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HEALTH AND SAFETY COMMISSION

Work Towards an HSE Chemicals Strategy A Paper by John Thompson Cleared by Sandra Caldwell on 22 October 2002

Issue

1. HSE's emerging Chemicals Strategy.

Timing

2. Routine.

Recommendation

3. HSE's emerging Chemical Strategy has six elements:
 - a) bringing together health and safety;
 - b) fulfilling statutory functions, including work on negotiating and implementing European Directives;
 - c) prioritising work particularly into programmes dealing with cancer, respiratory diseases and skin disease;
 - d) developing a robust compliance strategy linking risk to the necessary controls derived from industry sector good practice and enforcement through the Enforcement Management Model;
 - e) a communications/education drive; and
 - f) maintaining the existing regime for biocides.

Background

4. HSC has asked HSE to align its activities to the outcomes of the Strategic Plan. In relation to the regulation of chemicals, HSE's Health Directorate (HD) undertook an internal review of its work on chemicals and pesticides (2001 Review of HD Work on Chemicals and Pesticides). The attached annex, Developing a Chemicals Strategy (Appendix A) explains the context in which HSC/E's strategy for the safe regulation of chemicals in the workplace has been developed.
5. Though health and safety in major chemical manufacturing sites is generally well managed, the majority of the 1.3 million companies covered by specific chemicals legislation are small and medium sized enterprises (SMEs). Many of these duty

holders either do not understand or only partially understand what they need to do to comply with the law to protect their employees and others from risks from the use of chemicals. In consequence, these risks are often not adequately controlled. With the exception of asbestos, linking cancer to specific occupational causes is problematic, but the best estimates suggest some 6,000 cases of cancer are occupationally caused. In, addition, surveillance schemes indicate there may be up to 7,000 new cases of asthma which are either occupationally caused, or have work as a significant contributing cause; and some 66,000 new or existing occupationally related cases of dermatitis with around 30,000 additional cases that are exacerbated by the working environment.

Argument

6. The emerging Chemicals Strategy identifies the need for a more holistic approach, where both health and safety issues are addressed together, (acknowledging the fact that in the workplace there is no clear distinction between the two). It seeks to align HSE work more closely to Revitalising and Securing Health Together (SH2) agendas and demonstrate the need for a more visible link between policy and inspection/enforcement. It concludes that more emphasis needs to be given to the point of use – changing what happens in the workplace. Current work on developing and maintaining the legislative framework needs to continue (given its European and hence mandatory origin), but there needs to be increasing emphasis on work that will bring about change in the workplace leading to better controls. It proposes three major programmes looking at cancer (including the effects of asbestos), respiratory diseases (including the existing programme on asthma) and skin disease. Additionally, there needs to be a communication/education drive to raise duty holders' and employees' awareness of the hazards associated with chemicals.
7. The Strategy proposes a better link between policy and enforcement. But realistically the main focus for change cannot be through inspection and enforcement given the number and diversity of the SMEs concerned. To drive forward this programme it will be essential to work with partners, stakeholders and intermediaries much as is already being done (or developed) for the existing asbestos and asthma campaigns.
8. For biocides, we have a distinct permissioning regime. The issues raised by that are different (and are covered in paper HSC/02/141).

Consultation

9. Other Directorates/Divisions in HSE. The Advisory Committee on Toxic Substances (ACTS) has discussed the emerging strategy and is broadly in agreement. (Some were cautious about too strong a prioritisation. Others thought more work needed to be done on the epidemiology for cancer. These are issues we will develop thinking on further. ACTS are keen to work with us on developing and implementing the strategy.)

Presentation

10. Specialist chemicals press.

Costs and Benefits

11. The Strategy is cost neutral to HSE. Its emphasis on the necessary controls to manage exposure to hazardous substances should reduce the need for industry to

carry out expensive air monitoring. Its emphasis on making change happen in the workplace would contribute to the Revitalising and SH2 targets.

Financial/Resource Implications for HSE

12. None. The Chemicals Strategy will reallocate resources within the existing programmes on chemicals. There will be a reduction in measures addressing the supply side and the production of domestic occupational exposure limits and an increasing emphasis on communicating information about hazards and informing the workplace of how to ensure the controls are adequate (or what to do if the controls are inadequate).

