MEAT & LIVESTOCK
AUSTRALIA

Evaluation of MLA's Occupational Health and Safety Continuous Improvement Program

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A Report prepared by

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Abbreviations

CIP	Continuous Improvement Program
CIT	Continuous Improvement Team
DWHS	Division of Workplace Health and Safety
IADRI	Intent, Approach, Deployment, Results, and Improvement – the five elements of the improvement loop.
MISHCIF	Meat Industry Safety and Health Continuous Improvement Framework
MLA	Meat and Livestock Australia
MRC	Meat Research Council
OHS	Occupational health and safety
SOP	Safe Operating Procedure

Executive summary

A key element of research and development in the meat industry has been a focus on improving OHS performance through the implementation of systematic approaches to OHS. Over the last six years the industry has sought to develop models for best practice in OHS management that could be applied at the enterprise level. The Meat Industry OHS Best Practice Project grew out of this approach and was built on the recognition that best practice is a *process* that leads to improvement, and the understanding that the specification of precise activities does not help enterprises to improve their performance. The success of this project led to the Meat Industry OHS Continuous Improvement Project. A pilot of this project, which relied on the implementation of the Meat Industry Safety and Health Continuous Improvement Framework (MISHCIF), was conducted in Queensland and South Australia in 1999/2000 and is the subject of this evaluation.

The evaluation method took an improvement approach in order that recommendations could be offered that would lead to changes in the program, the model and its implementation as necessary. The objectives of the evaluation were to:

1. Evaluate the indicators of success and failure regarding the uptake of OHS Management Systems by enterprises, including an attempt to quantitatively analyse whether or not the Project has improved OHS (and workers compensation) performance at the target sites.
2. Qualitatively compare the performance of those enterprises that were involved in the Best Practice Program and the Continuous Improvement Program and identify their indicators of success.
3. Recommend whether the OHSMS approach will consistently improve the OHS performance of the industry.
4. Confirm any changes in the application of the OHSMS approach since the final report to the industry in June 1998.
5. Review the effectiveness of approach of the Continuous Improvement Project implemented in Queensland and South Australia.

In summary, the evaluation found that whereas the project achieved worthwhile improvements to site OHS management and the working environment in most participating enterprises, there were a number of implementation issues that diminished the impact achieved. These need to be addressed in any broader application of the OHS CIP.

In some enterprises there was substantial and realistic management commitment, which included adequate resourcing for the project to enable workforce participation and decision-making, but this was by no means universal.

Key features of success were identified:

- effective facilitation by either an external consultant or an internal specialist with skills in change management as well as OHS. This facilitator needs to be both

familiar with and committed to implementation of the continuous improvement approach;

- CEO/senior management commitment and involvement;
- Active workforce participation;
- Exchange of information through effective networking.

Conceptually, the MISHCIF model was found to be sound and, at those sites where it was properly employed, it was shown to provide a valid basis for implementation of a systematic approach to OHS management in the meat industry. There was no evidence that a 'better' model would have worked any more successfully. However, the application of the MISHCIF approach would be strengthened if the materials were reviewed to encourage consistent understanding and application by sites and facilitators in the future.

The evaluation found that there remains a need for guidance in implementing a systematic approach to OHS in the meat industry. At enterprise level there is lack of understanding and awareness of the work involved in managing OHS and there is little recognition of the importance of workforce involvement.

In examining the role of the consultants in the project it was clear that as well as OHS expertise, change management and facilitation skills are critical in those managing the implementation of OHS improvement programs. The more successful consultants engaged senior management, provided appropriate training, actively facilitated worker participation, allowed enterprises to define their aims for the project, and demonstrated visible achievements early in the project. In South Australia a top-down, expert-led and rule-bound approach was used instead of the MISHCIF process. This did not result in sustainable outcomes in that State.

Overall management of the project could have been improved if links to local Meat Industry OHS Committees were developed and used. These committees also provide a focus for communication between enterprises. Networking amongst meatworks was identified as an important and useful tool for improvement in OHS that could be supported by the MLA.

This pilot program has demonstrated that, properly implemented and with appropriate management support, the MISHCIF process can provide an effective means of improving OHS performance at enterprise and industry level. The pilot has also served a useful purpose in identifying a number of implementation issues that need to be addressed in any broader implementation of the OHS CIP across the industry.

Section 1 Introduction

Improving the OHS performance of the Australian meat industry has been a key element of research and development in the industry for many years. In particular, projects over the last decade have focussed on supporting the implementation of systematic approaches to OHS management. This focus reflects strategies evident in other industries, as well as enforcement and compliance approaches of the state OHS jurisdictions.

The Meat Industry OHS Best Practice Project grew out of this approach and sought to develop models for best practice in OHS management for the industry. The best practice project was built on the recognition that best practice is a *process* that leads to improvement and the understanding that the specification of precise activities does not help enterprises to improve their performance. The success of this project led to the Meat Industry OHS Continuous Improvement Project. This was intended to support and structure continuous improvement in OHS management by providing impetus to continue to address OHS, particularly for those enterprises that had participated in the OHS Best Practice Project. It was feared that, given their achievements under the best practice projects, some enterprises might decrease their emphasis and effort on OHS management with the risk of a corresponding decline in performance. Equally, the continuous improvement project was intended to provide a framework that would help poorer performing enterprises to develop and implement effective OHS improvement strategies.

The framework developed in the OHS continuous improvement project was not designed as a system specification. Given the work being undertaken by the jurisdictions and Standards Australia, the project sought to provide a tool that would enable meat industry enterprises to adapt system specifications promoted or supported by their jurisdictions to meet the needs of their individual enterprises. It also sought to move away from a compliance approach to OHS management systems to one focussed on improvement.

The approach to framework development was based on a review of the limited empirical evidence for the efficacy of formal safety management systems (SMS). The major Australian review of the area concluded that "a conclusive link between developed health and safety management systems and a sustained reduction in injury and ill-health levels has not been established" (Gallagher 1997:161). Indeed, a focus on formal systems without also addressing cultural and political aspects of the workplace seems to have limited effect on OHS performance, as Hale and Hovden (1998) report. Hale and Hovden claim "this limited structural approach misses three-quarters of the factors that have proven links to performance" (Hale 1998:156).

A number of studies suggest that a focus on rule-bound approaches alone can create more problems than they solve; it is important to consider the implementation of systems, not just their content (Wright 1994; Marcus 1988; Pitzer, 1997; Rasmussen

1994 and 1997; Weick, 1999). Australian research by Johnstone (1998) investigated the use of workplace health and safety plans in the Queensland construction industry. He found that it was not the *content* of the plans which influenced their effectiveness, but *how they were used*. Those companies that just used 'off the shelf' or 'tick and flick' approaches did not have positive effects, whereas those that developed their plans in-house demonstrated increasing understanding and control over their operating environment (Johnstone 1998:189). Similarly, a Swedish examination of the effects on working conditions of the implementation of ISO 9000 in six furniture making firms concluded that: "it appears that the change process, more than the actual quality standard as such, had a major influence on both the extent and the type of outcomes" (Karltun, Axelsson et al. 1998:231). As Gallagher acknowledges: " 'people management' factors underlying health and safety management systems may be just as important as the existence of comprehensive health and safety management systems" (Gallagher 1997:220).

In other words, effective safety management systems are designed and implemented by the people within the enterprise, who will work with them. Instead of imposing a system with accompanying policies and procedures (and paperwork!), the OHS continuous improvement project sought to help each enterprise develop a system to suit the culture, environment and risks of the specific meat industry enterprise.

The framework (MISHCIF) developed on this basis was presented to the MLA in 1998.

The MISHCIF outlined

MISHCIF, the Meat Industry Safety and Health Continuous Improvement Framework, was developed as an industry-sponsored means of improving OHS across the sector. Designed to be compatible with the OHS management systems supported by State OHS jurisdictions but with a focus on continuous and sustainable improvement, MISHCIF has the following five elements, with attendant sub-elements:

1. Leadership
   - Policy
   - Responsibility and accountability
   - Planning and goal setting
   - Allocation of resources
   - Demonstration of leadership
2. Monitoring and Improving
   - Incident investigation
   - Auditing
   - Performance measurement
   - Monitoring, evaluation and review
   - Improvement processes
3. Managing People
   - Training
   - Communication
   - Consultation and participation
   - Employment procedures (inc. contractors)
4. Managing Systems

Purchasing
Maintenance
Work procedures
Records and documentation
First aid
Emergency response
Issue resolution
Legislative compliance

5. Controlling Hazards
   Hazard identification processes & procedures
   Risk assessment
   Risk control processes

As a continuous improvement model, the approach necessarily has a people and outcomes focus rather than a procedures and compliance focus. This focus supports improvements in the OHS performance of enterprises. The MISHCIF can be used in three ways:

1. As a straightforward and simple review and planning exercise with a representative group from the enterprise, such as the OHS Committee.
2 As a way to structure a detailed strategic planning exercise with a representative group from the enterprise.
2 In a detailed (perhaps external) review or audit.

Each of these approaches uses the key features of MISHCIF - the five elements listed above model and the IADRI improvement loop.

IADRI allows the process of improvement to be explicitly addressed as illustrated in Figure 1 below.

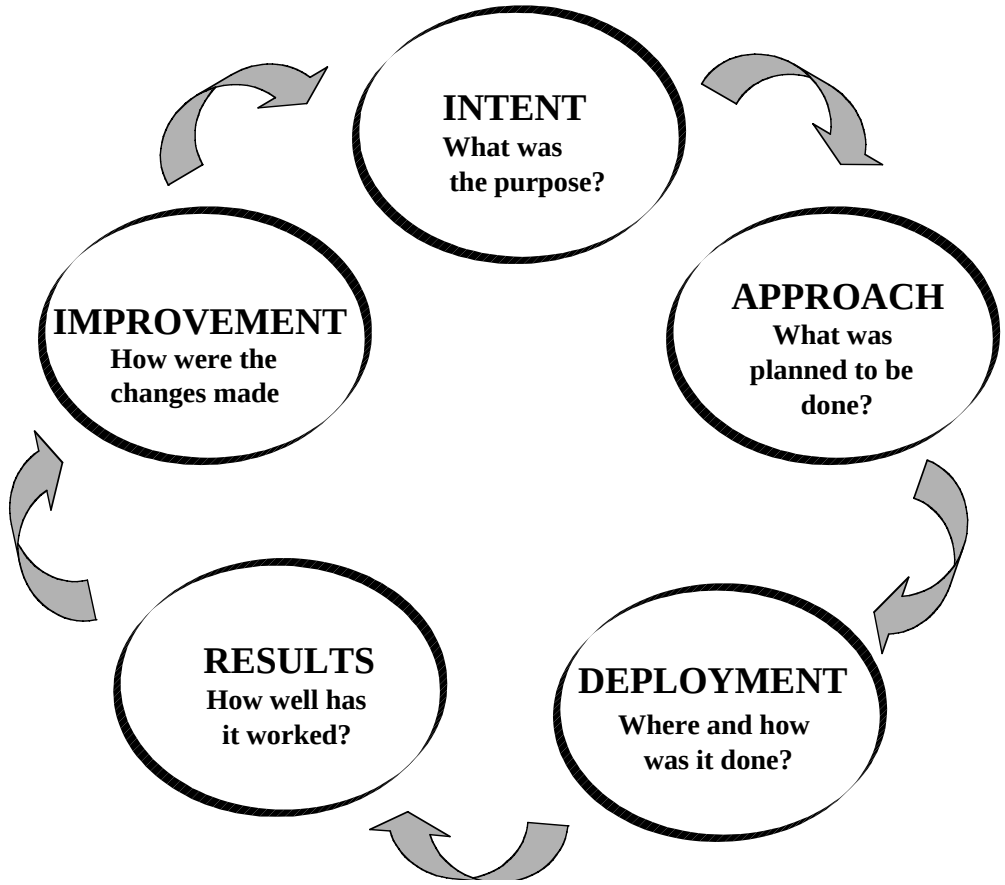

Figure 1 The IADRI Cycle

Intent outlines the purpose of the element - what was the enterprise aiming for?

Approach describes the way the enterprise decided to address the element - was the approach innovative, related to the intent, planned and preventive?

Deployment deals with the way the approach was put into practice – did it happen according to plan? Did it happen consistently in the enterprise?

Results covers how effectively deployment worked - did the enterprise get the outcomes aimed for?

Improvement refers to how the lessons of the previous steps have been used to improve intent, approach, deployment and, hopefully, results – were the activities changed as a result of what has been learned?

MISHCIF was the framework for a pilot project in Queensland and South Australia during 1998/2000. This pilot project is the subject of this evaluation.

Potential Industry Benefit

As the industry has recognised, poor OHS performance is a major barrier to the competitiveness of the meat industry. It contributes to unnecessarily high labour costs and is a major constraint on the industry's capacity to innovate. An effective industry framework for continuous improvement in OHS holds the potential not only for improved OHS performance, but also to realise flow-on effects for the competitiveness and security of the industry. As the evaluation of the OHS Best Practice Project found, enterprises which improve OHS management can find other workplace reforms are easier to implement, because of the platform for change that OHS provides.

