Final Report:

Case Study Policy Themes

Prepared for

Independent Taskforce on Workplace Health and Safety

by

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Introduction

This report provides a thematic overview of results from eleven workplace case studies of health and safety practice[1]. The case studies, completed during January-February 2013 were undertaken for the Independent Task Force on Workplace Health and Safety in order to provide 'lived' experience of health and safety systems in New Zealand workplaces. In particular the case studies sought to:

- look at the nature of health and safety systems operating in NZ workplaces
- look at how health and safety representatives operate in workplaces and how managers and employees interact with regard to health and safety
- consider how these are influenced by the size of the workplace, nature of industry, and organisational form.

A brief outline of the methodology used to conduct the case studies is provided below. This is followed by an overview of key themes emerging from the case studies (Section A). Lastly comment is made in relation to the themes being developed by the Taskforce as it considers final policy options (Section B). The report is not a comprehensive analysis of the case study findings but aims instead to provide an overview of findings to support the Taskforce's policy deliberations.

Overview of Methodology

The organisations participated on a voluntary basis. Most were identified by the Taskforce members, and approached by the researchers. An initial sampling frame sought to include a mix of up to 12 organisations including:

- those with fewer than and more than 30 employees
- those operating in priority industries of agriculture, construction, fishing, food manufacturing, forestry and metal manufacturing
- those operating in service industries such as health, personal care, local body
- a range of business models, including enabling consideration of health and safety management in the supply chain.

Table One below lists the case study organisations for whom case studies were completed, the number of employees they have and the sector in which they operate.

[1] Ten individual company case studies are provided in a separate report. Themes from the eleventh study are incorporated in the overall analysis in this report but due to a change in business structure, it was not possible to complete the study or have it approved by the company. It was a large company.

Table One: The Case Study Companies[2]:

Organisation	*Number of employees*	*Sector*
Goodman Fielder NZ Ltd	2000+ (1000+*)	Food manufacturing
Sealord Group Ltd	1000+	Fishing and fish processing
Tauranga City Council	522	Local government
Nelson Pine Industries Ltd	206	Fibreboard production
Hayes International Ltd	70	Engineering
Pullin Shearing Ltd	25 (125*)	Shearing
Contract Coatings Ltd	32	Building and construction
Reds	10	Hairdressing
RAL Logging Ltd/ Rayonier Ltd	10	Forestry contracting
Pye Southstream Dairy	5	Dairy farming

(*) = additional non-permanent workforce

The case studies were undertaken during January-February 2013 and involved between ½-2 days onsite data collection using semi-structured interview schedules. Between 4-31 individuals[3] were interviewed either individually or in groups in each organisation and in some cases researchers observed others engaged in health and safety meetings or other activities[4]. Interviewees held a range of roles, as set out in Table Two.

[2] Companies were provided with initial information about participating, including that their participation was voluntary and that they had the option to withdraw their consent to participate or have their case study reported anonymously.

[3] All interviewees gave their informed consent to participating.

[4] This was also supplemented in some cases with phone interviews where key people were unavailable.

Table Two: Roles and numbers of case study interviewees

Role	***Completed interviews***
General/senior managers	23
Health & Safety specialists	15
Line managers/supervisors	47
Health & Safety &/or union representatives	24
Other workers	40
TOTAL	***149***

Interviews explored how health and safety systems were operating in that workplace and interviewee's views on health and safety. Documentation on the operation of each company's health and safety systems was also collected from each workplace and in some instances interviews with external company advisors/service providers (e.g. a farm safety expert; occupational health nurses), and a contract principal were completed to inform the case study.

As agreed with the Secretariat the case studies are constructed using a set of common headings. A draft of each case study was provided to and subsequently approved for provision to the Taskforce by the organisations concerned.

It might be expected that companies that are willing to volunteer for a study such as this have a reasonable level of confidence in their approach to health and safety. This suggests that the case study companies are likely to reflect the 'better end' of practice in New Zealand.

Section A: Research Overview

This section provides a brief overview of the themes emerging from the findings in relation to the research questions about:

- the systems for health and safety management in the case study companies
- the approaches to employee participation and engagement
- workplace health and safety culture.

As a result of the analysis of the case study data a schema has been developed that categorises the practices employed by companies into different stages along a continuum: emergent, maturing and mature. Using this schema does not mean that companies can be said to only have practices that are mature (or otherwise) in every way, but that their practices fall into one end of a continuum of practices more so than another.

What helps companies to move along the continuum to increasingly mature practices? Each of the case studies has a story about their progress: for some a serious harm incident prompted a 'never again' heart-felt commitment to doing what it takes even though they had thought their systems were robust. In others, leaders passionate about their business being the best in health and safety has usually gone hand in hand with those leaders also playing a lead role in their industry on health and safety. Some of the workplace leaders have come from overseas jurisdictions where they say regulatory requirements are stronger and that has motivated them to do better than the minimum. One feature that stands out amongst these firms is that by and large they have not put a cost on good systems – they are a non-negotiable. The lives, safety and wellbeing of their employees are paramount to the business.

