Chapter 11

Health

August 1999

RoSPA response the stress DD

The Health and Safety Commission's most recent discussion document on stress is a necessary and worthwhile attempt to deal with a diffuse but nevertheless serious issue. The balance of evidence suggests that people's mental and physical health can be adversely affected by aspects of their working environment such as to produce feelings of anxiety and sometimes acute distress.

Factors such as long hours, workload, uncertain expectations and, very significantly, lack of control over work tasks lead to intense feelings of being unable to cope with such pressures. If prolonged this can lead to both short and longer term damage to physical as well as mental health.

But like many other kinds of contemporary health and safety issue (e.g. manual handling injury and even noise induced hearing loss) the causes of stress in individuals are not wholly occupational in origin but are affected also by what is happening to them outside work (marriage problems, bereavement, money worries and so on). Also, like many other occupational health issues (e.g. respiratory sensitisation) there is a wide range of individual susceptibility to stress and its short, medium and longer term effects.

Yet despite these difficulties, it is clear that the general duties (as well as the enforcement) of the *Health and Safety at Work Act* and the *Management Regulations* do have relevance in this area. More guidance is needed therefore on the kinds of reasonably practicable measures which can be taken to reduce levels of risk.

Admittedly mental overload is much harder to detect and, more particularly, much harder to measure than say, overload on the body from manual handling or exposure of the ears to noise. This is probably the reason why many health and safety professionals with backgrounds in the physical sciences have difficulties in getting to grips with the issue and may even be sceptical about its true significance.

The HSC discussion document concentrates, predictably perhaps, on the impact of stress and on the health of the individual who is experiencing it. But an important feature of the problem is that because it affects the mind rather than the body, the effects of stress in one person can affect others as well. This makes it distinct from most other occupational health issues.

A stressed manager or supervisor, for example, can affect the mental state of those other members of their team who become the victims of their stress affected behaviour. Also – and this is a fundamental point which has been completely overlooked in the HSC document – stress can impair the reliability of safety significant decision making. (The document does suggest in passing that stress may

be associated with an increase in accident rates but this is not really explored in any detail).

In its response to the HSC on what to do about stress RoSPA will seek to highlight the safety as well as the health impact of stress at work, particularly since this is a subject which has received very little attention thus far apart from a few notable exceptions.

One such exception was action by the HSC following the enquiry into the Clapham rail disaster in 1998 in which 35 people died. One of the immediate causes of this tragedy was a technical error by an overworked member of a maintenance team and this finding led to the HSC introducing the *Railway (Safety Critical Work) Regulations*. These highlight the need to ensure the mental fitness of key people in the railway sector carrying out work where failure to perform work tasks reliably and consistently could put the safety of others at risk. And yet the case for ensuring the mental fitness of such key workers goes well beyond the railway industry.

And it is not as if there were any lack of scientific understanding in this area. The contribution of fatigue and impaired mental states to an increase in error rates in people performing even simple tasks has been studied extensively and is well documented. Similarly, error itself is a complex and fascinating subject, the study of which has been the life's work of now eminent psychologists such as James Reason and other working in this tradition.

They have produced a fascinating taxonomy of error – from unconscious slips and lapses to active and latent errors through the misapplication of rules (e.g. applying the wrong rule but for the right reasons) through to more deliberate kinds of conscious decision making to disregard rules.

Similarly, much has been done to explore the impact on the quality and consistency of decision making factors such as fatigue – for example, Jim Horne's work on falling asleep at the wheel carried out at the Sleep Research Unit at Loughborough. (See this month's feature, *Dead tyred*).

Put simply, stress at work is as much a safety issue as it is a health issue – and nowhere is this seen more sharply than in jobs where other people's lives are at stake if a person is so stressed that they cannot carry out their work reliably.

Of course, where the safety of large numbers of people or the protection of the environment hangs on the assured performance of an individual, the preferred solution should always be to find some sort of engineered or technological solution which will exclude the possibility of operator error. This has been a dominant trend in the search for safety and reliability in many areas such as aviation and the nuclear and petrochemical industries.

Yet there are many situations where this sort of approach is just not possible and ensuring the competence and the mental and physical fitness of operators to perform reliably remains an essential link in the safety chain.

If a world where workers at all levels are subject to increasing pressure, both at work and at home, when average length of sleep is declining and when there is unremitting

pressure to increase productivity, what advice can be given to employers and employees about how to assess and control the effects of stress on safety? And similarly, what advice can be given about how to investigate, when things go wrong, the extent to which factors such as stress and fatigue may have contributed to so called ‘operator error’?

There are no simple answers but a first step must surely be to ensure that employers focus much more carefully on the stress exposure of those workers whose unimpaired performance is essential to the successful control of high consequence risks. This is far from being every employee but it is likely to be a very long list, including not just pilots, drivers, plant operators and key maintenance staff but other groups including junior hospital doctors, air traffic controllers and emergency services personnel. In short, a special duty of care in ensuring freedom from excessive stress is owed to those in whose hands we place the safety of others.

October 2000

Securing Health Together strategy 1

The 'Securing Health Together' strategy, which was jointly launched by five ministers in July, forms a key part of the Government's overall approach to 'revitalising' occupational safety and health (ten key themes/44 action points launched in June – see *OS&H* August, News).

For too long occupational health (OH) has been the 'poor cousin' in the health and safety relationship, even though work related OH damage is a far greater problem than occupational accidents. Often it has not been generally understood that, while some 400 people die annually as a result of notifiable occupational accidents, perhaps as many as 10,000 die as a result of past exposure to harmful working conditions (several thousand due to exposure to a single hazardous agent, asbestos). HSE estimate that there are 2.1 million cases of ill health every year caused or made worse by work. Moreover, some 25,000 people leave the workforce annually due to work related injury or ill health.

Two central themes in the strategy are: 1) that occupational health must not just be about preventing health damage but promoting good health and welfare and, 2) that health at work must in future involve everyone. This is seen as having a major contribution to make in achieving goals for improving public health generally.

The broad aims of the strategy are to reduce work related ill health (WRIH), meet needs for job adaptation and rehabilitation, reduce ill health and disability barriers in the labour market and use the workplace as an area for health improvement. Targets have been set for a 20 per cent reduction in days off due to WRIH by 2010 as well as universal access to job adjustment and rehabilitation by 2010.

A 'Partnership Board' has been set up to carry the process through, working through Project Action Groups at five levels: securing compliance; encouraging continuous improvement; building knowledge; developing skills; and providing access to OH support. It is envisaged that the NHS will provide increased OH support, particularly to small firms, via Primary Care Groups and Trusts. Beyond this, HSC/E will be looking for new initiatives and partnerships and seeking to publicise new approaches.

It is clear that HSC, in partnership with other Government Departments, are now moving well beyond the traditional view of OH (preventing health damage due to work) and encouraging a broader vision which sees this subject as primarily a management rather than a largely medical matter and one which focuses on reducing absenteeism, promoting rehabilitation following illness or injury (whether caused by work or not) and using the workplace as to encourage changes in lifestyle. The aim is to encourage a breaking down of barriers between OH and general health, with a stronger focus on improving employee welfare, particularly by encouraging more family friendly policies as well as a renewed effort to remove barriers to employment of those currently on invalidity benefit.

If OH is be 'demedicalised', a major effect will be required to raise the awareness of workers (but especially managers) of the effects of work on health and vice versa and show them how they can develop health management strategies to tackle them. There

will need to be a much better understanding of how living and working affects us but without any diversion of effort away from confronting the major causes/categories of work related health damage.

Put another way, we all need to become more health conscious at work but it will not be much use encouraging workers to adopt healthy eating habits by offering salad instead of chips in the canteen if they continue to be exposed carcinogens for the rest of the afternoon or if they get totally stressed out having to meet impossible deadlines!

Conversely, efforts to protect health from harmful influences at work will be wasted if not linked to action to help workers address things outside work which are adversely affecting their health. A considerable amount of health related absenteeism could be reduced by more effective OH policies, including not only better prevention of WRIH but more assistance to help people with health problems to continue to come to work.

The new strategy is bold and inclusive but it does pose some quite significant challenges.

Firstly, the baseline data on WRIH are universally acknowledged to be poor. By raising awareness of OH issues the strategy may simply lead to an uncovering of the true extent of ill health caused by work, making it look as if things have got worse.

