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HEALTH AND SAFETY EXECUTIVE

Senior Management Team

'Putting the Health into Health and Safety' – HSE's Response to the Strategy's Healthier Workplaces Goal

A Paper by Kären Clayton Steve Coldrick Peter Brown John Osman

Cleared by Jane Willis and Kerr Wilson on 28 October 2009

Issue

1. The Healthier Workplaces Strategy Action Team has begun co-ordinating the response to the strategy's healthier workplaces goal. The attached Board paper seeks approval for **what** future delivery on occupational health will look like.

Timing

2. For the Board meeting on 25 November

Recommendation

3. For the SMT to clear the attached draft Board paper

Background and Argument

4. See the attached Board paper

Consultation

5. Within HSE, through the Healthier Workplaces Strategy Action Team

Presentation

6. None

Costs and Benefits and Financial/Resource Implications for HSE

7. This paper does not make new proposals that are likely to require impact assessments. HSE resources for this work have been identified in the 2009/10 business plan, and future delivery post 09/10 will reflect resource at that time. Once we have Board agreement, HSAT members intend to work with colleagues across HSE to ensure that work plans for 2010/11 and

beyond reflect the paper, and that those best placed to deliver in HSE do so within existing resources and acknowledging competing demands.

Environmental implications

8. None

Health and Safety Executive Board			Paper No: HSE/09/
Meeting Date:	25 November 2009	**FOI Status:**	Fully Open
Type of paper:	Above the Line	**Exemptions:**	N/A
Trim reference:			
'PUTTING THE HEALTH INTO HEALTH AND SAFETY' - HSE'S RESPONSE TO THE STRATEGY'S HEALTHIER WORKPLACES GOAL			

A paper by:Jane Willis
Advisors: Kären Clayton, Steve Coldrick, Peter Brown and John Osman

Purpose of the paper

1. To invite the Board to:

   - Agree a broad direction of activity for delivery of the 'healthier workplaces' strategic goal 2010/11 onwards; and
   - Identify issues for further discussion at subsequent Board meetings.

Background

2 There has been some success in tackling health issues in the UK since the Health and Safety at Work Act was established but the scale of the remaining problem remains challenging and in numerical terms is far greater than that presented by safety issues:

Working days lost

- 34 million days were lost overall (1.4 days per worker), with **28 million due to work-related ill health** and 6 million due to workplace injury.

Ill health

- 2.1 million people were suffering from an illness they believed was caused or made worse by their current or past work
- 1.3 million of these cases were suffered by people working during the year, of which 563 000 were new cases
- 2056 people died of mesothelioma (2006), and thousands more from other occupational cancers and lung diseases.

3 Annex 1 provides a fuller picture of the data but in summary, health related deaths result primarily from current and historical exposures to carcinogens, dust, fibres, fumes etc. while the vast majority of working days lost result from either stress or musculoskeletal problems. There are also issues associated with skin problems and noise and vibration.

HSE interventions

4 We have developed a range of 'best mix interventions' to tackle health problems and we have an effective regulatory regime for the control of pesticides.

The following paragraphs suggest the key areas we need to focus on over the next few years given the statistical picture covered above and in Annex 1.

Long latency problems

5 Under the Disease Reduction Programme, we identified occupations where the risk of skin disease, asthma and asbestos-related disease was highest and set about working with stakeholders to bring about reductions in those risks. Exactly how was led by the evidence about the target groups' awareness, attitudes and influencers – then taking a best-mix approach to using, for example, awareness-raising publicity campaigns, stakeholder-led initiatives, and regulatory interventions as appropriate. For skin and asthma in priority occupations, we've reached a stage where risks and precautions are now much better known and are being adopted. We will continue to work to support stakeholders in embedding good practice. On asbestos, the work so far has successfully increased awareness amongst the at-risk groups and the impetus will be maintained to move towards changes in behaviour and practice. On cancers, we have been building a picture of where the higher risk occupations are to enable future prioritisation. An example is exposure to silica where our best evidence suggests past exposures are causing hundreds of current cancer deaths (Annex 1), and evidence suggests exposures remain in excess of the Workplace Exposure Limit. We have had success in promoting simple information about risks and precautions with one high risk group - kerb and block-cutters. A stakeholder group has been promoting simple information about risks and precautions that have received wise coverage and shows real signs of impacting with the at-risk group.

