Strategic Review of the Workplace Health and Safety System

Submission to the Independent Taskforce on Workplace Health and Safety

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About the New Zealand Nurses Organisation

The New Zealand Nurses Organisation is the leading professional and industrial organisation for nurses in Aotearoa New Zealand, representing over 46 000 nurses, midwives, students, kaimahi hauora and health workers on a range of employment-related and professional issues. Te Runanga o Aotearoa comprises our Māori membership and is the arm through which our Te Tiriti o Waitangi partnership is articulated.

NZNO provides leadership, research and support for professional excellence in nursing, negotiates collective employment agreements on behalf of its members and collaborates with government and other agencies throughout the health sector. Nurses are the largest group of health professionals comprising half the health workforce.

The NZNO vision is “Freed to care, Proud to nurse”. Our members enhance the health and wellbeing of all people of Aotearoa New Zealand and are united in their professional and industrial aspirations to achieve a safe, sustainable and accessible system of public health care for all New Zealanders.

EXECUTIVE SUMMARY

1. The New Zealand Nurses Organisation (NZNO) welcomes the opportunity to comment on the strategic review of the workplace health and safety system.
2. NZNO has consulted its members and staff in the preparation of this submission, including delegates who liaise with, or may also be, health and safety representatives, members of our specialist nursing Colleges and Sections, Te Runanga, Regional Council and Board members, and professional nursing, industrial, policy, research and legal advisers.
3. NZNO is an active participant in, and advocate of, the development of guidelines, regulation, education and monitoring of workplace health and safety, and materially supports members' and staff participation in relevant local, national and international health and safety standards and workplace committees.
4. NZNO is affiliated to the New Zealand Council of Trade Unions (NZCT) and fully supports its submission, the substance of which is not reiterated, but should be taken as integral to this submission, which focuses on issues in the health sector.
5. NZNO welcomes this review and the concise but comprehensive consultation document, but is concerned with its timing in the current context of extensive changes to employment and ACC legislation, and

standards and regulatory reviews, which may lead to substantial changes in workplaces before the review is complete and may therefore limit its potential to effect meaningful improvement.

6. The current thrust of workforce regulation, private-public partnerships, and reduced public oversight and control (Better Regulation, **Less**[1] Regulation, Treasury, 2009) in order to improve the business environment is not conducive to enhancing public trust or industrial relations, particularly when worker safety is so often considered in the context of a 'trade-off'' against, rather than central to, productivity and reduced costs. At the risk of stating the obvious, if workers can't be protected in an obviously high risk field such as mining (and the Pike River disaster makes it clear that they can't), what hope is there for genuine action to identify and address systemic factors causing occupational harm, particularly for gradual processes, which are often difficult to prove?

7. While it is useful to draw on other countries' systems, NZNO cautions against a narrowly focused approach where, for example, different approaches to worker compensation may equated with different outcomes as indicated in paragraph 43, without due regard to other factors. NZNO strongly supports Aotearoa's unique no-fault ACC scheme, the value of which is clearly attested to in the independent 2008 Scheme Review (PricewaterhouseCoopers, 2008), and rejects any suggestion that the Scheme allows health and safety to be taken for granted.

8. NZNO takes an holistic rather than issues-based approach to the Safer Workplaces discussion which follows, and identifies the main reasons for the poor standard of workplace health and safety in Aotearoa New Zealand, leading to preventable occupational injury, illness and death as being:

    - an actively negative/apathetic national culture towards health and safety - a result both of tradition and poorly informed workers and employers and general public;
    - lack of integrated legislation and regulation to mandate, monitor and enforce up-to-date, evidence-based international standards

[1] NZNO emphasis

promoting healthy industrial relations, a living wage, and safe working environments;

- increasingly insecure, casualised employment patterns, with a large underclass of poorly paid, part-time, powerless workers, many of whom are migrants;
- lack of integrated infrastructure with regard to collection and transparency of relevant injury, occupational health, safety performance data;
- lack of coordinated government policy on injury, occupational risks, exacerbated by poor consultation/ communication processes, inadequate planning, and the implementation of ideologically-driven, rather than evidence-based, strategies;
- fragmented research and monitoring of new risks and implementing international best practice; and
- failure to prioritise injury prevention.

9. Notwithstanding the above, NZNO welcomes the introduction of some excellent broad-based health and safety tools and initiatives such as nationally consistent reporting of incidents and sentinel events in hospitals; Care Capacity Demand Management (CCDM) in hospitals; and ACC's habit at work (http://www.habitatwork.co.nz/index.html), which address some of the systemic issues underlying workplace injury and harm.

