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Foreword by Duncan Wilkes, Project Closeout Director

The Thameslink Programme of works, as part of Network Rail’s Capital Delivery organisation, has been a major contributor to Network Rail’s strategic objective of providing a safer and more reliable railway through delivering enhancements to the network to increase its capacity and capability. The programme has run for approximately 10 years with many projects delivered along that journey. I am proud to say that I have been part of the majority of that journey.

Whilst much of the focus on Health & Safety has been about construction workers and them returning home safe every day there was also additional benefits to them working safer which include:

- Less impact on the travelling public (less accidents or damage during construction ultimately led to trains operating to the published timetable)
- Less risk to the travelling public (more aware / alert workers from design through to construction ultimately led to fewer errors or mistakes)
- Train operating companies benefited from a healthy & safe workforce through works being done to time and possession handed back on time to allow them to operate their timetables as published

This report has been written to highlight the journey the Thameslink Programme has been on with regards to Health & Safety. The statistics demonstrate the impact that has been made, however, the real difference cannot be written into a report. The real difference was made through people and their approach. A collaborative approach was taken by the Network Rail and it’s Suppliers and where Health & Safety was concerned there was a very joined up approach. It was through the actions of Leaders that I believe we made a real difference, the teams managed to create ‘safe environments’ whereby the workforce were able to speak up and share their concerns. On many of the projects within the Programme it was almost impossible at times to tell which members of the team were Network Rail and Suppliers. Relationships built up over time allowed teams to work in collaboration however at the same time holding each other to account. A legacy website documenting key learning has also been developed and is signposted at the end of this report.
Thameslink Safety Headlines—10 years at a glance

**Hours worked**
72,897,675

**Shared Learnings Produced**
99

**Close Calls submitted**
67,140

**Safety Inputs**

**Compliance Checks**

**Good Practices Shared**

KO1: 53
KO2: 43

Thameslink—10 Years of Thameslink 5
Thameslink Safety Headlines—10 years at a glance

Supplier Forums
4

Supplier Forums Attendees
470
Tier 1-3 Suppliers Organisations
50

Time2Talks—People Trained
307

Time2Talks Submitted
6996

Safety Communications

HSEA Cascade Face to Face Briefs
138

Hi Viz Newspapers
25

Where ever you are...who ever you’re with... let’s start taking the time to talk

Southern Capital Delivery
Health, Safety & Sustainability
Period 6 2019-20 Brief

Thameslink Managers’ HSEA Cascade Brief
Period 1
1st April – 26th April 2014/15

2009
2014
2019
Thameslink Safety Headlines — 10 years at a glance

**RIDDOR reportable injuries**
- **119**
  - Damaged tendon in foot required surgery

**Minor injuries**
- **1,090**

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**Total Injuries**

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<tr>
<td>RIDDOR Specified</td>
<td>5</td>
<td>11</td>
<td>13</td>
<td>6</td>
<td>3</td>
<td>5</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>0</td>
<td>50</td>
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<tr>
<td>RIDDOR Lost Time</td>
<td>5</td>
<td>9</td>
<td>14</td>
<td>16</td>
<td>6</td>
<td>8</td>
<td>1</td>
<td>5</td>
<td>5</td>
<td>0</td>
<td>69</td>
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<tr>
<td>Minor Injury (Lost Time)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>18</td>
<td>10</td>
<td>12</td>
<td>22</td>
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<td>18</td>
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<tr>
<td>Minor Injury (No Lost Time)</td>
<td>72</td>
<td>167</td>
<td>237</td>
<td>89</td>
<td>96</td>
<td>106</td>
<td>87</td>
<td>78</td>
<td>46</td>
<td>12</td>
<td>990</td>
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<tr>
<td><strong>Total Injuries</strong></td>
<td><strong>82</strong></td>
<td><strong>187</strong></td>
<td><strong>264</strong></td>
<td><strong>129</strong></td>
<td><strong>115</strong></td>
<td><strong>131</strong></td>
<td><strong>112</strong></td>
<td><strong>99</strong></td>
<td><strong>73</strong></td>
<td><strong>17</strong></td>
<td><strong>1,209</strong></td>
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**Injuries to people**

- RIDDOR reportable injuries
- Minor injuries

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- Damaged tendon in foot required surgery

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**Network Rail**
Significant Event Note:

It is important to note that it was a positive indicator that Suppliers culturally moved to reporting events that in most instances did not cause harm or loss but had the potential to. It was through leadership response to these that the Programme was able to learn and act upon issues found to prevent more serious events occurring where there could have been major harm, significant train disruption or damage to property / environment.

In approx. 85% of the significant events there were no injuries to people.
Thameslink Safety Headlines — Life changing events

In 2008 using industries safety performance as a benchmark, the Thameslink Programme predicted that if performance was only as good as the industry standard it was likely there would be two workforce fatalities based on the number of estimated hours to be worked during construction.

On 27th March 2011 there was a stark reminder of this, when a rail worker (overhead linesman) undertaking works as part of railway systems upgrades in the Cricklewood area came into contact with the 25kv overhead power lines whilst working in a Mobile Elevated Working Platform (MEWP) and received life changing injuries.

The Supplier responsible for the works was fined £350,000 following a prosecution by the ORR. They found that the Supplier had failed to properly plan the work and had not provided sufficient instructions to workers. It was found that there was poor communication between the planning and construction teams. The team planning the work did not request for the electric current to be switched off for all relevant sections of the overhead wire.

