TUC

Occupational health
Dealing with the issues

A TUC Education
workbook for union reps

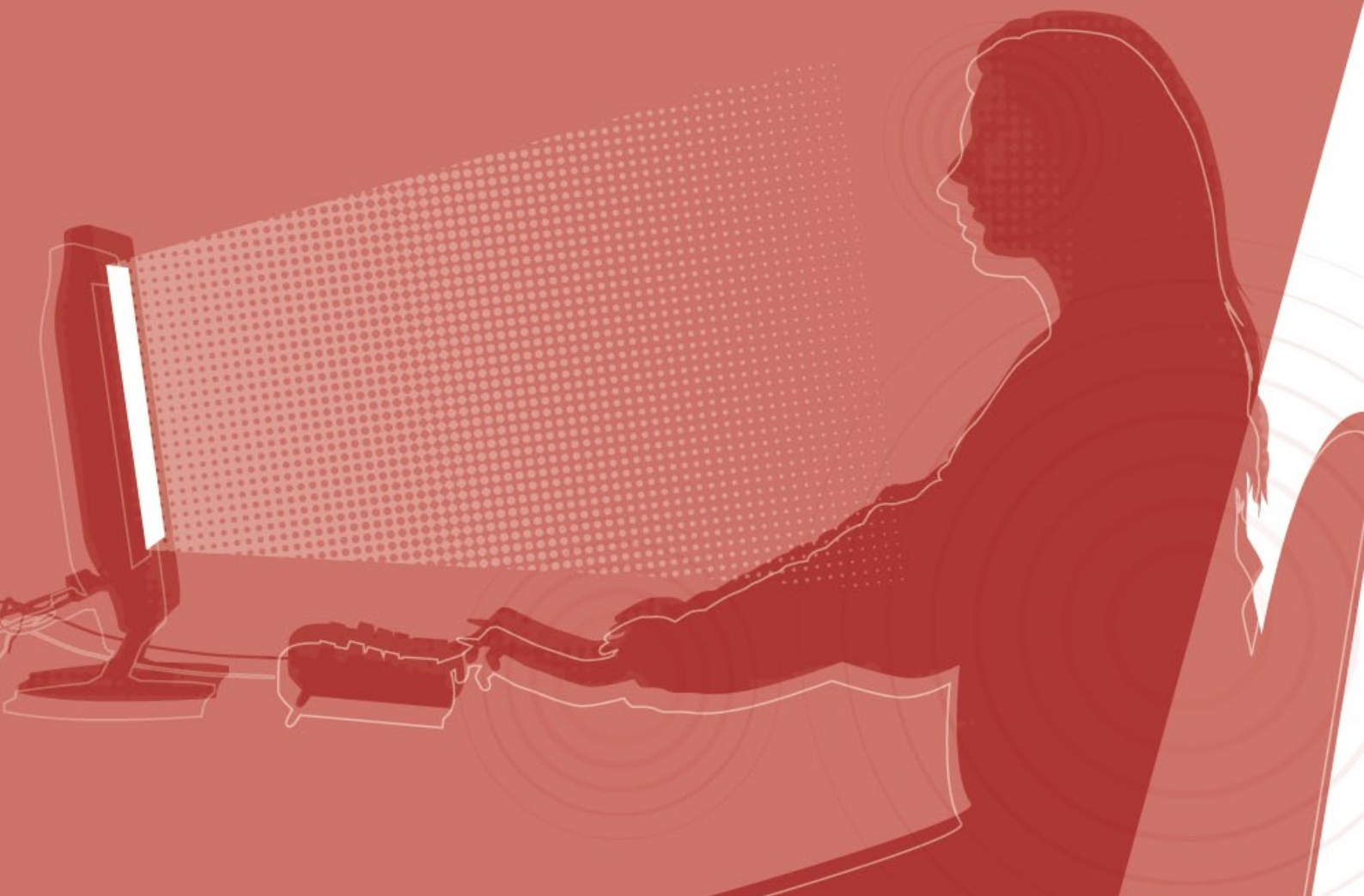# Acknowledgements

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Foreword

The role of safety representatives has always been clear; it covers not just safety but also health. Yet many employers involve safety reps only in safety issues. The TUC wants to ensure that employers fulfil their duties by consulting with safety reps across the whole range of health, safety and welfare issues. That means building safety reps' confidence in dealing with health issues.

The primary role of unions has always been, and must remain, preventing people becoming injured or made ill through work. However, when people are ill they need support. In recent years, the Government has started to put much more emphasis on what it calls the 'well-being' agenda, encouraging employers to tackle the wider health agenda. This is to be generally welcomed, but without access to decent occupational health services and rehabilitation when injured or ill, this will make little difference at workplace level. Instead workers find that often the 'well-being' agenda ends up being used as a smokescreen by management to crack down on sickness absence and force people back to work before they are ready.

This is the first TUC Education workbook on occupational health. It aims to give safety reps the tools they need to tackle occupational health issues and promote a climate in the workplace where people feel supported when they are ill and are given access to the services they need to ensure that they return to full health. It is designed to be used in a range of courses: all reps have a role to play in supporting members who suffer from ill health.

I hope you will find this resource useful. As ever, please feed back any views on the book to TUC Education.

Brendan Barber
General Secretary, TUC

Introduction

Tackling occupational health (OH) problems is one of the biggest challenges facing the trade union movement. Work-related sickness absence is on the increase and both employers and the Government have recognised the need to respond. One of the issues for trade unions is whether these responses are adequate to deal with the scale of the problem. Areas for discussion include:

- the framework that should be put in place to prevent work-related ill health
- the framework that should be put in place to rehabilitate and support workers who have suffered ill health
- how occupational health services should be funded
- how occupational health services can best be delivered
- how to ensure equality of access to all workers
- how unions should respond to the increased use of sickness absence management in capability/disciplinary cases
- how unions can contribute to the focus on 'lifestyle issues' promoted by some employers and the Government
- how unions can ensure that priority health risks like stress, bullying and musculoskeletal disorders (MSDs) are properly addressed.

Inevitably there will be different views on how these issues are tackled. This book is designed to encourage this debate. The TUC view is outlined at the end of each section.

Aims of this workbook

As well as encouraging a debate, this book is designed to help union reps understand the importance of OH by:

- assessing the scale of the OH problem in the workplace and in the UK
- understanding the components of a good occupational health service (OHS)
- comparing standards in other workplaces and countries
- reviewing rehabilitation and sickness management procedures
- examining existing state provision
- reviewing the legal duties on employers
- assessing the quality of their own OHS
- analysing a range of OH issues
- developing campaigns at local, regional and national level.

How to use this book

This workbook is a resource for all trade unionists and can be used in a number of ways:

- as a reference for discussions with employers about OH provision at work
- as a reference for raising membership awareness
- as a campaign tool for action at local, regional and national level
- on TUC Education and union courses.

In each section there are checklists and other tools that can be applied to different aspects of OH. Each section also has activities designed to review and create change in the workplace.

Things to find out

The activities in the book will be most useful if you have been able to find out information from your union and your employer. If you get the opportunity, try to find out about the following:

1. The union

Members

Speak to a cross-section of your members and ask them:

- what they see as the main OH issues
- what they know about how OH is managed in the organisation
- **if** they have had a work-related absence
- what if they thought of the quality of the support they received during the illness and on return to work
- what they think the union should be doing on OH issues.

Union officers and reps

Speak to branch officers and other reps and ask them:

- the five questions above
- if they know of any information and reports on OH produced by management
- if they have been involved in any discussions with management on the provision of OHS
- if they have any information on OH performance in the organisation
- whether they have dealt with any case work involving an OH issue

- if they have dealt with case work involving the use of sickness absence management procedures.

2. Management

Speak to a member of management who has responsibility for occupational health services (OHSs) in the organisation. If some or all of the service is contracted out, try to arrange an interview with someone from the company supplying the service. Useful information to ask for includes:

- copies of any reports on OH management performance, for example monthly/annual reports to the health and safety committee; audit reports
- copies of ill health statistics, including any identifiable trends since the year 2000
- a copy of the rehabilitation policy
- a copy of the sickness absence policy
- a copy of policies on particular aspects of OH, for example, stress, MSDs, asthma etc.

In addition, try to find out the following:

- current staffing levels for OHS delivery
- the role of the OHS in risk assessments
- the role of the OHS in implementing risk control measures
- access to specialist services where required, for example ergonomic advice
- the types of environmental monitoring that are carried out
- the types of health surveillance that are carried out
- the role of the OHS in fitness for work referrals
- the role of the OHS in rehabilitation of sick workers
- the role of the OHS in sickness absence procedures
- the role of the OHS in counselling
- the role of the OHS in health promotion
- the role of the OHS in first aid provision.

Not all of this information will be relevant in every workplace. Don't forget you have legal rights to be provided with this information (see page 20). In order to maximise the feedback you receive it can be good to put the request in writing and then follow it up with a meeting at an appropriate time.

1. Occupational health: a long history, short on results

Background

Occupational health (OH) goes back a long way – in fact thousands of years. But are things getting better?

400BC The environment and its relationship to workers' health was recognised when Hippocrates noted lead toxicity in the mining industry.

100AD Pliny the Elder, a Roman scholar, identified health risks to those working with zinc and sulphur. He devised a face mask made from an animal bladder to protect workers from exposure to dust and lead fumes.

1200-1500
Guilds worked at assisting sick workers and their families.

200 The Greek physician Galen accurately described the pathology of lead poisoning and also recognised the hazardous exposures of copper miners to acid mists.

1556 The German scholar Agricola advanced the science of industrial hygiene when, in his book *De Re Metallica*, he described the diseases of miners and prescribed preventive measures. The book included suggestions for mine ventilation and worker protection, discussed mining accidents, and described diseases associated with mining occupations, such as silicosis.

1700 Bernadino Ramazzini, known as the 'father of industrial medicine', published the first comprehensive book on occupational health, *De Morbis Artificum Diatriba* (The Diseases of Workmen). The book contained accurate descriptions of the occupational diseases of most of the workers of his time. Ramazzini's work had a huge affect on the future direction of industrial hygiene, specifically his assertion that occupational diseases should be studied in the work environment rather than in hospital wards.

1774 Percival Potts established a link between exposure to soot and nasal and scrotal cancer in chimney sweeps. It became the first official link between the work environment and cancer. The British Parliament passed the Chimney Sweepers Act in 1778.

1743 Ulrich Ellenborg published a pamphlet on occupational diseases and injuries among gold miners. He also wrote about the toxicity of carbon monoxide, mercury, lead, and nitric acid.

AD500

AD1000

AD1500

1833 The passage of the English Factory Acts beginning in 1833 marked the first cross-industry legislative acts in the field of industrial safety.

1888 Matchgirls Strike (see case study, page 16)

1898 The 'evil effects' of asbestos were first noted in the Factory Inspectors report.

1942 Publication of the Beveridge Report. During the nineteenth and twentieth centuries various aspects of industrial disease were studied. However, it wasn't until the publication of the Beveridge Report that any kind of comprehensive plan to tackle them was put forward. This called for the establishment of a national occupational health and rehabilitation service. It was intended that it would run alongside the NHS but it was never acted upon.

1961 and 1963 Factories Act and Offices Shops and Railway Premises Act passed. Both laws contained some references to occupational health issues, although they concentrated primarily on safety.

1972 Report of the Committee on Safety and Health at Work under the Chairmanship of Lord Robens. Paragraph 347 stated: "We have interpreted 'occupational health' as being concerned with preventing ill health through control of the working environment…"

AD1800

AD1850

AD1900

AD1950

AD2000

1845 Friedrich Engels provided a detailed account of the impact of industrialisation in his book *The Condition of the Working Class in England:*

"In Manchester, this premature old age among the operatives is so universal that almost every man of forty would be taken for 10 to 15 years older, while the prosperous classes, men as well as women, preserve their appearance exceedingly well if they do not drink too heavily.

The influence of factory work upon the female physique also is marked and peculiar. The deformities entailed by long hours of work are much more serious among women. Protracted work frequently causes deformities of the pelvis, partly in the shape of abnormal position and development of the hip bones, partly of malformation of the lower portion of the spinal column."

1946 The World Health Organisation defined health as the "state of complete physical, mental and social well-being and not merely the absence of disease and infirmity".

1974 The report led to the passing of the Health and Safety at Work Act and the current regulatory framework.

This framework has failed to address OH issues effectively. With no state scheme in place it has been left to employers to provide a prevention and rehabilitation service.

As a result the UK has one of the worst systems for occupational health services (OHS) in the European Union. This has meant personal suffering for thousands of workers as well as a considerable cost to the economy.

Definition of occupational health

In 1946 the World Health Organisation (WHO) defined health as the "state of complete physical, mental and social well-being and not merely the absence of disease and infirmity".

It was this definition that the European Court of Justice (ECJ) used when the UK Government challenged the legal basis of the adoption of the Working Time Directive. The court rejected the Government position – that health and safety related only to physical conditions and risks in the workplace and so could not be concerned with the length of a working day. This led to the introduction of the Working Time Regulations in 1998.

The Occupational Health Advisory Committee (OHAC) is part of the Health and Safety Executive (HSE). In 1998 it produced a report that described OH as:

- The effect of work on health, whether through sudden injury or long-term exposure to agents with latent effects on health, and the prevention of occupational disease through techniques which include health surveillance, ergonomics and effective human resource management systems.

- The effect of health on work, bearing in mind that good occupational health practice should address the fitness of the task for the worker, not the fitness of the worker for the task alone.

- Rehabilitation and recovery programmes.

- Helping the disabled to secure and retain work.

- Managing work-related aspects of illness and helping workers to make informed choices regarding lifestyle issues.

The above is an extract from the OHAC's *Report and Recommendations on Improving Access to Occupational Health Support, found* at www.hazards.org

The HSE has identified two aspects of OH.

The first and most important aspect is the effect of work on employees' health and the health of others. This includes:

- identifying what can cause or contribute to ill health in the workplace

- determining the action required to prevent people being made ill by work, based on a well-informed assessment of the risks; and

- introducing suitable control measures to prevent ill health, such as back pain arising from working conditions.

In the UK there were 175 million working days lost to sickness absence in 2006, costing organisations around £650 per employee.

The second aspect is to ensure:

◗ that people with health conditions, or who have a disability or impairment, are not unreasonably prevented from taking up job opportunities; and

◗ that people at work are fit to perform required tasks, for example, by adapting work practices for people with conditions such as epilepsy or asthma, or making sure that people working in compressed air are fit to do so.

The scale of the problem

The WHO and International Labour Office (ILO) estimate that there are two million work-related deaths every year. It also estimates that only 10–15 per cent of workers have access to a basic standard of OHS.

In the UK there were 175 million working days lost to sickness absence in 2006, costing organisations around £650 per employee. A large percentage of this absence is caused by work. According to the 2006/07 Occupational Health Statistics Bulletin, over 2 million people a year suffer from ill health that they believe was caused or made worse by their current or past work.

Other surveys suggest the total is much higher. In the 2005 European Working Conditions Survey, 20 per cent of workers interviewed in the UK thought they had work-related ill health problems.

The HSE has traditionally estimated costs for three types of stakeholder: individuals, employers and society.

The total costs in billions are estimated as:

Individuals: **£10.1 to 14.7**

Employers: **£3.9 to 7.8**

Society: **£20 to 31.8**

Revitalising health and safety

A set of targets were introduced by the Government in 2000 to try to address this problem. The Revitalising Health and Safety Strategy, launched in June 2000, set three national targets for improving health and safety performance by 2010:

◗ to reduce the incidence rate of **fatalities and major injuries** by 10 per cent;

◗ to reduce the incidence rate of cases of **work-related ill health** by 20 per cent;

◗ to reduce the number of **working days lost** per worker from work-related injury and ill health by 30 per cent;

◗ and to achieve **half** the improvement under each target by 2004.

The 2006/07 figures show that 36 million working days were lost to ill health at work. Comparing this with the previous year this represented a 10 per cent **increase.**

The HSE set out its technical approach to measuring progress against the Revitalising targets in a Statistical Note published in 2001, available at www.hse.gov.uk/statistics/statnote.pdf. Among other things, this said that a report on progress would be prepared each autumn, comparing the latest data with those for the base year (1999 or financial year 1999/2000).

The figures for 2007 suggest that the reduction in the incidence rate of **fatalities and major injuries** is **on track**. However, the figures for OH are not so good. The two key indicators, **work-related ill health** and **working days lost,** are **not on track.** The number of days lost due to ill health rose in 2006/07 whereas days lost from injuries fell. The national target reductions in the table below have **not been met.**

	National target
Incidence rate of ill health 2006/07 figures compared to 1999/2000	14% reduction
Incidence rate of ill health 2006/07 figures compared to 2004/05	4% reduction
Working days lost 2006/07 figures compared to 2001/2002	21% reduction
Working days lost 2006/07 figures compared to 2004/05	6% reduction

The role of trade unions

Safety and health has always been at the top of the union agenda.

Case study 1:

Health hazards in Bryant and May, 1888

One of the most famous strikes in history, the Matchgirls Strike of 1888, had the disease of 'phossy jaw' (phosphorus necrosis of the jaw) as a central issue. The publicity generated and its success was important in the growth of general unions representing 'unskilled' workers. The company banned the use of yellow and white phosphorus in 1901. Eventually there was an international ban introduced by the Berne Convention in 1906, implemented in the UK in 1908.

The 'safety representative revolution' that started in the 1970s illustrates how workers have increasingly tried to influence working conditions that are making them sick.

Case study 2:

Stress on the buses in 1979

Eddie Read, an NUR safety rep on Hants and Dorset buses, realised that a disproportionate number of his members were forced into early retirement or were dying as a result of heart conditions. During a TUC training course he drew up a stress questionnaire that he distributed in the depot which asked about work-related stress factors. Eddie was amazed by the response, which highlighted major concerns with shift patterns, rest breaks and access to hot meals. He used the results to negotiate changes to rosters and access to canteen facilities that resulted in vastly improved working conditions

Case study 3:

Ergo cabs follow union campaign in 2007

Rail firm Freightliner is improving train cabs after a campaign by drivers' union ASLEF. Union general secretary Keith Norman says the company's production director has given an assurance that the company is "more than happy to involve ASLEF as much as possible in the ergonomics of any new cab design". The union leader commented: "Freightliner has responded in a positive way to the concerns the union has raised in our Squash campaign – which called for radically improved cab conditions that are safe, healthy and modern." The company has ordered 30 locomotives from US firm GE Transportation Systems. It has also said it will improve seats, blinds and air-cooling on existing locos.

Trade unions have been a crucial element in the development of occupational health standards. Unions identify the problems and then campaign to ensure improvements.

When improvements in law have been made, unions have an equally crucial role in ensuring that they are implemented. The research done on the 'union effect' is contained in the TUC publication *The Union Effect: How unions make a difference to health and safety*. Studies show that workplaces with a trade union presence have a significantly lower injury and illness rate. The Government acknowledged this union effect in a DTI (now the Department for Business Enterprise and Regulatory Reform, DBERR) paper published in 2007, estimating that safety reps prevent between 3,000 and 8,000 work-related illnesses per year (DTI Consultation Paper *Workplace Representatives: A review of their facilities and facility time*).

