **O**ptions, **C**onsideration of the options i.e. pros and cons of each, and **C**onsensus decision.

See how INOCC is used to come to a consensus decision below and then think of your own challenge and apply the framework your relevant situation. Work through the sections below using a relevant situation for you right now which involves team members taking into consideration their needs and the 'givens' to generate a win/win outcome.



ACTIVITY

EXAMPLE SITUATION –

A worksite has recently become multi-functional i.e. it is both an operational site and customer facing. Customers now come in and out of the front entrance which is very close to where workers reverse their trailers for storage at the end of their shift. Initially, head office told staff they can no longer park trailers at this site due to the risk of injuring a customer. This resulted in a disgruntled workforce who now have to work late to drop their trailers at a neighbouring site and get back to their personal vehicles or rush their afternoon tasks to finish on time. Continued on the next page.



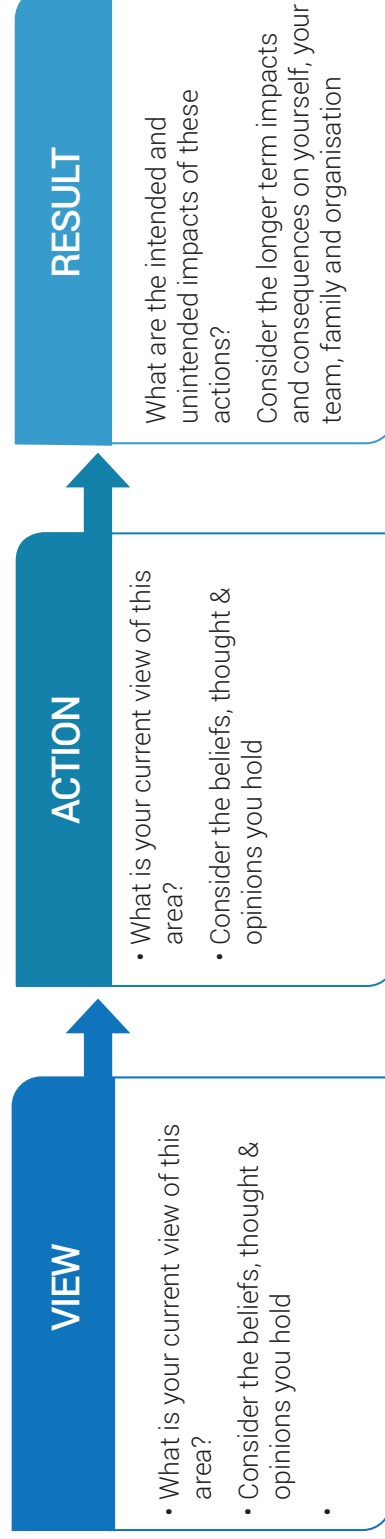
NOCC	EXAMPLE	YOUR RELEVANT SITUATION
ISSUE		
What is the common goal? What can you both agree you need to achieve?	<i>We need a solution that creates an engaged workforce AND safe customer</i>	
NEEDS		
What are my needs? What are your/their needs? My needs + your needs = our needs. Differentiate needs from options.	<i>Customer safety – prevent accident from occurring as the enter or exit the site. Practical location for parking a trailer that does not impact on workload or time. Organisational need – for the site to be multi-functional.</i>	
OPTIONS		
Generate options that meet and address each need (not just your own).	<i>Increase safety signage, parking lanes, and visual markers to enable trailers to be parked in the original location. Identify the time (likely a 30min window) that trailers will be parked at the end of a shift and have an administration staff member stand at the door to inform customers of the parking situation and manage the risk. Close the customer facing aspect of the site before the shift ends.</i>	
CONSIDER OPTIONS		
Consider the pros and cons of each	<i>Not possible to close the site before the shift ends. Will need to identify the appropriate administration staff member and ensure this does not impact on their workload. Consider driver training for any staff member who is reversing vehicles AND monitoring the situation to increase their awareness and capability.</i>	
CONSENSUS DECISION		
	<i>Conversation with staff on site AND representative from head office resulted in the consensus decision – park on site with the safety measures listed above put in place.</i>	

VIEW-ACTION-RESULT REFLECTION & TRANSFORMATION EXERCISE

EXAMPLE – PURPOSEFUL

What development area from Purposeful have you chosen to work on?	Engaging others in purposeful
Why is working on this area important to you?	I recognise while I am committed to safety through doing a lot, I haven't engaged others

Note: Before completing the following exercises, you can also have a read of the View Action Result (VAR) Instruction, found in section 2. This section provides background to the VAR model, why it's so important, how it works and examples to help you work through your own i.e.



EXAMPLE - CURRENT VIEW OF COMMITMENT

VIEW	ACTION	RESULT
It's up to me to fix all of the safety hazards	Do it all Work independently Don't delegate or ask for help Work until it's all done	Exhaustion and fatigue Acknowledgment for going above and beyond Resentment towards others and from others Miss a potentially better way of doing something Others don't grow and become complacent I'm a safety doer!

PERCEIVED BENEFITS. WHAT ARE THE PERCEIVED BENEFITS OF HAVING THIS VIEW?

BENEFIT	...AND WHAT IS THE BENEFIT OF THAT?	...AND WHAT IS THE BENEFIT OF THAT?
Acknowledgment of going above and beyond	Seen as a good worker	Job security
Safety doer	Get things done	Team value and like me, make the job safer

COSTS. WHAT ARE THE COSTS OF HAVING THIS VIEW?

COST	...AND WHAT IS THE COST OF THAT?	...AND WHAT IS THE COST OF THAT?
Exhaustion and fatigue	Lack energy to focus on the job	Increase chance of injury
Resentment towards others	Stop doing things for others	Increase chance of injury



EXAMPLE – CONSTRUCTIVE VIEW OF COMMITMENT

VIEW	ACTION	RESULT
We all play a part in keeping us safe	<p>Ask for others ideas and opinions</p> <ul style="list-style-type: none"> Delegate Listen to others Ask for help Empower others 	<p>Shared and collaborative outcome</p> <p>Sense of team, shared accountability</p> <p>Balance</p> <p>Others grow and everyone becomes a safety leader.</p>

BENEFITS. WHAT ARE THE BENEFITS OF HAVING THIS VIEW?

BENEFIT	...AND WHAT IS THE BENEFIT OF THAT?	...AND WHAT IS THE BENEFIT OF THAT?
Shared and collaborative outcomes	Share the workload	I have more energy and can focus
Sense of team, shared accountability	Increased commitment to safety practices	Reduced risk of injury

CHALLENGES. WHAT ARE THE CHALLENGES OF HAVING THIS CONSTRUCTIVE VIEW?

CHALLENGE	...AND WHAT IS THE CHALLENGE OF THAT?	...AND WHAT IS THE CHALLENGE OF THAT?
It can take longer when you engage others	Finding time to bring people together	Increased workload for self
A lot of opportunities to make it safer are identified	Empowering the team to implement ideas and complete their tasks	Coaching the team, rather than directing the team



NOW IT'S YOUR TURN...

VIEW-ACTION-RESULT REFLECTION & TRANSFORMATION EXERCISE

What development area from Purposeful have you chosen to work on?	
Why is working on this area important to you?	

YOUR CURRENT VIEW

VIEW	ACTION	RESULT



PERCEIVED BENEFITS. WHAT ARE THE BENEFITS OF HAVING THIS VIEW? (I.E. HOW DOES THIS VIEW PLAY OUT IN YOUR LIFE AT WORK AND HOME?)

BENEFIT	...AND WHAT IS THE BENEFIT OF THAT?	...AND WHAT IS THE BENEFIT OF THAT?

COSTS. WHAT ARE THE COSTS OF HAVING THIS VIEW? (I.E. HOW DOES THIS VIEW PLAY OUT IN YOUR LIFE AT WORK AND HOME?).

COST	...AND WHAT IS THE COST OF THAT?	...AND WHAT IS THE COST OF THAT?

WHAT BLIND SPOTS IN YOUR PERFORMANCE ARE OPENING UP FOR YOU WITH REGARDS TO THIS VIEW?

A CONSTRUCTIVE VIEW

What is an alternative, more constructive view or new belief that could give you a different result or outcome? Explore this using the activity below.

VIEW	ACTION	RESULT



BENEFITS. WHAT ARE THE BENEFITS OF HAVING THIS VIEW? (I.E. HOW DOES THIS VIEW PLAY OUT IN YOUR LIFE AT WORK AND HOME?)

BENEFIT	...AND WHAT IS THE BENEFIT OF THAT?	...AND WHAT IS THE BENEFIT OF THAT?

CHALLENGES. WHAT ARE THE CHALLENGES OF HAVING THIS VIEW? (I.E. HOW DOES THIS VIEW PLAY OUT IN YOUR LIFE AT WORK AND HOME?).

CHALLENGE	...AND WHAT IS THE CHALLENGE OF THAT?	...AND WHAT IS THE CHALLENGE OF THAT?



WHAT NEW ACTIONS MIGHT BE POSSIBLE FOR YOU WITH THIS NEW VIEW?

A series of horizontal lines for writing, contained within a rounded rectangular border.





Curious



Curious

Curiosity creates openness to learning how things actually happen in order to improve safe performance. It includes the capacity to suspend what you know, and actively seek out what you don't know. Openness means that people are slow to make judgments or to blame people when things go wrong. Inquiry is kept open as long as possible in order to fully understand what happened and to generate lasting change. People listen to as many diverse perspectives as possible in the time allowed in order to create a more complete picture.



LISTENING TO THE RIGHT PEOPLE

Listening to the right people is about listening to those that will increase your understanding of the situation minimising the impact of listening blockers, biases and opinions. Most of the time, it is about listening to the people on the ground who know the situation better than anyone.

“Most people do not listen with the intent to understand; they listen with the intent to reply.” –Stephen R. Covey, Author of The 7 Habits of Highly Effective People.

When we think about communication, the focus is often placed on the speaking role. Highly effective leaders can definitely speak well, but they listen even better. The following activities are designed to explore some of your blockers to listening with the aim of improving your listening skills.



ACTIVITY

LISTENING IS HARD! COMMUNICATION BLOCKERS

While we often think we're communicating well, there are things that get in the way of our messages being heard or us hearing others.

What might block your communication with others? **Remember even if it's not your intention, its what other people perceive in you!**

VISIBLE (WHAT PEOPLE CAN SEE)	INVISIBLE (WHAT PEOPLE CAN'T SEE)
e.g. Lack of eye contact, perceived as not approachable, timid/shy, perceived as overly sensitive, perceived as aggressive, impatience	e.g. your own self-talk or internal monologue (thinking about other things – what you need to do that day, or judging them/self), stress, brain fog

What can you do to help reduce these blockers?



ACTIVITY

LISTENING OBJECTIVELY

We all have and hold biases – comfortable and easy default tendencies/shortcuts (AKA slack) in our thinking. When we tend to show inclination or prejudice for or against someone or something it is usually due to a hardwired bias. These biases do not make us bad people, they were actually designed to help us survive by enabling our brain to take ‘short cuts’ in decision making and problem solving. However, they also affect how we listen, what information we pay attention to and what we take away from a message. It’s a prejudice and so is not an objective, fair or rational way of absorbing information and making judgements.

The following section introduces a number of common biases that may impact on your ability to listen objectively. Take a look and see if you can relate to any of them. By becoming aware of these biases, we can learn to ask more questions and be more curious when listening to listen more objectively.

Expectation Bias

- Tendency to agree with any information that fits with our own expectations/view, and discard or downgrade anything that conflicts with our expectations/view.
- Also: when we have a predetermined explanation, we require less evidence or support to conform this explanation = shorter investigations.

e.g. You expecting to find that the new business system that was introduced was to blame for the workplace incident that occurred. Then placing a lot of weight/attention on the information that is presented or offered that is in line with this expectation.

Can you think of an example when you’ve been guilty of this bias?

Confirmation Bias

- We seek out people who agree with what we already believe, view or know and we tend to avoid people who disagree – making our pre-existing belief even stronger. Confirmation bias includes the tendency to see things in ways that confirm your existing beliefs.

e.g. If you believe that someone is to blame for an incident, you will seek out examples or pay attention to pieces of information which confirm your belief about this. As opposed to keeping an open mind to other reasons or challenging yourself about this belief.

Can you think of an example when you’ve been guilty of confirmation bias?



In-group Bias

- We tend to overestimate the abilities and value of someone from our 'in group.'
- We tend to be suspicious, fearful and mistrusting of those outside our 'in group.'

e.g. You might find it harder to understand that one of your team members was to blame in an incident than someone from another team who you don't know or trust.

Can you think of an example when you've witnessed or been guilty of this?

Hindsight Bias

- The tendency to see past events as being predictable at the time those events happened.

e.g. now knowing that the process was outdated we assume that the people involved should have also known the process was outdated at the time.

Can you think of an example when you've been guilty of this?

Recency Bias:

- Tendency to put greater weight on more recent events in comparison to earlier events.

e.g. coming down harder on the person who broke the piece of equipment than those who cut corners in the past when maintaining the equipment.

Can you think of an example when you've been guilty of this?

Given all of these (and more) biases, how can you listen objectively? What strategies can you use to decrease your bias, knowing that it's normal to have these affecting your view?

e.g. seeking perspective from a wide range of people with different backgrounds and opinions



Here are three steps you can take to help overcome biases in yourself and your team:

- 1. Raise awareness.** Biases are so natural to our thinking. However, knowing that they exist – and can distort our thinking – will help lessen their impact.

e.g. Try posting short articles on notice boards and in newsletters about bias. Educate safety committees on the top five biases through short, engaging scenarios that are likely to trigger biases – such as disregarding near misses (“nothing bad happened last time, so it won’t the next”). The objective is to encourage healthy discussion.

- 2. Encourage inquiry and challenge.** We want people to speak up about safety, and there are many ways to surface concerns (such as near-miss reporting, card systems or sharing concerns with direct supervisors).

This practice needs to be deeply rooted in team and company culture. For example, at the senior manager level, choose someone (in advance) at a meeting to argue against the proposition being discussed. Even if he or she is in favour of the decision, they must play devil’s advocate. This encourages people to proactively offer opposing views and challenge conventional wisdom.

- 3. Promote collaboration.** It’s easier to see biases in others than to see them in ourselves. Cooperation breaks down barriers and exposes entrenched views (“this is the way we do things around here”). What mechanisms do you have in place for sharing ideas and working on initiatives across departments? Could you adapt toolbox talks, safety meetings or town hall meetings to enable colleagues to recognise the characteristics and dangers of cognitive biases?



LISTENING FILTERS

Listening filters are ways that we listen to others and interpret data. When we have our listening filter on, we can only listen through that lens – everything is tainted by the filter we choose.

We filter information in order to make sense of the vast amount of information we could pay attention to.

Deletion is similar to the biases listed above. Deletion occurs when we selectively pay attention to certain aspects of our experience and not others. We then overlook or omit others. Without deletion, we would be faced with too much information to handle with our conscious mind. In fact, some psychologists say that if we were simultaneously aware of all of the sensory information that was coming in, we'd go crazy.

There are many listening filters that people use, some common filters are:

- Fix-it filter
- 'I don't have time for this on top of everything else' filter
- 'I'm really excited about our future' filter
- 'I just need to get this done, then I will have some time' filter



ACTIVITY

How would each of the above filters affect how you listen?

What 'filter' can you adapt in your next conversation to keep yourself open, curious and help get to the real heart of an issue?

SEEKING TO UNDERSTAND

Sometimes the person (or people) we are listening to might not give us the information we need straight away. We may need to take a different approach by asking the right questions in a supportive environment. Coaching skills is a technique that enables us to seek to understand.

The power of coaching

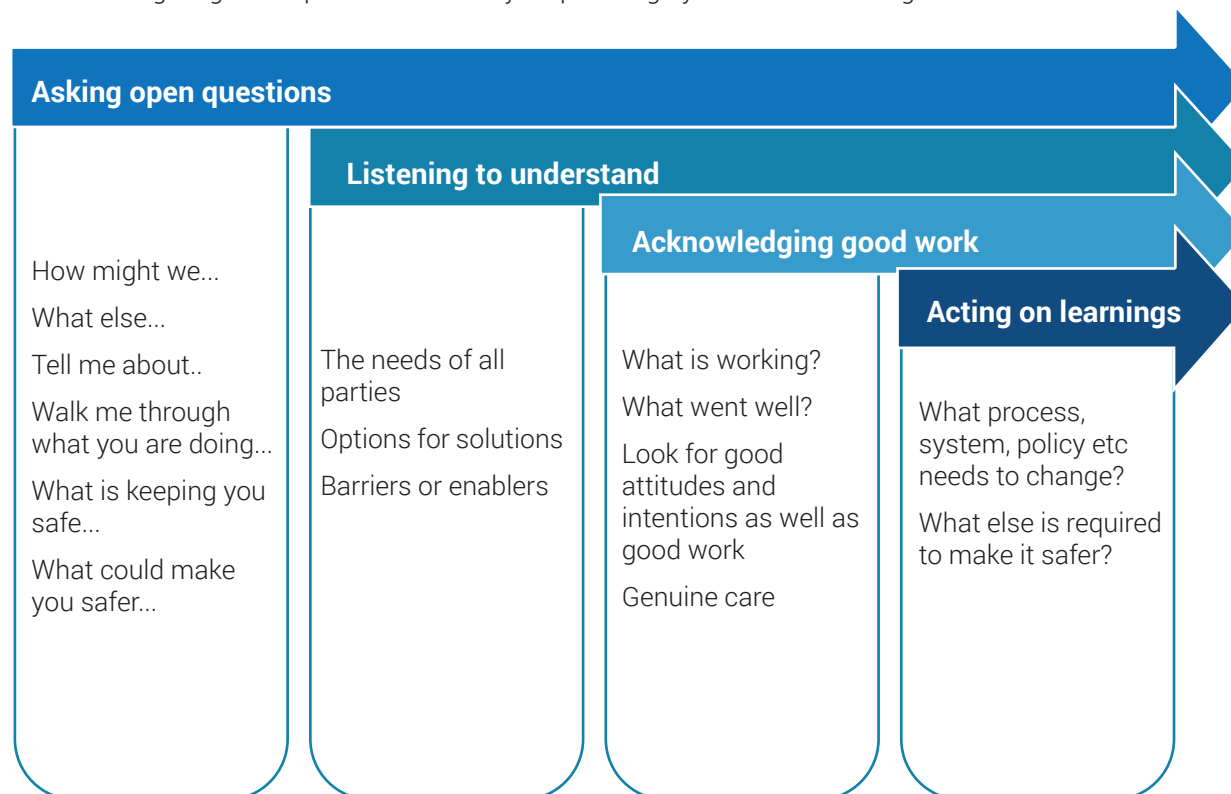
Coaching is a powerful skill to be used in safety leadership and performance. It requires deep listening, curiosity and powerful questions.

Like coaching in sport, leadership coaching is defined as an interaction between two people aimed at helping someone to define and work towards goals. Coaching occurs within a problem-solving, solution-focused context. With effective coaching, an employee can improve the quality of their working life in a collaborative and supportive environment. It's important to remember:

- Coaching conversations are different to 'friend' conversations
- The focus is on the speaker and the coach is simply there to guide and listen
- Ask powerful questions
- Active Listening: clarifying, encouraging, reflecting, restating, summarising
- Use attentive body language: remain free from distractions
- Don't rush in with a reply, allow for silences
- Don't criticise, give your own opinion, advice or version of the story
- Don't provide them with an answer or problem solve for them

Coaching Process

The following diagram explains the four key steps to highly effective coaching conversations.





Coaching to improve Safety Conversations

Ordinary site visits, safety inspections and safety conversations yield little information and the leader fails to seek to understand the situation. This is because the ordinary leader uses closed questions that are likely to elicit only one or two word responses.