What next?

Asbestos

6 We plan a further publicity campaign to build on and embed awareness in the at-risk groups and to move them towards taking precautions. Then moving forward, we plan to address the 'duty to manage' element, which is key to ensuring risks are avoided or reduced but currently is at a very low compliance level. We are also working with the vocational sector to ensure tomorrow's tradespersons start their working life knowing more about the risk from asbestos and how to protect themselves.

Skin/asthma

7 We need to maintain the push to embed the behaviour change that the evidence indicates is underway. To do this we will work in close conjunction with stakeholders with the objective that they carry forward ownership of the issue with support from HSE as appropriate.

Other long latency respiratory disease

8 Current evidence is informing us about which activities/occupations present higher risk of cancers, chronic obstructive pulmonary disease etc due to exposures

to carcinogens, silica etc. We are engaging with relevant stakeholders in these sectors/segments to refine our information on the risks and to work towards agreed solutions. We are gathering further research information about the extent of occupational cancer risks – including a major study into the possible links between shift work and cancer. When this is available we will consider what action is necessary. Priority targets at present appear to be:

- construction work involving exposure to silica dust
- foundry workers
- welding
- stonemasonry
- quarry workers

Other areas – painters, those exposed to diesel exhaust emissions for example – will be considered as further evidence emerges of the level of occupational risk. We propose to group our work in the above areas as a 'Dust, Fibres and Fumes' initiative.

Noise and vibration

9 Millions are exposed to levels that can cause harm. Work to date has focused on promotion across industry of recent legislation and encouraging/enforcing noise and vibration control strategies and working with the supply chain. Next steps involve targeting the highest risk activities and engaging with stakeholders to develop ways to reduce exposures. Early thoughts are that the utilities and woodworking sectors are likely candidates.

Musculoskeletal Disorders (MSDs)

10 MSDs are a key problem for most employers and the scale of the issue is immense. We have delivered a number of very broad campaigns over recent years with mixed success. However, we have looked again at this issue and agreed that we need to be more realistic about how much impact we can have on it. Our intervention strategies should flow from this e.g. we cannot hope to tackle all MSDs but we can work on some specific sectors/types of work that are particularly damaging. We therefore suggest that for now, we should focus our main efforts on a limited number of sectors:

- Manufacturing production lines, particularly in food
- Waste & recycling
- NHS/ social care
- Transportation (particularly loading and unloading activities).

11 Most recent HSE work has focussed on 'backs'. Given this, we should also develop our knowledge base on the extent and nature of upper limb disorders in terms of sectors and extent of the problem (e.g. call centres, tills, and keyboard users). The new Assessment Tool for Repetitive Tasks to help assess tasks likely to cause upper limb disorders, will be available to inspectors and duty holders in 2010 and we are planning awareness and inspection work using this tool.

12 We should also explore the co-morbidity and common causal factors (essentially psychosocial) of stress and MSDs and the impact on these issues of positive working environments and good management. These issues may be brought into sharper focus with the anticipated new European Directive on MSDs which currently introduces the concept of organisational factors as an issue for risk assessment.

13 It is probable that this Directive is about two years away from implementation in member states and that would be appear to be an appropriate point for a further more general push on MSDs.

Work related stress

14 This is a very real issue for large number of the population and continues to feature as a concern for many employers. We have achieved a world-leading reputation for our work in developing and introducing a practical tool for helping to address stress at work. However, as with MSDs, we need to review our involvement in terms of impact to date, potential future activity and the 'tractability' of the issue.