Identifying the problem

There is still a tendency to view occupational diseases and illness as being things of the past, mainly related to industries such as mining and heavy engineering. The reality is very different. Despite huge advances in technology and changes in the labour market, the *International Journal of Occupational and Environmental Health* has claimed that "never in history has there been so much occupational disease as exists in the world today".

Much of this is because of the emerging problems of new jobs and new work methods.

Official statistics fail to recognise many of the occupational diseases that are now leading to long-term illness. The estimates of 36 million days lost a year are, according to a report in *Hazards* magazine, an underestimation as many people are unaware that their illness is work-related. This is particularly the case with many musculoskeletal disorders (MSDs), occupational asthma, noise-induced hearing loss, and stress-related illness.

Trade unions have a long history of identifying occupational ill health. Often they are in the best position to make judgements about what is causing work-related ill health. A range of techniques has been developed to help with this:

- **Inspections** – Using the legal rights to carry out general and specific inspections of workplaces.

- **Ill health investigations** – Using the legal rights to carry out investigations of notifiable diseases.

- **Checking records** – Using the legal right to inspect documents.

- **Surveys** – A simple questionnaire is probably the easiest way to get information from members on ill health in an organisation.

- **Participation in safety committees** – These can be important forums when identifying health issues.

◗ **Mapping techniques** – Hazard and body mapping are visual techniques that can be an effective way for reps and members to identify common problem areas and issues. *Hazards* magazine has produced a range of resources to assist with this.

www.hazards.org/diyresearch/images.htm

Outside help

Sometimes reps will need assistance to either find issues or get advice on how to deal with them. There are no legal rights on this, with the only reference being Guidance Notes in the SRSC regulations:

Guidance Note 31

Where technical matters are involved the appointed safety representatives may find that the necessary expertise is not available within the undertaking. The employer and the safety reps may wish to seek advice from outside the undertaking, for example from appropriate universities or polytechnics. The Commission considers that arrangements should be agreed as to the persons from such institutions who may be called upon. If the representatives wish to have advice from their own technical advisers, such advisers may be called in where this has been agreed in advance with the employer. A copy of any report specifically relating to health or safety matters made to the safety reps should be made available to the employer.

Over the years there have been numerous examples where work-related diseases have been recognised by workers and trade unions but where employers and the medical and the political establishment have lagged behind. Examples include:

◗ asbestos-related disease

◗ heart disease

◗ cancer

◗ musculoskeletal disorders

◗ allergies

◗ reproductive problems in men and women

◗ stress-related disorders

◗ psycho-social disorders.

Worker surveys can be a powerful tool in both identifying problems and then getting employers and the Government to act.

Surveys

A simple questionnaire is often the easiest way to get information from members on ill health. The results can be invaluable when in discussions with employers about control measures.

Survey checklist:

◗ Keep it simple. Not only will it be easier for you to complete, it will be easier for you to analyse.

◗ Use a standard questionnaire to help compare the results.

◗ Keep it anonymous. If you want members to be honest and open they need to know that the replies cannot be traced back to them.

◗ Make sure you get enough information so that you can identify any problems among a particular group or workplace. If necessary ask questions about the type of job the member does and where they work. It may also be useful to know if they work full or part-time

◗ In big organisations, work together with other safety reps to cover the whole of the workforce.

◗ Always give members feedback on what you have found.

For more on surveys look at the USDAW survey on bullying in the booklet *Let's Put a Stop to Bullying at Work*, available from www.usdaw.org.uk

Mapping techniques

Mapping techniques offer a visual way of recording health problems. Mapping can also be used to produce pictures of conditions that existed years before.

According to the ILO there are a number of reasons to use mapping:

◗ it involves members, and shows them they are not alone

◗ it is participatory and develops a collective approach

◗ it encourages discussion and analysis

◗ it is simple to use

◗ it uses members' experiences and knowledge to paint detailed pictures of their working conditions

◗ it is more easily and widely understood than most other data

◗ it helps overcome problems of literacy and language differences

◗ it can be good fun.

There are two main types of mapping – body and hazard. For body mapping you will need front and back body outlines. You can draw these yourself or download then from www.hazards.org.images/blankbodymap.gif

Safety reps' rights to occupational health information

Safety reps need to have a good understanding of the extent of the problem in the areas they represent. Having accurate statistics on work-related ill health can help them:

- prioritise areas/departments that need improvements

- back up requests to employers for increased resources for OH

- provide a useful benchmark to assess workplace standards against national and sector averages.

Employers should provide this information but often they don't have it themselves. If they do have it, they may not release it to the union.

This means knowing what your legal entitlements are if you are encountering problems getting information from your employer.

Management of Health and Safety at Work (MHSW) Regulations 1999

Health and safety arrangements

5. - (1) Every employer shall make and give effect to such arrangements as are appropriate, having regard to the nature of his activities and the size of his undertaking, for the effective planning, organisation, control, **monitoring and review of the preventive and protective measures.**

This requirement implicitly requires employers to monitor and review OH performance. Employers are therefore under an obligation to show how they do this. One obvious way is to produce statistical evidence.

The Safety Representatives and Safety Committee Regulations (SRSC) 1977 provide a mechanism to obtain this evidence:

> SRSC Reg 7(1) Safety representatives shall for the performance of their functions under section 2(4) of the 1974 Act and under these Regulations, if they have given the employer reasonable notice, be **entitled to inspect and take copies of any document relevant to the workplace or to the employees the safety representatives represent** which the employer is required to keep by virtue of any relevant statutory provision within the meaning of section 53(1) of the 1974 Act except a document consisting of or relating to any health record of an identifiable individual.

This does not specify OH information but unions can use the Code of Practice to reinforce this request. There are five parts to the code of which three are particularly relevant:

SRSC Code of Practice 6

The Regulations require employers to make information within their knowledge available to safety representatives necessary to enable them to fulfil their functions. Such information should include:

a) **information** about the plans and **performance** of their undertaking and any changes proposed insofar as they affect the **health** and safety at work of their **employees**

b) information which the employer keeps relating to the occurrence of any accident, dangerous occurrence or **notifiable industrial disease** and any **statistical records** relating to such accidents, dangerous occurrences or cases of **notifiable industrial diseases**

d) any **other information** specifically related to matters affecting the **health** and safety at work of his employees, including the results of any **measurements** taken by the employer or persons acting on his behalf in the course of checking the effectiveness of his health and safety arrangements.

SRSC Reg 9 Safety Committees

The Guidance Notes issued as part of this regulation contain the following references under 'Objectives and functions of safety committees'*:

"GN 41(a) The study of accident and **notifiable** disease statistics and trends, so that reports can be made to management on unsafe and unhealthy conditions and practices, together with recommendations for corrective action…"

Safety reps need to be aware that the specific requirements in the code of practice and guidance refer to **notifiable** disease statistics. This limits the duty to those diseases specified in the Reporting of Injuries, Disease and Dangerous Occurrence Regulations 1995. If this proves to be an obstacle to getting more extensive information on work-related illness it will be important to try to get an agreement to broaden the requirement. The arguments to justify this are:

- the list of notifiable diseases is too narrow and excludes a number of important occupational health conditions

- compliance with the duty to monitor should cover all economic loss suffered as a result of work-related ill health

- it is in the employer's interest to know the full extent of work-related sickness absence problems.

Your employer's procedures

There is considerable variation in how much information employers possess on sickness absence. For this reason it will not always be possible to get an accurate picture and make comparisons with national rates. Reasons for this are:

- **First contact** – When you first notify your absence, normally by phone, not all organisations ask for and record the reason and whether it is work-related.

- **Self-certification** – For absences of less than seven days you may not be asked to detail on the form whether you think your absence is work-related.

- **Doctor's certificates** – Not all GPs will identify a relationship between work activity and the ill health they have diagnosed.

- **Return to work interviews** – Some procedures do not require an indication as to whether the absence was work-related.

- **Many employers use a standard letter to GPs asking for information –** This raises issues of confidentiality, particularly in the light of whether the information is provided to the line manager/human resources or just to an OH department.

The TUC view on prevention

The TUC believes that the first priority for the Government in dealing with the current epidemic of occupational ill health must be prevention. In recent years the HSE and local authorities have moved away from seeing their role in terms simply of dealing with occupational safety and have become involved instead with issues around OH. The HSE have been at the forefront of dealing with the prevention of stress-related illnesses and its guidance is among the best internationally. The HSE 'Fit 3' programme has also begun to pay dividends in influencing levels of MSDs.

Unfortunately this work is under threat from the significant under-funding of both the HSE and local authorities, which also have an important enforcement role. Since 1997, the UK workforce has increased by around 9 per cent. In the same time, the HSE workforce has shrunk from over 4,000 to a current figure of just under 3,250. The number of premises the HSE inspect has also gone up by around 20 per cent in the past five years.

The shrinking size of the HSE workforce has already had a significant effect on the service it provides. In the past four years the number of inspections has fallen by 25 per cent, while the number of prosecutions has fallen by 49 per cent. It is hardly surprising that last year saw the highest number of workplace fatalities in five years.

If more resources were to be allocated to prevention then there would be significant gains for the economy, employers, and of course, workers themselves. By preventing people becoming ill or injured through work the economy could save billions of pounds through sickness absence, benefits, medical costs and compensation. Yet the amount the Government gives to the HSE is less than a third of the amount the state pays out in compensation through the industrial injuries scheme.

In addition to the role played by the HSE and local authorities, one of the other most effective tools in preventing injury and ill health is the role of trade unions. There is a wealth of evidence to show that safety reps, safety committees and trade unions play major roles in reducing both injuries and ill health. Research has shown that those employers with trade union health and safety committees

Since 1997, the UK workforce has increased by around 9 per cent. In the same time, the HSE workforce has shrunk from over 4,000 to a current figure of just under 3,250.

The TUC is currently working with the HSE to provide training for at least 10,000 safety reps a year in OH issues and has produced a number of resources for them.

had half the injury rate of those employers who managed safety without unions or joint arrangements. Further studies in 1998 and 2004 have confirmed the general conclusion that a union presence significantly reduces workplace injury rates. But it is not just injuries that trade unions help reduce – it is also ill health.

In its publication, *The Union Effect*, the TUC included a range of case studies showing that where employers and unions work together they can make a significant reduction in the injury or illness rate within a workplace. The HSE has also produced a number of studies on its website.

Unfortunately, the TUC believes that for many in Government and within the OH profession, workplace health provision is something that is done *for* workers rather than *with* workers. The task of making real in-roads into the epidemic of workplace ill health can be achieved only in partnership. That means a partnership with employers, providers, insurers, Government, and the workers and their reps.

The TUC believes that involving union safety reps in the process is likely to have a major impact on the awareness and provision of OH in the workplace.

The TUC is currently working with the HSE to provide training for at least 10,000 safety reps a year in OH issues and has produced a number of resources for them. However, much more needs to be done to involve safety reps in the workforce.

If the Government and HSE were to increase the ability of safety reps to be effective by increasing their legal powers, and also encourage employers to work more closely with unions, then there would be a significant difference in the number of people becoming injured or ill as a result of their working environment.

In recent decades there has been a significant shift towards smaller employment units. That means that the traditional model of one safety representative covering a specific workplace or part of a workplace is often no longer practical and other models need to be developed, with safety reps able to operate across a number of employers or a number of workplaces, for example.

In addition, the low number of inspectors and workplace inspections mean that more use should be made of the

existing 200,000 safety reps, who could provide invaluable assistance to the enforcing organisations. The TUC has long called for safety representatives to be given the ability to issue notices to employers that they are breaking health and safety law and to give them the opportunity of rectifying a breach prior to the enforcing body becoming involved. This system has operated successfully in Australia and would be ideally suited to the UK.

The TUC also believes it is important that safety reps' role in the OH field is better recognised and that they be designated 'health and safety representatives' rather than safety representatives.

There is also far more that should be done to ensure that employers take health and safety seriously. Penalties that can be levied against those who are prosecuted are, by the Government's own admission, too small, and the lack of a specific duty on directors means that there is little incentive on directors to consider the health of their workforce when making decisions.

Equally, there is no requirement on employers to report their safety performance, let alone audit it. In its report on improving access to OH support, the Occupational Health Advisory Committee recommended that the Government look at the use of a mandatory self-audit by employers on the health and safety performance of their organisation, into which healthy-living issues could also be built. The TUC believes this would force employers to consider the adequacy of health and safety arrangements and prompt management in larger workplaces to question their arrangements. This approach would be particularly useful for SMEs.

Of course unions will only be able deliver on health and safety if they are properly organised. That means ensuring that all workers are members of the union and that there are enough safety representatives and other union representatives within the workplace. It also means having a strong and effective safety committee.

OH is a good issue for unions to use when recruiting and organising. There is detailed advice on health and safety and organising on the TUC website (see Contacts and resources, page 144).

Activity – Attitudes to occupational health

> ## Aims
>
> To help you:
>
> - examine a trade union approach to occupational health
> - raise awareness about the union role.

Task 1 – Individual

Look at the statements below. Indicate whether on balance you agree or disagree with each one. Note down reasons for your decision.

a) Unions do not have the expertise or resources to influence standards of OH.

b) Unions have safety reps, whose main job is to prevent injuries. It is not their job to deal with OH issues.

c) OH services provided by the employer will sometimes be biased in their favour because they provide the funding.

d) If unions prioritise things like sickness absence it will do more harm than good. For example, it will throw the spotlight on members who abuse the sick pay arrangements.

e) It is not the job of a trade union to get involved in 'lifestyle issues' such as obesity, smoking, drugs and alcohol.

Task 2 – Groups

Compare your responses to each statement. For each statement record the majority view and the reasons for it.

Report back

Appoint one person to give the majority view with the main reason for the decision in each case.

Activity – Issues in your workplace

Aims

To help you:

- ◗ evaluate any experience of using surveys or mapping
- ◗ practice developing a membership survey.

Task 1 – Individual

Choose a work-related ill health problem that you know or suspect is relevant to your members. You will then be allocated to a group dealing with that issue.

Task 2 – Groups

In your group prepare a report on the following:

1. Compare any experience of using surveys or mapping techniques to identify health problems. Identify anything that worked well and anything that did not.

2. Draft five questions to use in a short survey on the health problem you want to investigate.

Report back

Task 1 – If you have identified any successes or problems record them on a flipchart headed 'Guidelines on carrying out ill health surveys'.

Task 2 – Put your five questions on a flipchart for course discussion.

Activity – How big is the problem in your workplace?

> **Aims**
>
> To help you:
>
> - establish the extent of work-related ill health
> - establish the number of working days lost due to work-related injury and ill health.

Task 1 – Individual

Fill in the worksheet on the next page

Task 2 – Pairs

In pairs compare the information in your worksheet. Use the information to help you complete the tasks below:

1. Look at the sample letter and table. Adapt the letter or table to suit your organisation, taking account of any information you already have.

2. Decide how and when you will send the request for information. Remember to keep a copy of what you send and the date you sent it.

3. Outline any problems you anticipate in obtaining this information

Report back

Appoint one person to describe:

- any important gaps in your information about occupational health
- potential problems obtaining the information.

Worksheet – The procedures for obtaining ill health information in your workplace

Answer the questions below to establish the current state of play in your workplace.

1. Who is responsible for producing statistics on health and safety performance in your organisation?

Name

Job title/department

If you don't know, who are you going to ask to find out?

2. What information do you currently receive on occupational ill health? For example:

   ◗ general statistics

   ◗ specific statistics, e.g. stress absenteeism

   ◗ reports from the OHS

   ◗ are your rates of ill health/number of days lost statistics produced on a calendar year or cross-year basis (e.g. 2006/7)?

   ◗ how is this information provided to you e.g. example, frequency/format?.

3. Is work-related ill health recorded?

   Staff absence: do staff have to indicate the reason they are off sick – either when they phone in or when they return to work?

   If they do have to specify their sickness, are they expected to indicate whether it is work-related?

   Other indicators: results of exit interviews with leavers; numbers of past, present and anticipated civil cases for compensation; grievance cases that have an occupational health dimension.

   If work-related ill health is recorded, do you think it is an accurate record? If not, is the organisation tackling this?

4. Has your organisation established its own targets for reducing the incidence rate or days lost from occupational ill health?

Sample letter to request information on occupational health

Date

Dear

Request for information regarding occupational health in the organisation

I would appreciate it if you would supply me with the information in the attached table. We need these statistics in order to assess the effectiveness of occupational health and whether it is improving or deteriorating. If any of this information is not currently available please indicate whether it can be provided, with a target date for when it can be made available.

In order to make an assessment over a period of time it would be useful to have the figures for 2001/02 as a benchmark. This will allow us to make a comparison with the Government's Revitalising Target benchmark for the period 2000–2010. The statistics for 2004/05 will also provide a comparison against the Government's Public Service Agreement targets.

This information will be extremely useful in identifying trends and provide us with some of the evidence we need in order to keep our occupational health strategy under review. If you cannot supply the information requested I would appreciate it if you would outline the reasons why and forward me an action plan indicating the measures you need to take and when you think this information will be available.

Yours sincerely,

Summary of occupational health performance table

Year	Number of workers	Number of cases of work-related ill health	Incidence rate of cases of work-related ill health*	Number of working days lost per worker from work-related injury and ill health**
2001/02				
2002/03				
2003/04				
2004/05				
2005/06				
2006/07				
2007/08				

*The ill health incidence rate refers to the frequency of absence and is calculated by:

▶ Number of ill health absences divided by the number of workers

**The working days lost incidence rate is calculated by:

▶ Number of sickness days divided by the number of workers

Worksheet – Assessing your employer's response

This is a follow-up task to the previous activity. It may take a while before you get a response to your request for information. When you do:

1. Assess the response from your employer. If your request was not met, draft a reply to management. Include a reference to any legal rights.

2. Assess any information that you have been able to obtain and prepare a report evaluating the results.

Questions to ask include:

- ◗ Do you think the figures are a true reflection of the state of work-related ill health? If not, why not?

- ◗ Can you draw any conclusions about the performance of your employer against national targets?

Notes

2. Occupational health services: current provision

- ◗ Range of services
- ◗ Legal standards: employer's duties
- ◗ Evaluating occupational health services
  - ▷ Consultation
  - ▷ Staffing
  - ▷ Prevention
  - ▷ Equality of access
  - ▷ Environmental monitoring
  - ▷ Health surveillance
  - ▷ Other OH services
- ◗ **The TUC view on occupational health provision**
- ◗ **Activity – Reviewing your experience of OHS**
- ◗ **Activity – Assessing OHS in your workplace**
- ◗ **Worksheet – Evaluating OHS**
- ◗ **Activity – Negotiating OHS in your workplace**

Range of services

"A decent Occupational Health Service (OHS) is a real asset. It can troubleshoot health problems and help rehabilitate the sick or injured and accommodate those with disabilities. But these are rare and good ones rarer still."

(*Hazards* magazine)

Key facts

- An HSE survey revealed that only 3 per cent of UK companies use basic but comprehensive occupational health and safety advice.