It will thus be important to complement the kind of 'output' measures being set nationally with other 'input', activity based measures which can also be translated into sector and corporate targets – particularly into meaningful targets for small firms.

Also, OH needs to be given a much more robust treatment within approaches to measuring OH&S performance generally (for example, within proprietary auditing systems) and encouragement should be given to more OH awards schemes. (As its contribution, in its 2000 awards round RoSPA introduced *The Astor Trophy for Occupational Health* won in its inaugural year by East Herts NHS Trust.)

Secondly, there is the question of specialist services (occupational medicine, nursing, hygiene, etc). A start has been made with giving advice to employers on how they can get access to specialist services, but with emphasis on encouraging as much self reliance as possible. And encouragement will be given to developing services located within the NHS. This is an important development and one of the innovations for which RoSPA argued. But it will mean that the NHS, Britain's largest employer, must put its own OH house in order.

Thirdly, the emphasis on OH as a line management responsibility will mean that there will need to be new forms of training for managers. Nationally the current OS&H training 'menu' is till to heavily biased towards safety. IOSH's 'Managing Safely' has proved extremely popular. Perhaps what is now needed is a parallel OH awareness raising course for managers, giving them a good basic understanding of the main issues and their role in addressing them.

Finally there is the unavoidable question of resources. More can be achieved by unlocking under-utilised resources in other parts of the 'health and safety system' and

by encouraging innovation and partnership working. But additional HSE and Local Authority staff time will be required to make this happen.

November 2000

Securing Health Together strategy 2

Reducing sickness absence has emerged as a strong feature of the Government's and HSC's new strategy for occupational health (OH) called 'Securing Health Together'. The strategy (see *Parting Shot*, Oct 2000, *OS&H*) forms a key part of the Government's overall approach to 'revitalising' OS&H.

It is clear that the HSC are now moving well beyond the traditional view of OH (preventing health damage due to work/taking account of health in fitting workers to jobs) and encouraging a broader view which sees this subject as primarily a management, rather than a medical, matter. It is a view which focuses on reducing absenteeism, promoting rehabilitation following illness or injury and using the workplace as an area for encouraging changes in lifestyle.

There will also be a stronger focus on improving employee welfare, particularly by encouraging more family friendly policies as well as renewed effort to remove barriers to employment of those currently on Invalidity Benefit. (The aim here is to combat social exclusion, but there is clearly a Treasury interest in reducing the current cost of Invalidity Benefit, said to be over £70 billion per annum.)

The big traditional OH issues, however, remain.

What RoSPA has been trying to determine is what is the average scope for reducing sickness absence by better OH and welfare policies? The HSE view seems to be that, not only is the work-related component of overall sickness absence underestimated in most organisations, but there is major scope for helping people, particularly the long term sick, to return to work by making simple job adjustments. But given a certain incidence of general ill health in the population of working age, how realistic are the claims being made by HSE?

A recent Chartered Institute of Personnel and Development (CIPD) survey report based on 1700 responses by its members to a questionnaire about sickness absence rates, its causes and the perceived efficacy of various interventions shows that stress, headaches, colds, flu, and stomach upsets predominate as the main reasons given for self-certificated absence. Accidents are only a small part of the overall picture. About half of all sickness absence is due to long term health problems, as opposed to short episodes.

Opinions vary between those responding to the survey as to how much of self-certificated absence is actually due to the causes given. Although hard evidence was not presented to back this up, many said that up to half of self-certification was due to low morale or taking time off to deal with family sickness.

Opinions also vary as to the best way of reducing sickness absence. Some seem to have evidence that robust 'return to work' interview and disciplinary procedures help. Others claim success for morale boosting measures such as family friendly policies, confidential counselling, health promotion, rehabilitation, etc.

The survey also showed a marked difference in absence rates according to the size of organisation, with small firms showing lower absence rates. This reflects similar findings from the HSE's 'Self Reported Work Related Injury Survey' about the prevalence of minor reportable occupational injury in small firms. In manufacturing for example, you are twice as likely to suffer a fatal or major injury if you work in a firm employing less than 50 employees, than you are in a firm employing 1000 plus. On the other, the rate of absences of more than three days due to non fatal/major occupational injury in such firms, is roughly half that in large ones. Various explanations are proffered for this: less generous sick pay arrangements; less slack in teams; need to tackle urgent work; more team spirit and so on.

Clearly individual perceptions of discomfort and distress vary enormously from one person to another. One employee may continue to come to work with a heavy cold and work through it; another may not feel able to do so. Also, there can clearly be a link between employee health and family sickness (for example, where employees become depressed following bereavement or divorce).

The true pattern of causes underlying employee absence is obviously a rich and complex one and consequently, there are dangers in any over simple analysis, particularly if it leads to even more simplistic prescriptions. Thus the real challenge for any organisation which wants to reduce absence seems to be how to tailor a set of cost effective policies which will produce the best fit for the majority of staff, while at the same time still meeting individual needs.

There is obviously a wide range of measures or interventions which can be taken to reduce absence, some of which include: clearly defined policies, rules and induction processes; effective communication of corporate vision and mission; good appraisal, target setting, support, supervision etc; appropriate staff training; sound OH programmes and good OS&H management; team building measures; family friendly policies; general health screening; wider health promotion initiatives; return-to-work interviews; confidential counselling in specific cases.

But while many of these may seem desirable few good studies are currently available to provide robust evidence of their efficacy.

From a health standpoint, organisations have to tread a fine line between enhancing motivation in those who are already highly motivated but whose health might actually be damaged by attending work when they should be recovering or seeking medical help, and encouraging those who might be tempted to take time off when faced with significant discomfort but for whom attendance at work might actually aid their recovery. This latter approach is a key message in the Government's 'Back in Work' campaign where job adjustments for sufferer's from chronic back pain, supported by access to treatment, are seen as a better approach than their being signed off work and becoming resigned to incapacity.

From this point of view, across the board policies (particularly coercive policies) aimed at those taking allegedly unjustified sickness absence may actually damage health in more highly motivated groups as well as reduce overall morale and thus be counterproductive. Targeted and employee specific approaches delivered through line management are more likely to be cost effective.

There is also the question, of tackling ‘presenteeism’, i.e. those who may put their health at risk by working excessive hours, not taking their full leave entitlement or generally damaging their health by failing to achieve a correct life/work balance. Allowing people to burn the candle at both ends is bad for individuals and is ultimately bad for business and should be actively discouraged.

September 2002

Putting the 'h' into 'h&s'

In recent years the Health and Safety Commission (HSC) and Executive (HSE) have been working hard to put 'health and work' at the heart of contemporary health and safety strategy. Despite the fact that ill health caused or made worse by work is a much bigger problem than accidents (2.2 million cases annually compared with about 1.6 million workplace accidental injuries), the focus of health and safety (H&S) management in many organisations is still overwhelmingly on accident prevention.

Yet early death due to past exposure to hazardous conditions at work is clearly an order of magnitude greater than death due to accidents – although much of this occurs long after exposure has ceased (for example, as is the case with asbestos where deaths are set to rise up to 2020 simply because of continuing exposure of building and maintenance workers to the existing asbestos inventory in buildings, equipment and installations). Other major categories of ill-health associated with work include problems such as skin disease, asthma caused by sensitisation, deafness, VWF and a whole range of occupational cancers.

But the biggest categories of work related ill health by far are musculo-skeletal disorders (MSDs) and stress, both of which are associated with high levels of absence from work as well as a rising number of ill health claims. HSE estimate that some 25,000 workers leave the workforce annually as a result of health problems and even the Prime Minister has commented recently on the large numbers of workers receiving invalidity benefit as well as the contribution that unemployment due to health problems makes to social exclusion.

Traditionally the 'occupational health' challenge for employers has been to assess and control risks to health associated with work, to ensure that workers are fit to work and that suitable work adjustments are made to take account of their health status. They also need to address problems such as poor performance due to substance abuse and other impairments which can impact on both performance and safety.

While many organisations (including award winning companies) can describe their strategies and targets for improving their safety performance, few can give an account in similarly strategic terms of their approach to protecting and enhancing health at work. Similarly, while the same organisations will talk vigorously about the 'health of their business', few will acknowledge the direct connection between this and the physical and psychological health of their employees – even though in most cases their workers will be described in the corporate rhetoric as 'the organisation's most valuable asset'.

