IOM

WORKING FOR A HEALTHY FUTURE

Written evidence to the Work and Pensions Select Committee to inquire into the Health and Safety Commission and Executive – from the Institute of Occupational Medicine (IOM)

Executive Summary

- We acknowledge the vital role fulfilled by HSE (and HSC) as lead organisations with the mandate to ensure the health and safety of workers in Great Britain. We believe that these bodies take a balanced and mature approach to risk management in the workplace, and that they display a laudable commitment to partnership working.

  However:

- Given its mission, we question whether it is appropriate for HSE to have a PSA target based on working days lost to absence. This has led to an increased focus on sickness absence and incapacity, at the expense of the control of risks at work and the protection of workers from exposure to hazards. Together with reductions in real terms in its overall budget, it means that HSE is under-resourced to meet its core responsibilities.

- We believe there has been a significant weakening of HSE's specialist expertise, particularly in the medical arena, coupled with a net reduction in the resources available for enforcement. The consequences are that HSE is less able to provide clear, authoritative advice and guidance, and less able to carry out an effective enforcement programme.

- There has been a shift in approach towards encouraging companies to carry out qualitative risk assessments, as opposed to the collection of hard data and the expert interpretation of such data.

- There are some unfortunate perceptions of health and safety. Workplace health in particular is not widely perceived as an important issue, either by politicians or the general public. Occupational disease is often (wrongly) considered to be a thing of the past. In the worst case, workplace health and safety can be caught up in the media-led ridiculing of the general health and safety culture and the notion of the nanny state. These perceptions do not make HSE's job any easier.

- There is ambiguity over the role of the Health and Safety Laboratory, which on the one hand is the in-house laboratory of a government body, and on the other hand is a publicly-funded provider of commercial services. We believe that this has led to unfair competition in the market for commissioned occupational health science.

- The shift in emphasis towards the management of sickness absence, the weakening of HSE's specialist expertise and enforcement capability, the move towards subjective risk assessments and away from data gathering, and the low

public and political profile of occupational health have, we believe, contributed to a 'dumbing down' of occupational health and safety, particularly health.

- Many of these same factors are contributing to a narrowing of the science base in occupational health, and the unfair competition created by the activities of the Health and Safety Laboratory is resulting in an additional threat to the future security of the science base.

- Our recommendations are intended to redress these difficulties.

The Institute of Occupational Medicine (IOM)

The Institute of Occupational Medicine (IOM), a self-funding charity, and its subsidiary IOM Consulting Limited were formed with the primary aim of carrying out research, consulting and services to help make workplaces safer and prevent ill-health. Though our activities are international and include environmental as well as occupational risks, our main activities are focused on the health and safety of workers in Great Britain.

Overview comments

1. We see the health and safety of workers in Great Britain as very important, and something that needs to be safeguarded to a high standard, for ethical and for economic reasons.

2. We look on the HSC and the HSE as the lead organisations mandated to help ensure the health and safety of workers in Great Britain. Consequently, we are firmly in favour of a strong and effective HSC/E and we welcome the integration of the Health and Safety Commission and the HSE, for the reasons given in the initial consultation about the proposal to merge them. We hope these comments will help in some way towards strengthening health and safety in Great Britain. (Throughout the body of this response we use the acronym HSE and so do not distinguish between the Commission and Executive.)

The changing context in which HSE operates

3. The need to protect the health and safety of workers is unarguable. However, there are a number of unfavourable aspects of the overall context in which this needs to be done at present. We highlight three.

4. There is a problem of perception. Although occupational health and safety is taken very seriously by many of the individual politicians, workers, professionals, managers and members of the public that we encounter, there is a wider public perception that it is an old-fashioned subject, and no longer very relevant. In contrast, protection of the environment has (properly) become an issue highlighted among politicians and in public debate. There is, from time to time, major focus (sometimes in the form of panics) on food safety. Nutrition, physical activity and obesity have become topics of major importance. There is some ongoing focus on the conditions of those workers overseas, especially those in poorer countries, who produce, under conditions of exploitation, cheap

raw materials, goods and services for the UK market. However, apart from short-lived responses to occasional fatal accidents, the health and safety of workers in Great Britain is not perceived as an important issue among the wider body of politicians or the general public. This is particularly true where health rather than safety is concerned. There is a perception that occupational disease is a thing of the past, and that the well known occupational diseases have been eliminated. There is little understanding that, in proportion to the numbers of workers exposed to risk, the chances of developing even old-fashioned but fatal disease still constitute a significant problem. Moreover, there is little understanding of the contribution exposure to occupational hazards makes to the risk of developing a wide range of diseases not thought of as primarily occupational, for example lung and other cancers, and chronic obstructive pulmonary disease (COPD).

