

Health and Safety Executive Board		Paper No: HSE/09/102	
Meeting Date:	25 November 2009	FOI Status:	Fully Open
Type of paper:	Above the Line	Exemptions:	N/A
Trim reference:	2009/448393		
<b>'PUTTING THE HEALTH INTO HEALTH AND SAFETY' - HSE'S RESPONSE TO THE STRATEGY'S HEALTHIER WORKPLACES GOAL</b>			

A paper by: Jane Willis  
Advisors: Kären Clayton, Steve Coldrick, Peter Brown and John Osman

### Purpose of the paper

1. To invite the Board to:
  - Agree a broad direction of activity for delivery of the 'healthier workplaces' strategic goal 2010/11 onwards; and
  - Identify issues for further discussion at subsequent Board meetings.

### Background

2 From 'Good Health is Good Business' to 'Securing Health Together' HSE has committed to improving occupational health via good management and partnership working. This has brought much success, realising a reduction in self-reported incidences. But the scale of the remaining problem remains challenging and in numerical terms is far greater than that presented by safety issues:

#### **Working days lost**

- 29.3 million days were lost overall (1.24 days per worker), with **24.6 million due to work-related ill health** and 4.7 million due to workplace injury.

#### **Ill health**

- 1.2 million people who had worked within the last 12 months were suffering from an illness they believed was caused or made worse by their current or past work, of which 563 000 were new cases
- 2156 people died of mesothelioma (2007), and thousands more from other occupational cancers and lung diseases.

3 Annex 1 provides a fuller picture of the data but in summary, health related deaths result primarily from current and historical exposures to carcinogens, dust, fibres, fumes etc. while the vast majority of working days lost result from either stress or musculoskeletal problems. There are also issues associated with skin problems and noise and vibration.

## **HSE interventions**

4 We have developed a range of ‘best mix interventions’ to tackle health problems and we have an effective regulatory regime for the control of pesticides. The following paragraphs note past activity across health issues and some on-going/planned activities. Taken together, they show the full range of issues that **could** be covered; however, we will need to decide at an early stage the priority initiatives we **must** deliver in order to achieve the maximum return from finite resources. In addition, the following reflects to some extent the legacy of FIT3, and as we note later, proposed future efforts will take greater account of risk profiles, rather than focusing purely on individual health topics.

### **Long latency problems**

5 Under the Disease Reduction Programme, we identified occupations where the risk of skin disease, asthma and asbestos-related disease was highest and set about working with stakeholders to bring about reductions in those risks over the long term. The approach was informed by the evidence about the target groups’ awareness, attitudes and influencers – then taking a best-mix approach to using, for example, awareness-raising publicity campaigns, stakeholder-led initiatives, and regulatory interventions.

6 For skin and asthma in priority occupations, we have reached a stage where risks and precautions are now much better known and are being adopted. We will continue to work to support stakeholders in embedding good practice. On asbestos, the work so far has successfully increased awareness amongst the at-risk groups and the impetus will be maintained to move towards changes in behaviour and practice. On cancers, we have been building a picture of higher risk occupations in order to identify future prioritisation. An example is exposure to silica where our best evidence suggests past exposures are causing hundreds of current cancer deaths (Annex 1), and evidence suggests exposures remain in excess of the Workplace Exposure Limit. We have had success in promoting simple information - using a stakeholder group - about risks and precautions with one high risk group - kerb and block-cutters which has showed real signs of positively impacting the at-risk group.

## **What next?**

### **Asbestos**

7 We plan a further publicity campaign to build on and embed awareness in the at-risk groups and to move them towards taking precautions. Then moving forward, we propose to address the ‘duty to manage’ element, which is key to ensuring risks are avoided or reduced but currently is at a very low compliance level. We are also working with the vocational sector to explore the ways in which tomorrow’s tradespersons might start their working life knowing more about the risk from asbestos and how to protect themselves.