- A European survey has shown that the UK has the lowest level of OH provision in the developed EU, covering just 34 per cent of workers.

- Historically the UK has had one of the worst records in Europe for the return of employees to work after long-term illness.

- OH support is not widespread in the UK and is often neglected in favour of short-term absence management. Disciplinary measures are the most commonly used response to sickness absence, despite the fact that most non-attendance is due to ill health.

- A June 2007 Investors in People survey found that 17 per cent of employers believed it would be too expensive for them to improve their workers' well-being. Another 24 per cent of bosses said they did not know what action they should take. From the workforce side, almost a third (30 per cent) of employees said that their employers think healthy working is either a wasted investment, a waste of time, nothing to do with them, or that it doesn't mean anything.

An OH service should be seen as a multi-disciplinary service concerned with prevention as well as fitness for work. It is more than just an employee benefit. The prevention of ill health at work is not just a medical problem. We become ill for a number of reasons – exposure to substances, stress, badly designed workplaces, or poor work practices. This means that the skills needed to deal with these problems are not just medical. The interventions needed may be at the level of the affected individual, the team or the task, the workforce, the sector or the working age population.

Ideally the OHS that is provided should be a partnership between doctor, nurse, hygienist, ergonomist, nutritionist, health promotion specialist, physiotherapist, occupational psychologist, health and safety staff, human resources staff, and the workforce through its trade union. It is also important that the workforce has access to other professional services such as designers and engineers.

A European survey has shown that the UK has the lowest level of occupational health provision in the developed EU, covering just 34 per cent of workers.

There is no single model of a good OH scheme. It depends on the nature of the organisation, its size, the kind of work involved, and the service it provides. At a minimum, it should:

- advise on potential risk and any residual risk that may require health surveillance/health monitoring

- recommend solutions to remove/control risk, in partnership with others

- monitor the health of employees and report group trends to senior management and safety reps

- notify senior management of any gaps in compliance with health and safety legislation

- advise on reasonable adjustments and equality issues

- assist with sickness absence management and rehabilitation activities in line with *HSG 249 Managing sickness absence and return to work: An employers' and managers' guide*

- ensure any information collected on individuals in the workforce is managed and stored according to the defined legal and ethical requirements.

In its guidance, UNISON suggests that a good OHS would involve:

- keeping occupational health/medical records

- carrying out risk assessments and advising on preventive measures

- undertaking health screening and surveillance

- undertaking monitoring of the workplace

- investigating accidents

- undertaking sickness absence monitoring

- carrying out health education and counselling

- examining trends in ill health and accidents at work

- assessing fitness for work

- supervising first aid provision

- rehabilitation and return to work programmes.

These functions can be delivered in a variety of ways:

Employers' own schemes

A scheme may range from a single OH nurse to a multi-disciplinary department.

Commercial occupational health providers

These are buy-in arrangements ranging from large multi-national companies offering services through to individual GPs contracting their time.

State services

The UK does not have a statutory OHS. The state currently offers services in the form of:

▶ **HSE/Employment Medical Advisory Service (EMAS)**

EMAS was formed in 1973 following the 1972 Act of the same name. Set up as a source of expertise on OH matters, it replaced the former system of Medical Inspectors and Appointed Factory Doctors and became incorporated into the HSE in 1975.

EMAS is staffed by OH professionals, both doctors and nurses. They are available to give medical advice relating to work to a wide range of organisations, including trade union safety reps and workers. They have the same legal powers as all other inspectors appointed under the Health and Safety at Work Act (HASAWA). But Prospect, the trade union representing HSE professionals, is concerned about EMAS staffing levels and the future of HSE's Corporate Medical Unit. In January 2007 Prospect warned that there was the equivalent of just seven doctors and 26 nursing staff within EMAS. These numbers are likely to fall. The HSE faces a 15 per cent budget cut by 2011 to meet Treasury efficiency targets. Since 2002, it has lost more than 1,000 posts as a result of government spending cuts. The organisation now employs fewer than 3,250 staff.

▶ **NHS/NHS Plus**

The NHS is primarily a treatment service: individual workers who have developed an illness through exposure to health risks at work can be treated, but the link back to the workplace to prevent harm to work colleagues is absent. There are a limited number of NHS consultants in occupational medicine and a limited number of GPs with qualifications in OH. There is no dedicated part of the syllabus on OH in the seven-year training programme of a GP. In theory the NHS should be available for routine matters such as audiology, but in practice the resources are not there.

NHS Plus is a network of OHSs based in NHS hospitals launched in 2000. The network provides an OHS to NHS staff and also sells professional services to the private sector, working to agreed quality standards. There are currently around 90 NHS Plus providers, though they vary a great deal in size. The amount of resource they have available to local employers is limited. See www.nhsplus.nhs.uk for more details.

Community health workplace services

There are a number of OH projects in major cities that use workers and OH advisers to assist medical professionals in GP surgeries to diagnose and treat work-related illnesses. Findings from the projects help improve conditions in local workplaces. These services:

▶ take self-referrals and referrals from GPs and other professionals. This allows workplace ill-health problems to be identified and advice to be given on how to rectify them.

▶ conduct screening of patients in the waiting room. This allows problems in the patient's workplace to be identified before the health problem arises.

▶ gather data on patients seen by advisers. Evaluating this data and identifying emerging patterns allows advisers to promote methods for those at risk to avoid problems.

European models

European models for the provision of OH support vary considerably, In France the system is based on occupational medicine and mandatory medical examinations. This can lead to a wastage of resources on annual 'medicals' that in many circumstances would be better spent on prevention, and leaves little room for a non-medical approach. Scandinavia uses a multidisciplinary model that offers a better approach, but in some of the countries where it is mandatory, links with public health and, sometimes, employees remain weak. Legislation in the Netherlands, aimed at overcoming escalating sickness absence problems, means that all employers have to either secure the assistance of a certified OH unit or establish their own. However there is no penalty for non-compliance except through civil litigation.

Finland is often seen as the leader in OH expertise. Its legislation obliges employers to organise and finance OHSs for all workers, irrespective of the size of the enterprise. Up to 50 per cent of costs can be reimbursed through national sickness insurance if the service meets certain conditions regarding competence and worker consultation. Many services are bought from municipal health centres but employers are free to use private providers or set up in-house services.

In the UK the number of workers with access to a preventive service has fallen dramatically. The expansion of the small firm base and the privatisation of public

services have been major factors in this. It is clear that many employers are not meeting even limited legal duties.

Legal standards: employer's duties

Unlike other European Union member states there are no specific legal provisions in the UK on employers to provide or buy in OHSs. However, the following are relevant:

Health and Safety at Work Act 1974

Section 2(1) places a duty on every employer to ensure, so far as is reasonably practicable, the health, safety and welfare of all their employees.

Safety reps can use this general duty to identify a legal duty where no other more specific law exists.

Management of Health and Safety at Work Regulations 1999

Reg 3: Risk assessment

This enables the level of OH provision to be subsequently identified, for example, the competency and numbers of professionals.

Reg 5: Health and safety arrangements

Every employer shall make and give effect to such arrangements as are appropriate, having regard to the nature of his activities and the size of his undertaking, for the effective planning, organisation, control, monitoring and review of the preventive and protective measures.

This is the closest reference to the provision of an OHS that safety reps can quote.

Reg. 6: Health surveillance

Every employer shall ensure that his 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.

Employers have normally restricted this to assessments made under COSHH (see page 40). Safety reps need to try and broaden the duty out to other types of health surveillance.

Reg. 7: Health and safety assistance

Every employer shall, subject to paragraphs (6) and (7), appoint one or more competent persons to assist him in undertaking the measures he needs to take to comply with the requirements and prohibitions imposed upon him by or under the relevant statutory provisions. The number of persons appointed and the time and means at their disposal must be adequate.

Safety reps can use this in conjunction with the SRSC Regs to assess whether the persons appointed are competent (see below).

Safety Representatives and Safety Committee Regulations 1977

Reg 4A(1)(b) requires every employer to consult safety representatives in good time about their arrangements for appointing or nominating competent persons under the MHSW Regs 1999.

Safety reps have the right to consultation over who is selected to provide OHs.

◗ If no OHS exists this right can be used to trigger formal consultation about the need for 'competent persons'.

◗ If an OHS does exist but you were not consulted, or the necessary competence does not exist, you can use this right to trigger a formal consultation.

Control of Substances Hazardous to Health Regulations (COSHH) 2002

Reg. 11 requires that where it is appropriate for the protection of the health of their employees who are, or are liable to be, exposed to a substance hazardous to health, the employer shall ensure that such employees are under suitable medical surveillance. The Regulation then goes on to specify the circumstances in which health surveillance is appropriate and when health surveillance has to include medical surveillance under the supervision of an (HSE) employment medical adviser or an appointed (by HSE) doctor.

Safety reps need a clear understanding of what substances used in the workplace are covered by this provision.

Working Time Regulations 1998

Health assessments for night workers – An employer must offer night workers a free health assessment before they start working nights and on a regular basis while they are working nights. In many cases it will be appropriate to do this once a year. Workers do not have to take the assessment but they must be offered it. A health assessment can be made up of a questionnaire and a medical examination. The latter is necessary only if the employer has doubts about the worker's fitness for night work. Certain groups like new and expectant mothers and young persons should be given special consideration.

Safety reps could use this as an opening to try to extend this minimum legal requirement to cover all workers.

Data Protection Act 1998

Records containing specific medical information relating to the employee are deemed sensitive data and employers will have to satisfy the statutory conditions for processing such data.

Safety reps need to check that personal information is not being used inappropriately in relation to medical records. Equally, reps should ensure that information they need to support negotiations and consultation is not unreasonably refused by employers quoting the legislation. It is important to emphasise that the DPA does not cancel the rights to information.

Disability Discrimination Act (DDA) 1995

This legislation, among other things, makes it unlawful to discriminate against disabled persons in connection with employment, the provision of goods, facilities and services, or the disposal or management of premises. All employees are entitled to 'reasonable adjustments' where the physical working environment or practice places the disabled person at a substantial disadvantage compared with a person who is not disabled. Disability leave is regarded as a reasonable adjustment under the DDA, and is in accordance with good employment practice as recommended by the Disability Rights Commission.

Safety reps should check that the duty to 'make reasonable adjustments' is applied to occupational health. It has particular relevance when assessing rehabilitation strategies.

Disability Discrimination Act 2005

All public organisations must have a Disability Equality Scheme (DES) in place. Instead of responding to obligations they have to be proactive. A Code of Practice sets out general and specific duties.

Safety reps should check that a DES is in place. There is a duty to consult with employees so check with the union whether this was done.

Reporting of Injuries, Diseases and Dangerous Occurrence Regulations 1995

If a person at work suffers from a reportable work-related disease then it must be reported to the enforcing authority.

If a doctor notifies an employer that their employee suffers from a reportable work-related disease, then they must report it to the enforcing authority.

Reportable diseases include:

- certain poisonings
- some skin diseases, such as occupational dermatitis, skin cancer, chrome ulcer, oil folliculitis/acne
- lung diseases, including occupational asthma, farmer's lung, pneumoconiosis, asbestosis, mesothelioma
- infections such as leptospirosis, hepatitis, tuberculosis, anthrax, legionellosis and tetanus
- other conditions such as occupational cancer, certain musculoskeletal disorders, decompression illness and hand-arm vibration syndrome.

The employer can notify the enforcing authority by telephoning the Incident Contact Centre on 0845 300 99 23 or completing the appropriate online form (F2508A) www.hse.gov.uk/forms/incident/f2508a.pdf The full list of diseases is in the schedule.

Safety reps should check that this duty has been carried out when they suspect that a disease is notifiable. Check the HSE website www.hse.gov.uk under Legislation for the list of diseases.

Other regulations containing medical surveillance requirements include:

▶ Control of Lead at Work Regs 2002; the Ionising Radiation Regs 1999; and the Control of Asbestos Regs 2006.

▶ Offshore Installations and Pipeline Works (First-Aid) Regs 1989, which covers the treatment of workers on offshore installations who become ill at work.

▶ A number of regulations covering fitness for work in specific sectors, including the Diving at Work Regs 1977 and the Railways (Safety Critical Work) Regs 1994.

Safety reps need to identify whether any sector or hazard-specific regulations apply to their workplace.

European Framework Directive

Council Directive of 12 June 1989 on the introduction of measures to encourage improvements in the safety and health of workers at work (89/391/EEC).

The Framework Directive requires a coherent overall prevention policy to be provided. This entails giving a meaningful definition to the concept of service(s) used in the heading of Article 7.

The UK transposition of the directive does not put explicit duties on firms to provide OHSs. Instead, the assumption is that the NHS will fill the gaps.

Some recent enforcement actions support the view that employers have a legal duty to provide OHSs. This is supported by the HSE Operational Circular 'Provision of OHS to employers' OC244/5. Paragraph 8 states:

> "Because of the increasing complexity of health issues in the workplace, it is essential that employers obtain competent advice and assistance, as required in the MHSW Regulations. Inspectors will also need to consider the definition of 'competent' and how this might relate to the employer's particular needs and situation. Employers should be able to demonstrate the steps they have taken to ensure that those who provide occupational health support are competent to do so."

In the section 'Action by Inspectors' paragraph 15 states:

> "If there are clearly significant health problems and occupational health advice has not been sought then inspectors should consider issuing an improvement notice. If there are doubts about the competence of any doctor or nurse who is providing support, EMAS should be consulted."

Date issued: 10 May, 2000

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Case study 1:

Dundee City Council

In October 2006 an employment tribunal ruled in favour of the HSE and said Dundee City Council was in breach of the MHSW Regs 1999 Reg. 5 because it had no management system for health issues in place. A central system encompassing planning, organisation, control, monitoring and review of health issues and OH provision underpinned by integration of OH into risk management activities was required.

Case study 2:

Liverpool City Council

The HSE issued an Improvement Notice to improve the OHS for the 19,000 staff of Liverpool City Council or face legal action. The company operating the service claimed that, apart from hearing tests for call centre workers, it was contracted to provide services only after an employee became ill or was injured. There was no system for carrying out regular checks or screening to protect the health of its staff. A spokesman for the HSE said: "The belief was that the council reacted to illnesses well once they occurred but was not proactive in preventing them."

Case study 3:

NHS Trust

An NHS Trust had fewer OH staff for its size than recommended by the Association of National Health Occupational Physicians (ANHOPS) and a non-OH specialist registrar providing a specialist lead for the OH department. With a financially and professionally compromised OH department the Trust was still able to finance subsidised gym use and aromatherapy for its staff. An Improvement Notice was served by the HSE under MHSW Reg. 3 requiring an assessment of OH needs.

ILO Standards

C161 Occupational Health Services Convention, 1985

Article 2: In the light of national conditions and practice and in consultation with the most representative organisations of employers and workers, where they exist, each Member shall formulate, implement and periodically review a coherent national policy on occupational health services.

Unlike most countries the UK has still not signed up to this convention.

HSE guidance

In the absence of clear legal standards safety reps can refer to official guidance to interpret the general legal duties. The only published guidance from HSE books is Occupational Health Services in Further and Higher Education. The HSC OHAC produces a quarterly newsletter to update current developments.

Evaluating occupational health services

"A properly functioning OHS is not a souped-up first aid service, to patch up the wounded and get them back on the job or to direct the real long-term problem cases to the exit."

(*Hazards* magazine 99, 2007)

Hazards magazine has carried a number of articles giving guidance on this: www.hazards.org/workandhealth

What can go wrong?

There are nine common OHS defects:

- wrong health checks
- ineffective workplace monitoring
- health checks/questionnaires not analysed
- failure to act on recommendations
- ineffective remedies
- failure to appoint competent staff
- failure to take advice from competent staff
- no follow-up measurements
- lack of overall control in the OHS system.

Employers are required to monitor the effectiveness of safety management systems. Any OHS should be the subject of audits. Safety reps should participate in these audits and be provided with the results. The use of the HSE's Guidance HSG 65, *Successful health and safety management,* can provide a starting point for this.

Case studies

Getting it wrong

Case study 4:

Louise Brooks developed arthritis as a result of physically demanding, repetitive work in a shipyard. The 31-year-old was sacked by A&P Falmouth four years after being diagnosed.

The ship repair company was criticised by a 2007 employment tribunal for adopting an 'out of sight, out of mind' approach to her plight and ruled its behaviour amounted to disability discrimination and unfair dismissal. She had been diagnosed with an arthritic type disability and signed off sick in 2002; subsequent medical reports related the condition to her job. After spending the greater part of four years unpaid she was fired in June 2006. The tribunal heard there were at least 15 other suitable jobs Louise could have been offered but wasn't. Louise had been referred to the workplace OHS, which did nothing to help her and nothing to help her keep the job.

Case study 5:

A real life case history

What if you work for a company with a safety officer, access to a doctor, consultants, occupational hygienists, regular visits from HSE inspectors, doctors, nurses and technical specialists? You think you'll not end up sick? A real workplace case history at a UK engineering firm shows that if they don't work together and they fail to take the necessary action, then you are far from safe in their hands.

Year 1: Workers raise concerns about oil mist. The issue is raised at safety committee meetings. Air levels measured. Conclusion: "No risk to health." Occupational hygiene consultant recommends improvements to local exhaust ventilation (LEV).

Year 2: HSE is informed during a routine visit about breathing problems and calls for improvements in health and safety management.

Year 4: Oil mists found to be above exposure limits. Company concludes that no medical surveillance is required. Ongoing health concerns lead to a local GP being asked to see selected employees. The GP fails to diagnose occupational disease.

Year 5: Safety reps ask to be involved when the next survey of oil mist levels is carried out. Complaints made to visiting HSE inspectors.

Years 5–8: Safety committee minutes continue to register concern about oil mist.

Year 8: Industrial hygiene survey concludes "no special risk" from metalworking fluids. Concludes LEV not needed.

Year 9: Further complaints at safety committee meeting. Questionnaire planned and a programme of screening relevant employees offered "if required". One worker advised by NHS doctor he had occupational asthma. Union compensation claim started.

Year 10: HSE reports poor management leads to high risk of inhalation exposure. Says health surveillance should "continue".

Year 11: Local OHS carries out limited health surveillance. A third provider called in to carry out more breathing tests. Not all workers investigated. Occupational asthma identified. No changes made to extraction equipment. HSE puts improvement notices on the plant. Nothing is done. HSE medical team investigates.

Year 12: HSE investigate again and serves further improvement notices. The company plans to employ extraction specialists. As many as 15 current employees have occupational asthma; other affected workers have left the firm. The total number affected could be far higher.

Getting it right

Case study 6:

London Underground Health Improvement Plan

Key objectives included:

- ▶ reducing losses due to mental ill health and musculoskeletal disorder (MSD)
- ▶ early intervention with a focus on improving flexibility in accommodating people with health needs
- ▶ improving integrated corporate information on employee health to better target interventions.

This has led to a reduction in sickness absence of 33 per cent. The success of the plan has been put down to:

- ▶ buy-in from all levels of management, trade unions, local health and safety reps and employees
- ▶ ring-fenced funding
- ▶ getting people involved who are committed
- ▶ getting required administration into job descriptions rather than as an 'add-on' that is easily lost the minute there are cuts or efficiencies.