An integral safety leader uses coaching questions to create extra-ordinary site visits, safety inspections and safety conversations. Here is an example of an ordinary vs. extra-ordinary safety conversation with a staff member:

Ordinary Safety Conversation	Extra-ordinary Safety Conversation (coaching)
<ol style="list-style-type: none">1. What are you working on?2. Is it safe?3. Do you need anything from me?	<ol style="list-style-type: none">4. Can you walk me through the task you are doing?5. What are all the things that are keeping you and others safe while getting the job done well?6. Just suppose we had unlimited resources, what would make it more safe and effective? Let's come up with a list.



ACTIVITY

What are some examples of powerful safety-focused questions that you could ask your team that would promote growth, learning and improvement?

THE POWER OF PERSPECTIVE.

Everyone sees the world slightly differently because of their past experience, biases, personality, position, background and even mood. We might not even realise we have a different perspective because to us, we are 'right.'

Take this mug for example.

If one side is black and the other side is white and two people sit across from each other, what colour would each person say the mug is?

Who is right?



It all depends on perspective. Both are right according to where they are sitting, according to their perspective.

To fully understand the complete picture, we need to 'park' our own perspective to enable us to ask questions and seek to understand someone else's. We don't necessarily have to agree with their perspective, but in order for us to make more informed and quality decisions, we need to UNDERSTAND their perspective. This is a crucial aspect of curiosity.



ACTIVITY

Consider a situation where you have a different opinion or perspective to someone else – specifically think about a situation where you are ‘right.’

What is your opinion or perspective?

What has contributed to your perspective? E.g. past experience, prior knowledge, position.

What is the other person’s perspective? How do they see the situation and why do they see it that way?

What questions could you ask to FULLY understand their opinion or perspective? *Hint: You might need to use some coaching skills.*

DO YOU HAVE A KNOWER OR LEARNER MINDSET?

Sometimes we treat our views as if they are objective truth or facts. This leads to not seeking to understand others' perspectives, missing crucial information and basing our self-esteem on being right.

Shifting to a learner mindset is about not knowing. We treat our views as subjective interpretations and realise that we are missing information. It requires curiosity and humility. A learner-oriented leader is still decisive and driven. But they learn in a way that includes the perspective of others.



Watch this video to see Which one are you?
Link: <https://www.youtube.com/watch?v=Jy3yTEi8yz4>
Or scan the QR code to the left

THE CONFLICT CONTINUUM

One of the reasons we might avoid asking someone a difficult or powerful question is to avoid conflict. No-one likes conflict yet working well in teams requires a healthy amount of conflict. A healthy amount of conflict enables enough 'heat' in a discussion that promotes learning and 'doing things better and safer.'

Many teams operate at one end of the spectrum which is 'artificial harmony' and believe that any step towards conflict is negative, however experiencing some level of constructive conflict is important for teams to grow.



Watch this video with Patrick Lencioni as he explains the conflict continuum
Link: <https://thefruitfultoolbox.com/where-is-your-team-on-the-conflict-continuum/>
Or scan the QR code to the left

One way to promote healthy conflict is to build great relationships at work.

BUILDING RELATIONSHIPS

Integral safety leaders are adept at building and maintaining strong and trusting relationships with employees, and other stakeholders. Building relationships enable us to create an environment for learning, where the quality of both listening and speaking is increased.

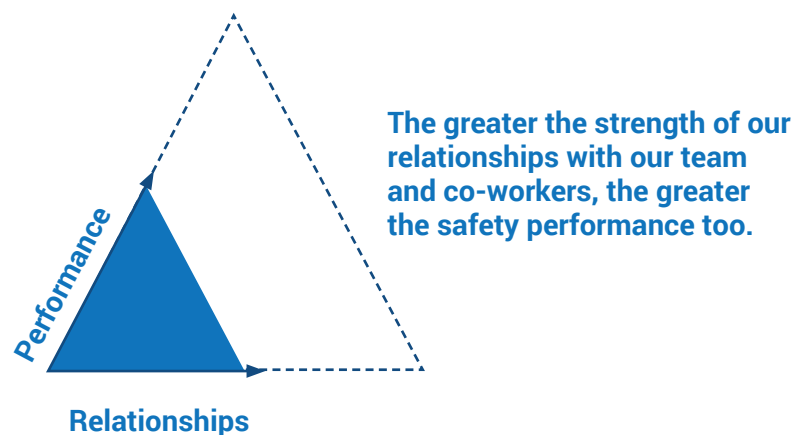
Leaders with a strength in this area appreciate situations and issues from the perspectives of others, they recognise the impact of their own behaviour or operating style on others and strive to find the best way of working with and leading others.

You can develop your strength in this area by completing the following section.

RELATIONSHIPS = PERFORMANCE

The better we know someone, the better we work with them. It explains why a sporting team made up of talented individuals that haven't played together before will always be beaten by a team that is less talented individually but have trained and played together for a long time.

It is also true in the workplace. As we increase the quality of the relationships with the people we work with, we also increase our overall performance with them.



Why is this?

The greater the relationship, the more care is shown between people. Rather than someone following safety process for the sake of process, they will follow it carefully because they truly care about the people they work with.

Research has shown that there are three fundamental skills to making effective relationships. These skills can be best described under three headings: Respect, Empathy, Genuineness (**R-E-G**).

Respect

Respect is behaviour that conveys to others that they are worthwhile, unique and valuable. It involves a commitment to interact with people in such a way that you hope to make others feel important. Respect is conveyed by:

- Giving positive attention
- Active listening
- Giving your time
- Remembering the person's name
- Introducing yourself
- Basic courtesies – offering a chair
- Asking questions
- Being complimentary
- Giving positive and corrective feedback.
- Asking their opinion
- Checking out assumptions you have made about the other person
- Being thoughtful, e.g. Remembering concerns a person may have and enquiring as to how that is going
- Showing concern
- Remembering something they have told you before and reminding them of it
- Asking for assistance or support
- Being assertive rather than aggressive

Empathy

Empathy is behaviour that shows you understand, or are trying to understand, another person's world view. In other words, you are trying to see the world in their way, or "walk a mile in their shoes." Empathy is conveyed by:

- Reflecting back to the other person feelings you are picking up i.e. "you must have felt very angry" or "you sound very happy"
- Smiling when the other person smiles, frowning when the other frowns, etc. – behavioural mirroring
- Trying to understand why a person "did what they did", or "said what they said"
- Asking questions to gather information
- Spending time listening
- Sharing related experiences of your own

Genuineness

Genuineness is behaviour that conveys to others that you are being "real" with them. In other words, that you are not hiding behind roles or facades, and that you are being open and honest within appropriate boundaries. Essentially, it is making sure you are not coming across as a "phoney." Genuineness is conveyed by:

- Talking appropriately about yourself
- Responding naturally
- Sharing feelings appropriately
- Being spontaneous
- Verbal behaviour consistent with non-verbal behaviour
- Not being defensive
- Not pretending to be someone or something you are not
- Being honest and up front with people
- Sharing your real feelings or thoughts in a caring and assertive manner
- Not saying things you don't believe simply because you think other people would want to hear them



ACTIVITY

Can you recall a time that building a solid relationship with someone helped you to achieve something that you couldn't have alone?



ACTIVITY

HOW WELL DO YOU KNOW YOUR TEAM?

The following activity is designed to compare how well you think you know each member of your team, to how well you actually know them. Fill in the following table for 3 other team members.

Name:			
How well do you think you know them? 1-10?			
What are their 3 most important values?			
What are their strengths?			
What do they love doing?			
When are they at their happiest?			
Can you name any favourite books? food? music?			

Once you have completed as much as you can on your own, we suggest finding out the rest of the answers by getting to know your team mates even further.



LINK TO YOUR PERSONAL DEVELOPMENT PLAN

What did you learn?

What have you decided to work on?

Add your actions to your Personal Development Plan.

BEING CURIOUS TO LOOK BEYOND THE NUMBERS:



Watch Prof Sydney Dekker talk about doing 'Safety Differently'
Link: <https://www.youtube.com/watch?v=nvGyreHrloM>
Or scan the QR code to the left



ACTIVITY

How do you measure safety?

What would you put on your billboard?

TRUST AND EMPOWER PEOPLE IN THE PROCESS

Work has never been as safe as it seems today. But bureaucracy and compliance demands have mushroomed, including many imposed by organisations on themselves. And progress on safety has actually slowed to a crawl.

Bureaucracy and compliance impose performance drag on our organisations and rob us of precisely the sources of human insight, creativity and resilience that tell us how success is created, and where the next accident may well happen.



Watch the following short movie about 'Safety Differently'
Link: <https://www.youtube.com/watch?v=moh4QN4IAPg>
Or scan the QR code to the left

The Movie tells the stories of three organisations that had the courage to devolve, declutter, and decentralise their safety bureaucracy. Safety differently is a story of hope; of rediscovering ways to trust and empower people, and of reinvigorating the humanity and dignity of actual work.



ACTIVITY

How have you changed/grown since watching this movie?

How can you engender trust and empowerment in others?

VIEW-ACTION-RESULT REFLECTION & TRANSFORMATION EXERCISE

EXAMPLE – CURIOSITY

What development area from Curious have you chosen to work on?	<i>Seeking to understand</i>
Why is working on this area important to you?	<i>I people to feel safe to offer ideas</i>

Note: Before completing the following exercises, you can also have a read of the View Action Result (VAR) Instruction, found in section 2. This section provides background to the VAR model, why it's so important, how it works and examples to help you work through your own i.e.

VIEW	ACTION	RESULT
<i>I know best</i>	<i>Tell people how it's done Finds fault in others Jump into action and direct other what, how and when to do. Closed to others ideas</i>	<i>Temporary fixes Others become demoralised and don't learn Safety knower which blocks everyone from learning Put people offside (no consultation) People feel criticised, fearful Cost blowout</i>

EXAMPLE - CURRENT VIEW OF CURIOSITY

PERCEIVED BENEFITS. WHAT ARE THE PERCEIVED BENEFITS OF HAVING THIS VIEW?

PERCEIVED BENEFIT	...AND WHAT IS THE BENEFIT OF THAT?	...AND WHAT IS THE BENEFIT OF THAT?
<i>People see what I know</i>	<i>Respect for my knowledge</i>	<i>People listen to me</i>
<i>Things get done my way</i>	<i>Fixes are put in place</i>	

COSTS. WHAT ARE THE COSTS OF HAVING THIS VIEW?

COST	...AND WHAT IS THE COST OF THAT?	...AND WHAT IS THE COST OF THAT?
People are put offside	Don't share ideas	Safety improvements are missed
Feel criticised, fearful	Don't act without checking first, become dependent on me	Can't get all my work done because I'm always being asked questions

EXAMPLE – CONSTRUCTIVE VIEW OF CURIOUSITY

VIEW	ACTION	RESULT
Nobody is as smart as everybody	Ask others for their thoughts Ask questions Collaborate with others I listen to understand and learn Stay curious	Optimal outcome Others feel included and valued Shared accountability Engaged and empowered workforce.

BENEFITS. WHAT ARE THE BENEFITS OF HAVING THIS VIEW?

BENEFIT	...AND WHAT IS THE BENEFIT OF THAT?	...AND WHAT IS THE BENEFIT OF THAT?
Others feel included	Feel like they can share ideas and be heard	Seen as a safety leader
Others feel included	Commitment to ideas and being safer	Make work more safe
Engaged and empowered staff	Less reliant on leader, feel they can work interdependently	Less interruptions and can focus on other work

CHALLENGES. WHAT ARE THE CHALLENGES OF HAVING THIS CONSTRUCTIVE VIEW?

CHALLENGE	...AND WHAT IS THE CHALLENGE OF THAT?	...AND WHAT IS THE CHALLENGE OF THAT?
What are the best questions to get others input?	Building skills in asking questions	Takes time, will not be perfect at it straight away





NOW IT'S YOUR TURN...

VIEW-ACTION-RESULT REFLECTION & TRANSFORMATION EXERCISE

What development area from Curious have you chosen to work on?	
Why is working on this area important to you?	

YOUR CURRENT VIEW

VIEW	ACTION	RESULT

PERCEIVED BENEFITS. WHAT ARE THE BENEFITS OF HAVING THIS VIEW? (I.E. HOW DOES THIS VIEW PLAY OUT IN YOUR LIFE AT WORK AND HOME?)

BENEFIT	...AND WHAT IS THE BENEFIT OF THAT?	...AND WHAT IS THE BENEFIT OF THAT?

COSTS. WHAT ARE THE COSTS OF HAVING THIS VIEW? (I.E. HOW DOES THIS VIEW PLAY OUT IN YOUR LIFE AT WORK AND HOME?)

COST	...AND WHAT IS THE COST OF THAT?	...AND WHAT IS THE COST OF THAT?

WHAT BLIND SPOTS IN YOUR PERFORMANCE ARE OPENING UP FOR YOU WITH REGARDS TO THIS VIEW?



A CONSTRUCTIVE VIEW

What is an alternative, more constructive view or new belief that could give you a different result or outcome? Explore this using the activity below.

VIEW	ACTION	RESULT

BENEFITS. WHAT ARE THE BENEFITS OF HAVING THIS VIEW? (I.E. HOW DOES THIS VIEW PLAY OUT IN YOUR LIFE AT WORK AND HOME?)

BENEFIT	...AND WHAT IS THE BENEFIT OF THAT?	...AND WHAT IS THE BENEFIT OF THAT?

CHALLENGES. WHAT ARE THE CHALLENGES OF HAVING THIS VIEW? (I.E. HOW DOES THIS VIEW PLAY OUT IN YOUR LIFE AT WORK AND HOME?).

CHALLENGE	...AND WHAT IS THE CHALLENGE OF THAT?	...AND WHAT IS THE CHALLENGE OF THAT?

WHAT NEW ACTIONS MIGHT BE POSSIBLE FOR YOU WITH THIS NEW VIEW?





Caring



Caring

Care is regard for the intrinsic value of people, actively providing what is needed to support health, safety and wellbeing. Care is personal, connecting with others based on understanding of how it is and what is needed from their perspective. Regard for others creates an environment where people respect each other and build trust and willingness to say what is true. Caring springs from care for oneself, ensuring one has the capacities and energy to provide real help. It balances a focus on building strengths with a compassionate drive to address gaps in performance and realise potential.





DEMONSTRATING CARE

Just like commitment, it is important to not only genuinely care about the people you work with (intent) but visibly demonstrate that care, so it positively impacts safety and performance (impact). The following section explores several ways you can demonstrate your care for the people you work with including:

- Being aware of their stress levels
- Supporting them to manage their wellbeing
- Having conversations about their performance (including attitudes etc.)
- How to have a conversation about mental health
- Demonstrating your care by understanding others' values

MANAGING STRESS PROACTIVELY

We want you and everyone you work with to be operating at their best. You're at your best when you have the 'right' level of pressure for you. This is different for different people as everyone has different 'set' points based on their skills, abilities, personality, history and genetics.

Too little pressure and this causes boredom which breeds complacency and often means we are not performing at our best. When we're bored, typically, there are not enough chemicals in our brain driving awareness, focus and alertness (like cortisol or adrenaline) resulting in lethargy, low energy and complacency.

However, too much pressure and this leads to stress, fatigue, anxiety, overwhelm. When stress levels become too high for a long period of time it can lead to a 'burnout.' A burnout is a psychological term for long term exhaustion and inability to attend to a situation. Burnouts can lead to:

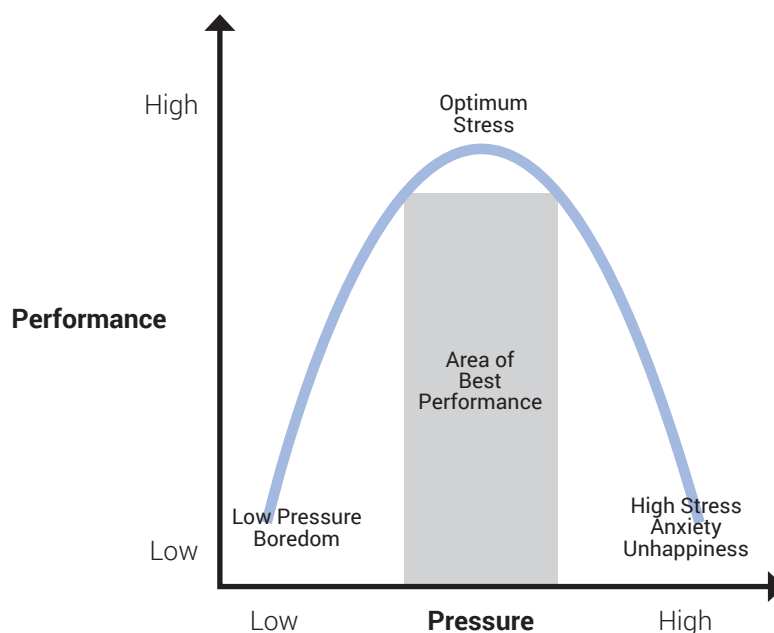
- Low energy
- Emotional exhaustion
- Lowered immunity to stress
- Lack of time/energy for personal relationships
- Pessimistic attitude
- Absenteeism
- Inefficiency at work

Too much stress and pressure becomes very unsafe because it affects our decision making, focus, performance, energy levels, and health. When we are overly stressed, the decision-making part of our brain (pre-frontal cortex) is flooded with a chemical called cortisol which clouds our ability to make logical, rational, clear and effective decisions. In fact, chronic stress has even been shown to skew us towards making more risky decisions¹⁷.

When we have 'just enough' pressure, this is our state of 'flow', focus, peak performance and where we are operating at our optimum.

¹⁷National Institutes of Health/National Institute for Mental Health, the CHDI Foundation, the Defense Advanced Research Projects Agency and the U.S. Army Research Office, the Bachmann-Strauss Dystonia and Parkinson Foundation, the William N. and Bernice E. Bumpus Foundation, Michael Stiefel, the Saks Kavanaugh Foundation, and John Wasserlein and Lucille Braun.

The Inverted-U relationship between pressure and performance



As a safety leader, you have a responsibility to not only take care of your own stress levels, but also to lookout for the levels of pressure and stress in others.



ACTIVITY

Reflect on those you work closely with or those in your direct team. Where would you map them in the above graph?

What are they doing or saying that leads you to believe that? (e.g. fatigue, anxiety, overwhelm, poor decision making, lack of focus, unhappy, bored etc).



If you're not 100% sure where to map them, how could you find out how much pressure they are experiencing? *(Remember, everyone has different 'set' points for pressure! Something you may see as low pressure, may be a high-pressure situation for someone else).*

What actions could you take to help move those who are experiencing too low pressure to towards the "Area of Best Performance"? How could you help remove some of the pressure from those who are experiencing too much?

What practices could you put in place to ensure your team and those you work closely with don't experience too much (or too little) pressure?

RESILIENCE AND WELLBEING

A long-term strategy to assist with increasing pressure is focussing on resilience and wellbeing. If you or your colleague appears to be under increasing pressure, you might want to explore strategies to increase their resilience or have conversations about wellbeing.

Wellbeing means attending to the major determinants of health including eating nutritious food, getting adequate sleep, exercise and personal space. It refers to being mindful of, and responsible for, how your own time and energy is spent and maintaining a personal support network of trusted confidants and advisors.

“Health and wellbeing is a state of complete physical, mental and social wellbeing – and not merely the absence of disease or infirmity.” World health organisation¹⁸

IMPORTANCE OF WELLBEING

Health and wellbeing does more than just make us happy at work. It's proven that promoting health at work can make us more productive too.

The biggest risk factors affecting health are smoking, alcohol misuse, poor diet, physical inactivity and unhealthy weight. There is also a recognised relationship between many of these risk factors and mental disorders such as depression. Adequate physical activity is at the very heart of good health – it promotes emotional wellbeing and assists in the prevention and management of disease.

The direct benefits of feeling fit, healthy and happy include:

- Increased morale, job satisfaction and motivation
- Improved mental alertness, concentration and energy levels
- Decreased stress and other work-related illness
- Improved prevention of chronic diseases
- Better sleep patterns
- Higher self-rated performance

First. Take the Personal Wellness Inventory below to self-assess your current level of 'wellness' and where you could focus your efforts in improving your overall sense of personal health and wellbeing.