## **Skin/asthma**

8 We need to maintain the push to embed the behaviour change that the evidence indicates is underway. To do this we will work in close conjunction with stakeholders with the objective that they carry forward ownership of the issue with support from HSE as appropriate.

## **Other long latency respiratory disease**

9 Current evidence is informing us about which activities/occupations present higher risk of cancers, chronic obstructive pulmonary disease and associated diseases due to exposures to carcinogens, silica and other such substances. We are engaging with relevant stakeholders in these sectors/segments to refine our information on the risks and to work towards agreed solutions. We are gathering further research information about the extent of occupational cancer risks – including a major study into the possible links between shift work and cancer. When this is available we will consider what action is necessary. Priority targets at present appear to be:

- construction work involving exposure to silica dust
- foundry workers
- welding
- stonemasonry
- quarry workers

10 Other areas – painters and those exposed to diesel exhaust emissions for example – will be considered as further evidence emerges of the level of occupational risk. We propose to group our work in the above areas under a ‘Dust, Fibres and Fumes’ initiative.

## **Noise and vibration**

11 Millions of workers are exposed to levels that can cause harm. Efforts to date have focused on promotion across industry of recent legislation and encouraging/enforcing noise and vibration control strategies and working with the supply chain. Next steps involve targeting the highest risk activities and engaging with stakeholders to develop ways to reduce exposures. Early thoughts are that the utilities and woodworking sectors are likely candidates.

## **Musculoskeletal Disorders (MSDs)**

12 MSDs are a key problem for most employers and the scale of the issue is immense. We have delivered a number of very broad campaigns over recent years with mixed success. However, we have looked again at this issue and agreed that we need to be more realistic about how much impact we can have on it. Our intervention strategies should flow from this e.g. we cannot hope to tackle all MSDs but we can work on some specific sectors/types of work that are particularly damaging. We therefore suggest that for now, we should focus our main efforts on a limited number of sectors:

- Manufacturing production lines, particularly in food
- Waste & recycling
- NHS/ social care
- Transportation (particularly loading and unloading activities).

13 Most recent HSE work in this area has focused on ‘backs’. Given this, we should also develop our knowledge base on the extent and nature of upper limb disorders in terms of sectors and extent of the problem (e.g. call centres, tills, and keyboard users). The new Assessment Tool for Repetitive Tasks to help assess tasks likely to cause upper limb disorders, will be available to inspectors and duty holders in 2010 and we are planning awareness and inspection work using this tool.

14 We should also explore the co-morbidity and common causal factors (essentially psychosocial) of stress and MSDs and the impact on these issues of positive working environments and good management. These issues may be brought into sharper focus with the anticipated new European Directive on MSDs which currently introduces the concept of organisational factors as an issue for risk assessment. It is probable that this Directive is about two years away from implementation in member states and that would be appear to be an appropriate point for a further more general push on MSDs.

### **Work related stress**

15 This is a very real issue for a large number of the population and continues to feature as a concern for many employers. We have achieved a world-leading reputation for our work in developing and introducing a practical tool for helping to address stress at work. However, as with MSDs, we do need to review our involvement in terms of impact to date, potential future activity and the ‘tractability’ of the issue.

16 There is a need for a more robust evidence base on the outcomes of use of the stress management standards. In addition, there is the need to embed the Standards into the agenda of management and human resources thus maintaining the momentum of the last few years. Current evidence would support continued effort on three sectors:

- Social Services
- Education
- Banking/finance

17 Although the NHS still has high levels of stress, we believe that the Boorman report (which references HSE work on stress – see Annex 2) now provides the primary impetus to tackle this area in the immediate future. However where appropriate, we could offer limited support to the NHS and central and local government so that we build on achievements to date e.g. West Midlands Civil Service project.

18 What appears to be emerging is that, following several years of field work, our resource is better targeted at communications, stakeholder work and further research into sector specific issues/evidence of impact.