10. NZNO recommends the following essential actions to improve workplace health and safety:

    - ensure robust, comprehensive engagement/ information sharing with the public, employers, and workers, including ongoing, multi lingual, multimedia campaigns to move to a culture of workplace safety;
    - prioritise injury prevention and proactive occupational harm research;
    - integrate legislation and regulation to mandate, monitor and enforce healthy industrial relations (i.e. safe, fair employment regulation and protection for vulnerable workers) and safe working environments;
    - develop cross-government evidence-based planning, policies and strategies to ensure consistent, transparent health and safety data collection, education and standards;

- support health and safety representatives by implementing CTU recommendations detailed below; and
- develop specific strategies to address the challenges presented by the large migrant workforce on which we are dependent for professional, semiskilled and seasonal labour.

11. The discussion below does not address all the template questions, but where an answer can be linked to a specific question, it has been highlighted.

12. With regard to questions relating to the legislation and regulatory processes we refer to the CTU recommendations which support the tenets of current health and safety legislation, and suggest improvements i.e.

    - strengthen the powers and protections for Health and Safety Representatives in regulation;
    - impose higher penalties for breaches of the HSE Act. Currently penalties are set at such a small amount that businesses can indulge in 'gaming' the system - a system of civil fines such as infringement fees should be implemented as an effective prevention tool;
    - include a presumption of safety in the New Zealand legislation. The Australian model law has the catch-all phrase that provides that unless the cost is "grossly disproportionate" all practicable steps to ensure safety are required to be taken. The 'grossly disproportionate' test is recommended for the New Zealand context. The economic factors that are legislated for under section 2A of the HSE Act need to be amended so that cost is not the 'catch all' at paragraph 2A(1)(e).
    - prescribe specific regulation in situations where there is a known hazard and a tried and true mechanism for addressing that hazard. A new obligation should be introduced to the Act that requires the promulgation of regulations where it will manifestly improve safety. This would provide a limit to the regulator's discretion thereby curbing the effect of political or business influences not to regulate;
    - create a new Independent Crown Entity with a tripartite governance structure as a specialist agency focused solely on the development, administration and enforcement of the

HSE Act and workplace enforcement of the Hazardous Substances and New Organisms Act 1996. The Workplace Health and Safety Council (WHSC) would become the board of this organisation;

- ensure the new Crown Entity is responsible for promulgating regulations and standards to ensure an independent process, free from political interference;
- introduce independent, publicly funded Health and Safety Centres reporting to the new Crown Entity. These regionally based Centres should employ Safety Advisors who should be available to advise and mediate on health and safety issues in any workplace.
- introduce a further two-day training course at level four for Health and Safety Representatives. This course would be run by the CTU and would enable representatives to issue Improvement Notices.
- introduce a criminal offence of corporate manslaughter into New Zealand law similar to the UK Corporate Manslaughter and Corporate Homicide Act 2007. This Act clarifies the criminal liabilities of companies including large organisations where serious failures in the management of health and safety result in a fatality.
- retain 'hazard' as the basis to the Health and Safety in Employment Act 1992 (SE Act.) The general approach to identify hazards and the steps to eliminate, isolate or minimise those hazards works to promote the prevention of harm, contrary to the concept of 'risk' which effectively increases the likelihood of harm by assessing an 'acceptable level of risk' rather than applying the precautionary approach.
- clarify that the Health and Safety in Employment Act 1992 (HSE) takes precedence over the Hazardous Substances and New Organisms Act 1996 (HSNO);
- ensure independent monitoring of hazardous substances at worksites.
- Change the "all practicable steps" test. Regulations made under the Act should not refer to practicable steps when specific prescription is required. In addition the economic

factors in section 2A of the HSE Act need to be amended so that financial cost is not the ‘catch-all’ at paragraph 2A(1)(e).

13. NZNO would be happy to discuss any part of this submission in more detail and consents to this submission being placed on the Independent Taskforce on Workplace Health and Safety website.

DISCUSSION

14. NZNO encompasses clinical expertise in all health settings - home, community, hospitals, prisons and residential facilities - and across a wide range of activities and disciplines including social work, labour organisation, health and safety education, management, research and policy.

