

**Health and Safety Executive Senior Management Team Paper SMT/08/09**

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**HEALTH AND SAFETY EXECUTIVE**

Senior Management Team

**Health at Work - HSE's contribution in 2008-09 and beyond**

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**Issue**

1 HSC/E has reviewed its health strategy on several occasions in response to improved information on health risks, the changing world of work and political initiatives. "Securing Health Together" (2000) and the HSC's Strategy for workplace health and safety in Great Britain to 2010 and beyond (2004) were the most significant strategic statements.

2 During this time the concept of 'health' at work has changed from a limited focus on occupational disease to the broader concerns for the health and well-being of working age people. The Health Work and Well-being (HWWB) strategy is the most recent example of how growing social and political interest can influence our work. This paper seeks SMT views on the issues, not least in the run up to HSE Board discussions on future strategy, and a steer on our priorities and broad programme of work

**Timing**

3 Routine.

**Recommendation**

4 That SMT notes progress to date on health at work and comments on the strategic options for clarifying our role and activities at paragraph 11.

**Background**

5 The publication of Dame Carol Black's review provides a timely opportunity to reflect on HSE's role in the health and work agenda. This agenda is potentially broad and with increasing political and media interest we need to provide greater clarity about what our contribution is - and is not - for stakeholders and our own staff. This will also help to inform discussions as the government considers its response to the Carol Black report. Some of these issues were covered in the recent DWP Select Committee report and a summary of the relevant recommendations is at **Annex A**. Alongside this:

- There is growing evidence that work in well managed organisations can be good for physical and mental health and well-being. This view draws attention to the "bio-psychosocial" model, where illness and wellbeing are seen as a

consequence of the interplay between biological, psychological, social, and environmental factors. The importance of these factors will vary amongst individuals, organisations and over time;

- HSE's work on stress has drawn attention to the effect that management behaviour and culture has on psychological health; more recent reviews have made links to the impact of management, leadership and organisational culture on "well-being". Based on these developments we have made the links between sickness, organisational and individual health and staff engagement and productivity so that "health" – including the prevention of ill health from work – is seen as more central to HR and business objectives;
- Aspects of the "new" health agenda, such as work related stress and MSDs do not lend themselves to the approaches that are familiar under more mature enforcement regimes – the outcomes of preventative interventions are not certain and depend on a range of other factors.

6 The HSC strategy recognised the need to do more on occupational health and made a public commitment to improving the management of health at work. There is evidence that best practice in the private sector recognises the benefits that the broader concept of employee health and well-being can offer as part of wider people (including health and safety) strategies. So in the last three years we have engaged with the broad HWWB strategy; used the language of sickness absence to get our H&S and prevention messages across; and used programme money to promote our messages on MSDs and stress to key audiences. While we have moved to fill gaps where this would support efforts to deliver the targets (e.g. on managing absence), we now have an opportunity to bring greater clarity to our role, while maintaining our profile as the lead/expert organisation and regulator on the prevention of work related ill health.

### **Argument**

7 HSC/E's primary emphasis is on prevention where work activities may pose a potential source of injury, ill health and death. In particular, in the ill-health context, we need to remain focussed on driving down the death toll resulting from historic exposures to hazardous substances. Exposure, e.g. to asbestos and silica, is still occurring and complacency towards the threats is rife. These so-called long latency diseases (occupational cancers – including asbestos-related cancers – and Chronic Obstructive Pulmonary Disease) account for an estimated 90% (10,000) of all work-related deaths each year.

8 At first sight, this long latency agenda is very different from the "new" health agenda - its focus is far more long term (so it sits uneasily with the PSA/DSO target régime) and prevention-led. Conversely, our work so far on common health problems - essentially work related stress and MSDs – has been particularly designed to contribute to delivering the "days lost" target, although these common health issues are affected by the wide range of influences referred to above.

9 The evidence suggests that changing behaviour in both cases requires strong partnership working across the health and safety system and sustained efforts to raise awareness. For example, raising awareness of the longer term risk of developing mesothelioma, or the shorter-term risk of developing MSDs, may be equally difficult in practice. So although there are some common approaches, the

differences lie in the earlier onset of “common health problems” such as stress and MSDs and their resistance to traditional control measures and physical risk reduction techniques – in effect the two agendas produce different outcomes over different timescales.

