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HEALTH AND SAFETY COMMISSION

Advisory Committee on Toxic Substances

Cancer and skin diseases programmes

A Paper by Bill Macdonald

**Cleared by Carole Sullivan
on 12 March 2004**

Issue

1. Development of the skin disease and carcinogens sub programmes as part of the chemical programme.

Timing

2. Routine.

Recommendation

3. ACTS is invited to note the progress made to date on the carcinogens and skin disease programmes and to offer comments.

Background

4. HSE's emerging Chemical Strategy proposed that work on chemical risks in HSE be aligned to three major programmes. These are carcinogens (including asbestos), respiratory disease (including the existing programme on asthma) and skin disease. Additionally, a further programme will centre on communications and education as a means of raising awareness of the hazards associated with chemicals.
5. The HSE Chemicals Programme Board is now reviewing the programmes of work and will shortly be appointing new programme managers. "Core" groups were set up for each programme. These include representatives of all the main disciplines and interest groups within HSE, including occupational hygiene, toxicology, policy, operational policy, medical inspectors, and HSL scientists. A wider "Community of Practise and Interest" group has also been set up for each programme to which all papers are copied.
6. The terms of reference for the skin programme originally included both skin disease and systemic effects caused by dermal absorption (due to the close association of potential control strategies in each area). However, in order to make an impact on this large topic area, HSE's Chemicals Programme Board has asked for the programme to focus exclusively on skin disease, particularly occupational dermatitis, for the time being. This would bring it into line with the paper (HSC/02/106) put to the HSC on 12 November 2003. This referred to the prioritisation of work, particularly into "programmes dealing with cancer, respiratory diseases and skin disease"
7. Due to the multi causal nature of cancer and the difficulty of separating occupational, environmental and social factors, much of the impact of the carcinogens programme would be lost if it restricted itself solely to chemical carcinogens in the workplace. On the other hand, many of these other areas are outside HSE's direct influence. Therefore, the terms of reference of the programme envisages that one of its' main subsidiary elements will be to liase with and support other groups, both inside and outside HSE, dealing with the prevention of cancer. Inside HSE, this would include all those dealing with ionising and non-ionising radiation, biological agents, environmental tobacco smoke, as well as psychosocial factors (e.g. shift work). There will also be a need to link in to OGDs, particularly DH, research institutes and charities to engage with the wider cancer prevention community.
8. The campaign to raise awareness of and promote effective compliance with the new duty to manage asbestos in non-domestic premises will be included as a separate element of the carcinogens programme. Other asbestos work, such as implementing directives and administering the licensing system for asbestos removal has been classified as non programme work.
9. A number of common themes are emerging in each programme:
 - The need to establish a sound evidence base: The reliability of both incidence figures and prevalence figures under Epiderm is questionable. For carcinogens, the multi-causal nature of cancer and the lack of reliable exposure data will make targeting problematical.

- Mapping existing work, including research, is proving to be a considerable challenge, due to the range and diversity of projects, both on going and proposed, in these fields. We have just completed an initial mapping of past, on going and future dermal projects in HSE to help us decide how to shape the skin diseases programmes, and will shortly be carrying out a similar exercise for the carcinogens programme.
- The development of robust success criteria (whether in terms of exposure reduction, successful adoption of control strategies, increased awareness, or in the case of skin absorption – biological monitoring values) will be essential.
- How best to engage with external stakeholders. On dermal risks a promising start has been made with the Forward Look Research Seminar hosted by HSL, and the meeting of International Experts organised by IEH at the Institute of Dermatology (see later). The next step will be to develop a formal mechanism, possibly via a body similar to the asthma board. In addition to social partners, there are a number of organisations, e.g. the National Eczema Society, the British Association of Dermatologists, that we might approach to set up a dermal programme board. We have also had meetings with the British Safety Industry Federation. Stakeholder conferences will be held for both programme areas.
- We will be ensuring that research is co-ordinated and commissioned in support of the agreed projects under the programme areas.