15. As such we are representative of those working in workplaces of all sizes, from 'corporate' District Health Boards (DHBs) to the medium and small business enterprises of Primary Health Organisations (PHOs) and sole practices; and representative of a range of workforce skills which span diverse technological and social complexity, from acute diagnostic, surgical, and treatment facilities, to the broader based whānau ora model of integrated care. Not surprisingly, we note a wide range of employer understanding and commitment to health and safety, both individually and between sectors.

16. In addition, almost one third of NZNO's members are internationally qualified nurses (IQN), some of whom are working for minimum wages as health care assistants (HCAs). NZNO's strategic nursing workforce research programme NZNO has given particular insight into the health and safety risks faced, and presented by, this large group of workers new to Aotearoa. These include language and communication difficulties, discrimination, and cultural misunderstanding. Little is being done to mitigate the risks of the misunderstanding, racism, and harm that does occur and NZNO strongly recommends appropriate workplace education for cultural understanding for both local and overseas health workers.

17. We draw your attention to original research and publications in peer reviewed journals which illuminate salient health and safety issues and workforce trends for IQN, younger nurses and older nurses (see http://www.nzno.org.nz/activities/research). NZNO has also developed guidelines for DHBs for the "safe and effective integration of internationally qualified nurses into Aotearoa's workforce" - IQN comprise a quarter of the nursing workforce.

18. We also applaud the English as a Second language (ESOL) qualification recently developed by the New Zealand Qualifications

Authority which hopefully will replace the foreign patented International English Language Test System (IELTS) which is culturally and occupationally inappropriate for most of the professional registration and immigration purposes it is used for (including by the Department of Labour for skilled workers).

19. Nurses have a dual perspective on workplace health and safety in that they both treat and experience occupational harm. Nurses have particular occupational risks such as risks from needle stick injury and infection, but others, such as musculo-skeletal disorders, repetitive strain injury, stress, etc. they share with many other groups of workers whose work involves 24/7 shifts, heavy lifting and exposure to hazardous substances. Identifying and addressing multiple, systemic risk factors leading to injury and harm, such as overwork and fatigue from inadequate resourcing (staff, tools, time etc.) is problematic, as is proving causal occupational links with the gradual onset of harm. However, the loss of health and productivity are real and preventable with good practice.
20. Employment factors such as low pay, job insecurity, split shifts, persistent understaffing, long hours, inadequate rest-breaks, heavy workloads, bullying, inadequate or unsafe equipment/resources which contribute to occupational risk of injury, disease and harm, also reflect the exigencies of the wider political, social and economic environment.
21. The current recession and direction of government policy has delivered an employment environment that is markedly less stable, more inequitable, unhealthy and unsafe, as indicated by the reversal of the decreasing rate of work related fatalities (Fig.3 Safer Workplaces), prolonged disputes at Auckland Ports and meat working facilities, the mining disaster at Pike River, chemical spill at Tasman Tanning, a fivefold increase of inpatient suicides in the past year(Health Quality and Safety Commission, 2012), increasing infectious diseases and those associated with poverty (Baker et al, 2012).
22. Fair and just industrial relations are embodied in the State Sector Act 1988, and other legislation evoking the concept of 'good employer' - an overt rejection of the control of labour by market forces and an affirmation of the 'trust, confidence and fair dealing' implicit in an equal relationship. Historically, where workers do not have a strong collective voice, health and safety is compromised firstly by the lack of regulation - mandatory standards, processes and oversight of fair and safe conditions of work, and secondly by the increased vulnerability of workers who must accept split shifts, longer hours, heavier workloads etc. to support their families, regardless of the safety issues.

23. For nurses and HCAs this is particularly evident in the mainly privatised aged care sector where wages and conditions of work are poorer than in District Health Boards where even the sector agreed minimum New Zealand standards published in NZS Handbook *Indicators for Safe Aged-care and Dementia-care for Consumers* (Standards New Zealand, 2005) have never been met in most facilities (NZNO, 2012), though increasing corporate investment testifies to the extraordinary profits being made. This year Ryman Healthcare, for instance, posted $84 million profit, up 17 per cent on the previous financial year. It is significant that the standards are voluntary and have not been reviewed though there is clear evidence that the acuity level of residents has increased markedly (Boyd, 2009).
24. NZNO recommends that where standards exist they should be mandatory.
25. In this context we also note that while suicide is no longer counted statistically as an injury (there are parallel and correlating factors with difficult employment environments, which suggests there may be mutual benefits with a common approach. Estimates of the social and economic cost of suicide indicate that it *exceeds* the cost of all motor vehicle injuries and is approximately *double* that of all identified occupational injury, yet investment in prevention has been miniscule and ineffective (O'Dea & Wren, 2010; Ministry of Health, 2010).
26. Coherent, integrated, strategies that address inequity and empower people to be responsible for safe (NOT safer!) workplaces are as essential as targeted strategies for particular harms such as falls or nosocomial infections, for example, or particular occupations.
27. The Report of the WHO Commission on the Social Determinants of Health strategies provides a comprehensive evidence-base and a simple framework for action for achieving this:
    - Improve the conditions of daily life – the circumstances in which people are born, grow, live, work, and age;
    - Tackle the inequitable distribution of power, money, and resources – the structural drivers of those conditions of daily life; and
    - Measure and understand the problem and assess the impact of action.