Health and safety management systems

All of the case study companies had well-documented health and safety systems that clearly identified processes and procedures for hazard identification and control, for reporting incidents and facilitating employee participation. These systems were all significantly influenced by standards set externally to the company. In the case of eight companies their tertiary level accreditation with ACC Programmes provided an external benchmark and three met audit standards required for compliance with AS/NZS 4801 for occupational health and safety management systems (two companies held both). Two of the smaller companies did not hold either of these accreditations although each of these effectively used external benchmarking, for example the hairdresser customised an industry association developed model, and the dairy farm had a farm safe expert to advise on their systems development.

The practices that sat behind the systems varied depending on organisational leadership and the timeframe over which the system had been operating. In all the workplace case studies an individual, usually a senior manager, was identifiable as having instigated the system, taking it in a new direction or championing the lived

systems in a very discernable way. The case studies show that having leadership of health and safety at a senior level had a number of features which led to approaches to health and safety moving past compliance to being integrated into every-day practices at work.

Where managers make health and safety a priority, it results in more attention being paid to it by other managers and also means that resources are made available for the implementation of improvement initiatives. Most importantly it leads to the emergence of health and safety champions and emergent leaders at other levels of the organisation, incorporates accountability, and focuses on behaviour. The result is that all employees, individually and collectively take ownership of health and safety outcomes.

One of the aspects of practice that the workplaces themselves were conscious of as their systems matured was a move from systems that were reactive and focussed on investigation of incidents, to ones that are proactive and focussed on prevention of harm. Several of the workplaces that had more mature systems noted that when they started to get serious about health and safety, they had begun to take a much more robust approach to the investigation of incidents, and ensuring that corrective action was taken to avoid a repeat occurrence. Over time, this attitude changed – in part because fewer incidents were occurring. Rather than sit back, however, the workplaces had moved to becoming more proactive, and taking a preventative approach by focussing more on investigation of “near misses” and risk assessment processes. Several of the workplaces had risk assessment matrices in place, where potential hazards are considered against the likelihood of their occurrence and the consequences if they did. In addition, these workplaces had a greater focus on thinking about work organisation and safe work practices as a means of controlling hazards.

A second area in which workplaces with more mature practices were conscious of having changed over time was in relation to the regularity with which staff and managers are engaged in conversations about health and safety practice. Several of the case study firms had long standing health and safety committees in place, some of which had been in existence for over ten years. However, they noted that over time, the way in which these committees operated had changed from being the only place where health and safety was discussed between managers and employees to being a place where actions that are being taken are formalised. Managers and health and safety representatives were talking about health and safety on a daily basis, and the nature of those conversations is characterised by a mutual concern to achieve the same outcomes.

In addition to the frequency with which managers and employees talk about health and safety, they appear to establish more channels through which health and safety is discussed and elevate its importance as an item for discussion. This can be seen throughout the case studies in the establishment of health and safety committees at different levels of the organisation with information flows going up and down, new forums being established, putting health and safety as an item on the agenda of existing meetings, and ensuring that health and safety is the first agenda item.

Overall, the case studies show that putting in place a health and safety management system is not a one-off event. The dynamic nature of work processes, responses to evolving technology, demographic shifts in the labour market, and changes in business models as firms seek to improve their competitive edge all require constant attention for their impact on health and safety. The workplaces that are most successful at doing this have systems in place that are alert to potential new hazards, understand the conditions under which existing hazards can become more or less hazardous, have a continuous conversation between employees and managers about hazards and risks, have mature employment relationship practices and treat employees as adults.

Employee participation

Employee participation has generally been recognised as one of the essential components of the Robens model, but did not become part of the New Zealand regulatory system until 2003. As noted earlier, some of the case study workplaces have had systems in place for health and safety representatives since that time, but the evidence from the case studies would suggest that how they work is somewhat different from that envisaged by the legislation.

Employee participation in the case study companies took two forms, which was largely dependent on the size of the workplace. In the smallest workplaces, employee participation generally took the form of open communication between managers and employees, with good communication being based on good employment relationships and an attitude of mutual respect. As workplaces increased in size they were more likely to have structures in place (e.g. health and safety committees) that employee representatives had formal input into, but these were still largely based on good communications and open dialogue. In systems relying on good communication, employee participation was commonly reactive. Although employees and their representatives might make suggestions for improvements, they are still largely management driven.

The second form of employee participation involved having health and safety representatives with formal responsibilities that involved them in interactions with both other employees and managers. Commonly, health and safety representatives were located in a functional area at the work place – for example, representing a particular team, or shift or physical location.

While the legislation envisages the election of health and safety representatives, the evidence from the case studies is that these are largely pro-forma. More commonly, individuals are approached or “shoulder-tapped” or volunteer. An election may be held, but these are usually uncontested. There are a number of advantages for workplaces in the way that the systems operate at present – it guarantees that health and safety representatives have an interest in the issue, and where people have been shoulder-tapped it is often for a logical reason such as being in a position to have contact with a large number of employees or being in a job where they are in a good position to have a positive influence on health and safety. In some workplaces, health and safety representatives had considerable tenure in the job, and had built up a wealth of in-

depth experience; while in others representatives were deliberately rotated in order to build up the depth of experience across the workforce as a whole.