### **Enforcement**

19 For most health risks there are clearly defined benchmarks to determine the risk gap and so inform enforcement action. However, these are lacking for some management aspects of controlling work-related stress and linked MSDs, short of carrying out a risk assessment and perhaps generic 'management arrangements'. In the absence of clear benchmarks for determining positive organisational cultures and leadership, for example, extending formal enforcement on stress beyond the requirement to undertake risk assessment may not be possible. Nevertheless, action of this sort in a suitably high profile context can have a significant knock-on effect in achieving change on health issues, for example the action in 2006 against Dundee council (Annex 3) and certain cases for control of infectious diseases, especially when combined with effective sector based communications. In addition we note the very real impact of the new Local Exhaust Ventilation Inspector Training initiative on COSHH enforcement.

20 We propose that we build on the real benefits and successes of enforcement, whilst at the same time revisiting the practicalities of enforcement as a lever for stress etc management by:

- Clarifying our expectations of acceptable standards for occupational health management across health risks';
- Examining on an on-going basis opportunities for skilling up' more of the HSE and Local Authority field force ;
- Examining how we are using health specialists; and
- Exploring the potential for ratcheting up the impact of high profile health enforcement cases in specific sectors, e.g. public sector, where there could be rapid communication among stakeholders.
- Work to understand and clarify the role of enforcement as commonly understood, in promoting the management of common health problems such as stress and MSDs

### **Data and Research**

21 We have a number of key research proposals under way and the bulk of our extra mural research budget is spent on research into long latency issues. The Black Report identified the need for greater cooperation and sharing of information and research across government but progress has been limited. We need to do more to link with Department of Health and DWP and the academic sector on:

- Existing topics
- Emerging topics
- Longitudinal studies along the lines of Whitehall II
- Data capture and leading indicators

22 We anticipate an opportunity with work within the Health Work and Wellbeing initiative on a "National Centre for Work and Health" and will actively work with other stakeholders to create a more robust UK occupational health research and information strategy particularly building on the existing health and occupation reporting system (THOR/THOR-GP) and the new electronic Fit Note

23 For many health issues, there is often a time lag between exposure and adverse effect. In addition, the scale of some problems means meaningful reductions may not be seen for some time. A reduction in incidence of disease or ill-health is not therefore a practical measure of success in the short- or medium- term. Leading indicators are a critical additional tool in measuring progress with reducing exposure alongside longer-term assessments of actual health outcomes. These leading indicators may be measures that provide information about a sector or particular activity, and which can show change, in awareness attitudes and behaviours for example, over a number of years.

### **Supply chain pressure**

24 The construction sector and recent Olympic Delivery Authority experience show the potential to use the supply chain to drive improvements. This has also been identified as a route to drive improvement among NHS supply organisations by the Boorman review. We need to examine the potential to do more of this in appropriate settings e.g. among local authorities and elsewhere in the public sector.

25 We also need to look at the contribution to the strategic goal that can be gained from capitalising on the Competent Authority role delivered by HSE in EU supply-side regulatory programmes on chemicals (e.g. Classification and Labelling, pesticides and biocides legislation).

### **Competence and the broader agenda**

26 A dominant feature of occupational health within the UK is the apparent lack of competence at a number of levels:

- I. Nationally, occupational health is a specialism among the medical community characterised by relatively small numbers and uneven distribution in relation to the size of the population served and prevailing risks. Questions are being raised about the quality of work provided by some professional occupational health organisations, and the lack of knowledge among many General Practitioners. Carol Black has identified the need for improvements in standards and both the Faculty and Society of Occupational Medicine are taking the work forward (with HSE input);
- II. Many employers find health difficult – lack of awareness, lack of knowledge of what to do, difficulty in accessing relevant and affordable advice - and

- III. Employees have a similar lack of awareness. There is a well established 'safety rep' network making welcome advances into 'health' but more could be done.