Health and Safety Representation

28. NZNO's members, delegates and professional nursing and industrial advisers sit on and contribute to a number of working and advisory

groups relating to both health (i.e. best practice, prevention of injury, disease generally) and occupational health and safety standards, including the NZS 8134.0:2008 Health and Disability Services Standards.

29. As with other sectors and industries where expertise and experience is required, many of NZNOs Colleges and sections are responsible for developing safety and quality standards in their specialist areas of practice. The National Division of Infection Control Nurses (NZNO), for example, represents New Zealand (at its own expense) on the Trans Tasman Infection Control Committee which sets standards for infection prevention and control for both countries.

30. NZNO is an active participant of the ACC Accredited Employers forum and our industrial advisers and organisers work closely with large employers (DHBs) on health and safety policy and standards, audits, return to work programmes etc. We expect other health providers such as primary health organisations (PHOs) will be part of the forum with the extension of the Accredited Employers programme (EAP).

31. NZNO has employee participation agreements (EEA) with most employers of nurses and HCAs with whom we work closely on health and safety issues, such as education, hazard identification, and return to work programmes. We are also involved with employers' health and safety committees through delegates who are also nominated health and safety representatives. We believe that all these opportunities for participation and education are effective routes to safer workplaces.

32. NZNO liaises with people and organisations responsible for health and safety education, and endorse the CTU's education programme for health and safety representatives which is widely used by ACC.

33. Employer compliance with and commitment to health and safety is highly variable, and without a legislated mandate, health and safety representatives are powerless. *In general,* we observe that larger and publically funded bodies such as DHBs have more transparent and standard processes for managing health and safety than smaller employers who may lack the capacity to implement comprehensive systems, including education, for managing risk and improving health and safety, but this is certainly not always true, which is why it is imperative that comprehensive public education about workplace safety is necessary.

34. Where employers are reluctant, ambivalent or actively obstructive about safety it is almost invariably attributed to cost. This testifies to poor

understanding of good business practice; safety is not an optional extra, but intrinsic to productivity.

35. To ensure health and safety representatives are effective, the CTU recommends:

- Selection of representatives on health and safety directly by workers (not those 'shoulder-tapped' by the management).
- Protection of health and safety representatives from victimisation or discrimination as a result of their representative role.
- Paid time off to be allowed to carry out the function of safety representative.
- Paid time off to be trained in order to function as a safety representative.
- The right to receive adequate information from the employer or principal on current and future hazards to the health and safety of workers at the workplace.
- The right to regularly (i.e. at least quarterly, but more frequently during periods of change) inspect the workplace during the representatives paid working time and when the operation is working (where safe and practical to do so).
- The right to investigate complaints from workers on health and safety matters in representatives paid time.
- The right to make representations to the employer or principal on these matters.
- The right to be consulted over health and safety arrangements, including future plans.
- The right to be consulted about the use of specialists in health and safety by the employer or principal.
- The right of Health and Safety inspectors to investigate and audit premises without prior notification;
- The right to accompany health and safety authority inspectors when they inspect the workplace and to make complaints to them when necessary and in confidence;
- Legal powers to serve written notices to employers or principal when they observe situations they deem to be serious problems.
- Legal powers to stop work on activities perceived to pose serious and imminent risks.
- Rights of access to representation for workers in small enterprises and measures to address the problems of

representation in multi-employer worksites and where work has been outsourced as a result of organisational changes.

36. NZNO supports those recommendations and having Environmental Science and Research (ESR) set up a division where health and safety representatives and government (ACC-based Labour Inspectors) can access the results of scientific testing and information.

