

Health and Safety Executive Board		Paper No: HSE/10/34	
Meeting Date:	31 March 2010	FOI Status:	Fully Open
Type of paper:	Above the Line	Exemptions:	N/A
Trim reference:	2010/115905		
DELIVERING FOR HEALTH – A FUTURE WORK PLAN IN RESPONSE TO HSE’S HEALTHIER WORKPLACES STRATEGIC GOAL			

Purpose of the paper

1. The paper provides the Board with an outline of a plan of work for future occupational health delivery, following its discussion on HSE’s ‘healthier workplaces’ strategic goal in November last year. It sets out an iterative approach to identifying and prioritising the agenda for action on health. Initially the plan aims to cover a relatively broad range of issues building on existing knowledge and experience. However, the aim over the longer term is to focus in on a number of key areas as we develop a better evidence base and refine our understanding of the problems, where they occur, and their tractability. The Board is asked to endorse this approach.

Background

2. Board paper HSE/09/102 provided a broad steer on the future direction of delivery, within the context of the scale of the continuing occupational health challenge and the range of activities that could be covered. Following agreement to the thrust of paper 09/102 the Board asked for a fuller narrative on priorities and activities for the future.
3. This paper provides an outline of work planned or ongoing in the short term and ideas on longer term priorities, set within the context of the HSAT’s preliminary work developing its destination statement for occupational health. It acknowledges that future work will be based on smarter use of evidence - from previous interventions, research and other intelligence - to inform targeting of resources within a mix of interventions.

ARGUMENT

Short Term Delivery

4. Activities over the next 18 months or so, will build on the existing evidence base developed from past interventions, research and other intelligence across the range of health issues - in particular through the better targeting of interventions at those sectors and workers most at risk. We intend concentrating on the following ill health issues: long latency diseases and common health problems such as stress and MSDs, with the latter two in particular involving close partnership working to move delivery forward. There is also our on-going policy and regulatory work

within various EU chemicals schemes, where options under these schemes may emerge for managing exposure. In addition, there is our engagement with Health, Work and Well-Being (HWWB), and the Scottish and Welsh administrations, and of course on-going operational work by FOD, HID and LA inspectors, with the latter as key delivery partners. Annex 1 provides a short breakdown of this work.

5. We acknowledge that health can be more difficult to manage than safety. To support employers we are, as part of the Managing for Health and Safety project, placing an increased emphasis on 'managing for health'. This will include emphasising the use of risk profiling to address immediate and tangible risks from safety hazards, as well as those health related and/or longer term. Key information on 'managing health' is being refreshed in the new website presence on Managing for Health and Safety, and will be incorporated into the refreshed HSG65 *Successful health and safety management*, which will be available by the end of 2010. Other sources of advice to enable employers to manage health effectively within their organisations will also be signposted from the website.
6. Past work (essentially FIT3) set out to change behaviours and practices in order to reduce exposure to substances/physical agents causing occupational ill-health, and to better manage those organisational and work activities leading to work-related stress and MSDs. There has been some success and the challenge going forward is to support stakeholders as they take ownership.
7. We need to understand better specific worker groups and the leverage interventions can gain, as well as the substances and activities that present significant risk. We know from the information we have that there are still large numbers of workers exposed to risk.
8. In effect, over the next 18 months, effort will focus on sensibly targeted, pragmatic and limited interventions. This latter statement is important. There is a risk we spread effort too widely given all that we *could* do. We argue that as an organisation we must accept both internally and externally that there are areas left largely untackled because the evidence suggests future effort will not be met with consequent gains, given the resources available to HSE and the timescales to which we would wish to work.
9. Below is an initial analysis of the priority areas for long latency diseases

Industry/sector group	Key activities	At risk population
Construction workers – tasks involving exposure to silica/other substances	Kerb/paving/block-cutting, stonemasonry, stone floor laying, tunnelling, demolition, chasing out/repointing.	90,000 general kerb etc cutting operatives, 30,000 road construction workers. Over 500 cases of occupational lung cancer in construction workers (2004). 8000 workers with breathing difficulty or disorder.
Foundry workers	Those associated with generation of dusts and fumes, and others due to materials used, or created by the processes	Estimated 24,000 workers may potentially be exposed to nickel compounds, silica and other substances presenting risk of cancers, silicosis etc.