Where systems were in place, the range of responsibilities undertaken by health and safety representatives varied. In all the workplaces, they had a role in hazard identification and control, and usually played a part in investigating incidents when they occurred. In some of the more mature workplaces, their role extended beyond this to (depending on the workplace) monitoring safe behaviour in their teams, performing spot checks on contractors, being part of discussions with ACC and the Labour Inspectorate when visits took place, participating in decision-making on health and safety capital expenditure and being involved in strategic planning on health and safety issues.

The range of responsibilities undertaken by health and safety representatives also impacted on the amount of time that was required to perform the role. In the case study workplaces, all of the companies recognised the role of health and safety representatives as being work that should be undertaken in paid work time. While some health and safety representatives found their role onerous (particularly where systems involved a lot of paper work associated with hazard identification and incident reporting), a surprising number of representatives, when asked how much time they spent carrying out their duties, replied that this was something they did “all the time”.

In companies with health and safety representatives, a variety of training regimes had been put in place. Virtually all companies had trained their representatives to Level 1 of the Health and Safety Representatives training and a small number had enrolled representatives (and in one case, managers) to Level 3. What was more common was participation of representatives and managers in industry or job-specific training that enhanced their skills in being able to both identify hazards and corrective actions that might be needed to address them.

Analysis across the case study workplaces suggests a variety of factors associated with systems for employee participation that work well. Most fundamentally, successful employee participation requires an approach to employment relations by management that respects and values employee voice. This was evident from case studies where managers described health and safety representatives as their “eyes and ears” or where managers perceived representatives as having added so much value that they were intending to increase numbers of representatives and the amount of money spent training them over the coming years.

The training of employees in health and safety issues was also seen as being crucial. This was true both for health and safety representatives and for managers. Training was seen as enhancing alertness to health and safety issues and how to resolve them. Industry specific training was seen as most valuable for identifying hazards and issues that might not be evident or thought about – particularly in relation to long-latency occupational health issues and new technology. This was true even in small workplaces and in lower-risk industries.

A last comment is made about the role of unions in relation to health and safety representatives. In each of the case study workplaces, health and safety

representatives were asked about whether there were union members and/or delegates, and how much information they received from their union in regard to health and safety matters. Around half the health and safety representatives were also union delegates, but few had positive comments on the support they received from their union.

Overall, the case study research demonstrated that employee participation is still important for the successful implementation of the Robens model. Those models have needed to be customised for the smaller size of many NZ workplaces, the changing nature of the labour market and a more diverse workforce. Involving employees in health and safety management – whether through formal systems or simply by open communication processes - remains fundamental for improving health and safety outcomes.

Workplace health and safety culture

The health and safety culture of workplaces has emerged as a crucial issue from the case studies. This is not surprising as it also emerged as a dominant theme from the consultations undertaken by the Independent Task Force. Some of the themes that were evident through the consultation process were repeated through the case studies – in particular, a macho mentality, the encouraging of risk taking behaviour, the "Number 8 fencing wire" approach to work, and a "rip s**t and bust" attitude. At the same time, other aspects of NZ culture were starting to take hold – the importance of families and communities, and of sending workers home safe and in one piece to their whānau. It was these aspects that were seen as being crucial to changing the culture of the workplace to one that took health and safety seriously.

In retrospect, the challenge for many of the workplaces that had mature systems had been changing culture. In some ways, developing systems for managing health and safety was relatively easy, but ensuring that this became embedded in the operations of the organisation had been much more difficult. There were a number of strategies that had been employed to achieve this, including:

- Investing in health and safety training for all employees
- Putting in place reporting systems with KPIs around health and safety
- Including health and safety outcomes in management accountabilities
- Including breaches of health and safety rules as grounds for misconduct and serious misconduct
- Encouraging employee participation in all aspects of decision-making around health and safety.

However, these practices were very much the mark of emerging systems. As systems became more mature, practices became embedded in ways of working. This included:

- Workers say that they think about health and safety all the time and are knowledgeable about how to keep safe
- Health and safety takes priority over meeting production targets, even where this is not an easy balance

- Workers are aware if they are taking shortcuts or risks and do not feel comfortable about this
- There is a 'no blame' culture to reporting and workers are comfortable reporting unsafe practice and reporting incidents and near misses
- Clear, unequivocal messages and practices
- Very low tolerance for poor safety behaviour throughout the organisation
- Good data is collected, analysed and used to inform actions.

One owner put the change process like this '*it's very scary for a business setting up a WSMP system, where you invest so heavily in management, and you do all that, and suddenly you've got to take your glorious little plan that you've come up with, and change and empower your staff to have ownership of it … you've got to have a culture change in your staff so that they become receptive to your ideas, value it for themselves and see how important it is*.'

It was argued by some that taking more of a risk assessment, rather than a hazard control approach to health and safety would help raise consciousness of health and safety as a more dynamic issue. Some workplaces had risk assessment processes as part of hazard control but were concerned that hazard control can lead to a false sense of security and can be less effective when people are fatigued and/or working long hours. They suggest risk assessment encourages workers to 'think ahead' more, to take more personal responsibility for their own and their workmates' safety and can more effectively facilitate recognition that risks change as conditions change.

Section B: Policy Themes

This section reports on the key policy themes of concern to the Taskforce as they emerge from the case studies. The themes addressed from the case studies concern:

- Employee participation
- Capacity and capability
- Occupational health
- SMEs/Supply chain[5]
- Population groups
- Workplace leadership
- Data and measurement.