37. The current list of individual hazardous components is barely helpful in those cases where they are properly contained and labelled, but become irrelevant and potentially dangerous when mixed in combination with others, or as a result of contamination. The current safety limits based largely on US recommendations, are entirely inadequate and unsafe. Ammonia, for example, is listed as having an eight hour safety limit yet people have collapsed after being exposed to levels 25% below the 'safe limit' for only 10-15 minutes.

Under reporting (Q1- Who gets hurt?)

38. We draw your attention to two important areas that are not identified: under reporting of well known occupational harm and under reporting because of, as yet, unknown or unquantified harm, from new technologies. Provisional results of research relating to musculoskeletal disorders among some workers, including nurses, presented at a seminar by Dr Helen Harcombe, Injury Prevention Research Unit, University of Otago (Seminar, 1st November, 2012) suggests that workers experiencing low level pain do not report it or seek treatment, thus reducing the opportunity for preventative strategies and early intervention which would reduce both injury and harm.

39. Secondly, though there have been widespread changes in employment, the process for identifying new occupational risks is opaque and there is no guarantee that they will be investigated or monitored in a timely fashion. NZNO has tried to find information and safe practice standards to address the risk of infection from diathermy plumes, for example, without success (though, ironically, nanotechnology has attracted considerable attention). In the event of a nurse being infected in a situation where diathermy plumes may be implicated, it is not clear that the source of infection would be correctly attributed to inadequate ventilation, and the risks associated with non reporting would continue. In both instances, the picture of who gets harmed at work is likely to be an incomplete one.

40. We caution against a solely targeted approach. The Health and Safety framework needs to support a wholesale change in attitude towards health and safety across the whole population, before a targeted approach for specific demographic groups and occupations is

considered, otherwise there is a risk that gains through investment in one area will be correlated with losses in another. For the latter, workers, employers, researchers and policymakers must be equally involved in the development of robust processes and appropriate and transparent strategies primarily focused on the prevention of injury, and, where necessary, fair rehabilitation.

41. The most pressing problem NZNO organisers deal with in terms of rehabilitation for nurses returning to work after injury, is the difficulty of finding appropriate 'light duties' and ensuring that no workplace conflict or further injury ensues as a result. Many people are reluctant to burden their colleagues with extra work, while some resent others 'having it easy'.

42. The incentive to prevent harm should be glaringly obvious, but it appears there is both a lack of resources and will to effect this. Inadequate and/or inappropriate equipment for lifting and transporting patients is appallingly common, with the increase in bariatric patients an exacerbating factor. It is unacceptable that people caring for the sick should put their own health at risk yet this is exactly what happens in health facilities throughout the country every day. All workers need to be educated and empowered to recognise and refuse to accept unsafe work.

Regulatory Framework (Q3 - 6)

43. As indicated in paragraph 22, too much reliance is placed on voluntary rather than mandatory standards, even when there are clear safety risks. Standards where they exist should be mandatory and must be monitored and enforced.

44. We also note the lack of clarity about responsibility for health and safety in contracting relationships, in spite of provisions in the Health and Safety in Employment Act, 1992. For example, the DHB's Aged Residential Care Contract (ARCC) must be consistent with the Health & Disability Act Standards requirements that there be "sufficient staff to meet the care needs of residents", but since unenforceable voluntary standards were substituted for regulated RN-to-patient ratios, unsafe staffing persists.

45. A good indication of how far standards have slipped under the current flexible arrangements, is that prior to 2002, the RN requirement for hospital level care (high dependency) was one full time RN to every five hospital residents; currently, aged residential care facilities which routinely cater for 60 or more residents, covering a range of acuities, are only required to have one RN nurse *on call;* only in acute or hospital level care is an RN expected to be on site, and often clinical staff here

cover emergencies in other facilities in the range that retirement complexes now cover. Other staffing is provided by enrolled nurses or far more commonly, HCAs. Thus clinical oversight for 60+ residents, some acutely physically and mentally ill, becomes the responsibility of one nurse, which is clearly unsafe, though 'under the radar'. The unaccounted effects of unsafe staffing (i.e. inadequate number and skill level) in aged care can be seen in the number of *preventable* emergency department (ED) admissions of older people for medication errors, urinary tract infections, falls, infection from wounds etc. *and* in the disproportionate number of competency cases against RNs, high staff turnover and high proportion of migrant workers and IQN - it is not only the poor pay that makes New Zealand RNs eschew work in aged care, it is the high risks associated unsafe workloads.