15 As a priority, we need to do more to provide a sound evidence base on the outcomes of use of the stress management standards. Alongside this, we need to maintain our efforts to ensure this issue is embedded into the agenda of management and human resources and that we do not loose the ground gained over the last few years. We should also focus continued effort on three sectors where problems are particularly evident:

- Social Services
- Education
- Banking/finance

16 Although the NHS still has high levels of stress, we believe that the Boorman report (which references HSE work on stress – see Annex 2) now provides the primary impetus to tackle this area in the immediate future. However, we will continue to offer some limited support to the NHS and central and local government so that we build on achievements to date e.g. West Midlands Civil Service project.

17 This suggests that, following several years of field work, we now primarily put our resource into communications, stakeholder work and further research rather than continuing to use any extensive field resource on this issue. However, there may be value in exploring what can be done with a small central 'select team' of inspectors with skills in this area who should explore action in a few sectors with vigorous communications support. This would not be a broad, general campaign of enforcement.

Does the Board agree that we should develop a pilot approach to selective enforcement on stress?

Enforcement

18 It is clear that there is far less enforcement on health issues when compared to safety. There appears to be a number of factors behind this – guidance/information is often a better response than enforcement; health issues can be complex and there can be a lack of competence in field teams alongside a 'safety takes priority' mindset in some circumstances. However, experience suggests that enforcement can be very effective in achieving change on health issues e.g. action in 2006 against Dundee council (Annex 3) and certain cases for control of infectious diseases, especially when combined with effective sector based communications.

We suggest that we look achieving a greater level of health enforcement by:

- **Clarifying our expectations of acceptable occupational health standards to employers;**
- **'Skilling up' more of the HSE and Local Authority field force ;**
- **Examine how we are using health specialists;**
- **Examine the potential for a 'health' specialist inspection team along the lines of the fairgrounds team - especially for health management and psychosocial risks; and**
- **Examine the potential for ratcheting up the impact of high profile health enforcement cases in specific sectors, e.g. public sector, where there could be rapid communication among stakeholders.**

Data and Research

19 We have a number of key research proposals under way and the bulk of our extra mural research budget is spent on research into long latency issues. The Black Report identified the need for greater cooperation and sharing of information and research across government but progress has been limited. We need to do more to link with Department of Health and DWP and the academic sector on:

- **Existing topics**
- **Emerging topics**
- **Longitudinal studies along the lines of Whitehall II**
- **Data capture and leading indicators**

20 We anticipate an opportunity with work within the Health Work and Wellbeing initiative on a "National Centre for Work and Health" and will actively work with other stakeholders to create a more robust UK occupational health research and information strategy particularly building on the existing health and occupation reporting system (THOR/THOR-GP) and the new electronic Fit Note

Supply chain pressure

21 The construction sector and recent Olympic Delivery Authority experience show the potential to use the supply chain to drive improvements. This has also been identified as a route to drive improvement among NHS supply organisations by the Boorman review. We need to examine the potential to do more of this in appropriate settings e.g. among local authorities and elsewhere in the public sector.

22 We also need to look at the contribution to the strategic goal that can be gained from capitalising on the Competent Authority role delivered by HSE in EU supply-side regulatory programmes on chemicals (e.g. Classification and Labelling, pesticides and biocides legislation.

Competence and the broader agenda

23 A dominant feature of occupational health within the UK is the apparent lack of competence at a number of levels:

I. **Nationally, occupational health is a specialism among the medical community characterised by relatively small numbers and uneven distribution in relation to the size of the population served and prevailing risks. Questions are being raised about the quality of work provided by some professional occupational health organisations, and the lack of knowledge among many General Practitioners. Carol Black has identified the need for improvements in standards and both the Faculty and Society of Occupational Medicine are taking the work forward (with HSE input);**
II. **Many employers find health difficult – lack of awareness, lack of knowledge of what to do, difficulty in accessing relevant and affordable advice - and**
III. **Employees have a similar lack of awareness. There is a well established 'safety rep' network making welcome advances into 'health' but more could be done.**