Yet assets need to be managed, so why then do so few organisations which present data on levels of accidental injury and associated costs, fail to gather meaningful data on the prevalence of work related ill health or indeed basic data on sickness absence? (I suspect this weakness is one of the reasons why the majority of the top 350 companies have refused to take up the HSC's challenge to include this sort of details in their annual reports.)

Recent survey work by the HSE has shown that the portion of Britain's workforce that has access to occupational health services is at an all time low (less than 3 per cent). Yet nearly all businesses need specific professional help if they are to tackle health at work issues, not just the services of occupational physicians and occupational health nurses but occupational hygienists, ergonomists and specialists in radiological and microbiological safety.

Such specialists have important roles to play in areas such as pre-employment health screening (ensuring candidates meet the health specification for the job); specific kinds of health risk assessment (for example, vulnerable groups such as pregnant workers etc); selection of health risks control measures; and on-going monitoring (including monitoring the working environment and targeted health surveillance). They can also have a role in assisting attendance management and in post injury/illness rehabilitation, in providing minor treatment services (e.g. on site physiotherapy), in advising about first aid and in developing health promotion programmes.

On the other hand, while OH professionals are clearly key players in helping to meet the 'health and work' challenge and need to work more closely together (a central challenge in a recent IOSH guidance publication, *Professional Partnership*), arguably the lead in health (as in safety) needs to be located very clearly with managers.

Senior managers in particular need to make it very clear that health is a strategic business issue and is thus far too important to be left to OH specialists. They need to stress that all line managers have to take the lead on health and work and work closely with their teams and with workers' representatives to take ownership of the 'health at work' agenda. They should see OH professionals as specialist resources rather than people to whom to refer/defer when things get too difficult.

There are many barriers to getting the right focus on the 'H' element in traditional H&S management. Some of these include: lack of strategic direction (particularly among senior managers); lack of motivation and negative management attitudes towards specific health issues such as stress; weak knowledge (what causes ill health at work, the long latency associated with many work related conditions and the multi-factorial nature of modern OH problems such as MSDs, stress etc; poor skills; low workforce expectations, few means of performance measurement (as mentioned, even tracking absence); and the extent of pressures on managers, especially in small firms.

Often organisations which have begun to address control of health risk as part of their overall management of health and safety (compliance with COSHH, asbestos, noise regulations, etc), have done little to address the impact of 'health on work'. Yet increasingly businesses need to focus on the wider 'health and work' agenda, particularly managing the health deficits and special health needs which employees bring to work with them. Senior managers need to understand the business case for 'manager lead' action on health, including creative approaches to work adaptation and a positive commitment to rehabilitation following injury or illness.

They need to work with their insurers on health issues and develop a broad vision of health in their organisation focusing on priorities rather seeing OH as a soft subject equating with changing canteen menus (salad not chips), installing a gym, setting up

'well woman' or 'well man' clinics at work or providing more rapid access to health care through private health insurance.

Encouraging businesses to adopt this broader, business based perspective is a key theme at the heart of the HSC's current strategy for OH called 'Securing Health Together' (SH2). (Thos who have yet to familiarise themselves with this programme should visit www.ohstrategy.net) SH2 is lead by a 'Partnership Board', chaired by HSC Chair, Bill Callaghan and has established some clear national goals: a 20 per cent reduction in the incidence of work related ill health (WRIH) by 2010; a similar reduction in work related harm to the health to members of the public; a thirty per cent reduction in the same period in the number of days lost to WRIH; everyone who is off work due to ill-health have access to rehabilitation; and everyone not in work due to ill-health to be made aware of and offered opportunities to prepare for and find work.

SH2 has established five programme action groups (PAGs): *Compliance*: looking at action to increase levers and reduce barriers to compliance; *Continuous improvement*: looking at tools and incentives; *Knowledge*: looking at data, statistics (including the 'business case'), research, training etc, *Skills*: examining key skills for priority groups that could make a difference, and *Support*: looking at the case for a national OH service or network.

As a member of the Skills PAG I have been asked to review the extent to which 'Health' is addressed in current H&S management practice and in H&S training for managers for example by looking at the 'H' content of key H&S competencies and courses aimed at managers. A further question which I have undertaken to address is whether there is a case for a stronger (or different) focus on 'health at work' in H&S management standards (BS 8800, OHSAS 18000 etc) and H&S management audit schemes. (This also links closely with safety – can extend its own base for influence, for example, by developing and promoting RoSPA's 'Astor Award' for corporate excellence in OH and publicising winners' profiles via the web.)

Views from readers would be welcome, particularly on some of the practical steps (e.g. by training managers in 'return to work' interview techniques, focusing of health in workplace tours or by training managers in disability issues).

Examples of generic health issues which needs to be understood by managers

A. Impact of work on health

Hazards to health
- Physical (noise, vibration, radiation, ergonomics)
- Chemical (toxicity, carcinogenicity, teratogenicity, mutagenicity, sensitisation etc)
- Biological (micro biological factors)
- Psychological (stress)

Issues:
Assessment and monitoring techniques
Latency
Multifactorial causation
Understanding health risk assessment (deterministic versus stochastic effects, dealing with uncertainty etc)
Hierarchy of approaches to control
Protecting the vulnerable etc etc

B. Impact of health on work
- Impairments due to common conditions (stress, alcohol, drugs etc)
- Impacts on safety and performance
- Employment/insurance issues

Issues:
Fitness for work standards (e.g. safety significant work);
Confidentiality
Costs
Disability issues

C. Management
- Policy (establishing objectives)
- Accountabilities and training
- Planning for health
- Monitoring
- Review and feedback

Issues:
Consultation/involvement
Corporate target setting and tracking performance
Recognising, celebrating achievement
etc etc

D. Solutions
Services/support
First aid/counselling
Health education/promotion etc etc
Issues:
Information
Access etc etc

July 2004

A new approach to H&S services?

The Health and Safety Commission (HSC) are continuing to give strong emphasis to their vision statement which is to win acceptance '*..of health and safety as a cornerstone of a civilised society...*'. Since Britain has been engaged in the pursuit of health and safety at work since 1833, one might be entitled to assume some level of acceptance had not already be won. On the other hand it could be argued that, with stories such as 'hard hats for high wire artists' and 'conkers, bonkers!' in the tabloids and attacks on HSE by broadsheet columnists such as Simon Jenkins, Christopher Booker and Jeremy Clarkson (who likes to describe safety people as fresh air loving, vegetarian, safety nazis), senior people in the Commission and Executive have been too influenced by the 'chattering classes'. There is some evidence however that the 'chattering classes' do have influence (particularly with those that surround No 10) and, as in many areas of life, it is always the case that, to some extent at least, nothing can be taken for granted and that values previously assumed to be secure have to be fought for again in every new generation. Nevertheless it was heartening that, in a recent HSE commissioned MORI poll on attitudes to health and safety, some 60 per cent of employers considered that health and safety law was good for business with only 14 per cent dissenting from that view.

This raises a fundamental question as to whether 'winning acceptance of heath and safety' in the abstract should be the prime focus of HSE's strategy (which, it has to be said, has many good points) as opposed to 'making health and safety happen'; that is, making high standards of protection from injury and health damage a reality for millions of workers who at present do not enjoy the working environment which the law, in theory, guarantees them.

It was Hazel Genn, then working for the Wolfson Institute back in the 1980s who divided employers into: 'Don't know, don't care, (worse still) 'Do know, don't care', (the majority arguably) 'Do care, don't know', and (a minority of higher performers) 'Do know, do care'. RoSPA has continued to argue, for example, to the current Select Committee Inquiry into HSC/E, that the greatest strategic challenge facing the Commission (and indeed the whole health and safety system) is that of ensuring that the vast majority of firms get access to the advice and services they need to help them to manage health and safety effectively.

Although there are requirements in the EC Health and Safety Framework Directive and the Management of Health and Safety at Work Regulations concerning access to competent advice and ensuring training and competence at all levels, in reality these tend to be regarded by many organisations as optional, 'nice to haves' rather than 'must dos'. The same is true when it comes to enforcement. The vast majority of enforcement notices are written to require employers to remedy serious and imminent risk issues when often the root cause of such unsafe conditions is, in large measure, failure by the organisations concerned to invest in professional health and safety advice and training. Some research commissioned by HSE looking at the health and safety training market confirms the suspicion which RoSPA has had for some time that good employers invest in things like health and safety training for line managers while poor ones do not. The same is true when it comes to employing the services of professionals in safety, health, hygiene, ergonomics etc.