(Above) Photograph where accident occurred showing overhead power lines.
Thameslink Safety Culture

Southern Capital Delivery — 10 Years of Thameslink
Safety is about people...

At the heart of the Thameslink Programme’s approach to Health & Safety was people. The journey within the Programme always aimed at making safety personal. During the Thameslink Programme Launch Week in 2008 the focus was on ‘pulling together’. One of the events that week demonstrated to the team how by playing their part they could achieve great results. Different musical instruments were given to people in groups and they worked on their instrument, the conductor then brought the groups back together and some great music was achieved. The key message to people on the day was around how they each played an important part in making the Thameslink Programme successful. This continued throughout the 10 years with Health & Safety messages being made personal and period face to face briefings taking place within Programme teams. This was really the start of Culture development within the Programme.

(Above) - Staff at the Pulling Together Event
Thameslink Safety—Leadership & Culture

Safety Culture was part of the Thameslink Programme from the outset. During 2008 and 2009 the Programme engaged with an external consultant and embarked on a Safety Leadership Programme. The leaders of the Programme believed that the underpinning attribute of extraordinary leadership was that leaders were committed to making a difference. The leaders wanted to eliminate worker injury and agreed that they were committed to the Thameslink Programme being safer than the industry standard. The NR and Supply chain leaders agreed that they needed to define and align on a clearly articulated message for those that they aspired to lead which represented joint commitment. The joint commitment was to become the driver for the change in culture needed to deliver “everyone gets home safe every day”.

The initial roll out of the safety culture change programme commenced in May 2008, with a two day Safety Leadership Workshop taking place in June 2008. An Executive level Safety Leadership team (SLT) was formed and launched in July 2008 and committed to meeting monthly and driving safety leadership for the Programme. The SLT then agreed to roll the programme out to individual programmes within the Thameslink Programme which commence in September 2008.

The roll out programme consisted of:

- **Interviews** were held with a range of staff to understand their opinion on the safety leadership style of key managers and leaders within the Programme. The information was important as it would help leaders reflect on their effectiveness as leaders in terms of their safety commitment to get everyone home safe.

- **Surveys** were undertaken to help understand what people working on the Programme thought about health and safety. This would help inform next steps.

- **Reports** were produced on the findings of the interviews and surveys

- **2 day leadership workshops** were held to get Network Rail and Suppliers into the same space with regards their health & safety commitments and to agree action plans to address outputs from interview and surveys

The individual projects then held monthly safety leadership team meetings to drive health and safety and dovetailed with the Executive level SLT. The Executive level SLT continued throughout the duration of the Thameslink Programme and later was referred to as the Directors Health & Safety Steering Group.

(Above) SLT Poster created for each Project within Thameslink. Farringdon Project one shown above.
The Directors Health & Safety Steering Group was formed of Network Rail and Supplier Delivery Directors. The meeting and attendees acted as the focal point for Health & Safety on the Thameslink Programme.

Together the group and the teams they led delivered strategic Health & Safety improvements through a collaborative approach.

The group led on the cultural change as well as the introduction of key initiatives documented in this report including the introduction of the significant event process and the various communication forums with teams.

Safe delivery of projects would be achieved through this commitment.

**DID YOU KNOW that YOUR Project Director meets with Directors from Network Rail and all the other main contractors every 4 weeks to discuss health and safety on YOUR sites?**

**A Directors Health & Safety Steering Group takes place every four weeks and has a single overarching objective of improving health & safety for everyone associated with the Thameslink Programme. All of the key supply chain partners are represented and the meeting is chaired by Tim Crawford, the Network Rail Major Programme Director.**

**Review of Significant Events**

A regular agenda item is the review of significant events that have occurred across the programme as this is an excellent opportunity for learning lessons to prevent similar future events. The lessons are cascaded in significant event heads up bulletins and periodic safety briefs so keep an eye out for these as they can help prevent something serious from happening on your site. If you don’t see these ask your site management team or your Health & Safety Manager.

**Close Call Analysis**

We also review the safety trends across the programme and the information you provide us by submitting don’t walk by’s and close calls allows us to target our action planning, so thank you and please keep telling us when you see something unsafe.

**Focus on Top 5 Risks**

A key focus of every meeting is to check that we are effectively managing the top 5 risks of working at height, electricity, plant operations, lifting and railway access. Working groups are established to review existing processes and procedures incorporating best practice from each organisation. We also regularly visit construction sites outside of Thameslink to find new control measures which we can steal with pride.

**Safety Conversation Training**

This month’s meeting was dedicated to having more effective safety conversations more effective safety conversations with each other in both the office and on site. The concept is that through effective safety conversations, teams can identify issues that could lead to an accident and take action to prevent it. The training is currently being rolled out to the Thameslink Network Rail team. At this month’s meeting the training took place for all the Directors which includes the Director for your team/site. Network Rail is actively encouraging each Director to consider rolling the training out within each of their teams.

**So what does all of the above mean for you?**

Well hopefully you’re more aware of what your Directors are discussing if you aren’t already aware.

We want you to know that we are working hard to drive improvements and recognise the good work and good practices that are in place all over the Thameslink Programme.

The decisions that are being made at this forum eventually will impact on you and your sites therefore it is crucial that if you have concerns or think you know a better way of doing a job that you speak up.

If you have an idea or suggestion that you’d like this forum to discuss, please forward these via your local Health & Safety Manager.