You might wish to use the inventory to support your colleagues or open up a conversation about wellbeing.

¹⁸ <https://www.who.int/about/who-we-are/constitution>



ACTIVITY

PERSONAL WELLNESS INVENTORY

Step 1: Rate yourself on each of the proactive stress reduction strategies with a circle on each line.

Step 2: Given that a challenge in each of these areas will help you better deal with stress, pick two or three that you'd like to work on in the next month and add a triangle to set your personal goals.



How much are you getting each week?

Exercise	0	10
Diet	0	10
Hydration	0	10
Fun	0	10
Relaxation	0	10
Sleep	0	10
Social Connection	0	10

Goals:

1. _____
2. _____
3. _____

What happens when we don't take the time to prioritise our own health and wellbeing? How does it impact our?

Energy levels, focus & mood	Relationships at work	Relationships at home	Performance

What do you notice in yourself and others when you're at your healthiest self?

Energy levels, focus & mood	Relationships at work	Relationships at home	Performance

How healthy are each of your team members?

Next, consider the health of your team. Are they prioritising their health and wellbeing? Try rating your perception of the health of each of your team members in a few key areas:

- Physical (exercise, nutrition, sleep/fatigue, hydration etc)
- Mental (emotional regulation, stress, mental alertness, mood etc)
- Social (relationships and connections with others)

1 = very poor, 2 = poor, 3 = OK, 4 = strong & well, 5 = very strong & well

	Name:	Name:	Name:
Physical			
Mental / emotional			
Social			

Are there any areas of concern with your team members?

If you don't know how healthy each of your team members are, how could you find out? What questions could you ask?



What could you do to help increase the wellbeing and health rating of your team members?

Consider the three key areas of health: Physical, mental and social. (e.g. leading by example, introduce certain health & fitness initiatives, have a conversation about it, meditation/mindfulness apps, suggest professional help, "Dry July", health books/podcasts/talks you could suggest, fruit bowls etc).

Pick one from the above list that you will introduce: _____

WILLING & ABLE MODEL

To create and maintain a safe and high performing workplace, we need people who are both willing and able to do the work required of them. Sometimes we avoid conversations about performance because they are 'difficult' or 'could lead to conflict.' However, avoiding these conversations actually result in an unsafe and unproductive workplace. As a leader, it is your responsibility to have these challenging conversations. **It actually demonstrates that you care!**

For example, *"I really care about you succeeding in your role and I believe you can be a high performer. At the moment there are some areas of your performance that I want to discuss so we can better support you to succeed in your role."*

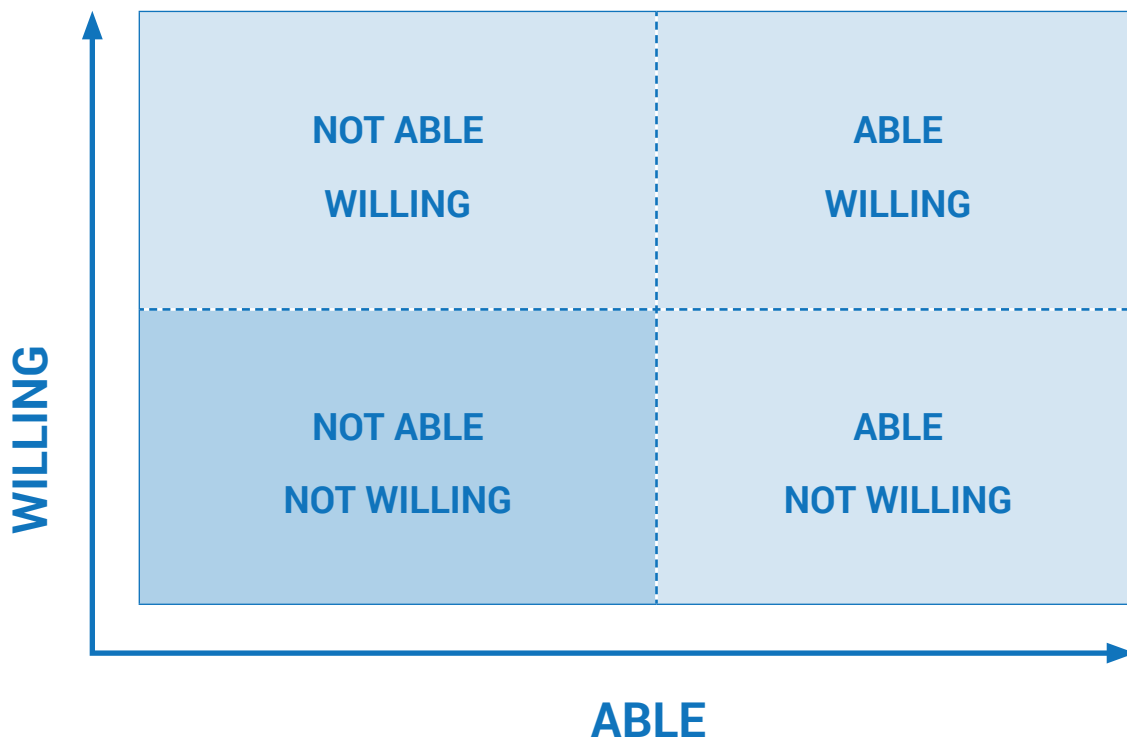
A useful tool to understand and assess employee performance is the Willing and Able Model. Performance can be measured on two scales:

1. Someone's willingness to do their job (motivation, attitude etc.)
2. Someone's ability to do their job (skills, knowledge, practical performance)

Plotting these two scales together provides us with four quadrants representing four performance categories.

Start by asking yourself the question: Do each of my team members have the skill and the will to get the job done well and safely?

See if you can think of someone you work with that would fall in each category or plot your team members in the matrix.





ACTIVITY

The appropriate performance management approach will vary depending on the quadrant the employee fits into. The following table provides an explanation of the appropriate approach. Complete the table with the four people you had in mind.

QUADRANT/ CATEGORY	APPROPRIATE APPROACH	YOUR EXAMPLE	YOUR IDEAS TO APPROPRIATELY MANAGE THIS PERSON
High – Ability High - Willingness	Give feedback, acknowledge their contribution, challenge them, further develop them etc.		
Low – Ability High – Willing	Give feedback, training, coaching, mentoring, additional support etc.		
High – Ability Low – Willing	Give feedback. Find out what motivates them & what has impacted their willingness and see if there is anything you can do about it e.g. they might be bored.		
Not willing or able	Formal performance management plan or process to manage poor performance.		



ACTIVITY

CAUSES OF POOR PERFORMANCE

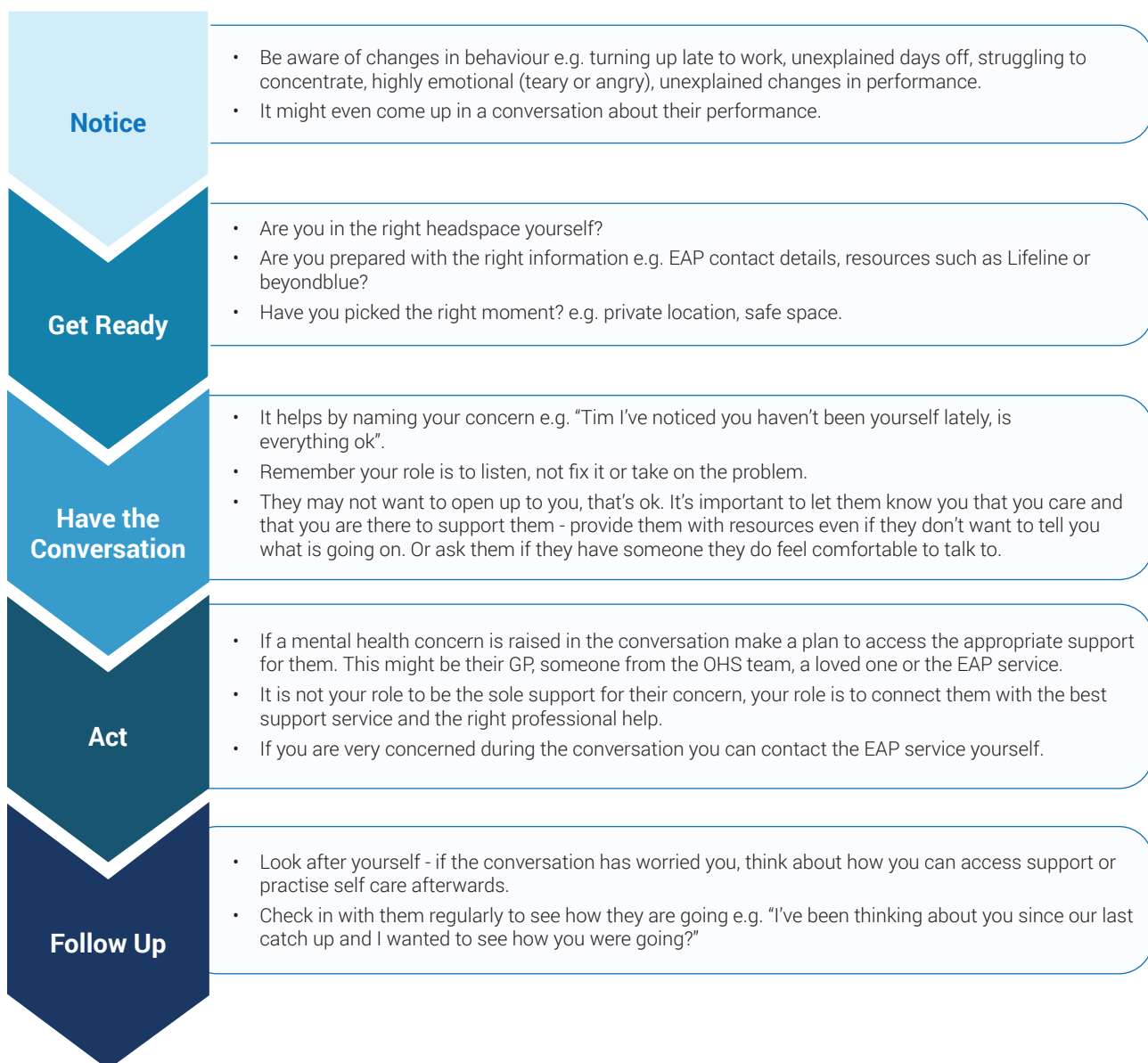
Think of someone you are/were working with that was underperforming. What was the reason for their under-performance? Where do they fit in the Willing and Able model?

Think back to the last time you weren't performing at your best, what were the main causes? Where were you in the Willing and Able model?

MENTAL HEALTH

Mental health is a state of wellbeing in which individuals can cope with the normal stresses of life, work productively and fruitfully, and are able to make a contribution to their community. Mental illness, on the other hand, describes a number of diagnosable disorders that can significantly interfere with a person's cognitive, emotional or social abilities. As a leader, you may come across staff members that you have concerns about and it is important you feel comfortable to have conversations with them about their mental health.

The following process can be used to guide you through a conversation when you are worried about someone's mental health.



CREATING A MENTALLY HEALTHY WORKPLACE



RUOK provides several resources including videos that can help you in having a conversation about someone you are worried about.

Link: <https://www.ruok.org.au/>
Or scan the QR code to the left

Your role as a leader extends beyond caring for individuals, it includes creating an environment or culture of genuine care. Heads Up is an online resource that was developed using funding provided to beyondblue by the Commonwealth Department of Health. The aim of this initiative is to provide Australian workplaces with access to a wide range of resources, information, advice and a planning tool with the aim of creating a mentally healthy workplace. We recommend that leaders use the 'Heads Up' website to begin the conversation about creating a mentally healthy workplace with all its employees. Beyondblue has long been Australia's leading resource in providing support for the mental health of all Australians. <https://www.headsup.org.au>.



Check out Heads Up here.
Scan the QR code to the left



HOW WELL DO YOU KNOW YOUR TEAM?

Caring involves taking the time to get to know the people you work with. Understanding and respecting each other's values is important. The following exercise will invite you to explore your values then consider how your values might explain why you and your colleagues act or respond differently.



ACTIVITY

Firstly, circle any values/beliefs that are important to you.

Abundance	Daring	Intuition	Preparedness
Acceptance	Decisiveness	Joy	Proactivity
Accountability	Dedication	Kindness	Professionalism
Achievement	Dependability	Knowledge	Punctuality
Advancement	Diversity	Leadership	Recognition
Adventure	Empathy	Learning	Relationships
Advocacy	Encouragement	Love	Reliability
Ambition	Enthusiasm	Loyalty	Resilience
Appreciation	Ethics	Making a Difference	Resourcefulness
Attractiveness	Excellence	Mindfulness	Responsibility
Autonomy	Expressiveness	Optimism	Responsiveness
Balance	Fairness	Open-Mindedness	Security
Being the Best	Family	Originality	Self-Control
Boldness	Friendships	Passion	Selflessness
Brilliance	Flexibility	Performance	Simplicity
Calmness	Freedom	Personal Development	Stability
Caring	Fun	Proactive	Success
Challenge	Generosity	Professionalism	Teamwork
Charity	Grace	Quality	Thankfulness
Cheerfulness	Growth	Recognition	Thoughtfulness
Cleverness	Flexibility	Risk Taking	Traditionalism
Community	Happiness	Safety	Trustworthiness
Commitment	Health	Security	Understanding
Compassion	Honesty	Service	Uniqueness
Cooperation	Humility	Spirituality	Usefulness
Collaboration	Humour	Stability	Versatility
Consistency	Inclusiveness	Peace	Vision
Contribution	Independence	Perfection	Warmth
Creativity	Individuality	Playfulness	Wealth
Credibility	Innovation	Popularity	Well-Being
Curiosity	Intelligence	Power	Wisdom

Can you narrow this list down to 3 core values? Discuss with a co-worker, friend or family member.

1.

2.

3.

WHAT DOES YOUR TEAM VALUE? WHAT IS IMPORTANT TO THEM?

If you don't know, how could you find out?

'WHAT PUSHES YOUR BUTTONS' EXERCISE

When was the last time you have lost your temper? You might have said something to a friend or relative that you regretted afterwards.

What do you think made you react like that? Can you explain your reaction by making a link with your core values?

Can you think of a time one of your co-workers lost their temper or appeared to overreact given the scenario? Now that you have an understanding of their values, can you explain their reaction by making a link their core values and how one of them might have been triggered?

EFFICACY

Dr E. Scott Gellar began using the term “active caring” in 1991 and defined it as having three key attributes which explains how a leader is able to become self-empowered.

1. **Self-Efficacy** (a belief or confidence that “I can do it”)
2. **Response Efficacy** (a belief that “it will work”)
3. **Outcome Efficacy** (a belief that “it’s worth doing”)

In a safety setting, caring about others in the workplace empowers a leader to create a workplace where the safety vision is a lived reality.



Listen to this Podcast where Dr Gellar talks about active caring.
Link: <https://experttalk.creativesafetysupply.com/behavioral-safety-is-actively-caring-for-people/>
Or scan the QR code to the left

LANGUAGE RELATING TO MATURITY LEVELS

As we move through the stages of maturity in our approach towards safety (see the introductory section that describes each of the Four Integral Stages in more detail), we move from an “us and them” mentality to a collective focus. A collective approach focuses on getting everyone home safely, that we’re all in this together and we’re all connected so it’s worth looking out for each other.



Reflecting on the language you hear most around the workplace and in your team, where do you feel you and your team are currently sitting?

Which language do you feel you use most?

When all four quadrants of the integral model are aligned and interacting with each other to cause high performance, an Integral Culture is achieved. Integral organisations typically experience the following outcomes/ results:

- High level of engagement e.g. motivation, staff satisfaction
- 'We' mentality – everybody is responsible for everybody else
- Low staff turnover
- Cost effective
- Great performance/outcomes

It's crucial to connect with and demonstrate the 'we' language to be an effective safety leader.

When have you experienced a "WE" culture or environment in the past? What did you notice people doing or saying to contribute to that environment?

What's your commitment to action to help build a "WE" safety culture?

PERFORMANCE = POTENTIAL – INTERFERENCE

Do you feel your team are performing at their potential?

One's performance is equal to what they are capable of when the obstacles are removed¹⁹. Without interference, performance would equal potential but as we all know, that's not always the case.

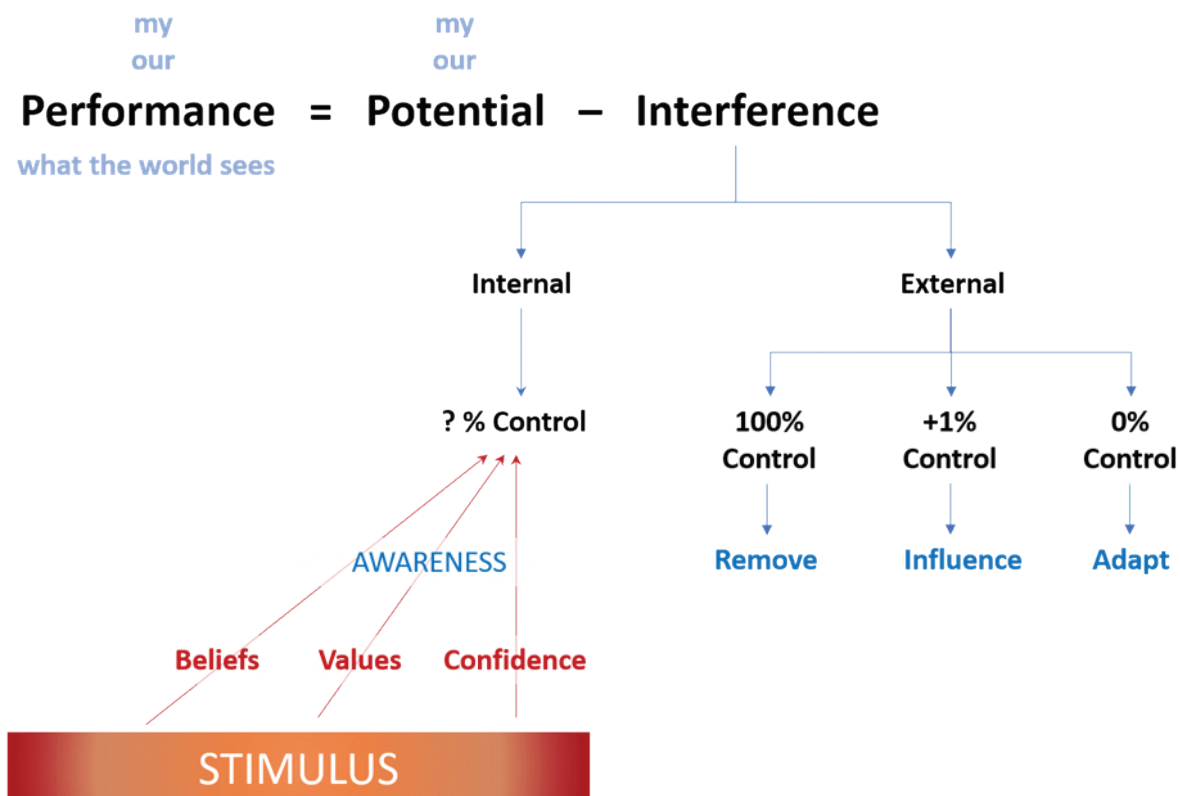
$$P = P - I$$

Performance is often associated with that which is visible and observable by others. Whereas your potential, or that which you have the capacity to develop into the future, is unknown even to you, until you test it.

However, there are always things getting in the way of our full potential being shown. This is known as interference. Interference can be both internal (within the mind and body) and external (e.g. in our environment).

Internal interference develops as a result of our beliefs, values and confidence and includes lack of self-belief, lack of knowledge or skill, motivation, confidence, fear, or a mental illness (stress or anxiety) or physical impairment (injury).