27 Looking more broadly, HSE already has a recognised key role in prevention of occupational ill health and we are currently seen as key players within Health Work and Wellbeing, Department of Health, and Scottish and Welsh public/occupational health initiatives. If we are to continue to engage effectively with exemplar organisations and innovators then we need to recognise that for many businesses, 'health' and 'wellbeing' are becoming part of the corporate social responsibility and productivity/engagement agendas, and accordingly we should 'speak the language of these areas' and show how we contribute to them. At the same time we need to be sure we are not drawn into activities which overstretch us and take resources away from our core interests around 'prevention' of occupational ill health. For example, there are certain 'public health issues' where we would wish to maintain a limited involvement e.g. sun beds, radon gas. Maintaining this position over the next few years will require a well-developed communications position.

28 Given the above, we suggest that we:

- Explore a partnership with Institution of Occupational Safety and Health (IOSH) which would build on work done over the last few years (DWP funded) to equip a sample of IOSH members with better occupational health skills, and spread this learning more widely among the very extensive membership base.
- Review HSE guidance on health for employers, particularly SMEs, as part of our developing SME engagement strategy.
- Work with the TUC to extend existing training and development work on health started by TUC into new areas including non-unionised environments as part of our 'worker engagement' initiatives.

29 Essentially we would be seeking to facilitate, with stakeholders, a situation where there are 'more intelligent customers and more intelligent suppliers'.

## **Resources**

30 The preceding discussions suggest a refocusing and rebalancing of our resources when delivering on health issues. The tractability of an issue will inform chosen interventions and implicit in this, is a reigning back of some activity for some areas. So for example, we may make more use of our traditional interventions - in terms of the use of field and campaign resource - in some long latency issues, than we are for stress and some MSDs. This is not to downplay the importance of the latter, simply a recognition that the issues require different responses. Given the topics/type of interventions discussed above, we consider that the majority of our resource on health (especially in the field) should be in the long latency area but we do need to ensure that we maintain a profile on stress and MSDs given the prevalence of

these conditions. We also need to resource activity necessary to develop our approach to competence, broader issues and health enforcement.

31 In addition, although there has been some external criticism of declining numbers of medical staff within HSE, there are now a wide range of staff (both specialists and generalists) engaged on health issues including a new Chief Medical Advisor post since October 2008. We will keep this situation under review as we develop the detail of our forward plans.

32 As part of our engagement on health we will want to consider how best to interact with a range of stakeholders and may need to review some well established relationships. For example, HSE has seen proposals from the Advisory Committee on Toxic Substances (ACTS) offering their expertise. Once we have had a steer from the Board on health matters, we will have further discussions with ACTS on what contribution they might make.

### **Conclusion**

33 Developing proposals in the above areas provides a way of building on past lessons so that we maintain an appropriate focus on specific topic areas whilst exploring the scope for advocating holistic management approaches to the prevention of work-related ill-health (as part of wider leadership and/or competence interventions wherever possible). Our role within the national health community should be as 'champions of prevention' with appropriate leadership of non-HSE core areas remaining with Department of Health and DWP e.g. (rehabilitation).

### **Action**

34 The Board is asked to:

- Within the context of the topics and activities listed, provide a steer on the future direction of HSE's work;
- Provide a steer on which activities are taken forward as a priority;
- Consider whether and what specific health issues might be brought to the Board for discussion at future dates;

### **Paper clearance**

This paper was cleared by the SMT on 4 November.

## ANNEX 1

### THE CURRENT STATISTICAL PICTURE

#### OVERVIEW






##### Working days lost

- 29.3 million days were lost overall (1.24 days per worker), with **24.6 million due to work-related ill health** and 4.7 million due to workplace injury.

##### Ill health

- 1.2 million people who had worked within the last 12 months were suffering from an illness that they believed was caused or made worse by their current or past work, of which 551 000 were new cases
- 2156 people died of mesothelioma (2007), and thousands more from other occupational cancers and lung diseases.