10 The challenge then is to play to both agendas, wherever possible, and to position ourselves where we can deliver our objectives and targets by identifying and exploiting opportunities to work with partners. That is, to promote our prevention agenda within broader environments such as the HR world, while avoiding the temptation to cross boundaries into broader management issues. On this basis our focus might be to highlight the impact of management actions and cultures on the psychosocial environment at work while allowing others such as the CIPD and IIP UK to take the lead in informing the wider HR community about the risks and how they can be managed (increasingly as part of the “good jobs” agenda). So while it is not realistic to assume that we can tackle these issues alone, we should continue to position HSE so that we make the best of our partnership opportunities while continuing to maintain our position as an expert regulator whose activities, including enforcement, are evidence led.

11 Given this background, our strategic position on health and work might now consist of one (or a combination) of a number of broad strategic options.. All assume that we pull back from further work on sickness absence, return to work and rehabilitation, but that we continue to persuade stakeholders to contribute to the wider aspects of the “new” health agenda, with HSE support, while HSE focuses on what it does best – in effect, persuading them to be advocates for our main concerns and messages:

- (a) Scaling back our work on “common health problems” (essentially, stress and MSDs) and simply resourcing our efforts in these areas to maintain our current position and learn from the evaluation of what we have done over the last three years;
- (b) As in (a), reducing the amount of direct advice and inspection resources devoted to common health problems while continuing to promote the management messages and offer techniques to support strategic, line and HR managers – in effect seeking to realise the benefits of our investment to date through communications and stakeholder engagement approaches. At the same time, looking at the role and nature of enforcement approaches in respect of common health problems;
- (c) As in (b) but undertaking some additional tactical activity by working with small numbers of organisations in specific target sectors, partly as a continuation of our contribution to HWWB;
- (d) Carrying on with the current (reduced) levels of activity and undertaking any further work to position our work on common health problems as part of the toolkit of wider management approaches.

A high level menu of activities that support these strategic options is attached at **Annex B**.

12 The Health Agenda Steering Group oversaw the ground work for the development of our approaches to common health issues and we propose to develop new governance structures once the board has considered the future strategic direction.

## **Consultation**

13 Primarily internal discussion at this stage.

## **Presentation**

14 We propose that there should be two key elements in our approach to communications:

- First, that HSE should develop a clear agreed statement of our role and what we are able to contribute to the wider health at work agenda. This should then be used to provide consistent messages to internal and external stakeholders;
- Secondly that we should use targeted communications approaches to ensure that we complete work that is already in hand and capitalise on our investment so far.

## **Costs and Benefits**

15 It is estimated that cases of work related ill health cost UK society between £11 and £17bn per year. These costs are incurred by individuals, employers and society as a whole.

## **Financial/Resource Implications for HSE**

16 At present, our aim is to ensure that existing resources available to deliver improvements in health at work are properly focused on the areas where we have specific expertise to offer. At this stage we are seeking agreement to a broad strategy and list of its key components that can be pursued – to a greater or lesser extent - within whatever overall resource package is available. Following PFPD advice, we have assumed that in 2008/09 it is unlikely that there will be any significant change of direction in HSE's intervention programmes, and that we would seek to preserve the resources that it applies to front-line health and safety intervention programmes.

## **Environmental implications**

17 None

## **Action**

18 SMT is invited to comment on the future strategy, and provide a steer on our priorities and broad programme of work based on the options at paragraph 11 and Annex A.

**Relevant recommendations by DWP Select Committee**

We do not believe that the SR04 PSA target for HSE to reduce the number of working days lost due to work-related injury and ill-health provided a realistic and appropriate target for HSE as many of the factors affecting its achievement are outside its control. (Paragraph 263)

Although the PSA targets relating to occupational ill health have been replaced with a Departmental Strategic Objective, we request that HSE continues to collect data on numbers of working days lost due to work-related injury and ill health. We also ask DWP to confirm that performance against the key indicators for the Departmental Strategic Objective will be fully reported on in the Departmental Annual Report and Autumn Performance Report. (Paragraph 264)

We commend the work that the HSE has done on Stress Management Standards but we call on HSE to increase its efforts to disseminate its guidance on the standards to SMEs. We are not yet convinced that the standards need to be placed on a statutory basis but we will await further research on their effectiveness with interest. (Paragraph 286)