Industry/sector group	Key activities	At risk population
Engineering - welding	Arc, oxy-acetylene, resistance welding.	79,000 workers exposed to welding fume – ongoing work to identify numbers involved in higher risk activities.
Quarry workers	Mining of high-silica stone. Sand pits, clay pits. Blasting, breaking, crushing and screening.	Around 88,000 employees mainly in major companies but number of SMEs, with around 35,000 with potential for silica exposure.
Stonemasons	Work in fixed premises, work on high silica, cutting, grinding, chiselling	Approx 8000 stonemasons, a large percentage of whom are potentially exposed to silica above WEL
Building and maintenance activities presenting asbestos exposure risk	Tradesmen – e.g., plumbers, electricians, joiners, carpenters	1.8 million employed in relevant trades. At least 500,000 commercial premises contain asbestos

10. The above are chosen as the areas on which to focus available resource on the basis that these activities are where the highest risks are - either because there is a large population potentially exposed or there is evidence of a high incidence rate. There are other work activities - examples of which are given below - which present long latency respiratory risks where further resource could be deployed.

Industry/sector group	Key activities	At risk population
Agriculture workers – grain handling	Harvesting, drying, storage, transport, dock activities. Associated maintenance/cleaning.	Grain farming workforce around 47,000. Animal feed mills – 3,000
Agriculture workers (excluding grain and poultry) – livestock, arable, vegetable cultivation, horticulture.	Preparation of bedding and feed, hay/haylage/silage making), straw baling, harvesting/cleaning/grading vegetable crops, flower bulb cleaning/grading/packing	Over 400,000 agricultural workers (2003 census). Up to 160,000 suffering from respiratory symptoms, 26,000 with bronchitis.
Painting – brush/spray	Application of paints and paint products (pigments, binders, solvents etc)	Work as a painter is linked with an increased risk of cancer – but difficulty re multiplicity of possible causative substances.
Diesel Engine Exhaust Emissions	Occupations presumed to have high/prolonged exposure to DEEEs – inc railway workers, dockers, bus garage workers, truck drivers	Approx 100,000 workers potentially exposed, and 100,000 workplaces where exposure takes places. Limited evidence of link between exposure to DEEE particulates and increased cancer risk. Environmental exposure also a key consideration.
Woodworking	Softwood/hardwood goods manufacture, sawmilling	>100,000 workers potentially exposed, wood dust classified as Gp 1 carcinogen by IARC. However, cancer incidence is low.

11. On noise and vibration, upcoming work will identify those industry sectors or segments of industry on which to focus using established criteria. We then propose to develop the partnership approach as for respiratory risks to engage with relevant stakeholders. Where appropriate, work will be co-ordinated where noise/vibration and respiratory risk are common to particular activities.
12. Following on from earlier partnership work, HSE will provide ongoing input and support as appropriate to continue embedding improved behaviours and practices to reduce skin disease and asthma in the highest risk occupations.

13. On work related stress and MSDs, the sheer scale of incidence makes the comprehensive segmentation by sector/occupation/task noted above problematic - though we have data for a few high risk tasks for MSDs and sectors where both stress and MSDs are most apparent. In addition, incidences of stress and MSDs are pervasive, occurring across industry sectors and occupations.
14. The activities on stress and MSDS noted at Annex 1 therefore seek to emphasise further the *management* of these issues, by further embedding the use of the Management Standards and evaluating their impact, and promoting the use of tools and techniques for managing some MSDs, working with and through partners as appropriate. Past activity focussed on five sectors where evidence showed particular problems - education, health, local and central government and finance. Going forward, the intention is to focus any effort on the health and social services, education and finance sectors, where we can build on the Boorman Review (health), support partnership working in a disparate sector lacking central coordination (education), and through LA-led work, reflect the changing nature of work and associated risks (in financial call centres for example). Operationally, stress is not a mandatory work block, though limited activity is planned in some regions, to conclude on-going work or to tackle locally identified problems.
15. On all activity noted in paragraphs 4 – 14 above the scope for partnership working with and through others will be a fundamental aspect of delivery - using the Boorman Review for example to gain leverage within the health sector is one reason for our focus here, and the leverage we can gain by supporting the work of ACAS and the CIPD.