External interference can include an array of factors, such as other people's opinions of you (i.e. their thoughts), instructions given to you, managerial style, as well as environmental factors such as the company culture, policies and procedures and economic factors.



¹⁹The Inner Game of Work" by Timothy Gallwey



ACTIVITY

Step 1. In what areas is your team (or team member) not reaching their potential?

Step 2. Work with them to understand the various aspects of their specific interferences.

e.g. You can ask, "If you are wanting to perform at this level and you know you are capable of more, what's getting in the way of this occurring?" (Sometimes it can be helpful to provide a few examples – e.g. "Is it stress, or a lack of information or a lack of skill... etc").

Step 3. Next to each of the items of interference you've listed, ask your team member, "How much control do you have over this?"

Step 4. Where they have control to change something, discuss what support they need to overcome this area.

e.g. "What needs to happen to help you move past this?" OR "What support do you need from me to help you clear what's getting in the way of you performing at your full potential?"

Where they do *not* have control over an area, discuss how they can best learn to cope or adapt to this stimulus.

Remember: *The only area in which we have FULL (100%) control is our mindset (our thoughts and beliefs) and our actions. Everything else, we can either influence or that which we need to learn to let go.*

THE VICTIM AND THE PLAYER

In any situation, there are always at least two causes for why it occurred, but often there is only one slot for an explanation. The explanation you choose can either lead to you feeling empowered or ready to throw in the towel. In any situation, we can either adopt the philosophy of the Victim or the Player.

What is a victim?

A victim privileges explanation with exogenous factors. They shun responsibility and whenever something goes wrong, they focus on factors that are out of control.

When something goes wrong, any of these sound familiar?

- "It broke"
- "The project got delayed"
- "They/he/she did it"

The Player

The Player on the other hand, takes responsibility. When they see an issue, they ask, "What can I do about it?" Even if I didn't cause it, the Player sees their ability to respond. They ask, "What can I do?"

The Player philosophy or mindset empowers a leader to achieve, to resolve the issue and respond to the problem. Many leaders say they care, but when faced with a difficult situation or problem, they are quick to point the finger or avoid responsibility (victim). To truly care actively, you need to adopt the Player mindset.



ACTIVITY



Watch this video to understand the difference between player/victim
Link: <https://www.youtube.com/watch?v=xXdN5kMioRQ>
Or scan the QR code to the left

Reflect on a recent or current issue in the workplace where something went wrong or didn't go to plan. What is/was the cause of the issue?

Reflecting on that issue, were you guilty of asking any of these questions in response to the situation?

- What happened to you?
- Who's to blame?
- What did he/she/you do wrong?
- Why did he/she do it?
- What should have he/she done?

Are these questions representative of a Victim or a Player mindset? Why?

Remember, if you don't feel part of the problem, you cannot be part of the solution.

Reflecting on the Video clip, what questions could you ask to shift from a Victim mindset to a Player?

- What can I do to respond to this situation?
- How did I contribute to the problem?
- What can I do now?
- What can I learn from this?
- _____ (What else can you ask?)

How can we create a Player-focused team environment?

A team with a Player mindset is one that cares and looks out for each other, and thus is focused more on finding a solution than on finding someone to assign blame.

How could you adopt the questions above to drive a team ("WE") focus?

e.g. "Regardless of the cause..."

- What can WE do to respond to this situation?
- How did WE contribute to creating the problem?
- What can WE do now?
- What can WE learn from this?
- _____ (What else can you ask?)

HUMAN ERROR MODEL

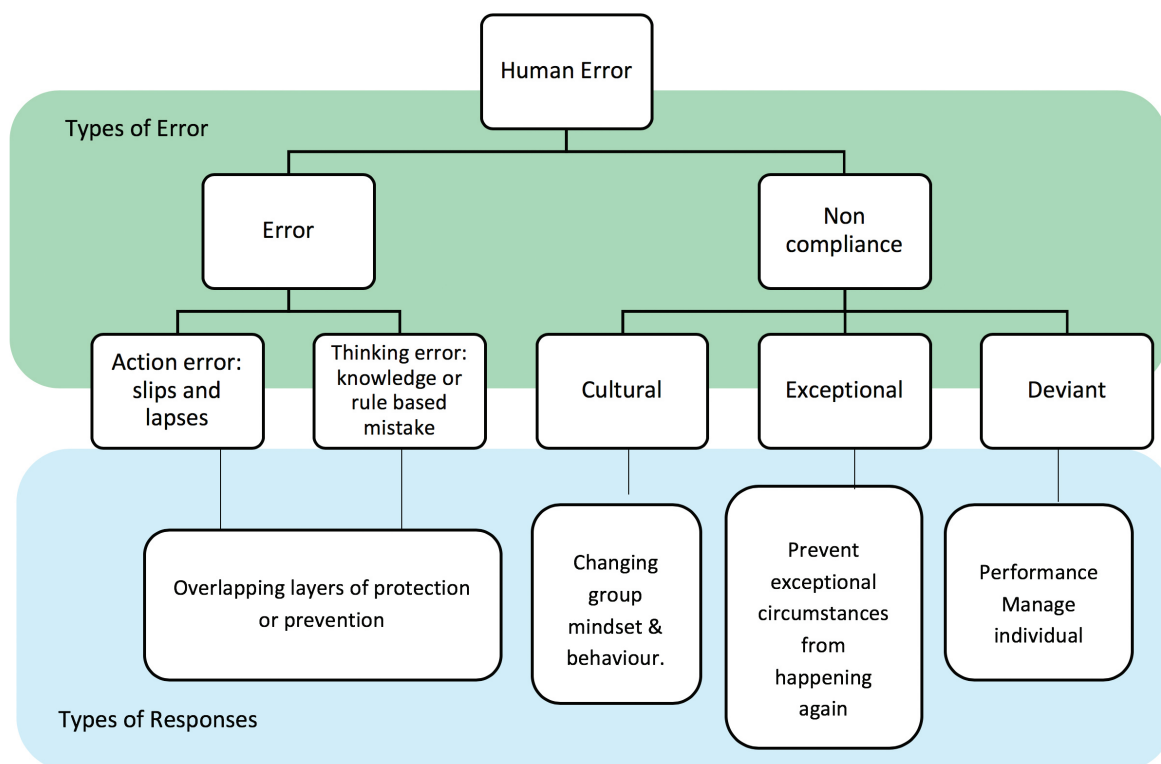
Error is often caused by a number of things and is rarely caused by one single person or process.

When things go wrong, for example, when an employee or manager has breached an organisation's conduct expectations, it can be challenging for leaders to manage these situations in a fair and equitable way.

To create a safe workplace where we are shown to look out for and support each other, it's important that we understand the complete picture, and care enough about each other's safety to put 'blame' aside.

We can respond to 'error' more appropriately using the model below. It helps to create a safe working environment as it provides a clear, transparent, equitable and consistent approach for all employees. It takes into consideration the types of human error that can occur in the workplace, contributing factors to that error and appropriate responses to that error.

Human Error - Understanding error and Appropriate Courses of Action (Fair Play Model)



When we put blame aside, and focus on the picture as a whole, we learn more, are more constructive, and more solution focused. We are also more likely to achieve our goal – **to prevent the error from happening again.**



ACTIVITY

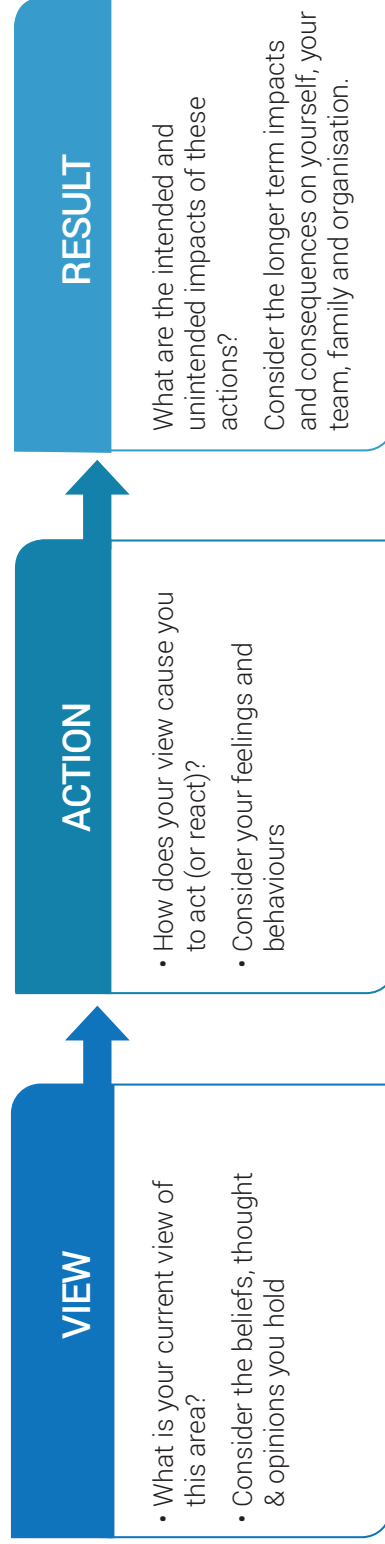
HUMAN ERROR	YOUR EXAMPLE	APPROPRIATE ACTION
Action error: slips and lapses <i>Indicator instead of windscreen wipers</i> <i>Reading 1000mls instead of 100mls</i>		
Thinking error: knowledge or rule-based mistake <i>Assuming \$20 will be enough for lunch but underestimating prices</i> <i>Referring to and following an out-dated procedure</i>		
Routine/Cultural error (when noncompliance becomes the norm) <i>The rules state that everyone must wear sunscreen when outdoors for more than 20mins, but no one follows it</i> <i>Driving 5kms over the speed limit</i>		
Exceptional or situational <i>Completing a task unsupervised because Supervisor was late</i> <i>Not wearing gloves because there were none left</i>		
Deviant <i>Modifying budget amounts to make the department look more profitable</i> <i>Not wearing gloves because of laziness</i>		

VIEW-ACTION-RESULT REFLECTION & TRANSFORMATION EXERCISE

EXAMPLE – CARING

What development area from Caring have you chosen to work on?	Changing my language (efficacy)
Why is working on this area important to you?	I want my genuine care for people to have a positive impact

Note: Before completing the following exercises, you can also have a read of the View Action Result (VAR) Instruction, found in section 2. This section provides background to the VAR model, why it's so important, how it works and examples to help you work through your own.. i.e



EXAMPLE - CURRENT VIEW OF CARING

VIEW	ACTION	RESULT
I stick up for my mates	Point out what the organisation isn't doing to keep us safe Defend my mates Quick to fight for what's right Miss what is working	Seen as negative Things don't get fixed Not taken seriously No one listens People roll their eyes Nothing changes

PERCEIVED BENEFITS. WHAT ARE THE PERCEIVED BENEFITS OF HAVING THIS VIEW?

PERCEIVED BENEFIT	...AND WHAT IS THE BENEFIT OF THAT?	...AND WHAT IS THE BENEFIT OF THAT?
Honour my values	Speak my mind	Seen as passionate

COSTS. WHAT ARE THE COSTS OF HAVING THIS VIEW?

COST	...AND WHAT IS THE COST OF THAT?	...AND WHAT IS THE COST OF THAT?
Don't listen to others	Frustrate my mates	No one listens to me
Seen as negative	People don't involve me in conversations	Can't help my mates safe/make improvements

EXAMPLE – CONSTRUCTIVE VIEW OF CARING

VIEW	ACTION	RESULT
The best way to show care is getting into action with everyone	Noticing hazards Speaking up in a way that makes it easy for others to listen Offers solutions Asks questions to clarify more safe objectives	Seen as genuinely caring about workmates and the organisation. Workplace culture and performance is optimised. Safe and effective

BENEFITS. WHAT ARE THE BENEFITS OF HAVING THIS VIEW?

BENEFIT	...AND WHAT IS THE BENEFIT OF THAT?	...AND WHAT IS THE BENEFIT OF THAT?
Seen as someone with ideas	Get involved in making things better	Able to help make work safer for my mates
My mates raise concerns and ideas with me	I can help them find a way to stay safe and work with the organisation	Happier, engaged team that care

CHALLENGES. WHAT ARE THE CHALLENGES OF HAVING THIS CONSTRUCTIVE VIEW?

CHALLENGE	...AND WHAT IS THE CHALLENGE OF THAT?	...AND WHAT IS THE CHALLENGE OF THAT?
Can be more complex and take longer to make changes	Being patient and resilient to stick with it	Helping others to do the same





NOW IT'S YOUR TURN...

VIEW-ACTION-RESULT REFLECTION & TRANSFORMATION EXERCISE

What development area have you chosen to work on?	
Why is working on this area important to you?	

YOUR CURRENT VIEW

VIEW	ACTION	RESULT

PERCEIVED BENEFITS. WHAT ARE THE PERCEIVED BENEFITS OF HAVING THIS VIEW? (I.E. HOW DOES THIS VIEW PLAY OUT IN YOUR LIFE AT WORK AND HOME?)

BENEFIT	...AND WHAT IS THE BENEFIT OF THAT?	...AND WHAT IS THE BENEFIT OF THAT?

COSTS. WHAT ARE THE COSTS OF HAVING THIS VIEW? (I.E. HOW DOES THIS VIEW PLAY OUT IN YOUR LIFE AT WORK AND HOME?).

COSTS	...AND WHAT IS THE COST OF THAT?	...AND WHAT IS THE COST OF THAT?

WHAT BLIND SPOTS IN YOUR PERFORMANCE ARE OPENING UP FOR YOU WITH REGARDS TO THIS VIEW?



A CONSTRUCTIVE VIEW

What is an alternative, more constructive view or new belief that could give you a different result or outcome? Explore this using the activity below.



BENEFITS. WHAT ARE THE BENEFITS OF HAVING THIS VIEW? (I.E. HOW DOES THIS VIEW PLAY OUT IN YOUR LIFE AT WORK AND HOME?)

BENEFIT	...AND WHAT IS THE BENEFIT OF THAT?	...AND WHAT IS THE BENEFIT OF THAT?

CHALLENGES. WHAT ARE THE CHALLENGES OF HAVING THIS VIEW? (I.E. HOW DOES THIS VIEW PLAY OUT IN YOUR LIFE AT WORK AND HOME?).

CHALLENGE	...AND WHAT IS THE CHALLENGE OF THAT?	...AND WHAT IS THE CHALLENGE OF THAT?

WHAT NEW ACTIONS MIGHT BE POSSIBLE FOR YOU WITH THIS NEW VIEW?





Connecting



Connecting

Allows us to see how things are related, people seek to understand how roles, teams and functions must integrate in order to optimize the performance of the whole system.

Connecting is increased when people work together to create models of how the system works and then continually updated as new information is revealed. There is a concerted effort to understand how people close to the work understand the work, updating systems to match how work is actually done. When there are gaps in understanding, we use inquiry and expert knowledge to study and enhance our view. Open access to information as a way to understand how a system is functioning is key to identifying and addressing risks to performance.

There is work on the right things at the right time with the right people. There is use of highly intentional and focussed approaches that leads to operational discipline and maximises the use of all resources to achieve the purpose





PERSPECTIVES IN PROBLEM SOLVING

“To really understand people and their needs, we need to be out in the world. We need to be in context with people, observing them in their spaces and their interactions.”

— Coe Leta Stafford, IDEO U Managing Director.

PROBLEM SOLVING REQUIRES COLLABORATION

Hazards are problems waiting to be identified and resolved. People have many ways of seeing the same hazard or problem and having these differing views or perspectives in the room are key to finding optimal solutions, both in a reactive or proactive situation.

However, having the right people in the room is just the beginning. Below is a combination of concepts taken from an article by Paul Bennett, IDEO’s Chief Creative Officer²⁰ and reflection questions to help connect with how to generate creativity to solve problems and find solutions, using collaboration with empathy.

Effective collaboration is fuelled by empathy—an awareness of others and an ability to detect their emotions and understand their perspective. To come up with truly innovative solutions requires new ideas. And to bring new ideas to light requires seeking a diversity of perspectives and creating a welcoming space for people to share their ideas without fear of judgment.

Leaders who are skilled at empathic collaboration know that voicing an opposing opinion can be a moment of tension for a member of their team, but that those tense moments are the greatest opportunity to unearth impactful ideas. They design ways to intentionally push their people beyond their comfort zones and guide them through the process of creative problem solving by providing support—asking questions instead of calling shots—at critical steps along the way.

To build your capability for empathic collaboration, start by asking more questions, actively listening, assuming a curious mindset, and building on others’ ideas. Then, work to encourage empathy and creative collaboration across your team by taking these four steps.

1. Bring in a diversity of perspectives

Lay the groundwork for innovation by building a diverse team—one where people bring different perspectives, skill sets, backgrounds, and experiences to the table—and uniting them under a collectively held goal. Research shows that diverse teams outperform non-diverse teams by significant margins, especially on problems that require creativity, new thinking, and synthesis of knowledge.

Think about how you can create diversity in teams and in activities like; incident reviews, safety stop action days, site safety inspections, design workshops, etc.

²⁰ <https://www.ideo.com/blogs/inspiration/4-ways-to-encourage-empathic-collaboration>

2. Make time to build trust

The key to maximising the benefits of a diverse team is making sure each person feels able to bring their fullest self to work, so focus on establishing a culture of trust and belonging to enable those vulnerable moments.

Think about how you can create the environment that allows all team members to have a voice and share their differing perspectives. How can this be done over time with a team that work together all the time, and when teams come together for specific activities.



Watch this great Ted Talk as Simon Sinek explains why good leaders make you feel safe

Link: <https://youtu.be/lmyZMtPVodo> (Simon Sinek - Safe)

Or scan the QR code to the left

3. Hold the space for tensions and positive friction

Tensions naturally arise when opposing perspectives meet, but that's not a bad thing when approached with the right mindset. IDEO explored the upside of tensions through a partnership with the Sundance Institute Theatre Program. The partnership resulted in Creative Tensions, a unique live event series where participatory theatre met collective conversation. Opposing viewpoints were assigned to opposite ends of an empty room and participants reflected their perspective on the issue by where they stood—or moved to—within in the room. The resulting dialogue inspired open conversation around challenging topics.

With your team, keep an open mind and make it a rule to assume the positive of each other—that every person's intention is to contribute to the shared goal. Also, raise awareness of individual biases so that you can identify if a reaction to a new idea is out of instinct or evidence.

Can you recall a time when tension and friction was handled in a way that enabled it to contribute to solving a problem or generating new ideas?

What made it successful? If it wasn't successful, what was missing? How can you contribute to these moments of tension to support collaboration?



4. Make others successful

“On any giving project, I’m always looking for the person who is the flower facing the light,” says Susan O’Malley, Head of Strategy and Office of the CEO at IDEO, about supporting people who are actively looking for growth opportunities. As a leader, you can inspire your team and build trust by demonstrating your desire to help each individual grow into their potential. Set the tone for collaboration instead of competition—make it clear that there isn’t a limited supply of success and one person’s growth doesn’t impede the growth of another.

When people come together to make others safer, is a great time for skills, knowledge, passions and capability shine. How do you recognise those who contribute to safety conversations, lead themselves and others in safety? What else could you do?



LINK TO YOUR PERSONAL DEVELOPMENT PLAN

What did you learn?

What have you decided to work on?

Add your actions to your Personal Development Plan.



BUILDING RELATIONSHIPS ACROSS THE ORGANISATION

We have highlighted the importance of building quality relationships throughout this self-development guide. To truly excel in connecting, a leader must build these high-quality relationships with their own team AND people throughout the organisation. Organisations are an interconnected web of relationships, an action or decision caused by someone in a completely different area might actually result in you or your colleague being in an unsafe situation, and vice versa.

Often, we think of 'our team' being the immediate people we work with. An integral leader views their 'team' as everyone in the organisation. Consider the following diagram, who can you identify from your team that would fit in each interaction level? **Note: you might be including people who you have never met before, this is ok, they are still part of your team.**





ACTIVITY

Identify someone in your team (above) that you feel you could develop a better relationship with. You might even identify someone who is responsible for work that significantly impacts your job, but you have never met them!