Argument

SKIN

10. A number of sources provide HSE with information on occupational skin disease. These include the EPIDERM (dermatologists) and OPRA (occupational physicians) surveillance schemes and the self reported work-related illness survey (SWI).
11. The 2001/2002 SWI estimated the prevalence of self-reported work-related skin disease in Great Britain as 39,000. The underlying incidence of occupational skin disease reported through the surveillance schemes appears roughly constant at between 2700 and 3400 new cases per year. About 80% of these cases are occupational contact dermatitis. These schemes only register the more serious cases of dermatitis, and do not reflect the incidence of skin disease amongst SMEs.
12. In 2000-2002, dermatologists reporting to EPIDERM estimated that the highest risks of OSD were:
 - ✓ For occupations such as hairdressers and barbers, beauticians and related occupations, and printers.
 - ✓ For workers in industries such as other services (mainly hairdressing), manufacture of basic metals, and tanning and dressing of leather etc
 The most common agents cited by dermatologists and occupational physicians as causes of skin disease were rubber chemicals and materials, followed by wet work and soaps and cleaners.

13. The under reporting of occupational skin conditions, particularly "mild" ones, is well known. The degree of under-reporting depends on several factors, not least, by the criteria of the reporting scheme in question, but also by other factors such as occupation. In one UK study (HSE RR158-2003) of a group of printers, 41% of respondents had suffered a skin complaint at some time. In addition, 17 of the 60 control subjects (28%) did not know or acknowledge that they had an occupationally related skin disease when examined by a dermatologist.

Targets

14. An aspirational target of – say – a reduction in skin disease and occupational cancer of 20% within the next 10 years could be included into programmes. However, measurement against the target will be extremely difficult, particularly for cancer where the effects of any initiative will not be seen in improved health effects for 25 years due to long latency periods. Although improvements in levels of skin disease could be detected 2/4 years after a successful initiative, the positive effects of any project are likely to be drowned out by increased levels of awareness and recording – especially as existing levels are thought to be substantial under estimates of the real level of skin disease.
15. One solution to this difficulty could involve the identification of key risk groups and/or activities. Projects directed at these subjects could then have an assessment of current disease levels in their target group included in their plan. A follow up study of a sample group could then be done at the end of the initiative. In that way, ill health targets could be set and monitored against, and an assumption made that if these targets are met for high-risk groups, then the overall target is likely to be achieved.
16. Due to the cost of integrating such studies into projects, most projects under these programmes will have to use proxy targets. These could include numbers exposed, levels of exposure, biological monitoring results, use of control measures, increased purchase of safety equipment and materials, levels of awareness etc. Examples of proxy targets could be measurable improvements in awareness and increased levels of compliance (duty to manage asbestos), and increased uses of materials (after work creams in the hairdressing business).

Approach

17. Although current knowledge levels are imprecise, the programme has initially identified a number of projects to be given priority. This followed an exercise in which agreed selection criteria were applied. Some of these are designed to make a direct contribution on specific high exposure groups, e.g. awareness raising amongst SMEs and micro SMEs in the construction sector, supply side initiative with glove suppliers and distributors, campaign to reduce dermatitis in hairdressing. Other projects are more general in nature but could lead to longer-term improvements (glove selection in the printing industry, COSHH essentials to be made more skin orientated, progressing a new HSE skin at work WebSite). These will be refined and extended in 2005 in the light of work done on the knowledge base and after consultation with stakeholder groups.

Stakeholder involvement

18. Dermal Exposure Research Forward Look Seminar: This was a useful forum for those with an interest with dermal risks to exchange views and establish priorities. These have been fed into core group discussions.
19. IEH event: This involved dermatologists from Denmark, Austria, Germany, Netherlands and the UK, representatives of industry, unions (Bud Hudspith) and HSE. Purpose was to summarise the state of knowledge on occupational dermatitis across Europe, identify gaps in the knowledge base, and discuss how any barriers to effective prevention could be overcome. Although much of the initial focus was on the printing industry, the discussions revealed valuable information on wider issues including other high-risk areas.
20. The National Eczema Society is producing guidance on occupational dermatitis. HSE will be commenting on and contributing to this work.
21. Some of the skin disease work will involve local authority enforced premises (e.g. hairdressers). We will be putting a paper to a HELA subcommittee meeting in late April to explore ideas for a communication campaign focusing on skin disease aimed at hairdressers and their trainees. This campaign should ideally include key messages about occupational asthma. It will be important to involve key stakeholders such as HABIA (The Hair and Beauty Industry Authority) and organisations representing local authorities if we are to make any progress in this area.