Looking forward

16. In the longer term there is a need to refine and refocus further. A rationale for the basis of post-2011 delivery is noted at Annex 2, reflecting the early stages of work to develop a destination statement for the healthier workplaces theme. These articulate the need for clarity of HSE's role in and approach to improved occupational health, informed by an improving evidence base, using effective partnerships within a broad national architecture for health. The preliminary draft statements are attached at Annex 3, though we emphasise thinking is still on going.
17. Alongside sustained activity on many of the existing initiatives, we intend to review activity across HSE on work related health issues, and consider whether these are sufficient; potentially identify where work should be scaled up or down; and continue to develop an appropriate health research programme.
18. This is likely to identify that there is work ongoing which is not supporting the destinations and as such there would need to be decisions made about such work - stop and redirect resources, or continue when there is an agreed "business case" for the work (e.g. a political imperative).

19. That said, occupational health delivery will comprise five overarching areas of activity:

- Data, research and targeting
- Partnership working
- Building competence to manage health
- Communications
- Enforcement

20. Work has already started on these themes, which provide an opportunity going forward for a new, more focused and integrated approach to delivery, with activity in the following three areas:

- HSE-initiated work in specific segments/activities where there is evidence of significant risk and reasonable prospects of bringing improvements. This will be based on stakeholder engagement and partnership working wherever possible.
- Underpinning this is more general work on improving competence to manage occupational ill health, which will include health surveillance, guidance on the use of OH professionals, bespoke support for SMEs and so on.
- Continuing HSE involvement in the development of a national architecture for public and occupational health and delivery of appropriate contributions, which includes the work on HWWB and with the devolved administrations.

ACTION

21. This paper describes an outline of proposed and ongoing work over the next 18 months or so. It notes emerging destination statements for healthier workplaces, and five areas of work informing likely patterns of activity. The Board is asked to:

- a) Note the on-going activity planned for 2010-11 at Annex 1;
- b) Comment on the emerging destination statement and overarching areas going forward (paragraph 16 - 20 and Annexes 2 and 3)
- c) Endorse the evidence based approach to prioritising and tackling areas of concern in relation to occupational health.

ANNEX 1

EMERGING DELIVERY WORKSTREAMS 2010-11

Activity	Lead	Comments
<p>Asbestos</p> <ul style="list-style-type: none"> a) Assess the impact of tradesmen campaigns delivered to date b) Improving compliance with duty to manage c) Getting key asbestos messages into vocational syllabuses d) Necessary policy work – possible infraction; REACH Asbestos interface; Duty to Manage evaluation 	<ul style="list-style-type: none"> LLHRD/CD LLHRD, plus operational resource (FOD/LAs) LLHRD LLHRD/LAO 	<ul style="list-style-type: none"> Asbestos partnership board to agree next steps following impact assessment Key element is the identification of stakeholders best placed to influence duty holders
<p>Noise and Vibration</p> <ul style="list-style-type: none"> a) Identification of high risk activities and occupations and understanding of attitudes and perceptions b) Promotion of 'Sound Advice' via LAs c) Engagement with supply side to improve noise reduction at source 	<ul style="list-style-type: none"> LLHRD/CSD/CSAG LLHRD/CSD/LAs/Comms LLHRD/CSD 	<ul style="list-style-type: none"> Insight research to provide evidence for future segmented and targeted work, stakeholder analysis and engagement to follow
<p>Respiratory Disease</p> <ul style="list-style-type: none"> a) Research into attitudes, knowledge and influencers of long latency respiratory disease target groups b) Work with stakeholders in long latency target activities c) Asthma: Continued support for stakeholders in embedding changed behaviours for sectors with higher risks – in particular bakeries and MVR d) Skin disease – maintain support for hairdressing industry lead in embedding changed standards and behaviours e) Improve use and effectiveness of local exhaust ventilation and respiratory protective equipment as key precautions in controlling exposures to dusts etc by engagement with supply-side and users 	<ul style="list-style-type: none"> LLHRD/Comms LLHRD/OPSTD LLHRD/OPSTD/CSD LLHRD, plus external stakeholders LLHRD/CSD3/FOD 	<ul style="list-style-type: none"> Insight research to provide evidence for future segmented and targeted interventions Intention is to develop <i>stakeholder-led</i> interventions On-going activity maintaining positive stakeholder relationships to drive delivery The Hair and Beauty Industry Association has assumed the lead role in promoting and driving up standards – HSE will provide appropriate support. Opportunity for the use and piloting of user-side leading indicators