*Article by Laurence Whitbourn, Project Director, K02 Outer Areas & K01 Close Out, Network Rail*
Leaders within the Key Output 2 stage introduced a supply chain partnership which became known as the London Bridge Area Partnership (LBAP). The partnership’s initial aim was to act as the optimal commercial arrangement to deliver the works. A governance structure for LBAP was introduced and a key-performance indicator dashboard was used to measure performance. This covered all aspects of partnership performance and allowed for intervention and support by senior leaders, as well as leading to opportunities for organisational sharing and best practice. The governance and structure were defined by a relationship management plan. The KPI measures were split into hard (e.g. agreed milestones, commercial performance, safety and quality measures, stakeholder management) and soft (e.g. openness, honesty, communication) indicators that helped measure the effectiveness of the structure.

From a Health & Safety Perspective LBAP developed a Principal Contractor Agreement which aimed to ratify the arrangements between Network Rail and the respective Principal Contractors (PCs) in relation to: how all parties would coordinate, cooperate and interface with regards to safely and effectively delivering the respective construction projects within the LBAP in line with the Construction (Design and Management) Regulations. The arrangements covered everything from shared inductions, welfare and access control through to boundary and interface diagrams. It was quoted as safety being one of the best examples of success in relation to collaboration. (taken from ICE article Thameslink programme, UK: collaboration).
Thameslink Safety Culture….Beyond Statistics

Whilst the focus on Safety Culture was part of the Thameslink Programme from the outset, it was in 2013 that the programme team embraced the model that had been established within Network Rail’s HQ Safety Leadership and Culture Change team. The model was based around a cultural ladder from steps 1-5, with 5 being a mature status where individuals take responsibility and lead the way in doing the right things. The ladder was supported by 7 key themes (as shown in the diagram below). This was to become the framework by which all Health & Safety initiatives would fit into and as each was rolled out, the team were able to give the project teams clear linkage back into the culture of the Programme. In March 2014 a number of independently run workshops were held for the Network Rail team however this was further rolled out to Suppliers and their front line teams to get a real sense of culture from office to worksite. As a result of the findings, action plans were put in place. As a result of this focus and action, when the same workshops were run 2 years later the team saw their score move from 3.7 to 4.1 on the ladder, the Programme had collectively moved into a higher step on the ladder thanks to the focus and effort given by Network Rail and the Suppliers to adopt and drive improvement in the 7 cultural themes. This report reflects on each theme in turn highlighting the main initiatives for each.

The Culture Ladder

The 7 themes

- Compliance is a Given
- Fairly Treated
- Risk Aware
- Feel Included
- Desire to Learn
- Free to innovate
- Able to Report
In November 2012 the Thameslink Programme made a conscious decision to replace Planned General Inspections (Safety Inspections) with Compliance Checks. Historical data from accident and incident investigations had highlighted that either the Work Package Plans (WPPs) or Task Briefs (TBS) had either not been in place, were incorrect or had not been adhered to and therefore a focus on compliance checks would help to address this issue. These of course would be in addition to any inspections undertaken by Suppliers. The focus of these NR compliance checks would be to check that the actual risks / controls and methodology were being adhered to what has been documented by the Suppliers. Checks were done to make sure that the Suppliers were undertaking their own Safety Inspections.

**Advantages**

Team members stopped checking things that were already being checked by the Suppliers e.g. toe-boards on scaffolding, fire extinguishers in date etc.

Team members instead checked that the Suppliers had systems in place and were complying with them.

Team members were focused on the risks and controls relevant to the works rather than generic safety issues which were still able to be highlighted.

The approach encouraged conversations between the Network Rail and Supplier site teams relating to the risk from the work activities (rather than just a generic checklist which would have been filled in during a normal safety inspection), this then fed in well to the time2talk process. Team members focused their efforts on checking that the Suppliers were doing what they said they would on site i.e. that they were complying with Task Briefs and Work Package Plans.

**Compliance Checks**

There are various compliance checks that can be carried out depending on type of programme activity:

- ALO
- TBS
- WPP
- Temp. Works
- SSOW

**1. Risk Scoring**

All programme activities are scored according to construction risk and operational risk. Each programme activity that scores above a certain limit is assigned a compliance check.

**2. Allocation**

Each compliance check is allocated to an appropriate member of the team to carry out whilst the work activity is taking place.

**3. Completion**

Compliance checks consist of a series of questions relating to the documentation in place and the work activity itself; including if the two are consistent with one another. They are completed on site with a contractor’s site representative present, and each question is given a ‘compliant’, ‘partially compliant’, or non-compliant’ rating.
Compliance and Culture are linked....

There was a recognition within the Programme that we had to try and deliver messages in different ways if we were to get people to buy into it. We tried to take different approaches so as to get different results. Often stand downs were done in small groups, on projects 1:1 leader and worker safety commitments were made which made safety more personal and not a generic mass delivered message.

An example of a different approached was in the delivery of drugs and alcohol briefings. The Programme used an external person who told the teams ‘how he was going to help them save money and be professional drinkers!’". At the heart of this message was about their own health and safety.

Feedback from teams was amazing and as a result many Suppliers went on to deliver the same sessions to their teams.

(Above) Photos of briefing and images used

An alternative view given on Drugs & Alcohol Awareness

A total of 197 staff attended the briefings held over 3 days in December 2012. This was a briefing with a difference, not based on rules but the:

1. effects on body
2. production of drugs
3. conditions of drug factories
4. dealing with the aftermath associated with drugs and alcohol
The Programme worked with Suppliers to build trust with the workforce and in turn, worked hard to get to the bottom of events rather than to blame the person at the sharp end. Clearly the fair culture needed to be applied but the team made sure this was done in the correct manner and Suppliers and NR teams were held to account. This matrix below was used to establish the root cause of why a rule was broken as part of the investigation process following a safety accident or incident.