Case study 7:

Benefits of physiotherapy

It makes sense for your employer to include a physiotherapist in the OH team – or in its contract for services. Numerous studies have shown that physiotherapy helps workers back to work more quickly, reducing sickness absence and lost wages. Good practice is to offer physiotherapy, whether the problem is caused by work or not, to avoid fruitless arguments. The benefits are the same either way. Access should be fast, so referral routes should be short. Other workplaces have used occupational therapists (who design exercises and work activities to speed recovery) – London Transport, for example – or osteopaths. At British Polythene Industries in Leeds the investment paid back twelve times over. Where investment is required, the pay-off period is only a few months. Some physiotherapists have additional training in job design. This is an ideal combination as physiotherapists see the effects of bad design and can advise on remedies.

Case study 8:

CWU initiatives

The Communications Workers Union (CWU) was involved in discussions with Royal Mail to set up a 'Well-Being Board' that oversees OHS provision. The CWU is represented on the board and it has also undertaken independent activities like establishing health forums for men and women. It has carried out awareness-raising activities on stroke and heart conditions and is currently involved in the production of a health manual for members.

Consultation

The law provides for union safety reps to be consulted about all aspects of an OHs (see SRSC Regulations, page 40). If you have not been consulted about the setting up of the service you are entitled to request this. If there was initial consultation but there has been no review of the performance of the OHS, put this on the agenda of the safety committee. Before engaging in consultation you should ensure:

- you understand what is currently provided
- you identify the main areas for improvement; this will vary according to the size of the workplace and the sector you are in
- you compare standards in similar workplaces
- you consult with members, other reps and reps of other unions.

Issues for consultation could include:

- the range of services that is required
- how the service will be provided – either in-house, outsourced, or a combination of the two
- coverage of the service in terms of sites, shifts and types of worker
- qualifications of staff
- work programme and targets
- numbers of staff and their level of competence
- independence and confidentiality of the service
- systems for collecting and reporting ill health information
- procedures for auditing the effectiveness of the service.

Staffing

OHS staff must be competent to at least the standard in the MHSW regulations. This means having the necessary skills, knowledge and experience to do the job. For most services the knowledge will need to be backed up by qualifications in the appropriate specialism. Any qualifications will need to be supported with evidence of continuing professional development to indicate an up-to-date knowledge of the subject.

There are 14 professional bodies for practitioners of OH and together they form a collective group to facilitate discussions on strategic matters, called Professional Organisations in Occupational Safety and Health. The group is administered by the Faculty of Occupational Medicine.

Any staff must show professional standards of confidentiality and impartiality. If they are providing confidential medical information to the wrong people then trust in the service will quickly be undermined. Equally, if they are perceived by workers as a tool for management to facilitate capability dismissals they will lose credibility.

The HSE has identified six questions to consider when assessing competence:

(1) What are the qualifications of the doctor or nurse?

(2) Are they based in the workplace? If not, is the workplace visited regularly?

(3) What experience does the doctor or nurse have of occupational health?

(4) Does it look as if they have things organised properly, i.e. medical facilities, record keeping etc?

(5) What about contractual issues relevant to maintaining competence, i.e. training, provision of information by the employer, continuing medical education etc?

(6) How exactly did the employer secure the services of the doctor or nurse?
(HSE Operational Circular 24/5 *Provision of OHS to employers,* paragraph 12)

Prevention

Applying safety management principles – active and reactive

Only a minority of OHSs place primary emphasis on preventive activities. The results of the 2006 TUC safety reps survey show how limited OHSs are in the UK in relation to preventive services.

Respondents identified that OHSs concentrate on:

Sickness monitoring	63%
First aid	55%
Health surveillance	52%
Pre-employment medical screening	44%
Disciplinary assessments	36%

Access to rehabilitation	35%
Advice on prevention	34%
Treatment	23%
Records that safety reps are given	11%

The preventive role is much further down the list than most other categories including disciplinary assessments. The TUC wants to see OHSs that are based on the principles of prevention. This can be achieved by ensuring the tendering process/job descriptions/organisational aspects of the OH provision is aligned with the needs of the organisation – as identified by work-related ill health data and risk assessments.

There should also be a consistent approach to accident and ill health investigations. The standard approach to a safety/injury accident is usually different to that followed for incidences of ill health. The search for underlying causes rather than just immediate causes is not applied in the same way. For example, an internal transport accident investigation is likely to focus on more than personal factors. It is more likely to consider organisational issues like training, supervision and safe systems. An ill health investigation is far more likely to concentrate on the individual and will not prioritise organisational factors in the same way.

The link between safety and OH is important. The HSE make this clear in Operational Circular 244/5

Paragraph 6: There are increasing demands on employers to consider occupational health, not only to deal with the effects of workplace exposures on health but also the effects of health on capacity to do work safely, i.e. safety critical work; 'human factors'.

Paragraph 7: At the same time there is evidence that the population is ageing and that the proportion of those in work over 50 is rising steadily. Thus, employers increasingly need to take cognizance of naturally-occurring illness and disability and to resolve potential conflict between anti-discrimination legislation and safety implications in the workplace.

Equality of access

The traditional view of health and safety has often resulted in some people being overlooked or marginalised.

Gender

"Taking a gender neutral approach to risk assessment and prevention can result in risks to female workers being underestimated or even ignored and can also fail to address gender related risk factors for men."

The European Agency for Safety and Health has highlighted the need to address the different impacts on men and women at work in its report Gender Issues in Safety and Health at Work (quoted above). The European TUC has produced a report, *The Gender Workplace Health Gap in Europe* (2003), which gives three main reasons why women have less access to preventive services than men:

- female workers' segregation into what are wrongly stereotyped as low-risk sectors and occupations

- the higher concentration of women in small and medium-sized enterprises (SMEs) in the private sector, and in public services where the organisation of prevention is deeply deficient

- the growing contingency (atypical work) of female employment and the scale of part-time work, which is disproportionately carried out by women.

The TUC's Gender and Occupational Safety and Health (G&OSH) Working Party has produced a checklist to help safety reps and others check whether their workplace health and safety policies and practices are gender sensitive. Use the checklist at www.tuc.org.uk/h_and_s/tuc-14179fO.cfm

Workers with disabilities

"Despite changes to the law to protect people with cancer and long-term health conditions from unfair treatment at work, many employers still haven't got the message. Direct discrimination and failure to make adjustments is turning the world of work into a very hostile environment for workers with these disabilities."

The Human Rights and Equality Commission has highlighted the fact that 82 per cent of cancer-related complaints refer to the failure of the employer to make reasonable adjustments. For example women with breast cancer are being pressurised to return to work after major surgery without being given the option of a phased return.

Migrant workers

Many migrant workers do not have proper access to OH services due to their employment status, communication problems and the short-term nature of much of their employment. This is compounded by the fact that they are often employed in jobs with some of the biggest risks to health.

Older workers

Workers, particularly in manual trades, may be reluctant to access OH when they get older, as they are worried about the repercussions. If you are no longer capable of working at high speeds, or in certain conditions, then you may feel vulnerable to ill

health retirement or the sack. Older workers are more likely to be affected by ill health, including conditions such as MSDs.

The Age and Employment Network has produced two publications dealing with these issues:

> *Older women, work and health – Reviewing the evidence* (Nov 2006)

> *Older men, work and health – Reviewing the evidence* (Jan 2008)
> www.taen.org.uk

Categories of worker

Temporary, agency and other types of vulnerable worker may not have the same access to services if they are not contractually entitled. Other groups like shift workers may not have the same access because of availability at certain times of the day. Voluntary workers and those on secondments may also be overlooked in health and safety risk management activities. Currently there is confusion over entitlements and there is a need for a legal framework governing the respective health responsibilities of agencies and user organisations

Environmental monitoring

The extent of the environmental monitoring function will depend on the complexities of the health risks.

Hazardous substances – COSHH places a duty on employers to monitor exposure where the assessment concludes:

- there could be serious risks to health if control measures fail or deteriorate

- exposure limits might be exceeded, or

- control measures might not be working properly.

Other methods can be used – for example a system that sounds an alarm if it detects hazardous substances. The COSHH ACoP provides examples of other methods of evaluation.

Air monitoring must be carried out when employees are exposed to certain substances and processes specified in Schedule 5 to the COSHH Regulations. Where it is appropriate to carry out personal air monitoring, the air to be sampled is the space around the worker's face from where the breath is taken, i.e. the breathing zone.

Employers must **keep and maintain a record** of any exposure monitoring for at least five years.

Where an employee has a **health record** any monitoring results relevant to them as an individual must be kept with their health record. Employees are allowed access to their personal monitoring record.

Further details are available in HSE Guidance *Monitoring strategies for toxic substances HSG173*.

Monitoring may also be needed for other risks like noise levels, radiation levels

Safety reps will need to:

▶ identify what monitoring is currently taking place

▶ check that the appropriate equipment is being used. This will be influenced by what is being monitored, e.g. gases, vapours, dust or fumes. Advice may need to be obtained on this.

▶ check that the monitoring is being done at a time and place that will provide representative results

▶ use official exposure standards with caution. For example, some Workplace Exposure Limits (WELs) do not guarantee an absence of health risk. WELs are listed in the HSE document *EH40 Workplace Exposure Limits*

▶ obtain results

▶ seek advice on interpreting any results where applicable.

Where personal monitoring has been conducted reps will need to get authorisation from the individual to see their health record.

Health surveillance

Health checks are required by law for certain kinds of work and should form part of the risk assessment process required under the Management of Health and Safety at Work Regulations. Checks may be called health/medical surveillance or medical monitoring but the principles are the same whatever they are called.

They must be carried out by a person who is:

▶ competent to carry out the test properly

▶ competent to interpret the results and relate them to what workers have been exposed to

▶ competent to analyse patterns in the results for all those exposed

▶ competent to make recommendations to prevent a problem. This might involve getting further environmental monitoring done, seeking a hospital specialist's opinion, putting control measures in place or moving a worker to a suitable alternative job.

Checks must be right for the health problem under investigation, done as soon as needed and performed at the right intervals.

Sometimes procedures are set out in the law – for example for ionising radiation or lead exposure; and some in guidance – for example MS 25 on the tests required where occupational asthma is suspected.

You must be given results with an explanation. If the problem is possibly or likely to be work-related you should be told (even if this could lead to a compensation claim). If you are told by a health professional that a problem is work-related you should consult your union legal services.

Results of tests should be kept for a minimum of 30 years and protected in the case of closure or change of ownership of a company. You can request the written results of a test, but you should keep them to yourself.

If medical help is needed the occupational health provider should make this clear so that a GP can be consulted. If you need a further specialist test to work out what is happening, your employer should make sure that this occurs.

Any occupational illness identified should be reported under RIDDOR.

A safety rep should ask for grouped anonymous results so that any patterns of ill-health relevant to safety practices are made clear.

If health checks show up a health problem that is a disability then reasonable adjustments to work arrangements should be discussed.

Safety reps should discuss any dissatisfaction relating to the quality of health surveillance with HSE or environmental health inspectors.

Other OH services

OH services should support a rehabilitation policy (see Section 4, pages 99–109). Other services will vary according to the size and type of employer. They could range from:

- **Health counselling:** Providing individual support on ill health issues.
- **Health screening:** Voluntary individual testing to provide assessment and support. For example, cholestoral, body mass index, blood pressure, prostate, lung function.
- **Health education:** A preventative strategy but one often aimed at personal lifestyle issues. This could cover things like stress management; exercise; drugs and alcohol; healthy eating.
- **Fitness for work:** This could be in the form of initial medical examinations prior to starting work. It could also include referrals from Human Resources following a period of sickness absence.
- **Supervising first aid:** OH services will often oversee the arrangements for meeting the requirements of the First Aid Regulations 1985.
- **Testing:** Some employers have compulsory testing for drugs and alcohol (see Section 5, pages 86–7).
- **Wellness at work programmes:** Often covers things like offering flu jabs to staff.

The services above can be a useful addition to what an OHS can offer. However, they should not take preference over the primary role of preventing ill health by focusing on work organisation factors.

At present it is estimated that fewer than 20 per cent of workers are covered by any kind of basic OH support and only three per cent of employers provide comprehensive support.

The TUC view on occupational health provision

At present it is estimated that fewer than 20 per cent of workers are covered by any kind of basic OH support and only three per cent of employers provide comprehensive support. Even employers that do have OH provision often see it in terms of a glorified first aid service aimed at patching up the wounded and getting them back to work as soon as possible.

However, good OHSs can improve the quality of work, help assess, reduce and remove risks and ensure suitable jobs and adaptations go to ill, disabled or injured workers.

A good OHS will:

- identify what can cause or contribute to ill health in the workplace
- determine the action required to prevent people being made ill by work
- introduce suitable control measures to prevent ill health
- ensure people with health conditions or who have a disability or impairment are not unreasonably prevented from working
- ensure people at work are fit to perform the required tasks through adaptations etc
- provide health surveillance, review records and promote research
- provide health education and counselling
- support sick or injured workers.

The TUC has always contended that the UK Government is failing to meet its minimum legal duty under the European Framework Directive, which requires all workers to have access to preventative OHSs. There is a clear case for a legal requirement on all employers to provide such a service. Following action by the HSE, an employment tribunal recently ruled that a local authority was in breach of the MHSW Regulations by not providing an OHS for its employees.

Although the TUC believes that in-house provision is the best model for large employers, this may be inappropriate for smaller ones and we would welcome the expansion of NHS Plus.

NHS Plus was set up to provide occupational health for SMEs, but unfortunately its effectiveness has been patchy. Due to a lack of resources and the way that NHS budgeting works, it really became more of a re-branding exercise for the pre-existing NHS OH provision, and has effectively acted more as an in-house NHS OH provider than an external provider. It has also been suggested that staff within the NHS often feel there is a lack of consultation and involvement.

The TUC believes that if it were properly resourced NHS Plus would have the potential to become a significant provider of OH services to SMEs. Its expertise would also be of use to many large employers.

However NHS Plus will be effective only if there are major structural changes in the way the NHS operates and is funded, and also if there are greater incentives for employers to use an OHS – or ideally if it were to be underpinned by a statutory requirement on employers.

Another model of OH provision is local partnerships. An example of this is the Sheffield Occupational Health Development Group, which was funded by the HSE to develop the OH needs of SMEs in the Sheffield area. The results of this work helped develop an OH support service for businesses in the area, which is seen by many as an example of very good practice.

The TUC is concerned that the existence of EMAS is also under threat. This service has dropped from having 120 staff in the early 1990s (half doctors and half nurses) to the equivalent of seven full-time doctors working as medical inspectors and 25 nursing staff working as OH inspectors. The TUC believes proper resourcing for EMAS is necessary to drive forward OH in the UK and provide leadership to the system. A fully restored advisory service, such as EMAS, could be effective in providing incentives to employers to make OH provision and would be able to provide the necessary advice to employers, as Parliament originally intended when it was set up under the Health and Safety at Work Act.

The fourth report of the Select Committee on Work and Pensions specifically drew attention to reduced funding for EMAS and expressed the view that this had considerably reduced the capacity of the HSE to provide advice on OH issues.

Activity – Reviewing your experience of OHS

Aims
To help you:
▶ examine the key components of an OHS
▶ discuss what your employer provides.

Task 1 – Individual

Look at the type of service outlined in the table below. Indicate whether your employer provides it. If you are not sure make a note and try and find out.

Task 2 – Pairs

In pairs compare the range of services provided. Put a:

✓ if provided   ✗ if not provided   ? if you don't know

Does your employer provide the following type of OH service?	Your employer	If yes, how is it provided?	Other employer	If yes, how is it provided?
Prevention of health risks – e.g. policy, risk assessments, planning control measures				
Access to specialist services to design safe working systems – e.g. ergonomists, ventilation engineers				
Keeping OH records				
Producing ill health statistics and examining trends e.g. dusts, fumes, radiation				

Does your employer provide the following type of OH service?	Your employer	If yes, how is it provided?	Other employer	If yes, how is it provided?
Health surveillance of individuals exposed to specific health risks – e.g. blood tests, hearing tests, cancer, lung function.				
Health screening of workers who request it – e.g. cholesterol, body mass index, lung function, blood pressure, eye tests				
Fitness for work referrals – start of employment or following periods of sickness				
Supervising first aid				
Health education – e.g. alcohol, smoking, stress, drugs, debt, bereavement				
Individual counselling for any of the above				
Rehabilitation role and return to work				
Testing e.g. for alcohol, drugs				
Any other (please list)				

Report back

Prepare a report outlining the main differences between the two workplaces.

Activity – Assessing OHS in your workplace

Aims

To help you:

- ▶ evaluate the standard of provision of OH services in your workplace
- ▶ compare any strengths or weaknesses with other workplaces.

Task 1 – Individual

Complete the checklist on OH services on the next page.

Task 2 – Groups

Compare your results with other members of your group.

Prepare a report identifying strengths and weaknesses in provision. For each strength or weakness indicate the workplace concerned.

Use the following table as a guide:

Standard	Strengths	Weaknesses
Trade union consultation		
Standard of competency		
Equality of access for all workers		
Adequate staffing levels		
Quality of any additional specialist services		

Standard	Strengths	Weaknesses
Quality of environmental monitoring		
Quality of health surveillance of the workforce		
Standard of role in return to work referrals		
Standard of any advice or counselling		
Standard of management		
Any other		

Report back

Appoint someone to report back on two main strengths and two main weaknesses.

Worksheet – Evaluating OHS

You may not know the answer to all these questions. If you don't, make a note in the comments column that you need to find out

Standard (✓ if standard being met)	Comments
Consultation Are safety representatives consulted about: ▶ services required? ▶ qualifications of OHS staff? ▶ how services will be provided? ▶ OHS work programmes and targets?	
Staffing ▶ Are OH staff competent? ▶ Are they sufficiently independent of management? ▶ Are there sufficient numbers and resources? ▶ Do they provide appropriate health checks? ▶ Do employers follow the advice?	
Prevention ▶ Is the main focus of the service on prevention rather than dealing with sickness? ▶ Are OH staff sufficiently involved in the development of risk control measures to prevent ill health?	
Equality of access Is there equality of access for the following workers: ▶ women? ▶ men? ▶ workers with disabilities? ▶ migrant workers? ▶ older workers? ▶ certain categories of worker, e.g. shift, agency?	

Standard (✓ if standard being met)	Comments
Environmental monitoring Are services required to identify, evaluate and advise on the control of the following: ▶ airborne dust, fibres, micro-organisms, chemical fumes, gases and vapours that are likely to be inhaled or absorbed via the skin? ▶ noise and vibration? ▶ ionising and non-ionising radiations? ▶ heat or cold leading to discomfort or stress? ▶ prevention and control measures and their ability to minimise the effects of the above?	
Medical services Are services required for: ▶ advice about medical aspects of systems of work? ▶ routine health surveillance of workers at risk from harmful factors in the workplace? ▶ regular assessment of fitness for certain safety critical jobs? ▶ are fitness standards used fair and in line with current best practice? ▶ advice about rehabilitation and adaptation? ▶ advice about first aid? ▶ health education and health counselling? ▶ medical record keeping? ▶ is privacy guaranteed?	
What other specialist services might be required: ▶ radiation protection? ▶ ergonomic advice? ▶ microbiological control? ▶ process design, e.g. local exhaust ventilation systems, heating and ventilation, chemical detection systems.	