Activity	Lead	Comments
f) Embed key health risk messages into vocational training syllabuses for trades with highest risks; target activities through initially developing pilot learning packages for priority trades	LLHRD/CSD3/FOD	This comprises two areas of work: - research into how best to communicate desired messages to young learners - using this, development of pilot learning material for delivery colleges Aim is to ensure the next generation of workers is better informed on risks, and simple ways to protect themselves
Stress a) Continue encouraging the implementation of the Management Standards b) Build on the existing core group of stakeholders to assist with delivery of a) c) Examine co-morbidity aspects of stress and MSDs	WERG WERG WERG/CSD	This work will involve prioritising involvement in specific sectors, and probably occupations within these sectors – current thinking is within the Social Services, Education and Banking/finance sectors In the Health Service for example, the Boorman Review provides a primary impetus for delivery. We should look to others Contractor agreed and project team established. Outputs clearly defined
MSDs a) Continue encouraging the effective management of MSDs b) Proposed EU MSD Directive	WERG – with support from HUPPS/HSL/FOD/CSD/LAs and Construction Division WERG/CSD and International Branch	Delivery intended to be a mixture of sector-specific activity and the use of bespoke tools – the ART Tool; checkout activity in retailing; handling paving slabs. Emerging evidence of issues in waste and recycling and work design activities in transportation Publication of the Directive could provide for a major MSD drive in the future
Health Management a) Learning for the Managing Health and Safety Project b) Assessment of the Management Standards Experience c) Improving management competence d) Further development of tools e) External engagement with stakeholders to encourage good management in SMEs f) Radiation • With higher risk site radiography operations, targeting	WERG/LLHRD WERG/CSAG WERG, plus external liaison through CIPD/ACAS WERG/CSAG/OPSTD WERG/LLHRD/SID/Scotland CSD	Initial, important work on the delivery 'theme' of building competence to manage Push/pull tool for assessing manual handling tasks underway External engagement with FSB and SFF

Activity	Lead	Comments
<p>poor performers;</p> <ul style="list-style-type: none"> • To evaluate levels of compliance with radiation protection in medical uses of Ionising and non-ionising radiation in NHS trusts, dental and veterinary practices; • To assess standards of radiation protection by major industrial users of IP and NIR in well- logging and site radiography operations at offshore and onshore drilling operations Stakeholder workshop and liaison with EA/SEPA; • With large employers in areas and premises most likely to be affected by radon gas working with FOD and LAs. 		

FIELD OPERATIONS DIRECTORATE – PLANNED PROACTIVE WORK 2010-11

A snapshot of delivery is given below but importantly, health management is generally well embedded in inspection work across sectors and topics. So for example, within manufacturing, inspectors will always tackle wood dust in joineries, dermatitis in engineering and printing with UV inks, and in NHS and social care, violence and aggression for example may be looked at. Some Divisions are also doing work with stonemasons specifically (silica) as well as quarries inspection, and there will be limited agriculture work - both inspection and health topics covered at SHADs. These sorts of issues are well established within inspectors' training, but don't appear as specific projects in FOD plans.

1. Current planning in FOD notes planned core activity on health topics (at least one) in a number of areas, including:
 - Waste;
 - Manufacturing (which is a priority for FOD's interventions with SMEs);
 - Respiratory issues in motor vehicle repair/LEV/use of metal working fluids; and
 - Other sectors as appropriate like transport and health and social work.

2. In addition, planned regional/piloting work that some of FOD will do includes activity with/on:
 - Stonemasons/competence in the use of RPE;
 - Baggage handling at airports; and
 - OHI activity in food and drink.

3. Proposed occupational health and hygiene inspectors' contributions include work with/on for example:
 - Waste and recycling (including 'hotspot' inspections);
 - Silica exposure in quarries;
 - Other sector/activity issues with respect to respiratory disease;
 - MbOCA exposure; and
 - Working with other regulators such as the Training Care Quality Commission on patient handling.