ASBESTOS

22. Asbestos and asbestos-related disease form the most serious occupational health issue ever to occur in the UK. Currently at least 3500 people are dying each year due to exposure to asbestos fibres between 15 and 60 years ago.
23. The duty to manage asbestos in premises (brought in by the Control of Asbestos at Work Regulations 2002) has been introduced to address the risk to maintenance workers from asbestos. An analysis of mesothelioma deaths over the last 20 years by occupation showed that at least a quarter of all male mesothelioma deaths were among those whose last occupation was associated with the construction and building industries. - This means there are likely to be at least 750 male deaths each year from this sector, which is now the biggest group at risk. Around 500,000 commercial and public premises are thought to contain asbestos and in many cases no one is managing the risks from the thousands of tonnes still present in them. Those working on these buildings, such as plumbers, electricians and other maintenance workers, often do not know they are at risk from disturbing the material, and they do not know whether their work is putting others in the buildings at risk.
24. The duty to manage asbestos will therefore give rise to both large costs and significant benefits. If current levels of exposure to asbestos were to continue, approximately 4,800 lives would be lost as a result of new exposures to asbestos in such buildings over the next 50 years. This equates to a financial equivalence of £3.3 billion. The new legal duty will play a key role in saving these lives. In comparison, the total costs of

compliance will be £1.5 billion; this will include the costs associated with asbestos inspections, removal, management etc.

Approach

25. A 5-year campaign to increase awareness of dutyholders to the new duty to manage asbestos and to promote effective compliance commenced in 2002. Elements of the campaign included:
26. The production of briefing material to be distributed to intermediaries (over 3,000 organisations have already used this material), comprehensive guidance including joint free guidance produced with the FSB, Web based initiatives such as good practice guidance, co-operative approaches with the TUC, several initiatives in the LA enforced sector and a site visit programme by HSE inspectors).

OTHER CARCINOGENS

27. Current (official) best estimate of the proportion of cancer in GB due to occupation is 4% (uncertainty range 2% to 8%). This equates to approximately 6,000 deaths annually (3,000 to 12,000) of which over 3,500 are due to asbestos.
28. A workshop of international experts in epidemiology and closely related disciplines is being organised in Autumn 2004, with the aim of producing an undated estimate of the current and future burden of occupational cancer in Great Britain. This will aim to produce a more an updated estimate to be made of from the current and future burden of occupational cancer in Great Britain. To the extent that the data will allow, it is also planned to produce a breakdown into high-risk industries and substances.

Approach

29. In the early part of this programme, a substantial effort will be made to produce a picture of current exposure patterns for carcinogens. This will be done as a stand-alone project, and is likely to involve substantial input from an outside research contractor (possibly HSL). This project could take between 12 and 18 months to complete and will feed into the main stage of the programme which will commence after that date.
30. In the meantime, a mapping exercise is shortly to be carried out of all current projects being carried out by HSE on carcinogens. These will be evaluated and where they show potential additional resource will be input to expand their outcomes. Possible short-term initiatives to be supported in the programme include substitution of hexavalent chrome in the electroplating industry and measures to decrease exposures to PAHs.

Stakeholder involvement

31. See above.

Communication Plan

32. The programmes are still being developed – it is too early to set this out. .

Evaluation Plan

33. (See Targets above). Evaluation will be achieved through examination of the success of individual projects and their eventual cumulative impact.

Relevant Control Systems

34. Not applicable.

Consultation

35. All relevant HSE Directorates have been involved in the development of these programmes – through membership of both the “core” groups and Community of Interest groups. External stakeholder communications are less well developed at this stage.

Presentation

36. These sub programmes form major pillars of the chemical strategy approved by the Commission.

Costs and Benefits

37. The costs and benefits of the campaign to introduce the new duty to manage asbestos in premises are set out above. The other two programmes have not yet been developed to the point where meaningful RIAs can be produced.

Financial/Resource Implications for HSE

38. See annex 1 for provisional figures.

Environmental Implications

39. None relevant.

Other Implications

40. None.

Action

41. To note and comment on HSE's approach to taking forward the 2 sub programme areas (paragraphs 17, 25 - 26 and 29 - 30).

Contact

42. Bill Macdonald, PG, CFPD2

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