24 Looking more broadly, HSE already has a recognised key role in prevention of occupational ill health and we are currently seen as key players within Health Work and Wellbeing, Department of Health, and Scottish and Welsh public/occupational health initiatives. If we are to continue to engage effectively with exemplar organisations and innovators then we need to recognise that for many businesses, 'health' and 'wellbeing' are becoming part of the corporate social responsibility and productivity/engagement agendas, and accordingly we should 'speak the language of these areas' and show how we contribute to them. At the same time we need to be sure we are not drawn into activities which overstretch us and take resources away from our core interests around 'prevention' of occupational ill health. For example, there are certain 'public health issues' where we would wish to maintain a limited involvement e.g. sun beds, radon gas. Maintaining this position over the next few years will require a well-developed communications position.

25 Given the above, we suggest that we:

- **Explore a partnership with Institution of Occupational Safety and Health (IOSH) which would build on work done over the last few years (DWP funded) to equip a sample of IOSH members with better occupational health skills, and spread this learning more widely among the very extensive membership base.**
- **Review HSE guidance on health for employers, particularly SMEs, as part of our developing SME engagement strategy.**
- Work with the TUC to extend existing training and development work on health started by TUC into new areas including non-unionised environments as part of our 'worker engagement' initiatives.

26 Essentially we would be seeking to facilitate, with stakeholders, a situation where there are 'more intelligent customers and more intelligent suppliers'.

Resources

27 Given the topics/type of interventions discussed above, we consider that the majority of our resource on health (especially in the field) should be in the long latency area but we do need to ensure that we maintain a profile on stress and MSDs given the prevalence of these conditions. We also need to resource activity necessary to develop our approach to competence, broader issues and health enforcement.

28 In addition, although there has been some external criticism of declining numbers of medical staff within HSE, there are now a wide range of staff (both specialists and generalists) engaged on health issues including a new Chief Medical Advisor post since October 2008. We will keep this situation under review as we develop the detail of our forward plans.

29 Last, as part of our engagement on health we will want to consider how best to interact with a range of stakeholders and may need to review some well established relationships. For example, HSE has seen proposals from the Advisory Committee on Toxic Substances (ACTS) offering their expertise. Once we have had a steer from the Board on health matters, we will have further discussions with ACTS on what contribution they might make.

Conclusion

30 Developing proposals in the above areas provides a way of building of past lessons so that we both maintain a tight focus on specific topics while also contributing to broader national themes such as competence. In effect, this gives us a role as 'champions of prevention 'within a 'virtual' national occupational health strategy with appropriate leadership of 'non HSE core' areas remaining with Department of Health and DWP e.g. (rehabilitation)

Action

31 The Board is asked to:

- Agree that the activities identified above provide an appropriate response for key health issues;
- Provide a steer on any other priorities for future delivery;
- Consider whether and what specific health issues might be brought to the Board for discussion at future dates;

Paper clearance
Produced by Cross-Cutting Interventions Directorate and cleared by the SMT on 3 November 2009

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ANNEX 1

Statistics – The current picture

OVERALL

Working days lost

- 34 million days were lost overall (1.4 days per worker), with **28 million due to work-related ill health** and 6 million due to workplace injury.

Ill health

- 2.1 million people were suffering from an illness they believed was caused or made worse by their current or past work
- 1.3 million of these cases were suffered by people working during the year, of which 563 000 were new cases
- 2056 people died of mesothelioma (2006), and thousands more from other occupational cancers and lung diseases.