What can you do in the next month to consciously build a better working relationship with this person/people?

What is the desired impact of building a better relationship? I.e. if you knew this person really well, what could you achieve together?

Look back at this activity in one month's time to assess your progress, identify any changes that have occurred as a result of this relationship and choose someone else to focus your efforts on next month.

PARTNERING TO ACHIEVE OPTIMAL OUTCOMES (INNOC)

The ability to engage and empower all employees, suppliers, contractors, leaders, etc. in having a “preoccupation with failure”, to identify and remove hazards and achieve a better outcome is a key leadership capability. What does a ‘better’ outcome mean though?

The ‘orange’ analogy can be used to understand the difference between partnering with someone to achieve consensus or ‘win/win’ outcomes vs. competing or ‘giving in.’ The orange is an analogy and can be replaced with anything you might be trying to decide on or negotiate about with someone else.

If there was one orange left in a fruit bowl and both you and the other person wanted it, what could you do? Here are the three most common answers.

1. Give it to them

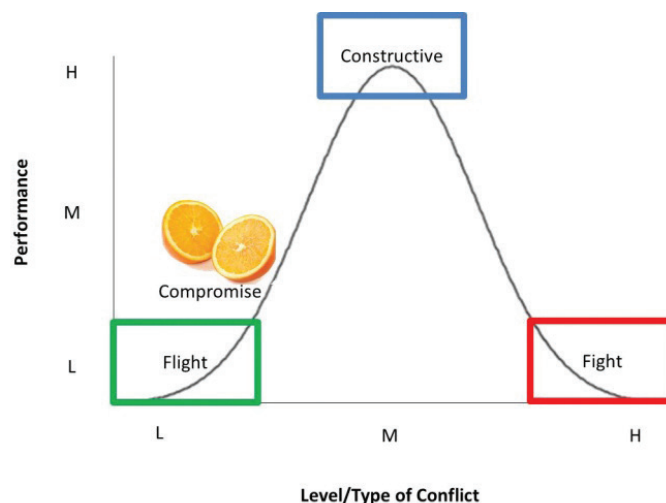
While this option might be the ‘nice’ option it can actually lead to a relationship breakdown between you and the other person. Your ‘needs’ aren’t being met and over time, this may lead to resentment building in your relationship. It is known as the passive or ‘flight’ way of dealing with conflict. This is especially relevant for people that ‘give the orange’ all the time because eventually this resentment builds and erupts.

2. Take it from them

You could take it from them so that your needs are met, but it means the other person’s needs are not met and again, this will lead to resentment in the relationship. This is known as the aggressive or ‘fight’ way of dealing with conflict. Even if they insist you take it, if you haven’t discussed ways of getting both your needs met they may fall into the category above.

3. Cut it in half

Most people when faced with this analogy suggest cutting it in half. It might seem like the ‘right’ answer, but it actually falls into one of the above two categories because the crucial aspect of partnership is missing – communication. When we jump to cutting it in half without discussion about needs and options, we might find that cutting it in half doesn’t meet either person’s needs. What if one of you wanted to eat the flesh of the orange and the other person wanted to bake a cake with the rind? A conversation about this would enable you to get both of your needs met. Ultimately, if you have discussed your needs and options and it is the only orange you can get your hands on and you are both satisfied with cutting it in half then go for it – but only after a thorough discussion.



Together with the analogy, the following framework can be used as a step-by-step guide for reaching a consensus decision that best meets the needs of all parties. It can also be used as the framework for meetings that need to recognise a range of needs from different people.

INNOC - CONSENSUS FRAMEWORK

Step	Intent	Types of questions to ask
Issue	To get a full view of the issue from different perspectives	What is the common goal? What can you both agree you need to achieve?
Needs	My needs + your needs = our needs. Differentiate needs from options. e.g. I need to get from home to work versus I need a car (which is an option)	What do we need to be able to do? What capability do we need to have? Who do we need to consider? What requirements/rules/standards do we need to consider? What's the end goal?
Options	The team generates options that meet each need - not just their/your own.	How could we... How might we... Where has this been done before...
Consider Options	Understand the pros and cons of each option	What will this option give us (in relation to our needs) what won't it? Are there any unintended outcomes/impacts? Can these be mitigated?
Consensus decision	Agree on a final option or outcome	What are the next steps? Can we get behind the decision and support it?



ACTIVITY

Thinking about the orange analogy, what option is your natural tendency? I.e. do you tend to 'give' oranges when faced with conflict? What impact does this have (on you and others)?

What could you do differently to create optimal solutions?



LINK TO YOUR PERSONAL DEVELOPMENT PLAN

What did you learn?

What have you decided to work on?

Add your actions to your Personal Development Plan.

DECISION MAKING

Decision making can be regarded as the mental processes resulting in the selection of a course of action among several alternative scenarios. Every decision-making process produces a final choice (decision).

There are many different contexts in which a decision needs to be made. Some decisions are harder than others and this is often to do with the environment, people involved and the number of options available.

These are highlighted in the table below.

CONTEXT	DESCRIPTION
Simple	These are characterised by a controlled environment and clear cause and effect relationships. The right answer or option is often clear and undisputed. Simple contexts, properly assessed, require straightforward management and monitoring. Here, leaders sense, categorise, and respond. That is, they assess the facts of the situation, categorise them, and then base their response on established practice.
Complicated	In more complicated contexts there are often multiple right answers and while the clear cause and effect relationship is there, this may not be clear to everyone. While leaders in a simple context must sense, categorise, and respond to a situation, those in a complicated context must sense, analyse, and respond. This approach is not easy and often requires expertise.
Complex	In a complicated context, at least one right answer exists. In a complex context, however, right answers can't be 'ferreted' out. Most situations and decisions in organisations are complex because some major change—a bad quarter, a shift in management, a merger or acquisition—introduces unpredictability and flux. That is why, instead of attempting to impose a course of action, leaders must patiently allow the path forward to reveal itself. They need to probe first, then sense, and then respond.
Chaotic	In a chaotic context, searching for right answers would be pointless: The relationships between cause and effect are impossible to determine because they shift constantly and no manageable patterns exist—only turbulence.



ACTIVITY

CONTEXT AND DECISION MAKING

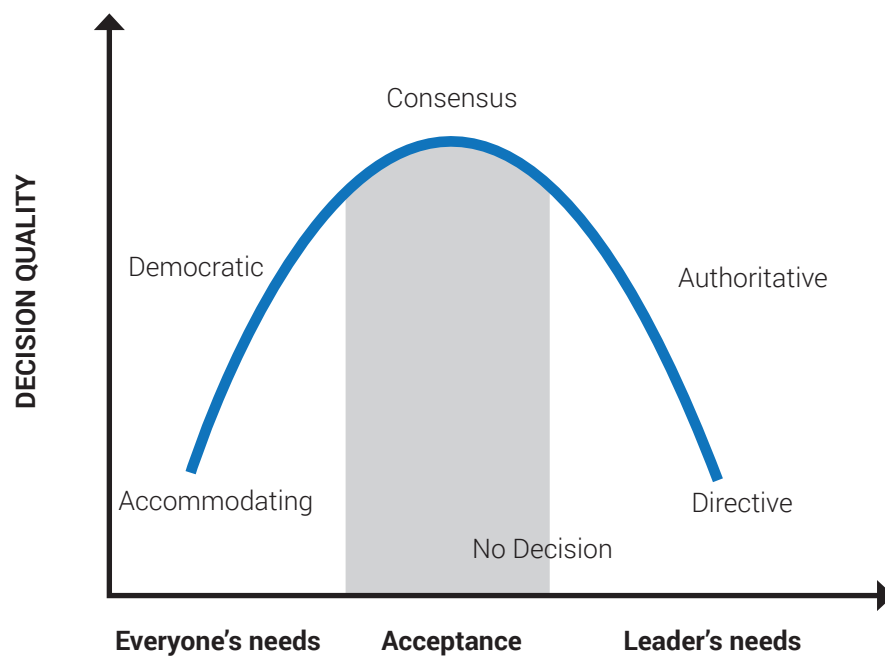
Can you think of an example in your workplace for each of these contexts? What decisions were harder than others to make?

CONTEXT	DESCRIPTION	EXAMPLE	YOUR EXAMPLE
Simple	These are characterised by a controlled environment and clear cause and effect relationships. The right answer or option is often clear and undisputed. Simple contexts, properly assessed, require straightforward management and monitoring. Here, leaders' sense, categorise, and respond. That is, they assess the facts of the situation, categorise them, and then base their response on established practice.	A customer makes a complaint because they did not receive the right treatment and needs an apology.	
Complicated	In more complicated contexts there are often multiple right answers and while the clear cause and effect relationship is there, this may not be clear to everyone. While leaders in a simple context must sense, categorise, and respond to a situation, those in a complicated context must sense, analyse, and respond. This approach is not easy and often requires expertise.	A motorist may know that something is wrong with his car because the engine is knocking, but he has to take it to a mechanic to diagnose the problem.	
Complex	In a complicated context, at least one right answer exists. In a complex context, however, right answers can't be ferreted out. Most situations and decisions in organisations are complex because some major change—a bad quarter, a shift in management, a merger or acquisition—introduces unpredictability and flux. That is why, instead of attempting to impose a course of action, leaders must patiently allow the path forward to reveal itself. They need to probe first, then sense, and then respond.	Cutbacks in a team need to be made while reshuffling in other departments are occurring contributing to confusion and lack of security within the team.	
Chaotic	In a chaotic context, searching for right answers would be pointless: The relationships between cause and effect are impossible to determine because they shift constantly, and no manageable patterns exist—only turbulence.	Crisis or accident in the workplace.	

DECISION MAKING STYLES

There are five different decision-making styles, whilst they all have their place, some have greater success at meeting all needs of all the stakeholder. These styles are Consensus, Democratic, Accommodating, Authoritative and Directive.

The decision-making skills curve shows the relationship between conflict and the decision quality and how they affect different decision-making styles.



Consensus - Input is sought from all key stakeholders. All valid information and options are put forward and evaluated by the team. Generally, the most effective style of decision making that involves/empowers all members involved. Most importantly it is the agreement of most participants but also the resolution or mitigation of minority objections.

Democratic - Input is sought from all key stakeholders and a number of options are generated. All members of the team vote on the options and the majority (>51%) wins. This method involves less discussion and less consensus as the final vote counts. This can also lead to a low decision quality if only a small majority wins.

Accommodating - Input is sought from all key stakeholders. A decision is made by trying to please everyone in the team. The leadership style is driven by considering other people's needs and feelings.

Authoritative - Input is sought from all key stakeholders but the leader makes the final decision. The authoritative decision-making style is useful when the leader possesses all the necessary information from the group and has the required expertise to make the best decision. He/she makes the decision and the subordinates are then informed of what the decision is.

Directive - The directive method is based on a top-down decision-making model. The leader makes the ultimate decision based on his/her knowledge and the decision is often unwavering. The decision does not factor in the group's input. This method is mainly only effective when safety or time is a concern.

CHECKLIST FOR DECISION MAKING

Sometimes decision making does not come naturally or is left to intuition. The following checklist can provide a useful guide when trying to make a decision.

Do I have all the facts from everyone's viewpoint?
Who are the stakeholders and have I considered all of them?
Is there a previous framework/policy/legislation that needs to be considered?
What similar decisions have been made in the past or in other departments?
Have I considered every option - even the abstract ones?
Do I have authority to make this decision?
What is the potential impact on my team? Others? Externally?
Have I done a risk assessment?
Do I have the skills and competence to make this decision? Is it within my reach?
What are my recommended decisions?
Will I have my manager's support on this decision?
Do I need to refer to anyone else before making the decision?
Is there anyone else I need to discuss options with?

AVOIDING INEFFECTIVE DECISIONS

Eventually even good managers will make ineffective decisions, but there are ways to minimise the frequency and severity of mistakes. The following examples are underlying faults in thinking that decision makers should watch out for and avoid, as well as examples of disastrous past decisions that have resulted from corporate leaders falling prey to these four logical missteps.

1. **Misleading experiences**, or memories that seem similar to the current situation, but in reality are not. This fault contributes to more than half of all flawed decisions.
2. **Misleading prejudgments or situations** where previous decisions or judgments influence current decision making.
3. **Inappropriate self-interests or personal interests** that conflict with the responsibility's leaders have for other stakeholders. Crystal clear case in point: former Merrill Lynch chief executive John Thain proposing a \$10 million bonus for himself while the financial sector was in dire straits.
4. **Inappropriate attachments, or the strong feelings** people tend to have towards a particular group, tribe, place or possession, and which are inappropriate given the decision. For an example, look at President Obama's appointment of Tom Daschle, with whom he had a close relationship, despite early warning signs that the nomination would run into trouble.



ACTIVITY

GROUP DECISION MAKING

When used effectively, group decision making can result in greater outcomes and higher quality decisions. The following table introduces some advantages and disadvantages of group decision making.

Activity: What other examples can you think of to add to the table?

ADVANTAGES (IF MANAGED WELL)	DISADVANTAGES (IF NOT MANAGED WELL)
Pooling of resources Access to more information and knowledge Generation of more alternatives Several stakeholders are involved Can increase acceptance and legitimacy Greater quality decisions based on more ideas	Time consuming Responsibilities are sometimes ambiguous Unequal participation Domination of a minority or leader Pressures to conform
Can you think of any other examples?	Can you think of any other examples?

Where have you experienced group decision making work well? What was present to make it so?

Where have you experienced group decision making not work well? What was missing?

GROUP DECISION MAKING FRAMEWORK

There are constructive skills and processes that help support positive group decision making. They enable creative problem solving that will enable teams to move towards a safer workplace. The equation that sets the frame for this is:

$$\text{OS} = Q \times A$$

Optimal Solution **Quality** **Acceptance**

Quality requires rational skills and processes like; analysing the situation, setting objectives, simplifying the problem, considering alternatives and discussing consequences (pros and cons).

Acceptance requires interpersonal skills and processes including; listening, supporting, differing, participating and striving for consensus.

To combine (x) these skills effectively we need task skills, knowledge and resources.

Here is a checklist you can use to assess if you have all the elements in place for your next group decision making session.

INTERPERSONAL PROCESS	RATIONAL PROCESS
<p>Listening</p> <ul style="list-style-type: none"> <input type="checkbox"/> Actively listen, take turns to speak <input type="checkbox"/> Reach clear decisions before jumping subject/topic <p>Supporting</p> <ul style="list-style-type: none"> <input type="checkbox"/> Focus on what is 'right' about an idea – to build on <input type="checkbox"/> Express frustration or disagreement with each other in a constructive way <p>Differing</p> <ul style="list-style-type: none"> <input type="checkbox"/> Comfortably discuss different/conflicting views <input type="checkbox"/> Differ to build on an idea rather than inhibit an idea <p>Participating</p> <ul style="list-style-type: none"> <input type="checkbox"/> Involve everyone in the discussion (where needed/valuable) <input type="checkbox"/> Intervene when there are disagreements between other group members 	<p>Analysis</p> <ul style="list-style-type: none"> <input type="checkbox"/> Analysing the problem – reviewing the facts <input type="checkbox"/> Alignment on what the facts are <p>Objectives</p> <ul style="list-style-type: none"> <input type="checkbox"/> Establish objectives before discussing actions/options <input type="checkbox"/> Clearly agree on objectives before moving on <p>Alternatives</p> <ul style="list-style-type: none"> <input type="checkbox"/> Are there any alternative strategies? <input type="checkbox"/> Have we 'squeezed the lemon' on this? <input type="checkbox"/> Have we explored the alternatives before accepting/rejecting them? <p>Consequences</p> <ul style="list-style-type: none"> <input type="checkbox"/> Explore possible consequences of 2 or more strategies <input type="checkbox"/> How can we know we have a viable solution?
<p>Consensus</p> <ul style="list-style-type: none"> <input type="checkbox"/> Reaching agreement <input type="checkbox"/> Everyone supports and get behind final agreement 	



LEADERSHIP STYLE

There is a Chinese proverb that says that the wise adapt themselves to circumstances, as water moulds itself to the pitcher.

Perhaps at no other time in recent history has adaptability and versatility been more important than it is now. Adaptability is the ability to change (or be changed) to fit new circumstances and is a crucial skill for leaders. Different situations call for different responses, approaches and styles in leadership and communication. This is particularly true in dealing with situations that effect the health and safety of yourself and others.

Daniel Goleman (2000)²¹ determined that leaders use six leadership styles, but only four of the six consistently have a positive effect on climate and results. They are all valuable and useful in different situations.

The Authoritative Style (also known as Visionary)

Primary Objective: Inspiring others by providing long-term direction and vision for individuals

The Coaching Style

Primary Purpose: Long-term professional development of individuals.

The Affiliative Style

Primary Purpose: Creating harmony among individuals and between leaders and individuals.

The Democratic Style (also known as Participative)

Primary Objective: Building commitment and generating new ideas.

The Pacesetter Style

Primary objective: Accomplishing tasks to high standards of excellence.

The Coercive Style (also known as Directiveness or Commanding)

Primary Objective: Immediate compliance.

²¹ D Goleman, D. (2000). Leadership that gets results. Harvard business review, 78(2), 4-17.



ACTIVITY

Which leadership style did you use the most? Note sure? Complete the activity on the next page.

How do you think this has impacted the team or safety outcomes?

Which of the leadership styles would you like to introduce more/less often in your current role and why?



ACTIVITY 2

LEADERSHIP STYLES

What type of leadership and communication style do you use most? Consider each of the statements and circle the one that is most appropriate to you.

1	Engage employees in working towards a shared vision	OR	Nurture personal relationships between your employees
2	Get active participation from all your team members	OR	Keep tight control, preferring not to delegate
3	Have a high level of initiative and are ready to seize opportunities	OR	Help employees identify their unique strengths and areas for development
4	Allow problems to be resolved through team discussions	OR	Clearly link performance and strategy with the vision
5	Role model high standards of performance and expect the same of others	OR	Expect 'do it because I say so'
6	Help employees to establish plans for achieving long-range development goals	OR	Value your employees, their feelings and openly share emotions
7	Guide employees to create their own solutions in moving forward	OR	Ensure close monitoring and don't rely on employee input
8	Quickly pinpoint poor performers and demand more from them	OR	Allow decision making to occur through consensus
9	Promote harmony and foster friendly interactions	OR	Develop and articulate an inspiring vision of how the future will look
10	Are more focused on your goals than on your employees goals	OR	Demand immediate compliance with your orders, without explanation
11	Actively collaborate with your employees to seek out their new ideas	OR	Encourage your employees to innovate, experiment and take calculated risks in pursuit of the vision
12	Link employees' strengths and areas of development to their personal career development goal	OR	Identify opportunities for positive feedback and praise for your employees
13	Expect employees to know what to do without clear guidelines	OR	Operate from a common set of shared core values and beliefs
14	Listen intently to your employees thoughts and concerns	OR	Provide feedback on what employees have done wrong
15	Limit constructive advice on how to improve as relationships are more important	OR	Encourage employees to take on challenging assignments that stretch their capabilities
16	Remind employees of the larger purpose of their work	OR	Know exactly the way things should be done
17	Focus on the emotional needs of your employees over task direction, goals and standards	OR	Link personal and career development goals with organisational results
18	Trust your employees' capability and experience	OR	Rescue the situation, if your employee doesn't deliver on performance
19	Create a team where employees feel a sense of belonging to your team and the organisation	OR	Encourage your employees to work together as a team
20	Apply continual high pressure to achieve performance goals	OR	Focused on telling others what they need to do
21	Avoid performance related confrontation with others	OR	Provide ongoing constructive performance feedback that builds motivation
22	When giving instructions, believe in 'Do as I do'	OR	When giving instructions believe in 'try this' then 'how does that work for you?'