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Standard (✓ if standard being met)	Comments
▶ Is the OHS role in sickness absence appropriate?	
▶ Is the OHS centrally managed? ▶ Is it integrated into the health and safety and management of the organisation?	
▶ Are OH services subject to regular audit? ▶ Do safety reps receive the results of any audits?	

Activity – Negotiating OHS provision in your workplace

Aims

To help you:

◗ plan improvements in OH services

◗ review your plan based on feedback.

Task

The last activity will have identified weaknesses in some workplaces.

Select a weakness or weaknesses identified in your workplace or a similar sector. Work in a group to prepare a negotiating plan for improving the OHS provision.

Use these headings for your report:

1. Improvements required
2. Main arguments for improving provision
3. Anticipated counter-arguments
4. Dealing with counter-arguments
5. Fallback position
6. How members, other reps and other unions can be involved
7. Pressure that can be applied
8. Procedure and timescale to be used.

Report back

Appoint someone to report on your negotiating plan. Note down any comments made during the presentation and amend your plan if you agree with the point(s) made.

3. Occupational health issues

- Checking your health
- Occupational cancer
- Stress
- Musculoskeletal disorders (MSDs)
- Noise-induced hearing loss
- Hand-arm vibration syndrome
- Asthma
- Skin disorders (demititis or eczema)
- Identifying new risks
- Wider health issues
- Summary – TUC policy statements
- The TUC view on lifestyle issues
- Activity – Is it work-related ill health?
- Activity – Investigating the issue
- Activity – Proposing a course of action

Checking your health

You don't have to be an expert to suspect that health problems are caused by work – if problems are common, and workers are exposed to a relevant risk at work, a pattern will emerge.

The way a problem starts sometimes gives a good indication of its origins; sudden outbreaks of dermatitis or upper limb disorders can often be traced back to a change at work (a new chemical causing dermatitis, a change in line speed for a work-related upper limb disorder (WRULD) for example). Deafness and white finger, and some lung diseases like bronchitis and emphysema that result from dust diseases, develop gradually – normally after several years of exposure.

Many work-related health problems can, however, have non-work causes. Sometimes people can have exposure to dangerous chemicals outside work (for example, fishermen used to get bladder cancer from dyes used to colour maggots), or they may have an inherited tendency to get a particular problem (e.g Raynaud's disease or white finger). It is always worth asking people about family history of a disease, or whether they had had symptoms before exposure at work started (asthma that was made worse by work rather than being caused by it, for example).

Traditionally doctors diagnose, but in practice you can do it too (we generally know if we have a cold). Relating exposures to health problems will almost always give you a good idea about the nature of a work-related health problem. There are tests that can make things clearer and which can confirm or contradict what you think. A GP, practice nurse or hospital doctor will be able to carry out the appropriate test in each case.

Where to get help

If you still suspect that there is a work-related health problem, seek expert advice. You may be seeing links that are rare or not well known with a new technology or material; trust your hunch and get it checked out. If a trade union solicitor is willing to take up the case, they will contact an expert for their medical opinion. Your trade union safety officer may know where to find a specialist with the skills needed. A few hospital specialists have expertise in occupational medicine; for example, dermatologists (skin diseases), respiratory physicians (e.g. occupational asthma or asbestos-related diseases) or toxicologists (chemical poisoning) may be able to help.

This extract from the OHAC Report on Improving Access to OH Support illustrates the change in approach needed:

11.1 With the notable exception of asbestosis, and certain occupational cancers, occupational health issues are now less dominated by diseases and conditions that are directly linked to exposure to particular substances etc. at work. There is increasing recognition that much ill health at work is of a multi-factorial nature e.g. stress-related illness and musculoskeletal disorders, and that there are links between common illnesses and work e.g. higher incidence of certain heart conditions amongst shift workers, effects of work organisation on coronary heart disease and passive smoking. It is therefore important that occupational health support offers an integrated, holistic approach to health management that, (whilst giving priority to the prevention of work-related risks), will improve the quality of life for the working population within and outside working hours. This also has the merit of reducing sickness absence costs, enhancing productivity and competitiveness and, for individual workers, employability.

Occupational cancer

What is it?

Cancer or 'malignant' disease is the name given to uncontrolled growth of particular kinds of cells in the body, that disrupts normal functioning of the organ or part of the body affected. There are many work causes of cancer. Some are substances and some are physical factors such as radiation.

How common is it?

Among manual workers the proportion of cancer cases that are work-related could be one in five or more. Overall estimates vary from five to 15 per cent that can be put down to work.

Checklist – Is it work-related?

Onset

Cancers take time to develop. The gap between exposure and cancer being diagnosed is called the latency period. It varies from cancer to cancer and from case to case. For example, the asbestos-linked cancer, mesothelioma, occurs on average 20–25 years after exposure to asbestos, but it can be more – up to 50 years – or as little as five years.

Do any other workers have the same problem?

In large workforces several people may have the same cancer and the same exposure, but this is quite uncommon – cancer incidence (new cases each year) is quite low. Finding out about retired workers may add new cases. Careful investigation is needed to find out what the cancer type was, when it occurred and whether the date fits with latent periods and chemical exposures. The number of cases in a cluster can be compared with the number that would be expected in the population that is not exposed at work.

Is it a known risk of this job?

Many cancers are a known risk for a particular job. To check this use a database such as www.occam.it

Is there a known risk from exposure?

A database such as www.healthandenvironment.org can tell you whether exposures at work have been linked to a particular cancer and how strong the evidence is.

Has the exposure been enough?

Any exposure to a carcinogen carries some risk; heavier short exposures and long periods of exposure carry higher risks.

Family history and past medical history

Is there a family history of the cancer concerned? Had there been a diagnosis before exposure took place (this would rule out a cancer being related to the exposure).

Does it have special marker features?

Science is developing quickly to find particular marker features that would identify work-related cancers. So far there is no one technique that can do this. Some cancers are, practically speaking, found only where there has been exposure to a particular substance; mesothelioma and asbestos, angiosarcoma (a liver cancer) and vinyl chloride monomer.

What tests can be done?

By far the most important information in assessing what the risk of cancer at work is comes from knowing the chemicals and other factors you are exposed to. There are tests for early stages of some cancers.

Rehabilitation

As cancer survival times increase, more and more people are able to resume work after they have been treated for cancer. Just what kind of help they may need to return to work varies from one kind of cancer to another. For more information see www.cancerbacup.org.uk/Resourcessupport/Practicalissues/Workcancer or, from the US Job Accommodation Network, www.jan.wvu.edu/media/canc.htm

Relevant legislation and guidance

The main legislation is the Approved Code of Practice (ACoP) on exposure to Carcinogens, which is part of the COSHH Regulations. Some carcinogens have cancer risk phrases R40, R45, R46 and R49, but many do not. The priority with any carcinogen is substitution or process change, because there is no safe level of exposure. The use of health records is required under the ACoP.

Compensation

State Industrial Injuries Benefits are available for some cancers. Few damages claims are settled each year for occupational cancer apart from asbestos-linked diseases

Stress

What is it?

Work-related stress is the mind and body response to certain aspects of the psychological working environment. There are psychological aspects of stress: fear, anger, frustration, loss and lack of care, which can lead to depression or anxiety or can aggravate existing psychiatric problems. There are also physical consequences of fear, anger and frustration that include increased blood pressure and risk of heart attack, palpitations and irregular heartbeat, stomach disorders and changes in the immune (defence) system.

How common is it?

Stress can be considered an aspect of most workers' lives; 20 per cent of people think they are moderately or severely stressed by work.

Checklist – Is it work-related?

Onset

Onset can be gradual or is often triggered by a change in management practice; a new manager or increased performance pressure, threat of redundancy or dismissal, bullying or discriminatory behaviour. Consistently high demands or unfairness in rewards or in the way people are treated at work can lead to gradually accumulating stress.

Pattern after onset

After onset, the root causes need to be identified and tackled, otherwise psychological problems become persistent, leading to longer periods of sickness absence, and physiological changes become semi-permanent, leading to the risk of more serious disease.

Do any other workers have the same problem?

If one person is being bullied then everyone feels stressed. It is rare for just one individual to be stressed. Stress is a psychological and a social problem.

Is it a known risk of this job?

Some jobs are said to be more stressful than others – often jobs in which people report that they are stressed more often. But research suggests that most stress is silent; people show the psychological and physical effects of stress but accept them as normal. This is especially true of routine unskilled jobs.

Is there a known risk from exposure?

Many of the risk factors are listed in the HSE Management Standards for stress; high demands, low control, unfair or threatening behaviour, insecurity and change, uncertainty about role, lack of support from managers or occasionally from co-workers.

Has the exposure been enough?

People vary so much that what is tolerable to one may be intolerable to another. Background events – bereavement, money worries, family illness and so on – may make some individuals more prone to suffer from stress. Risk assessment needs to look at the needs of individuals.

Family history and past medical history

Past psychological and physical health is relevant. Heart disease – one of the main effects of stress at work – is affected by inherited factors.

Does it have special marker features?

Like most work-related health problems, it is the fit between what you are exposed to at work and the pattern of your ill-health that marks stress out as work-related. As knowledge increases it may be possible to find special features for some kinds of work-related stress, but we are not there yet.

What tests can be done?

There are standard questionnaires for various psychological patterns of ill-health such as burn out, depression or anxiety. There are also tests for high blood pressure and for certain chemicals found in the blood that mark out the body's response to stress. There are no tests specific to work-related stress.

Rehabilitation

The focus is on changing the psychosocial working environment; work rates, working relationships, reward systems and recognition, communication and training opportunities (which protect against risk of job loss). When workplaces are inflexible then the individual must move on, possibly using the grievance procedure and an unfair dismissal to compensate for financial losses. Techniques like cognitive behavioural therapy (cbt) may have a role to play in managing stress, but this will not address organisational issues.

Relevant legislation and guidance

General duties apply. Guidance is in the *Management Standards on Stress.*

Compensation

Civil damages are exceptionally rare for occupational stress – a scandal given how common the ill-effects of stress are. Damages under anti-harassment legislation, and compensation for unfair or constructive dismissal are possible. The Industrial Injuries (Disablement Benefit) scheme will take into account the psychological effects of occupational diseases and injuries, and psychological stress due to traumatic incidents.

Case study 1:

METRO

Tuesday 22 January, 2008

Stress in the civil service

Stress at work is pinpointed as a direct cause of heart disease in a groundbreaking study published in January 2008.

Employees who suffer from chronic stress have a 68 per cent higher risk of becoming victims of Britain's biggest killer, researchers found.

The figure holds good after other lifestyle factors such as drinking, smoking and poor diet are taken into account. The link was also found to be stronger among the under-50s.

TUC general secretary Brendan Barber said: "This provides further evidence that stress is not just a major cause of mental health problems but is also often behind serious, and sometimes fatal, physical diseases."

The findings come from a study of 10,000 Whitehall civil servants since 1985. A tenth of them were found to be suffering from chronic stress.

The work, by University College London, has revealed the biological effects of stress on the heart, brain and hormone secretion.

Anxiety was found to damage the way the heart dealt with tense situations.

Under-pressure staff were also found to have higher than normal levels of the stress hormone cortisol when they woke in the morning.

Their problems were exacerbated because stress led to bad habits, such as poor diet and smoking, which increased the risk of heart disease.

June Davison, cardiac nurse at the British Heart Foundation, said the research "takes another step towards deciphering how stress may alter our body's chemistry to affect our heart health".

About 100,000 people die from heart disease every year, making it Britain's most common killer.

Musculoskeletal disorders (MSDs)

What is it?

Any of the parts of the body involved in movement and posture – muscles, joints, tendons, and nerves in particular – can be affected by overuse. Symptoms include pain, tenderness, numbness, tingling, swelling, colour changes, coldness or hotness and limitation of movements.

Medical names include: tenosynovitis, tendonitis, epicondylitis (tennis and golfer's elbow), carpal tunnel syndrome.

These disorders mainly affect the back, neck, shoulders and upper limbs. Some MSDs, such as carpal tunnel syndrome in the wrist, are specific because of their well-defined signs and symptoms. Others are non-specific because only pain or discomfort exists without evidence of a clear specific disorder

How common is it?

MSDs are probably second only to stress in the league of common occupational health problems. At least half a million people report that they have an upper limb disorder in any given year, but the symptoms listed are much more common than that, affecting half the workforce in any given workplace – and sometimes more.

Checklist – Is it work-related?

Onset

The start of an MSD may be gradual, but occurs more often after a change at work; increased workload, change of workstation or work design, more psychological pressure at work, return to work after sickness or holiday. It may follow an injury or strain at home but be obvious only at work.

Pattern after onset

MSDs rarely get better unless work factors are dealt with. Worsening means longer periods of more intense pain with less complete recovery overnight or at weekends.

Do any other workers have the same problem?

Clusters of problems are frequent among people doing the same job – even though different people often do the same job in slightly different ways – leading to slightly different patterns of MSD.

Is it a known risk of this job?

There is a risk of developing an MSD in almost every job, but office work and assembly/production line work are particularly high risk.

Is there a known risk from exposure?

The risk comes from repeated use of the same movement, use of postures far from neutral for the joints concerned, strong force or heavy load in a particular action, repetition without adequate breaks, repetitive work with psychological pressure, and physical work in cold conditions.

Has the exposure been enough?

Workers vary in their physical strength and size, with age also being a factor, so there are no firm loads or repetition rates that can be said to be safe. However one set of authoritative guidelines suggests:

- Extreme exposure (over half the range of movement of a joint regularly during the working day)
- Highly repetitive (actions performed more than two to four times a minute or cycles of less than 30 seconds)
- High force (hand weights of more than 4 kgm)
- Too little recovery time (less than 10 minutes' break possible each hour of high repetition movements)
- Low social support
- High psychological demands

Family history and past medical history

It is always worth considering whether joint problems or other musculoskeletal problems are common in someone's family (e.g. arthritis), or whether there has been another injury or a previous history of problems in the part of the body concerned.

Does it have special marker features?

Every upper limb disorder can be related to features of the job. Look for the part of the job that causes most pain, or the kind of movement that was specially common when the problems started, then analyse whether particular force or a particularly awkward posture is involved. (Most joints are designed to be held straight; the further you bend to left or right, up or down, the weaker the joint and the more the risk of damage. The shoulder, neck and elbow also have neutral postures.)

What tests can be done?

There are few diagnostic tests; the tissue involved may be sensitive to pressure or sensitive at the end of its range of movement. Blood tests can help eliminate certain illnesses that affect the joints (like rheumatoid arthritis). Nerve conduction tests can confirm if there is pressure on a particular nerve – though other simpler observations are also useful; numbness, tingling, and weakness in particular muscles.

Rehabilitation

Remaining active within the limits of acceptable pain is better than rest, which can lead to weakening and increased risk of further problems. The most important thing is to alter the job done, the speed it is done at, and the way that it is done before returning to work.

Relevant legislation and guidance

The legislation is general; the Manual Handling Operations are more concerned with risk of back injury than repetitive strain or trauma. Guidance is available from the HSE; general guides and industry-specific ones. The HSE Better Backs Campaign Pack contains some very useful checklists. The MSD section of the site provides access to videos and worked examples using tools like the Manual Handling Assessment Chart (MAC). www.hse.gov.uk/msd/campaigns

TUC Education runs a short course called Lighten the Load.

www.unionlearn.org.uk/courses

Compensation

State Industrial Injuries Benefits are available for a few conditions; tenosynovitis, carpal tunnel syndrome and beat conditions, but check the rules for each disease. Many damages claims are settled each year for upper limb disorders but far below the number of cases recorded in surveys. For a successful damages claim you will need strong evidence of deficient risk assessment and failure to control a risk that an employer is aware of.

Noise-induced hearing loss

What is it?

Noise can cause several problems including deafness, tinnitus (ringing in the ears), raised blood pressure and stress.

How common is it?

Half a million people below the age of 65 are believed to have been made moderately or severely deaf by work. Fewer people are exposed to damaging noise levels at work now, but the number of people of all ages whose hearing has been damaged to some degree (quite small amounts of deafness affect hearing in social situations) runs into millions.

Checklist – Is it work-related?

Onset

Your hearing may seem more sensitive after a weekend, and less sensitive to noise at the end of the week. Your ears may ring after exposure to loud noise, while temporary deafness (reduction in hearing ability) is a sign of exposure to possibly damaging levels, and the risk of permanent damage increases the more this occurs.

Pattern after onset

Hearing recovers after brief exposure to noise, but recovery takes longer the longer you are exposed. The sounds that noise-induced hearing loss mainly affects initially are those involved in speech, like the sounds d, s and t.

Do any other workers have the same problem?

If one person has deafness others exposed to the same sound will have to. There is a little variation in sensitivity to noise between different people but not much. Your employer should do a noise survey. Make sure you get the anonymised results.

Is it a known risk of this job?

Certain jobs carry particularly high risk; metal industries, construction, driving (particularly older vehicles), and leisure industries.

Is there a known risk from exposure?

Any noise exposure over 80dB (decibels are the measurement of sound pressure in noise) can damage your hearing. Some people's hearing is more sensitive to damage at this level. The higher the noise level and longer you are exposed, the greater the risk of damage.

Has the exposure been enough?

There are tables of expected levels of deafness for different amounts of exposure and durations, but continued exposure over 80dB is likely to cause damage.

Family history and past medical history

A family history of deafness at an early age, a childhood history of hearing problems, or an injury to your ear could point to other causes of deafness or mean you are more susceptible to hearing loss than others in the workplace. Some drugs and solvents can damage hearing. Other sources of noise include gunfire, loud music or headphones, which can cause noise-induced deafness.

Does it have special marker features?

Noise-induced hearing loss normally has a special frequency pattern. Hearing loss is mainly affected at frequencies below 8kHz giving a 'notch' pattern around 4kHz with slightly better hearing at 6 or 8kHz than at middle frequencies. In older people whose hearing has been affected by noise and ageing, the notch is not so clear. Noise-induced hearing loss is present in older people when the loss of hearing rises unusually quickly at higher frequencies.

What tests can be done?

The main test is a pure-tone audiometry – a hearing test in which single frequencies are played into your ear until they are loud enough for you to hear them. This threshold sound level tells you how much hearing you have lost. Other kinds of deafness require investigation by hospital specialists.

Rehabilitation

Hearing protection and noise control will protect what hearing you have left. Hearing aids, intercoms and changes to the surroundings in which you work will help you hear better if you have some deafness. Few jobs have a strict entry requirement for hearing ability.

Relevant legislation and guidance

The main relevant legislation is in the Control of Noise at Work Regulations 2005. There is guidance for many jobs and industries on the HSE website.

Compensation

Occupational deafness is covered by the Disablement Benefit (Industrial Injuries) scheme for exposure to noise in a few named jobs, and only where there is severe loss of hearing. Civil claims (for damages) are more straightforward, but you must claim within three years of knowing that your hearing has been affected by work. Levels of compensation are far below what is required to make up for the social effects of deafness.