Over many years HSE have wrestled quite unsuccessfully with the whole question of services. One of the first jobs I undertook in the TUC nearly thirty years ago was to write a pamphlet, 'Occupational Health and Safety Services: the need for a team approach'. This was in response to an HSE discussion paper of the time, 'Occupational Health Services, the way ahead'. What the TUC paper argued for was a Code of Practice which would require employers to employ or have access to a team of specialists from relevant disciplines, breaking down the artificial divide (which sadly still exists in many quarters) between 'health and safety' and 'occupational health'.

In the last few years the call for the setting up of an occupational health service has been voiced by the HSC's Occupational Health Advisory Committee and more recently by a Programme Action Group of the HSC/E's 'Securing Health Together' strategy'. The HSE's consultation on their new 'Strategy to 2010 and beyond' has also reconfirmed what we have know for a long time, namely that many employers will not approach HSE for advice for fear of receiving a notice or being prosecuted. In consequence the Executive are now embarked on developing guidance on where to get 'advice, free from the fear of enforcement'. There are also plans possibly to amalgamate current HSE free leaflets on consultancy and understanding training needs.

Of course good guidance is always to be welcomed but, having lived with this gap in Britain's health and safety regime for so long, I cannot help wondering whether a much bolder and more determined approach is not now required. At the Select Committee we were asked by MPs whether new legislation is required (usually seen as the remedy for all ills) whereas we pointed out that we already had general duties in place in the Management Regulations; what was required was the political will to spell out what they meant in particular circumstances and to use enforcement where necessary to require them to be met.

It has always seemed ironic to me that, for many years we have had a reasonably clear but flexible framework of regulations and guidance in place to require employers to make provision for the last link in the health and safety services chain, namely first aid; yet we have had enormous difficulty in developing a similar approach to services required to assure prevention. Surely it is now time to put definition and teeth behind the 'competent advice' requirements of the Management Regulations' and to link these to the many other requirements concerning monitoring, periodic inspection and so on that are scattered across the corpus of health and safety law.

If HSC/E are unable to do this for fear of being accused by the columnists and by advisers to No 10 of creating unnecessary 'red tape', then perhaps an alternative approach would be for key stakeholders outside the regulatory structure to begin to develop a consensus code setting out some simple, indicative standards; for example, banding organisations according to size, risk, complexity and indicating the mix of services which they should employ or have access too.

Such an initiative would also need to be accompanied by new self-regulatory moves to license practitioners, to set standards to outlaw cowboy consultants (who 'gold plate' and promote consultant dependency), and to create effective signposting by key intermediaries. It would also need to be accompanied by co-ordinated monitoring to

evaluate the effectiveness of various kinds of provision and by pressure on HSE (including seeking judicial review where necessary) to use its enforcement powers to require non-compliant employers in the worst cases to make use of services.

Of course there are still major practical difficulties to be overcome. There are still not enough trained professionals (especially in occupational medicine and hygiene) to meet every need. Yet by developing creative approaches to the sharing of services and by promoting maximum training and empowerment of managers and safety representatives, the practical effect of these shortages could be greatly minimised.

Several fora already exist such as POOSH (Professional Organisations in Occupational Safety and Health) and there are many key influencers such as the trades unions and the insurers, both of whom for example, have expressed a very strong interest in promoting better rehabilitation. Where perhaps the focus of debate needs to be readjusted is away from questions such as competence (not unimportant but something of a 'holy grail') towards standards and mechanisms of provision.

Perhaps what is required is a new 'Health and Safety Services Alliance', bringing together the wide range of key players in the health and safety services, training and research fields, to work together to campaign around a consensus code on provision and delivery and to highlight the extent and consequences of current gaps in provision. In their new strategy HSE say that they cannot be expected to do everything, so perhaps it is time to take them at their word and for professionals themselves to take the lead. Please Email comments to me at rbibbings@rospa.com.

December 2004

No mean feet

When he was in a joyous mood in the morning my father would often attempt to sing 'How beautiful are the feet ...' from Handel's Messiah, particularly while he was shaving. As a busy G.P. in a single handed rural practice he admitted however that for him the words of this famous aria had a somewhat ironic significance since, rather than conjuring up heavenly images, they made him think instead of many of his patients who came to him with foot problems, most of which were far from beautiful.

Of all parts of the body the feet are perhaps the most used, the most taken for granted, the most abused and possibly the most neglected. And when they go wrong, along with bad backs they must rank as one of the biggest single causes of misery, particularly for those people whose jobs require them to spend much of their working time on their feet, whether they stand at a workstation or spend their day pounding the shop floor or busy city streets. People very rarely die of foot ailments but countless millions suffer, mainly in silence (many in the workplace) because of foot problems.

It is surprising therefore that so little guidance is available on the health of feet in the context of work. The Workplace Regulations have requirements for facilities to be provided for workers who do their work standing to sit down from time to time. The Personal Protective Equipment Regulations require the provision of suitable protective footwear where risk assessment shows this is necessary - but how much badly fitting industrial footwear actually ends up making people's foot problems worse? There is even guidance about controlling vibration risks to feet as well as to other parts of the body; so why is there no HSE guidance at all on what one might call 'occupational podiatry'?

With so much work done standing or walking about, the health of people's feet at work must rank as possibly one or the most important but most unrecognised of all occupational health issues. Perhaps it is assumed that people's feet are their own affair but, as any chiropodist will tell you, very many Police Officers, Fire fighters, Traffic Wardens and other peripatetic workers tend to have terrible foot problems. Only a few mainly larger employers invest in chiropody for their staff. Most individuals only invest in this sort of service when things go wrong or when, with the onset of middle age, their feet seem to get just that little bit more remote and harder to get to. Yet what is known about the epidemiology of work related foot problems? How do these problems affect people's sense of well-being at work and their overall mood and productivity? How much absence from work is due to bad feet? How many people have to 'downshift' in their job or give up work altogether because of serious problems with their feet? And how many people at work make their feet problems worse by choice of unsuitable shoes? While men may be fairly pragmatic about their choice of shoes, a recent survey by the American Academy of Orthopaedic Surgeons found that 60 per cent of women admitted to wearing uncomfortable shoes. A similar study by the British Journal of Podiatry found one in five women wear uncomfortable shoes to please their partners or employers. Unfortunately, 80 per cent of these women also said they wouldn't be prepared to change their style of shoes to improve a foot problem.

Perhaps the answers to these problems are already out there but certainly the whole subject of healthy feet at work does not seem to figure very clearly on the occupational health (OH) radar screen. Certainly when compared with lower back pain, stress, dermatitis, noise induced hearing loss and so on it is not a subject that comes up that often in conversation when contemporary health and safety problems are under discussion. It is certainly not an issue around which employers are encouraged to be proactive in the same way as they are on other OH issues. It does not seem to figure that much in workplace health education where there is usually lots of emphasis on the importance of good diet, cutting down on the booze, giving up smoking and, of course, taking more exercise. But how likely are you to go down the gym after work - or even out for a good walk - if your feet are killing you? Far more likely that you'll make for the pub and order a few pints for the anaesthetic effect if nothing else!

People's feet seem in some senses to be more private than other parts of the body. To some extent this may be because in Western Societies virtually no one goes barefoot. We invest hugely in elaborate and elegant footwear. Few people wear sandals, certainly in Northern Europe. And the adornment of feet with cosmetics or jewellery is the preserve of mainly younger women. Rarely will one person compliment another on the magnificence of their feet in the same way as they might comment favourably, for example, on the appearance of their face or their hands. Consequently, whether it is a question of bunions, cracked heals, in-growing toe nails, fallen arches or more serious orthopaedic problems affecting the feet (any one of which can make walking or even standing at work a real nightmare), it is generally assumed that these are personal health matters which individual employees will be reluctant to talk about and which they will need to raise in confidence with their own doctors. They tend not to be seen as key issues which fall within the employer's duty of care. They are certainly not seen as issues which might result in a common law claim for damages, such as might be the case with an allegedly work-related back injury. And rarely will the state of an individual's feet be taken into account in assessment of fitness-for-work or job adaptation.

