Safety Maturity Assessment – Descriptors

| Scoring | |
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| | **1. Safety Feedback** |
| 1 | The organisation uses a variety of approaches to engage and gain feedback from their employees. This includes surveys, workshops, direct meetings, safety tours, etc. Feedback and improvements arising from these are provided in a timely manner. |
| 3 | The organisation may have a limited set of feedback opportunities (e.g. an annual engagement survey). Feedback is delayed or limited. |
| 5 | The organisation doesn't seek feedback from their employees. |
| | **2. Human Impacts of Change** |
| 1 | The organisation recognises the 'human element' of change is critical to a successful change and clearly plans for, engages, and seeks to optimise the system for the human user. |
| 3 | Change management is primarily technical, but established processes and risk assessments require a focus on human performance impacts. |
| 5 | There is little or no consideration of human factors or the impacts on human performance and error during the change process. |
| | **3. Action Timeliness** |
| 1 | Corrective actions are completed on or ahead of schedule. These are actively monitored and escalated where necessary. |
| 3 | There is an established process for management of corrective actions. This process ensures that open actions are followed up on, and reasons for deviation from established dates are documented and provided. |
| 5 | Corrective actions are frequently overdue, remain open, or have their timeframes extended for various reasons. Completion of these are at the discretion of the action owner. |
| | **4. Encouraging Improvements** |
| 1 | The organisation has recognised processes for employees to raise safety improvements. Senior leaders support their employees / teams to come up with safety solutions, providing resources to deliver on these, and helping address 'hurdles'. |
| 3 | There are instances of safety improvements being delivered on independent of incidents or change drivers, but this is by exception. |
| 5 | Safety improvements are done only following an incident. |
| | **5. Safety Indicators** |
| 1 | The organisation has outcome and activity based indicators which demonstrate that risk controls remain effective. There is clear demonstration of action taken where indicators suggest otherwise. |
| 3 | The organisation monitors safety incident indicators, some precursor indicators, and is seeking to move towards outcome and activity based indicators (lead indicators). |
| 5 | The organisation monitors lag safety incident indicators only (e.g. LTI trends). |
| | **6. Employee Perception of Change Drivers** |
| 1 | Employees understand the need for continual improvement, and engage in change activities in a constructive and positive manner to improve safety. |
| 3 | Employees recognise that change and continual improvement will occur, and engage in these activities. They may remain cautious and / or they may place an emphasis on matters other than improving safety (e.g. increase pay or similar) |
| 5 | Employees do not trust that change is being done to improve their safety or wellbeing, and as a result they are not included in change planning or delivery by the organisation. |
| | **7. Change Process** |
| 1 | The organisation applies a continuous improvement approach to its change process. It has an established process / standard which is uniformly applied for change, and proactively regularly reviews this to integrate improved ideas and learnings from prior changes. |
| 3 | There is an established process / standard which describe how changes are to be undertaken, and this is uniformly applied. |
| 5 | Every change is individually managed. There is no consistent underlying approach or methodology. |

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| | **8. Safety Innovation** |
| 1 | The identification of innovative safety solutions is actively encouraged and rewarded, and there are processes in place to support this. |
| 3 | Safety innovation is generally encouraged where it will also have an operational performance benefit. |
| 5 | Safety innovation is not encouraged within the organisation. |
| | **9. Control Monitoring** |
| 1 | The degree of monitoring of a risk control is directly associated with the criticality of the control. Data trends or other 'flags' are used to trigger additional oversight or review. |
| 3 | All risk controls are monitored in a systematic and consistent way across the organisation. |
| 5 | The organisation doesn't have an approach to monitor risk controls apart from those that are considered 'routine maintenance'. |
| | **10. Safety Sharing** |
| 1 | The organisation seeks out new opportunities and ideas on how to effectively communicate safety information. |
| 3 | The organisation conventionally presents safety information targeted towards specific employee groups on issues that matter to them. |
| 5 | The organisation may present 'basic' safety information, but not targeted to any specific employee group. |
| | **11. SMS Application** |
| 1 | The SMS is regularly updated to reflect new ideas and opportunities raised by the workforce, to ensure it remains 'fit for purpose' and to keep people safe. |
| 3 | The SMS is established, and clear standards drawn. There is little innovation explored, and improvements tend to be incremental only (large changes are rare, and potentially discouraged). |
| 5 | The SMS is available, but there are routine accepted deviations to established systems and processes - normally to 'get the job done' faster / easier. |
| | **12. Action Scope** |
| 1 | Corrective actions target the systemic causes, and have led to organisation wide changes when required (e.g. when a similar issue exists in other parts of the organisation). There is clear linkage with risk profile improvements. |
| 3 | Corrective actions address the immediate cause of an incident / finding, and sometimes the systemic cause. |
| 5 | Corrective actions are 'quick and simple' to implement, and only address the immediate cause of an incident or finding. |
| | **13. Investigation Scope** |
| 1 | Investigations regularly produce recommendations that address the 'systemic factors', and have impacts across the organisation (not only the area that had the incident). |
| 3 | Investigations seek to understand the underlying causes of an incident, and recognise the importance of human factors as part of this. |
| 5 | The investigation focuses on the actions of the individual and potential errors / violations ('blame'). |
| | **14. Human Risks** |
| 1 | Human and organisational risks are thoroughly understood, considered and appropriately mitigated. |
| 3 | There is a consistent approach to considering human and organisational factors during the risk process, with potential to draw on relevant SMEs. |
| 5 | Risks arising from human factor issues do not appear to be considered during risk assessment. |
| 5 | **15. Safety Priority** |
| 1 | Safety is clearly stated as the primary aim, and leaders will always prioritise safety when making operational decisions. Safety will never be compromised as a result of a change. |
| 3 | Safety is always considered when making operational decisions, though is not necessarily the primary factor. |
| 5 | Safety is regularly talked about, but other factors (financial, performance) are the key decision drivers and drive change. Any safety improvement is a benefit. |