Hand-arm vibration syndrome

What is it?

Hand-arm vibration syndrome (HAVS) is a pattern of damage to the blood vessels and nerves in the fingers following exposure to vibration. The fingers or fingertips go white in cold conditions. Colour returns when the blood flow is restored, often with painful 'cold aches'. Numbness, tingling and reduced sense of touch result from damage to the sense cell in the fingers.

Early effects include tingling after using vibrating tools. Late effects include severe and permanent damage to the flesh of the fingers, particularly the fingertips.

How common is it?

Five million people are exposed to vibration at work. At least 800,000 people in Great Britain are estimated to have the effects of vibration exposure at work. So far 170,000 former miners have been compensated for HAVS.

Checklist – Is it work-related?

Onset

Onset normally follows a few years of use of vibrating tools, though people vary in how quickly and severely they are affected. If you do not already have symptoms of HAVS it is very unusual for it to appear after you left your last job, provided you are no longer exposed to hand-arm vibration.

Pattern after onset

Longer exposure to vibration leads to more advanced HAVS; more finger joints going white (blanching) more often, and more difficulties with sense of touch (things are harder to pick up and fine movements with the fingers are harder to control).

Do any other workers have the same problem?

How quickly people are affected varies but you would expect everyone using the same equipment over a period of years to have some effects.

Is it a known risk of this job?

Grinders, tree surgeons, concreters (from pokers), road workers (from pneumatic drills), fettlers (chipping tools) are frequently affected. But it may occur in any job where there is frequent vibration exposure to the hands e.g. floor-cleaners, buffers.

Is there a known risk from exposure?

All equipment should be tested for vibration. Vibration levels exceeding 2.5m/s2 should be controlled.

Has the exposure been enough?

Fingers that are more exposed to vibration are most likely to show HAVS symptoms. Just one hand, or particular fingers on one hand, may be affected because of the way the vibrating tool is handled during use.

Family history and past medical history

There are other causes of blanching (white finger) and poor sense of touch. These include Raynaud's Disease, diabetes and some uncommon problems affecting the blood or circulation in the arms. Any signs of white finger before you were exposed to vibration make a diagnosis of HAVS less likely.

Does it have special marker features?

There are no solid tests that show symptoms are caused by vibration. The history of tool use and pattern of use since onset, as well as the parts of the hands affected, are all features.

What tests can be done?

Investigations aim to show how much the circulation and nerves are affected and rule out other possible diseases that can cause similar effects.

Tests cover the sensitivity of the fingers to edges, temperature changes and vibrations. A simple test with a widening groove can be done by anyone with an interest.

Tests for blanching are not yet reliable; if blanching occurs when the fingers or body are exposed to cold this is strong confirmation of HAVS, but if blanching does not occur the negative result does not rule out white finger.

Other effects of vibration

Hand-arm vibration can also affect the muscles, bones and joints in the arms. Arthritis is more common in affected joints. Pressure on the nerves in the wrist can occur, resulting in numbness in the hands. Carpal tunnel syndrome, which affects sensitivity in some fingers more than others, is a recognised effect of vibration.

Rehabilitation

Continued exposure makes HAVS worse. Stopping exposure can lead to small improvements to the circulation of the hand over a period of years. However, if there is evidence of nerve damage this is largely irreversible. So introducing better equipment or changing tasks is essential. Moderate to severe HAVS is a disability and under disability legislation your employer must look for suitable alternative work or accommodate you in other ways.

Relevant legislation and guidance

The Control of Vibration at Work Regulations, 2005.

For guidance see: www.hse.gov.uk/vibration/hav

Compensation

State compensation through the Industrial Injuries Scheme (Disablement Benefit) is available where damage is quite severe and you have worked in certain listed jobs. Carpal tunnel syndrome is also covered by the Industrial Injuries scheme.

Civil compensation (damages) is available for all levels of damage and in any job where you have been negligently exposed to vibration. Contact the union solicitor to claim this.

Asthma

What is it?

Asthma is a condition in which the airways in the lungs have a greater than normal tendency to become narrower in response to irritation or exercise. Occupational asthma is asthma that has been caused by work. Sudden airway narrowing causes an attack of shortness of breath or wheezing or coughing. Use of a drug designed to relax or open the airways can help end the attack.

How common is it?

One in five adults with asthma is thought to have asthma related to work. About five per cent of the adult population has asthma.

Checklist – Is it work-related?

Onset

Asthma that has never occurred before the suspect exposure at work could be work-related. Asthma can also start following a single heavy exposure to a chemical. If existing asthma has worsened, then this could be work-aggravated asthma.

Pattern after onset

Occupational asthma generally worsens with continuing exposure. First symptoms may be unusual wheeziness, a sense of tightness in the chest or attacks of coughing.

Do any other workers have the same problem?

Where there is one case of occupational asthma there are often others. Symptoms may vary (wheeziness, shortness of breath, coughing). Some people are more affected than others and some people are more prone to get asthma (at least occupational asthma of certain types) than others.

Is it a known risk of this job?

There are very high risks of asthma in certain jobs; paint-spraying, looking after laboratory animals, soldering, etc. But occupational asthma affects large numbers of people in jobs such as cleaning, catering and healthcare.

Is there a known risk from exposure?

Some chemicals are known to cause occupational asthma. A list of 200 or so substances is available on www.whig.org.uk. Most of these are known as sensitisers. A few will have the Risk Phrases R42 on the data sheet, but many sensitisers do not. It is best to check substances on the data sheet against the list mentioned. New sensitisers are being found all the time.

Has the exposure been enough?

How much exposure and how long an exposure has to be to cause asthma varies from person to person. Heavier exposures put more people at risk.

Family history and past medical history

A family history of asthma, hay fever or eczema may mean that the individual is at greater risk of occupational asthma. A previous history of breathing problems, for example, when the person was a child, means this may be a worsening of asthma, or that there is a greater risk of a new episode of work-related asthma.

Does it have special marker features?

There is no single feature that distinguishes occupational asthma. Hospital specialists can carry out 'challenge tests', where the effect of a particular chemical on breathing is checked, or blood tests to look for a response from the body's defence system to the chemical suspected, but neither of these tests gives definite results.

What further investigations can be done?

The best test is to take peak flow readings (peak flow meters are available from chemists without a prescription – most asthma sufferers will be familiar with them), every two hours during periods of work and again after a week away from work. You can get help with understanding the results from a hospital specialist.

The pattern

Occupational asthma shows a special pattern when it starts; breathing is worse on workdays than at weekends or during holidays, and often becomes worse during the working week.

Rehabilitation

As long as exposure to the substance continues breathing will be affected – often becoming worse as time goes on. Return to the same job should be on the basis that the chemical levels are tightly controlled. Masks and other protective respiratory equipment are a last resort and rarely acceptable to asthma sufferers. Alternative work away from the chemical is almost always needed.

Relevant legislation and guidance

The main relevant legislation is in the COSHH Regulations. Guidance can be found in HSE L55 *Preventing Asthma at Work. How to control respiratory sensitisers*. ISBN: 0717606619, published by HSE Books. Employers are expected to carry out health checks where there is a risk of or reason to suspect occupational asthma.

Compensation

Occupational asthma is compensated under the Disablement Benefit scheme (a sensitising chemical must be identified) and through civil claims. Civil claims (for damages) must be started soon after onset; serial peak flows taken during a period of work are practically essential.

Skin disorders (dermatitis or eczema)

What is it?

Dermatitis is a skin problem in which the skin becomes inflamed (reddened), itchy, scaly, cracked or blistered. It is also called eczema. Dermatitis or eczema can result from irritation or an allergic reaction to a substance at work.

How common is it?

Half of all hand dermatitis is believed to be due to work. Dermatitis affects between five and 10 per cent of adults.

Checklist – Is it work-related?

Onset

Occupational dermatitis starts after exposure to a particular substance at work.

Pattern after onset

Dermatitis normally persists if contact with the substance continues and is slow to improve when contact has ended. Medical treatments improve the condition of the skin but not the underlying risk of dermatitis returning.

Do any other workers have the same problem?

It is common for several people in the same job and exposed to the same substances to have dermatitis.

Is it a known risk of this job?

Certain jobs carry particularly high risk; hairdressing, healthcare and engineering are good examples.

Is there a known risk from exposure?

Some substances are known sensitisers (they can cause the body's immune system to react). Some substances can cause skin irritation but do not sensitise the skin.

Water (e.g in repeated hand-washing or working in wet conditions) is one of the most common causes of irritant dermatitis.

Has the exposure been enough?

Small exposures from strong sensitisers can cause dermatitis.

Family history and past medical history

A family history of eczema, hay fever or asthma means there is a higher risk of allergic skin reactions. A past history of eczema/dermatitis also makes it more likely to occur again.

Does it have special marker features?

The clearest sign that dermatitis is occupational is by looking at the location of the skin reaction – almost always where the skin comes into contact with the suspect substance.

What tests can be done?

Hospital specialists can carry out a number of tests that help to confirm the diagnosis. Patch tests measure the sensitivity of the skin to particular suspect substances, but understanding what the results of patch tests mean is not always straightforward.

Rehabilitation

As long as exposure to the substance continues dermatitis is a risk and will return when treatment stops. Careful process control can prevent exposure in almost all jobs. Hand protection and skin cleansing are also important. In severe cases alternative work away from the chemical is needed.

Relevant legislation and guidance

The main relevant legislation is in the COSHH Regulations. Guidance can be found in Preventing Dermatitis at Work. Advice for employers and employees IND(G) 233. Employers are expected to carry out health checks where there is a risk of or reason to suspect occupational dermatitis.

Compensation

Occupational dermatitis is covered by the Disablement Benefit scheme, but the chemical responsible must be identified. It is rarely severe enough for benefit to be paid. Civil claims, for damages, must be started soon after onset, at the latest within three years. A late claim is unlikely to be successful.

Identifying new risks

The EU has established a 'Risk Observatory' to identify new occupational health risks. It anticipates risks associated with new technologies, biological hazards, complex human-machine interfaces and the impact of demographic trends.

Biological risks

The European Risk Observatory (ERO) identifies emerging biological risks that are most likely to affect workers in the EU. Farmers, healthcare workers or people in evolving industries such as waste treatment are particularly concerned. Communicable diseases such as severe acute respiratory syndrome (SARS), avian flu or dengue are of increasing concern. Despite existing European law, knowledge is still limited and in many workplaces biological risks are poorly assessed and prevented. The report emphasises the importance of taking a global and multidisciplinary approach involving occupational safety and health, public health, environmental protection and food safety.

"Biological risks often remain underestimated although they may be very harmful for EU workers in literally any sector," says Jukka Takala, Director of the European Agency for Safety and Health at Work, of which the European Risk Observatory is an integral part. "The challenge is to identify them quickly as they appear and analyse the consequences they might have on people's health and to work out policies and procedures to minimise their spread." The ERO expert forecast identifies new and increasing biological risks related to occupational safety and stresses the importance of considering all collective responsibilities and means of control, both inside and outside the workplace.

Communicable diseases threaten EU workers

It is estimated that 320,000 workers worldwide die every year of communicable diseases caused by viral, bacterial, insect or animal-related biological hazards. Although most fatalities occur in developing countries, some 5,000 workers fall victim in the EU. Women are more likely to be concerned than men as they typically work in occupations that involve more biohazards and exposure.

Most emerging risks relate to global epidemics with new contagious pathogens – for example SARS, avian flu and ebola – and re-emerging ones such as cholera and yellow fever. Given the speed and volume of international traffic and trade, these substances may spread around the globe within a few hours and start new pandemics.

Industries with highest risk

As many of these diseases jump the species barrier from animals to humans, workers in contact with livestock are particularly at risk. Other pathogens such as tuberculosis have become resistant to known drugs and can result in severe infections in healthcare workers.

Complex exposure situations are found in new industries such as waste treatment where workers come into contact with a variety of airborne micro-organisms and organic compounds. Moulds can spread in indoor workplaces due to poorly maintained air-conditioning and can cause asthma and allergies.

As the 21st century unfolds, unions will need to ensure that new risks – particularly those associated with nano-technology – are effectively researched.

Wider health issues

Smoking

Supporting employees to quit

Many employers with existing employee assistance programmes or other counselling services are considering extending these to include helping people to stop smoking, according to research carried out by Industrial Relations Services (IRS). Others will reimburse the cost of smoking-cessation products, like nicotine patches, up to a fixed limit, typically £60 to £70 .The chart below provides details of the range of support that employers are currently providing:

Employers' provision of smoking-cessation support
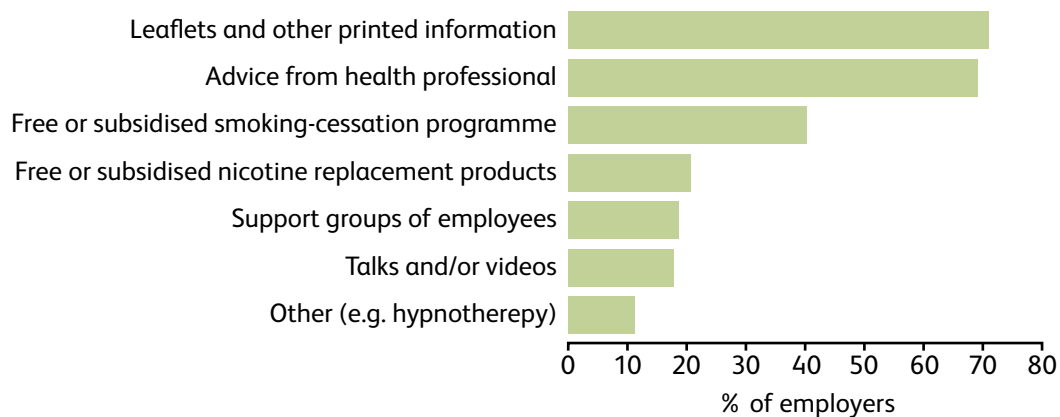
The Smokefree Regulations 2006 mean most workplaces prohibit smoking. Not all smokers stop as a result of working in a non-smoking workplace. However, providing a non-smoking environment at work does prompt more to try and give up and increases the likelihood that they will succeed.

Drugs and alcohol

Trade unions have a role to play in promoting healthy lifestyles, but there is often a fine line to tread before appearing to be moralising. In the case of drugs and alcohol a key area for union scrutiny is the way workplace testing is increasingly being adopted.

A 2007 CIPD survey report found that 65 per cent of firms didn't test employees and had no intention of starting. However, 22 per cent said they did test, with a further 9 per cent planning to start. This means testing is a trade union issue – especially as the survey indicated that firms are more willing to take disciplinary action against those testing positive than providing workers with support. The 2004 Independent Inquiry into Drug Testing at Work (IIDTW) noted that:

> "For the majority of businesses, investment in management training and systems is likely to have more impact on safety, performance and productivity than the introduction of drug testing at work."

Drug and alcohol policies should be impairment-based, recognising that impairment includes workplace factors like fatigue, stress, noise, heat and chemicals. They should:

- have an educational component
- be non-punitive and supportive
- not be based on biological testing
- have rehabilitation as a key component,
- help provide a safe and productive working environment.

Obesity

Obesity is an issue that is increasingly in the news. The proportion of adults in England categorised as obese on the basis of their body mass index (BMI) has increased by more than 50 per cent in the past decade. The rise in obesity is particularly marked in men, among whom the rate has tripled since the mid-1980s, making men as likely as women now to be obese.

IRS carried a report on obesity in 2006. Dr Nerys Williams, an OH physician previously with the HSE, believes that workplaces foster poor dietary and fitness habits. For example, lifts in offices mean that people do not have to take the stairs, technology allows people to email colleagues rather than walk around to their workstation, and vending machines too often dispense high-calorie snacks and drinks rather than healthier options.

> The rise in obesity is particularly marked in men, among whom the rate has tripled since the mid-1980s, making men as likely as women now to be obese.

Working patterns, particularly shift work, are often associated with poor eating habits, because they can encourage employees to eat inappropriate foods at strange times. A 2005 Finnish study suggested that a relationship between working overtime and weight gain could be explained by a high intake of snacks and fast food, eaten in place of regular, rounded meals, because workers don't get enough time to eat properly.

Those working overtime may also be too tired to take regular exercise – which also impacts on weight gain. Early evidence is also emerging from the 'Whitehall II Study' of an association between work and stress – stress is associated with weight loss in lean people and weight gain in heavier ones.

Obesity and the DDA

Employers are legally obliged in some circumstances to make reasonable adjustments to the workplace and jobs to accommodate obese people under the Disability Discrimination Act 1995 (DDA). Obesity is covered by disability legislation if it is associated with an underlying, ongoing medical condition. Even without the presence of such a condition, an obese person could have rights to redress under general discrimination law depending on the circumstances involved.

Weight-management and fitness schemes

A small number of large organisations, particularly those with resources to devote to OH and health promotion, have operated 'lifestyle' programmes in the workplace for a number of years but, as yet, most employers remain unconvinced of the return on investment of such initiatives.

Dieticians and OH experts believe that employers should be helping to prevent obesity and treat it by offering health screening to all staff, and providing support for employees through weight-loss clinics.

Case study 2:

Rolls-Royce wins workplace obesity award

The first workplace award in an annual scheme for weight-management initiatives run by the National Obesity Forum was recently awarded to the Rolls-Royce Group. The company has put together a multidisciplinary team, including doctors, nurses, psychologists and health promotion specialists, to develop a co-ordinated approach to weight management across its UK sites. The Reduce Hazardous Waist programme is an ongoing project, and the judges of the award scheme were impressed by its upbeat, positive approach, which also manages to use humour to get the message across.

Summary – TUC policy statements

Trade union approach to lifestyle issues

There are economic and legal reasons for promoting healthy lifestyles and trade unions are active in support for healthy living campaigns, while also ensuring that individuals who do not partake are not stigmatised. It is also crucial that such campaigns do not detract from the central objective, which is to make workplaces safe for workers rather than make workers safe to work in unsafe workplaces.

The TUC view on occupational health and occupational diseases research

Much of our knowledge of occupational illness is based on information from health surveillance obtained from doctors working for large companies or organisations, who have had access to the health records of employees over a long period of time. This allowed the causal relationship between various diseases and risk factors to be more quickly understood, although in some cases, like asbestos, employers did their best to stop the evidence becoming known.

In recent decades there has been a shift away from large employers to smaller ones; fewer people stay in the same workplace, or even industry, for all of their working lives, and the number of doctors working for a single employer is also much lower. This means we have far less research evidence available on the causes of modern occupational diseases.

In addition the number of people involved in academic research has also fallen. While there are some centres of excellence they are few and far between. Funding is difficult to come by and the Research Assessment Exercise for academic institutions is a disincentive for research into OH and medicine as fewer points are given for occupational medicine than other comparable disciplines such as environmental medicine.

The research budget of organisations like the Industrial Injuries Advisory Council is too small to allow it to be particularly useful. The TUC believes that funding of research into OH and medicine should be a priority for the Government. If we are to understand and combat the diseases of the 21st century, we need to know what we are facing as early as possible to ensure that preventive action is taken.