#### Ill health incidence: Assessment of change 1999/00 to 2008/09

Musculo-skeletal disorders		The 2008/09 incidence rate of self-reported work-related musculoskeletal disorders was statistically significantly lower than that in 2001/02, the closest available year to the revitalising baseline. THOR surveillance data points to a fall in reported cases from rheumatologists 1999 to 2007, although some or all of this fall may be due to changes to referral rules and procedures.
Stress, depression or anxiety		The incidence rate of self-reported work-related stress, depression or anxiety in 2008/09 is significantly lower than in 2001/02. THOR surveillance data shows a mixed picture with a stable trend in psychiatrist reports of work-related mental health between 2000 and 2008, but with a clear upward trend in occupational physician reports. The ONS omnibus survey shows no clear trend in the proportion of people saying their job was very or extremely stressful between 2004 and 2009.
Asthma/short-latency respiratory		THOR data shows a statistically significant decrease in occupational asthma cases from 1999 to 2008. The number of cases compensated under the IIDB is smaller and has fluctuated since the base year.
Dermatitis/skin		THOR data show a statistically significant decrease in work-related contact dermatitis and all skin disease cases from 1999 to 2008. The number of dermatitis cases compensated under the IIDB is smaller but has also fallen sharply over the period.
Mesothelioma/long-latency respiratory		The rate of mesothelioma deaths and other cases of asbestos-related disease, which dominate this category, continues to increase. However, for men aged under 60

		years the rate of mesothelioma deaths in 2007 was lower than in 1999. Death rates from coal workers' pneumoconiosis and silicosis are on a long-term downward trend, and were lower in 2007 than in 1999. In terms of numbers, the impact of these diseases on the overall target is small.
Vibration-related	↘	In the period between 1999 and 2007, the annual total of compensated cases for conditions linked to vibration fell substantially. A widening of the prescription rules saw this number increase between 2007 and 2008. Cases seen by rheumatologists contributing to THOR have fallen steadily since 2001.
Hearing loss	→	The number of new compensated cases of occupational deafness has fluctuated since 1999.
Supporting research		A report analysing trends and fluctuations in the self-reported illness incidence rate was produced last year and is available at: <a href="http://www.hse.gov.uk/statistics/pdf/LFSissue1.pdf">http://www.hse.gov.uk/statistics/pdf/LFSissue1.pdf</a> . The question of progress between 1999/2000 and 2001/02 is important to the judgement decision. Hence we will be commissioning external research to weigh up all the available evidence from the period and provide an expert view on the most likely trend over the first two years of the Revitalising period.
Overall direction	↘	Stress and musculoskeletal disorders are the largest components of work-related illness. Based on self-reports, there has been a statistically significant reduction in the overall illness incidence rate which is largely consistent with information from other sources.
Size of change		From 2001/02 to 2008/09 the decrease in the incidence rate of work-related ill-health was statistically significant, with a central estimate of 17% and a range of possibilities from 9% to 25%. There is no comparable estimate for the base year 1999/2000. An assumption has been made that there was no change in the ill health rate between 1999/2000 and 2001/02 primarily due to indications that work-related stress was increasing over the two years whilst MSDs were falling. On that basis, in order to meet a 20% reduction over ten years, a pro rata reduction of 18% would be required between 2001/02 and 2008/09. The statistical judgement is that <b><i>on the balance of probabilities progress is not on track to meet the Revitalising target</i></b> , although the reduction since 2001/02 is <u>very</u> close to the required target.  Based on the most recent data, the statistical judgment is that DSO target of sustained improvement in the incidence rate is <b><i>on track</i></b>