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| | **16. Industry Leadership** |
| 1 | The organisation is recognised as a current industry leader in safety, and leads cross-industry safety improvement programs. |
| 3 | The organisation participates in cross-industry improvement programs, and may play a leadership role in a small number. |
| 5 | The organisation does not actively participate in cross-industry improvement programs unless required. |
| | **17. Non-Technical Skills** |
| 1 | Non-technical skills are part of everyone's role, and these skills are routinely refreshed and further developed. |
| 3 | Non-technical skills are specified in PDs, and staff receive the relevant training when first moving into a role. |
| 5 | Non-technical skills are not considered or developed. Employee performance are based on their technical capabilities only. |
| | **18. Action Governance** |
| 1 | Audit outcomes, investigation findings, and corrective action status are appropriately communicated to senior leadership and the Board as appropriate to provide the relevant assurance. This includes relevant KPIs, identification of critical issues, etc. |
| 3 | Senior leadership and the Board receive some advice as to the status of audit outcomes, investigation findings, and corrective actions but there is no systematic approach to highlight key concerns. |
| 5 | There is no oversight of audits or corrective actions. |
| | **19. Change Communication** |
| 1 | Communication of changes to processes, instructions, etc. is viewed as integral to successful change, and is subject to planning and review to ensure optimal effectiveness. |
| 3 | Communication of changes to systems, processes or operations is reliably done in a conventional manner. |
| 5 | Staff are not alerted to the presence of a new or changed system, process, or operations. |
| | **20. Manager / Staff Engagement** |
| 1 | Managers provide instruction and guidance, and also listen and act on feedback received to continually improve safety. A key focus of conversation is on human factors. |
| 3 | Managers give instructions and guidance which reinforces processes to help achieve safety objectives. |
| 5 | Managers do not talk to non-managerial staff, or do so ineffectively about safety. |
| | **21. Recognition of Change** |
| 1 | The organisation recognises that any change may impact on (or provide an opportunity to improve) safety. This includes organisational changes, personnel changes, system changes, technical / asset changes, etc. |
| 3 | Technical / asset changes are primarily considered, though significant operational process / rule changes are also recognised. |
| 5 | Technical / asset changes are subject to management (e.g. type approval). |
| | **22. Investigation Engagement** |
| 1 | Individuals involved in incidents are freely and actively engaged in investigations recognising that the outcomes are to improve safety for all. |
| 3 | Staff engage in investigations when necessary |
| 5 | Investigations do not engage with individuals involved. |
| | **23. Change Review** |
| 1 | A clear review process is in place that analyses the effectiveness of the change that occurred - particularly for 'higher risk' changes, and contrasts these to planned outcomes. This includes technical, organisational, and process changes. |
| 3 | Once a change is implemented, incidents or issues arising are monitored to ensure it is successful. |
| 5 | Once a change is implemented there is no formal monitoring to ensure it was successful. |

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| | **24. Fostering Learning** |
| 1 | The organisation monitors reports (and similar) from the rail and other industries to identify potential improvements to safety and risk control. The organisation is an 'early adopter' of new standards improving safety. |
| 3 | Safety learnings, when identified through audit, incident investigations, etc., are considered constructively. Standards are adopted over time. |
| 5 | There is limited or no pro-active pursuit of safety learnings. |
| | **25. Safety Data** |
| 1 | The organisation uses data analytics to support its monitoring of all safety data in addition to the established KPIs normally reported. |
| 3 | There is a defined process to monitor established safety KPIs. |
| 5 | There is no process to establish or track safety targets. |
| | **26. Trust** |
| 1 | Leaders have created an environment of trust, allowing people to speak up, share opportunities and ideas, and to discuss safety errors. |
| 3 | Employees are supported and encouraged to speak up about safety in some areas of the organisation. |
| 5 | Employees do not want to speak up about safety as this is responded to by blame or ridicule. |
| | **27. Change Scope** |
| 1 | It is understood that a change can affect other aspects of an organisation or external stakeholders (e.g. other operators). The organisation ensures that the full scope of impacts of a change are understood, and that all risks are considered. |
| 3 | There is a consistent approach to managing change, including understanding the risks directly associated with that change. Impacts on external stakeholders (e.g. other operators) is sometimes considered. |
| 5 | Changes are implemented in isolation. No consideration of other stakeholders or wider risk impacts. |
| | **28. Audit Program** |
| 1 | The audit program is based on risk, and is also flexible to allow for issues / concerns arising to be proactively explored (i.e. before an incident occurs) and provide confidence that controls are in place and effective. |
| 3 | The audit program is coordinated, provides effective coverage of the organisation risks, and is up-to-date. |
| 5 | There is no defined audit program, and audits are either 'as desired' or not carried out. |
| | **29. Risk Inputs** |
| 1 | Ensuring the appropriate information regarding a risk is known is fundamental to managing the risk and making related decisions, and this includes leveraging internal and external knowledge and experience. |
| 3 | Risk assessments include inputs from employees and other groups as specified in processes. |
| 5 | No intelligence is collected (or shared) to better understand risks or available controls. |
| | **30. Engagement Process** |
| 1 | The organisation makes full use of its employees experiences and skills in managing safety, and actively develops these further. |
| 3 | The organisation has a set processes to ensure consultation and participation occurs at all levels on safety matters. |
| 5 | There is no process to involve staff on safety matters. |