5. In fact, the situation is worse than this. It has become fashionable within the popular media to attack the notion of safeguarding health and safety. Partly this is a ridiculing of occasional instances (either real or mythical – 'Myth of the Month' on HSE's website is informative as well as amusing) where health and safety precautions have clearly been taken to extremes; and though often these apply to safety of children, not workers, the attack becomes an attack on the 'health and safety' culture as a whole. Partly it is an attack against the whole notion of affording protection to workers and others, on the grounds that this is a further example of the so-called "nanny state". Either way, it puts under attack the concept of protecting the health and safety of workers, and it puts the essential work and role of the HSE on the defensive. The current treatment of health and safety in popular culture is like the ridiculing of European legislation which was in vogue about 20 years ago – interestingly, this has largely subsided in recent times.

6. <u>There is a problem of resources.</u> While there have been real increases in public spending on areas such as healthcare and education, there have been cutbacks in other areas. These include the DWP, of which HSE is a part. We understand that, in real terms, HSE's budget has been cut in recent years leading to reductions for example in the numbers of inspectors available for enforcement.

7. Resources mean not only numbers, but knowledge and skills. We understand that increasingly, HSE inspectors may lack the solid grounding in science or engineering that is necessary for understanding many issues of occupational exposure and its control, and for making good judgements on-site. We recognise the importance of inspectors having good inter-personal and other skills, for example in winning co-operation; but core skills in health and safety must not be compromised.

8. A related element is the downgrading of HSE specialist knowledge, for example in occupational hygiene and notably in HSE's medical capability – what remains of the Employment Medical Advisory Service (EMAS). This means that front-line inspectors do not necessarily get the specialist back-up they need, in a job which of its nature is a multi-disciplinary one. From a medical point of view, the NHS doctor who suspected occupational disease in a patient used to have a

ready local source of occupational medical advice and experience in the local EMAS physician. This allowed discussion of the case on a confidential basis, and confidence that the medical issues that affected the specific patient and, importantly, his or her workfellows, would be investigated and resolved. For at least a decade this has no longer been the case, and such issues may well go unresolved and workers may suffer as a consequence. The extensive experience and understanding of occupational medical problems that existed in HSE's medical inspectors no longer exists. The decline in EMAS, and the expert knowledge therein, has significant implications for the future of occupational health in Great Britain.

9. There is a problem of an explicit or implicit change in role for HSE. It seems that increasingly, HSE is under pressure to help the economy, by managing outcomes such as sickness absence and incapacity, rather than focus on its central mission, of ensuring that risks at work are controlled properly. Of course the latter remains important to HSE; but we perceive a change in emphasis. This may be consolidated by the culture of target-setting and management to targets. While two of HSE's three headline Public Service Agreement (PSA) targets focus on reducing respectively (i) work-related fatalities and injuries and (ii) work-related disease, the third focuses on reducing days of sickness absence, whether work-related or not. We consider the first two to be appropriate targets for HSE, given its mission – to protect people's health and safety by ensuring risks in the changing workplace are properly controlled. The third is, however, about the overall effective management of businesses, rather than the control of risks at work, and the associated protection of workers from work-related hazards to health and safety. (Disease and injury caused or exacerbated by work is a relatively minor determinant of the amount of sickness absence from work).

10. There are other changes, e.g. the changing nature of British industry, with the long-term decline of production and growth of services; changing demographics of the workforce, with an ageing workforce and more immigrant workers; new hazards, for example from asthma-causing chemicals and possibly from manufactured nanomaterials. But these might be looked on as 'business as usual' changes, of the kind that HSE might under any circumstances expect and be expected to respond to. Those we have highlighted earlier are contextual changes of a different kind.

HSE's response to that context and some implications

11. HSE has made many changes in response to this change of context. Generally, we think the broad thrust of HSE's response has been good. For example,
    a. HSE has, correctly, judged that it cannot deliver its PSA targets in isolation, that it needs partnership working to do this. This is a good move, in that it places HSE at the head of a movement to control risks in the workplace, rather than as a body acting in isolation.
    b. HSE puts forward a balanced attitude to risk; it accepts that some risk is inevitable, but emphasises that risk can and should be controlled and reduced.

c. HSE has streamlined its organisation and activities to deliver its PSA targets. This includes developing and publishing its strategy for achieving them, and monitoring progress. This is good – though we do not think that having a target on sickness absence is appropriate.
d. Also, we think that HSE has handled well the fact of devolved administrations in Scotland and Wales. Our direct experience is with the situation in Scotland, where we see effective co-operation between HSE and the Scottish Government, in ways that respect the planned distribution of responsibilities.

However, some other aspects of HSE's response have had what we assume are unexpected or unintended consequences.

12. HSE's focus on partnership working has some drawbacks (none of them intrinsic). One is that HSE seems to be trying to do too much by co-operation and persuasion, at the expense of its role in giving strong and clear direction, and in strong enforcement. This is a consequence also of scarcity of resources – of not having enough inspectors to make enforcement a real threat. From our many contacts with industry we get the impression that many companies think that HSE is without teeth – that the chances of an inspection are small and, if something untoward is found, then there will be a lenient timescale for correcting it. This means that the 'threat' of HSE enforcement is not seen as a real one, and so is not seen as a motivator for better practice. It is possible to have co-operation as a main model, without compromising enforcement. This may mean more resources but it is also a question of viewpoint, of the balance between direction and persuasion.