Objectives

The purpose of this evaluation is to ensure continuous improvement in the industry's OHS improvement strategy by allowing changes to the framework and implementation to be developed before wider application is undertaken in industry. As specified in the brief, the objectives of the project are to:

- Evaluate the indicators of success and failure regarding the uptake of OHSMS by enterprises, including an attempt to quantitatively analyse whether or not the Project has improved OHS (and workers compensation) performance at the target sites.
- Qualitatively compare the performance of those enterprises that were involved in the Best Practice Program and the Continuous Improvement Program and identify their indicators of success.
- Recommend whether the OHSMS approach will consistently improve the OHS performance of the industry.
- Confirm any changes in the application of the OHSMS approach since the final report to the industry in June 1998.
- Review the effectiveness of approach of the Continuous Improvement Project implemented in Queensland and South Australia.

Evaluation approach

Evaluation is the systematic collection and analysis of information to allow informed decision making about a program or activity. Our approach to this evaluation focussed on the effects of the project so far to identify strategies which would allow improved implementation of an OHS Continuous Improvement Framework in the industry. This approach is based on the recognition that the objective of improving the management of OHS in the meat processing industry is not under debate in this evaluation. Rather, the evaluation aims to identify the lessons learnt from the OHS Continuous Improvement Project so far, in order to establish an improved approach for the future. This includes potential changes to the content and structure of the framework itself as well as improved implementation strategies.

Given this orientation, the methodology described below aims to answer six key questions:

1. To what extent have the objectives of the project been attained?
2. What changes have occurred in the context of the project that have affected and will continue to affect implementation?
3. What have been the intended and unintended outcomes of the project?
4. How has the content of the framework affected these outcomes?
5. How have differences in implementation and internal and external environment affected outcomes?
6. Has the project met identified needs?

The answers to these questions have been used to develop practical, concrete recommendations for improved implementation of OHS continuous improvement across the industry.

This report

This report analyses the data from the evaluation. It summarises its findings, poses questions for consideration and makes recommendations for action that arise from the data. This report is presented in six sections:

1. **Introduction** – which outlines the background to the evaluation.
2. **Method** – detailing the manner in which the evaluation was conducted.
3. **Evaluation criteria** – which presents the findings of the evaluation against the evaluation criteria.
4. **Evaluation questions** – provides an analysis of the findings
5. **Conclusions** – summarises the findings of the evaluation in relation to the objectives of the evaluation
6. **Recommendations** – sets out the recommendations.

Section 2 Method

The evaluation was conducted by four consultant groups: Shaw Idea Pty Ltd (Andrea Shaw), New Horizon Consulting Pty Ltd (Verna Blewett), Turning Point Pty Ltd (Sharon Murray) and ACIL Consulting Pty Ltd (Paul Balfe and Helen Dent). The work was undertaken in four stages:

Stage 1 - Develop evaluation questions and criteria

Evaluation questions and criteria were developed based on:

- The key evaluation questions identified in the last section; and
- The objectives of the project.

The consultants developed the draft questions and criteria in consultation with the project coordinator and the reference group. This was an iterative process and the questions and criteria were modified on the basis of feedback provided through consultation. The interview schedule was devised on the basis of this information and can be found at Appendix 1.

Stage 2 - Collect information about the criteria

Data relating to the questions and criteria were collected from:

- All participating meatworks;
- Two non-participating meatworks in each of South Australia (SA) and New South Wales (to investigate any effects relating to external strategies such as jurisdictional enforcement activities);
- Three non-participating meatworks which were previously involved in the OHS Best Practice Project;
- Stakeholders, including the consultants involved in the implementation of the project; and
- Relevant documents and literature (eg enterprise records, project reports, industry investigations, investigations into the use and effectiveness of OHS management systems, the evaluation of the OHS Best Practice Project and related case studies).

The following data collection techniques were used:

- Structured interviews and document reviews were conducted with personnel at each participating meatworks, with the exception of one company which had multiple plants in Queensland. Access to these plants was not provided, although limited

written notes in response to the structured interview questions were provided by that company's head office. Site inspections were conducted of a cross-section of plants in SA and Queensland.

- Interviews and document reviews were conducted at two non-participating meatworks in SA and NSW, as well as at three Victorian sites that participated in the OHS Best Practice Project. Site visits were conducted of all Victorian and both SA sites.
- Interviews were conducted with key stakeholders identified by the reference group.
- A review of the literature was conducted.

Non-participating enterprises were identified and recruited using the contacts of the reference group and project consultants. Participants in the OHS Best Practice Project were selected on the basis of Andrea Shaw's experience in evaluating this previous project, using the evaluation criteria and questions to determine selection criteria. These selection criteria were also used to identify the four non-participants, using the reference group for information. Agreement to use these particular enterprises was confirmed with the OHS project leader before approaching them.

Stage 3 - Analyse information collected

The data were analysed to identify findings in relation to the evaluation criteria and questions. In particular, key features of successful projects, as defined by the criteria, were identified. Where necessary, case study firms were re-contacted for comment and confirmation on particular issues. This preliminary analysis was discussed with the OHS project leader.

Stage 4 - Prepare and present the evaluation report

A draft report was prepared, based on the analysis of Stage 3. Andrea Shaw presented this to the project's Reference Group on 13 February 2001 on behalf of the consultants.

This final report completes Stage 4.

Confidentiality

During data collection, each enterprise was assured of the confidentiality of the information collected in the enterprise. Identifying the enterprise from which specific data were collected is not significant for the purposes of this study, since the enterprises were recruited as part of a pilot project or as representatives of meat industry enterprises that did not participate. Consequently, the identity of enterprises that were sources for information documented in this report is not revealed. Instead, codes (eg SA 1 – 5 and Qld 1 - 11) are used.

Similarly, all participants in group and individual interviews were assured of the confidentiality of the information they provided. We have therefore been careful to protect the identity of the interview participants from enterprises in this report. We have worked on the basis that participants gave informed consent to participate in

interviews and that they gave information on the basis that they would not be identified, and that no harm would come to them arising from this report (Kellehear 1989:63). Stakeholders are identified, however.

Section 3 Evaluation criteria

The evaluation criteria were established during the first stage of the evaluation. This section details the findings of the evaluation with respect to these criteria. Data outlined in this section were used to answer the six key evaluation questions about the project models and project outcomes in the subsequent section of the report.

Evaluation criteria

1. Project models

1.1 Enterprise level projects:

- Nature and range of models developed by participating meatworks;
- Common features of the models.

1.2 Senior Managers / CEOs:

- Role of Senior Managers / CEOs in implementing changes;
- Nature and extent of Senior Manager / CEO involvement in projects (enterprise and industry);

1.3 Participation:

- Number of plants involved in project;
- Number (and %) of employees involved in each project;
- Extent and nature of employee involvement in decision-making about projects;
- Perceived roles of individuals in the projects;
- Extent and nature of management involvement.

2. Project Outcomes

2.1 Achievement of objectives:

- Completion of planned activities;
- Achievement of performance targets (where defined);
- Attitudes to the projects (eg about the worth or value of project);

- Uptake of the projects post-July 2000 and desire/intention to continue or extend projects.

2.2 Assessment against MISHCIF criteria:

- Leadership
- Managing by system;
- Managing people;
- Controlling hazards
- Monitoring and improving.

2.3 Compensation data and other statistics:

- Changes in LTIFR, accident and incident data, number and costs of compensation claims as available at enterprises, including comparison with non-participants.
- Changes in any other performance indicators used by participating enterprises.

2.4 Productivity and quality:

- Changes in profits, productivity/yields, costs of production, quality statistics as available at enterprises and industry wide, including comparison with non-participants.

1. Project models

In general, the MISHCIF model was not thoroughly introduced into any of the participating enterprises. Distinct approaches were used in the two states and by the different consultants. In South Australia the MISHCIF process was substituted by extensive legislative audits, whilst in Queensland a variety of alternatives was employed, depending on the areas of expertise of the different consultants.

1.1 Enterprise level projects

Nature and range of models developed by participating meatworks

In South Australia no option was given to plants to pursue the MISHCIF program as outlined in the MLA documentation. Instead, the consultant conducted a legislative audit to determine "the gaps" in performance by each plant. The MLA understood this was intended to be regarded as part of the 'Controlling Hazards' component. Thus the consultancy in each plant consisted of a legislative audit conducted by the consultant but there was minimal input from people at the plants. There was no attempt to introduce the MISHCIF framework as a means of self-assessment by the plants, which could enable continuous improvement teams (CITs) to examine their own hazard

management practices and determine their performance gaps themselves. Instead, the model of the 'expert' was used, contrary to the principles of the MISHCIF program.

Expectations in each plant varied, depending on their OHS knowledge and experience. For instance, at SA4 the OHS Coordinator had "no idea what to expect". At SA1, concern existed about OHS, but activity had been minimal because of uncertainty about how to initiate improvements. The OHS Coordinator wanted training for the OHS Committee and wanted to improve his own understanding and knowledge of OHS legislative requirements.

In Queensland, the MISHCIF was used as the starting point, while the intentions of participating enterprises varied. Qld10 wanted to change its 'ad hoc approach' to safety management and wanted tools to review and monitor their safety management system. They sought a reduction in incidents and injury and to document policies and procedures. A number of other sites wanted to make use of the extra training that was available through the project as well as project-planning assistance for site OHS committees. Qld4 and Qld11 intended to develop an OHS manual, confined spaces procedures and improved communication of OHS issues as a result of their involvement with the program.

Qld3 came to the program with little OHS experience. It had a "non-existent OHS program" prior to the CIP, did very badly on the self-audits but want to see a "leap in OHS performance" as a result of the company's participation in the program. At Qld6 the new HR Manager started just prior to the commencement of the OHS CIP project and saw it as an opportunity to try to develop more proactive OHS systems.

Common features of the models

In South Australia the single common feature of the program was a detailed legislative audit. This comprised a tour and inspection of the plant by the consultant, accompanied by the enterprise's OHS Coordinator, in order to identify hazards. In some plants, the more serious hazards were fixed immediately. For example, in one plant, gas bottle storage was made safe and procedures for storage and use were prepared, in another an unsafe door was repaired and rehung. While these audits were regarded as successful in themselves, they were essentially mechanical and lacked the participative and consultative activities that would have allowed people in the enterprises to learn how to identify, assess and control hazards proactively for themselves. As a result, these audits cannot be regarded as being consistent with the intention of the model, nor did they add value to the MISHCIF approach. At SA3, where an egalitarian OHS Committee and a participative approach already existed, the legislative audit added nothing to its development. The OHS Committee expressed concern about their lack of involvement but the consultant did not invite their participation. At SA2, despite considerable on-site attendance by the consultant, there was no knowledge of the MISHCIF framework or the IADRI process. Instead, the consultant introduced the Safety Achiever Bonus Scheme (SABS), the SA jurisdiction's OHS management system model. The OHS Coordinator found the structured approach of SABS useful. However, the company has determined it did not find involvement in SABS cost effective and will not continue with this approach. Arguably, the company could have used MISHCIF to approach SABS, developing a process for improvement that was sustainable.

At SA1 the useful features of the project, as identified by the OHS coordinator, were the hazard identification and risk assessment process and the prioritising of needs. These were each important to the company at that time, although they were delivered within the context of the legislative audit and fostered a compliance, rather than a continuous improvement, approach. The OHS Coordinator suggested that it was good that the program was flexible enough to allow such deviations to occur. He said, "the material needs to be very down to earth and applicable to *this* workplace". He thought the process could be improved by using the OHS committee to identify problems and assess them. The committee could do the planning for improvements and monitor them. To do this, they would need to be realistic about what's achievable and "just chip away at things to get runs on the board" – in effect he was describing the MISHCIF and IADRI processes, which were not introduced to the plant. Finally, SA1 people insisted that any training should be conducted when people were fresh, not following the end of the shift when people were tired. Although they acknowledged that the content of the training they received was good and they had no doubts about the expertise of the trainer, they found the training boring and fell asleep.

SA5 wanted to be introduced to the use of the MISHCIF model. They would have appreciated more contact with the consultant and would have preferred to have had the project team involved in the work. The OHS Coordinator considered that better management of the consultant combined with more explicit descriptions of how the model should be implemented may have prevented misinterpretation of the program.

At SA4 the OHS Coordinator complained that "the place is sinking under the weight of consultants … we need to kill meat or the rest is academic". He observed that "systems can be used to hide anything" and that emphasis on paper-based work was not necessarily useful in making the workplace safe. What he wanted was action taken that involved the people who do the work; MISHCIF had not been represented as allowing and encouraging this.

For his part, the consultant in South Australia believed that including a legislative audit as part of the process and allowing a longer time for change to occur could improve the program. He felt that more time should be allowed to incorporate basic OHS training into the project, but that this need would be cancelled if better entry criteria for the program were established. He suggested that companies are too undeveloped "at ground zero" to use IADRI successfully. The consultant claimed the IADRI model was "too subjective" and wanted to find an "external driver" that would motivate the companies to continue to improve. This he judged to be WorkCover SABS (Safety Achiever Bonus Scheme). He determined that MISHCIF could only be used successfully by companies that were already doing well. That is, the consultant was not committed to the process himself and possibly misunderstood it. He also suggested that better briefing for the consultants could have been conducted up front so that they fully understood the process, procedures and approaches specifically relating to MISHCIF and IADRI.

Participant companies in Queensland fared somewhat differently. In most of these plants the consultants made some attempt to introduce IADRI and the MISHCIF model. Qld5's approach had three main features: they used the existing safety committee, the IADRI process was used systematically, and they identified priority areas that required focus. They reviewed existing systems and identified four areas needing upgrade and overhaul and addressed each of these using the IADRI framework. Booklets, manuals or

forms were produced for each area as necessary and then implementation was scheduled. IADRI was used to develop and implement four initiatives: revised accident/incident report form and procedures; introduction of a stretching program (but not manual handling risk assessment and control); development of a contractor conditions handbook, and the development of a visitors' handbook.