Teams used this to discuss with Suppliers actions taken and whether this was fair.
The Programme introduced the significant event process in 2012. The purpose of this was to focus greater attention not only on the actual outcome of the event that had occurred but more importantly on the potential of what could have resulted. This was a key challenge as in the early stages leaders, managers, supervisors and operatives struggled to understand why so much focus was being given to events when there had been no real loss or damage. Culturally there had to be a mind shift on reporting of events and subsequent follow through. The process required real time reporting, leaders to be committed to holding event reviews within 48 hours, remits / investigation panel and timescales being agreed. When the investigation was completed the leaders again committed holding close out meetings to review findings and actions and to commit to an embedment check to make sure that learning had been action and embedded. As at the end of the 2018/19 reporting year, a total of 147 safety incidents between 2012 and 2019 were deemed significant. These 147 incidents generated a total of 928 remedial actions which our Suppliers embedded in their organisations.
One of the key factors in the reduction in the fatality weighted index (FWI) is believed to be the introduction of the significant event process in 2012. Prior to the introduction of this process there was often the tendency to focus on actual harm rather than potential which meant serious issues could easily be overlooked if there had been no significant harm or loss. In the majority (85%) of the significant events experienced after the process was adopted there had been no major loss. However due to the Programme focusing on what could have happened the significant event process resulted in more thorough investigations, action plans and embedment checks of safety events that could have otherwise have gone with little or no investigation previously. This focus ultimately improved the safety of the Programme and therefore reduced further events occurring and therefore a reduction in the FWI was noted.

(Above & Below— Photos of a range of significant events)
The Thameslink Programme was committed to making sure that the people working on it were aware of their health and safety. The aim was to provide them with a safe working environment, and a place where they felt free to raise any concerns so that health or safety could be improved. The commitment of helping everyone get home safe everyday, was reinforced through the production of H&S specific advent calendars. These were given to staff for them and their families to share on the run up to Christmas. A letter accompanied each calendar with a message from the Programme Director. With December being a busy period both at work and at home, simple safety messages behind each door acted as prompts to help remind staff of the importance of staying safe especially at that time of year. Feedback received told the team that often family members would ask “what does that mean?” …instantly families were having safety conversations. These were shared prior to the Christmas periods between 2008 and 2015.

Messages on the calendar

1. Always have a valid safe system of work
2. Use equipment that is fit for purpose
3. Never drive or work under the influence of drugs or alcohol
4. Always have a valid permit to work where required
5. Only enter the agreed exclusion zone when permitted
6. A tidy site is a safe site
7. Always test before applying earths
8. Always wear a seatbelt and obey the speed limit
9. If in doubt, remember to stop work and raise the concern
10. Never assume equipment is isolated, always test before touch
11. Never use a hand-held device while driving
12. Max. 14 hrs a day door to door—fatigue puts you and others at risk
13. Only carry out activities you are trained and competent to do
14. We are working to ensure a Fair Culture on our jobs
15. See someone doing something unsafe…talk to them
16. Reported close calls - help prevent accidents
17. Take responsibility for your own safety
18. Question anything you’re unsure of
19. A briefing is your protection be sure you’ve had one
20. PPE is there to protect you—please wear it
21. Our overall aim is that you return to your loved ones as you left them
22. Exclusion zones protect you—remember ‘Hope Station’
23. Be drink aware—know the limits
24. 2500 Close calls reported—thank you & keep reporting
25. Merry Christmas from the Thameslink Programme
During the delivery of KO2 track and signalling works it was identified the team needed a simple way of carry out a risk assessment if anyone’s shift needed to be extended due to problems or program changes. To make it simple for the Duty Project Manager within the established control room (known as the War Room or gold control) the team produced a pack with an easy to follow risk assessment flowchart and the necessary forms in line with NR/L2/OHS/003 Fatigue Risk Management.

Management of Fatigue – Exceedance Authorisation and Guidance

(Above—front cover of one of the advent calendars)
The Railway Systems team within the Programme recognised that there was a lack of detailed signage at access points. The team believed this could create an unnecessary risk and decided to implement signage similar to that which had been introduced on other parts of the Network e.g. as part of the West Coast Mainline Project. The team identified all the access points that were suitable for use and designed and procured the detailed signage. Once installed the team left the signage in situ to aid future Maintenance access. This as well as other good practices are available on the Thameslink Learning Legacy Website.
Feel Included – Stand Downs

Linked with the cultural work undertaken in 2009 the Directors Health & Safety Steering Group decided that they would commence with a series of safety stand downs and the first would take place in June 2010. A working group was established to run each one lead by Directors from within the steering group.

Core Principles

- Focus minds on Health & Safety
- Set a consistent communication themes across all projects within the Programme
- Deliver key messages to the workforce
- To engender thinking across the projects in relation to H&S
- To review and reflect on the H&S arrangements in place across projects
- To see and hear best practice and improvement required across the projects
- To give a structure approach but with flexibility to include the entire Thameslink community to be part of the stand downs

The working party decided that to make a real difference the stand downs could not be stand alone and as such developed the first 3 as a package. They believed that by adopting this approach it would allow areas to be reviewed in the first part (Look), then in the following months part two (Learn) would be rolled out, allowing the team to learn from findings and take positive actions. It was planned that in early 2011 part three would be rolled out which would facilitate a review and measurement of the actions taken during the previous two stand downs (Check).