ACTIVITY 2 CONTINUED

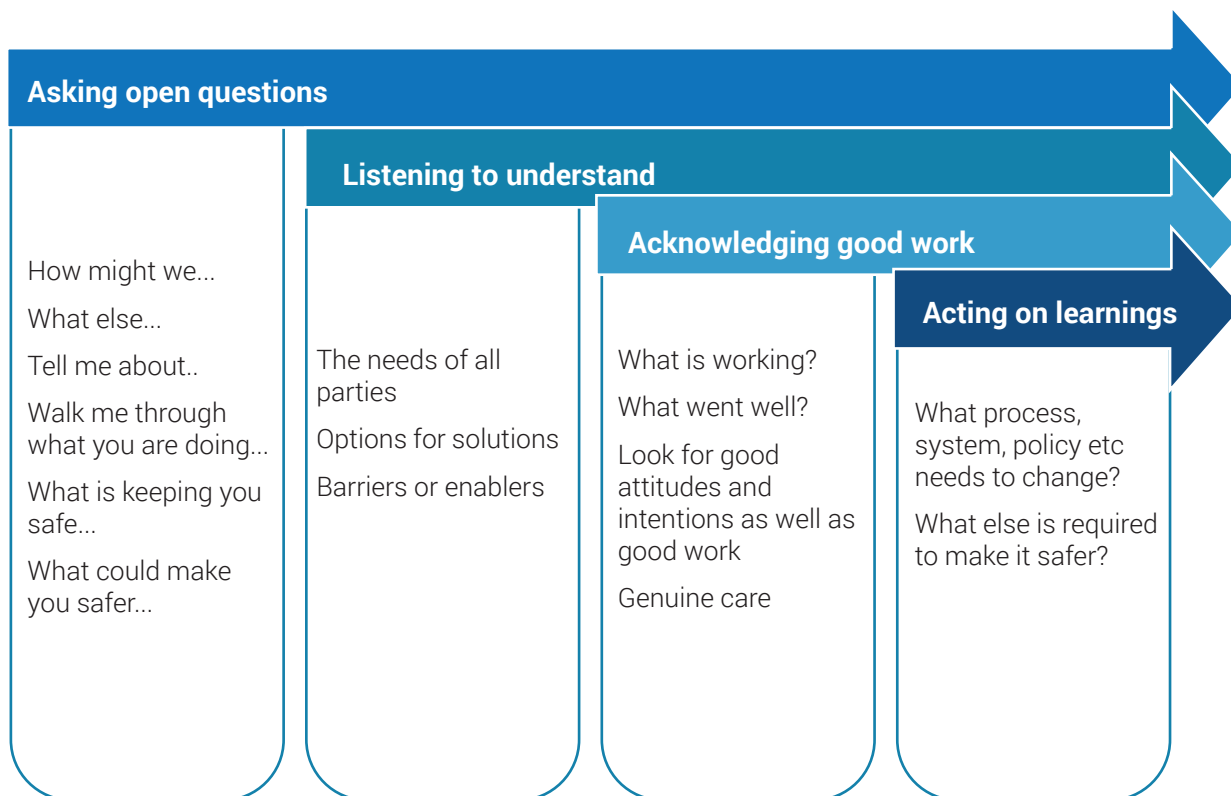
The following table corresponds to the type of Goleman's (2000)²² leadership style that best matches the descriptions. Copy your answers from the descriptions by circling the corresponding word in the following table to indicate which type of leadership style you chose in each case. Which is your most utilised style?

1	Authoritative	OR	Affiliative
2	Democratic	OR	Coercive
3	Pace Setting	OR	Coaching
4	Democratic	OR	Authoritative
5	Pace Setting	OR	Coercive
6	Coaching	OR	Affiliative
7	Coaching	OR	Coercive
8	Pace Setting	OR	Democratic
9	Affiliative	OR	Authoritative
10	Pace Setting	OR	Coercive
11	Democratic	OR	Authoritative
12	Coaching	OR	Affiliative
13	Pace Setting	OR	Authoritative
14	Democratic	OR	Coercive
15	Affiliative	OR	Coaching
16	Authoritative	OR	Coercive
17	Affiliative	OR	Coaching
18	Democratic	OR	Pace Setting
19	Authoritative	OR	Democratic
20	Pace Setting	OR	Coercive
21	Affiliative	OR	Coaching
22	Pace Setting	OR	Coaching

²² Goleman, D. (2000). Leadership that gets results. Harvard business review, 78(2), 4-17.

SAFETY COACHING

As a leader of people within your organisation, coaching is a skill or style of leadership that is universal to any situation or issue. The four key coaching skills that can be used to assist you as a leader help make your staff, environment and clients more safe are:



Powerful Questions

Encouraging staff to see hazards, take ownership and work across teams to make a change is a challenging task. As a leader you are working with many personal, team and organisational perceived and real barriers to making work more safe.

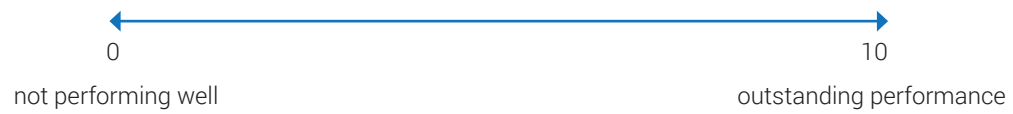
However, a leaders most useful tool is powerful questions. Here is a selection of questions designed to; get clarity of the issue, create empowerment to act, generate ideas and commitment to deliver.

1. Suppose you were at your best when handling this situation what would you be doing?
2. Suppose this issue was resolved. What would be different? What's in your control to make this happen?
3. Imagine things going really well, how would you like to see yourself handling the situation?
4. What concerns you the most here?
5. What do you hope to achieve first and how will that look?
6. When in the past have you faced a similar challenge and what did you do to get through it?
7. How can I best support you in this?



ACTIVITY

How would you rate your coaching and powerful question capability on a scale of 0-10 right now?



What are you doing that puts you at that rating right now?

What could you do to move up the scale +1? How would you know what impact this+1 had?



INFLUENCING CHANGE

Influencing change is about creating a culture of constant renewal of safety practices through connecting reporting of hazards and incidents into new ways of working that are integrated into safety processes and system²³. It's about generating discussion and review of safety practices and turning ideas and opportunities into new ways of working that support an integral safety culture.

To achieve this an effective leader, needs to:

- Ask questions about processes and procedures to determine their effectiveness.
- Acknowledges when procedures are outdated or irrelevant.
- Continuously looks for gaps in current safety practices.
- Ensure updates to processes and procedures are disseminated across the organisation.

Key concepts worth exploring here are:

- Influencing skills
- Systems (integral) thinking – McKinsey 7s Model
- Locus of control – Victim or Player
- Understanding the change curve (for self and others)
- Making change stick (ADKAR)

Throughout this section we are going to work with the following situation:

It's too heavy. Karen attended a site as part of her role and whilst on site noticed a pallet that appeared to be stacked with too much weight. She asked a workmate familiar with the site and storage procedures who confirmed that the pallet was load tested for 750 kgs yet it had about 1 tonne stacked on it. They agreed that they'd remove additional weight so that it was compliant. A few weeks later the same situation occurred, and the same response was undertaken.

²³ Safety Culture and Leadership. A 21st Century Safety Solution for Safety Performance: Integrating Personal and Process safety, R Strycker, JMJ Associates 2011 (pg6)

INFLUENCING SKILLS

Influence refers to the ability to make things happen through others without relying on formal authority. It shapes outcomes by steering negotiations and influencing stakeholders. It can also include presenting reasonable and convincing arguments to persuade others and shape outcomes.



ACTIVITY

WHAT'S MY PREFERRED STYLE OF INFLUENCE?

There are different ways of influencing others. Some examples of these are explained in the table below. Rank the styles of Influence in the order (1-7) that you use them the most. To clarify, think back to memorable occasions or conversations.

RANK	INFLUENCE STYLE	BEST USES	WORST USES
	Friendliness Influencing others by making them like you	Personal favours. Cross-functional situations. You're not in charge	You are in charge, especially for new supervisors – employees expect a boss Substituting it for formal authority
	Bargaining Influencing others by exchanging favours	Need something from a co-worker or peer. Equal exchange of resources	Overuse sets pattern of obligations and paybacks You give more than you get back Use it instead of formal authority
	Reason Influencing others by relying on facts, data and concrete information	Most popular strategy in organisations. Discussions based on prepared logic and evidence	Overuse when situation calls for emotional response too, i.e. downsizing Poor logic or facts disguised as truths
	Higher Authority Influencing others by referring to chain of command	Back-up strategy for seeking compliance on unpopular changes or rules. Support for lower managers' opinions	Seen as "running to the principal", potentially creates mistrust in team Perceived as incapable of making own decisions or taking own actions
	Aggressiveness Influencing others by showing you are "in charge"	Need employee compliance with standard rules and regulations You're absolutely sure you're right	Overuse results in resentment and fear among employees "Crying Wolf"
	Assertiveness Seeking support through clearly and respectfully stating your views and preferences and asking for your needs to be met	No hidden agendas Opens up room for negotiation and learning	None
	Coalition Building Seeking support from most likely proponents first in order to take on severest critics	Gain alliances to get what you need Sell your ideas or requests to others	Overuse seen as a conspiracy, especially by insecure leaders Seen as "rocking the boat"



ACTIVITY

HOW WELL DO YOU MAKE FRIENDS AND INFLUENCE PEOPLE?



Watch the following clip: How to win friends and influence people – video book review
 Link: <https://www.youtube.com/watch?v=0uMZi1gc0Nc>
 Or scan the QR code to the left

Rate yourself against the skills talked about in the above video, we see that these are some of the skills for influencing people.

Skill	Rating		
Arouse in others an eager want	0	5	10
Genuine interest in others	0	5	10
Admit you are wrong and do it emphatically	0	5	10
Talk about your own mistakes first	0	5	10

Which skill do you want to improve?

What's one thing you could do that increases your capability or consistency in these skills?

Reflecting on the above activities, what influencing style and skills would you use in the "Its too heavy" situation on page 14?



LINK TO YOUR PERSONAL DEVELOPMENT PLAN

What did you learn?

What have you decided to work on?

Add your actions to your Personal Development Plan.

SYSTEMS THINKING

To influence change in an organisation, there needs to be a recognition that the organisation is a complex system that requires more than one element to change, to create a sustainable shift in safety practices.

A system isn't just any old collection of things. A system is an interconnected set of elements that is coherently organised in a way that achieves something. For example, a football team is a system with elements such as players, coach, field and ball. Its interconnections are the rules of the game, the coach's strategy, the players communications, and the laws of physics that govern the motions of the ball and players. The purpose of the team is to win games or have fun or to get exercise or to make millions of dollars, or all of the above ²⁴

How does this relate to safety? Think about the "It's too heavy" situation - what makes up the elements in this system? How do they affect each other?

e.g. the employees knowledge, views, behaviours, the pallet, the load, the rules procedures.....

MCKINSEY 7S MODEL

Another way of seeing elements in an organisational system and consider how they interrelate is by using the McKinsey 7s Model.²⁵

The model categorises the seven elements as either "hard" or "soft":

Hard Elements	Soft Elements
Strategy	Shared Values
Structure	Skills
Systems	Style
	Staff

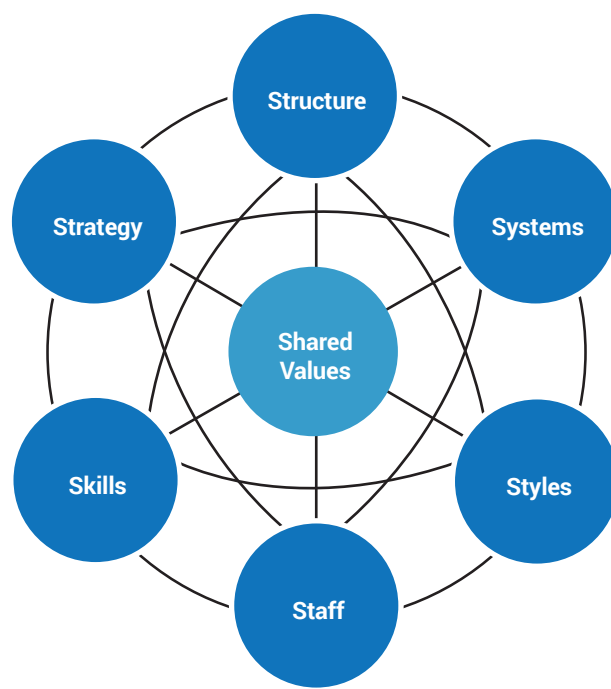
The three "hard" elements are strategy, structures (such as organisation charts and reporting lines), and systems (such as formal processes and IT systems.) These are relatively easy to identify, and management can influence them directly.

The four "soft" elements, on the other hand, can be harder to describe, less tangible, and more influenced by your company culture. But they're just as important as the hard elements if the organisation is going to be successful.

²⁴ Thinking in systems, Donella H Meadows, Sustainability Institute, 2008 (Pge 11)

²⁵ https://www.mindtools.com/pages/article/newSTR_91.htm

The diagram below, shows how the elements depend on each other, and how a change in one affects all the others.



- **Strategy:** the plan devised to set and deliver on organisational vision and goals.
- **Structure:** the way the organisation is structured and who reports to whom.
- **Systems:** the daily activities and procedures that staff members engage in to get the job done.
- **Shared Values:** these are the core values of the company that are evidenced in the corporate culture and the general work ethic.
- **Style:** the style of leadership adopted.
- **Staff:** the employees and their general capabilities.
- **Skills:** the actual skills and competencies of the employees working for the company.

You can apply the McKinsey 7-S framework to almost any organisational or team effectiveness challenge. If something within your organisation or team isn't working, chances are there is inconsistency between some of the seven elements identified in the model.

Once you reveal these inconsistencies, you can work to align these elements to make sure they are all contributing to the shared goals and values.

The process of analysing where you are right now in terms of these elements is worthwhile in itself. But you can really move your organisation or team forward by determining the desired future state for each of the factors.



ACTIVITY

Using this frame – identify which elements could be impacting the outcomes in the “Its too heavy” scenario.

Seven S's	Items from scenario
Strategy	
Structure	
Systems	
Shared Values	
Skills	
Style	
Staff	

How could this analysis of the situation be undertaken to include other perspectives?



Want to explore systems thinking further?



Watch the following clip: Systems Theory
Link: <https://www.youtube.com/watch?v=JGCBFFiT85k&t=2s>
Or scan the QR code to the left



LOCUS OF CONTROL

Locus of Control as a principle was originated by Julian Rotter in 1954. It considers the tendency of people to believe that **control** resides internally within them, or externally, with others or the situation.

Note that, like other preferences, this is a spectrum. Some people have a wholly internal or external locus of control, but many will have some balance both views, perhaps varying with each situation. For example, some may be more internal at home but more external at work.

Internal People with a high internal locus of control believe in their own ability to control themselves and influence the world around them. They see their future as being in their own hands and that their own choices lead to success or failure.

Rotter (1990)²⁶ describes the internal locus of control as:

‘The degree to which persons expect that a reinforcement or an outcome of their behaviour is contingent on their own behaviour or personal characteristics’

Their belief in their ability to change things may well make them more confident and they will hence seek information that will help them influence people and situations. They will also likely be more motivated and success oriented. These beliefs may even lead them to be more politically active.

They are more likely to have **expectancy shifts**, where a sequence of similar events are expected to have different outcomes. They tend to be more specific, generalising less and considering each situation as unique.

A challenge of an internal locus of control is that, in accepting responsibility, the person could fall into the trap of being blamed for failures. Alternatively, they could view failure as a necessary ingredient for success.

External People with a high external locus of control believe that control over events and what other people do is outside them, and that they personally have little or no control over such things. They may even believe that others have control over them and that they can do nothing but obey. e.g. “because the weather is bad, I have no choice but to be in a bad mood because my plans for the day are ruined.”

Rotter (1990) describes the external locus of control as:

‘The degree to which persons expect that the reinforcement or outcome is a function of chance, luck, or fate, is under the control of powerful others, or is simply unpredictable.’

With such beliefs, people with an external locus of control tend to be fatalistic, seeing things as happening to them and that there is little they can do about it. This tends to make them more passive and accepting. When they succeed, they are more likely to attribute this to luck than their own efforts.

They are less likely to have expectancy shifts, seeing similar events as likely to have similar outcomes. they hence step back from events, assuming they cannot make a difference.

²⁶ Rotter, J. B. (1990). Internal versus external control of reinforcement: A case history of a variable. *American Psychologist*, 45(4), 489-493.

Do you have an internal or external locus of control?



Watch this short video to understand where you are, at the moment
Link: <https://www.youtube.com/watch?v=xXdN5kMioRQ>
Or scan the QR code to the left



ACTIVITY

INTERNAL LOCUS OF CONTROL

Think about a situation where you had an external locus of control view. Examples might be when a change was introduced, a new process or way of doing something, or when an incident occurred or when someone provided feedback to you.

Example: I reversed my work vehicle into the roller door of the tool shed.

What was your first reaction (feeling, thoughts, actions):

Example: I felt annoyed and embarrassed, I thought about how the reversing sensor must not be working, the signage wasn't clear, there should be a bollard there to protect the door. I reported the incident and wrote the cause as faulty reversing sensor.

I felt...

I thought...

What I did or said was...

What was the impact of the external focus? Consider impact on self and on others.

What were the benefits for you of having this view?	What were the costs for you and others of having this view?

Example:

Benefits: I saved face; I didn't have to fix anything.

Costs: lost opportunity for learning, to keep others safe, prevent repeat incident, loss of respect from people who thought I wasn't taking responsibility.

After your initial reaction, what did you do to shift to an internal locus of control?

Example: Reflected on the incident - As I was writing up the report, I realised I should have checked behind me before getting into the car.

What else could you do? How could you build on what you already do?

Example: Take a step back in the moment and be curious.

What are the payoffs of an internal locus of control?

Example: Respect from others, demonstrate safety leadership, improve safety practice.



Watch this video to learn more about Personal Mastery - Locus of Control

Link: http://youtu.be/wCa_CAAd5A

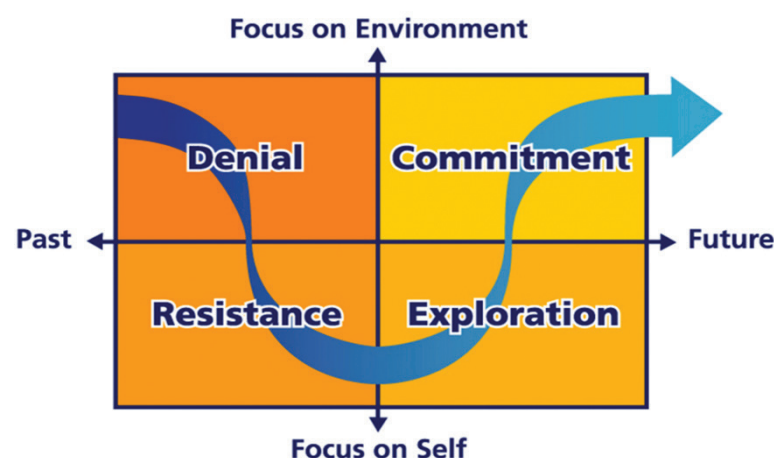
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THE CHANGE CURVE

Influencing change requires an understanding of how people (individuals and collections of) respond to change, big or small. Leaders often fail to recognise that the people they work with might be at different stages of processing the change which can result in conflict, assumptions and failure to implement change.

Change does not occur in a straight line. It is a journey that flows through a series of different stages as people come to terms with the change (for example, a Change Curve is provided below). According to Jaffe & Scott (2003)¹, the Change Curve consists of four phases. It starts with business as usual at the top left ('Denial') with little change showing outwardly. When the changes manifest, there is a turn downward into a zone that involves stress, uncertainty, upheaval, and reduced productivity ('Resistance'). As acceptance of the change takes place there is a climb up the other side of the curve towards 'Commitment' as a sense of direction is regained, new skills and roles are learned, and a new way of working begins.