At Qld6, Qld7, Qld10 and Qld11 a two-day workshop was run to introduce MISCHIF. Day 1 looked at the "big picture" and Day 2 covered analysis of site issues and action planning. One plant (Qld10) shut down the plant for the day so all staff could attend a full-day site briefing. Companies developed their priorities for action from the biggest gaps in the initial audit. The consultants provided training on the concepts but also reported that "a lot of effort had to be put into guidance and facilitation". At each plant, the consultants saw that it was important to "get some early runs on the board" so that teams could see positive achievements and their credibility was built.

At Qld7 and Qld6 the OHS Coordinator said, "the model is great – if you follow it you get results. It's not difficult to keep on track … it's not the model, however, it's the commitment to it, the time available, that makes the difference." The consultant judged that the CI teams became self-starting at these plants. Line managers were involved after some initial reluctance, and came to recognise the value of worker input. The teams were "good, effective and well balanced". At these plants MISHCIF was used to identify projects and IADRI was used to work out how to resolve them. However, Qld6 gave the consultant primary carriage of the project instead of having them provide training for on-site personnel. At Qld7 the consultant dealt primarily with the OHS Coordinator rather than the committee or team. Although IADRI was used, the review and improvement steps were not undertaken, so the loop was never closed.

At Qld3, the MISHCIF was not used. The consultant did the audit and the outcome was the engagement of a health and safety officer (HSO). This was a useful appointment, but this person, together with the HR Manager, proceeded to take the major role in the project, so that there was no worker involvement. The HSO's focus was on administrative arrangements, record keeping and documentation. At this site, the consultant took on a "coaching and support" role, but in the words of the HR Manager "there was no way that a visit one day a month would achieve anything … it was never what we were going to need".

At Qld4 and Qld11 initiatives that arose out of the program concerned confined spaces training, a documented OHS system and an OHS newsletter. At Qld6 the program identified the need for health and safety training for all representatives, changes to the auditing system, and the need to reassess new starters after one month of employment. However, at Qld3 the main focus of the OHS improvement effort was record keeping and other non-compliance issues that were identified by the consultant. Physical changes were made to signage, guarding and equipment as a direct result of the audit.

Potential improvements to process

Potential improvements to the process were identified by participating companies as well as by consultants. No changes to the model itself were recommended, rather comments focused on the delivery of the program, rather than on the model itself. The importance and value of networking between plants and adherence to strict entry criteria were common suggestions. Other themes for improvement included the skills of the

consultant in facilitating the process and the supply of written materials suitable for low-literacy environments.

At Qld5 the strong opinion was that the program would have worked better if team members had been given a better understanding of their roles and functions and had been able to share their experiences by networking with other participating sites.

SA2 wanted to see language specific materials – translations for common languages on their sites and documentation that was worker friendly for their low literacy environment.

SA4 suggested that focussing on one issue at a time so as to make incremental improvements might have been more useful than a plant-wide audit. "Many bites at the cherry would have been better" as changes would be made progressively and there would have been better opportunity to involve workers in the process. Given the nature of the program in South Australia, this view tends to confirm that properly applied, the MISHCIF program could have had benefit for participating companies. The OHS Coordinator had established informal networks with other meatworks and had found them valuable in solving hazard control problems and in developing policies. He considered that such networking, with the auspices of the MLA, would be a valuable addition to the program, or could stand alone.

Qld11 and Qld4 both suggested that networking with other sites would have been a valuable addition to the program, especially networking amongst other companies, not just different sites of the same company. The OHS Coordinator also suggested that more time needed to be spent on facilitation with more regular consultant contact. In particular, the process would have been improved if the consultant had worked through the first and second applications of IADRI to ensure that participants understood the process. This would amount to "putting a chock under that issue" and being sure it was dealt with before moving on. These sites were in danger of imminent closure so the consultant focussed on developing personal skills rather than on organisational systems.

The South Australian consultant and one Queensland consultant both expressed the view that stricter selection criteria should have been applied for entry to the program. Neither consultant believed that any of the plants with which they dealt were ready to operate at the level required by MISHCIF. One company identified that the program was provided too early in their development. Coverage of the companies was also a concern for the consultants; one asserted that the load was too much for one consultant.

OHS Coordinators in both States suggested that the approach of the consultant was important to the success of the program. Facilitation skills coupled with technical expertise were necessary, but there was a need for consultants to be led by the teams in the companies, rather than impose their particular expertise. At Qld5 the CIP was regarded as more effective after a change in the consultant. The first consultant's approach was to push the team into things they did not think were appropriate, whereas the second consultant built on existing systems.

1.2 Senior Managers / CEOs

Role of Senior Managers / CEOs in implementing changes and nature and extent of Senior Manager / CEO involvement in projects (enterprise and industry)

In general there was little involvement of CEOs in implementing changes in the participating plants. Their role was mostly confined to agreement to provide resources, which, although important in itself, was not matched with personal involvement in any activities. Aside from OHS Coordinators and Human Resource Managers (where these existed), senior managers were also not usually involved in the program. Three Queensland sites were exceptions to this, exhibiting substantial senior management involvement. For example, senior management at Qld10 were committed to significantly improving OHS in the plant and this led to high involvement in the program. As a result, projects at these three sites also exhibited considerable involvement from all levels of the organisations. The small number of sites with senior management involvement is disappointing, given the importance of senior management involvement in organisational change and the explicit coverage of this as a critical feature of MISHCIF.

1.3 Participation

Number of plants involved in project

Ten companies and a total of 16 plants were involved in the MISHCIF project. Five plants were in South Australia with the remainder in Queensland. The plants were located in a mix of metropolitan areas, regional centres and rural environments.

Number of employees involved in each project

In each of the South Australian plants, the OHS Coordinator was the primary person involved in the project. Six members of the OHS Committee were involved in training at SA2 and seven at SA1. This training covered aspects of OHS Committee activity as well as risk identification, assessment and control. No training on the operation of MISHCIF or IADRI was provided.

In Queensland, the key involvement also came from the OHS Coordinators at the plants. Continuous Improvement Teams (CITs) or OHS Committees were also involved in various project activities at most Queensland sites. Broader involvement occurred at a limited number of sites. At four plants, CITs were established to undertake the project and received two days of training to commence the project. One of these plants, Qld10, also shut down the plant to provide a full day of briefing on the project for all staff. However, ongoing involvement by the teams was limited in most cases. At one site, involvement was even more limited, with only the newly appointed Workplace Health and Safety Officer and the HR Manager involved in carrying through the project. At three Queensland sites, the project did not directly involve on site workers at all.

Extent and nature of employee involvement in decision-making about projects

In South Australia there was no involvement of employees in decision-making about the projects. Instead employee involvement was limited to brief encounters with the consultant during the conduct of the legislative audits or as recipients of training in two plants.

The extent of employee involvement in decision-making about the projects in the Queensland plants was also limited in most cases. Although continuous improvement teams operated with employee involvement at most sites, employees played only a limited role in determining priorities for action. In general, management nominated these, or the MLA consultant recommended priorities. Exceptions were Qld10, Qld 4 and Qld 11, which involved employees extensively in identifying priorities and initiatives.

Perceived roles of individuals in the projects

In South Australia, where the project was conducted as a legislative audit undertaken by the consultant, there was very narrow involvement in the project by company personnel. In the main this was limited to the OHS Coordinator in each plant. Typically, the OHS Coordinator showed the consultant around the plant, answered questions and introduced other members of the organisation to the consultant in order to answer specific questions. Senior management were informed that the consultant was on-site, but were not further involved in project activities. For most plants the consultant wrote an extensive report and developed a 'strategic action plan'; in each case he liaised with the OHS Coordinator about the preparation of these documents. Other than this, there was little contact with either management or employees.

At SA5, the OHS Coordinator said, "no-one [other than he] knew the OHS CIP was going on". At SA3, members of the very active OHS Committee remembered the content of the visit by Andrea Shaw when she introduced the MISHCIF framework in 1998, but could not remember the program consultant's visit of several days during which he conducted the audit. At SA2 the members of the OHS Committee were actively engaged with the consultant, but this was limited to assistance with the conduct of the audit; there was no attempt in any of the SA plants to introduce a framework of continuous improvement.

In Queensland, the consultants introduced an OHS CIP program, however there were variations in the involvement of people in the program. At Qld6 the OHS Coordinator reported that the consultant, not the OHS Committee, did the work of identifying problems and developing solutions. They expressed the view that it would have been better if the Committee had been more involved in devising the solution. At this plant the supervisors were supportive and released employees to participate in the Continuous Improvement Team (CIT) but the chosen projects did not require much involvement. The story was similar at Qld3 where, despite the support of the CEO, the workforce was hardly engaged in the process.

Both Qld6 and Qld7 reported that union involvement was vital to the successful introduction of the program. At both sites union representatives were actively involved in the process and played a significant role.

Extent and nature of management involvement

Senior and line management involvement varied in the plants. In SA, there was limited involvement by management, apart from OHS coordinators. In Qld6 there was no involvement of or commitment from senior management to the CIP. As the OHS Coordinator claimed, "Had senior management had a role and shown commitment there may have been more lasting outcomes". At some other Queensland sites management involvement was more extensive. At Qld7 the plant manager was actively involved in the program and this was regarded as important to its success. However, line manager involvement was limited. At Qld5, on the other hand, the CEO was not directly involved but supported the program and provided the resources that were needed. The Operations Manager regarded the program as 'his baby' and, perhaps as a result of his enthusiasm, the supervisors demonstrated commitment to it. Even so, he considered that the program would not have been visible to those members of the workforce not directly involved in the program. At Qld11 the involvement and commitment of the HR Manager was "absolutely critical" to the success of the project. This plant rated the project team, senior management, the union and the workforce as having full involvement in the OHS CIP. Supervisors were moderately involved however, while the support of the CEO was regarded as vital, he was not involved on a day-to-day basis and this was regarded as appropriate. Where there was strong support from the CEO, project teams, senior management and the workforce were fully involved in the project.

2. Project outcomes

2.1 Achievement of objectives

Completion of planned activities

While activities planned by the SA consultant were completed, these activities were not in keeping with the spirit or content of the MISHCIF program. From the outset, the emphasis was on 'establishing a base' and doing this through legislative audits. In some enterprises a form of hazard management was implemented, but the consultant claimed that much of this was done free of charge and was outside the actual project. In all cases the audits were conducted and in all but one case reports were prepared. However, there were no sustainable outcomes, possibly because there was no attempt to introduce a CIP framework to the enterprises or to provide skills to the organisation to undertake such activities independently. .

Having been introduced to the concept of the legislative audit, SA1 management planned to develop a better understanding of hazards that people had looked past before and to rectify previously unrecognised hazards that were there but that had been unrecognised. This was supported by the audit, but there was no process development that would allow this activity to be sustained. Limited training on hazard management provided some insight on these processes to the newly appointed committee members. However, at the end of the project SA1 had a 300-page report, but no skills to interpret it or implement it. This small firm had no OHS infrastructure so that this situation served to bewilder and disempower, rather than provide access to the path to improvement.

Lack of sustainability was a concern for SA2, too, although the company was pleased that the legislative audit had identified some important hazards. At the time of the evaluation 70% of the non-conformances that the audit identified had been addressed and an infrastructure for dealing with newly identified hazards had been developed. However, the remaining items to be attended to included some manual handling hazards that required capital expenditure to resolve. These are unlikely to be dealt with promptly. Nonetheless, SA2 was one company that commenced the project with a clear objective that it reached with the consultant. This was to integrate the legislative audit with SABS in order to reach Level 1 standing and gain a rebate of workers' compensation premium as a result. This objective was achieved. Indirect results of the project were the establishment of an OHS Team with the potential to act as a driver of change and the training of fire wardens and first aid officers. However, there was no ongoing commitment to SABS (as the company considered it not cost-effective) although the OHS Team remains active. Thus, although in the objective was achieved, it was not relevant to the aims of the CIP, in that no sustainable basis for ongoing improvement was established.

SA5 asserted that there had been no outcomes from the project other than a "very thorough audit that involved only the consultant" and a report that was too big to handle, even for a large company with resources and expertise allocated to OHS. However, as a result of the audit some problem areas in the rendering plant were fixed with positive results.

SA4, which already had a viable OHS committee in operation at the time of the project, was also the subject of a detailed legislative audit. The firm drives its own CIP approach through its safety committee and actively engages in networking within the industry. The legislative audit was regarded as the principle outcome of the project, but it was not conducted in a participative manner and did not involve the safety committee. They reported that it therefore added little value to the management of OHS in the organisation. However, the audit led to some changes to guarding of equipment in the plant and in work practices in the rendering plant. It was regarded as useful in sounding alarm bells on areas of concern that had not been picked up before. The report was used as evidence of effective OHS activity in the subsequent SABS audit by the South Australian WorkCover Corporation.

