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HEALTH AND SAFETY COMMISSION

CONSTRUCTION INDUSTRY ADVISORY COMMITTEE (CONIAC)

Report from CONIAC Occupational Health Working Party

Summary

This paper reports on the outcomes of the Occupational Health Working Party meeting of 13 February 2003.

The Work Of the Occupational Health Working Party

1 In light of the guidance issued by the Health and Safety Commission on how Industry Association Committee Working Groups should operate, the OHWP have considered their current role and purpose. The working party have recommended a revised statement of purpose, which can be found in **annex A,** along with a list of key priorities for the group over the next 18 months – 2 years. The working party recommends these to CONIAC as our contribution to the discussions on reconstitution.

Revitalising Health and Safety in Construction

2 The working party submitted its comments on the Discussion Document to Safety Policy Division prior to the deadline of end December. These can be found in **Annex B.**

Occupational Health Pilot in Construction

3 The working party heard a presentation from the section of Health Division who are working on the Pilot. It was agreed that OHWP should support a recommendation to CONIAC that they set up an action forum made from influential members of the Industry who would take responsibility for taking the pilot to the next stage. CONIAC paper M1/2003/9 refers.

MCG Occupational Health Policy

4 The working group heard from Andy Sneddon and John Morgan about the launch of the MCG occupational Health Policy which took place on 4 February. The commitments in the policy were welcomed by the working party, and members agreed to help out in any way they could to turn the commitments into reality.

Updates

5 The working party received updates on progress with the European Parliament proposal to remove Chrome VI from Cement, the introduction of the new Asbestos Regulations and Guidance and progress with the development of the health projects for inclusion in the Construction Division Work Programme for 2003/4.

Action

6. CONIAC is requested to note the contents of this report, and to consider the recommendation for the OHWP's role and purpose at annex A when discussions take place about the reconstitution of CONIAC.

Contact

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Occupational Health Working Party Meeting 13th February 2003
New Ways of Working

At our last three meetings, the OHWP have reviewed the role and purpose of the working group in the light of the guidance issued by the Health and Safety Commission. The existing terms of reference for the working party are:

'This working party provides a forum in which health risks common to the construction industry can be identified and ways found for removing and minimising them. It seeks to increase the awareness of Occupational Health issues in the industry and of the steps that can be taken to reduce ill health through design and management.'

In discussion, members came up with the following points which we would like to see reflected in our on role and purpose:

- The OHWP should focus on a few priorities, taking an active role in seeing these through to conclusion;
- Should influence what is going on both inside HSE and in the construction industry at large;
- Should help our industry to get to grips with occupational health
- Identify deliverables
- Act as a stimulus to industry
- Set agendas for the industry
- Identify and remove hurdles for the industry
- Act as a link between policy and inspection practice

Our Revised Role and Purpose:

Following these discussions, the OHWP agreed to recommend to CONIAC that our role and purpose should be revised as follows:

The OHWP provides a forum in which health risks common to the construction industry can be identified and ways found for removing and minimizing them. The OHWP manages identified projects to increase the awareness of occupational health issues and sets an agenda for change in the industry.

Our Key Priorities:

We will also need to identify the key deliverables which should form the core of our work over the next two-three years. We suggest the following:

(i) To act as champion for the occupational health pilot, identifying and removing hurdles to its success;
(ii) To promote the MCG charter on occupational health and encourage large and small companies to adopt its key principles
(iii) To assist in the development of a new guidance booklet which will highlight best practice in managing occupational health in the Construction Industry;
(iv) To oversee and promote the development of new and existing information sheets including:
- Review heavy blocks CIS
- Produce a CIS on kerbstones
- Revise CIS on transient welfare

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13/02/03

Revitalising Health and Safety in Construction.

This paper represents the thoughts of the Occupational Health Working Group to CONIAC on Chapter 6 of the discussion document.

Chapter 6 concentrates on Tackling health in construction and is suited to the work of the group to comment on.

The questions asked at Chapter 6 are:

19. How can we get people to recognise, understand and avoid health risks?

20. How can unhealthy processes, materials and equipment be designed out of projects?

The membership of the OHWG support the discussion document and the challenge that it extends to the construction industry. However, the group believe in the recognition and the prevention of ill health and believe that the worker should be directly involved in the recognition and prevention. This would be a secure approach to question 19.

A simple analogy may be:

'A carpenter may go through his career without the knowledge of a mortice and tenon joint thus not recognising the benefits of using such a joint, however, if at the outset of his career he was involved in the making of such a joint it would probably be the king of his skills.'

Although there is an abundance of much improved information in circulation throughout the industry, this has been the case for many a year, there is a strong doubt that the information gets to those that can be or are affected by many of the diseases listed in chapter 6. This results in lack of involvement and understanding thus blocking recognition and prevention. Using the carpenter analogy things will never change.

It has been recognised by the group that advice on 'what to do when you see an occupational health problem' is sadly missing from many of the documents alluded to in the last paragraph. The group would like to suggest that such information could be included in an information for manager's section in a number of these documents but bear in mind the carpenter.

Regulation 6 of 'The Management of Health and Safety Regulations' imposes a duty to conduct health surveillance to ensure the upkeep of the workers health. Whilst the industry should recognise that larger companies do comply with this regulation there are a number of well known reasons why the greater part of the workforce never receive the benefits of health surveillance and hence are not equipped to recognise or prevent the risk of the development of health problems.

There are examples where some sites have provided access to occupational health advice on site, during the life of the site, the outcomes and the results speak for themselves. But alas the life of sites come to an end and thus the service.