Guidance was provided to teams on the aim of the week and what they were to look at. For example in Planning the Work the teams were advised to look at any particular aspects of planning the work that they thought were relevant to their projects including things like Designer Risk Assessments, H&S Risk Register for the Project, Working Areas / Environment, Work Package Plans, Task Briefings, Emergency Preparedness Plan, Access to Work Site, Planned / Unplanned / Forward Plans, Signage etc. Other example gives where in terms of Putting People to Work for example Communications / Briefings, Competence Checks, Supervision, Review of Work Area / Tasks. They were advised to look at Other Factors which might influence behaviours on site which could include Culture / Behaviours on site, Travel to and from work and the amount of travelling time and linking back to how people behave at home.

Whilst each Contractor and project team had the ability to look at what was important or particular to their site, there were a number of mandatory events that were a must during the week which were Emergency Preparedness Plan Review, A desktop review should be undertaken as a minimum to understand what arrangements are in place during emergencies. Safety Tours To be undertaken by Senior Management on sites other than your own. Safety Truck Visit—To run a pre-determined safety culture questionnaire across the projects to gather feedback. This should include the whole range of project personnel.

A toolkit was provided to each project which included Posters to help advertise the week, a DVD to get across some of the key messages, Safety Tour pro-forma to capture feedback on site visits, Safety Tour programme to allocate Companies to sites, Safety Truck programme to allocate the Truck to key sites, Culture Questionnaire to run on sites where the truck would not visit, Emergency Plan Check sheet to provide a guide to a desktop exercise.

An “Orange Oscar” was purchased and awarded after each stand down to one contractor based on the approach and initiatives run during the week.
Feel Included – Stand Downs

The 3 stand down dates were
Stand down 1 “Look”: 7-12th June 2010
Stand down 2 “Learn”: 26th Sept—2nd October 2010
Stand down 3 “Check”: 2011

Some of the feedback from the first of the three safety stand downs is shown below and in the following pages.

Some Additional Events - Farringdon

The Apprentice initiative at Farringdon
Alex a Quantity Surveyor learns the trade secrets from Liam a steelfixer

(Above and right—slides from the feedback sessions on the first safety stand down)

Some Additional Events - Borough

Dumper truck blind spot awareness at Borough
Feel Included – Safety Trucks

The Safety Trucks were used during Thameslink Key Output 1 and were used as another method of engaging with the front line teams. Between 2009—2015 Thameslink booked out the safety truck 240 times with a total of 6235 staff attending various events.

In 2010 during a planned safety stand down week the Safety Trucks were used to specifically run some cultural questionnaires with teams on site to get their anonymous feedback using the millionaire type handsets. The safety stand down week held on 7-12th June 2010 had 708 people take part in Safety Truck events using both the truck and a virtual truck (set up in meeting rooms) from across projects on Thameslink which included Blackfriars, City Thameslink, Farringdon, Borough Viaduct, and Railway Systems.

Truck Visits to Site

240

People Engage

6235

(Above—Safety Truck on site)

(Above—Staff from site on the truck)
Following on from the earlier work of safety stand downs the Directors Health & Safety Steering Group felt the next approach required was bringing leaders, managers, supervisors and the workforce closer in driving improvements. It was agreed that Supplier Conferences would be held to achieve this. A total of 4 suppliers conferences were organised. Each conference had approximately 150-200 participants from over 40 different organisations. The conferences aimed at engaging Suppliers from tier 1, 2 and 3.

The first two run in December 2015 and April 2016 and focused on middle managers, covering topics which included NR sharing the Client’s perspective on safety and performance going hand in hand, Suppliers sharing their perspective on the challenges and opportunities of getting the job done and done safely. Suppliers showcasing areas they had developed such as on line close call systems and dramatisation of safety events.

The latter two held in October 2016 and May 2017 focussed on project teams and the workforce. These were more interactive and utilised practical demonstrations covering items such as Driver awareness run by Bridgeway, Plant demonstrations and simulator run by Lynch Plant, Health & Wellbeing sessions, PPE showcases, Tethering of tools, Dust extraction systems for tools, Cable avoidance tools, watches to measure hand arm vibration and many other items. Feedback was always extremely positive from attendees and it helped drive improvements and make teams feel they were included.

(Right—One page feedback communications were sent out for the Thameslink Programme so that people throughout the organisation were aware of the event, the focus, feedback and outputs / improvements from the day).
Feel Included – Suppliers Conferences

The four conferences involved a wide range of personnel including Project Directors, Works Managers, Supervisors, Project Managers, Engineers and Health & Safety professionals. The days were always planned to be interactive, giving those attending the opportunity to network with suppliers and experts in areas of health and safety. Feedback from culture surveys, accidents and other areas informed the planning for the events with themes targeting:

- Supplier perspective—sharing the challenges and opportunities to get the job done and done safely.
- Dramatisations of safety events including leadership communications driving behaviours on site and fair culture
- Manual handling demonstrations and opportunities to try lifting equipment
- Different tools on the market for dust extraction / cable avoidance, HAVs monitoring, tethering of tools etc
- Drug & alcohol awareness (stories and real life experiences shared by a drug expert)
- Health including mental wellbeing, stress, healthy eating and health assessments including nurses on site to undertake tests and a Comedian to deliver talks in a funny way about a serious matter—men’s health