In Queensland, where the implementation of the project was quite different, longer-term outcomes were achieved. Consultants in Queensland believed that by the end of the program most teams had at least a rudimentary understanding of the model and were able to identify issues and approach them within the framework. For example, Qld10 developed a comprehensive safety management plan that was later tested by an audit conducted by the Queensland OHS jurisdiction, the Division of Workplace Health and Safety (DWHS). At Qld3, "significant improvements" were achieved through the project because dedicated resources were applied to addressing matters that were identified in the external audit process. Long-term changes were achieved at Qld6 including the introduction of review interviews for new starters in the first three months of employment and a system of 6-monthly, plant-wide health and safety audits.

At the outset at Qld4, management clearly identified that there was a lack of technical skills, which reduced the ability of workers and supervisors to conduct proper risk assessments. On the agenda for improvement was the need to: raise general awareness of OHS, address issues of work in confined spaces, and prepare a consolidated OHS

manual. They considered that a successful project should result in increased awareness, knowledge, understanding and enthusiasm; and this should be an ongoing process. The workplace should be a safer, happier place where OHS costs are minimised and there is a concomitant increase in profit. Management of the plant acknowledged that these outcomes had been achieved through the project, but found this difficult to quantify.

Qld5 was one enterprise that had an established and extensive safety management system in place prior to the program. This system already used the IADRI model. Qld5 was looking to "polish their systems" and considered they had achieved this.

Unplanned outcomes

There were also unintended outcomes that were achieved. In South Australia one participating company has done considerable work in OHS since the conclusion of the program; however, this work was reported as happening "in spite of the program". A consultant from the company's insurer turned the results of the legislative audit (from the OHS CIP program) into an action plan that helped the company achieve recognition from SA WorkCover. The OHS Coordinator cited the active development and training of the safety committee, and obtaining recognition for its safety-related work from WorkCover as recent achievements.

At Qld10 the project resulted in implementing a SMS, but the OHS Coordinator did not consider this a valid outcome of the CIP. He suggested that this means they did not undertake continuous improvement *per se*.

Achievement of performance targets (where defined)

The South Australian sites involved in the project were critical of aspects of the program as introduced by the consultant. Although they were satisfied that the legislative audit was thorough and useful in its own right, they found the lack of structure in the process unsatisfactory. No South Australian plant defined performance targets as a result of the program. SA5 found the consultant difficult to contact and then unresponsive, they did not like the lack of collaboration and considered the consultant's interpretation of the model flawed.

Flaws in the interpretation of the model were perceived at other sites, too. For example, SA1 was regarded as "too small for strategic planning" by the consultant and although the legislative audit was translated into action with the help of the local OHS authority, workers were not involved in this process. The OHS Coordinator at SA1 concluded that to be successful the project needed to be lasting, effective and relevant and that the consultant had not provided this sort of support.

A similar situation existed in Queensland where the consultants had difficulty in helping plants define measurements and criteria for evaluation. One of the Queensland consultants observed that lack of readiness of sites was a problem given that there was not even basic legislative compliance in some instances. At Qld6, OHS issues were invariably passed to the Group OHS Manager rather than local resolution being sought. At Qld6 and Qld7 the project was considered to have had partial success because the consultant was able to "make this happen", however, they considered that with a longer time frame and greater access to the consultant better results would have been

forthcoming. The CIP team was not strategic in its approach and focussed on listing things that needed fixing (and that could have been dealt with locally) rather than focussing on "the big picture". The OHS Coordinators considered that networking would be an appropriate strategy for the company to enable it to learn from other, similar plants. At Qld6 and Qld7 the minutiae of reacting to maintenance schedules "swamped desires to plan a structured approach to managing OHS".

Three sites within the one enterprise each cited oversight of OHS activities by Head Office as "stifling local initiatives" and suggested that the proliferation of manuals ("we have manuals on everything") was a problem in itself, because these were considered the safeguard. Unfortunately it was also observed that the safety representatives "wouldn't even know they exist". At these plants the consultants were only allowed to conduct high-level presentations as all specific proposals were managed out of the Head Office. They were denied access to on-site workers, thus undermining the purpose of the program.

Generally amongst the Queensland sites the tasks requiring action that arose from the OHS CITs were given to safety officers or trainers rather than operational employees. This was attributed to the difficulties associated with getting workers released from production to attend meetings or training programs.

Attitudes to the projects (eg about the worth or value of project)

Where MISHCIF was introduced as the model intends, those directly involved in the program assessed it positively. For example, at Qld7 the approach encouraged involvement and projects were selected that required involvement across levels. This meant that a wide group of people was trained in the MISHCIF approach and had the opportunity to practice the skills they had acquired. The Project Team was very enthusiastic as a result. OHS CITs developed fire and evacuation procedures and developed a system of post-engagement interviews to be undertaken one month after commencing with the company, which are still conducted.

In South Australia the assessment of the worth of the project varied considerably. All plants acknowledged that the legislative audit had been valuable, but they believed that they had missed the more important focus of the program. People at SA3 thought it was "a wasted opportunity" and identified that they would have liked to have a workshop on the program "by someone who knows what they are doing". This plant was expecting to face closure and the consultant conducted the legislative audit but did not follow this up with a report. The OHS Coordinator at the plant said, "we want everything right at this plant right up to the end" and considered the lack of a report a substantial negative as considerable time had been spent with the consultant to no avail. The OHS Coordinator said, "we would have been committed to implementing that report". Another legislative audit, arranged by the OHS Coordinator, has been conducted at the plant since that time using a different consultant.

The concern of those involved in the project at SA4 was that the strategy used by the consultant meant that they would have needed ongoing consultation with him, rather than becoming self-sufficient. The OHS Coordinator did not consider ongoing contact with the consultant desirable.

At SA2 those involved thought the work had "got them on the right track", but although they recognised that there was "still a long way to go" they did not believe that they were left with the skills to implement an OHS CIP and thus take the work further. Negative attitudes to the project were evident at SA1 and SA5 where the OHS Coordinators were overwhelmed by plant-wide reports that were "the size of a phone book" that effectively paralysed, rather than stimulated, action.

In a sense, all of the SA plants could be regarded as non-participants as none was introduced to MISHCHIF or IADRI as a workable process. Instead, IADRI was used, inappropriately, as a reporting tool for the legislative audit. The principle focus of the consultant was two-fold; to conduct legislative audits in each plant to determine "status", and to link the plants into the WorkCover Safety Achiever Bonus Scheme (SABS) and associated audit. Neither of these aims involves the collaborative improvement focus that is at the centre of MISCHIF. The end result, in the words of one participant, was that the companies "moved from being excited, enthusiastic and voluntarily engaged to being disenchanted". This person doubted that there had been any real improvement in OHS as a result of the project. Thus, none of the South Australian plants could comment in a meaningful way on the content or validity of the model because they have never seen it in operation.

One of the consultants involved in the project in Queensland viewed their own involvement positively, suggesting that their role was a facilitative one, rather than an 'OHS expert' role; that is, their job was to assist people to get involved in the project. Another suggested that the sites that gained most from the program were those that focussed on specific areas and issues using the IADRI model. These plants did not try to change the whole plant in one fell swoop, but chose isolated projects that were practical and workable within an achievable timeframe. Nonetheless, there were times when the approach of a plant was regarded as "piecemeal" and the need for "broader management integration" of OHS was acknowledged. They said, "the success of the broad safety management program depends on the overall management approach and acceptance that OHS activity is important" and this appeared to be easier to achieve in more modern and generally well-run plants. For example, at Qld5, a young organisation without an entrenched culture, there was a strong consultative structure, a positive attitude to OHS and a broad approach to the issues.

Qld5 was one plant with an existing CIP approach in place. Members of the project team felt that the OHS CIP did not advance their knowledge of CIP processes but they valued the increased focus on safety issues. They also valued the access to an external consultant having identified that they have a need for a consistent source of advice on OHS matters and better coordination of their activities.

The OHS Coordinator at Qld3 suggested that the project had not been as successful as it could have been because the site was not ready for this type of intervention and went so far as to suggest that the plant should probably not have been accepted for the program in the first instance. Nonetheless, a positive outcome of the project was that it provided a focus to successfully lobby for a WHSO on site. Lack of training and inability to get people released from production work meant that many people struggled with the concepts in the program and this was a problem. High absenteeism and consequent problems with planning and scheduling contributed to these difficulties.

At Qld7 the Project Team was very enthusiastic, as the OHS Coordinator observed, "they were really committed across all levels, but once it finished the consultants went

away and they just reverted". At Qld6 the story was similar, the IADRI framework was not firmly entrenched and there was little practice with it as a cyclical process. However, members of the project team knew about the model and were trying to use it in a proactive manner to avoid the trap of reactivity to OHS issues; they found the plant was becoming more consultative in operation. The framework provided a useful focus and helped to develop skill but the OHS Coordinator believed that it needed a driver to keep it alive and moving in the long-term.

At Qld4 and Qld11 people were positive about the process, despite imminent closure of the plants. Employees said, "wouldn't this be great if we were going on … we are only just starting to scratch the surface". The members of the project team and the CEO regarded the program as "very valuable", while supervisors were moderately pleased with it. Indeed, the project teams were delighted to find that the CIP and IADRI models were applicable to quality issues as well as OHS and work proceeded in this direction, too. In these companies the project was seen to increase and reinforce employee involvement in decision-making and in innovation. The increase in participation and involvement and ownership of change and the reported cost reductions that were experienced were unintended, but welcome outcomes. Overall, the process was said to have helped to improve the OHS culture in the organisation, despite the imminent closure of the plants.

Uptake of the projects post-July 2000 and desire/intention to continue or extend projects

Despite the patchy implementation of the program, as already observed, many plants found value in the program and have plans to continue the OHS-related work that has been stimulated.

At SA4 next steps in improving OHS will be directed at improving supervision and addressing the issue of drugs and alcohol in the workplace. However, there is no intention to use the OHS CIP framework to achieve this as there is almost no knowledge about it in the plant. The OHS Coordinator indicated that they would not be seeking external assistance from consultants, but would instead seek this support from their meat industry networks. This had proven valuable in the past. He suggested that SA4 would operate on the principle that they will "take nothing for granted" as one learning from the program had been that they had seriously overestimated their OHS performance until results of the legislative audit were made known.

Next steps for SA1 include the development of their OHS Committee. The OHS Coordinator intends that this group will drive incremental improvements that will help push the organisation towards an OHS culture. Arguably, this could have been the focus of the project.

SA5's plans include front-line manager training as there is now a sense of urgency about OHS throughout the company. More site-specific policies will be developed and SOPs (Safe Operating Procedures) will be put in place and existing ones reviewed. A new performance appraisal system is being developed. Together these activities are intended to lead to OHS cultural change. SA5 will continue to increase its networking with other companies as this activity has proven value.

In Queensland, plants generally found that involvement in the program brought a renewed focus to OHS which has provided a basis for further activity. For example, the

OHS Coordinator at Qld6 said, "I don't think this should be lost – even though I don't know how we should implement it. We need at least a 3-year plan just to get a systematic approach. It's given me a great model to strive for". The plans at this plant are to complete some systems and tighten others as well as standardise activities across a number of different sites in order that the company becomes proactive in its approach to OHS. There will also be a concerted approach to addressing ergonomics issues and attempts to improve the attitude to change. Attention at senior management level is considered a priority such that the cost of poor OHS management and workers' compensation can be linked to performance.

The OHS Coordinator at Qld3 advised that all of the initiatives had "fallen over" and that, with hind-sight, an attempt at a CIP for this plant was premature. During the project a new CEO, with increased commitment to OHS, was appointed to the plant. This may result in a resumption of OHS CIP activity in the future; the OHS Coordinator suggests the company is working towards developing a CIP culture. The most important OHS issues now are the completion of a compliance program and training in OHS basics for all employees. The company plans to conduct another OHS audit in twelve months time.

Qld2, Qld1, Qld8 and Qld9 each reported good outcomes and the intention to use the training package developed by the project consultants for ongoing development of OHS committees. However, as no access to these plants by the evaluators was possible this cannot be verified.

The OHS Coordinator at Qld5 considers that the OHS management approach is sufficiently robust that they will be able to continue their work without ongoing assistance. The company intends to "work through each of the MISHCIF elements as [they] review the safety management system". It calls for more networking within the industry to further its company's aims and to improve industry practices in OHS.

2.2 Assessment against MISHCIF criteria

Leadership

Achievements in this element were limited, but varied considerably between sites. One of the Queensland consultants observed that, "overwhelmingly, what determines the success of the CIP process is how supportive senior management is". For example, he cited the case of one plant where the communication channels and processes worked effectively as demonstrated by the fact that the maintenance engineer and the safety coordinator have regular meetings to discuss OHS issues and how they might be resolved. However, a problem at some sites was "a lack of involvement of or communication with senior management throughout the process".

Those sites where leadership was sustained or even improved usually had pre-existing management commitment. At SA4 the commitment of the CEO to OHS was regarded as "unwavering and very significant".

In some cases, however, involvement in the project created stronger leadership in OHS. As a result of the program at SA2, the CEO/owner now chairs all OHS meetings and gives final approval for OHS-related changes that require capital expenditure. Although

the OHS Coordinator described the owner as being committed to OHS it was noted that he is very reluctant to address some obvious and pressing manual handling issues that could be readily resolved. His view was, "I did this sort of work and never got injured" and suggested that today's legislation effectively "wraps people in cotton wool". The leadership in OHS comes from the OHS Coordinator in this plant, who has worked out the most effective ways of encouraging the CEO to put funds to work for OHS issues. At this site, managing up has been reasonably effective, although slow.