In all eleven case studies there are examples of excellent health and safety systems and practices. The extent to which these had filtered through companies and were part of everyday business practice varied according to the length of time in which the systems had been in place, and the leadership that had initiated, led and enabled a health and safety culture. As such the features of the systems that were observed are described on a continuum of development.

[5] These themes have been grouped as the issues identified for SMEs were also the flip side of issues identified by larger companies who subcontract SMEs in their supply chain.

These are labelled as emergent, maturing and mature practices. In each of the policy theme areas below there is a description that summarises the approach at each of the three levels of maturity, based on the evidence collected from documentation and interviews. While the themes are set out as distinct areas of practice, across the range of practices as a whole there are overlaps and dependencies, the most significant of which concerns leadership practices.

Companies also exhibit varying levels of maturity in relation to the different themes. In other words they may have mature practice in one area, but may be maturing in others. Each section below begins with an outline of the key feature exhibited along the continuum to the most mature. This seeks to provide a framework for the descriptions of actual practices amongst the different case study companies. Each section concludes with a summary of key issues for policy consideration that arise from this research.

Employee participation

Key feature of practice in each stage:

Emergent Practice	Maturing Practice	Mature Practices
• Good communication across the organisation for discussing health and safety issues • Employees involved in hazards identification and control and incident investigation	• Systems are in place and support employee involvement	• Employee representatives are involved in all aspects of the health and safety system (including decision-making) and all employees own their role in health and safety

Case Study Company Practices

Employee participation refers to both the existence and involvement of employee health and safety representative structures and the participation of all employees in a company. The extent to which health and safety representatives were representative of a particular group varied. For most companies representatives were representative of particular functional groups in the company (e.g. a product line in a factory). In some case representatives formally represented union members. Using the framework above the employee participation practices observed in the case study firms are discussed below.

The diary farm and hairdresser demonstrated emergent practices. The former is new to a formalised and documented approach to health and safety. They have a newly appointed health and safety officer and workers have engaged in the new development process with interest and responded well to the external advisor who assisted them as they felt he understood their situation. Similarly, the hairdresser had recently developed a comprehensive health and safety manual, based on best-practice industry standards.

Three of the companies could be described as having maturing practices with regard to employee participation. These companies have effective health and safety committees operating at operational, and in some cases, other levels in their companies. Two of them have annual elections for representatives, while the third encourages anyone

who wants to be a representative to do so[6]. Health and safety representatives in these firms have all completed training at Level 1, have developing knowledge and are said to play a particularly key role in coaching and training their colleagues around health and safety. Health and safety committees include staff and management and while most have consistent membership, there was an example of some managers in one of the larger companies delegating their responsibility. In one of the companies 'guests' (workers) are invited to meetings so as to lift overall knowledge around health and safety systems.

Amongst the firms with the most mature practices there continues to be a range of practices. Along with specified processes for participation the practices amongst this group tend to demonstrate a higher level of 'ownership' amongst health and safety representatives and amongst staff more generally. The most distinctive feature in achieving this ownership is the degree of leadership exhibited in the company; health and safety is integral to the business and its mode of operation, there is a well articulated understanding of that throughout the company, and an unequivocal lack of tolerance for poor practice. These firms have and continue to explore a range of ways to effectively engage workers. Some of these are:

- Having health and safety representative work recognised as part of a person's job to be undertaken in work time has supported longevity and increased competence
- Annual worker vote has endorsed rotation of health and safety representatives on health and safety committee, which workers like as it demonstrates it is everyone's responsibility and gives everyone a chance to do the role
- Ensuring that information loops are always 'closed' and workers know what has been done about an issue
- Health and safety requirements are incorporated into performance systems for every staff member
- Short daily meetings keep all staff up to date with health and safety information, any issues and how they are addressed
- Representatives and other workers report they perform health and safety roles all of the time as an integral part of what they do
- Good relationships exist between representatives and managers and representatives are increasingly asked to participate in health and safety functions and decision-making
- The evolution of effective participatory practice is a result of:
    - continuity of personnel
    - visible financial commitment of the company to health and safety
    - staff commitment to implementing behavioural safety.

Employees in these firms routinely engage with their colleagues, as well as with management, to proactively suggest ways to improve safety performance. In one company this was also observed with subcontractors where employees in the principal firm sought advice and engagement with subcontractors as a means to influence

[6] Around half of all representatives have completed their training since 2010.

subcontractor practices. In these firms workers did talk about taking short cuts or risks but they also said they did not feel comfortable about this.

In three of the larger companies representatives include union representatives in their formal structures and two have formal agreements on employee participation with the unions at their worksites.

Finally a key feature of companies with mature practices concerns the clarity and transparency of communication and engagement with workers around health and safety. This contributes significantly to the level of comfort workers have in raising issues, in reporting near misses (which in the forestry company are called 'near-hits'), in knowing reporting makes a difference, and in knowing they will be backed 100% by management when they interrupt poor practice.