46. Fortunately the work of the Safe Staffing Healthy Workplaces Unit, following the Safe Staffing/Healthy Workplaces Committee of Inquiry 2006 Report, which identified the seven elements of SSHW, has researched, developed tools and implemented systems for managing complex staffing issues in dynamic work environments in DHBs. Care Capacity Demand Management (CCDM) is a way of matching service demand with service capacity in order to ensure the right number and skill mix of staff are available to meet the needs of patients.

47. CCDM is an outstanding example of the power of partnership between employers, employees, unions and professional associations and government and we invite you to review the resources available from NZNO's website and read the appended Department of Labour's case study.

48. In general there is a poor understanding of regulatory and standards frameworks, how they are (or should be) integrated, and the contribution they make to public health and safety. In health for example, robust legislation (the HPCA Act 2003) ensuring the fitness and competence of health practitioners to practice, can be undermined by employers substituting regulated practitioners, who are accountable for their practice, with unregulated workers, who do not have a scope of practice. The difference is not well understood and not only lowers protection of public safety, but may also put the regulated practitioner at professional risk.

49. The confusion is clear even at a high level. The recent review of the HPCA Act, for example, unexpectedly canvassed health and safety issues for health practitioners, including, bizarrely, whether regulatory authorities should be responsible for pastoral care and, far more seriously, implied that there should be a trade off between the safety of

the public and access to services (*"the cost society is willing to bear for the benefits of public safety and the trade-off between highly qualified and regulated health practitioners and improved access to services",* Review of the HPCA, Ministry of Health, 2012).

50. This review was one of a plethora of rushed, poorly informed, fragmented, and duplicative policy documents developed, and potentially implemented, in isolation and without regard to standard consultation processes that, together with the downsizing of the public service, are rapidly changing the regulatory infrastructure and knowledge base underpinning robust health and safety standards. The Standards and Conformance Infrastructure Review (Ministry of Business, Innovation and employment, 2012) is another.

51. Though the Health and Disability Services Standards NZS 8134 set the essential public health requirements for all health facilities, and are fundamental reference tools for all health providers and workers, the review focused almost solely on business and trade, with virtually no health sector input apart from NZNO (2012), which was belatedly effected through the CTU[2]. There is a very real danger of losing the high quality independent professional knowledge and skills base essential to maintaining a national standards infrastructure which assures public health and safety, through lack of meaningful engagement and such a fragmented approach. Robust, evidence-based standards, sound environmental monitoring and research underpin the quality of health and safety in the workplace.

CONCLUSION

52. In conclusion, NZNO thanks you for this opportunity to contribute to review of workplace safety, which we have tried to demonstrate goes well beyond specific regulation for health and safety. We believe that the employment environment reflects the wider political, social and economic context, and note with dismay a dangerous tendency for safety to be fiscally 'balanced' against risk, as if the cost of providing a safe workplace was extra, rather than integral, to the cost of production and regulation.

[2] In seeking further information informally, the message was that the Ministry was not interested in a health sector response to the review "...but, tell us what you don't want to lose."

53. Similarly, we are concerned that the rapid pace of some targeted governmental change, based on inadequate information and consultation, is seriously undermining our ability to maintain the robust safety standards which underpin occupational health and safety, just as changes to employment legislation undermine equity.

54. Improvements to worker safety must *begin* with addressing the prevailing negative and/or apathetic attitude to workplace health and safety, and be progressed through actions based on the principles of our founding document Te Tiriti of Waitangi - partnership, participation and protection.

55. NZNO suggests a more aspirational commitment to Safe rather than safer workplaces and recommends the Taskforce:

    - ensure robust, comprehensive engagement/ information sharing with the public, employers, and workers, including ongoing, multi lingual, multimedia campaigns to move to a culture of workplace safety;
    - prioritise injury prevention and proactive occupational harm research;
    - integrate legislation and regulation to mandate, monitor and enforce healthy industrial relations (i.e. safe, fair employment regulation and protection for vulnerable workers) and safe working environments;
    - develop cross-government evidence-based planning, policies and strategies to ensure consistent, transparent health and safety data collection, education and standards;
    - support health and safety representatives by implementing CTU recommendations detailed below; and
    - develop specific strategies to address the challenges presented by the large migrant workforce on which we are dependent for professional, semiskilled and seasonal labour.