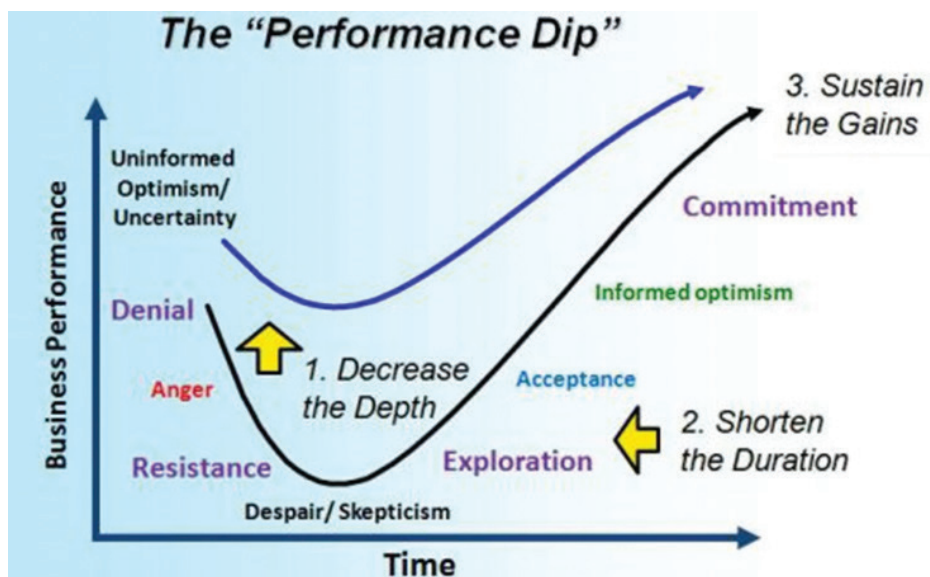
Jaffe & Scott (2003) state that complete mastery of change involves people moving through each of the four stages, particularly if the change was imposed upon them. People can move through changes at different speeds and orders. Sometimes people move back to a previous phase or get stuck in one phase. Regardless, one must always reach 'Commitment' in order to be engaged and perform well within the changed organisation.



LEADING TRANSFORMATION AND WORKING THROUGH AMBIGUITY

There are two key roles a leader has in leading through change; to lead self and to lead others through change. The types of behaviours assessed in the Leading Change domain are based on the typically expected behaviours for all levels of leadership. The change curve provides a frame for leaders to consider why, what and how to manage transformation and working with ambiguity.

Organisations often experience a 'dip' in performance during periods of change. This corresponds with the change curve as employees are responding to the change through each of the four phases. While the four phases are part of the normal human response to change, a leader can reduce the amount of time employees spend in the Denial and Resistance phase. A leader can also make a significant impact once employees have moved into the Commitment phase by acknowledging and supporting them.



A leader can make a positive impact during change in three key ways, each of which requires a different leadership style:

1. Decreasing the depth of the resistance i.e. helping people move through denial and resistance quickly
2. Shortening the duration of the exploration phase i.e. helping people move through their concerns and questions and into commitment
3. Sustaining the gains i.e. supporting and acknowledging those that have committed to the change

A different leadership style is needed at each stage because employees present differently. E.g. an employee in Denial will need to be listened to rather than 'talked to' in a way that might be more suited to those in exploration.



ACTIVITY

ADAPTING LEADERSHIP STYLES DURING CHANGE:

Consider the table below. Thinking of the needs of the employees during each phase, what do leaders need to do at different stages of the change process in order to:

Decrease the depth i.e. move through denial and resistance quickly	Shorten the duration i.e. move from exploration to commitment quickly	Sustain the gains i.e. maintain commitment

What would you include here if a change was introduced to the “It’s too heavy scenario”? What type of behaviours could you experience in each stage and how would you respond?

What stages do you feel most comfortable supporting staff in? What area could you develop more to enable changes to safety practices and processes to be made?



LINK TO YOUR PERSONAL DEVELOPMENT PLAN

What did you learn?

What have you decided to work on?

Add your actions to your Personal Development Plan.



ACTIVITY

LEADING SELF THROUGH CHANGE

When you face major change and feel threatened/vulnerable, what is your default way of handling these feelings? What does it look like?

What pay-offs does this way provide you?

What are the costs of your default way in regards to change? I.e. impact on yourself and others.



UNDERSTANDING THE HUMAN RESPONSE TO CHANGE:

It is normal for people to respond to any major or minor change with resistance. There are various causes and types of resistance to change, particularly at the organisational level. Individuals resist change as they fear letting go of the old, safe, routine ways of conducting their work for a something that is potentially unknown.

As humans, we prefer routines and tend to stick to our habits. But fear of change may be attributed to the possibility of failure, the relinquishing or diminishing of one's span of control and authority or that the planned change has little or no effect on the organisation whatsoever.

People may need time to integrate and get comfortable with the change. Any one of these possibilities can cause doubt and thus fear, understandably causing resistance to the change efforts.

Consider some negative behaviours/responses to change that you have seen in the past. Then consider the emotions or 'views' that might underpin the negative behaviour. You may see that the majority of behaviours come from a place of fear or vulnerability.



ACTIVITY

HUMAN RESPONSE TO CHANGE

Negative behaviours or response	Emotions or thoughts (views) that might underpin
<i>E.g. spreading rumours to others</i>	<i>E.g. 'I don't know what's happening'</i>

As a leader, what can you do to effectively manage change given these views or perceptions of change?

MAKING CHANGE STICK

The ADKAR Model

Created by Prosci founder Jeff Hiatt, ADKAR is an acronym that represents the five tangible and concrete outcomes that people need to achieve for lasting change: awareness, desire, knowledge, ability and reinforcement.²⁷ It is a framework for understanding change at an individual level, and then extendable to show how organisations can increase the likelihood that their changes are implemented successfully.

Below is a re-creation of the ADKAR Roadmap (PROSCI 2006) which shows that to achieve each of the five elements or objectives, there are key players and channels that have the biggest impact.

Important points:

- Each element in order - An individual will find it very hard to build knowledge on how to change if they aren't aware of why and then desire the new way or outcome.
- All five for success – all elements need to be in place to ensure success. Missing one or under doing an element can lead to prolonged change processes as shifts stall or retract.
- Change is a people activity – so work with people to plan, deliver, monitor and adapt the change approach.
- And don't forget the rest of the system – as discussed in the Systems Thinking item, if we want change to occur, we need to think about what changes are required in the whole system. Combine ADKAR with the 7S model and you have a way to consider how your technology, training, work instructions, etc need to work together to create the ability to work in the new way and have that reinforced.

ADKAR Element	Who – the most influential players	How – the most influential channels	Factors influencing success
A wareness – of the why the change is needed	Change sponsor, leaders, direct supervisors	Communication, sponsorship, coaching	Employees perception of the current state, how each employee perceives problems, credibility of the sender, rumours and misinformation present in the background conversation, the contestability of the reasons for change
D esire – to support and participate in the change	Change sponsor, leaders, direct supervisors	Sponsorship, coaching, resistance management	The nature of the change and WIIFM (what's in it for me) from the perspective of the employee, organisational context and history, an individual's personal situation, those intrinsic motivators unique to each person
K nowledge – of how to change	Project team, training teams, Human Resources	Training, coaching	An employee's current knowledge level, the capability of the employee to learn, the resources available to deliver training and education
A bility – to implement the change	Project team, training teams, Human Resources	Coaching, training	Mental and psychological blocks, physical limitations, intellectual capability, the total time available to develop new abilities
R einforcement – to sustain the change	Change sponsor, leaders, direct supervisors	Sponsorship, coaching	How relevant and meaningful the recognition or reward is to the employee, the connection of the reward or recognition to a demonstrated achievement, presence of a performance measurement and accountability system, absence of negative reinforcements

²⁷ <https://www.prosci.com/adkar/adkar-model>



ACTIVITY

Using the ADKAR model, explore what actions and who might be best placed to support them in making a change in the “it’s too heavy” scenario.

Note: Reflect on what you covered in the change curve – what can you anticipate in potential behaviours that might be present, and can be factored into your change activities?

ADKAR Element	Who – the most influential players	How – the most influential channels	Success Factors
A wareness – of the why the change is needed			
D esire – to support and participate in the change			
K nowledge – of how to change			
A bility – to implement the change			
R einforcement – to sustain the change			



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What did you learn?

What have you decided to work on?

Add your actions to your Personal Development Plan.

BUILDING OVERLAPPING LAYERS

Based on the swiss cheese model – this is a focus on addressing weaknesses in people, processes and equipment to ensure that hazards are anticipated, seen and/or eliminated when possible. Leaders need to generate a ‘preoccupation with failure’ mindset that constantly updates what is known and unknown about risks.

This mindset is brought about by all safety leaders:

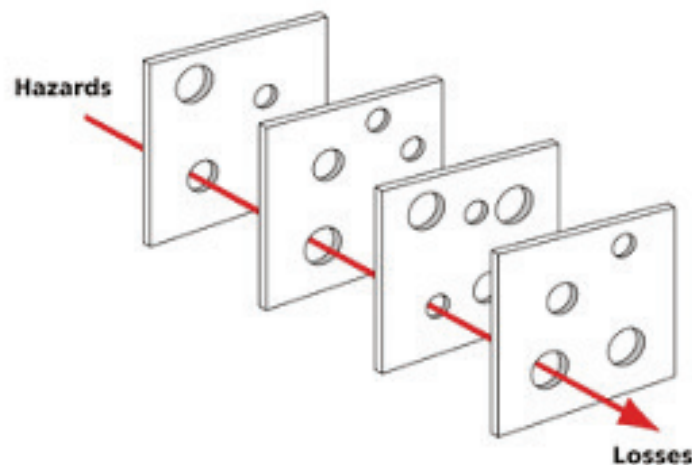
- Asking questions to get up-to-date information about current risks.
- Communicating the importance of above the line controls to others.
- Acknowledges that it’s impossible to control for all risks so builds appropriate layers of protection (inspiring awareness).

Capabilities and concepts that support these behaviours include:

- Swiss Cheese model
- Coaching to find risks
- Risk perception (over time) – Asleep at the wheel
- Human Error model

Swiss Cheese Model

One of the most common models used for illustrating the process safety perspective is the Swiss Cheese model (James Reason)²⁸, a metaphor that includes several layers (or barriers) of protection that can potentially prevent hazards from breaking loose – until the weak spots of each layer happen to align, as shown in the diagram below. Each barrier has mix of plant, process and people components and each has potential weaknesses, or holes in the Swiss cheese.²⁹



²⁸ Reason J. (2000). Human error: models and management. *BMJ (Clinical research ed.)*, 320(7237), 768–770. doi:10.1136/bmj.320.7237.768

²⁹Safety Culture and Leadership. A 21st Century Safety Solution for Safety Performance: Integrating Personal and Process safety, R Strycker, JMJ Associates 2011 (pg3)

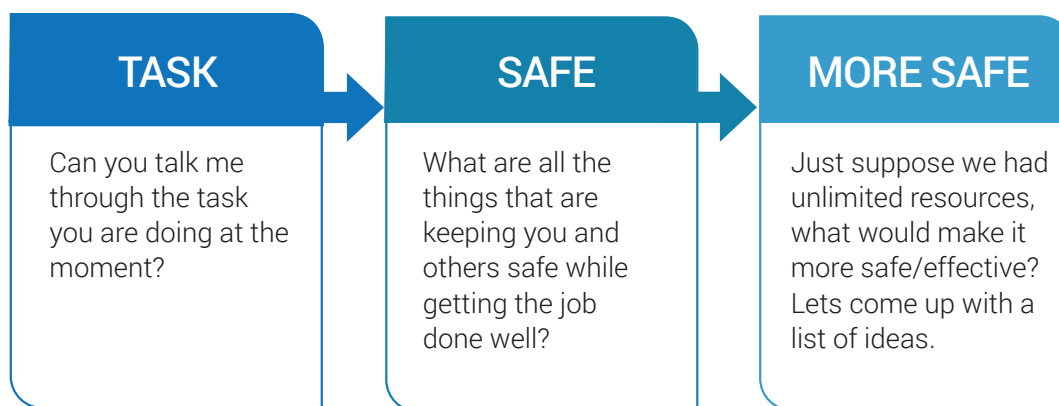


COACHING TO FIND THE RISKS

Working with employees in the moment, in planning, and after a job, to see where the holes are and where they may line up requires a specific type of conversation. Ordinary conversations often fail to identify holes in the system because they ask closed questions that do not stimulate thinking outside the box. Examples of ordinary questions include

1. *What are you working on?*
2. *Is it safe?*
3. *Do you need anything from me?*

The following three step process takes a coaching style of conversation which is more likely to generate richer discussions and identify any holes.





ACTIVITY

AS A SAFETY LEADER, CONSIDER:

What are the benefits of using these questions?

What are the challenges?

What gets in the way of you using these coaching questions?

What can you do differently to engage your team in building layers of protection?

RISK PERCEPTION



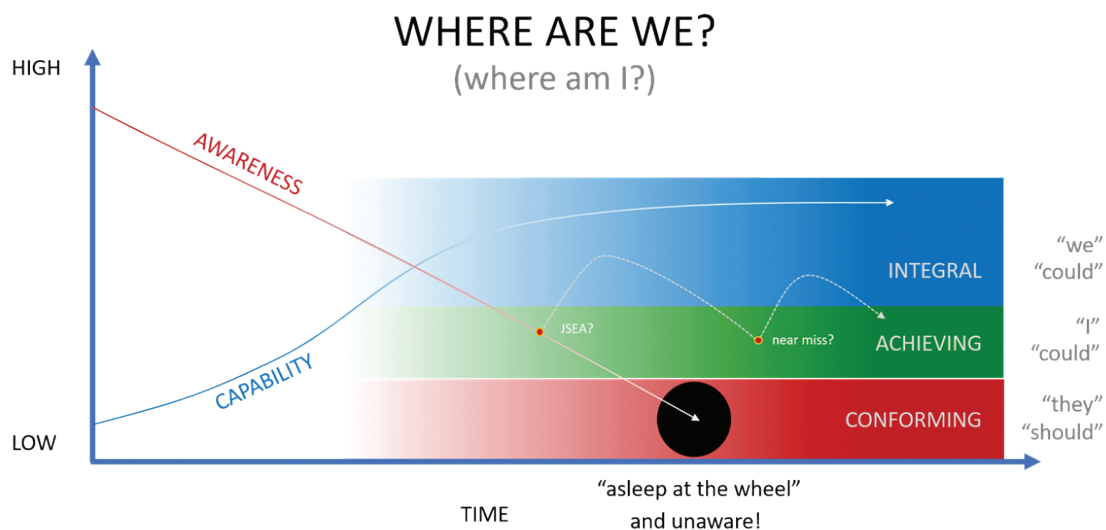
Risk perception is something that can limit or support the building of overlapping layers of protection.

Risk can be defined as a situation involving exposure to danger. Assessing risk generally has two elements; consequence (severity of e.g. extreme, high, low) and likelihood (possible, probably, likely, etc.). By considering these two elements we can increase the visibility and understanding of a risk and therefore improve our decision making.

Risk perception is the subjective judgement that people make about the characteristics and severity of a risk. This is based on our different experiences and skills; hence we all have different risk perceptions. The person who does professional car racing on the weekend will have a different risk perception of driving than a learner driver.

Our perception of risk is influenced by two elements; competence (skills and knowledge) and time (experience). Using the graph below and the driving example; when a new driver first starts they have low competency or skill in driving and their awareness of risk is high. They are at high risk.

On the other hand, someone who has been driving for a long time can become normed to the risks – so their awareness reduces. This is called complacency. This may sound like “I’ve been doing this for years; I know what I am doing”. Ever arrived at work and realise that you don’t even remember leaving home? We kind of go on ‘autopilot’. Another way of viewing this is that we are essentially ‘asleep at the wheel’.



The real risk with complacency, is that we are unaware that we are complacent, and it takes an event (a near miss or incident) to wake us up.

In the workplace this could be a routine check-up or inspection, something you do every day. Interestingly, the longer you've been doing something, the more 'at risk' you are of being 'asleep at the wheel' and not even realising it

The challenge for everyone, and particularly those leading people, is to help them be in the Integral (blue) zone, in the diagram above. This is where we match our high capability with high awareness, of what we're doing and why we're doing it.

Some examples may be:

- Use processes and systems to help keep awareness at constructive level e.g. 'step backs' or safe job planning.
- Use training to keep capability increasing and as opportunities to see risks in a different way.
- Encourage staff mentoring to have experienced and new staff working together so that experience can be shared and help manage the anxiety of new staff. New staff could even share with the experienced staff a different/fresh perspective on the risks.
- Engage variety of people in incident reviews to get different perspectives on risks and solutions.
- Share lessons learnt, rather than each of us having to learn the hard way.
- Reminding each other, in handover meetings, why it's important that we're aware of the risks.
- Adding a safety 'thought of the day' to the staff notice board.



ACTIVITY

Note: if you have trouble doing this activity on your own, consider working with a colleague or friend.

Reflect on a time where you were essentially 'asleep at the wheel'. What was the situation? What contributed to that experience? If you were sharing this story with friends what would you say?



What layers of protection kept this experience from being an incident? What additional layers of protection could you put in place or what layer could you optimise to prevent this happening again?

Imagine this happened to someone close to you. How would you coach them to find ways to prevent this occurring again and be in the 'integral' zone? What questions would you ask?



LINK TO YOUR PERSONAL DEVELOPMENT PLAN

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HUMAN ERROR MODEL

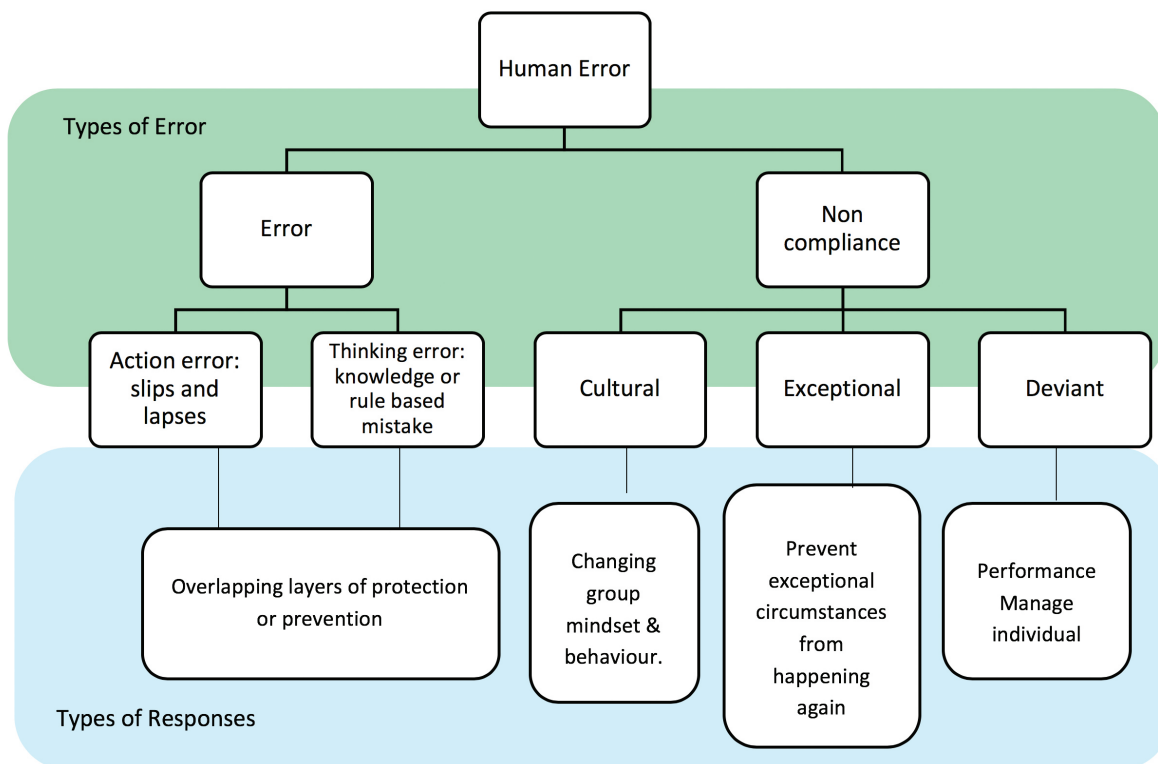
Error is often caused by a number of things and is rarely caused by one single person or process.