Policy Considerations: Employee Participation

- Effective mechanisms for employee participation in health and safety systems can and should be developed regardless of company size. Managing health and safety must be a shared responsibility
- Effective employee participation processes take time, increasing knowledge, commitment and experience to mature
- Workplace employee participation processes require a 'horses for courses' approach that enables workers the opportunity to fully participate
- Guidance on the practices that might be exhibited could be further developed for firms and workers
- Managers/owners demonstrate what they value through their behaviours. Poor safety behaviour by managers is perceived as hypocritical by workers
- Overall workers and managers felt unions were poorly equipped and resourced to assist them with health and safety knowledge and skills
- Employers must invest in the development of health and safety representatives to enable their effective participation in the company's systems
- Effective worker participation in workplace health and safety is built off effective safety management systems, the existence of organisational health and safety leadership and having the capacity and capability to enable knowledgeable participation.

Capacity and capability

Key feature of practice at each stage:

Emergent Practices	Maturing Practices	Mature Practices
• Capacity and capability is being built, particularly through training e.g., some awareness of hazards, using an external adviser to support document development and practices	• There is solid health and safety capability and capacity amongst management and employee representatives; safe workplace practices are known about and adhered to by all workers	• All workers have the capability and capacity to recognise health and safety issues in the workplace, adhere to safe working practices, contribute to the ongoing refinement of safety practices and take responsibility for themselves and other workers

Case Study Company Practices

Health and safety capacity and capability issues for organisations impact at a number of levels. Firstly, those that concern ensuring that all employees have adequate skills, knowledge and competence to complete their jobs safely and in ways that protect their ongoing health and wellbeing are discussed. This is followed by a discussion of those that concern people with additional responsibilities such as health and safety representatives, managers and health and safety specialists to also meet the requirements for those positions.

All of the case study companies had made significant investment in training of staff to increase their capacity and capability. At the emergent end, this included ensuring health and safety matters are included in induction and that job specific training is available to workers.

Those that can be described as having maturing practices utilise external support to build capability, including training in health and safety. For example, one of the small companies has three managers with Level 3 and each of their representatives has level 1 or 2 qualifications. The apprenticeship training received by trainees in another small company includes health and safety components for all tasks. And in a third company there are some practices to build capability and provide assurance of competence, including requiring the Health and Safety co-ordinator to observe new employees practice before signing them off.

Companies with more mature practices have systematic approaches for building health and safety capability amongst staff. Typically this includes thorough induction processes, job specific training requirements with processes for ‘sign-off’ as new workers achieve competence, training needs analysis and annual action plan development and good administrative systems to support regular access to on-going training and refresher courses. However, despite these systematic approaches, the challenge of maintaining a workforce with a high level of capability and competence requires constant vigilance and there is not always a clear and systematic framework

for building capability more generally or sufficient clarity about what desirable levels of competence ‘look like’.

Workers spoken with were generally well aware of the hazards facing them in their workplaces and were familiar with the language and concepts of hazard control. Some managers and employee representatives argued that capacity could be improved by moving to a risk assessment rather than hazard control approach and by more consistent application of proven practices e.g. use of task analysis.

Most of the case study workplaces identified a low level of capacity and capability in terms of:

- Availability of specialist staff
- Training for line managers
- Concerns about quality of available training and advice
- Lack of attention to health and safety as part of job training/industry training.

The three largest companies employed dedicated health and safety specialists at multiple sites around the country or across different areas of the business. One of these companies however said it was extremely difficult to find experienced and qualified staff for the specialist jobs. Other companies employed between 0-1 specialist staff, but explicitly held managers/supervisors accountable for health and safety and had provided them with training. A big focus of some of the case study organisations was training line managers in hazard identification and control, and their responsibilities under the legislation. It was noted that it can take some time for managers to become good at this. Once competent, companies would move to deepen training for line managers in more proactive practices around analysis of ‘root causes’ of hazards and in the rationales and importance for near-miss reporting.

Several of the case study companies experienced problems in accessing good quality health and safety advice. It was sometimes difficult for organisations to judge the quality of advice and a number felt that the regulator should play a much stronger role in providing advice and guidance. The availability and quality of training were also commented on by a number of those in the case studies. Some felt the lowest levels of training (level 1) were now out of ‘kilter’ with workplace practices and that the standard of this training needed to lift.

Managers in case study organisations commented that the health and safety component of existing industry training was often very general and superficial. Several argued that more needs to be done at an industry training level to ensure trainees are able to competently incorporate health and safety considerations into the design of activities they undertake, e.g. by including more health and safety measurements in assessment processes.

<u>Policy Considerations: Capacity and Capability</u>

- Systematic approaches and key components of more mature workplace capacity and capability development includes provision for specialist roles, manager accountability, induction, job training, on-going development to

enhance competence and refresh skills, regular training needs analysis and planning, good administrative systems

- There is a gap in provision which means firms, particularly SMEs are not always clear about what effective health and safety capacity and capability is for their organisation
- Investigate the supply of experienced and qualified health and safety specialists and consider approaches that support workplaces to make assessments of quality e.g. registration
- Increase guidance and advice to workplaces to support their ability to assess specialist advice
- Consider opportunities for enhancing industry and other job training attention to health and safety matters
- Regulator may be positioned to develop tools and resources that will help workplaces identify ways in which they can build their capability.