*Left to right* Project Director trials digger simulator, Commercial Manager checks out products being demonstrated, Drug awareness stand and Comedian talking about men’s health
Thameslink introduced this bi-monthly publication in May 2013, aimed at communicating to front line staff as well as office staff. The main idea of the newspaper was to informally get information to workers in a format that would appeal to them and which could be easily understood. There were 25 issues published and all contained a variety of serious and soft topics ranging from beaches of lifesaving rules, fair culture and general positive communication on safety, healthy & wellbeing. Below are the covers for issues 1, 16 and 23.
Desire to Learn — Shared Learning

Thameslink was split into 2 key stages which were Key Output 1 and Key Output 2 (KO1 & KO2). Near the end of KO1 (during 2012) a number of workshops were held to understand the lessons that could be learnt and transferred onto KO2. Approximately 150 contractors & NR staff attended these workshops. The key H&S lessons learnt were drawn out and shared with Network Rail and it’s key Suppliers who formed the Thameslink Directors H&S Steering Group. Lessons learned experiences gained in KO1 have also been actively adopted by KO2 in many areas due in some instances of personnel working on both phases and transferring the learning naturally. Where feasible these were built into process and systems.

A key element of the significant event process that was introduced was the requirement for a lessons learnt to be issued following the closure of an investigation report. These were one page documents used to communicate the main causes and actions taken for the significant event. The key element was to share the event, findings across the Programme and the wider Network Rail and Supplier team so as to help others learn. It was also then used as a planning tool so that future works would not make the same mistakes. Meta data on the lessons learnt was agreed entered into a search tool in the document control system so that projects could easily find relevant lessons learnt to prevent a repeat event when undertaking similar works.

The Thameslink Directors H&S Steering Group used these to discuss events which in turn fostered a more collaborative approach to reporting and investigation of safety events which further embedded safety in the culture of the project teams and delivery partners.

Since the inception of the significant events process, a total of 99 shared learnings were issued. These shared learnings have been communicated round the programme, to our suppliers and to Network Rail and the rail industry through the Safety Central website. They are also available on the Thameslink document control system and on the Thameslink learning legacy website. A meta data search tool was developed on the document control system to help Project Managers find relevant learning.

1st Lessons learnt issued in Dec’12

Changed to ‘Shared Learning’ in line with other parts of Network Rail

eB search tool with meta data developed to provide a search tool to help Project Manager find relevant learnings.
Desire to Learn — Time2Talk

Time2talk was a Network Rail initiative (nationally known as safety conversations) adopted by Thameslink Programme to complement other safety processes and initiatives with the aim of promoting challenging, inquisitive conversations about safety with a view to improving safety performance. It was aligned to our vision of ‘Everyone Home Safe Every Day’. Time2Talk encouraged participants to investigate further their understanding of project processes and procedures formed on the basis of the ‘layers of protection’ defined in the ‘Swiss cheese’ model.

The basic premise was that safety events once investigated shine a light on gaps / holes in the management system or behaviours of those involved however time2talk was about identifying these through asking open ‘coaching style’ questions to help find the gaps / holes and plug them rather than wait for a safety event to occur. It was encouraged to plan the conversations in advance to determine what the aim of these were. There were three main categories:

- Motivation – for example, what human factors are influencing behaviour
- Verification – for example, what practices are being adopted and whether there is compliance with process
- Education—for example, where the coach is simply trying to understand a process in more detail

The Programme initially utilised the services of an external organisations to run the events however it was later recognised that the Programme’s own health & safety team could give valuable insight and began to run their own internal training for staff. An external organisation was used to develop of supporting animation to help with the training sessions.

Further information is contained within the Reporting Culture section.
The London Bridge Project being part of Thameslink Key Output 2 recognised that their safety performance had improved from the initiatives within Thameslink and also through their own learning as a project from when it commenced in 2012 however in 2017 with 2 years left to complete the works the team decided to launch time2focus.

Engagement levels had been good for Thameslink Programme. However, there were several key challenges. Until 2017 Time2Talk was being mandated for the team but focussed on topics of their choice. There was also a risk that safety incidents could see an upturn as the project entered its final stages. With the end of the London Bridge Station Redevelopment project coming into sight, the management team were aware that resources and commitment would continue to decline and that other projects in the programme had suffered an increased accident frequency rate in the latter stages. (see graphs below). Armed with this prior experience, where there was a significant increase in incidents at the end of the project, the management team wanted to ensure that we actively reduced the risk of an increase in safety incidents. The key factors were identified as:

- Resources (the project would start to demobilise and so less people would be engaged on Time2Talk)
- Engagement (those remaining may be increasingly concentrating on future assignments and attention may drift due to the nature and stage of the project)
- Quality (that ultimately the quality of engagements would be less effective as a result.)

Mindful of these challenges, the London Bridge Redevelopment Project wanted to improve the targeting and engagement by launching a new campaign to place an emphasis on a periodic topic, pairing team members up to ensure good quality conversations and coverage. The team devised a risk based approach for conducting Time2Talk which would provide a framework for future engagement. This was called **Time2Focus** and was linked to key relevant schedule activities so that our period focus was always on the highest risk priority at that time.