Environmental Implications

13. None.

Other Implications

14. The Chemicals Strategy specifically addresses the needs of SMEs, who want to be told what to do to control chemicals.

Action

15. HSC is asked to consider the recommendations at paragraph 3. In particular it will want to:
- a) discuss the Chemicals Strategy; and
 - b) determine the extent to which it should take the Chemicals Strategy into account in developing its programme of work.

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Developing a Chemicals Strategy

Issue

1. A chemicals strategy for HSE

Background

2. Last year Health Directorate conducted an internal review of its work on chemicals and pesticides. A recurrent theme of the final report was that HD needed to develop an explicit strategy for its work in chemicals and pesticides. The absence of such a strategy has made it difficult to fulfil the other main conclusion of the review that we should prioritise our work streams. The strategy would make clear how work on chemicals contributes to the Revitalising and SH2 agendas, and to operational policy. It was clear that it makes little sense to look at health and safety as distinct issues when that is not how they are viewed in the work place, and that what was needed was a holistic approach to HSE's overall needs for a chemicals strategy.
3. The major manufacturing sites for chemicals are regarded as potentially hazardous and so most are covered by the COMAH regime. For them health and safety are crucial elements of planning and design and are priorities for the companies and for HSE. The chemical manufacturing industry are primarily concerned with sudden loss of containment, rather than long term health risks of chemicals. The COMAH regime reinforces a positive health and safety culture. One side effect of this can be expected to be reliable compliance with COSHH. But much of the rest of industry also uses chemicals, or chemical products, to some degree. Some 1.3 million companies are covered by the specific chemicals legislation including the Control of Substances Hazardous to Health Regulations (COSHH), the Chemicals (Hazard Information and Packaging for Supply) Regulations (CHIP) and the Biocide Regulations. For many of these, the majority SMEs, health and safety are often not priorities and knowledge of the legislation is limited.

4. But many chemicals, even in common use, are inherently hazardous and the risks are not adequately controlled. This has implications for the workforce and the public readily comparable in terms of mortality and morbidity to the major priorities for HSE. An important estimate of the overall proportion of cancer attributable to occupational exposure remains that put forward by Doll and Peto in 1981 in a report to the US Congress. They estimated that 4% (plausible range of estimates 2% to 8%) of cancer mortality was due to occupational causes. This equates to approximately 6000 cancer deaths per year in Great Britain (plausible range 3000 to 12000). Although, these estimates relate to the US over two decades ago and more work needs to be done on the present UK position they are seen as broadly applicable to Britain today and the best overall estimates available for all cancers. Each year 66000 people suffer from a new or existing skin disease caused by work, around two-thirds having dermatitis or eczema. Each year an estimated 4000 to 5000 new cases are seen by dermatologists or occupational physicians. Some 1500 new cases of occupational asthma annually are seen by specialist chest and occupational physicians while there may be up to 7,000 new cases in total that are either occupationally caused or have work as a contributing cause.
5. That is why in recent decades the HSE, and latterly the European Commission, have spent much time and effort producing a comprehensive legislative framework, which, if complied with fully, would afford high levels of protection. The legislative framework is sound and largely meets the needs of the UK.
6. Knowledge about the hazards inherent in individual chemicals is less good but, nevertheless, considerable efforts have been devoted domestically, and increasingly at European level, to developing occupational exposure limits for hundreds of chemicals. (There are, however, some 30,000 chemicals, produced in volumes in excess of 1 tonne).
7. Much of the mortality and morbidity described above derives from exposures to chemicals in the past. Given the long latency periods for many chemicals that will always be the case. Nevertheless, the lack of awareness among many duty holders about just what is required of them by existing legislation, inevitably means that present day workers are being avoidably exposed to hazardous chemicals.

Way Forward

8. The attached annex starts from first principles to look at what the HSE needs to do further in relation to chemicals and what the constraints upon it are. It comes to the conclusion that too much of the current effort certainly in policy terms is devoted to the supply side measures and that far more emphasis needs to be given to point of use, that is in the workplace. Current work on developing and maintaining the legislative framework is valuable (and inescapable given its European origin). It probably already gives us all the legislative tools we need. The problem is not lack of regulation but limited awareness and understanding and so compliance, particularly in SMEs. The priority should be on work that will make change happen in the workplace. It suggests that there should be three major programmes looking at: -

- a. Cancer (including the effects of asbestos);
- b. Respiratory diseases (including the existing programme on asthma);
- c. Skin disease.