At SA1, the CEO/owner was identified as having minimal commitment to OHS. However, the OHS Coordinator has recognised and fostered the interest of an influential manager in the plant, described as having an "enlightened approach" to the management of the organisation. The manager has worked in every job in the plant, understands the conditions of work intimately and has maintained good communication with the employees. As he is expected to manage the plant when the CEO retires, the OHS Coordinator considers it is appropriate to engage him in OHS activities.

On those sites with less positive leadership, this clearly had negative affects on the project. At Qld6 the OHS Coordinator observed that, "had senior management had a role and shown commitment there may have been more lasting outcomes".

At Qld6 and Qld7 each plant suggested that a strong and committed senior management would have "sent a message to the workforce" and could have considerably enhanced the outcomes".

Managing by system

Many project activities focussed in this area, with some success. More successful projects occurred in some Queensland sites, where the idea of a reviewable and systematic approach to OHS, rather than a pre-determined and rule-bound " OHS system", was implicit in the CIP activities. For example, at Qld5 the OHS Coordinator asserted that the OHS CIP program gave them confidence that they were doing the right thing. It made them mindful of the need to continuously examine and review their systems.

In contrast, less positive results were achieved in SA, where the systems approach was attempted in a legalistic, pedantic, "tick and flick" manner.

Managing people

The implementation of the MISHCIF program resulted in improvements to the management of people where the principles of continuous improvement, worker involvement and participation were embraced.

There were some examples of strong teams in participating plants in Queensland. The features of these teams were:

- a high level of commitment from the players in the teams,
- members who understood the CIP process,
- an ability to use the consultant constructively,

- a willingness to feedback on progress to the workforce (using such tools as open forums with workers), and
- the skills to prepare and present a case to management.

There were a few instances in Queensland where supervisors and line managers were engaged in the CIP process. The consultants regarded this as a strong mark of success.

An improved working relationship between workers and management was reported as an outcome of the project at Qld2 and Qld1, although this cannot be verified because the evaluators did not have access to the plants.

At SA2, where an OHS Committee was established, English literacy was observed to be a problem and a barrier to effectively implementing the OHS CIP. As a result the company has taken on a WEL program and has had moderate success thus far.

Controlling hazards

This was the primary focus of activities in SA. According to the South Australian consultant, each of the plants in that State had over-estimated their OHS performance and had been shocked by the degree of non-compliance with legislation once they had received his report. In general, he considered their attempts to control hazards to be poor. Most participating companies agreed that they had over-estimated their OHS performance, but were not given strategies for improvement as part of the program. Each of the participating plants described how hazards that had been pointed out during the audit were quickly resolved, so it is reasonable to assume that there was some commitment to change in these companies. Rather, it appears that lack of expertise and lack of an improvement framework prevented sustained improvements in these companies.

Lack of in-house expertise in this domain was a significant issue at SA1 that was not addressed by the program. The OHS Coordinator described the audit process as a "pretty harsh eye-opener" and felt the project had not provided workers with information about the ongoing management of hazards. The business was described as being "in survival mode" with no specific OHS-trained person on-site. Thus, the failure of the program to provide the organisation with the skills necessary to identify and manage hazards effectively in the future was seen as a significant deficiency.

The experience in those Queensland sites that followed the MISHCIF principles showed that managing hazards is not only possible to achieve with strong worker participation, but can also be sustainable. Actual improvements that were made in these sites have been described above.

Monitoring and improving

Few sites undertook activities in this area prior to or as a result of the pilot project. Any auditing or review processes were undertaken by the project consultant or initiated by them. Ongoing processes have been initiated or are planned in a limited number of sites, but this remains a significant gap in OHS management on all participating sites.

2.3 Compensation data and other statistics

Changes in LTIFR, accident and incident data, number and costs of compensation claims as available at enterprises, including comparison with non-participants

These data were unavailable to the evaluators at any of the plants in the evaluation. At some sites, positive trends were reported, but these were not backed with evidence. For two Queensland sites, this was because access was not possible due to plant closures. As a result, it is not possible to determine whether outcome data has been affected by participation in the project, nor to compare performance with non-participants. Significantly, non-participants were also unable to provide reliable outcome data.

Changes in any other performance indicators used by participating enterprises

Staff turnover on the factory floor at SA2 hovers at about 10%, too high in the eyes of the OHS Coordinator. This figure was stable and had not changed during the period of the program or since. People often leave in the first week of employment. The OHS Coordinator suggests this is as a result of early starts, the cold environment and the smells that go with the job. None of these factors is seen to be in the control of management.

No other changes in performance indicators were offered by participating enterprises that were backed by evidence.

2.4 Productivity and quality

Changes in profits, productivity/yields, costs of production, quality statistics as available at enterprises and industry wide, including comparison with non-participants

No plant was willing to share data concerning profits, productivity, costs of production or quality as statistics or other quantitative data. However, some data was presented as trends in an anecdotal manner.

Costs of involvement in the program varied considerably. For example, in South Australia where expenditure was principally related to the involvement of the OHS Coordinator, costs were between $2,500 (at SA5 where considerable travel was undertaken) and a few hundred dollars at SA3. At other plants, where limited training of workers was undertaken costs of people's time was estimated to range from $10, 000 at SA2 (and a further $5,000 on capital expenses) to $3,000 at SA1. At SA4 $4,000 has been spent thus far on the wages of employees who have been taken off line to implement the changes recommended in the audit and a further $6,000 has been spent on changes in the plant.

This is in contrast to the costs of activities in Queensland. At Qld3, for example, the main costs associated with the program were about $50,000 covering wages and an external audit. Qld4 and Qld11, both plants that have subsequently closed operations, limited spending on changes to items with a short return on investment. Qld11 spent about $3,700, while Qld4 outlaid $1,850 on wages. Qld6 applied funds to salaries and wages and also bought extra consultancy services for OHS Committee training. At

Qld5 salaries and wages were outlaid specifically for the project with the support of the CEO whose attitude was that effective OHS saves money so expenditure in this area was seen as a good investment in OHS management, however actual or estimated costs were not revealed.

Section 4 Evaluation questions

The findings described in the previous section provide the information needed to answer the evaluation questions established in Phase 1 of the project. These questions are:

1. To what extent have the objectives of the project been attained?
2. What changes have occurred in the context of the project which have affected and will continue to affect implementation?
3. What have been the intended and unintended outcomes of the project?
4. How has the content of the framework affected these outcomes?
5. How have differences in implementation and internal and external environment affected outcomes?
6. Has the project met identified needs?

1. To what extent have the objectives of the project been attained?

The objectives of the pilot project were to:

- Develop a strategy for completing a national implementation strategy of the OHS continuous improvement model (MISHCIF);
- Undertake training for meat processors in each state to assist them in the development of their OHS CIP;
- Conduct pre- and post-assessments of the sites involved in the implementation to determine the impact of the CIP; and
- Prepare performance indicators for the industry so that they can compare their performance on the adoption of improved OHS practices.

As the previous section reports, all sites reported benefits from their participation in the project and it supported the implementation of a continuous improvement program.. However, the extent to which the formal objectives of the project were attained is somewhat limited. This was the result of:

- Inconsistent implementation of MISHCIF;
- Lack of clarity in site goals, which were not properly addressed by all consultants; and
- Lack of commitment to the objectives of the project by some participating sites and consultants.

While the project provided valued OHS consultancy services to the participating sites, the services were often tangential to the objectives of the project. For example, on one Queensland site, the consultant developed and implemented a stretching program as a result of identifying manual handling problems, rather than conducting a thorough risk identification, assessment and control strategy as required under the Queensland manual handling regulations. This would also have been more consistent with the MISHCIF process. A number of SA plants reported a degree of cynicism and frustration as a result of their participation in the project which the MLA may wish to address in future strategies.

1.1 Develop an implementation strategy

While all participants valued the benefits that they reported, the pilot project emphasised a number of issues that will need to be addressed in any broader implementation of the OHS continuous improvement model. These matters are addressed in the recommendations (Section 6) of this report, and include the:

- need for clear project management guidelines, including formal links between state meat OHS committees and consultants.
- need for effective change management guidelines.
- need for a clear definition of competencies required of the implementation consultants.
- need for involvement of management and staff at all levels of the enterprise.
- importance of networking and information exchange requirements.

1.2 Undertake training for plants

In SA, the training provided was not directly related to the development or implementation of a CIP. In Queensland, training directly related to MISHCIF was provided in most, although not all, cases. At a number of sites, the nature and effectiveness of training was adversely affected by difficulties in access to site personnel. In at least one case, the training provided was not directly relevant to MISHCIF because both the consultant and site personnel believed the site lacked the basic familiarity with OHS concepts needed to deal with the more advanced concepts involved in the continuous improvement program.

1.3 Pre- and post-assessments of sites

Pre-assessments conducted by the consultants were not all based on the MISHCIF model. Rather, consultants applied their own pre-existing management approaches. For example, the SA consultant undertook legislative audits which had questionable value for the sites. No sites were subject to post-program assessments. Often, the assessment approach used did not assist the sites to identify and plan to address priorities. While some outcome data was collected prior to the conduct of the project,

this was difficult to obtain because of poor quality data collected at site level. This had not improved by the time of the conduct of the evaluation and post-assessment of sites was not conducted in any meaningful way, apart from this evaluation. The scoring system contained in the MISHCIF materials was not used by consultants.

From this evaluation, the following improvements in MISHCIF elements have occurred at the participating sites in Queensland:

Site	MISHCIF element	Reported improvement
Qld3	Leadership	Increased resourcing of OHS, through the appointment of a WHSO.
	Managing by system	Greater attention to basic legal compliance
Qld6	Managing people	Increased consultation through the establishment of consultative forums.
	Controlling hazards	Improved inspections.
Qld5	Managing people	Introduced a competency based training system.
	Managing by system	Strengthened system for contractor management.
	Controlling hazards	Improved hazard identification and reporting.
	Monitoring and improving	Improved incident investigations.
Qld1/11	Leadership	Greater, more meaningful management involvement.
	Managing by system	Produced a coherent, consolidated OHS policy and procedures manual.
	Controlling hazards	Specific hazards addressed
Qld10	Leadership	Increased resourcing through the appointment of an OHS coordinator.
	Managing by system	Implemented a systems approach using the specification model of the jurisdiction.
Qld7	Managing people	Provided training. Implemented consultative forums for the first time.

It was impossible to do the same assessment of the SA sites, because they did not use the MISHCIF approach at all.

1.4 Prepare performance indicators

As the preceding description suggests, the preparation of OHS performance indicators for the meat industry remains a considerable challenge. This is now the subject of a separate report to the MLA.

2. What changes have occurred in the context of the project which have affected and will continue to affect implementation?

Changes internal to the participating enterprises and changes occurring in their external operating context affected implementation and will affect future activities in this area.

2.1 Internal changes

The following changes occurred in some or all participating enterprises with both positive and negative consequences for the project:

- Staff turnover
- Absenteeism
- Management changes

Staff turnover and absenteeism promoted the importance of OHS to the operation of the enterprises. Poor OHS performance was recognised as contributing to these problems. Management changes had both positive and negative effects. Where corporate memory and drive was lost as a result of management change, this had negative consequences for the project. Where a more committed manager was appointed to a critical position, this supported the project. Where these internal changes were positive, they supported a higher priority for OHS within management priorities.

2.2 External changes

A number of external changes also had positive and negative consequences for the project. Some were specific to the meat industry, while others affected all industry in the relevant area:

- Increases in workers' compensation premiums which directed attention to OHS;
- The Asian crisis which affected the market for export plants;
- A tight labour market which made good OHS an important recruitment tool;
- Audits by regulatory agencies which highlighted legislative compliance.

3. What have been the intended and unintended outcomes of the project?

In general, goals for involvement in the project were not clarified with sites at the commencement of the project. This makes the identification of intended outcomes somewhat difficult. It also may have lead to some misconceptions about what the project involved. A number of sites appeared to be seeking a 'quick fix' for their OHS problems. However, many OHS coordinators had their own aims for participating, as reported in the previous section. Many of these were addressed through participation in the project.

Outcomes of involvement in the project for sites included a range of specific improvements, such as:

- Formation and strengthening of OHS committees and teams. At a number of sites this has provided a critical support to ongoing improvements. For example, at one site it was the first time any cross-site, multi-level group had ever been established.
- Development and implementation of specific systems, eg management of confined spaces.
- Physical changes to the workplaces, eg improved guarding of machinery.
- Increased awareness and understanding of OHS management. One site reported that a key result for them was "a small but much appreciated contribution to a very long process of educating more people at middle management levels in basic OHS systems concepts". Another site reported that "there is now a high level of involvement and knowledge throughout our organisation."

Experience in implementing the model itself was also cited as a valuable outcome by some participants. One site assessed the project as "a valuable exercise that broke up the identified problem and gave a structured approach with regard to who, how, what and when for action to be taken. It increased in-depth awareness of OHS issues and made people much more enthusiastic" (QM)

Many sites reported that the most positive outcomes for them resulted from free access to OHS consultants provided by the project.

Unintended outcomes included greater involvement by senior management in OHS. For example, at one site, the project contributed to the formal involvement of a previously uninvolved, but influential, manager in the site's OHS committee.

Unintended outcomes also included negative results reported by some SA sites. One site reported that the main outcome for them was a "report the size of a phone book, which is pedantic and splits hairs … one photo isn't even of the plant!" As this suggests, one outcome in SA has been the growth of a degree of cynicism and frustration at some plants, accompanied by lost opportunities for improvements.