(Right—graph shows safety performance at London Bridge was significantly better than at Blackfriars however the focus was on not spiking as Blackfriars had at the end of the project)
Desire to Learn — Time2Focus cont’d

Time2Focus was a series of Lunch & Launch events which were aimed at educating people in the team on a particular subject matter in terms of processes, standards, and safety events that had occurred on the project and the actions already taken. The subjects were linked with the remaining works so that focus was given at the right time. Each period there was a lead from NR and the Supplier who arranged a formal presentation at the lunch event. Those in attendance were advised how they could personally help verify the standards. Members of the NR and supplier teams were paired up at these events to undertake a walkout and time2talk around the chosen subject - this was good for both education from both sides and collaboration. At the next period event the learning from the previous subject would be shared. This meant each period the teams were given the opportunity to investigate and report on their findings so continual improvements could be identified and acted upon.

The event each period also linked with behavioural theory in that positive recognition and talking about safety in a positive way could lead to more engagement. It was used as a way to celebrate success and recognise the difference people had made during the period through their efforts.

The first subject covered was ‘temporary works’ which took place on 27th June 2017 and was attended by approximately 60 people from the Network Rail and Supplier teams working together at London Bridge. As a result of the focus on temporary works there were 155 close calls raised and 51 conversations held. The team learnt that whilst some improvements could be achieved through improvements in the processes around temporary works that the main issue was in relation to behaviours around implementing the process. The work on this subject continued for several months after the time2focus to address the findings of the focus.
Time2focus continued from June 2017 through to September 2018 with subjects covering temporary works, work at height, lifting, utilities, small tools, electrical systems, controls (operating systems), logistics / site control, slip trips and falls & housekeeping and small tools. It was evident that these sessions helped increase the overall team awareness on these subjects and that it also helped focus attention for close calls and time2talks on the subject.

(Above — data showing increase in close calls and time2talks due to time2focus)
Desire to Learn — Site Eye

Site Eye was set up as a monitoring system for sites across Thameslink to monitor progress and capture a timelapse video. It was not a health & safety tool however it was useful in some instances after a safety event had been reported and was in some instances useful in providing information for the subsequent investigation.

Site teams however became wary when they knew that management had access to check cameras. It didn’t help when on one occasion a member of the team was seen to have breached work at height controls and an investigation commenced into it. The management team had to work hard with the on site team to not focus on the fact it was found as a result of the camera but instead on the fact that someone put their lives unnecessarily at risk.

Subsequent communications about the event did not use the time lapse photo to remove that from being the focus.

(Above—photo of site marked with unsafe working situation)
The Thameslink Programme encouraged proactive thinking amongst project teams and Suppliers to develop and introduce new approaches to improve health, safety and wellbeing. These good ideas were shared through the Directors H&S Steering Group to encourage the sharing of ideas. Between 2014-2018, a total of 43 Good Practices were produced.

During KO1 the Network Rail Health & Safety team with input from key suppliers produced learning on a periodic basis and shared this across the Programme via the HSEA cascade pack to share what each project was doing in terms of positive safety. Examples of good practice can be seen in the following pictures.

In 2014 a new approach was introduced and one-page good practice sheets were developed and shared similar to the one page lessons learnt from significant events. These were also a way of making sure that safety communications were balanced and some positive reinforcement messages were being issued out to the teams.

**Good Practice - Blackfriars**

- Working on the track of a lorry is assisted by having suitable access. Puddled steps prove to be an asset on and off a lorry.
- The use of strapping lets the operatives know where the edge is and serves as a timely reminder.

**Good Practice - Railway Systems**

New information signs have been fitted to Access Gates at the 12 most used access points.

These signs will include additional information such as alias names to help COSS’s identity they are at the correct location, which has been an issue in recent irregularities.

**Good Practice slides shared during KO1 as part of the Health & Safety brief (HSEA Cascade pack)**

**Thameslink Programme Health & Safety — Good Practice 001**

‘Thumbs Up’ signage on Moving Plant & Machinery

**Overview/Description**

Vehicle movements were identified as one of the top 10 risks & safety risks across the Thameslink Programme. This, in turn, contributed to a significant number of major injuries within the construction industry.

The Health & Safety teams were able to reduce this by developing the ‘Thumbs Up’ signage. The signs are situated on the stand of all plant & machinery to act as a prompt for the person operating the plant.

**Benefits**

- The concept originated from the Contractors who have introduced the same campaign on their other work. This now comprises of an integral part of the corporate awareness programme.
- The signs are also shared between plant operators and personnel, which has been enhanced from one machine to another easily.

As the Programme progressed into KO2 the slides were replaced with one page communications to share good practice.
As can be seen from the photo below, the Thameslink Railway Systems team recognised that railway wagons often arrived on site with materials that required un-strapping. This often resulted in workers having to climb onto wagons. As can be seen there was also no edge protection. The team therefore had a challenge to change behaviours. In conjunction with the National Supply Chain team the team arranged for any strapping to be accessible from the edge of the wagon. This meant that the team therefore had no need to climb on top however there was still a challenge for them to reach the strap. The team then worked with the Track Safety Alliance (TSA) to develop specifically designed collapsible step ladders to provide safe access to unstrap.
Able to Report — Predicted vs Actual from 2009—2019

At the start of the Thameslink major programme, industry predictions were made on how it would perform in the field of health & safety using formulas that incorporated trends and information from around the construction industry. Below is the prediction based on the Bird Triangle and on the right is what was actually reported from 2009—2019. Positively the Programme actively engaged the people within the Programme to report safety concerns and issues reducing overall risk. Importantly, the Programme injured 66% less people than predicted overall. That said, there was a significant number of major injuries however approximately 50% of those occurred early in the Programme prior to the increased focus on Health & Safety, Leadership, Culture and processes such as the Significant Event Process.
The predicted triangle was used at the outset to focus the attention and get the team to understand the importance of knowing the lower level issues and actioning these to reduce the more serious events occurring. Some Suppliers developed online systems to make reporting and feedback easier. The graph below demonstrates the level of engagement with close calls and how this improved throughout the Programme. The decrease in 2018/2019 was as a result of the Programme nearing completion.
The feedback on close call reporting often stated ‘nothing ever gets done about them’ or ‘they disappear into a black hole’. As a direct result of this feedback Railway Systems Supplier Balfour Beatty together with the Network Rail team introduced close call feedback stations in site cabins (see photo below). These were introduced to build confidence that action was being taken. Meanwhile other Suppliers such as Costain developed on line reporting tools that provided feedback directly to those that opted to submit an email address alongside their close call.