Occupational health

Key feature of practice at each stage:

Emergent Practices	Maturing Practices	Mature Practices
• A general awareness of occupational health issues is evidenced through availability of Personal Protective Equipment (PPE) and it is expected to be worn/used	• Regular health monitoring checks are undertaken and occupational health hazards are monitored on an annual or site specific basis	• Health monitoring and wellness programmes in excess of those required by legislation are in place and promoted to support workers and their families to have healthy lives at work and at home

Case Study Company Practices

As with the previous themes all the case study sites had practices on occupational health in place on the emergent, maturing and mature continuum. The nature of the work and the workplace determines, to a certain extent, the systems and practices in place. Common to all the practices was the availability of personal protective equipment (PPE). However the difference between the emergent and the maturing/mature was the expectation and accountability for the consistent use of PPE and the active monitoring of occupational health and wellbeing issues.

While the dairy farm was new to fully-documented practices an aspect of occupational health that was managed best was dealing with fatigue, a significant issue in the farming sector. The contract manager, as a result of having spent time as a farm worker himself, actively manages this aspect of his staff's well-being through rostering and good time management practices to ensure that staff do not become over tired.

Workplaces with maturing practices, have processes in place that monitor the health of the people and aspects of the plant that affect health 9e.g. air quality). In such companies, health monitoring is not mandatory but workers are provided with an opportunity annually for respiratory and hearing checks and the flu vaccination.

In one of the larger companies there is a comprehensive and long-standing health monitoring programme in place, with personnel from an external specialist occupational health and safety practice being on-site every second week for annual monitoring which takes place through 45-minute individual consultations. The monitoring includes audiometry, lung function and respiratory health tests. Testing is done at pre-employment, on an annual basis and on termination. Additional health services are also offered to employees. These include blood pressure monitoring, weight monitoring and weight management support, stress management and assistance, basic sight tests for near vision, flu vaccinations, work station assessments, post accident or illness rehabilitation, and drug and alcohol rehabilitation.

Another organisation has also introduced systems to deal with the wider well-being of staff. The regional District Health Board runs “Work Well” wellness programmes and the organisation participates in this and offers health insurance, gym membership, back and neck massages and assistance with financial planning. Some of these services are offered free to employees and others are offered at subsidised rates. The organisation also has well-established policies on the prevention and management of bullying, harassment and stress.

Mature practices were also seen in smaller companies where owners were proactive about the occupational health and general well-being of staff, especially in relation to occupational hazards related to overuse injuries. The shearing company is very conscious of getting younger workers into good habits and provides advice on useful exercises as well as written material. Similarly, the hairdresser ensures that staff are properly trained in how to stand to minimise the possibility of back problems arising from poor posture.

The forestry company, in addition to managing fatigue and having regular health checks in place, contribute industry wide to improving occupational health through the production of two DVDs related to the impacts of stress and of drugs and alcohol on health and safety in the workplace.

Environmental health monitoring happens in industries with both maturing and mature practices, especially in the engineering, processing, and food manufacturing case studies.

The value placed on the health and well-being of workers is demonstrated by the practices that companies have in place and the ongoing resource it takes to support these practices. Underpinning this is the commitment shown by company leaders who view staff from a holistic perspective rather than seeing them only in terms of their employment status. To exemplify this the shearing company works with the local Primary Health Organisation, to organise a mandatory Shearing Wellness Day, where staff are rotated through various health and wellness speakers over the course of a

day. The company sees this as particularly important for the casual and itinerant workers, many of whom (and their families) do not have a relationship with a health provider because of frequent locational moves.

Policy Considerations: Occupational Health

- Improved information for companies on the value / cost benefit of occupational health practices such as medical checks may assist in promoting greater attention to occupational health
- Incentivising companies to be proactive and take a preventative approach in relation to occupational health issues that are particular to their industries
- Incentivising companies to regard health and safety at work as including general health and well-being as well as specific occupational health issues
- There is little monitoring data produced on occupational health trends or issues at the workplace level
- Occupational health nurses are not often well linked with other primary health providers, although this may reflect the extent to which different DHBs have made use of workplaces as sites for delivering health-related messages.

SMEs/Supply chain

Key feature of practice at each stage:

Emergent practices	Maturing Practices	Mature practices
• Use external experts for advice and practice and have developed health and safety systems	• Building internal expertise and own customised approach and beginning to see cost as investment • Identifying approaches to enhancing supply chain practices	• Business owner is effective leader • Drive consistent expectations through supply chain using all levers available

Case Study Company Practices

This section considers issues from the perspectives of SMEs and from the experience of companies contracting SMEs to provide goods or services. Four of the case study companies are SMEs and five actively engage SMEs as subcontractors. At the emergent end one of the companies will take some time for practices to be consistent. One of the biggest barriers to this is the manager's view that workers should 'do as I say, not as I do.' This is likely to be a common approach in New Zealand SMEs and represents both a high tolerance by small business owner/managers for their own risk and a greater likelihood of risk taking where workplaces are more remote and there is little access to examples of 'good' practice for the purpose of comparison. A more positive feature of emergent practice however is the attitude of owners/manager who want to do health and safety better but find it hard to prioritise, particularly in terms of resourcing (comment from subcontractor).

Two of the larger companies both noted dissatisfaction with compliance with good health and safety practice amongst some SMEs in their supply chain. Managers from one of these companies would like to undertake more intensive auditing and monitoring to lift compliance, but believed that this could require a lot more resource to do so.