This is not to say of course that good employers do not take care in offering employees a range of comfortable footwear for use of work or ensuring that they do not have to stand on cold hard surfaces and so on. There is a lot of good ergonomic practice here which can be cited which others should follow. Care is also taken to allow pregnant workers or those recovering from injury to take a rest and to 'take the weight off their feet'. It is just that feet that are fit for work, while clearly important, are not seen as anywhere near as important as other 'health at work' issues.

On the other hand healthy feet on the job are not a stand-alone issue! (excuse the pun). Besides affecting people's sense of well being and their occupational stress experiences they can also adversely affect things like safety, for example, where foot problems make climbing stairs or ladders safely - or operating foot controls - that little bit more difficult. People's feet can be injured at work for a whole raft of reasons including injury as a result of unsafe manual handling and, of course, foot problems may be a risk factor in slips, trips and falls on the level.

The TUC has encouraged union safety reps in recent years to carry out 'pain surveys' in the workplace. These have been aimed mainly at identifying work related upper

limb disorders but it would be interesting to know how often they have thrown up foot pain at work as an issue troubling employees.

There is clearly a strong busy case for healthy feet. Perhaps ‘put your business on a healthy footing’ could become the next HSE OH campaign or perhaps it could become a new marketing angle for the various purveyors of foot care products and services.

Certainly in high profile areas such as sport, foot care is a top priority. In services such as the military, from time classical times onwards the importance of healthy feet to the fighting efficiency of your army has been well understood. The Romans equipped their legionaries with nailed but open sandals to let the feet breathe; a lesson which was forgotten in the slaughter of 14/18 when ‘trench foot’ wrought havoc on both sides as millions of soldiers wallowed in the mud of Flanders. The Russians equipped their soldiers with felt ‘valenki’. Napoleon’s men (and later Hitler’s) had only their summer boots.

Rarely will the working environment be as challenging as the Russian steppe in winter or the Somme in spring but it is undoubtedly worth challenging the health and safety community to think a little harder about workers’ needs in this area and to resist the temptation to regard unhealthy feet as the stuff of slapstick comedy or the sea-side postcard. There is every reason to believe that what is currently known about foot problems at work represents only the tip of an iceberg. With an ageing workforce across the whole of Europe, paying more attention to employees’ needs in this area is not only logical but will be increasingly essential.

HSE have said that in future they do not intend to produce much new guidance so perhaps it is up others to take up the challenge here. Is there a case for those offering nationwide chiropody services, protective footwear manufacturers and suppliers, employers’ associations, OH services, trades unions, the NHS etc - to all get together to promote a more proactive approach to healthy feet at work? Rhetoric such as ‘British industry marching forward to a bright future’ has something of a hollow ring when so many workers’ feet are in such poor shape!

February 2005

Waking up to fatigue

Quite rightly the Health and Safety Commission (HSC) have made stress at work their number one occupational health (OH) issue yet the cyclical link between stress and fatigue (stress impairs sleep; impaired sleep enhances stress) is still largely ignored in the HSC's guidance. During consultation phase on the HSC's Stress Management Standards my colleague, Dr Lieu Nguyen did a useful exercise in reviewing world-wide literature on this subject (see http://www.rospa.com/occupationalsafety/occupational_health/stress_european.htm#alert). Admittedly fatigue has been addressed in HSG48 (HSE's excellent guidance on human factors in occupational safety) but in general fatigue as both a threat to health and a source of impairment in human reliability has still not received enough attention.

In an interesting pamphlet (Dream on: sleep in the 24/7 society) published recently by the think tank Demos (www.demos.co.uk b), Charles Leadbeater offers some fascinating and provocative thoughts on the mounting sleep deficit which he claims is affecting Britain. Most severely affected according to a survey undertaken by Demos are young managers, particularly women (juggling home and work commitments) and those whose sleep patterns are adversely affected not only by work stress, but by long and irregular hours, difficulties in coping with domestic crises and particular problems such as caring for young children with sleeping problems or in caring at night for elderly and infirm relatives. Leadbeater argues that sufficient good quality sleep is necessary not just for recuperation, it is also vital to enable us to embed learning (apparently sleep helps us to 'hardwire' learning experiences) and it is also essential to facilitate creativity, the life blood of any brain based economy such as UK PLC. It is also essential, of course, to help ensure safety.

The relentless drive towards 100 per cent 24/7 living in Leadbeater's view is a huge folly since it threatens to kill the creative goose which lays the golden economic egg. On the other hand, far from urging that we should attempt to turn the clock back to the last century he suggests that what is really needed is a new level of awareness of the importance of sleep and a more flexible and imaginative response by employers to ensuring better work life balance, particularly by providing flexible hours for working parents and more provision for working from home. Among some of his more challenging suggestions is the idea that employers should actually encourage sleeping (napping) during working hours to help sleep deprived workers to recover and improve their efficiency. He quotes Churchill who famously always slept between lunch and dinner every day, countering criticism from colleagues by saying that, far from reducing his work output, it actually increased it. Other observations include the fact that the need to nap increases with age and thus with an ageing workforce urging employers to provide suitable quiet areas in the workplace where employees can sleep for short periods during the day may not be as daft as it sounds. Rather than fearing being 'caught napping' (as was the case when workers had to work massively long shifts) a positive approach to short periods of sleep (especially in people focused businesses) may actually help employees to improve their performance.

A part of its campaign to get work related road safety accepted as part of the H&S mainstream RoSPA has placed a lot of emphasis on the need for employers to raise

awareness of the need for good quality sleep before driving for work and not to compromise safety by requiring employees to drive too far in a single day or to attempt to drive long distances home, especially where they have been working some distance away from their normal base. There is considerable evidence to suggest that falling asleep at the wheel is now a much bigger problem than drink driving and yet many companies still put a lot of emphasis (quite understandably) on avoiding driving under the influence of drugs and alcohol but are much less proactive about preventing employees driving while tired. In its 'Safe Journey Planner' (see http://www.rospa.com/roadsafety/info/safer_journey.pdf) RoSPA highlights advice which was also introduced in the Highway Code (largely as a result of the excellent work of Professor Jim Horne and his colleague Dr Louise Reyner of the Sleep Research Unit at Loughborough University) about 'caffnapping' as a coping strategy in an emergency (pull over in a safe place, take two cups of strong coffee and sleep for no more than 15 minutes). On the other hand, where we need to do more work perhaps is in investigating the contribution which fatigue and sleep deprivation make to accidents and poor safety decision making in other work settings. It may not just be a case of the sleep deprived production worker making errors due to lapses in concentration but the sleep deprived designer failing to consider a key safety issue at the planning stage of a project. Or it may be the safety lapse by the young person who doesn't sleep at night due to having to comfort a crying baby; or this problem may in reality be compounded be their older supervisor failing to pick up on this because and they too are sleeping badly because they already have too much on their plate, they are drinking too much in the evening and waking everyday in the early hours due to worry and stress.

One of the problems in all this is that while common sense might suggest that poor sleep patterns compromise work safety, available evidence from individual investigations or from epidemiology makes this much harder to establish. As the Police find at the scene of sleep related road crashes, it is very hard to allege what you cannot prove and evidence of sleepiness just before an accident tends to evaporate almost immediately in its aftermath. Nevertheless consideration of sleep deprivation and fatigue ought always to be among factors which are considered in any workplace accident investigation.

Getting people at work to admit that they are sleep deprived is extraordinarily difficult. As with admitting that you are stressed, telling your line manager that you cannot concentrate because you cannot sleep at night will be seen by many as 'career suicide', especially where the same line managers are under intense pressure themselves to deliver.

In many high hazard activities (for example, road transport of petroleum and LPG) responsible employers have for many years required their staff to get adequate sleep before coming to work and not to moonlight or engage in late night DIY etc. But quite rightly employees themselves have on occasions raised questions about the extent to which their managers should have the right to pry into what they are doing in the own homes or even their bedrooms! Understandably sleep is a very private and sensitive issue and needs to be addressed with care and in this sense it is clearly one of those issues that should figure prominently in OH awareness training for managers (especially since most managers still get very little appropriate H&S training and most of the emphasis in such training as is provided is on Safety rather than on Health).