These negative outcomes could have been reduced and positive outcomes strengthened and made more visible if the goals of the participants had been identified and developed as part of initiating the project.

4. How has the content of the framework affected these outcomes?

The MISHCIF model itself made a positive contribution to outcomes at some, but not all, sites. In South Australia, the framework did not affect outcomes simply because the implementation consultant did not implement the model. One Queensland site did not adopt the model because of the perceived need to focus on more basic issues at this stage of the plant's OHS development. Nevertheless, the continuous improvement process embedded in the model was reported by a number of sites to have made a valuable contribution to improvements. For example, sites reported that the step-by-step approach "focussed group thinking on a particular issue and a particular stage". One site believed that "the structured approach gave a strategic element to the process that goes beyond the usual problem solving processes". Another site reported that "the CIP provided an extremely useful and timely focus for our safety performance". The model also helped overcome resistance to change. The IADRI cycle itself was viewed extremely positively by many participants and some consultants.

Despite these positive views, consultants exhibited some confusion between the improvement *process* set out by MISHCIF and a *specification* of what needs to be done as provided by different jurisdictional models, such as Queensland's Tri-safe audit. Indeed, as the preceding descriptions suggest, the project exhibited significant lack of alignment between consultants in implementing the framework in different states and on different sites. This is perceived as both a strength and a weakness. On the one hand, the variation between the consultants' use of MISHCIF resulted in patchy application of the concepts as has been illustrated. On the other hand, one participating enterprise, with two sites involved, had different consultants with different approaches on the sites. The enterprise reported positive results on both sites and suggested that this "demonstrates that the model is outcome focussed no matter how it is approached".

In general, the MISHCIF was not fully implemented at any site. To some extent this was a consequence of the project's timeframe, which consultants claimed was too short to close the continuous improvement loop. The difficulties with implementation and the negative outcomes reported above are generally seen to be the result of external factors which can be addressed in future iterations of the program, as described in the next section.

5. How have differences in implementation and internal and external environment affected outcomes?

The implementation of MISHCIF was the most significant influence on whether outcomes were strongly positive or had negative aspects. The key issue was the application of the model by the consultants engaged.

5.1 Role of consultants

Consultants had substantial influence on project outcomes at each of the sites.

In SA, the consultant limited the project to a legislative audit and did not introduce MISHCIF to the plants. This had a negative influence on project outcomes. The SA consultant reported that the audit documents he prepared were "living documents" but the companies report that they have largely been shelved. He also provided a 'survey of hazards', a 'systems report', a 'strategic action plan' and developed KPIs for most plants. None of this was done consultatively; the consultant produced it with limited input from each of the OHS Coordinators. As a result, there was no local expertise or local knowledge or ownership built into these documents. He did not test the MISHCIF system, judging that it couldn't work without any evidence to support his claim. His only use of the MISHCIF framework was to use the main headings to frame the systems development reports for the companies, that is, as the headings for reporting action to be taken that arose from the legislative audits. He developed KPIs for each element without consultation with the companies, conducting the project as a sole practitioner, using OHS Coordinators as plant guides. He asserted that it was faster to go into the companies unilaterally and tell them what to do and get things moving than to engage people in the process. This style of consultancy was completely out of keeping with the MISHCIF program.

One negative outcome of this approach by the consultant was the lack of sustainability of the activities. At SA4 the OHS Coordinator asked "where do we go once we've fixed it all up? The consultant didn't make the process sustainable". At SA2 the consultant's role was described as too "hands off". At SA1 the consultant's role was the "driving force", providing information and support. The OHS Coordinator estimated that the company only had a 50-50 chance of succeeding at any change without external input. He reported that he felt helpless to continue to do any work in OHS as he regarded his own knowledge as limited.

The common feature of an expert-led audit to the exclusion of the introduction of CIP processes was not useful. The approach of the consultant in South Australia was described as "legalistic" and "overwhelmingly academic". Sites also observed the lack of collaboration with workers in the plants as a negative feature. The consultant was expected to report on progress to the state's Meat Industry Committee, which was done but the reports were late and regarded as uninformative.

In Queensland, consultants played a more positive role. Two of the Queensland consultants said they sought to take a consultative, facilitative role with the sites. Mostly this assertion was backed up by the participating enterprises.

Qld4 and Qld11 believed that they could not continue without the consultant's support but that this need would decrease over time as they gained familiarity with the process.

However, there would be an ongoing need for technical advice. An external driver would also be useful to overcome the daily production pressures. The consultant acted as a facilitator and provided technical expertise and kept the process on track.

The technical expertise provided by the consultants was also a positive feature for Qld10. Here, the consultant introduced the company to the Tri-safe audit, which they found very useful.

Physical access to consultants was considered important. For example, it was suggested that sites near Brisbane achieved more than more geographically remote sites because of the greater frequency of consultant visits. Sites such as Qld8 and Qld2, received only two consultant visits each.

In general, consultants did not demonstrate sophisticated understanding of a continuous improvement approach, conflating improvement cycles with specification standards as discussed above. That is, the consultants did not understand that the project provided a means of achieving compliance as well as improvement beyond this. Lack of understanding of the content and implementation of a CIP by the consultants was demonstrated in their inability to convey the material to the plants and use their technical expertise to support this. For example, a consultant confronted with significant manual handling problems at Qld5 instituted a stretching program to deal with the physical working environment – instead of solving the problem of poorly designed plant, equipment and workplace practices; an approach that is arguably in breach of legislative requirements. One consultant argued that MISHCIF was a "great model" but was "not quite prescriptive enough … it doesn't suit everybody". Thus, the lack of OHS management systems in the meatworks was seen as a problem, rather than an opportunity for action through the OHS CIP.

5.2 Role of the sites and enterprise management

On many sites, senior management did not demonstrate real commitment and preparedness to undertake the project. Evidence of this was the substantial difficulty with gaining access to the workforce or for the formation of CITs experienced on many sites. One consultant suggested that the main difficulty had been that the OHS CIP was not high on the agenda in participating organisations in comparison to production. Another cited resource constraints, management practices and inflated expectations as limitations to success. In some cases, enterprises were seeking a "quick fix" to OHS problems but did not exhibit preparedness to undertake the work involved in addressing OHS management. The federal secretary of the AMIEU argued "Until employers are prepared to accept that they have a responsibility and a problem and that they have to do better, things won't change." This is reinforced by the positive outcomes achieved by those sites which exhibited substantial senior management commitment and which involved their workforce directly in project activities and decision-making. As the OHS coordinator for one site with less positive outcomes observed, "for the program to be successful, it would need to be driven by senior management".

There was also evidence at some sites that other management objectives and programs cut across or modify the approach taken to implementation of the OHS CIP. For example, we understand that a consultant's decision to use a framework based on an OHS jurisdiction's safety audit protocol, rather than MISCHIF, at one site was

influenced by site management objectives in relation to worker's compensation. More generally, it was apparent that in the number of instances, the scope of initiatives developed by the CIT was constrained, either by management intervention or by site circumstances. To some extent, this simply reflects the reality that OHS must be dealt with in the broader context of the overall management of the enterprise. However, it emphasises the importance of the involvement of senior and line management throughout the process, to ensure that the CIT is able to function with a sound appreciation of the organisational context within which it operates.

5.3 Lack of attention to change management

Key principles of change management were neglected in the implementation of MISHCIF. In particular, many sites did not identify and agree their priorities for participation. Resource needs for participation were neither determined nor provided and addressing immediate needs ("getting runs on the board") did not necessarily take place.

5.4 Comparison with non-participants

The seven non-participants examined for the project reinforce the importance of implementation in creating positive outcomes.

Non-participants in Victoria had previously been involved with the Meat Industry OHS Best Practice Project. The impetus and structure provided by this program had been of significant benefit to these plants. As a result, they reported that their ongoing OHS activities would benefit from a structured industry program. To some extent, the lack of an external focus for their OHS strategies had weakened the impetus for further improvement. This was one of the concerns which underpinned the development of MISHCIF in the first place.

The NSW sites were both involved in the Injury Management Project run through that state. Both sites reported substantial benefits as a result of the networking fostered by the project and access to technical expertise from the project consultants. These sites reinforced the importance of site commitment to improvement processes and demonstrated the value of following the basic principles of change management.

The two SA non-participants differed greatly. SA6 was a small country meatworks with a largely casualised workforce. Although the management of the firm had sought to engage the workers in an OHS Committee there had been little emphasis given to OHS until the OHS jurisdiction, WorkCover, targeted the company for improvement. Under the guidance of the WorkCover consultant, SA6 discarded its ad hoc approach to OHS and was developing a systematic approach. At the time of the evaluation an OHS improvement team had been established and was operating as a *de facto* OHS Committee and steps had been taken to improve the physical working environment. The CEO could see benefit in a formal CIP approach and expressed interest in learning more about the MISHCIF.

SA7 was a large enterprise that had considered being part of the OHS CIP program but had decided against it because of changes that were occurring in the plant at the time.

The company has since developed formal systems for consultation and communication (using elected health and safety representatives and an active OHS Committee) and has implemented its own version of a continuous improvement model. These processes were still evolving at the time of the evaluation visit and the OHS Coordinator expressed the view that the company would like to revisit MISHCIF to determine its applicability to the site now. Both the OHS Coordinator and members of the OHS Committee could see value in a structured approach that would allow room for local interpretation. SA7 relied heavily on the benchmarking activities that it had initiated with other SA meatworks. The OHS Coordinator suggested that these valuable networks could be fostered by the MLA. The HSRs agreed that this would be useful, particularly if shop floor representatives were given the opportunity to engage in discussion with HSRs from other plants.

6. Has the project met identified needs?

For most sites, their involvement in the project helped them to address identified needs for improvements to OHS management. Many important and significant achievements were made, as described above. However, because site needs were not always clarified at the beginning of the project, the extent to which these needs were met was unnecessarily limited for many sites. In some cases, this resulted in tangential work being undertaken by consultants. It also meant that some sites reported that their expectations were not met. In several cases, this was because their expectations were unrealistic, as described above. In the SA cases, this was because of problems in project implementation, also described above.

A number of sites commented that they were disappointed that networking was not part of the project. Given the very positive views about this as an aspect of other projects (eg the NSW Injury Management Project and the OHS Best Practice Project), this is worth consideration in future strategies.

Section 5 Conclusions

As the preceding sections of the report describe, the pilot implementation of the MISHCIF model in Queensland and SA helped participating sites achieve improvements in OHS management and in their working environment. In most cases, this involved increased use of a systematic approach to OHS management, based on a continuous improvement orientation. However, diversity in the implementation approaches used by different consultants limited the extent and degree of achievements.

In relation to the objectives of the evaluation, this evaluation has reached the following conclusions.

1. Evaluate the indicators of success and failure regarding the uptake of OHS Management Systems by enterprises, including an attempt to quantitatively analyse whether or not the Project has improved OHS (and workers compensation) performance at the target sites.

As described above, the project achieved important improvements to site OHS management and working environment in most participating enterprises. In some cases, these achievements would not have resulted from projects with a narrower scope. As one site reported, "the CIP provided a review mechanism and brought some things forward in time." The most positive outcomes occurred in enterprises and on sites with:

- Substantial and realistic management commitment. As well as statements of support, this included adequate resourcing and preparedness to allow workforce participation and decision-making.
- Realistic goals for participation. These sites did not expect a 'quick fix' or 'instant solution' to entrenched problems. They used MISHCIF to provide a structured approach to finding sustainable improvements.
- Ability to manage the project. This meant that the sites were in control of the project, not the consultants.
- Substantial workforce participation. As well as involvement in problem solving, this included real control over the decisions and directions of the project.
- Previous experience with OHS improvement projects. One such site reported that "the CIP built on previous MRC/MLA projects and training initiatives and was the highest level of involvement achieved to date."
- While inevitably sites with more sophisticated OHS management prior to involvement in the CIP made more substantial improvements, sites which were willing and committed to engage in the process and put resources into it were also able to make gains.

2. Qualitatively compare the performance of those enterprises that were involved in the Best Practice Program and the Continuous Improvement Program and identify their indicators of success.

The findings of this evaluation reinforce key features of success identified in the OHS Best Practice Project, particularly:

- the importance of process in establishing sustainable changes;
- the value of networking
- the need to build on CEO commitment and involvement; and
- the criticality of workforce participation.

Sites involved in the CIP which had earlier participated in the OHS Best Practice Project found that their earlier involvement had built a solid foundation for success in implementing the CIP and were amongst the most positive in their assessment of the CIP.

Sites which had been involved in the OHS Best Practice Project but which had not been involved in the CIP expressed some concern that their cycle of improvement had slowed or even stopped and would welcome the impetus for continuous improvement a more comprehensive industry improvement framework would provide.

3. Recommend whether the OHSMS approach will consistently improve the OHS performance of the industry.

Conceptually, the MISHCIF model is sound and provides a valid basis to implementing a systematic approach to OHS management in the meat industry and thereby OHS performance improvements. Certainly, MISHCIF is superior to narrowly conceived approaches to OHS management systems, such as the legislatively driven, expert-focussed model used by the SA consultant. We found no evidence that a 'better' model would have worked any more successfully. On the contrary, there is increasing evidence that improvement oriented models have more positive effects on performance than rule-bound approaches.

To strengthen the application of the MISHCIF approach, however, the presentation of the MISHCIF material should be reviewed to encourage consistent understanding and application by sites and facilitators in the future.