The companies with the most mature practices put considerable systemic effort into setting standards, monitoring and auditing supply chains and taking action to both lift performance and enforce standards. Frequently this involves participation in industry developed bodies, although many noted that it is often difficult to engage all and key players in such initiatives. One of the barriers to this is the cost on smaller businesses of engagement. One company commented that it would be preferable to take health and safety out of the tendering process and that common standards should be developed for industry benchmarking to 'create a level playing field' for subcontractors who struggle to meet the differing requirements of different principals.

Similarly, the SME case study group with mature practice have developed tailored and comprehensive systems. In the case of forestry and shearing these systems assist the companies to manage quite high risk environments in remote locations, and in the case of shearing with a less stable workforce, including both seasonal and casual labour.

Policy Considerations: SMEs/Supply chain

- Size does not need to be a barrier to effective systems. However smaller organisations may require access to specialised assistance to customise and ensure generic systems are 'fit for purpose'
- Resourcing effective systems is likely to be a larger barrier for SMEs although effective advice from industry associations can assist in reducing barriers
- Benchmarking health and safety standards for SMEs could assist with streamlining expectations within an industry, reduce compliance costs to SMEs and principals and enable more effective health and safety outcomes by removing it from scope during competitive tendering
- Industry leaders play a key role in promoting and supporting good practice through the supply chain. These initiatives could be profiled and the templates and tools used shared with other industry players.

Population groups

Key feature of practice at each stage:

Emergent practices	Maturing Practices	Mature practices
• Recognise different groups of employees may respond differently to behaviour expectations	• Some attention to managing difference/ resistance from different groups e.g. addressing low literacy, English as a second language, older workers resistant to change	• Have expectations and practices that ensure all workers will have access to the information they need and are expected to meet performance standards

Case Study Company Practices

A feature of companies at the pre-emergent stage might best be typified as a 'we are all the same and everyone knows what is expected of them'. This fails to recognise the diversity of the workforce, different ways that workers may access information and the benefits that come from ensuring all are able to operate effectively and contribute their best. While some companies talked of the impetuousness of young (male) workers and the resistance amongst older workers to change it was clear that not all companies set clear behavioural standards that all staff had to meet. One company talked of the process of moving workers from being resentful or resistant to change, through to embracing change. Their workers agreed with this analysis, noting that it "all made sense" in retrospect.

A number of the companies employed workers who were new migrants, had English as a second language or were transient. They take considerable lengths to ensure they are able to understand and behave according to the company's health and safety requirements. One company has their longer standing employees from Burma act as interpreters for their 31 staff from Northern Burma; another uses their health and safety co-ordinator to help non-English speaking workers to fill out forms. A health and safety representative did however express concern that non-English speakers may be less likely to report or raise safety concerns out of embarrassment or fear.

The impact of low levels of literacy and numeracy on health and safety was also an issue in a number of the case studies. Many of these issues are addressed through good training practices, use of graphics, simple language, verbal briefings and support to fill out forms. A number of companies provide literacy and numeracy programmes for their employees.

Policy Considerations: Population Groups

- Those who face barriers to understanding and speaking, or reading and writing English can be at greater risk in terms of safety and health, and can place others they work with at greater risk also
- Workplaces require practical assistance with both understanding what their workforce may require to meet health and safety requirements and ensuring they can provide support for this to happen

- A clear expectation must be set, along with training or other resourcing provided, that all workers must meet changing safety expectations.

Workplace leadership

Key feature of practice at each stage:

Emergent practices	Maturing Practices	Mature practices
• Owner/manager introduces and leads health and safety systems and practices	• Commit time and resource to health and safety systems, practices and training • All managers have accountability for ensuring achievement of health and safety KPIs	• Champion a system that prioritises health and safety, encourages bottom up, no-blame reporting, continuous improvement and engagement in industry initiatives

Case Study Company Practices

In all of the case study companies, health and safety was driven by the commitment of senior managers or business owners. In some of the larger companies Boards had also had a role in heightening the priority given to health and safety management. At the emergent end of practice, it was also at the initiative of owners and managers that systems and processes were being introduced.

At the most mature end of practice, attention to health and safety systems cascaded throughout the company at all levels and into all functions. At some point companies moved from top-down leadership, to leadership that also supported bottom-up initiatives and leadership from health and safety representatives, workers and from managers. This can be described as collective leadership with individual accountability.

Leadership is very intertwined with workplace health and safety culture. Companies that had more mature practices demonstrated very clear and open communication and focused on building strong and effective relationships e.g. with their supply chain. Leaders interacted with people throughout the company, and workers felt comfortable that their managers and colleagues would back them up (and have their backs) on safety issues.

Company leaders communicated clearly and unequivocally. Although leadership on health and safety matters must be driven from the top of an organisation, it must also be encouraged to emerge at all levels. Leadership that is spread throughout a workplace in our view is the most critical ingredient for improving workplace health and safety culture.