Of course it can be argued that presenting for work in a condition that will enable them to work safely is the employee's responsibility. That cannot be denied. No worker, for example, should drive tired (it's irresponsible, crazy and just not worth it) but at the same time it has to be recognised that people are under enormous pressures, especially balancing work and home commitments. Many employees will try to cut corners and convince themselves that they can cope. What is needed perhaps is a little more honesty all round and some practical measures which demonstrate to everyone at work that the sleep deficit is a real and a legitimate issue and it is something which employers are prepared to take seriously. For example, besides investing in some reclining chairs in a quiet room put aside especially for 'napping', other things which might be considered include: conducting a survey on sleeping patterns and sleep deprivation and reviewing the results; asking OH staff and Employee Assistance lines to focus on the issue in their discussions with individual employees; including the importance of sleep in workplace health education (even advice perhaps on buying the right kind of bed); focusing on sleep deprivation as an issue in anonymised incident case studies; and above all, letting it be known that employees who have admitted being sleep deprived have been thanked for revealing this and have actually been treated positively.

We live in a world which is full of exciting and expanding opportunities on all sides - yet work, commercial and general societal pressures are clearly placing many individuals under pressure to reduce the hours which they devote to the essential, recuperative process of sleeping. This is bad for individuals, bad for families and bad for performance at work, including safety. Let's get this vital topic out into the open and find better ways of helping people to get adequate, good quality sleep that they so badly need.

Sleep on it!

Age concern

➤ **With the government** changing the pension age and workers being encouraged to delay the date of their retirement, RoSPA's occupational safety adviser, ***Roger Bibbings***, examines the growing debate about health and safety and the ageing workforce.

Legislation to outlaw age discrimination in employment and vocational training – *The Employment Equality (Age) Regulations 2006* – comes into effect this October (www.dti.gov.uk/employment/discrimination/age-discrimination/index.html). It will cover private and public sectors and include every member of the workforce, young and old. This means employers will no longer be able to recruit, train, promote or retire people on the basis of age, unless it can be objectively justified.

Age discrimination legislation has been introduced in part to deter employers from unfairly sacking older workers who want to go on working or from deliberately not employing older job applicants just because they might seem to be too old.

There is a lot of interest in this subject but curiously not a lot of clear guidance about the scale of any potential problems that employing older workers may pose for health and safety professionals.

I last wrote about this issue in *Parting Shots* in December 2004 (see: www.rospa.com/occupationalsafety/partingshots/info/chapter17.pdf#nameddest=sep2004). Since then the Health and Safety Laboratory (HSL) published a report (May 2005) entitled *Facts and misconceptions about age*, health status and employability (online at: www.hse.gov.uk/research/hsl_pdf/2005/hsl0520.pdf) which has helped to put age and health and safety into perspective.

The HSL report provides quite a lot of practical advice on steps which employers can take to address the health and safety of older workers but it still leaves quite a few questions unanswered.

Some of the issues which most commonly get raised about older workers' health and safety include:

Behavioural safety: It is often suggested that employing older (and possibly wiser) workers is good for safety performance because they are more likely to avoid hazards and thus have fewer accidents. On the other hand, it is often suggested that as we age there is some deterioration in our cognitive abilities (alertness, concentration, eyesight, hearing, reaction times etc) and this may lead to more accidents due to slips and lapses etc.

There is some evidence in agriculture that older workers may be more predisposed to accidents with farm machinery, and in road safety there is an ongoing debate about safety and older drivers. But there are many companies (such as some of the major utility companies that enter for the RoSPA awards) which put their good behavioural safety performance down to the higher proportion of older workers in their workforces and the moderating effect which this also has on curbing deviant safety behaviours by younger employees.

One point to bear in mind here is that whilst older workers may be good for maintaining a positive safety culture, they can equally be a reservoir of ingrained bad habits.

So what does the evidence from things like 'safety climate surveys' and 'behavioural safety observation programmes' suggest? Well, being old should certainly not be equated with being unsafe or accident prone and where systems require high levels of concentration and consistent operator response, younger workers can also find that they are not immune from impairments and distractions.

Musculoskeletal disorders: It is often suggested that physical deterioration through ageing is likely to render older workers more prone to MSDs such as tenosynovitis, carpal tunnel syndrome etc, frozen shoulder, lower back pain etc. or degenerative conditions such as spondylitis.

We all tend to develop more aches and pains as we get older but how should this affect ergonomic and manual handling risk assessments? It would be worrying if some companies, particularly those that were anxious to limit common law liability, used outputs from risk assessments to set health and fitness-to-work criteria which were too high and thus excluded many older workers.

Jobs need to be adapted to the needs of people as individuals and it is very likely that any older worker who was artificially excluded from physically demanding work simply on age grounds would have a strong case for unfair discrimination at an Employment Tribunal.

Fatigue: However, taking the previous point into account, common sense suggests that older workers are less able to cope with work that involves extreme physical demands. In general, as we get older our strength and stamina reduce and we may need to rest more frequently. We may be less able (or less willing perhaps) to cope with the stresses of shift work. Many older workers may face problems caused by having to stand for prolonged periods. This should not be a barrier to employment but adaptation of some jobs may not be that easy.

Slips, trips and falls: This is a key HSE priority at present. Falls affecting older people, especially at home and in public places, are a big problem and a major cost to the NHS. Osteoporosis is a particular problem for many older women but are there reliable data about how big a problem this is in the workforce? Also, is it actually true that older workers are 'less steady on their feet' when compared say with young men who may be more prone to rushing about?

When undertaking slip, trip and fall risk assessments, we need to look at the accident

data to see if older people are actually over-represented among those having injuries due to falls on the level.

From a '24/7 safety' perspective, there are many things which employers can explore to help prevent falls of older workers outside work. For example, it may be that employers need to encourage appropriate exercise programmes for their older employees for safety as well as health reasons. Tai Chi for the elderly might seem a trifle bizarre but it has a proven record in helping to keep older people mobile.

Pre-existing health conditions: Many older workers present with various age-related health impairments. How significant can these be? How can new approaches to rehabilitation (which the HSE and DWP are currently very keen to promote) help? Looking at specific issues like presbyacusis and exposure to hazardous noise levels, standards of protection from noise at work are now much tighter but compliance becomes ever more important for older workers whose reduced hearing capacity means the little they have left becomes even more valuable to protect. The same point might be made about vibration. Many older workers experience peripheral circulatory problems which can be made worse by exposure to vibrating tools and equipment.

Harmful agents: Where exposure to harmful agents leading to health effects with long latency (carcinogens, for example) is concerned, some people, in the past, have tried to suggest that we should relax control standards for older workers who might not live long enough for disease effects to express themselves. This has been suggested in the past in relation to controlling ionising radiation doses or exposure of women to teratogens where they are beyond child-bearing age. This idea has generally been discounted as unethical. The principle of ensuring higher standards of risk control to young workers was applied early on in the nineteenth century. It would be ironic if the reverse became true for older workers in the twenty-first!

Stress: This is the number one source of work-related ill health days lost but what evidence, if any, is there about the vulnerability of older workers to stress? HSE's *Stress Management Standards* recognise the link between work and non-work related stress. Is there evidence that older workers are more resilient? Or can they be under even greater pressure? And what about issues like controlling risk of violence and ensuring personal safety, for example, for itinerant older workers who may be less agile and robust? Again, it is wise not to harbour stereotypes but to treat people as individuals.

Work/life balance: With people living longer, more older workers (particularly women) are likely to find themselves in a more intense caring role as relatives and dependants become frail and infirm. Where fatigue and stress are a consequence of increased caring, what are the health and safety consequences and how should employers respond? Certainly they should not discriminate simply because someone has become a carer. Indeed bodies like Carers UK have much useful advice that can help employers address any issues this raises (visit: www.carersuk.org).

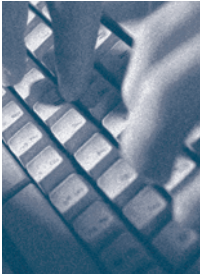
Pre-employment health screening: Employers increasingly are encouraged to ask new employees to undergo pre-employment health screening. The aims of this are: to assess any existing health conditions, to review results against any fitness-for work standards that may have been set, and to establish baselines from which to measure any subsequent deterioration in health which might later be felt to be work-related.

It is important that a fair and objective approach to health screening is adopted for older workers. If organisations set the health standards bar too high, for example, for safety significant jobs such as working at height, driving plant or operating machinery etc, this may lead to unnecessary exclusion of many older applicants.