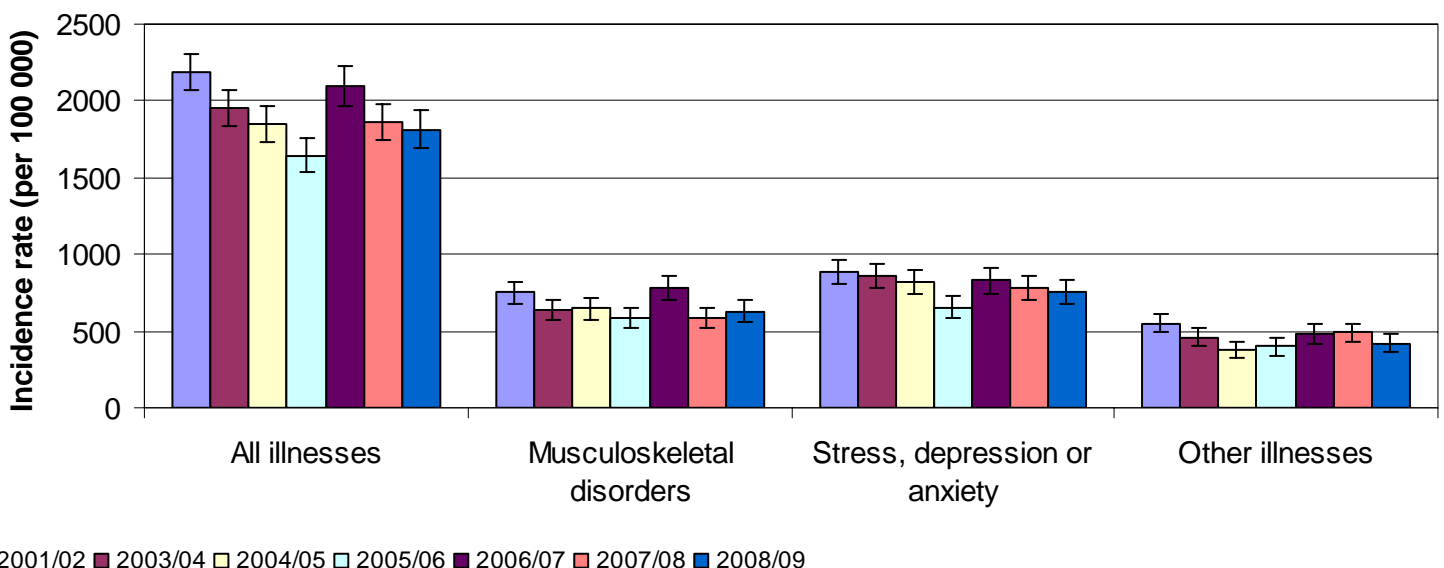
## Working days lost: Assessment of change 2000/01 to 2008/09

Days lost from work-related ill-health	↘	The estimated number of working days lost per worker due to work-related ill health in 2008/09 was statistically significantly lower than in 2001/02 (the closest available to the Revitalising base year), according to the Labour Force Survey.
Days lost from work-related injuries	↘	The estimated number of working days lost per worker due to workplace injury in 2008/09 was statistically significantly lower than in 2000/01 (the closest available to the Revitalising base year), according to the Labour Force Survey.
Supporting research		Sources on general sickness absence tend to lag the Labour Force Survey results and are sector specific. In addition, work-related absence is only a small proportion of all absence, and hence sources on total sickness absence only provide weak supporting evidence of the trend in work-related absence.
Overall direction	↘	Based on self-reports of working days lost due to work-related illness and injury, there has been a statistically significant reduction in the days lost per worker between 2000-02 and 2008/09.
Size of change		The central estimate for the decrease in days lost per worker 2000-02 to 2008/09 is 29.5%, (with a range of possibilities - 95% confidence interval - from 20% to 39%), compared to a <i>pro rata</i> target of 27%. The statistical judgement is that on the <b>balance of probabilities progress is <u>on track</u> to meet the Revitalising target.</b>

- ↗ Rise since base year
- ↘ Fall since base year
- No clear change since base year