Policy considerations: Workplace Leadership

- The priority given by CEOs (and Boards) to health and safety are critical to the consistency with which messages are received throughout companies and the consequent behaviours that are acknowledged as acceptable and rewarded
- Support and guidance material that enables leaders to understand the staging of system maturing and the dynamic, continuous improvement approach to health and safety systems would be useful

Data and measurement

Key feature of practice at each stage:

Emergent Practices	Maturing Practices	Mature Practices
• Have a hazard register in place • Gather data on incidents and serious harm accidents, and identify corrective actions needed	• Track and analyse data collected, provide results to workers and use the data to inform safety systems, practices and training	• Have easily accessible lead and lag indicators linked to KPIs, workers are engaged in analysis and use data to improve systems and practices

Case Study Company Practices

Ten of the eleven companies collected data. For the most part this was information about:

- near misses, or as the forestry company called them, 'near hits'
- incidents
- serious harm accidents
- lost time injuries
- lost time days.

The remaining company reported incidents to the owner. In companies with maturing and mature practice the data were collated in tables and graphs and reported to management, and usually also to staff.

The real point of difference between workplaces with maturing and mature practices was the way in which the company analysed the data, reported it to workers and used it to implement changes in work practices. For example one of the small companies collates health and safety reports and analyses these for trends. This allows the pre-causes of incidents to be identified and an action plan developed and implemented. The trends are shared with the workers every six months (earlier if required) via colourful graphs and charts, which provide a clear justification when remedial actions are suggested. For example, a pattern of incidents after the morning smoko break was discussed across a company, and the simple prevention strategy of warming up again after a break was suggested and implemented.

A further difference can be seen in the most mature companies having well developed systems that measure lead indicators as well as the lag indicators. Lead indicators enable the integration of the positive steps a company takes to improve health and safety performance and achieve targets. In case study companies this includes factors and targets such as:

- safety audit compliance greater than 90%
- 100% sub-contractors site safety plan compliance
- near-miss reports at or greater than 20 per month per region
- completion of health and safety cultural survey
- actual completion of staff meetings to discuss health and safety greater than 90%.

Policy Considerations: Data and Measurement

- Health and safety targets, measures and outcomes provide powerful tools for assessing and improving performance. Greater external transparency of such measures could have an impact within industries where common indicators ere developed and used
- Promote the use of lead or performance driving indicators to build ownership of positive actions that can be taken to improve health and safety outcomes.

Summary of key policy considerations

This section collates the policy considerations that derive from examining the experiences in eleven New Zealand companies. These are not companies that can be said to have practices that are representative of other sectors or industries, but rather they provide a snapshot of companies who while not complacent about their health and safety, think they are doing some things right. The themes emerging from the case studies suggest the following issues for policy consideration:

Employee Participation

- Effective mechanisms for employee participation in health and safety systems can and should be developed regardless of company size. Managing health and safety must be a shared responsibility
- Effective employee participation processes take time, increasing knowledge, commitment and experience to mature
- Workplace employee participation processes require a 'horses for courses' approach that enables workers the opportunity to fully participate
- Guidance on the practices that might be exhibited could be further developed for firms and workers
- Managers/owners demonstrate what they value through their behaviours. Poor safety behaviour is perceived as hypocritical by workers
- Overall workers and managers felt unions were poorly equipped and resourced to assist them with health and safety knowledge and skills
- Employers must invest in the development of health and safety representatives to enable their effective participation in the companies systems
- Effective worker participation in workplace health and safety is built off effective safety management systems, the existence of organisational health and safety leadership and having the capacity and capability to enable knowledgeable participation.

Capacity and Capability

- Systematic approaches and key components of more mature workplace capacity and capability development includes provision for specialist roles, manager accountability, induction, job training, on-going development to enhance competence and refresh skills, regular training needs analysis and planning, good administrative systems
- There is a gap in provision which means firms, particularly SMEs are not always clear about what effective health and safety capacity and capability is for their organisation
- Investigate the supply of experienced and qualified health and safety specialists and consider approaches that support workplaces to make assessments of quality e.g. registration

- Increase guidance and advice to workplaces to support their ability to assess specialist advice
- Consider opportunities for enhancing industry and other job training attention to health and safety matters
- Regulator should be positioned to develop tools and resources that will help workplaces identify ways in which they can build their capability.

Occupational Health

- Improved information for companies on the value / cost benefit of occupational health practices such as medical checks may assist in promoting greater attention to occupational health
- Incentivising companies to be proactive and take a preventative approach in relation to occupational health issues that are particular to their industries
- Incentivising companies to see health and safety at work includes general health and well-being as well as specific occupational health and well-being
- There is little monitoring data produced on occupational health trends or issues at the workplace level
- Occupational health nurses are not often well linked in with other primary health providers, although this may reflect the extent to which different DHBs have made use of workplaces as sites for delivering health-related messages.

SMEs/Supply chain

- Size does not need to be a barrier to effective systems. However smaller organisations may require access to specialised assistance to customise and ensure generic systems are 'fit for purpose'
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- Workplaces require practical assistance with both understanding what their workforce may require to meet health and safety requirements and ensuring they can provide support for this to happen
- A clear expectation must be set, along with training or other resourcing provided, that all workers will adapt to meet changing safety expectations.

Workplace Leadership

- The priority given by CEOs (and Boards) to health and safety are critical to the consistency with which messages are received throughout companies and the consequent behaviours that are acknowledged as acceptable and rewarded
- Support and guidance material that enables leaders to understand the staging of system maturing and the dynamic, continuous improvement approach to health and safety systems would be useful

Data and Measurement

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