PLANNED LOCAL AUTHORITY- ONLY DELIVERY

- Asthma in bakeries;
- Dermatitis in catering and hairdressing;
- Noise;
- MSDs;
- Sun beds and
- Work-related violence and aggression

HAZARDOUS INSTALLATIONS DIRECTORATE

'Topic Programme 1' was initiated in 2003, and aimed to reduce work related illness by improving the management of health risks by offshore duty holders. This was to be achieved by raising awareness; helping industry to establish baselines; securing compliance with regulations and by targeting priority occupational health issues (MSD, noise and vibration, asbestos and chemicals) during inspections. Inspections have been completed for the ten largest offshore operators. The management of health risks by six other offshore operators is currently being reviewed and will continue into 2010/11. Progress with operators previously inspected will be reviewed.

In addition, to the inspection project on the management of occupational health risks there will be targeted activity on:

Noise and Vibration

- Topic Pack and training for Inspection Management Teams
- Industry seminar
- Development and start of a targeted Inspection Project.

Asbestos

- A questionnaire based survey on the Duty to Manage Asbestos
- Targeted Inspections of asbestos notifications

Hazardous substances

- Develop, test and promulgate offshore COSHH Essentials Guidance on good control practice. This work will involve collaboration with industry stakeholders and input from CSD Occupational Hygiene Unit

CROSS-CUTTING

1. We are still committed to engaging with the Health, Work and Well-Being agenda, in particular ensuring that the benefits good standards of health and safety bring are reflected. The Board are taking an information paper on the status of our engagement at this March meeting. Activity continues on the wider 'health and work' agenda, and we should seek to gain leverage through this where possible. For example, the Scottish Initiative *Health Risks at Work* is a package of advice aimed at helping SMEs manage health risks better, and reflects an analysis of their needs. This will be evaluated over the next 12 months.
2. We are aware of many stakeholders and organisations doing good work, and similarly we intend learning from these. For example, the ODA have done work on supply chain issues and occupational provision. The intention is to learn as much as we can from the 'Olympics project' and we are engaged already on how best to use evaluations from this going forward as a lever for change in the construction sector and potentially more generally.

SOURCES OF EXPERTISE AND COMPETENT SUPPORT

3. There are several respected professional groupings and networks whose experience can be brought to bear on health issues - including occupational physicians and IOSH, and the ACTS, as well as expert and competent individuals. The future status of HSE's own EMAS is to be the subject of a Board paper in due course. Internally, the HSAT is considering the role health surveillance can play within a delivery framework which emphasises occupational health management.
4. HSE via its Chemicals Regulation Directorate delivers the UK competent authority functions within various EU chemicals regulatory schemes, aimed at protecting human health and the environment from the potential adverse effects of chemicals. This will continue. Where there are concerns about chemical-induced occupational ill health, it will be important for HSE and others to examine the impact on such schemes that might be gained by utilising the options offered by these regulatory schemes.

ANNEX 2

DELIVERY POST-2011

1. As we note in the body of the main paper, the aim of future delivery is the creation of healthier workplaces through improved standards of occupational health management, leading in time to reduced incidences of death and ill health.
2. Annex 1 noted work over the next 18 months or so, and flagged our intention to better target and focus interventions where possible. Post-2011 we suggest further refinement underpinned by a recognition that:
 - Our focus is very firmly on prevention;
 - Efforts are targeted where the evidence shows:
 - Where the biggest health risks are;
 - We can get traction and make a difference; and
 - We can lead and make a difference *but* also where we can work with others/encourage others to lead.
 - It is important to have ways to measure progress in reducing health risks. We believe stakeholders with whom we will work will be best placed in their particular sectors to identify 'leading indicators' that can provide the necessary assurance matters are improving (as incidence rates, particularly for long latency illness, are not a realistic measure in the short or medium term).
3. On what we propose below, work has already started in many areas and is coming on stream; in addition, in its generality, the delivery over the next 18 months at Annex 1 reflects this too. Discussions internally and externally will continue, leading no doubt to some refinement in due course. And there is also the HSAT's emerging 'destination statement', where initial thinking has started.
4. We stress that for many health issues, the latency period is long, or the scale of the current and likely continuing challenge is huge, meaning that immediate returns are largely unrealistic.
5. Thus going forward there is a real need to keep managing expectations. For many long latency issues, it is not realistic to expect reductions in incidences in the short and medium term. For common health problems such as stress and some linked MSDs, the sheer numbers make meaningful reductions in the short and medium term again unrealistic. Rather, as the destination statement suggests, we should look to future interventions that encourage the good management of occupational health, but backed by bespoke leading indicators demonstrating increasing numbers of organisations doing just this.
6. This means that good **management** of occupational health is at the heart of future work. In addition, it means changing perceptions both internally and externally. Internally, in that we need to give as great a priority to health in all that we do as we do to safety - so that we are confident operationally in 'upping' our presence on health through say enforcement; and that in communicating the importance of health *and* safety, we emphasise on occasions the ill-health burden as being the equal of, if not greater than, safety.
7. Externally, we need to educate the health and safety system as a whole to recognise the reality of the ill-health challenge. Safety is still, for many, what health and safety is about,