Tackling these would make significant contributions towards the Revitalising and SH2 targets.

Enforcement

9. It also suggests that there needs to be a closer link between policy work and HSE work on inspection and enforcement because those are inevitably major incentives to better compliance.
10. The paper proposes a conceptual model to address this. Starting with risk phrases and existing exposure limits it is possible to look at the industry sector good practice that would deliver controls sufficient to meet those exposure limits or the hazards identified. It is those controls (of which there are only a limited number available), which would form the basis of the compliance requirements in the Enforcement Management Model (EMM). The EMM could then also suggest the appropriate regulatory response to any non-compliance.

Securing Change

11. Realistically inspection and enforcement are only minor tools in securing change in what happens in the workplace, particularly SMEs. The prospect of many of the 1.3 million workplaces being visited by an inspector in a decade is not high. The emphasis must be on other intervention strategies through
 - compliance aids, such as electronic COSHH Essentials
 - through intermediaries such as trade associations, chamber of commerce, safety representatives
 - through partnerships with local authorities, NHS Trusts, voluntary organisations, academic institutions
 - dissemination of industry sector good practice rather than a concentration on exposure limits.

Revitalising and Securing Health Together

12. A major question is how does this relate to Revitalising and SH2? The short answer is that with its focus on outcomes and making a difference in the workplace it is fully consistent with the spirit of these. But that is not to dodge the issue that because of the latency many of the adverse outcomes would not arise in the 10 years span of the current priorities, Yet few would doubt that preventing cancer is more important

than, say, preventing a broken bone even though that could result in months off work.

13. Nor should we underestimate the fear factor connected with chemically induced ill health, in particular cancer. It is a legitimate matter of public concern not at present explicitly covered with the current round of priorities. Similarly the use of chemicals in the workplace is ubiquitous and in many they represent the most significant hazard.
14. Therefore we believe the work on chemicals at least complements RHS and SH2 priorities. In some cases the work proposed would play a more direct part linked to both HSE work on compliance and continuous improvement.
15. In the longer term we intend to do more work to justify the adverse effects of chemicals – cancer, respiratory disease and skin disease – being a priority for the next round of priorities, post 2004. After all annual occupationally caused mortality rates of some 8,000 far outstrip any other. Also progress is measurable in the shorter term by looking at proxies – such as reductions in levels of exposure, increased substitution and the adoption of best practice solutions.
16. The paper suggests that the strategy for HSE, therefore, needs six elements: -
 - d. Bringing together Health and Safety.
 - e. Fulfilling statutory functions; including work on negotiating and implementing European Directives (IOELVs, CHIP, CAD, COSHH) etc.
 - f. Prioritising work particularly into programmes dealing with cancer, respiratory disease and skin disease.
 - g. Developing a robust compliance strategy linking risk to the necessary controls derived from industry sector good practice and enforcement through the Enforcement Management Model;
 - h. A communications/education drive.
 - i. Maintaining the existing regime for biocides.

Little in this is totally new. It builds on existing work and would be consistent with the decision making process outlined in “Reducing Risks, Protecting People”. The overall required effect can only be achieved in partnerships, including with stakeholders, OGDs the voluntary sector and the health services.

Annex 1

TOWARDS A CHEMICALS STRATEGY

Issue

1. This paper looks at what the Health and Safety Commission/Executive needs to do in relation to chemicals, why and what the constraints are upon it. It starts from first principles rather than what we do now. It looks at both health and safety because many of the issues are the same for both. It seeks to align HSE work on chemicals more closely with the revitalising and SH2 agendas and demonstrate the visible link between policy and inspection/enforcement. The term “chemicals” includes products, process generated substances (e.g. welding fume) and natural materials (e.g. grain dust).

Recommendation

2. A determined shift over the next 2 years to an emphasis on the workplace and improved outcomes.

Background

3. The HSC mission is to ensure that risks to people’s health and safety from work activities are properly controlled. For chemicals, this means that people in the workplace are not adversely affected by chemicals and that the use of chemicals in the workplace does not adversely affect the public. This paper, therefore, focuses on what needs to be done to ensure that the right things happen in the workplace. Although, the Health and Safety At Work Act puts general duties on the HSC and HSE (either in support or acting independently) relating for instance to provision of information, training, research, work with national partners etc, the main thrust of the regulation is the onus placed on employers.