### In a little more detail.....

Estimated incidence rates of self-reported illness caused or made worse by work, by main type of complaint, for people working in the last 12 months, 2001/02, 2003/04-2008/09



## ANNEX 2

### Extract from the Boorman Review

1. In 2006-07 Blackpool, Wyre and Fylde NHS Foundation Trust had a sickness absence rate of 5.34% and were undergoing a significant amount of change. Occupational Health also noted a marked increase in the number of employees who were presenting at clinics with work-related stress issues that were causing them to be unfit for work.
2. The Trust's staff opinion survey also indicated that the principal causes of stress in the workplace were excessive hours, restructuring and bullying and harassment. At the same time, the Health and Safety Executive (HSE) was planning to audit the Trust in relation to its management of stress in the workplace and how far it complied with the HSE Management Standards for stress in the workplace.
3. The Trust proposed to the HSE that it undertake its own Stress Project in order to identify and explore in some detail the sources of stress in the workplace. Having identified the sources of stress in the workplace, the project team would then make recommendations to reduce stress levels and develop a robust action plan that would ensure the implementation of all the key identified solutions.
4. Key targets for the project were to:
  - reduce the levels of sickness absence across the Trust by over 10% in the first instance (and a stretch target rate of 4.3% has been set for this year);
  - reduce the number of employees presenting at Occupational health due to work-related stress, reducing the ratio of psychological problems compared to musculoskeletal problems from 4:1 to 2:1 as a start; and
  - work with the HSE to convince inspectors that this was an acceptable alternative approach to an audit against compliance with the Management Standards and would go a long way to achieving the aim of reducing workplace stress.
5. The Trust established a Stress Management Group to oversee the project and also recognised the need for a comprehensive approach to tackling the underlying issues, engaging the Trust Board, managers, trade unions and the workforce to identify underlying issues and develop and implement plans for tackling them.
6. Since the beginning of the project, sickness absence rates have improved by over 10%; there has been an almost 50% reduction in cases of workplace stress; employee grievances have reduced by over 50%; disciplinary action has reduced by nearly 25% and rates of participation in appraisals have increased from 27% to 88%.
7. The Trust's staff opinion surveys have shown improvements for the last three years, and the most recent survey had a 61% participation rate, one of the highest in the NHS, and indicated that Blackpool, Fylde and Wyre is in the top 20% of Trusts. Notably, the scores for bullying and harassment by managers have reduced by 50% since 2006 and results for staff being unwell due to workplace stress have reduced by nearly 40%.

## **ANNEX 3**

### **Enforcement Action against Dundee Council**

*Extract from LA newsletter 2007*

#### **Councils told to address staff health**

The Health and Safety Executive (HSE) is warning local authorities across Scotland to be proactive in identifying and addressing health and safety issues affecting their staff following a case involving Dundee City Council.

In March last year, HSE issued Dundee City Council with an Improvement Notice for failing to have adequate management systems and provisions in place to deal effectively with occupation health risks faced by staff.

The legal duty to provide OH provisions for staff is outlined in a range of regulations including the Management of Health and Safety at Work Regulations, which state that 'employers have a duty to carry out risk assessments, make health and safety arrangements to manage risks, and ensure staff have access to competent health and safety advice'. The council appealed against the issuing of the Notice, but this failed and HSE's decision was upheld. Since then Dundee City Council has put a comprehensive OH action plan into force.

HSE inspector, David Steven, said: "The appropriate use of occupational health expertise and resources is necessary to comply with statutory duties but will also help employers meet non-statutory principles such as reducing work-related sickness absence."

HSE says there are examples of good practice...Lanarkshire Council, in partnership with their trade unions, has introduced a holistic approach to maximising attendance, based on a variety of new and innovative early intervention themes, including free physiotherapy provision for employees whether they are attending or absent from work with ill health, and access to a comprehensive occupational health service.