4. Confirm any changes in the application of the OHSMS approach since the final report to the industry in June 1998.

Industry's needs for guidance in implementing a systematic approach to OHS management have not changed in the period since the final MISHCIF report was presented. This evaluation has found continuing lack of understanding and awareness of the work involved in managing OHS, particularly the importance of workforce involvement. Many meat industry enterprises still seek a "quick fix" or "instant answer" to their entrenched OHS problems.

Similarly, jurisdictions have continued their focus on OHS management systems. A significant change, however, is that there is now increased likelihood that premium rebates will be tied to performance in the implementation of these systems. For example, NSW WorkCover plans to introduce a Premium Discount Scheme (PDS), with discounts to workers' compensation premiums obtainable according to performance in a system audit. At the same time, jurisdictions are paying more attention to the meat industry with concerted efforts to foster systematic approaches to OHS in meat industry enterprises being made in most states.

5. Review the effectiveness of approach of the Continuous Improvement Project implemented in Queensland and South Australia.

The consultant's role was critical to the project's success or lack thereof at different sites and in different states. This reinforces that the skill and experience of the implementation consultant, as well as familiarity with and commitment to the continuous improvement framework, are essential ingredients of success. OHS expertise, change management and facilitation skills are critical in those managing the implementation of OHS improvement programs. Important features which marked out more successful implementation were:

- Training and participation for the workforce and their representatives;
- Engagement with senior management;
- Making demonstrated and visible achievements early in the project; and
- Allowing enterprises themselves to define their aims and goals for the project.

While the process can be damaged by poor implementation, the experience of two Queensland sites where different consultants were used with different approaches but both with good results suggests that the model is robust. Indeed, an important feature of MISHCIF is that it is sufficiently flexible to allow implementation approaches to be tailored to site circumstances. It will not have benefits, however, when it is not used at all. The SA approach, which reinforced a top down, expert led and rule bound OHS management style, did not serve the SA sites well. This is reinforced by other research findings which suggest that this style of OHS management does not support improved OHS performance (Wright 1994; Marcus 1988; Pitzer, 1997; Rasmussen 1994 and 1997; Weick, 1999).

Section 6 Recommendations

Recommendations arising from this evaluation are directed to the MLA and the AMPC and fall into three main categories:

1. relating to the MISHCIF model itself;
2. relating to the implementation of the MISHCIF model; and
3. relating to strategies to improve the industry's performance in OHS.

1. The MISHCIF model

As the previous section reports, no modifications to the model itself have been identified from the evaluation. Rather, the evaluation highlights needed improvements to the presentation and context of the model.

1.1 A plain English version of the materials should be produced which can be used on sites.

1.2 The critical features of the model should be identified, making the scope for interpretation clear. For example, the importance of clarifying the goals for OHS management and application of the MISHCIF model should be obvious from the materials produced to support the model.

2.3 The materials should provide advice about possible elements to focus on in an improvement program. For example, it appears from this evaluation that Leadership is a critical foundation for achievements in other elements of the model.

2.4 There is a need to provide guidance for process facilitators as to how the model can best be applied at sites with differing levels of OHS preparedness. Lack of comprehension of the ways in which the framework could be applied were apparent at sites where there was a belief that the MISHCIF approach was too sophisticated for their current OHS status. At some sites audit-based systems were in use, or being examined and there was little understanding about how MISHCIF could be used in conjunction with them or instead of them to achieve superior results.

2. Implementation of continuous improvement processes

2.1 Project management guidelines for future implementations should be developed. This should include clear definitions of the scope provided to consultants to change the project processes.

Overall management of the project would be improved with a formal link between the relevant State Meat OHS Committee and the consultant. Payment of the consultant could be tied to achievement of agreed goals. State-based people are in the best position to monitor progress in achievement of these goals. Local management would have been more effective in this project, particularly in South Australia where information given to the State Committee was late and inadequate and did not keep the local industry informed about progress of the project.

2.2 Change management guidelines should be developed. These should include specifications of the key principles to be followed, namely:

- clarify site goals;
- engage senior management;
- involve the workforce appropriately;
- ensure adequate resourcing;
- provide training to all involved; and
- get the runs on the board.

Such guidance would also make it more straightforward to monitor and manage site commitment to the process. For example, if the resources needed were explicitly described in such guidance, a site which would not provide such resources could be excluded from the project.

Indeed, there is a need for a very clear contract or agreement between the MLA and each host site that sets out clearly the resourcing commitments of both parties. With such an arrangement participating enterprises would be accountable for the funds or services provided by the MLA and would be obliged to demonstrate a commitment to provide appropriate resources, and to apply them to the specific objectives of the project.

We do not believe that these guidelines should include a specified or required level of OHS development in the firm. The implementation issue is one of whether or not a company is prepared to commit the resources and energy required for improvement, rather than the company's starting point.

2.3 The competencies required of consultants engaged to facilitate the implementation of a continuous improvement project should be clearly stated. In particular, it should be clear that any consultants involved in the future need change management and facilitation as well as OHS expertise and the ability to modify their approach to deal with enterprises with different starting points.

2.4 The importance of involvement by all levels in an enterprise, including senior management, should be clearly set out. There should be no opportunity for enterprises to be mistaken that this is a project which just involves the OHS Coordinator.

3. Industry OHS improvement strategies

3.1 Any future OHS improvement strategies should include networking as a critical feature. Informal networking exists now amongst some firms – all engaged in this project agreed that this should be the subject of attention by MLA.

3.2 Intervention with owners and CEOs is critical. The MLA should directly address this level of the industry, as well as support OHS managers/coordinators in managing up. These strategies should incorporate strategies to address skill levels in middle management as well.

In this regard, the low priority given to OHS activities in some organisations – notwithstanding the common management rhetoric of high level commitment to workplace safety – needs to be addressed. This lack of priority was evidenced by widespread reports of difficulties in resourcing CIT activities (for example, gaining release of employees from day-to-day duties) and in the loss of momentum once the MLA-funded consultancies were completed. Continuous improvement is not achievable without continuous support and commitment at senior management level.

3.3 Given the element of cynicism and frustration expressed by participants in the project in SA, some effort to engage them in ongoing OHS improvement strategies should be made.

3.4 Those states which have not been involved in this project should be provided with the opportunity to engage in a coordinated industry OHS improvement program. This could take the form of facilitated networking, with implementation of the MISHCIF program as an option for action by a network of plants.

3.5 Improved OHS performance measurement techniques and strategies should be addressed. This is the subject of a separate report to the MLA.

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Appendix 1
Interview Questions

1. To what extent have the objectives of the project been attained?

1.1 What are the main features of the OHS CIP in your enterprise?
Please identify three main features.

1.2 Did you regard the project as successful?
- If YES, what was it about the project that made it successful?
- If No, what contributed to its failure,
- What would have made it work better?

1.3 How did the OHS CIP approach worked in practice, ie what did you actually do?

1.4 What do you think counts as a successful project at a meatworks?
- What are the hallmarks of a successful project

– what would you expect to see in a successful project at a meatworks?

1.5 Go through the CIP scoring process with the informant and score their performance at this stage.

2. What changes have occurred in the context of the project that have affected and will continue to affect implementation?

2.1 In the course of the project, were there any changes in the company that altered the way the project was implemented?
If so, what were they and how did they impact?

2.2 What things happened external to your enterprise that affected the project outcomes? How did they impact?

2.3 Are any of these changes likely to have ongoing impact on implementation of the OHS CIP?

2.4 As well as funding from the MLA, please estimate how much you have spent on the project.

2.5 What were the main problems or barriers that you came up against during the project?

How did you address them?
Overall, how successful were you in overcoming these problems/barriers? On a scale of 1 = not successful to 5 = very successful.

2.6 Overall, what was the level of involvement of particular people during the OHS CIP? Use the scale of 1 = no involvement to 5 = full involvement:

	1	2	3	4	5
Project Team					
Owner/CEO					
Senior Management					
Supervisors					
Union					
Workforce					

2.7 In your opinion, what do the following groups think about the OHS CIP conducted at your meatworks? (on scale of 1 = waste of time and money to 5 = very valuable experience

	1	2	3	4	5
Project Team					
Owner/CEO					
Supervisors					
Workforce					

3. What have been the intended and unintended outcomes of the project?

3.1 What project outcomes were intended or anticipated at the commencement of the project?

3.2 To what extend have those outcomes been attained?

3.3 Have there been any significant outcomes that were unintended or not anticipated?

3.4 What changes have you made to the workplace through the OHS CIP? (eg re-tooling the kill floor, fitting dampers onto air knives, introducing job rotation, changes in responsibilities, changes in supervisors' role…)
Overall, how satisfied were you with the changes?
(Use a scale of 1 = unsatisfied to 5 = very satisfied)

4. How has the content of the framework affected these outcomes?

4.1 What were the useful aspects of the framework for your site (ie the particular items in MISCHIF, the IADRI process)?

4.2 Why were these useful? How did these help you make the achievements you have cited?

4.3 Were there any significant changes to the scope or structure of the project in the course of implementation? If yes, what caused the changes and what impact did they have?

5. How have differences in implementation and internal and external environment affected outcomes?

5.1 Who played the key roles in the project at your meatworks and what did they do that was so useful? (eg facilitation, communication, expert advice, support and advocacy).

5.2 What roles did the CEO and other senior managers play in the project? How significant was this?

5.3 To what extent has the level of commitment of senior management (including CEOs) influenced the outcomes achieved?

5.4 To what extent were you engaged in networking activities or other processes that shared information about the project (between sites, with other enterprises, or within the industry)? In what ways, if at all, did these communication processes contribute to the project?

5.5 What role did the consultant play in achieving the outcomes? (In particular, are you able to continue without on-going consultant support?)

5.6 In what ways have differences in implementation affected outcomes at the site?

5.7 What improvements to implementation strategies might support more positive outcomes?

5.8 What improvements to dissemination strategies might support more positive outcomes?

5.9 From your experience, what do you think could be learned by the rest of the meat industry from the OHS CIP? (Within and between sites/enterprises/industry)

5.10 In your opinion, what does the industry need to do to effectively promote further improvements in OHS performance?

6. Has the project met identified needs?

6.1 What particular needs were identified at the commencement of the project that the OHS CIP was intended to address?

6.2 To what extent have those needs been met?
How do you know?
How far does this go?

6.3 What do you see as the most important OHS issues that now need to be addressed at your site?

6.4 What can/will you do to improve or refine the project in the future?

6.5 Are there any features of the program's implementation that you regard as unique to your enterprise?

6.6 Do you see value in other sites seeking to further refine their projects? If yes, how should they do so?

6.7 Does the MISHCIF Program provide an effective means of promoting further improvement in OH&S performance in the meat industry?

If yes, are there ways the program could be made more effective?
If no, what approach might be better?

6.8 How could the MLA promote further improvement in OHS performance in the industry most effectively?

Ask for any of the following data to be sent if it is available:

- Compensation data and other statistics:

  Changes in LTIFR, accident and incident data, number and costs of compensation claims

- Changes in any other performance indicators used by participating enterprises.
- Productivity and quality:

  Changes in profits, productivity/yields, costs of production, quality statistics as available at enterprises

Appendix 2
Participant organisations

SA1– Small regional meatworks

SA1 is a family-owned business that employs about 42 people in the slaughter of cattle, goats, sheep, deer and camels. At the commencement of the OHS CIP project, SA1 had no OHS systems in place and activity with respect to OHS was described as ad hoc and minimal. The consultant working with SA1 conducted an extensive legislative audit and provided the firm with a very long report. The report has not been acted on because the OHS Coordinator says he does not know what to do with it.

As a result of the project an OHS Committee was formed at the plant. This met during the life of the project in order to undergo training in basic OHS and hazard management conducted by the consultant. It did not meet again until the evaluation of the OHS CIP because the group did not know what it could or should do.

There is considerable commitment to improving the working environment at SA1 and the committee members are enthusiastic about engendering change. However, a significant outcome of the project has been to make the participants at the plant feel inadequate to deal with the challenges they face.

SA2 – Small, urban meat processor

Located in an outer suburb of Adelaide, SA2 employs about 60 people and processes meat for large retail chains and small retail outlets. It is characterised by high labour turnover, which is attributed to the early starting hours, cold working environment and the smells associated with the work. Despite the high labour turnover, there are many workers who have a long employment history with the plant. The company has a full-time human resource manager who is responsible for OHS and who led the campaign for OHS change in the company.

The working environment at SA2 is very cramped, which limits the potential for expansion of the business on the present site, although there has been some discussion about this. Despite the extensive audit that was conducted by the consultant, successful participation in the WorkCover SABS audit and continued work by the OHS committee, significant workplace hazards exist in the plant. These are unlikely to be resolved until the owner of the company acknowledges that they present a hazard.

SA3 – Large country meat works

Located in a small town near Adelaide, SA3 processes pigs and manufactures pork, and pork smallgoods. The company employed 260 people at the commencement of the project although by the time of the evaluation this had reduced to about 60 people. Targeted for closure in late 2000, the company was still operating as an abattoir at the time of the evaluation, although many post-slaughter processing activities had been stopped.