The Role of the Regulator

4. In the course of the internal review of chemical and biocides the independent consultant, Michael Spackman described the role of the regulator as:

- standard setting;
- information gathering;
- behaviour modification.

From an HSC policy perspective we have tended to concentrate on standard setting but in essence our role is to ensure that a robust framework is in place to enable compliance and enforcement and then do what is necessary to facilitate that. Enabling and facilitating cover the whole process at the workplace. There is no point fine-tuning the framework if it does not impact on the ground. Enforcement and inspection are crucial to achieving improvements to health and safety. Arguably a major role is to ensure that enforcers have the tools and understanding needed to play that role. But at present working links are not strong.

5. Similarly there is little point in providing employers with standards if they cannot perform the risk management and so implement effective controls. Development of a standard, such as an OEL or even an ACOP, is only part of the process and has little significance if the full process does not take place.
6. Facilitating compliance entails identifying problems and providing advice and information in the right form, practical tools and compliance aids. It is a primary role of HSE to:-
 - identify priorities (but based on input from the field)
 - promote a better working environment;
 - reach and engage SMEs;
 - motivate employers and other stakeholders;
 - create partnerships.
 - assist others, both inside and outside HSE, to target risks more effectively
7. Enabling enforcement means giving inspectors the tools, as part of the Enforcement Management Model, to determine whether enforcement action is necessary and if so what the appropriate enforcement response should be. This means displaying the link between the risk, the control measures necessary (derived from industry sector good practice where

that is adequate) to address that risk, and the implications of those controls not being in place.

What Employers have to do

8. The efforts of HSE need to be directed at where they will best enable practice in the workplace to improve. This means identifying each of the stages that users of chemicals have to go through to prevent adverse safety or health outcomes. And then determining how best either to assist the local stakeholders, and in particular duty holders, to improve outcomes or encourage those processes that deliver safety through design.
9. In terms of chemicals, employers must control the hazard to prevent adverse health and safety outcomes ranging from immediate asphyxiation to fire and explosion or eventual cancer. To do that employers must do a standard risk assessment. They must:
 - identify the inherent hazard in the chemical or process;
 - determine the potential for exposure or other risk;
 - identify what control mechanisms are in place;
 - and assess their adequacy.

If the control mechanisms are not adequate, that must be rectified. The duty is continuing and where necessary there must be monitoring, health surveillance and training. There is also a duty to inform and consult the workforce.

10. If the HSC mission is to be achieved, the employer in the workplace must be incentivised and **able** to do all of those things. It is worth looking step by step at what provides the incentive and the ability.
11. Firstly the duty holder must **know that they have that duty**. In this employers who use chemicals in the workplace are no different from other employers. There is nothing chemical-specific. There is a general awareness, though health and safety may not be priorities. Awareness comes from general background culture assisted by trade associations, trade unions, industry groups, as well as contact with HSE. Incentives come from potential inspection and enforcement, and the need to avoid civil claims. Employers must, of course,

also realise that the products they deal with are, indeed, hazardous chemicals or contain them. Many employers want to do the right thing but are unaware of their duties.