When things go wrong, for example, when an employee or manager has breached an organisation's safety expectations, it can be challenging for leaders to manage these situations in a fair and equitable way.

To create a safe workplace where we are shown to look out for and support each other, it's important that we understand the complete picture, and care enough about each other's safety to put 'blame' aside.

We can respond to 'error' more appropriately using the model below. It helps to create a safe working environment as it provides a clear, transparent, equitable and consistent approach for all employees. It takes into consideration the types of human error that can occur in the workplace, contributing factors to that error and appropriate responses to that error.

Human Error - Understanding error and Appropriate Courses of Action (Fair Play Model)



When we put blame aside, and focus on the picture as a whole, we learn more, are more constructive, and more solution focused. We are also more likely to achieve our goal of preventing the error from occurring again.



ACTIVITY

Using the human error model, consider examples that you are aware of, have experienced or witnessed and what might be the appropriate actions.

HUMAN ERROR	YOUR EXAMPLE	APPROPRIATE ACTION
<p>Action error: slips and lapses</p> <p><i>Indicator instead of windscreen wipers.</i></p> <p><i>Reading 1000mls instead of 100mls.</i></p>		
<p>Thinking error: knowledge or rule based mistake</p> <p><i>Assuming \$20 will be enough for lunch but underestimating prices.</i></p> <p><i>Referring to and following an out-dated procedure.</i></p>		
<p>Routine/Cultural error (when noncompliance becomes the norm)</p> <p><i>The rules state that everyone must wear sunscreen when outdoors for more than 20mins but no one follows it.</i></p> <p><i>Driving 5kms over the speed limit.</i></p>		
<p>Exceptional or situational</p> <p><i>Completing a task unsupervised because supervisor was late.</i></p> <p><i>Not wearing gloves because there were none left.</i></p>		
<p>Deviant</p> <p><i>Modifying budget amounts to make the department look more profitable.</i></p> <p><i>Not wearing gloves because of laziness.</i></p>		

INTEGRAL MODEL

The integral model details the importance of both objective (or visible) factors and subjective (or invisible) factors relating to business performance, including safety. Often leaders focus on the visible factors only, e.g. business process, performance management systems, shared information systems, training, skills and staff competency.

While consideration of these factors is crucial to any organisation, the organisational performance will also rely on the subjective/invisible factors e.g. beliefs, values, attitudes, resilience, motivation, morale, shared purpose and team dynamics.

All quadrants within the system need to be optimally **interconnected** and **interdependent** for organisations to reach their full potential.

	INVISIBLE	VISIBLE
INDIVIDUAL	VALUES BELIEFS ATTITUDES	BEHAVIOURS SKILLS
ORGANISATIONAL	CULTURE	SYSTEMS PROCESSES PRACTICES

What does this mean from a building overlapping layers of protection perspective? Complete the activity over the page to explore this.



ACTIVITY

Use the model to think about road safety, and the barriers in place to keep the community safe. A couple of examples have been added to get you started.

	INVISIBLE	VISIBLE
INDIVIDUAL	Its ok to drive 5km hr over the limit	Driving skills/experience
ORGANISATIONAL		Driving lessons, test required

SCENARIO

Working at heights above 1m is a common activity in your organisation. There have been some near misses lately, where team members may have fallen or dropped equipment. The safety team have been asked to develop a procedure for doing these tasks more safe.

Using the integral model, what barriers/layers of protection should be considered here?

	INVISIBLE	VISIBLE
INDIVIDUAL		
ORGANISATIONAL		

How could you ensure these were considered from different perspectives?



LINK TO YOUR PERSONAL DEVELOPMENT PLAN

What did you learn?

What have you decided to work on?

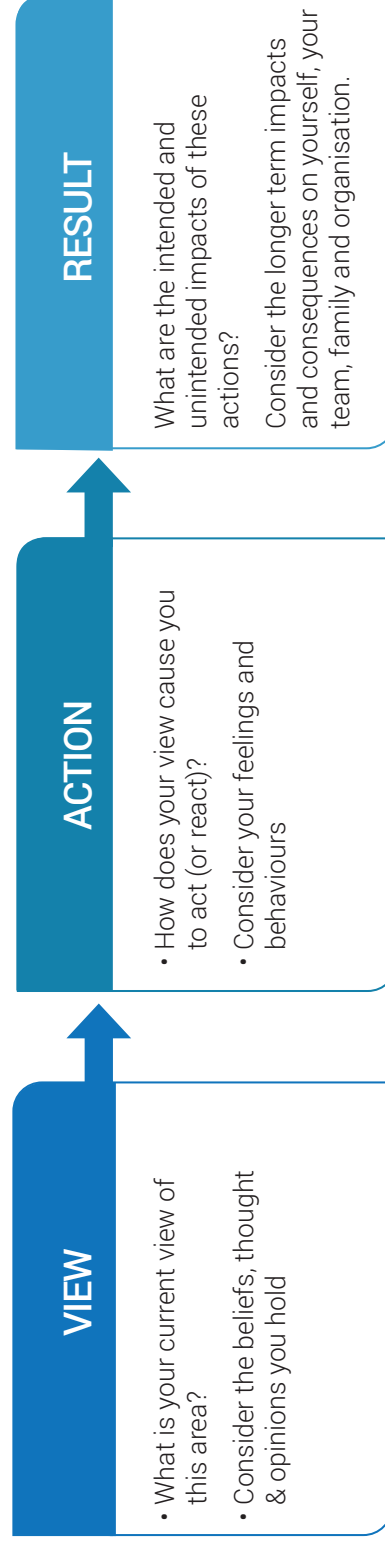
Add your actions to your Personal Development Plan.

VIEW-ACTION-RESULT REFLECTION & TRANSFORMATION EXERCISE

EXAMPLE – CONNECTING

What development area from Connecting have you chosen to work on?	Systems thinking – connecting across teams to improve
Why is working on this area important to you?	I want to break down silo's that are making things harder, inefficient and less safe

Note: Before completing the following exercises, you can also have a read of the View Action Result (VAR) Instruction, found in section 2. This section provides background to the VAR model, why it's so important, how it works and examples to help you work through your own i.e.



EXAMPLE - CURRENT VIEW OF CONNECTING

VIEW	ACTION	RESULT
If all leaders are responsible for their own areas everything should be safe	Focus just on own team Fixes are made in own team	Silos are created (them and us) No learnings between the departments are shared, creates inconsistencies, cost blowouts Don't identify hazards and speak up to other areas. Miss out on learnings and sharing resources from other areas Conflicts with other areas.

PERCEIVED BENEFITS. WHAT ARE THE PERCEIVED BENEFITS OF HAVING THIS VIEW?

PERCEIVED BENEFIT	...AND WHAT IS THE BENEFIT OF THAT?	...AND WHAT IS THE BENEFIT OF THAT?
Focus on managing my own time and resources	Manage my own stress/workload	Short term stress/workload reduction
Focus on what I can control	Make improvements in my team/function	Seen as getting stuff done

COSTS. WHAT ARE THE COSTS OF HAVING THIS VIEW?

COST	...AND WHAT IS THE COST OF THAT?	...AND WHAT IS THE COST OF THAT?
Miss out on knowledge and skills of others	Improvements to my team/function may miss the mark	Rework of changes (inefficient), frustration of team and others
Creates silo's	Other teams don't engage with us for making changes	Our team gets frustrated with others and me (my ability to influence other teams)

EXAMPLE – CONSTRUCTIVE VIEW OF CARING

VIEW	ACTION	RESULT
We are all one team	Share learnings Look out for each other in all areas Seek others input and ideas	Cost savings Solutions are applied Respect for me and my team Sort out for making improvements

BENEFITS. WHAT ARE THE BENEFITS OF HAVING THIS VIEW?

BENEFIT	...AND WHAT IS THE BENEFIT OF THAT?	...AND WHAT IS THE BENEFIT OF THAT?
Changes are accepted and adopted	Less rework – more efficient	Safety increased and cost savings
I get help from others to make improvements	Extra resources and support	Get changes done

CHALLENGES. WHAT ARE THE CHALLENGES OF HAVING THIS CONSTRUCTIVE VIEW?

CHALLENGE	...AND WHAT IS THE CHALLENGE OF THAT?	...AND WHAT IS THE CHALLENGE OF THAT?
Creating trust with others to engage (break the silo's)	Past experiences impact their view	
People feel overwhelmed with workloads already (resist coming to the table)	Creating time and space to come together	Engaging other leaders to empower their people





NOW IT'S YOUR TURN...

VIEW-ACTION-RESULT REFLECTION & TRANSFORMATION EXERCISE

What development area have you chosen to work on?	
Why is working on this area important to you?	

YOUR CURRENT VIEW

VIEW	ACTION	RESULT

PERCEIVED BENEFITS. WHAT ARE THE PERCEIVED BENEFITS OF HAVING THIS VIEW? (I.E. HOW DOES THIS VIEW PLAY OUT IN YOUR LIFE AT WORK AND HOME?)

BENEFIT	...AND WHAT IS THE BENEFIT OF THAT?	...AND WHAT IS THE BENEFIT OF THAT?

COSTS. WHAT ARE THE COSTS OF HAVING THIS VIEW? (I.E. HOW DOES THIS VIEW PLAY OUT IN YOUR LIFE AT WORK AND HOME?).

COSTS	...AND WHAT IS THE COST OF THAT?	...AND WHAT IS THE COST OF THAT?

WHAT BLIND SPOTS IN YOUR PERFORMANCE ARE OPENING UP FOR YOU WITH REGARDS TO THIS VIEW?



A CONSTRUCTIVE VIEW

What is an alternative, more constructive view or new belief that could give you a different result or outcome? Explore this using the activity below.

VIEW	ACTION	RESULT

BENEFITS. WHAT ARE THE BENEFITS OF HAVING THIS VIEW? (I.E. HOW DOES THIS VIEW PLAY OUT IN YOUR LIFE AT WORK AND HOME?)

BENEFIT	...AND WHAT IS THE BENEFIT OF THAT?	...AND WHAT IS THE BENEFIT OF THAT?

CHALLENGES. WHAT ARE THE CHALLENGES OF HAVING THIS VIEW? (I.E. HOW DOES THIS VIEW PLAY OUT IN YOUR LIFE AT WORK AND HOME?).

CHALLENGE	...AND WHAT IS THE CHALLENGE OF THAT?	...AND WHAT IS THE CHALLENGE OF THAT?

WHAT NEW ACTIONS MIGHT BE POSSIBLE FOR YOU WITH THIS NEW VIEW?



Appendices

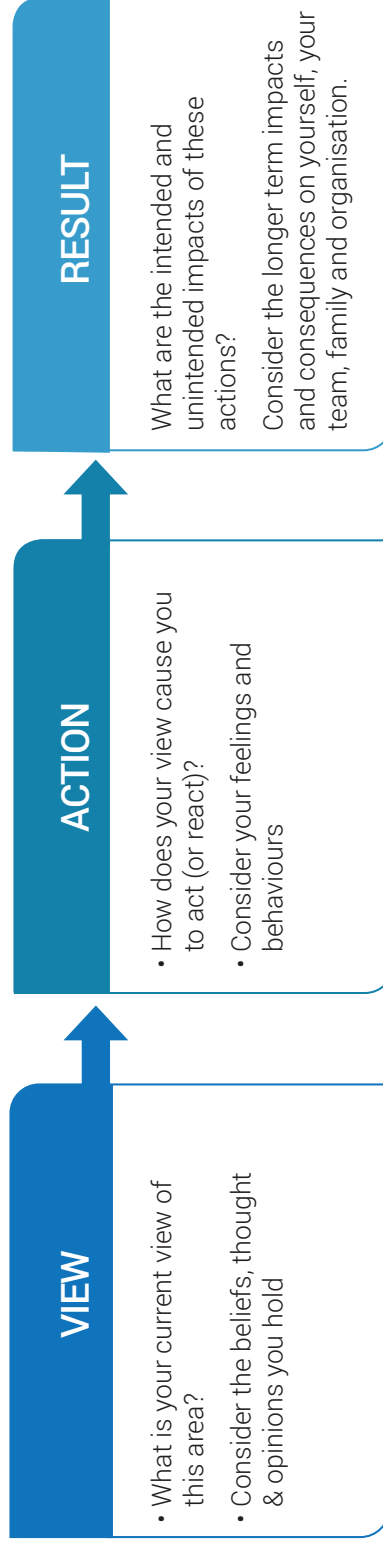
Notes and Spare VARS



VIEW-ACTION-RESULT REFLECTION & TRANSFORMATION EXERCISE

<p>What development area from Leading Self have you chosen to work on?</p>	
<p>Why is working on this area important to you?</p>	

Note: Before completing the following exercises, you can also have a read of the View Action Result (VAR) Instruction, found in section 2. This section provides background to the VAR model, why it's so important, how it works and examples to help you work through your own i.e.



CURRENT VIEW

VIEW	ACTION	RESULT

PERCEIVED BENEFITS. WHAT ARE THE PERCEIVED BENEFITS OF HAVING THIS VIEW?

BENEFIT	...AND WHAT IS THE BENEFIT OF THAT?	...AND WHAT IS THE BENEFIT OF THAT?

COSTS. WHAT ARE THE COSTS OF HAVING THIS VIEW?

COSTS	...AND WHAT IS THE COST OF THAT?	...AND WHAT IS THE COST OF THAT?

CONSTRUCTIVE VIEW

VIEW	ACTION	RESULT

BENEFITS. WHAT ARE THE BENEFITS OF HAVING THIS VIEW?

BENEFIT	...AND WHAT IS THE BENEFIT OF THAT?	...AND WHAT IS THE BENEFIT OF THAT?

CHALLENGES. WHAT ARE THE CHALLENGES OF HAVING THIS CONSTRUCTIVE VIEW?

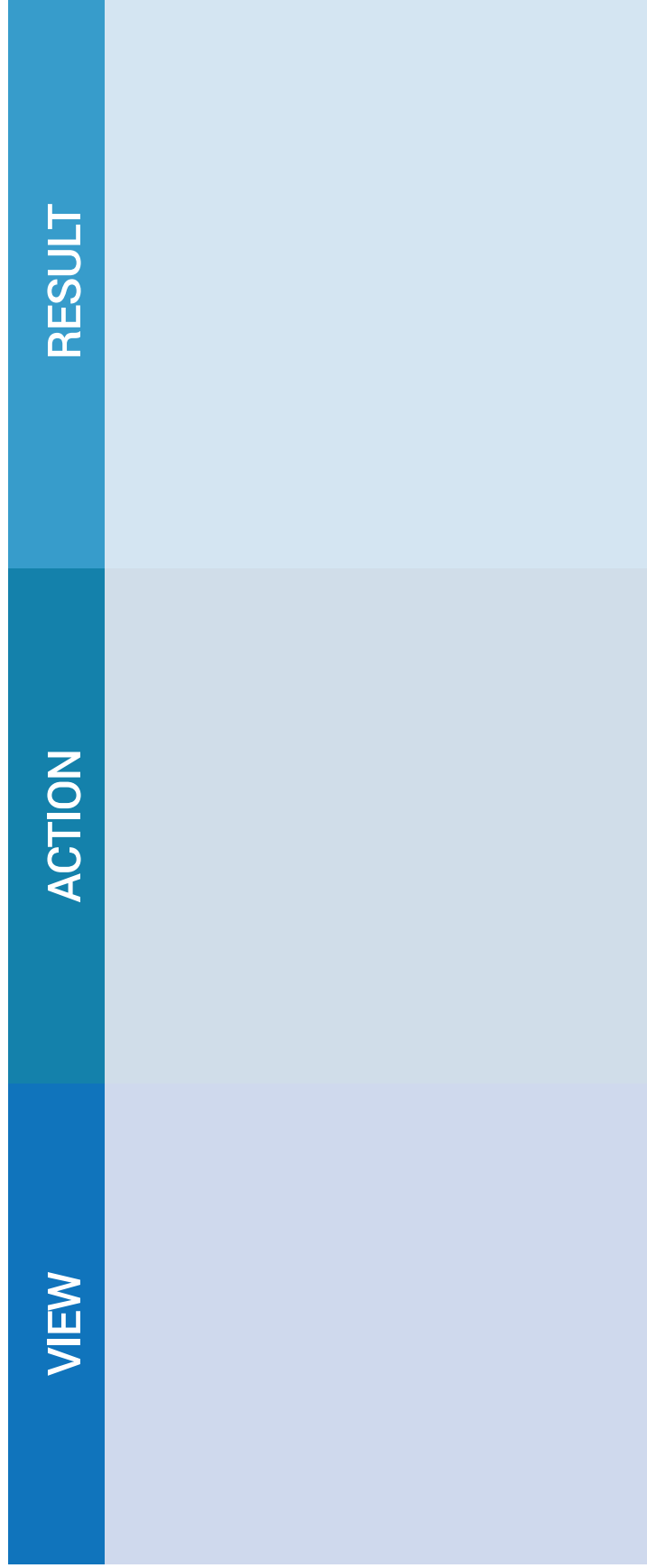
CHALLENGE	...AND WHAT IS THE CHALLENGE OF THAT?	...AND WHAT IS THE CHALLENGE OF THAT?



VIEW-ACTION-RESULT REFLECTION & TRANSFORMATION EXERCISE

What development area have you chosen to work on?	
Why is working on this area important to you?	

CURRENT VIEW



PERCEIVED BENEFITS. WHAT ARE THE PERCEIVED BENEFITS OF HAVING THIS VIEW? (I.E. HOW DOES THIS VIEW PLAY OUT IN YOUR LIFE AT WORK AND HOME?)

BENEFIT	...AND WHAT IS THE BENEFIT OF THAT?	...AND WHAT IS THE BENEFIT OF THAT?

COSTS. WHAT ARE THE COSTS OF HAVING THIS VIEW? (I.E. HOW DOES THIS VIEW PLAY OUT IN YOUR LIFE AT WORK AND HOME?)

COSTS	...AND WHAT IS THE COST OF THAT?	...AND WHAT IS THE COST OF THAT?

WHAT BLIND SPOTS IN YOUR PERFORMANCE ARE OPENING UP FOR YOU WITH REGARDS TO THIS VIEW?



CONSTRUCTIVE VIEW

WHAT IS AN ALTERNATIVE, MORE CONSTRUCTIVE VIEW OR NEW BELIEF THAT COULD GIVE YOU A DIFFERENT RESULT OR OUTCOME? EXPLORE THIS USING THE ACTIVITY BELOW.

VIEW	ACTION	RESULT

BENEFITS. WHAT ARE THE BENEFITS OF HAVING THIS VIEW? (I.E. HOW DOES THIS VIEW PLAY OUT IN YOUR LIFE AT WORK AND HOME?)

BENEFIT	...AND WHAT IS THE BENEFIT OF THAT?	...AND WHAT IS THE BENEFIT OF THAT?

CHALLENGES. WHAT ARE THE CHALLENGES OF HAVING THIS CONSTRUCTIVE VIEW? (I.E. HOW DOES THIS VIEW PLAY OUT IN YOUR LIFE AT WORK AND HOME?)

CHALLENGE	...AND WHAT IS THE CHALLENGE OF THAT?	...AND WHAT IS THE CHALLENGE OF THAT?

WHAT NEW ACTIONS MIGHT BE POSSIBLE FOR YOU WITH THIS NEW VIEW?







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