The legal requirement on employers to provide health surveillance applies only to certain jobs and industries where risks are known. It therefore means that information on new areas of work or emerging illnesses are far less likely to be identified at an early stage. This contrasts with the much wider surveillance programmes in some northern European countries.

A lack of both surveillance and epidemiological analysis based on that surveillance means we could easily have a repeat of the asbestos tragedy of the latter part of the 20th century.

If the employer is going to be involved in lifestyle issues then it should do it in partnership with staff and their unions rather than on behalf of staff.

The TUC view on lifestyle issues

There is a growing interest in using the workplace to promote solutions to 'lifestyle issues' such as obesity, smoking and drug and alcohol abuse. In some cases there is a link to health concerns and the working environment. These links include both sedentary work and long hours with obesity, and the links between stress and the use of tobacco, recreational drugs and alcohol.

The TUC believes that, where possible, the organisation of work should promote positive health through avoiding working arrangements that mean a person is inactive for long periods of time, or that a person is exposed to adverse levels of stress. Work-life balance policies are also an important contribution towards encouraging a healthier lifestyle.

In addition, an employer can assist in the promotion of good health through a range of initiatives including providing access to healthy food, subsidising gym membership or encouraging exercise classes on the premises. Other successful initiatives have included subsidising nicotine replacement therapy, and access to counselling for those with a drug or alcohol problem. The promotion of cycling to work through providing secure bike-parking facilities, or of running through the provision of showers have also proved popular.

These initiatives are not, however, an alternative to ensuring that workplace factors that may lead to addictive behaviour or other risks to health are removed. Lunchtime yoga classes are not a substitute for reducing stress in the workplace. Access to fresh fruit will not help employees who cannot take a lunch break, nor will gym access be of use to those who work late every evening.

Often initiatives are introduced in a paternalistic, patronising way. If the employer is going to be involved in lifestyle issues then it should do it in partnership with staff and their unions rather than on behalf of staff. The TUC is aware of a number of instances where attempt to introduce 'healthy eating options' while at the same time removing traditional fare has led to considerable resistance from staff who do not take kindly to employers telling them what they can and cannot

eat. Instead such initiatives should involve consultation with staff and have an element of choice rather than compulsion.

The TUC also has concerns over attempts by employers to introduce moral elements to lifestyle issues. Drug and alcohol issues, for instance, are a concern when they affect the performance of a person in the workplace or put at risk the safety of workers or the public. Good employers will also wish to assist any employees who have an addiction that is affecting them or their work. However, that is very different to an employer seeking to prevent drug or alcohol use outside the office if it has no bearing on a person's work.

There is also a difference between an employer positively attempting to introduce choices and working methods that will help those people that chose to seek to control its weight, and an employer that sees it as its duty to make sure that anyone with an above-average BMI loses weight by creating a working environment where overweight people feel stigmatised.

The workplace can, like any other environment, be a useful place to encourage people to make healthy choices, but it must be done in a non-judgemental way that creates the opportunities for people to make healthier choices should they chose to rather than forces them to adopt a particular lifestyle that has no bearing on their employment.

Activity – Is it work-related ill health?

Aims

To help you:

- ▶ identify potential cases of occupational ill health
- ▶ carry out an initial assessment on a priority risk.

Task 1 – Individual

Look at the table below. Tick those health issues that may have been caused or made worse by work. Add any others that are relevant to your workplace that may not be on the list. Prioritise your list and choose your number one priority for Task 2.

Increased work-related health risk	Tick if it could be linked to a workplace exposure (✓)	Priority order
Cancer		
Stress		
Musculoskeletal disorders		
Hearing loss		
Vibration		
Asthma		
Skin disorders		
Wider health issues		
Any other (specify)		

Task 2 – Groups

Work in a group that has selected your priority. Use the relevant checklist from this section of the book and any other resources available to check the extent to which it is work-related.

Report back

Select one workplace from your group and use the headings below to summarise your report:

▶ What are the facts?

▶ What do the members want?

▶ What are the causes?

▶ Is it a one-off or a broader problem?

▶ What additional information may be needed to establish the extent of the problem?

Activity – Investigating the issue

Aims

To help you:

▶ practise research on an occupational health issue.

Task

Use the information from the previous activity to carry out some research on your topic. Refer to the information references in this book to direct you to relevant sources. Fill in the worksheet on the next page.

Report back

Use the table below to identify any important gaps in your research and how you plan to fill them

Information still needed	How you plan to obtain it	Target date

Occupational health investigation worksheet

Topic:

Fill in this worksheet with any references you can find on the topic you have chosen.

- ▶ What does my union say?

- ▶ What do my agreements/policies say?

- ▶ What do my members want?

- ▶ What does the law say?

- ▶ What does the official guidance say?

- ▶ What do professional organisations say?

- ▶ What questions should I put to management?

- ▶ What questions should I put to the OHS?

- ▶ Should I ask the HSE/EMAS or other government body for advice?

- ▶ Should I ask an OH resource centre for advice?

- ▶ Any other relevant questions.

Activity – Proposing a course of action

> ## Aims
>
> To help you:
>
> ◗ decide how you are going to take up the issue at work.

Task

Use the worksheet on the next page to draw up a report for your union on your strategy. Use this information to:

1. Draft a communication to management outlining the union position.

2. Circulate this to another group for comment.

3. Adapt the communication if you agree with any comments made.

Report back

Appoint someone to present your plan.

Occupational health plan worksheet

Topic:

▶ What are the union's aims?

▶ How should I involve my members?

▶ How should I take up the issues?

▶ What pressure and arguments should I use?

4. Rehabilitation and sickness absence management

Rehabilitation

Although prevention is the primary aim, a good OHS will also need to support workers who are not fit for work. Rehabilitation is about supporting employees who are experiencing difficulties in their personal or working lives. There is a wide range of service providers and in the absence of a national framework for providing OH services the first port of call for most workers who become ill is still their GP.

Key facts

◗ Currently 7.5 per cent of the working age population is claiming Incapacity Benefit (IB) because of sickness or disability.

◗ Approximately 25,000 people a year leave work for ever because of a workplace injury or illness.

◗ In Scandinavia one in two people return to work after a major injury. In the USA it is one in three. In the UK it is just one in six.

◗ A European survey identified the UK as having the second highest number of workers suffering from long-term sickness.

◗ The director general of the Association of British Insurers has described Britain's rehabilitation services as unhealthy, with the current system failing workers and their families.

◗ Only a quarter of employers offer any form of rehabilitation.

◗ There is no legal requirement on employers to consider rehabilitation following an injury or illness.

Existing guidance

There are no specific laws on rehabilitation. In the absence of clear legal standards and national framework there are the following:

◗ TUC – A number of reports have been published which are referenced on the rehabilitation section of the TUC website (www.tuc.org.uk).

◗ HSE Guidance – *Managing Sickness Absence and Return to Work* HSG249 contains advice to employers. The role of trade unions is emphasised in the guidance, and reps should quote from it when setting up or reviewing procedures. It states: "It is essential that you involve them in agreeing your procedures for helping employees return to work."

◗ The Vocational Rehabilitation Association (VRA) was set up to promote the knowledge, attitudes and skills of people in the profession. It defines vocational rehabilitation as "a process which enables persons with functional, psychological, developmental, cognitive, and emotional impairments or health conditions to overcome barriers to accessing, maintaining, or returning to employment, or other useful occupation". The VRA has published a set of professional standards that can be used to assess quality of provision at www.vocationalrehabilitationassociation.org.uk/standards

◗ The Chartered Institute of Personnel Development (CIPD) has issued a guide entitled *Recovery, Rehabilitation and Retention*. This covers support for employees suffering from stress and other mental health problems. www.cipd.org.uk

There needs to be a clearly understood policy to help employees return to work. The TUC believes that a rehabilitation policy framework should be part of the health and safety policy. The important thing is that there is a clear policy rather than ad hoc arrangements.

UNISON lists a number of features that should be part of a rehabilitation policy:

◗ It should be consistent with related policies like return to work, sickness absence management and capability procedures.

◗ It should not be linked with the disciplinary procedure.

◗ There should be a clear relationship with any OHS provision.

◗ An independent case manager should be allocated to liaise with.

◗ Advice of the GP or medical specialist should be followed in planning a return to work.

◗ A range of options should be available:

▢ alteration of job/task where necessary

▢ alteration of workplace/workstation where necessary

▢ phased return to work

▢ provision of adaptations, aids or re-training

▢ changes to working hours

▢ transfer to a different job on a temporary or permanent basis

▢ transport arrangement – for example, the option of home working where travel is difficult.

◗ If hours are reduced or the job is changed there are no legal rights to pay protection. However, it should be considered sympathetically. Equally, reduced hours are no good unless the workload is reduced accordingly.

Case study 1:

Royal Mail

Staff have access to a trauma management programme if they have been exposed to abuse or violence. This provides assistance in cases ranging from verbal abuse to armed raids. Independent research conducted in 2007 by the British Occupational Health Research Foundation (BOHRF) reported that effective trauma management can reduce staff absence. The support offered by the employer played an important part in recovery.

Case study 2:

Rehabilitation in Royal Mail

Following discussions with the CWU, Royal Mail set up a Rehabilitation Centre on the Mount Pleasant site, North London, in 2005. Additional centres have now been established in Birmingham and Sheffield. Discussions are taking place in Scotland to extend coverage of the centre to include the Royal Mail supply chain. The centres are run by an external provider, which manages individual cases and produces a return to work plan.

Return to work policies

Return to work policies can be used in a positive way if the correct procedures are in place. If not they may be used to intimidate staff on return from sick leave. UNISON suggests some of the following safeguards:

◗ Employers should ensure that an employee is fit to return to work. In many places a culture of 'presenteeism' exists that drives people back to work before they are recovered. TUC research found that 75 per cent of workers have struggled into work when they are too ill. The most common reason given was that they 'did not want to let people down'.

◗ Employees should be routinely offered assistance, help, counselling or action on work-related problems.

◗ An employee should be able to talk to someone of the same gender, another disabled person or someone other than their immediate supervisor.

◗ Where return-to-work interviews are used:

▷ there should be clarity on their purpose so that they do not change into a disciplinary process. It should be made clear how the disciplinary process may be triggered.

▷ there should be clarity on the circumstances under which they can be held (e.g. period of absence).

▷ there should be safeguards on confidentiality and limits on the range of questions. This may need to be considered alongside any agreement on the process for obtaining ill health data (see Section 1 of this book).

▶ the right to be accompanied by a trade union rep

▶ the outcome should be agreed. Employees should be able to challenge aspects they are not happy with

▶ managers should be trained on the policies, including duties under the Disability Discrimination Act.

The HSE identify six elements in the return to work process in HSG249:

1. **Recording sickness absence.** The HSE has developed a Sickness Absence Recording Tool to standardise data.

2. **Keeping in contact with sick employees, including return to work interviews.** The HSE suggests "it is advisable to contact sick employees as early as possible, and certainly before 14 days go by". This is a sensitive issue and HSE make the point that "such visits should be carefully prepared with the employees' consent and in liaison with relatives or other appropriate people, e.g. **trade union** and other employee representatives…". The conduct of the return to work interview is an opportunity to discuss any reasonable adjustments before the return to work. The guide says: "The employee may wish to have a trade union representative present."

3. **Planning and undertaking workplace controls or adjustments to help workers on sickness absence to return and stay in work.** Examples of reasonable adjustments are:

   ▶ Adjustments to working arrangements, for example a phased return building from part-time to full-time hours, or flexible working.

   ▶ Adjustments to premises, for example alterations like ramps.

   ▶ Adjustments to the job, for example provide new or modified equipment, modify work patterns to reduce pressure and give the employee more control. Jobcentre Plus may provide support via an Access to Work (ATW) adviser. Grants may be available to cover the cost of adjustments.

Case study 3:

Reasonable adjustments

Paula was employed as a customer service assistant for a local newspaper when she was involved in a motorcycle accident on a day off. Her injuries meant she needed a wheelchair. Hers was a desk job dealing with customer queries but it did involve her moving from office to office in a big building. To enable Paula to return to work, her employer made adjustments to the glass panels in the doors on her routes at wheelchair height, changed the work surface area so that Paula's wheelchair could fit in and provided a suitable car parking space.

(from: HSE Guidance – *Managing Sickness Absence and Return to Work* HSG249)

4. **Making use of professional advice and treatment.** There may be occasions when specialist advice is needed. This may be available in-house or from an external service.

Case study 4:

Professional treatment

A long-standing back problem kept a 55-year-old mechanical fitter off work regularly. During the latest absence, he suffered constant pain, restricted mobility and depression. But, after a three-week course of exercises, physiotherapy, hydrotherapy, gym work and pain management, the future looked much brighter, as he was able to return to work on a phased plan.

(from: HSE Guidance – *Managing Sickness Absence and Return to Work* HSG249)

5. **Agreeing and reviewing a return to work plan.** The plan needs to be tailored to the specific needs of the employee concerned. The guide recommends that "arrangements have been made to review the plan with the employee and trade union at suitable intervals and at its end".

6. **Co-ordinating the return to work process.** In many cases this means appointing someone to act as a co-ordinator to ensure arrangements proceed smoothly. The guidance says: "in some cases a **trade union** or other employee representative may be able to act as co-ordinator." In more complex cases 'case management' may be needed. A 'case manager' is typically someone professionally qualified in a relevant medical area who may be involved in the treatment of the returning employee.

Case study 5:

Return to work

Sheffield Occupational Health Advisory Service (SOHAS) has produced a useful fact sheet on 'Return to Work'. It refers to a study of workers who were sick after a heart attack. Those who had received the best help available returned to work three weeks earlier and were almost £1,400 better off six months after the heart attack than those who hadn't.

Seven key actions for a successful policy statement

Appendix 4 of HSG249 provides guidance on the content of a return to work policy. It suggests:

1. Discuss and agree the content with trade union representatives.

2. Get the practice right – consider piloting it before committing it to a statement.

3. Write the content in plain language, ensuring it is clear who is responsible and accountable for carrying out any actions or procedures.

4. Make sure everyone understands their responsibilities and has the skills and knowledge to put them into practice and provide training if necessary.

5. Check that procedures are put into operation and are carried out consistently for all employees affected.

6. Invite feedback from employees, trade union and other employee representatives and review the content accordingly.

7. Keep factual information up-to-date.

Rehabilitation and the Disability Discrimination Act

For the purposes of the DDA, an individual is defined as having a disability if they have a "physical or mental impairment which has a substantial and long-term adverse effect on her/his ability to carry out normal day-to-day activities". When considering whether a person is disabled, an impairment is taken into account only if it affects the person in respect of one or more of the following:

▶ mobility

▶ manual dexterity

▶ physical co-ordination

▶ continence

◗ ability to lift, carry or otherwise move everyday objects

◗ speech, hearing or eyesight

◗ memory or ability to concentrate, learn or understand and/or perception of physical danger.

A 'long-term effect' is one that has lasted or is likely to last at least a year, but an individual does not have to have been disabled a year to claim – as long as the disability is likely to last that long or is recurring (Greenwood v BA [1999] IRLR 600).

The relationship between rehabilitation and the DDA can be examined by looking at an example of a physical impairment (cancer) and a mental impairment (mental ill health).

Cancer

When the DDA was amended in 2005, people with cancer, HIV infection or multiple sclerosis were deemed to have a disability from the point of diagnosis. However, this has not made using the law automatically easier.

Almost 15 per cent of workers with cancer claim they are forced into redundancy or ill-health retirement, according to an analysis of calls to a helpline operated by the Disability Rights Commission (DRC). (see 'Employers still discriminating against workers with cancer despite new legal protection', press release, DRC, 5 October 2006, www.drc.gov.uk)

Since December 2005, when amendments were made to the DDA extending legal protection to people with cancer, the DRC has taken an average of two calls a week from women with breast cancer complaining of unfair treatment at work.

Some women complain to the helpline of being bullied and pressurised into returning to work full time immediately after major surgery, rather than being given the option of a phased return.

Others have reported of job offer withdrawals after disclosing their medical history, or being expected to return to a lower-paid, or lower-status job after medical treatment.

The vast majority (82 per cent) of workers with cancer who had made employment-related complaints to the DRC said that employers were failing to make reasonable adjustments to enable them to stay in work. A further 14 per cent of the 103 callers to the helpline claimed they had been threatened with dismissal as a result of their illness (see table, page 106).

Following amendments to the employment provisions of the DDA in 2005, workers with cancer and other long-term health conditions have been protected against direct discrimination at work – that is, less favourable treatment on the grounds of disability.

For example, denying promotion or training to a person with cancer is unlawful, as are recruitment policies that exclude prospective employees with cancer or a history of cancer. Employers are required to make reasonable adjustments to employment practices and premises if these substantially disadvantage people who have cancer or other long-term illnesses.

For example, if a person with cancer needs to undergo treatment and rehabilitation the employer should consider granting leave to cover this period and enable a return to work after treatment.

The DRC commented: "Despite changes to the law to protect people with cancer and long-term health conditions from unfair treatment at work, many employers still haven't got the message. Direct discrimination and failure to make adjustments is turning the world of work into a very hostile environment for workers with these disabilities."

Cancer-related complaints made to the DRC	
Nature of complaint	**Per cent of all calls relating to cancer**
Employers not making reasonable adjustments	82.0
Dismissed because of disability; capability concerns; sickness absence; dismissed after informing employer of medical condition	18.0
Forced into redundancy/ill-health retirement	14.5
Threatened with dismissal/redundancy	13.5
Disability-related absence has led to disciplinary action	7.5
Job relocated due to disability	5.8
Issued with formal warning due to taking time off to attend treatment	5.8

Based on 103 calls to the DRC helpline between December 2005 and August 2006. Source: DRC.

Mental ill health

Safety reps have identified stress as the biggest risk facing their members in all of the TUC biennial surveys. In 2006, 61 per cent cited stress as a main hazard of concern to workers. Section 3 of this workbook shows how reps can identify and deal with the problem (see pages 70–73). Sometimes stress can become so bad that it develops into mental ill health. Interventions at an early stage are crucial to avoid job loss. Once someone has lost their job it is very difficult to get back into employment. People with mental health problems have the lowest employment rates of any of the main groups of disabled people. Helping people with mental health problems to retain their employment is vitally important. As well as a source of income, work supports social status and self-esteem and is often an important part of the recovery process for those with mental ill health.

In 2005 the CBI estimated that based on a working year of 228 days, 6.8 days per year are lost due to absence, and 36 per cent of absences are caused by stress, anxiety and depression. This is 2.5 days per person per year caused by the most commonly experienced mental ill health problems.

Research undertaken by The Mental Health Foundation found that 47 per cent of people who had experienced mental distress said they had experienced discrimination in the workplace, and 37 per cent had experienced discrimination when seeking employment. Under the DDA there is no longer a requirement for a mental impairment to be 'clinically well-recognised'.

Mental health issues are not just a matter for safety reps. Stewards and branch officials often deal with attendance and sickness absence through HR and management structures – not always familiar territory for safety reps. This means keeping in touch with other reps is a priority.