12. For **identifying the hazard**, the employer is reliant upon safety data sheets and labels, upon in-house technical expertise informed by HSE guidance or information from trade associations. The content of the SDS derives from previous and continuing work on classification and labelling by HSE. But for the system to work the SDS must not only be sufficient and intelligible but readily available at all stages throughout the supply chain. The incentive here is inspection and potential enforcement. But the 3Rs work shows that communicating through SDS is not at all effective and also that standards and availability of SDSs are at best variable. Similarly, the traditional approaches adopted in HSE guidance are not sufficient in many cases.
13. Once the hazard has been identified, the employer must **assess the potential risk**. This will depend on the form of the chemical, how much is used, the process, the location etc. The expertise comes from many sources not least trade associations, health and safety professionals, HSE, industry advisory committees etc. The incentive comes from potential inspection and enforcement under HSWA. In practice this step may be beyond the grasp of many SMEs particularly lower down the supply chain.
14. Once the potential risk is known, the appropriate control mechanisms need to be identified. Knowledge of what these might be will differ markedly from site to site and by size of company. The incentive comes from potential inspection. It is in fact mainly the next step, to make a decision on whether controls are adequate, that is crucial. No employers wants to make their employees ill but many are unaware, or not sure, of what they should do. Arguably HSE needs to be smarter at establishing what is in fact occupational hygiene practice in the actual industry sector.
15. In terms of exposure, the **ability** to make a **decision on adequacy** can be based on two things. Firstly, in absolute terms, whether a specified exposure limit has been met. But even without measuring exposure, it is possible to be confident that control mechanisms are adequate if recognised industry sector good practice is followed. The ability to do the first derives from the intensive, chemical by chemical, work on assessing and setting exposure limits, whether international or domestic. HSE does high quality, internationally respected

work in this area for instance on ESR, NONS, OELs etc. The second is seen in approaches such as COSHH Essentials and the availability of good industry/sector advice and guidance. It is probable that the bulk of employers (particularly in SMEs) would prefer to know what good practice is, rather than simply the limit they are meant to achieve. Getting practice right requires the application of occupational hygiene knowledge to the appropriate hazard, which is why in HSE it requires close working between HD and TD.

16. If the risk assessment suggest that controls of exposure are **not adequate**, there is a hierarchy of priorities in which employers are expected to make changes starting with substitution of a safer chemical. But there is limited general understanding of that. The incentive comes partly from potential inspection and enforcement. But it is likely that the knowledge of how to achieve better controls is variable. It will come from trade associations, HSE etc. But it is not straightforward. Taking for instance substitution, it is readily possible to substitute for a known dangerous chemical one whose inherent hazards are not known to be dangerous, but in fact are.
17. Risk assessment in terms of safety is perhaps more closely aligned with the HSC priority programmes. The incentive is self preservation but also potential inspection. Knowledge on adequacy would come from HSE and trade associations/industry guidance. Safety is more readily understandable, because failures are so much more immediate and can be dramatic. The challenge is to raise standards of health awareness to those of safety.
18. For biocides, and increasingly other chemicals, a different regime applies. We have a central approval system which determines which biocides can be used and in which circumstances. This is labour intensive at the centre but makes compliance and enforcement/inspection simpler. It is contrary to the risk-based approach common to HSE but is gaining momentum at the European level. This is apparent in the European White Paper proposals which will lead over the next 5 years to the establishment of the REACH (Registration, Evaluation and Authorisation of Chemicals) system.

Present HSE Policy

19. A lot of work has been done in the past decades to make sure that the building blocks are there, so that if employers complied with them fully workers' health and safety would be protected. For chemicals, the framework (largely based on EU directives) has been in place for some years. But current work is necessary to modify it. This includes work on CAD, ATEX and CHIP. Work on the new OEL structure and the duty to manage asbestos are further refinements. In the context to the European White Paper the aim for HSE is to ensure the existing structures are maintained and the challenge is to make sure they are improved. There is continuing work to optimise the legislative framework.
20. Other work is aimed at assisting workplace compliance through enforcement, investigation and pre-emptive inspection. From the centre COSHH Essentials or e-COSHH Essentials fill a recognised gap but need promoting. HSE at present puts much effort into enabling the first stage of risk assessment - the inherent hazards of chemicals (NONS, ESR etc) - and in one aspect of assisting control - developing OELs, CHANS etc to enable the judgement to be made as to whether control is adequate. We also put in much effort to guidance on hazards from chemicals such as fire, explosion, looking at, for instance, planning for land use, and transport of dangerous goods. But the analysis above suggests that the gaps are in communicating information about hazards, (particularly about health) to the workplace and informing the workplace of how to ensure the controls are adequate (or what to do if controls are found not to be adequate).
21. Many employers are also suppliers of chemicals to others and they have specific duties under HSW legislation to those to whom they supply. A major weakness at present is the poor quality of data going down the supply chain. However good HSE communication with small firms, suppliers will always be an important source of information for this group. It is essential that end users receives appropriate information from their suppliers. This is not a new problem and there have been several initiatives over the years, recently with the Chemicals Industry Association. But, certainly in SMEs, workers at the point of use do not routinely have access to labels or safety data sheets. And for many that do, the data is wrong.
22. For biocides we have a distinct permissioning regime. There are no policy reasons for that to be altered.