However, there was also a behavioural change required in that some close calls could be actioned at source. The Programme developed promotional images and materials such as pens and mouse mats which were used alongside presentations to educate teams that if it was safe for them to fix the issues they should.

(Above—The Programme developed promotional images a which were then utilised by other parts of Network Rail

(Above) Network Rail & Balfour Beatty feedback stations on site
The teams also recognised that if they developed online systems it could make reporting and feedback easier, with the key being on the actions taken to resolve the issues found. This was taken a step further as it progressed and stand-alone machines were implemented on the London Bridge project by Costain to give their on-site teams access to a direct system to report. They also used their free wi-fi login area in their canteen to make sure when staff used the wi-fi that the first page they saw was the close-call page in a bid to remind their teams they could log close calls from their personal phones too. The management team recognised that this also had additional benefits of saving lots of unnecessary admin time. The case study is on the Thameslink learning legacy website.

(Above) Costain took on-line systems a step further and placed electronic machines throughout their site for reporting close calls real

(Above) Costain presented the admin benefits at one of the Supplier forum
To get further below the surface in the triangle Thameslink rolled out its safety conversation initiative - Time2Talk in 2015. Using an online system the team were able to capture the safety conversations they were having and the safety team were given not only another means of capturing safety trends but also having engagement with the programme on these issues as the system allowed the H&S team to feedback and engage with the individuals submitting these. This was one of the key successes as the conversations were not just going into a black hole. Someone was reading and responding to them. The focus was still on the individuals taking action but the H&S team were able to capture information and use this in discussions with Project teams. The response to individuals also helped coach them. In order to promote understanding of the initiative and drive engagement, the safety team ran multiple workshops. In all, 307 people attended workshops with roughly half of attendees going on to hold at least one Time2talk. Some teams embraced this more which often was a result in the leaders believing in the cause and driving their teams but as they culturally improved some teams were doing this as they could recognise it was the right thing to do. Analysis undertaken proved that the teams who were more engaged with time2talks and close call reporting had better H&S performance.

(Above—posters developed to help communicate and educate the team on Thameslink which was supported by training)
As can be seen from the graph, a significant improvement in safety performance was achieved during the Thameslink Programme journey. From 2012 there was a shift change in the approach with safety culture being the umbrella under which a number of key themes were used to drive improvements. This report aims to outline that journey and the stepped improvement.

The graphs above shows the 10 year safety performance of the Programme and uses the Fatality Weighted Index (FWI) measurement. FWI is an industry measurement that was used to monitor safety performance. Injuries that are of a significant nature are weighted higher, providing a gauge of safety performance that can be measured.
This report serves to highlight some of the work done by the Thameslink Programme. The Thameslink communications team has produced a legacy website for the programme containing more information about the work done for health & safety on the programme is available from:

https://www.thameslinkprogramme.co.uk/learning-legacy/health-safety/

Thameslink Programme has been a major contributor to Network Rail’s strategic objective: Providing a safer, more reliable railway through delivering enhancements to the network that increase its capacity and capability. The vision and objective was to send everyone home safe, every day.

As well as safety, health and well-being were both key themes for Thameslink Programme. National standards for occupational health were embedded across the supply chain to improve the health of the workforce.

Continuous improvement was also essential to eliminating harm in our workplaces. Today’s world class performance is tomorrow’s business-as-usual. This Health and Safety learning legacy is intended to share with others the good practice and lessons that we learnt along the way.
Conclusion by Duncan Wilkes, Project Close Out Director

Over the ten years that the Thameslink Programme has delivered its on-site works, the ability to grow and learn has been paramount to its success in terms of Health & Safety. The early processes evolved and with that the Programme had to change, educate, continually assess and feedback to those involved. This facilitated cultural improvements and demonstrated what can be done by allowing the time and space and how the compliant environment can grow into one where people take responsibility and drive improvements. None of the cultural and behavioural successes would have been possible without the partnership between Network Rail, its Suppliers and the workforce.

The maturity shown around safety events that occurred and the fair way they were investigated allowed an environment to be created where the consequences were positive rather than negative. This approach nurtured a growing awareness amongst the workforce, management and leaders and there was gradual confidence in the on-site teams and a belief that their efforts made a real difference. Engagement of teams through briefs and two way interactions led to them being actively engaged in participating in safety conversations, close calls, lost time reporting, fair culture, good practices, and safety stand-downs. The teams could see the benefit! This ultimately led to the actual safety record being better than that predicted from the outset. This was key to creating the environment to allow cultural change.

I reflect back on the Thameslink journey and I am proud and humble that I am able to say that I have played my part but equally to put on record a thank you to all our staff, past and present, and to all our suppliers and their people for all that they have contributed to make the Thameslink Programme the benchmark for health and safety for all future major infrastructure projects and programmes.