56. NZNO would be happy to discuss this submission and has no objections to it being made public.

57. We recommend that the Taskforce adopt the CTU recommendations to:

    - strengthen the powers and protections for Health and Safety Representatives in regulation as indicated in paragraph 36;
    - impose higher penalties for breaches of the HSE Act;

- include a presumption of safety in the New Zealand legislation, that requires all practicable steps to ensure safety are required to be taken unless the cost is “grossly disproportionate”;
- prescribe specific regulation in situations where there is a known hazard and a tried and true mechanism for addressing that hazard;
- create a new Independent Crown Entity with a tripartite governance structure as a specialist agency focused solely on the development, administration and enforcement of the HSE Act and workplace enforcement of the HSNO Act with the WHSC as board;
- ensure the new Crown Entity is responsible for promulgating regulations and standards to ensure an independent process, free from political interference;
- introduce independent, publicly funded Health and Safety Centres reporting to the new Crown Entity and employing Safety Advisors who should be available to advise and mediate on health and safety issues in any workplace;
- introduce a further two-day training course at level four for Health and Safety Representatives;
- introduce a criminal offence of corporate manslaughter into New Zealand law;
- retain ‘hazard’ as the basis to the Health and Safety in Employment Act 1992 (SE Act.);
- clarify that the Health and Safety in Employment Act 1992 (HSE) takes precedence over the Hazardous Substances and New Organisms Act 1996 (HSNO);
- ensure independent monitoring of hazardous substances at worksites.
- Change the “all practicable steps” test. Regulations made under the Act should not refer to practicable steps when specific prescription is required. In addition the economic factors in section 2A of the HSE Act need to be amended so that financial cost is not the ‘catch-all’ at paragraph 2A(1)(e).

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CASE STUDY

Department of Labour
TE TARI MAHI

The Power of Partnership

"Our partnership just changed Tauranga hospital."
Lynne Hansen, Worksite Convenor, New Zealand Nurses Organisation

The return on investment:

- The return on the partnership investment in reducing absenteeism is conservatively estimated to be 1150 percent
- Sick leave reduced from 13 days on average per employee to eight days over a 12-month period
- Labour turnover has steadily reduced falling from 9.5 percent to 7.8 percent over a 24-month period
- Staff engagement improved over 17 percent between 2007 and 2009

In addition, the partnership enabled the successful implementation of the Releasing Time to Care programme which in turn enabled significantly more face-to-face time with patients.

A workplace partnership has "transformed" the Bay of Plenty District Health Board's workplaces. The lessons learned by the DHB are relevant to organisations large and small, and in all sectors.

BACKGROUND

Tauranga and Whakatane hospitals are regular destinations for health sector managers searching for the secret of lasting and effective workplace relationships with staff.

The hospitals standout for the way a partnership-based resolution to long-standing employment relations issues was seized upon to introduce a culture change throughout the organisation.

An "us and them" confrontational relationship has been transformed into a whole-of-organisation partnership that has unlocked latent potential to improve services and cut costs.

For example, for the three months from November 2011 to January 2012, the DHB's hospitals cared for 875 more acute patients while keeping bed utilisation at 2008 levels.

The original workplace partners at the hospitals – the Bay of Plenty District Health Board (DHB), which runs the hospitals, and the New Zealand Nurses Organisation representing the DHB's nurses – say there is no secret: success comes from commitment, investment and constant attention to their relationship.

And they tell their visitors that the partnership is still a work in progress. Managers say its 75 percent towards where they want it to be; nurses feel there are still outstanding issues to be resolved.

But both parties agree their relationship has come a long way since 2007 when DHB management took its initial steps to confront its adversarial employment relationship with nurses that had dogged the hospitals for as long as anyone could remember.

Work began by engaging external facilitators who brought together management and senior nursing union representatives to scope the "current reality" at the hospitals with the aim of getting all cards on the table – good and bad.

The partners were then put through a training programme focusing on possible joint solutions rather than hard-and-fast answers. They next agreed on processes to find solutions.

Nurses representatives admit to being sceptical about management's partnership proposal (they didn't trust managers and saw the proposal as a "waste of money"), but by lunch on the first day of their meetings with management they believed it could work.

The new environment produced quick dividends with reduced sick leave and improved staff engagement.

This early relationship building laid the groundwork for extending the partnership under a pilot programme that originated in a

CASE STUDY

Department of Labour
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national employment agreement between nurses and DHBs. This agreement sought to balance nurses' expectations regarding workload and pay, management calls for greater efficiency and joint concerns about patient care.