13. Another aspect is that HSE looks to companies to carry out health and safety work themselves, for example through risk assessments. This is good insofar as some risk assessments get done which otherwise would not, and – for routine hazards and risks – the quality of the assessments may be sufficient to help manage the risks effectively. There are however many situations where measurement is needed to properly evaluate a situation, and we note a trend in industry to back off from measurement in favour of subjective assessments. Also, there are situations where access to in-depth knowledge and specialist skills is needed in order to deal effectively with more difficult problems; and this may be overlooked by somebody less experienced, especially if the risk assessment is being done as a formality rather than as a real exercise in risk management and reduction. We think HSE could and should emphasise more strongly that 'lay' assessments need to be underpinned by measurement and by specialist knowledge.

14. A third aspect is that some HSE guidance is vague, and leaves it too much to companies to assess for themselves what changes to make and when to make them. This would work well if companies (i) saw good health and safety practices as intrinsic to good management, rather than something to be done minimally; and (ii) had sufficient access to and use of specialist knowledge. There are many situations where these two desirables are not in place. As it stands, more authoritative guidance could be beneficial.

15. This progressive weakening of HSE's expertise and enforcement roles, together with a focus on managing sickness absence, has contributed to a kind of dumbing-down of health and safety knowledge and expertise, to the point where the demand for specialist knowledge is far short of the need, and the science base in occupational health and safety is in danger of being seriously compromised. We believe this is particularly true for occupational health, though we re-emphasise that in our work, we meet many capable and committed health and safety professionals working effectively to control risks, and getting help when needed.

16. HSE, through its Chief Scientist, Dr. Patrick McDonald, recognises there is a problem with erosion of the science base. We support the work he is doing, with others, to try to rectify it. We are not convinced, however, that HSE's own unintended part in this erosion is properly recognised.

17. The situation is added to by HSE's policy of placing its commissioned science work, as far as practicable, with its own Health and Safety Laboratory (HSL). This is an understandable response to the high costs of the new building that HSL occupies at a time when HSE's overall budget is simultaneously being cut in real terms. The policy does not however guarantee best value-for-money in relation to the specific projects that HSE needs to commission; and, together with the policy of supporting and in effect subsidising HSL to gain 3rd-party funding, in competition with other providers of research, consultancy and services, it creates unfair competition, and risks further narrowing of the overall science base in occupational exposures and health. We think it is inadvisable and inappropriate, that the regulator should also aim to become the principal provider of commercial services in this area. These comments reflect an element of self-interest on the part of IOM in that we compete with HSL for this type of work, but the view expressed in this paragraph is widely held in the British occupational health community and we make the comment in the spirit of trying to ensure that the whole arena of workplace health and safety in Great Britain should work well.

18. HSE signed up to three headline PSA targets. As noted above, we think two of these are fully consistent with its mission, while the third is not. These targets have informed HSE activity in recent years. However, the associated push for quick gains in reducing work-related injuries and disease has led to a focus on situations where the adverse consequence is more-or-less immediate, at the expense of areas where there is significant latency before serious disease becomes manifest. We see signs that HSE is finding ways of re-asserting the importance of traditional occupational diseases which may take many years to develop. (The current PSA targets discourage this focus.) We support the moves to re-focus on traditional long-term issues to complement the recent emphasis on seeking immediate gains.

Recommendations

19. Our primary recommendation is that HSE – without reduction in its resources – be allowed and encouraged to return to its original mission, i.e. "to protect people's health and safety by ensuring risks in the changing workplace are

properly controlled". This implies a greater focus on reducing work-related disease and injury, and a reduced focus on managing sickness absence (except insofar as this is work-related, or an early return to work might imply unacceptable risks). Relieving HSE of what we see as an unwarranted responsibility for workplace sickness absence, without loss of resources, would we think bring with it a resolution of many of the other difficulties noted above.

20. A less satisfactory alternative is that HSE keeps its current targets, including that for sickness absence; but gets substantially more resources to deliver them. These resources would logically come from Departments (DWP, BERR, maybe Health) who gain from HSE taking on this work, which in our view is really outwith its core role. We consider this way forward less satisfactory because the associated expansion of HSE's role is confusing with regard to HSE's core mission. We think it better if HSE could focus on that mission, without distraction.

21. We recommend that HSE's complements its policy of encouraging companies to move forward on health and safety issues with in-house and possibly lay expertise, with a policy of emphasising the need for companies to underpin this work by drawing on specialist expertise.

22. We recommend that HSE re-builds its own specialist expertise, particularly medical, in its traditional role of providing authoritative advice and guidance to inspectors and other practitioners, and not as a commercial service.

23. We recommend that HSE removes the ambiguity in the role of HSL, between that of an in-house laboratory providing services to a government body, and that of a publicly-funded commercial service provider.

24. Finally, we recommend a greater emphasis on effective enforcement. This would mean more inspectors, and so more resources. It need not compromise effective partnership working.