These are just a few of the thoughts which have occurred to me when talking to colleagues about the issue of older workers and H&S. A sharing of knowledge and experiences, not only between health experts but between health and safety practitioners, could be useful and also provide some evidence as to whether some of the anxieties people have about older workers' H&S are in fact real. As with gender and race, it is very important not to generalise.

RoSPA believes it would be very useful if we could establish better signposting to case studies of how various organisations have addressed these issues in order to move this discussion forward.

Readers with comments or case studies should email: **rbibbings@rospa.com**



August 2007

Parting Shots

Health for safety

➤ **RoSPA** is currently working on advice for employers (or more specifically line managers) on health issues that need to be considered in the context of managing occupational road risk (MORR). The Society's occupational safety adviser, ***Roger Bibbings***, discusses the issues raised when setting health standards across all industry.

I have just read a truly excellent article written by two occupational physicians, Dr Andrew McGregor and Dr Neville Byrne, (published in *Occupational Health at Work* – June/July 2007: 4(1): pp 17-20) about setting meaningful health standards for driving airside at UK airports. What is particularly interesting about their approach is their insistence on the need to tie in the discussion of health requirements for drivers to risk determinants in the airside environment.

There is a network of overlapping duties relating to health in the context of workplace driving (road traffic, civil aviation, health and safety etc). Significantly, *Regulation 6* of the *Management of Health and Safety at Work Regulations* requires employers to *'…ensure that their employees are provided with such health surveillance as is appropriate having regard to the risks to their health and safety which are identified by the assessment'*. This is usually taken to refer to health surveillance required to check up on harmful effects of workplace exposures but, in the context of *Regulation 13* which deals with 'capabilities' (and of course *Sections 2* and *3* of the *Health and Safety at Work Act* generally), there is an implied duty for health surveillance to ensure workers are fit to work safely. For example, those undertaking safety critical work (SCW) where the 'safety case' depends critically on factors such as good communication, colour vision, good concentration, certain physical capabilities and so on, need to be suitably fit.

Surveillance

Many employees and their managers still share in the general perception that health surveillance of workers is 'a good thing'. Most health professionals on the other hand accept that it is only likely to be of value if it has defined, achievable objectives. For example: to determine if the worker's condition may reduce their capacity to perform work; if aspects of their health may be adversely affected by work; or if there is a health problem that may carry an excess risk either to the worker (e.g. if liable to epileptic fits and working at heights or operating dangerous machinery) or to work colleagues or the wider community (e.g. reduced ability to drive safely, risk of infecting food or patients).

Health standards and periodic health surveillance for key staff such as airline pilots, large goods and passenger service vehicle drivers, train drivers, divers, nuclear workers, food handlers, certain healthcare workers – to mention only a few – have been with us for many years. These standards continue to evolve and are generally regarded as non-controversial. Clearly in certain environments you need to be sufficiently healthy to be safe.

The approach to establishing criteria in each setting seems to vary a good deal. And there is not much good data from accident investigations or studies to indicate the precise contribution which health impairments (especially chronic and temporary impairments) make to either accident causation or outcome. This is true not just in environments such as ports or airports (where obviously unsafe vehicle driving on the apron could have severe consequences) but also in transport generally and indeed across the whole occupational safety scene.

In fact, I think it is true to say that few, if any, health standards set for safety critical work are really evidence-based at all. This means, especially at the high hazard end of things, in the absence of hard evidence about exactly which kinds of health impairment are associated with accidents, standards have to be set on a precautionary basis, judging what level of fitness might be reasonably expected to help ensure faultless

performance, particularly in situations where the overall safety case depends heavily on high standards of human reliability. This is the case under road traffic law, for example, where all drivers are required to be fit to drive and conditions such as heart disease and epilepsy have to be notified and assessed.

Yet, when it comes to the detail, it is hard to avoid drawing the conclusion that each authority has evolved its own health standards on an historical basis, basing these on what seems reasonable but keeping them under review.

Interestingly, the Health and Safety Executive's (HSE) *Workplace Transport Safety Route Map* to be launched in September/October (see HSC paper at: **www.hse.gov.uk/aboutus/hsc/meetings/2007/150507/c05.pdf**) makes reference to the need for employers to identify appropriate health standards. The *Route Map* draws together all the relevant regulations and guidance into one framework.

Responding to consultation responses (including those from RoSPA) and other developments, it will now include *INDG382*, HSE's and DfT's guidance on driving at work on the public highway – reinforcing the fact that employers' transport safety management duties have applied on public roads for sometime and have to mesh with DfT requirements.

RoSPA is presently working on advice for employers (or more specifically line managers, as the key audience) on health issues that need to be considered in the context of managing occupational road risk (MORR). DfT is funding this work and the guidance will be similar in style to other online supplementary guidance (to our hard copy MORR guide), which we have developed on a variety of MORR topics (see: **www.rospa.com/roadsafety/resources/employers.htm**).

Assistance

Our underlying premise is that health standards should not be set primarily as a way of excluding people from driving for work but to provide a framework within which those with possible health problems can be identified so that, as far as possible, with suitable support and assistance, they can continue driving safely for work purposes.

The main focus of our publication will be on the health of the millions of workers who have to drive cars and vans to do their jobs and not just on the higher health requirements that may be required for those whose job is driving and who generally drive larger vehicles.

Obviously individual drivers have duties here but so too do employers. We need to encourage an approach, which is balanced and proportionate and does not lead to excessive risk aversion where health problems are identified.

There are clearly challenges involved in establishing suitable health standards for driving in different settings. These may stem not only from the different risk determinants in those settings (which McGregor and Byrne allude to in their article); the problem is also influenced by the expectations of other parties such as employers, unions etc and also by the lack of a broad conceptual framework for setting meaningful health standards for safety critical work generally.

Consideration of exactly how healthy people need to be is clearly of fundamental importance when trying to ensure safety. This issue is not addressed in HSE's guidance on human factors (*Reducing Error and Influencing Behaviour* – HSG48), which was written from a psychological perspective rather than a physiological one. (Chapter One provides the definition and explanation).

'Fitness' is, however, covered (to an extent) in HSG61 (*Health Surveillance at Work*) and HSG65 (*Successful Health & Safety Management*). There is also guidance in Appendix 2 (Medical Standards for Forklift truck Operators) of HSG6 (*Safety in Working with Lift Trucks*), which might possibly be extended to cover work-related transport generally.

What seems to be missing in the HSE toolbox is some sort of basic, risk linked, decision-making algorithm (particularly to meet the needs of managers and non-OH professionals) to help allocate safety critical work health standards in some sort of banding system (from moderately important to absolutely critical).

Of course each field of work has its own special features (and once particular standards become established those involved do tend to get very protective of their own approaches!). And then there is the question of specifying appropriate and reliable clinical methods etc to determine whether standards are met in particular cases. It is certainly not easy territory, particularly when one realises that continued employment for many workers can rest on the way health standards are set and interpreted.

While most of the focus of discussion about minimum health standards and safety critical work is likely to be on permanent and gross health impairments that could adversely affect safe working, in practice the area where line managers need most help is in understanding temporary health impairments (particularly related to issues such as poor sleep quality, stress and anxiety and even heavy colds, flu, migraine etc) that can affect safety.

We now know that falling asleep at the wheel is a bigger cause of impairment in road accidents than impairment due to alcohol (drugs and alcohol seem to be much more on the minds of safety professionals than hitherto), so what about falling asleep or losing concentration during safety critical work, for example, as result of inadequate good quality sleep before commencing work? Again, this is dealt with in areas such as railway safety critical work but not universally.

Data

Clearly the whole debate about health standards and safety critical work is hampered by a lack of good data on the contribution which poor health status actually makes to accidents – and transport accidents in particular.

Pre-employment and periodic medical examinations undoubtedly provide a sense of re-assurance to duty holders (through the ritual laying on of the stethoscope and the pronouncement by a medical practitioner that the worker is fit) but in reality they may often contribute very little to overall safety assurance. They are expensive (in time as well as money) and arguably the resources involved could often be used more cost effectively to enhance safety in other ways.

On the other hand, workers undertaking safety critical work who have less than perfect health, often develop ways of coping which may seem successful until that is they fail to recognise just how much their abilities have deteriorated, and then it can be too late.