Closer Alignment with Revitalising and SH2

23. The objective of the HSE's work on chemicals in the workplace is to reduce the adverse effects on the workers and public. The focus therefore, should be on those effects and what can be done to prevent them. In health terms significant threats are cancers, respiratory diseases and skin diseases. An important estimate of the overall proportion of cancer attributable to occupational exposure remains that put forward by Doll and Peto in 1981 in a report to the US Congress. They estimated that 4% (plausible range of estimates 2% to 8%) of cancer mortality was due to occupational causes. This equates to approximately 6000 cancer deaths per year in Great Britain (plausible range 3000 to 12000). Although, these estimates relate to the US over two decades ago they are seen as broadly applicable to Britain today and the best overall estimates available for all cancers. Each year 66000 people suffer from a new or existing skin disease caused by work, around two-thirds have dermatitis or eczema. Each year an estimated 4000 to 5000 new cases are seen by dermatologists or occupational physicians. Some 1500 new cases of occupational asthma annually are seen by specialist chest and occupational physicians while there may be up to 7,000 new cases in total that are either occupationally caused or have work as a contributing case. Quite apart from the mortality rates, morbidity rates at these levels represent a high proportion of the totality of work related ill-health and therefore the number of workdays lost. HSE efforts to reduce them are plainly fully consistent with Revitalising and SH2 targets.
24. For asthma, HSC has agreed a specific target of a 30% reduction over 10 years. A strategy to meet this target has been developed. One aspect is a specific ACOP and regulations. But the main asthma programme is based on identifying the 8 industry sectors or causes of asthma and identifying, with stakeholders, the targeted actions needed to reduce incidence. This includes specific programmes for FOD, HID and HELA.
25. Similar focuses can be developed for both cancers and skin disease where mortality and morbidity rates are even higher.

Better Alignment between Policy and Enforcement / Inspection

26. The internal review of chemicals and Biocides work noted that the majority of policy work done on chemicals in HSE related to supply side measures with relatively little resource devoted to intervention at the point of use. The objective of the work is, of course, to produce impact at the point of use, that is the workplace. Much can be done to achieve this through working with stakeholders and intermediaries such as trade associations and the voluntary sector. But as the analysis above suggests a main incentive for duty holders to take action comes from the probability of inspection and consequent enforcement action. Again it is not that the employers do not want to do better (though it may not be a priority). They tend not to know what to do.
27. HID and the COMAH regime cover the major chemical sites and petro chemical refineries. But some 1.3 million companies, most of them SMEs, use chemicals and chemical products and their workers are potentially at risk from dangerous exposure. Traditionally this has not been regarded as a priority for FOD or local authority inspectors, (other than for asbestos or asthmagens). This is not just because there are other priorities, but also because they are not convinced of the actual impact on the health of the workforce, and are not always fully conversant with the detail of the regulations (COSHH and CHIP) or the tools available (COSHH essentials), and are uncertain as to the appropriate regulatory response. Although some initial thought has been given to chemical use in the Enforcement Management Model, this is rudimentary so far.
28. It remains essential for HSE to fulfill its statutory responsibilities which include monitoring and developing the regulatory legislative framework eg on classification and labelling (though increasingly that is driven by consumer and environmental concerns) and implementing European exposure limits – the Indicative Occupational Exposure Limit Values (IOELVs). There will still be a need to maintain a limited programme of developing domestic limits, though the emphasis should be making sure the European system works satisfactorily. But as the analysis above suggests exposure limits are little understood and do not of themselves, have anything like sufficient impact in the workplace. Nor are they readily useable for inspection or enforcement purposes.
29. The approach adopted in COSHH Essentials is to start from risk phrases and from these derive the workplace controls that will be necessary for any given chemical. Similarly in the ACTS discussion document on exposure limits it is proposed that the exposure limit should

in effect be the “long stop” with far greater emphasis on industry sector good practice which would set out the controls which, for that industry sector, will be technically feasible but also reduce exposure below the exposure limit.