Ill health incidence: Assessment of change 1999/00 to 2007/08

Musculo-skeletal disorders	↘	The 2007/08 incidence rate of self-reported work-related musculoskeletal disorders was statistically significantly lower than that in 2001/02, the closest available year to the revitalising baseline. However, the rate in 2007/08 was of a similar order to that in 2004/05 (the PSA baseline), but in recent years the rate has fluctuated.THOR surveillance data points to a fall in reported cases from rheumatologists 1999 to 2007, although some or all of this fall may be due to changes to referral rules and procedures.
Stress, depression or anxiety	→	The incidence rate of self-reported work-related stress, depression or anxiety in 2006/07 is of a similar order to that in 2001/02 and 2004/05. THOR surveillance data shows a mixed picture with a stable trend in psychiatrist reports of work-related mental health between 2000 and 2007, but with a clear upward trend in occupational physician reports. The ONS omnibus survey shows no clear trend in the proportion of people saying their job was very or extremely stressful between 2004 and 2008.
Asthma/short-latency respiratory	↘	THOR data shows a statistically significant decrease in occupational asthma cases from 1999 to 2007. The number of cases compensated under the Industrial Injuries Disablement Benefit (IIDB) is smaller and has fluctuated since the base year
Dermatitis/skin	↘	THOR data show a statistically significant decrease in work-related contact dermatitis and all skin disease cases from 1999 to 2007. The number of dermatitis cases compensated under the IIDB is smaller but has also fallen slightly over the period.

Mesothelioma /long-latency respiratory	↗	The rate of mesothelioma deaths and other cases of asbestos-related disease, which dominate this category, continues to increase. However, for ages under 60 years the rate of mesothelioma deaths in 2006 was lower than in 1999. Death rates from coal workers' pneumoconiosis and silicosis are on a long-term downward trend, and were lower in 2006 than in 1999. In terms of numbers, the impact of these diseases on the overall target is small
Vibration-related	→	In the period since 1999, IIDB compensated cases of vibration white finger have reduced in number, while those of carpel tunnel syndrome have increased – though these too have fallen for the latest few years. Vibration-related conditions presenting to THOR have remained broadly constant.
Hearing loss	→	The number of new compensated cases of occupational deafness has fluctuated since 1999. The number of cases presenting to the THOR network has generally fallen but quite erratically.
Supporting research		The self-reported illness incidence rate has fluctuated significantly in recent years. A number of methodological factors have been examined for their possible contribution to these changes, but most of these make no contribution to the observed changes, and none make a major impact. A report setting out evidence for this is available at: http://www.hse.gov.uk/statistics/pdf/lfsissue1.pdf.
Overall direction	↘	Stress and musculoskeletal disorders are the largest components of work-related illness. Based on self-reports, there has been a statistically significant reduction in the overall illness incidence rate which is largely consistent with information from other sources.
Size of change	Given the consistency of evidence of change it is reasonable to assess the size of change using the broadest measure, namely self-reports of work-related ill health. From 2001/02 to 2007/08 the decrease in the incidence rate of work-related ill-health was statistically significant, with a central estimate in the order of 15% (with a range of possibilities from 7% to 23%). There is no comparable estimate for the base year, 1999/2000, although the closest self-reporting data suggests that the incidence rate would be lower. This implies the change from 1999/2000 would be less than that measured from 2001/02. Despite the reduction in rate, set against a *pro rata* target of a 16% reduction, the statistical judgement is that ***on the balance of probabilities progress is probably not on track to meet the Revitalising target.*** Over the shorter PSA period 2004/05 to 2007/08 self-reports of work-related ill-health show no change. Thus the statistical judgement is that ***the PSA target has not been met.***	