An active and egalitarian OHS committee operated at the plant and had introduced significant innovations in plant and equipment and in policies and operating procedures over the last five years. The OHS record was enviable in any industry, but particularly so in the meat industry. Despite the imminent closure, the management and employees of SA3 decided that they would keep the plant a healthy and safe place to work until it closed down. Although the plant will close many people will remain in the company's employ at another plant nearby and others will take their knowledge to other firms in the district. Given the attitude of the people in the company it was disappointing that the consultant chose not to report on the extensive, three-day legislative audit that he conducted on this company. The company regarded their involvement in the program as a lost opportunity and were sorry to have lost the opportunity to be introduced to the MISHCIF process.

SA4 – large country meatworks

SA4 is an export abattoir located in country South Australia. The company employs about 400 people on a two-shift operation and slaughters and processes sheep. At the commencement of the project SA4 had some systems in place for managing OHS, some of which were preventive in nature. There was room for improvement and the will to improve.

An extensive legislative audit conducted by the consultant was followed by a very lengthy report and strategic plan all developed by the consultant with minimal consultation with the OHS Coordinator. These documents were re-interpreted by a consultant for the company's insurer and then presented to WorkCover as documentation for a SABS audit. SA4 was subsequently granted a Level 1 rating for SABS. The OHS Coordinator considered that OHS CIP had minimal impact on the company and their involvement had been a wasted opportunity. He now relies on networking opportunities with other firms to find answers to OHS questions.

SA5 – Large country meatworks

SA5 employs a seasonal workforce of between 100 and 250 employees. The firm is one division of a larger company and is located in a regional centre in South Australia and specialises in slaughtering cattle. The company was intent on developing improved consultative and participative processes and recognised the OHS CIP as an opportunity to do this. The consultant conducted a legislative audit and presented this to the company. Major issues identified by the audit were addressed immediately and other

issues were accorded a priority for attention. A change in senior OHS personnel during the course of the project slowed the process for a short while.

The central management of the company had knowledge of the OHS CIP process and were seeking changes in the operation of OHS management at the plant. They expressed disappointment in the lack of involvement of employees, although the management were committed to providing resources to the OHS CIP. They considered that SA5's involvement in the program was largely a waste of time and a missed opportunity.

Qld1 – Large country meatworks

This large, near-urban plant employs in excess of 1,000 staff and processes beef for export markets.

The operator chose to provide limited written responses to the review evaluation criteria, rather than facilitating discussions between the evaluation team and staff involved in the CI program. Accordingly, the information on approaches to and outcomes of the program have not been subject to verification by the evaluation team. It is reported that the initial focus of the CI team was on development of an OHS strategic plan; subsequently the team addressed communication processes including consultation procedures prior to implementation of engineering changes. They established a Workplace Improvement Team with representation across various workplace disciplines, with the role of finding practical solutions to OHS problems.

Qld2 – Large country meatworks

Located near a provincial city, this plant employs around 450 staff and processes beef for export markets.

The operator chose to provide limited written responses to the review evaluation criteria, rather than facilitating discussions between the evaluation team and staff involved in the CI program. Accordingly, the information on approaches to and outcomes of the program have not been subject to verification by the evaluation team. It is reported that the initial focus of the CI team was on development of an OHS strategic plan; subsequently the team addressed communication issues including consultation processes. The team is also reported to have addressed improvement in maintenance systems, including preventative maintenance.

Qld3 – Large country meatworks

This site in a small rural town processes beef (550/day) sheep(970/ day) and bones out 380 beef per day. It also has a rendering plant. The slaughter floor is relatively new but the remainder of the plant is much older.

The main area of improvement was the development of a management system. This reflects a focus on regulatory compliance issues and getting basic systems in place.

The main focus of OHS improvement effort over the past 12 months has been, and continues to be, to address the basic non-compliance issues, particularly in relation to matters such as administrative arrangements, record keeping and documentation.

Involvement in the CI project lead to an external audit of OHS. A major recommendation arising from the externally-commissioned audit was that a full-time health and safety officer should be engaged. This recommendation was subsequently acted on with the appointment of a full-time Workplace Health and Safety Officer (also with responsibilities for Environment).

Further improvements arising from the audit (rather than the CI process) were the redesign and modification of some processing equipment; and improved safety guards.

Qld4 – Large country meatworks

A large site where slaughtering, and rendering were carried out. Species processed are cattle (250/day), calves (200/day) and pigs (200/day) with approx 180 employees. The plant was over 40 years old with capital upgrades.

In the course of the project the site conducted confined space training, and developed and tested confined space procedures. With the help of the consultant they collected and collated various pieces of OHS policy and procedure held by different people and consolidated the fragmented information into a structured and cohesive OHS Policy and Procedures Manual.

Qld5 – Large country meatworks

A mid-sized site employing approximately 250 staff, in a rural location. The plant processes beef for export and domestic markets. This site used the CI Project to review their existing OH&S systems/approaches. Four areas were identified as needing upgrading or overhaul and this was done using the IADRI model. As a result new booklets, manual and forms were developed and implemented.

Tangible results of the program are regular audit and hazard reporting program developed; development of a stretching program; and policies and procedures for visitors and contractors.

Qld6 – Large country meatworks

This site employs approx 550 and processes over 900 beef /day and has a full range of activities on the site. CIP provided an opportunity to try to develop more pro-active systems.

The site used the model to identify and agree on matters that needed addressing.

They then determined the approach and deployment details using the IADRI model.

The approach tended to be one of identifying the need, working out how to implement it, implementing it and finishing there. It was suggested that this may have been in part because there had not been sufficient elapsed time yet to close the review/improvement loop.

Qld7 – Large country meatworks

This site processes about 650 cattle per day and has the full range of associated activities. The plant is over 40 years old and has had some upgrades.

The CI project involved including supervisors in OHS for the first time resulting in immediate action. Supervisors were able to make decisions and make a lot of changes immediately, many of which were not documented.

An example is the training of new employees and the implementation of refresher training at 3 months, which were developed as a result of the CIP project

Training in OHS was supplied to supervisors and workers as a result of the process for what appears to have been the first time there was any attempt at consultation on this site.

Qld8 – Large country meatworks

This plant, employing more than 400 staff, is located in a large provincial city. It processes beef for export markets.

The operator chose to provide limited written responses to the review evaluation criteria, rather than facilitating discussions between the evaluation team and staff involved in the CI program. Accordingly, the information on approaches to and outcomes of the program have not been subject to verification by the evaluation team. It is reported that the CI team proposed the development and application of a set of Manual Task Risk Assessment tools, but that this initiative was halted in light of management concerns over possible liability issues. Focus then apparently shifted to training for safety representatives, with implementation of a trial H&S training package.

Qld9 – Large country meatworks

This plant, located near a large provincial city, employs approximately 400 staff and processes beef for export and domestic markets.

The operator chose to provide limited written responses to the review evaluation criteria, rather than facilitating discussions between the evaluation team and staff involved in the CI program. Accordingly, the information on approaches to and outcomes of the program have not been subject to verification by the evaluation team.

The main outcome of the CI program at this site was reported to be the development of a H&S training package for safety representatives.

Qld10 – Large country meatworks

This large site employs approximately 1300 and is located in a mid-sized provincial town. It produces beef for local and export markets.

It was identified early in the process that the appropriate OHS policies and procedures were not in place at this site.

The site then adopted a systems approach to safety and developed a comprehensive Safety Management Plan.

Qld11 – Large country meatworks

A large site where slaughtering, and rendering were carried out. Species processed were cattle (815/day) and pigs (1400/day). There were approximately 370 employees. The plant was over 20 years old but a number of capital upgrades have been carried out.

In the course of the project the site conducted confined space training, and developed and tested confined space procedures. With the help of the consultant they collected and collated various pieces of OHS policy and procedure held by different people and consolidated the fragmented information into a structured and cohesive OHS Policy and Procedures Manual. Communication of OHS issues to employees was improved through the development of an OHS newsletter.

Appendix 3
Non-participants enterprises

SA6 – Small country abattoir

A small country meatworks that employs about 40 casual employees, SA6 slaughters and shells cattle on a contract basis for either hoof or on-hook owners.

The company has an OHS committee with two worker-level representatives that have been appointed by management. They meet monthly to review incident reports, review policies and discuss any safety matters that have come to light. The company has been targeted for assistance by WorkCover and is receiving training and support through its targeted employer program.

All jobs in the plant have a written Standard Operating Procedure (SOP) and these are explained to workers who are new to the job. The OHS component of the SOPs tend to focus on safe behaviour rather than safe place. For example, workers are exhorted to "be careful" when using the boning saw.

SA7 – large regional abattoir

Located in a regional centre, SA7 employs about 750 people on a two shift operation slaughtering and processing cattle and sheep largely for the export market. The company has well-developed OHS systems, some of which are proactive in nature, including daily OHS inspections of the factory floor. Eight elected health and safety representatives work on the factory floor and each is trained in accordance with South Australian legislation. An OHS Committee meets monthly to discuss hazard reports, injury and illness statistics and to consider policies and procedures that are up for review.

The biggest issue facing the company is occupational overuse injury and attempts to deal with this are being monitored by the OHS Committee. There have been some significant changes to the packing area with the introduction of semi-automated processes. Other changes have been introduced to reduce manual handling. The company is also trying to deal with drugs and alcohol in the workplace and pre-employment medical and psychological testing.

Vic 1 – medium-sized regional plant

Vic1 is a medium sized domestic plant, operating in a regional centre. It employs 120 in processing, with about 25 casuals used regularly. Vic 1 was involved in the Meat Industry OHS Best Practice project and reported very positive results from that involvement. Since this project, Vic 1 has continued to grow, both in volume and in the scope of processing undertaken.

Key focuses of their best practice project were training, participation and problem solving, mostly addressing manual handling on the slaughter floor. Many of the initiatives from that project have continued and the problem solving tools it developed continue to underpin their approach to OHS problems. However, Vic1 reported that some impetus has been lost through lack of an external focus. For example, the regularity of meetings of the OHS Committee has dropped off. Recent OHS issues addressed at Vic 1 have been associated with injury management and ongoing improvements to the plant to address manual handling.

Vic 1's owner assesses that the most effective strategy they have or could use is networking and benchmarking with other plants. Recent contacts dealing with injury management have provided valuable information and support and the benchmarking resulting from the OHS Best Practice Project was highly regarded.

Vic 2 – large regional plant

Vic 2 is a large mixed domestic and export plant, operating in a regional centre. It has grown quickly in recent years and now employs more than 450 on the slaughterfloor, with nearly a further 100 employees in the boning room. Vic 2 had short involvement in the OHS Best Practice Project, but did not pursue this approach. Instead, over the last 2 years, the HR manager has focused on establishing basic systems and procedures, such as an OHS policy, emergency procedures and injury management systems. Strategies to address specific hazards have also been implemented. For example, the use of cut resistant gloves has been promoted and is now compulsory. Job rotation is now practiced, despite the initial resistance of some middle managers. The success of the program has changed their minds.

Vic 2 sees their next challenge as addressing the design of the workplace and plant to reduce manual handling risks. They believe that this will require significant investment by the industry.

Vic 3 – large regional plant

Vic 3 is a large domestic plant, operating in a regional centre. It has grown in recent years and now employs about 221 people. Vic 3 was closely involved in the OHS Best Practice Project and used this project to address a number of entrenched workplace design problems in a participative way. The role of their OHS Committee was strengthened by the plant's involvement in the OHS Best Practice Project and the Committee continues to meet monthly "come hell or high water" in the words of the

Committee's chair. The chair reported that the committee now focuses more effectively on solutions, rather than merely listing problems.

A key focus of their activity in recent years has been training and they are in the process of implementing a comprehensive induction program which includes OHS as a major aspect. Visits to other sites have also supported ongoing improvements. Communication and participation were also nominated as critical underpinnings of good OHS.

NSW 1 – small region abattoir

NSW 1 is a small family owned domestic abattoir in regional NSW, with about 67 employees. NSW 1 participated in the Injury Management Project which operated in NSW prior to the OHS CIP. In the last 2 years, NSW 1 has directed more attention to OHS, instituting formal consultation through an OHS committee and developing policies and procedures for OHS and injury management.

Their involvement in the Injury Management Project supported increased management commitment to OHS by the owners and senior managers. Other benefits of this involvement were the development of formal systems and procedures (including some for prevention) and the opportunity for networking and informal benchmarking with others in the industry. The HR manager reported that the next steps for NSW 1 are to establish a coherent OHS management system and to improve training and induction of employees.

NSW 2 – medium-sized rural plant

NSW 2 is a medium-sized domestic plant owned by a private company. It is situated in rural NSW and employs 110 across the enterprise. NSW 2 participated in the Injury Management Project. The plant is fairly new and ergonomics was reported to have been a primary consideration in the design of the plant. Increasing workers' compensation premiums in NSW have lead to greater management focus on OHS and improved performance as a result of the Injury Management Project has helped to "make OHS a serious component of the company".

Networking and sharing ideas were cited as the main strategies which lead to what NSW 2 considers substantial achievements from the Injury Management Project. Next steps include addressing legislative compliance and seeking to integrate the OHS system with the QA system. NSW 2 aims for best practice and sees improving its OHS management as a way to be a leader in the industry.

Appendix 4
List of stakeholders interviewed

The following stakeholders were interviewed:

- Gwynneth Evans, OHS Officer, AMIEU
- Tom Hannan, Federal Secretary, AMIEU
- Tom Maguire, National Director of Policy, NMAA
- Margie Mahon, OHS Program Manager, MLA
- Janice Quarrie and Barry Shaw, SA WorkCover Corporation
- Project consultants in Queensland and SA