We believe that there is potential for HSE to build on its Stress Management Standards as a tool to demonstrate what a 'good', healthy workplace should be including what constitutes a good occupational health structure within an organisation. (Paragraph 290)

It is crucial that inspectors have the expertise to conduct comprehensive inspections and investigations and are able to offer accurate advice. We recommend that HSE ensures occupational health is embedded in the inspectors' training programme. (Paragraph 295)

We believe that if the Government is committed to combating ill health in the work place then enforcement action needs to be taken against those who breach their statutory duties. (Paragraph 298)

If businesses would be expected to pay towards the consultancy service we are unconvinced that take-up would be sufficient when a free service failed to reach its advice line targets. We would also be concerned if advice services were tax-payer funded in Scotland and Wales but not in England. (Paragraph 318)

We believe that EMAS has an important role as an advisory service for doctors and employers as well as HSE. We endorse Dame Carol Black's emphasis on occupational health provision and support her contention that there is a need for an occupational health advice service for medical professionals and employers. In time we see the role of EMAS being supplanted by a national occupational health service as envisaged by Dame Carol Black; we await the Government's response to her report with interest. This will enable HSE to re-allocate resources to core workplace health and safety functions. However we are concerned by evidence of a decline in the numbers of occupational health professionals. (Paragraph 319)

We are convinced that HSE must continue to play an important role in occupational hygiene regulation and enforcement. (Paragraph 324)

We commend Dame Carol Black's vision for a Fit for Work service and look forward to the Government's response to her report. We are concerned whether exhortation will be enough to engage employers in the provision of vocational rehabilitation and we await with interest the findings of Lord McKenzie's task force. We believe that there may be a need to incentivise employers financially. (Paragraph 330)

We recommend that the Government introduces a similar system in England and Wales to the health and safety award scheme "Healthy Working Lives" which operates in Scotland. We also urge the Government to include a health and safety component in the Investors in People award as a means of encouraging employers to maintain good health and safety standards. (Paragraph 340)

Headline activity, 2008-09	Rationale	Strategic option
Evaluating the effectiveness of interventions on stress and MSDs to date and the lessons from Workplace Health Connect.	We have invested heavily in these activities, and we need to make sure that we have a full understanding of what works before we look at how these activities are contributing to better management of the relevant risks on the economy	All
Defining and communicating our role, including a tight focus on prevention.	This includes proving greater clarity in the expectations of key stakeholders, where our contact with duty holders can sometimes be seen as a mechanism for the promotion of wider health messages (obesity, smoking, etc) and aspects of rehabilitation and sickness absence management that go beyond our remit	All
As part of our contribution to longer term thinking on these issues, considering the scope for the development of common health models that make the link between mental and physical ill health at work	There is evidence and interest in the possibility of developing the management standards approach to take in other common health problems such as MSDs	10 (d)
Leading indicators. Long latency disease does not lend itself to conventional performance indicators, eg RIDDOR data, given that the impact of preventative measures to tackle such disease will not show up in the short term.	To help plug this gap, leading indicators will identify instances where industry has implemented such measures – and thus provide some evidence of reduced risk	10(c), (d)
Looking at the scope for developing enforceable standards for aspects of work related ill health that will better align with HSE's approach to more mature programmes where enforcement support can be more useful	The need to test the extent to which the development of (e.g.) enforceable standards is possible	10 (b), (c) and (d)

<p>Developing plans for coordinated field activity on work related stress, MSDs and particular cancers.</p>	<p>There is scope for greater coherence in how HSE makes the best use of its resources, but recognising that the approaches for different health outcomes will not be the same</p>	<p>10 (d)</p>
<p>Being clearer and smarter about how we work with and through stakeholders, such as the CIPD and Acas</p>	<p>Stakeholder activities contribute to the wider aspects of the “new” health agenda, with HSE support, while HSE focuses on what it does best – in effect, persuading them to be advocates for our main concerns and messages</p>	<p>All</p>
<p>Maintaining our momentum and profile through targeted communications work (e.g. website development and promotion, the completion of work on management competences)</p>	<p>Much of this is about completing what has been started and realising the benefits. Working with and through key partners to promote good management practice, with support from both FOD and LA inspection staff.</p>	<p>10 (c) and (d)</p>