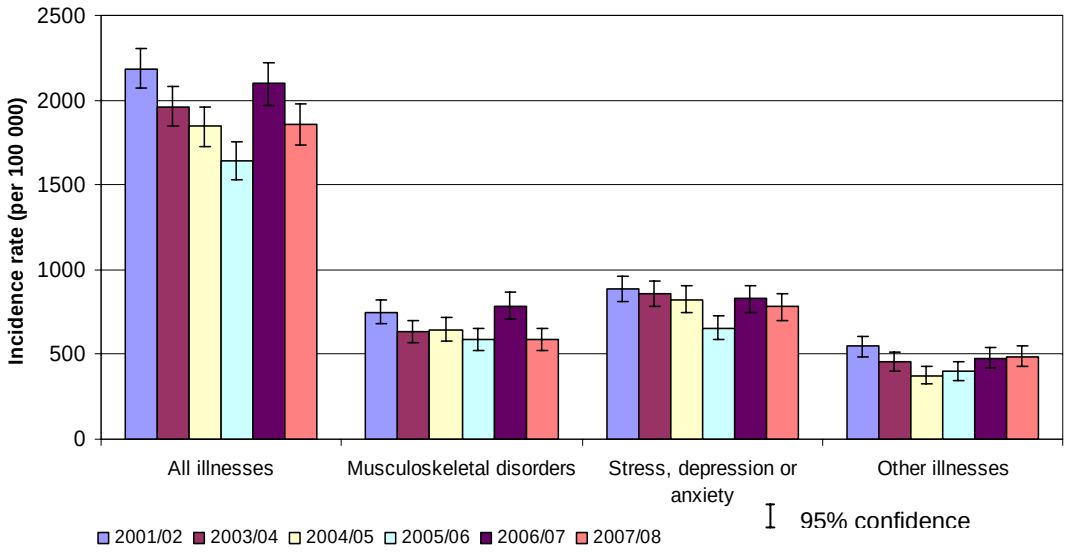
Working days lost: Assessment of change 2000/01 to 2007/08

Days lost from work-related ill-health	↘	The estimated number of working days lost per worker due to work-related ill health in 2007/08 was statistically significantly lower than in 2001/02 (the closest available to the Revitalising base year), according to the Labour Force Survey. However compared to 2004/05, the PSA base year, the rate has remained broadly level.
Days lost from work-related injuries	↘	The estimated number of working days lost per worker due to workplace injury in 2007/08 was statistically significantly lower than in 2000/01 (the closest available to the Revitalising base year), according to the Labour Force Survey. However, compared to 2004/05, the PSA base year, the rate has remained broadly level.
Supporting research		Sources on general sickness absence show stable levels in the few years up to 2006/07, the latest available data for most sources. However, assessment of these sources provide only weak supporting evidence. Notably, work-related absence is generally only a small proportion of all absence and such sources usually relate to periods earlier than those of interest.
Overall direction	↘	Based on self-reports of working days lost due to work-related illness and injury, there has been a statistically significant reduction in the days lost per worker between 2000-02 and 2007/08.
Size of change	The central estimate for the decrease in days lost per worker 2000-02 to 2007/08 is in the order of 20%, (with a range of possibilities - 95% confidence interval - from 10% to 30%), compared to a *pro rata* target of 24%. Despite the fall from the baseline the statistical judgement is that on the ***balance of probabilities progress is not on track to meet this Revitalising target***. Over the PSA period 2004/05 to 2007/08, although the days lost per worker due to workplace illness and injury in 2007/08 was lower than that in 2004/05, the difference was not statistically significant. Considering the range of possibilities for the difference, whilst there is a chance that a reduction of 9% was actually achieved, ***on the balance of probabilities the statistical judgement is that the PSA target has not been met.***	