Moving to the next level

The programme gave the Bay of Plenty DHB the tools and framework to take its partnership to the next level, to operationalise the partnership. How could the DHB improve capacity at its hospitals by having the right staff available at the right time and ensuring safe patient care?

To do this, the partners leveraged their now-positive relationship to jointly identify and fix outstanding issues in hospitals' wards. Key among these were reviewing base staffing and workplace flexibility (responding to workload demand by transferring nurses to where they were more urgently needed) and ensuring electronic reporting on patient care needs by nurses was accurate and acted upon by management.

At this stage, the DHB was still focused on the partnership between nurses and management. It was also seen as a human resources/employment relations undertaking.

But the partners were realising that what they had on their hands was capable of much more. They were only tapping into a fraction of the power of the partnership model.

They wanted to use it to manage a culture change throughout the DHB. In fact, different parts of the organisation, including other unions and business units such as finance, also wanted to be counted in after seeing what was being achieved.

This resulted in the partnership being extended beyond nurses and management to one that encompassed the whole organisation, using the principles that had served the original partners so well. These principles include trust, joint decision making, sharing of information, shared ownership of problems and pushing decision making down to the lowest possible level of the organisation.

All activities were tested by the question: "How does this improve the patient journey?"

The HR team has now been joined by senior DHB leadership, including the chief executive, chief operating officer and chief financial officer as active contributors to the partnership.

The results have been dramatic.

A key ongoing focus for the enlarged partnership is to maintain momentum for change and in particular not letting relationships stagnate through being taken for granted or not worked on.

Healthy relationships are at the heart of the DHB's success.

Lessons

Define your relationship. Set out a shared vision, and what you want to achieve, and then document your progress.

Total commitment is required from the start. Commitment-phobes do not belong in successful workplace partnerships. Find the right people who will support partnerships in spirit as well as in word. The Bay of Plenty DHB partners, after initial leaps of faith, have been "dogged" in their commitment.

But feel free to say what you think. Be transparent. Unions should back their members and managers need to manage. Create an environment where inevitable conflicts are depersonalised and everyone focuses on the issues.

Invest in the partnership. The DHB and nurses committed time and money to make sure their partnership was a success. This includes hiring facilitators, attending workshops, training and meetings and buying IT to share information.

Recognise that getting started can be tough. "You have to eat your broccoli before dessert." Allow time for the full potential of a partnership to be realised.

But get early runs on the board. To build trust in both the partnership and its processes, quickly show that a genuine and long-term partnership can produce results. At the DHB an early win was a reduction in absenteeism.

Bring in outside help. Use an external facilitator who can provide impartial advice and at the same time ask hard questions. Facilitators experienced and knowledgeable in employee engagement and union-employer relationships keep everyone focused.

Stay focused. There are lots of distractions in relationships including new people coming on board, issues not related to the partnership arising and success can lead to neglect. Continuously work on the relationship to prevent it going backwards. The DHB has held a partnership "refresh".

Little things matter. Don't fixate on "big issue" processes and meetings. Simple acts like staff and management sharing a ride in a taxi or stopping to talk in the cafeteria make a difference.

Workplace partnerships offer more than just improved employment relations. Partnerships can unleash the full potential of organisations. The DHB's experience has been that it has achieved more by collaborating than by having "everyone stuck in their corner".

More information

Bay of Plenty District Health Board: www.hopdhb.govt.nz

New Zealand Nurses Organisation: www.nzno.org.nz

Department of Labour: www.dol.govt.nz/er

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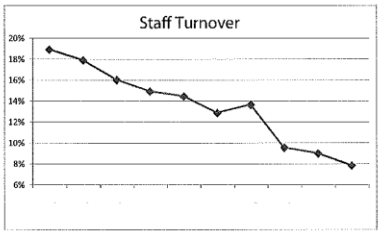

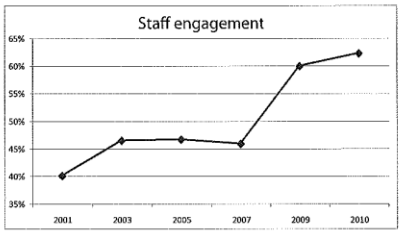

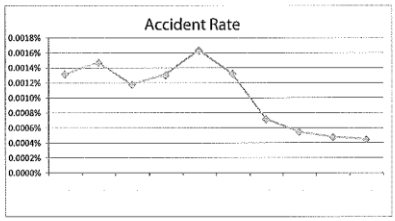

3.3.3 Bay of Plenty DHB