As part of its role in bringing safety stakeholders together, RoSPA would be willing to facilitate an exploratory discussion to help define a way ahead on this issue. I would be grateful for reactions to the questions and ideas discussed in this article. Email **rbibbings@rospa.com**

Work and wellbeing

➤ **Dame Carol Black**, the Government's first ever National Director for Health and Work has been gathering evidence and views as part of an inquiry into how to improve and promote the health of the working age population. ***Roger Bibbings***, RoSPA's occupational safety adviser, gave evidence as part of the inquiry and here he explains some of the points he put forward.

As part of her review which started last March, Dame Carol Black has held evidence meetings in various parts of the country to get ideas on issues such as reducing sickness absence rates, setting up staff counselling services and introducing sickness absence management policies, as well as looking at what might follow on from the Health and Safety Executive's Workplace Health Connect pilot, the free service launched by the HSE for small and medium sized enterprises offering impartial advice on occupational health (OH), safety and return-to-work issues.

I attended one of these evidence meetings where I stressed that RoSPA firmly welcomes the inquiry into how to improve and promote the health of the working age population and the need for further innovative action to improve the health of the UK workforce.

I pointed out that although RoSPA's mission is *'to save lives and reduce injuries'* this does not mean that we are only focused on prevention of accidental trauma. RoSPA's activities in the workplace sphere have always embraced health issues – both prevention and fitness for work. Our training, auditing and awards work has always focused on issues such as periodic health monitoring, fitness standards, pre-employment health screening etc and occupational health is always covered in our journals and ebulletins.

That said, a lot more could be done by all stakeholders to develop health promotion activity in the workplace. The workplace (especially in larger higher performing organisations) is often a setting where you can get the attention of a captive audience and harness expertise and positive peer pressure to help workers adopt healthier lifestyles. (Care has to be taken however to avoid corporate interference in personal choices). It can also be a platform for influencing prevention outside working hours too, for example, by promoting '24/7 safety' *(see page 43)*.

But it makes little sense in RoSPA's view, to encourage weight loss, smoking cessation, avoidance of substance misuse or to promote stress coping strategies or return-to-work policies – if workplace health risks remain uncontrolled. (As one HSE colleague said to me, *'It is no use serving your staff salad instead of chips at lunchtime if you expose them to carcinogens all afternoon!'*) And the kind of firm that does not have a proper health and safety policy, has not done any risk assessments, is not monitoring or reviewing performance, is not the kind of company that is suddenly going to get all enthusiastic about healthy lifestyles.

Of course there is a real need to address current levels of sickness absence and to improve rehabilitation but a key point I made to the inquiry is that the priority must continue to be on prevention – on tackling work-related health issues such as musculoskeletal disorders, occupational skin disease, respiratory sensitisation, noise induced hearing loss, asbestos linked diseases and occupational cancer (where a renewed effort is needed, particularly given recent upward revisions in morbidity projections). Stress and mental health problems also remain a major issue.

Given the scale of the health and work challenge, it is of concern that HSE's resources are in a critical condition. HSE has been asked to take a lead on the issue, but over the last five years, in particular, it has had its available resources squeezed considerably. Further cuts are mooted. There are now only seven full-time occupational physicians working in HSE as medical inspectors and twenty five occupational health nurses. Also, there is little sign, despite efforts over the last few years to increase their interest in occupational medicine, that more GPs, for example, have availed themselves of OH training. A capability in occupational health must become a condition of funding for primary care trusts.

But the health and work challenge cannot be met by OH professionals in isolation. Health in the work context is above all a management challenge. Managers at all levels (particularly line mangers) need better training to help them engage positively to help ensure better health outcomes for workers. Most health and safety training for managers, however, focuses on H&S protection not issues like stress, rehabilitation

etc. Similarly most auditing schemes (especially if they are law compliance and not risk-based) do not probe issues such as health promotion or rehabilitation. For example, how well are these issues addressed in standards such as OHSAS 18001?

As part of its response to the inquiry, RoSPA suggested a series of practical steps:

Leadership

We have welcomed the revision of HSC's guidance on directors' health and safety responsibilities (INDG417 – developed jointly with the Institute of Directors) but additional guidance is needed for boards on how to review and lead health performance in organisations.

Key aspects of health such as days lost due to ill health should be included in performance reporting to stakeholders. RoSPA has developed guidance on measuring and reporting corporate H&S performance and target setting. A web portal, 'Going Public on Performance' has been developed (**www.gopop.org.uk**) which encourages organisations to put their H&S performance information in the public domain.

Training

RoSPA is calling for an urgent review of how well 'health and work' issues are being addressed in training for H&S professionals and in proprietary auditing schemes. Organisations say proudly (and with justification) that their people are their greatest asset but provide little or no training to their managers on how to safeguard or promote employees general health and welfare and few organisations have meaningful methods to assess corporate health status.

SMEs

Similarly HSE and all other key H&S system players need to look to see how health and work questions (and solutions) can be integrated effectively into all the various forms of SME outreach. RoSPA's National Occupational Safety and Health Committee is currently examining how SMEs' H&S capability is being assessed in pre-qualification schemes operated by clients, major contractors and training bodies etc. Because the level of interaction with small firms via this route is so extensive it would seem a prime channel for disseminating information on health and work issues.

First aiders

RoSPA would also like to see a much more developed role for workplace first aiders, so they act as local health listeners, wellbeing champions and signposters. There are many trained first aiders in workplaces in the UK, including in those workplaces which do not benefit from having on-site H&S professionals, safety reps or occupational health services.

Because of legislative requirements for first aid provision, first aid training penetrates to SMEs more effectively than H&S training. As safety performance improves and there is less call on their services, many first aiders appear willing and able to take on a wider role. They are on the face of it, an under-utilised resource.

Like safety representatives, first aiders are usually drawn from the workforce and are able to gain the confidence and attention of their peers, often informally. With the right training and support they would seem to be well placed to undertake an important role in disseminating health awareness information and in guiding colleagues in the workplace to sources of information advice.

Local involvement

I also believe there is scope for developing further health awareness packages which can be delivered by appropriate, trained presenters to audiences at a local level. A model here might be provided by the Safety Groups UK DERM project (see: **www.rospa.com/safetygroupsuk/derm.htm**). RoSPA would be interested in training up 'barefoot' OH educators, for example, to talk to groups and in support of Workplace Health Connect activities.

Health events

RoSPA continues to organise 'Exchange' or 'Network' events around the UK, which allow participants to mix and match from advice tables and presenters. The formula is readily adaptable to different contexts and settings and we will ensure we have more 'health and work' issues in these events in the future.

Awards

At present health risks management is covered in the RoSPA awards scheme but we would like to promote a stronger focus. Currently entrants are asked to declare their organisations total days sickness absence (but this is not always forthcoming) and judges look for OH provision and policies on key issues such as stress, substance abuse etc. Many of the entries for the Astor Trophy (The RoSPA Occupational Health Award) however only describe the work of OH professionals in the business rather than corporate strategy for health. RoSPA would welcome advice on how we might better address wider 'health and work' performance issues and also cross-link our scheme with other awards schemes in this area.

24/7 safety

It seems clear that time taken off work due to injuries to employees which happen outside work may account for between three to five times the amount of time lost due to workplace injuries. There would therefore appear to be a strong business case for extending safety life-skills beyond workplace H&S to help employees – and their families – remain safe when not at work.

RoSPA is promoting a three level model:

1) Adapting and extending H&S information and training programmes delivered at work to encourage employees to apply safety and skills outside the workplace, for example in the home, while driving and in leisure pursuits.
2) Inviting community based safety programmes (on road, home, fire safety, for example) into the workplace to deliver their safety messages directly to employees.
3) Encouraging organisations to become safety champions in their own communities, for example, by supporting local groups and LASER activities *(see below)*.

Safety education

RoSPA is passionate about the need to extend safety and risk education as a spiral thread in the National Curriculum, particularly in key subject areas and as part of PSHE (personal, social and health education).

At a local community level we are heavily involved in developing the LASER movement (**L**earning **A**bout **S**afety by **E**xperiencing **R**isk – see: **www.lasersafety.org.uk**). There needs to be further discussion on what can be done to widen the engagement of young people around health risks, particularly as they start work.

Going forward

RoSPA believes that the artificial separation of 'safety' from 'health' has been one of the reasons why action to tackle health issues at work has been so slow. We are keen to play our part in taking forward Dame Carol's agenda. For details about the inquiry, see: **www.workingforhealth.gov.uk**

Readers' views welcome.
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