and there are good perceptual reasons for this. So to summarising thinking on the themes mentioned at paragraph 19 in the main paper.

Data, Research and Targeting

8. We can't do everything. We intend to concentrate on what we can achieve rather than what others might expect (but we will commit to an 'advisory' role where appropriate across health topics - provision of guidance, websites etc). This implies evidence-based delivery - using the evidence as appropriate to assess in particular:
 - Tractability (where we, or others, could make a difference);
 - Scale (numbers exposed, and where); and
 - Progress (indicators which show improved management and not simply reduced incidences).

Partnership working

9. Occupational health has many and varied competent, authoritative and influential stakeholders. Working in 'partnership' must then operate at several levels, with everyone playing the role best suited: employers and their leaders/employees and their representatives; ourselves, as regulators and policy makers, along with LAs and wider-Government and the devolved administrations with respect to both policy and delivery (e.g. HWWB). In addition, there are several respected professional groupings with experience to bring to bear - occupational physicians and IOSH - as well as the ACTS.

Competence

10. Occupational health is an issue to be managed. There is an argument that unlike safety - where many hazards are well-known and immediate - health is more difficult. The scale of some issues, the latency of others and identifying the work element from other 'lifestyle issues are problematic. In addition, these difficulties imply a reliance on measures other than simply outcome statistics. One measure is the improvement in health management amongst duty holders.
11. Furthermore there are legitimate questions on for example:
 - Levels of confidence amongst regulatory staff in relation to health issues (which also applies to LA inspectors), notwithstanding the good work seen in FOD/LAs on for example, local exhaust ventilation, skin disease, asthma and legionella;
 - The degree to which we can engage with and use, as well as build on, other sources of competence (the professional institutions/ OGDs/the Devolved Administrations, TU reps etc).
12. Last, traditional interventions on health have encouraged a focus on the topic rather than the whole. We intend to change this.

Communications

13. We have argued that health is sometimes seen as the 'poor relation' of safety, in that it does not sit in the consciousness of duty holders to the same extent. We will change this. We will work to ensure health is given the same weight as safety, and that the consequences of poor health management are just as 'costly' as poor safety management. Our future messages will emphasise the health burden to the same extent as the safety burden.
14. In addition we will explore and pilot imaginative messaging and media for these messages, involving third parties where appropriate.

Enforcement

15. As we noted in the previous paper, for some health issues there are no benchmarks for evaluating the risk gap thus making formal enforcement problematic - some of the softer management aspects of common health problems such as stress and linked MSDs. In addition, we must explore the lessons we can learn and others might learn from the health enforcement that does take place.

Concluding comment

16. We suggest that future sector/issue interventions through the business be designed using the optimum leverage from each of these areas. In doing so we must ensure that, given the cross-cutting nature of our future efforts on health, all interventions reflect initiatives flowing from other SATs (leadership, worker involvement, SMEs, competence).

Annex 3

Healthier Workplaces Emerging Destination Statement

In 2015:

- *We have a clearly articulated role and approach to work related ill health - defined, understood, and realistic which is agreed by HSE, Local Authorities and our stakeholders.*
- *HSE has an improving evidence base, and a set of indicators in place which we are using to effectively identify, target and monitor the key work related health problems.*
- *HSE has forged effective partnerships with those stakeholders who we know are best placed to bring about improvements in health outcomes.*
- *Where it is best placed to do so, HSE is using the right mix of interventions at its disposal to affect behavioural change.*
- *HSE is successfully influencing policy makers across Government to take account of occupational health issues in setting their agendas and we are working together to provide consistent and joined up health messages.*