The OHWG believe that the lesson is here to learn. The group has supported for a long time the introduction of a scheme (possibly national) that provides the worker with evidence of his health. This maybe made available to prospective employers to ensure that throughout the work provided, the workers health will not suffer. The hope would be that advice on clinical intervention at an early stage will help both primary and secondary prevention of disease. The potential should not be underestimated as the group believes that as the scheme gets established the need for intervention will decrease. The benefits to the worker and his employer in reduced hidden costs are there for the taking. By doing this all the small businesses, self employed and temporary workers could be reached as it is commonly accepted that our industry is unique for the employment of these groups.

The obvious benefit is that the scheme will never stop, unlike sites, and the worker his always touching and relating to his health at work and probably in his private life to.

The following paragraphs deliver some thoughts on such a scheme and makes reference to the proposed pilots. However, the group wishes to make it known that they are not in favour of delaying the introduction of such a scheme into the construction industry whilst the possibility is explored of expanding the initiative to other industries. This may have the effect of enlarging the scheme to extinction before the benefits to our industry can be recorded.

The industry needs to develop a data base now that will capture health surveillance, demographic, job and environmental risk information. This database, if properly thought through and constructed, would enable ever improving epidemiological, economic and operational information. The use of the information gathered will be the vehicle to enable the reduction of the hidden costs by the increase of efficiency in the industry by helping to gradually reduce bad practice, reduce ill health and promote the retention of skills.

Awareness and services are crucial, and the pilots should tell us what works best. The pilots really matter, need to be specified, run and evaluated without delay.

The group agrees with the following criteria:

- pre-assignment employee health assessment.
- medical/health surveillance as required under regulations and as identified by risk assessments.
- direct advice to employees on exposure management.
- through advice and possible training at the surveillance.
- advice on and the arrangement for the delivery of specialist support.

The collection of data relating to occupational health must be a fundamental component of the pilot. Clinical opinion is essential in getting meaningful data. It is clear that the findings of the pilot should be strong enough to set the standard for years to come.

Health screening will be a valuable component for managing workplace risks and should include a clear set of principles for legitimate health screening to achieve success.

Once simple surveillance techniques are firmly established as the normal expectation more ambitious targets could be considered, such as proposed above, and therefore there should be some resistance to pressures for comprehensive coverage in the early stages.

The question of funding of the final scheme, with some regard to the pilots, has been discussed widely within the OHWG, it is not surprising that there are a number of differing views around the table dependent on the sector the member represents. As the HSE has indicated that the question of funding should not detract from the pilots we have chosen not to explore funding in detail in this document.

However, we would like to point out the following simple views:

The opinion of an employer: -

If the final scheme or the pilot is subject to a levy then this will deter SME's from embracing the scheme no matter what the 'Management of Health and Safety Regulations' say. This will hit hard at the requirements that the OHWG set out above and will result in a part scheme which will help no one.

The opinion of the non-employer with an interest in SME's: -

The question of funding was always going to be the death nell of this scheme. This is quite apparent from the lack of progress made in the area of health (and safety for that matter) in the groups we have to target in order to gather the data needed to help convince these groups of the benefits. Let us stop for a minute and discover who the real winners are from a scheme being developed - the worker - so there should be no hang-ups in asking him to contribute to his own health maintenance.

The opinion of a medical man: -

You will be aware of the chronic shortage of occupational health practitioners in the UK as well as the projected shortfall of 15000 doctors and many more nurses from all disciplines as a background manpower problem. If there is nobody to turn to that can help resolve dermatitis, HAVS, asthma etc. then progress will not be made. Lets then embrace the mandatory scheme, based more on the continental service delivery model.

With regard to question 20 the OHWG see this as an essential element of prevention but as there are many areas that can be considered to satisfy this requirement it is not intended to clutter this paper as most are already well known. However, please note the following.

It is generally thought that health risks are designed in so there must be a clearer message to designers to design them out. Recent documents such as the revised CDM ACOP provide that message and guidance notes are more proactive in the advice given about designing out but there should be more emphasis on designing out health risks. It is worth reminding the reader that the OHWG, as stated above, feel that more advice should be given on the identification of health conditions and how to get advice in HSE publications.

In our view a key to improving standards is to create success stories that can be held up as excellent examples of good design practices.

The success of the 25kg cement bags was a major achievement. It required the commitment of a large industry to invest in new machinery to improve what was recognised as a national health risk. From this the OHWG is one group that is looking at many health risks in the day-to-day necessary construction jobs. Large blocks, kerbstones, plastering, bricklayers, carpenters – the list is endless. However, if the industry has to wait for the initiatives from the HSE and groups like the OHWG (who are committed) the wait may be long.

The problem is sometimes greater than the designers, as the 25kg bag achievement shows, products and materials are often put on the market to suit the needs of the producer and not the end user. Designers have to use what they are given.

The natural progression from the cement bag achievement should have been that all other bagged materials should have followed. No bagged products should be produced over 25kg. It does not stop here either as the message should have been gathered up by producers of materials, not necessarily large in weight, but large in size.

It seems that the industry waits until changes have to be made rather than develop from good examples. The cement bag achievement undoubtedly had a greater impact (as far as it goes) than the raft of existing guidance etc. It should be remembered that such guidance is least likely to have an impact on the less health and safety committed.

So what are we saying?

There will be more mileage in identifying producers who can make the difference and convince them of the risks that they are putting into our industry and insist that they change. The designers can help by refusing to specify offending materials, where this is not possible the material should be identified for action.

Occupational Health Working Group to CONIAC. 14th November 2002