30. It should be reasonably possible to derive specific controls from industry sector good practice. Those controls would form the compliance requirements that would be part of the Enforcement Management Model. Inspectors could therefore determine in any workplace where a specific chemical was used what controls ought to be in place according to the processes undertaken. The EMM could then alert them to their appropriate enforcement response for non-compliance so that effective regulatory action could be taken.
31. In so far as the employer is also a supplier, there is also an enforcement role in ensuring that chemicals are correctly classified and labelled. (But more important, arguably, is a communication campaign to ensure that smaller manufacturers understand the classification system).
32. The legal requirement on the duty holder is to reduce risk as slow as reasonably practicable. The conceptual model is:
Risk → exposure limit → industry sector good practice / control → compliance requirements in the EMM → appropriate enforcement action.
The principles set out in the ALARP guidance give the link between good practice and meeting the requirement of reasonable practicability.
33. The actual controls available in the workforce are limited. The number of risk phrases is limited. If the actual exposure limits are long stops and the statutory duty on the duty holder is not merely to meet the exposure limit but also to meet the more rigorous requirements of industry sector good practice, then it should be possible to achieve sufficient controls through banding chemicals by their risk phrases as in COSHH Essentials. To the extent this is possible it would simplify the process to manageable proportions.

Constraints

34. The major constraint to changing the existing work programme is that it largely derives from implementing EU Directives. Of the 14 workstrands identified by the internal review, at least 7 are

required in whole or part by EU legislation. That means the debate is about the level of HSE involvement and whether others can be persuaded to take it on. Even in areas such as classification and labeling where there is increasing relevance for consumer and environmental protection, there remains a strong occupational health interest - it is the bedrock of our regulatory framework. This points to incremental change albeit with clarity about direction of travel.

35. The next constraint is Ministerial policy. But there is no evidence that current Ministers are wedded to our current programme of work on chemicals.
36. The HSC and stakeholders generally are rather better informed. While the HSC itself may welcome a radical shift more closely to align chemicals work with the Revitalising and SH₂ agenda, individual stakeholders may not. Some may welcome a more workplace/outcome focused approach. Others would be concerned about any lessening of their ability to influence the impact on industry (eg because of the increasing reliance on European setting of exposure limits). but that is not necessarily a consequence of focusing on the workplace.
37. A major constraint is a lack of hazard recognition or understanding of the appropriate remedial action, whether by employers, safety reps, trade associations or trade unions. There is much in the Three R's research findings that needs to be fed into an effective communications campaign.
38. The final constraint is HSE priorities/resources. The potential work programme in developing a workplace focus is large but needs to be tailored to the resources available. Prioritisation needs to be based on outcomes, on the degree to which an element in the work programme contributes to enhanced health and safety in the workplace.

Conclusions

39. It is essential to carry on meeting the statutory function with all that that entails in terms of data collection and interpretation relating to the potential adverse effects of chemicals. We need to preserve an ability to scan the horizon and to deal with emerging risks or issues (e.g. dioxins), which has a high political profile. There needs to be the technical and scientific support for investigative work.

40. That said, the policy work of HSE (as for all parts of HSE) needs to be refocused on outcomes and on making a difference in the workplace. Three broad programmes based on cancers (including the effects of asbestos) respiratory diseases (including the existing programme on asthma) and on skin diseases should be developed. There needs to be a better read across from policy to enforcement.
41. People in the workplace see no distinction between health and safety in terms of what they are required to do. HSE also needs to take a more holistic approach. It would be, for instance, a nonsense to promote workplace controls that met health requirements but did not also address risks of fire and explosion.
42. The strategy for HSE, therefore, needs 6 elements: -
- a) Bringing together Health and Safety.
 - b) Fulfilling statutory functions; including work on negotiating and implementing European Directives (IOEL_s, CHIP, CAD, COSHH) etc.
 - c) Prioritising work, particularly into programmes dealing with cancer, respiratory disease and skin disease.
 - d) Developing a robust compliance strategy linking risk to the necessary controls developed from industry sector good practice and enforcement through the Enforcement Management Model.
 - e) A communications / education drive.
 - f) Maintaining the existing regime for biocides.

This would be consistent with the decision making process outlined in “Reducing Risks, Protecting People”. This type of effect can only be achieved in partnerships, including with stakeholders, OGDs the voluntary sector and the health services.