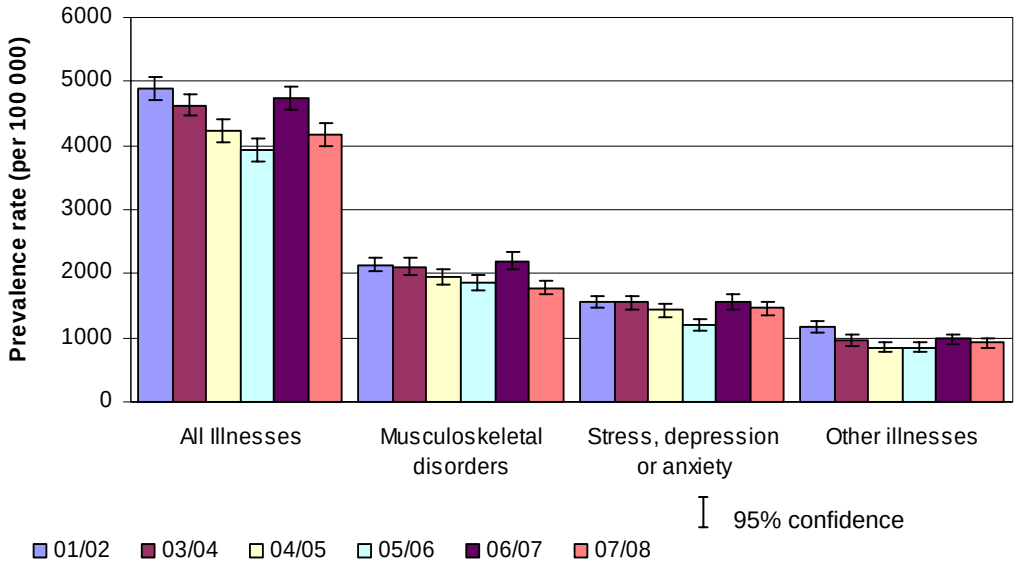
↗ **Rise since base year**
↘ **Fall since base year**
→ **No clear change since base year**

In a little more detail……

Estimated incidence rates of self-reported illness caused or made worse by work, by main type of complaint, for people working in the last 12 months, 2001/02, 2003/04-2007/08



Estimated prevalence rates of self-reported work-related illness, by main type of complaint, for people who worked in the last 12 months, 2001/02, 2003/04 - 2007/08



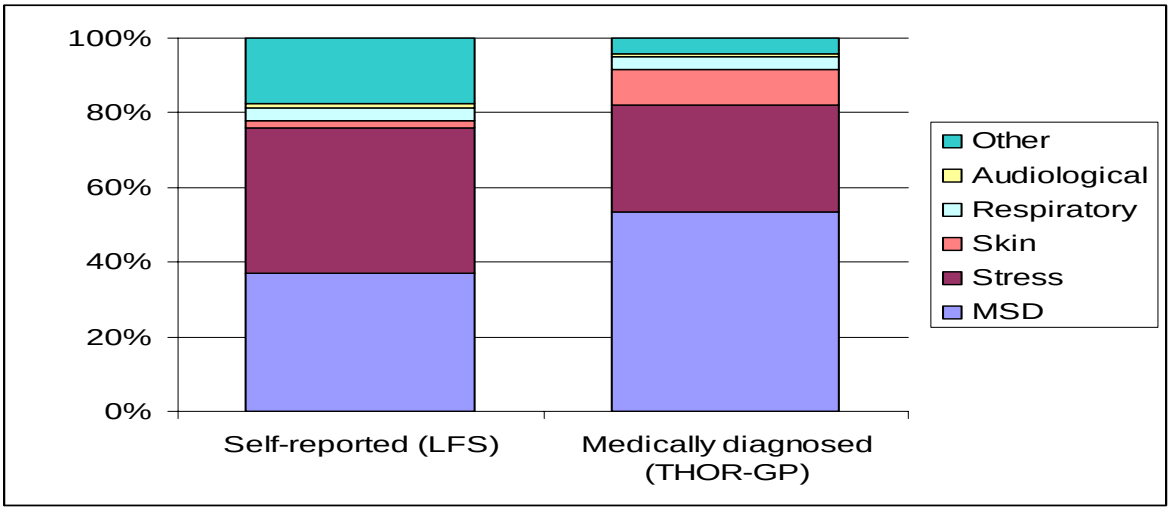
Long Latency/Future burdens

Carcinogen/Occupation	No. of registrations
Asbestos	4215
Shift work(breast cancer)	**1971**
Mineral oils	1690
Solar radiation	1549
Silica	**908**
Diesel engine exhaust	803
Coal tars and pitches	545
Painters	437
Dioxins	334
Environmental tobacco (non-smokers)	284

Note:

1. Almost 2000 breast cancer registrations a year attributed to shift working
2. Close to 1000 lung cancer registrations due to silica exposure (large current exposed workforce)

Distribution of work-related ill-health incidents



Note:

1. Stress and MSDs make up 80% from both data sources
2. Dermatitis may be more of a burden than the LFS has previously suggested

ANNEX 2

Extract from the Boorman Review

1. In 2006-07 Blackpool, Wyre and Fylde NHS Foundation Trust had a sickness absence rate of 5.34% and were undergoing a significant amount of change. Occupational Health also noted a marked increase in the number of employees who were presenting at clinics with work-related stress issues that were causing them to be unfit for work.
2. The Trust's staff opinion survey also indicated that the principal causes of stress in the workplace were excessive hours, restructuring and bullying and harassment. At the same time, the Health and Safety Executive (HSE) was planning to audit the Trust in relation to its management of stress in the workplace and how far it complied with the HSE Management Standards for stress in the workplace.
3. The Trust proposed to the HSE that it undertake its own Stress Project in order to identify and explore in some detail the sources of stress in the workplace. Having identified the sources of stress in the workplace, the project team would then make recommendations to reduce stress levels and develop a robust action plan that would ensure the implementation of all the key identified solutions.
4. Key targets for the project were to:
    - reduce the levels of sickness absence across the Trust by over 10% in the first instance (and a stretch target rate of 4.3% has been set for this year);
    - reduce the number of employees presenting at Occupational health due to work–related stress, reducing the ratio of psychological problems compared to musculoskeletal problems from 4:1 to 2:1 as a start; and
    - work with the HSE to convince inspectors that this was an acceptable alternative approach to an audit against compliance with the Management Standards and would go a long way to achieving the aim of reducing workplace stress.
5. The Trust established a Stress Management Group to oversee the project and also recognised the need for a comprehensive approach to tackling the underlying issues, engaging the Trust Board, managers, trade unions and the workforce to identify underlying issues and develop and implement plans for tackling them.
6. Since the beginning of the project, sickness absence rates have improved by over 10%; there has been an almost 50% reduction in cases of workplace stress; employee grievances have reduced by over 50%; disciplinary action has reduced by nearly 25% and rates of participation in appraisals have increased from 27% to 88%.
7. The Trust's staff opinion surveys have shown improvements for the last three years, and the most recent survey had a 61% participation rate, one of the highest in the NHS, and indicated that Blackpool, Fylde and Wyre is in the top 20% of Trusts. Notably, the scores for bullying and harassment by managers have reduced by 50% since 2006 and results for staff being unwell due to workplace stress have reduced by nearly 40%.

ANNEX 3

Enforcement Action against Dundee Council

Extract from LA newsletter 2007

Councils told to address staff health

The Health and Safety Executive (HSE) is warning local authorities across Scotland to be proactive in identifying and addressing health and safety issues affecting their staff following a case involving Dundee City Council.

In March last year, HSE issued Dundee City Council with and Improvement Notice for failing to have adequate management systems and provisions in place to deal effectively with occupation health risks faced by staff.

The legal duty to provide OH provisions for staff is outlined in a range of regulations including the Management of Health and Safety at Work Regulations, which state that 'employers have a duty to carry out risk assessments, make health and safety arrangements to manage risks, and ensure staff have access to competent health and safety advice'.
The council appealed against the issuing of the Notice, but this failed and HSE's decision was upheld. Since then Dundee City Council has put a comprehensive OH action plan into force.

HSE inspector, David Steven, said: "The appropriate use of occupational health expertise and resources is necessary to comply with statutory duties but will also help employers meet non-statutory principles such as reducing work-related sickness absence."

HSE says there are examples of good practice……Lanarkshire Council, in partnership with their trade unions, has introduced a holistic approach to maximising attendance, based on a variety of new and innovative early intervention themes, including free physiotherapy provision for employees whether they are attending or absent from work with ill health, and access to a comprehensive occupational health service.