TUC Education has developed a course on Mental Health Awareness. For more information see www.unionlearn.org.uk/courses

In 2006, 61 per cent cited stress as a main hazard of concern to workers.

Occupational health referrals

An OH referral is a form of personal assessment. It is important that workers are designated as 'fit to work', but as with other policies it is important that safeguards are built in to ensure they are not abused. PCS has produced a 'Know Your Rights' information series with advice that recommends:

- ▶ trade union involvement at all stages of the process
- ▶ putting in writing any concerns about the request
- ▶ agreeing the content of the line manger's report before consenting to the OH referral
- ▶ that the staff member should be given a reasonable period of time to consider the OH report before subsequent meetings with the line manager
- ▶ that any recommendations should be kept under review.

What can safety reps do?

There is a growing acceptance that greater effort is needed to retain employees who have been affected by poor health, injury or disability in paid employment. As seen, employers and OH services have a key role to play in this. Safety reps can negotiate a rehabilitation policy framework (using TUC and HSE guidelines) and integrate this with policies related to disability, sickness absence and retirement. Key elements of the policy could include the following:

- ▶ making rehabilitation a policy goal
- ▶ investing in employee health, providing access to good OH facilities and workplace health initiatives
- ▶ being responsive to absence: monitoring health, keeping in touch with sick employees, responding early with referral for medical checks, being alert to disability issues and applying practical rehabilitation measures
- ▶ not making health a disciplinary matter
- ▶ assuming in the first instance that sickness absence may be due to work-related causes that should be investigated
- ▶ involving all levels of management in rehabilitation, including line managers, personnel/human resources managers, OHSs and senior managers
- ▶ working with unions and their members, being open on health and absence issues, and involving them fully in the development of relevant policies.

One of the main purposes of medical examination must be to see how the employer can help people adjust to the demands of their work, assessing permanent disabilities or those that arise temporarily from injury or illness or age or other factors. Employees – who may need alternative work or adjustments in their work regime or continued medical surveillance up to the time of full resumption of normal work – should have the benefit of an OHS.

Confidentiality and mutual trust are vital in this process. Disclosure by workers of difficulties in coping with their work must not lead to transfer, downgrading or even redundancy. As advised by the OHS, employers should arrange for alternative and comparable employment or suitable retraining. These new arrangements should be put in place only after discussions between management and trade union reps.

Compensation

The TUC believes the key task of any government should be to prevent people being made ill through work. However, when an injustice has been done the victim should be entitled to redress for any loss or injury. In many cases the actual loss or suffering can be mitigated if the person has early access to rehabilitation.

Trade unions do not see litigation as an obstacle to rehabilitation because despite the adversarial aspects of compensation cases they have been one of the main drivers for interest in rehabilitation. It is worth noting that in practice the vast majority of people for whom rehabilitation would be useful never lodge a claim. A TUC survey showed that only one in eight people injured or made ill through work made any claim from either their employer or the state.

Safety reps investigating work-related ill health will need to ensure that all relevant documentation is collected and forwarded to the union legal department if there is potential for a claim. Sometimes the threat of a claim may be sufficient to make the employer act to improve control measures to deal with the risk. In some cases unions will contact the employer's insurance company directly and inform them of poor occupational health standards, which has sometimes led to insurers carrying out investigations and insisting that unless changes are introduced cover may be withdrawn.

Making a claim for work-related ill health is usually not as straightforward as it is for an injury. Apart from often taking longer it is more likely to be complicated by an employer's defence that non-work factors caused or contributed to the problem.

Sickness absence management

Key facts

▶ According to the HSE, sickness absence costs the UK £12 billion a year. Employers pay on average £537 in direct costs for every employee (CBI statistics, 2006).

▶ 83 per cent of employers respond to non-attendance with disciplinary measures, according to the Chartered Institute of Personnel Development (CIPD).

▶ The Confederation of British Industry (CBI) reports that employers believe that 14 per cent of absence is 'non-genuine'.

The CBI Report *Attending to Absence – Absence and labour turnover 2007* (www.cbi.org) found that employees took an average of seven days, sick leave in 2006. The CBI also claim that absence is 44 per cent higher in the public sector compared to the private sector.

There is an increased public focus on sickness absence, with many employers reviewing their procedures. Not all sickness absence is caused by work, but a significant amount is directly or indirectly related to it. The current push on sickness absence is influenced by a suspicion held by many employers that a significant percentage is not genuine. This ignores the fact that there are many people who struggle into work sick and not only infect their colleagues but are also far less productive as a result. This approach also fails to recognise the influence of work factors. For example, distortions in absence patterns could be due to stress and overwork.

Independence of OH staff

In many workplaces OH advisers are expected to be more business-focused and proactive in managing sickness absence. This can affect how OH staff are perceived by workers. OH staff must always be independent of management, given the conduct and medical ethics that apply to the profession.

In recent years there has been an increased linkage of sickness with disciplinary procedures. In some organisations a specified number of sick leave days will trigger a disciplinary interview. In some cases this is linked to a capability procedure that allows for 'short-term health problems' and 'poor attendance at work, related to genuine ill health' as reasons for dismissal. Formulae like the contentious 'Bradford Factor' (see opposite) are used to target short-term absence. Issues around sickness absence are often dealt with through HR within management structures, usually involving branch reps rather than safety reps so it is vital that the link between safety reps and branch reps is strong and that they talk to each other.

The 'Bradford Factor'

The Bradford Factor is one of several trigger mechanisms for dealing with absence. It is meant to illustrate how disruptive short-term absence can be compared to less frequent but longer spells of absence. The number of absences squared is multiplied against the total number of days to give a weighted 'score'. It produces a different 'score' for the same number of days off depending on how many episodes make up the absence. The problem is that the score can be applied too rigidly and may create an unfair system.

Safety reps will need to work closely with other union colleagues on this as there is considerable overlap with other procedures. Prospect has given the following guidance for union reps:

▶ Establish at the outset exactly how the Bradford Factor (or any other similar scoring system) is to be used in your organisation. Get this in writing with its remit established. Otherwise, there is a risk that it could creep into other areas without prior agreement.

▶ Ensure that your employer agrees to remove any disability that qualifies under the Disability Discrimination Acts 1995 and 2005, and any pregnancy-related absence.

▶ Find out what other measures are going to be used to manage overall sickness absence levels, not just those of a high-frequency, short-term nature.

▶ If there are ongoing or impending organisational changes, establish what, if any, allowances are going to be made for the likely increase in sickness absence as a result.

UNISON has suggested that, in addition to disability and pregnancy-related absence, the following types of absence should be excluded:

▶ absences due to work-related injury/illness and assaults by members of the public

▶ absences due to communicable diseases

▶ particular illness outbreaks like flu epidemics

▶ one-off planned absences (e.g. an operation).

UNISON sickness absence survey

A survey of more than 800 UNISON safety reps found that fewer than two-thirds (61 per cent) of policies incorporated the need to identify and remedy illness caused through employment.

UNISON's guidance recommends the introduction of agreed policies such as bullying and harassment procedures to stop employers abusing the sickness absence policy. This should be linked to a stress prevention policy with 'stress audits' undertaken as a first step. Absence caused by work-related ill health "should always be excluded from general absence monitoring".

UNISON suggests that the sickness absence policy itself "should be subject to risk assessment, to ensure that it is not contributing to work-related stress or causing workers to return to work before they are fit".

Union agreements on sick leave

A worker off sick with a work–related injury has no enhanced legal rights to sick pay or sick leave. A number of unions have covered this in agreements:

Fire Brigades Union (FBU) has an agreement that staff on authorised sick leave are entitled to full pay for the first six months – but if their absence is the result of an injury arising out of authorised duty, they receive full pay for one year.

Union agreements with local government have clauses like:

Any absence resulting from injuries sustained while undertaking council work "will not be included in calculations for general sick pay entitlement unless the employee is at fault". (Buckinghamshire County Council).

Absence arising from normal sickness "is entirely separate from absence due to alleged industrial disease, accident or assault arising out of or in the course of employment with the council". (Peterborough City Council)

Disability leave as a collective bargaining issue

The DRC has drawn up a Code of Practice that includes disability leave and gives some examples of where disability leave would be a reasonable adjustment:

DRC example of disability leave

A woman with an autoimmune disease has taken several short periods of absence during the year because of the condition. When her employer is taking absence into account as a criterion for selecting people for redundancy, he discounts these periods of disability-related absence.

Case study 6:

UNISON and the London Borough of Merton

In the London Borough of Merton, a joint trade union/employer policy on disability-related leave states:

"Disability leave will not be used for the purpose of assessing performance, promotion, attendance, selection for redundancy or related other issues. To do so could lead to potential claims of discrimination by the disabled employee."

Scott Arlow, the local UNISON rep, feels "this is a really positive move for our members who have disabilities, they feel this is a real achievement and it takes away any fear of taking time off".

The law and other standards

Employment Rights Act 1996: Sickness absence comes under the definition of 'capability' so is potentially a fair reason for dismissal. This can be as a result of a long-term illness or frequent short-term illness. Whether it is fair will depend on the 'reasonableness' in the circumstances. The cause of the absence is a factor in determining what is reasonable. An employer can dismiss someone who has a work-related injury or illness, but the cause of illness should still be taken into account.

Access to Medical Reports Act 1988: Gives employees the right to see medical reports prepared by their own GP, or any other medical practitioner responsible for their care, in connection with their employment. Under this Act an employer must obtain the employee's consent before seeking a report from their doctor and must inform the employee of their rights under the Act. The individual has the legal right to have a copy of the report before it is forwarded to the employer and is entitled to query items in it and ask the doctor to amend it. If the doctor refuses to accept changes to the report, the employee can attach a statement to it stating their objection.

Access to Health Records Act 1990: Gives individuals the right to apply for access to records relating to them that are held by a health professional. The definition of 'health professional' covers a company doctor who is not responsible for the employee's care.

Data Protection Act 1998: Health and sickness absence information is classed as 'sensitive personal data' under the Act, which means it is subject to greater controls. Employees have the right to see information that is held about them either on computer or in a manual filing system.

Case law on sickness and dismissal

Legal rights in the field of unfair dismissal are not as good as they should be. The case of McAdie v Royal Bank of Scotland [2007] EWCA Civ 806 established certain principles but still resulted in victory for the employer. Nevertheless, the Employment Appeal Tribunal (EAT) held that the reason for an employee's sickness absence is a factor that a tribunal can take into account in deciding whether a dismissal was fair.

The EAT did state that employers should "go the extra mile" in looking for alternative employment, or tolerate longer periods of absence than might otherwise be considered reasonable, in situations where an illness or injury was caused by work.

This case was brought under the unfair dismissal provisions of The Employment Rights Act 1996, but if the worker comes within the scope of the DDA they may be able to bring a claim of disability discrimination. If a dismissed employee's sickness absence was caused by bullying or harassment (such as sexual harassment), a claim could be brought under the relevant equality legislation.

Health and Safety Executive guidance

The HSE has produced a guide for safety reps, Working Together to Prevent Sickness Absence becoming Job Loss. This can be found on the worker's homepage of the HSE site at www.hse.gov.uk/workers/safetyreps/

It has also produced guidance and tools for employers. These include a Sickness Absence Recording Tool (SART), available at www.hse.gov.uk/sicknessabsence/issues.htm

UNISON's guide to sickness absence agreements, Making Us Better, is available at www.unison.org.uk

There are also case studies on how sickness absence has been improved in five organisations: www.hse.gov.uk/sicknessabsence/experience.htm

The TUC view on rehabilitation

The TUC believes that access to rehabilitation is vital. Clearly rehabilitation can work only if it flows from wider OH provision. However there are some aspects of rehabilitation that do require it to be dealt with separately.

The TUC has raised the importance of rehabilitation with the Government many times in recent years. It held three conferences on rehabilitation in 2000 and in 2002 produced a discussion paper jointly with the Association of British Insurers (ABI). It has followed that up with policy papers on rehabilitation and retention.

Britain is certainly lagging behind many other countries when it comes to rehabilitation. In Scandinavia 50 per cent of people return to work after a major injury. In the USA it is roughly a third. In the UK the figure is one in six.

Currently access to rehabilitation primarily focuses on serious injuries. However there is some evidence that rehabilitation can be extremely effective in relation to both MSDs and also mild to moderate health conditions caused by stress. Between them these groups of conditions make up over 70 per cent of work-related sickness absence. They are also the major cause of long-term sickness absence, whether work-related or not.

Unfortunately uptake of rehabilitation is extremely limited. There is no legal requirement on an employer to consider rehabilitation following an injury or illness.

At the same time, even if an employer does wish to provide access to rehabilitation, there are many barriers in the way. The first is how to access rehabilitation services. In the absence of a national framework for providing rehabilitation services, the first port of call for most workers is still their GP. The majority of employers are content to allow the GP to deal with the condition rather than instigate any other intervention.

There is also a lack of knowledge on the part of employers (and many others) about what action is effective, for what condition and when.

Britain is certainly lagging behind many other countries when it comes to rehabilitation.

Vocational rehabilitation is an industry where, in some areas, there is a lack of consensus on issues around competency and professionalism. While there are some areas where levels of competency are well understood, such as physiotherapy, this is not universal across all disciplines.

Sadly, while everyone agrees that rehabilitation is important, making progress is a different matter. Often access to rehabilitation is dependent on the employer's insurers and is therefore reliant on both a claim for compensation being lodged against the employer and liability being agreed. Unfortunately only around one in 10 workers injured or made ill through work makes any claim and often this is many months after the incident.

In addition, half of all compensation claims are lodged, not against the employer, but with the state Industrial Injuries Benefit Scheme. Again there is no link with rehabilitation. As most claims under the accident provisions are made at least 90 days after the injury, and often several years after, the scheme would have to be changed to encourage early claims before a condition has become chronic and disabling.

For employers, the main issue – apart from where to go to access services and when – is who pays up-front for rehabilitation; them, the insurer, or the state. They are also concerned about tax implications.

Nevertheless, there is a consensus that access to rehabilitation can, in most cases, be cost effective. There is also a consensus that the case manager system is the most effective way of providing and managing rehabilitation.

The TUC believes there is an urgent need for a national framework of rehabilitation, underpinned by national standards. It also wishes to see greater provision of rehabilitation through the NHS, preferably using NHS Plus, as well as a statutory right to access to rehabilitation.

The TUC view on sickness absence

The management of sickness absence in the UK is, to say the least, patchy. Many employers still believe that Britain has a 'sickie culture'. The reality is very different. The average number of sick days lost has fallen consistently over the past 10 years and numerous surveys have found that far more people come into work when ill than do not come into work when actually well by faking illness.

Much has also been made of the difference between absence rates in the public and private sectors. It is claimed that this shows that the private sector deals with the issue better and that a lot of absence in the public sector is therefore faked. However, differences relate almost exclusively to long-term sickness absence and simply reflect the differences in payments made to workers while off sick between the sectors rather than any real difference in how the sectors deal with the issue.

Unfortunately many managers still see the management of sickness absence as being about trying to get an employee to return to work as soon as possible. This means sickness absence policies are often just another method of employer control that do nothing to tackle work-related causes of ill health and injury and can increase workplace bullying through the way they are implemented by managers. Often punitive policies are used against those who are ill, or absence targets and scoring systems are used that ignore valid causes of sickness and individual circumstances.

A positive sickness absence policy can help to pinpoint work-related issues such as health and safety risks, stress and bullying. It can tackle organisational issues that give rise to absence and provide support to promote staff attendance through positive interventions, which can have a significant effect on reducing absence. It must be linked to return to work policies and rehabilitation policies. There is considerable evidence that where an employer has attempted to manage sickness absence and return to work issues with trade unions or safety reps is has made considerable inroads.

The HSE has produced clear and practical advice on the management of sickness absence and the TUC would commend this as the template employers should use. The

The TUC believes that any shift to company doctor-issued sick notes would work only if staff believed there was 'unbiased and independent advice on treatment'.

production of further guidance, such as that being considered by the National Institute for Health and Clinical Excellence (NICE), confuses the issue. Instead the Government should be encouraging employers to adopt the HSE guidance.

Linked to the management of sickness absence and return to work is the role of GPs. There is considerable pressure for a change in the way GPs are involved in sickness absence from employers who want to maximise attendance and also from GPs themselves who feel that it is not their role to write sick notes. The piloting of alternatives is already underway. Some of these pilots, such as proposals to introduce electronic sick notes, may prove to be useful, but in addition there is considerable interest in company doctors and other OH professionals becoming the first contact for sick employees.

This move is not a practical one for most employees as very few have access to an occupational physician and for many workers, even if there is provision, it often only amounts to an OH nurse at a company head office that can be many miles away. Nurses are also not in a position to diagnose and treat conditions in the same way as doctors.

The TUC believes that any shift to company doctor-issued sick notes would work only if staff believed there was 'unbiased and independent advice on treatment'. Many workers see employers' doctors as having closer links to the HR department than the workforce. On the other hand, GPs are seen as independent health advocates from outside the workplace whose sole concern is the health and wellbeing of the patient rather than industrial relations issues.

It is likely that, for the vast majority of workers, the GP will remain the first point of contact. Unfortunately many GPs will have no idea what job a person does or who they work for. The TUC believes that GPs should have to record the occupation and postcode of the employer for every patient who is in work. As well as helping GPs relate a problem to a person's work, it would also make work-related ill-health trends surveillance easier.

In addition, most GPs at present have little training or awareness of occupational medical issues. It is only recently that there has been any mention of occupational medicine in undergraduate medical training and even now it is woefully inadequate. Also, there is currently no occupational medicine element in the training of most GP registrars, though that is likely to change in the future. The TUC would like to see more training of GPs in OH issues, more GPs with an interest in occupational medicine, and also the introduction of occupational medicine into secondary care.

The TUC believes there is a role for both GPs and OH physicians and other professionals in the management of sickness absence. In January 2003, a survey by Leeds Occupational Health Advisory Service found GP referrals to surgery-based OH advisers led to 55 per cent of patients saying they made fewer visits to their GP, 30 per cent saying it helped them return to work earlier, and over 30 per cent saying it led to 'positive action' to improve health and safety at work.

The preference for the TUC is a mix of interventions in OH involving GPs, specialist GPs within each area and also the use of OH advisers working alongside GPs in surgeries. However, replacing GPs as the first point of contact for most workers would be completely inappropriate. Not only do most workers have no access to an occupational physician, but they also have no idea whether their illness or injury is occupational or not. Other models, such as setting up telephone lines for people to discuss their illness with a nurse, are usually viewed as an attempt by employers to get people to return to work as soon as possible rather than to seriously support those who are ill.

Unfortunately, at the other extreme, the TUC believes that the current 'sick note' system has led to a position where employers often abdicate responsibility for a sick individual, seeing it as simply a matter between the individual and their GP. This often means that workers have no contact with their employer while signed off sick beyond simply sending in a new sick note at regular intervals. This has major implications for access to rehabilitation.

In addition the sick note system has led to the development of a culture where a worker is considered either completely unable to work, or completely fit to work. The reality is that for many workers there will be a period where they may feel able to return to work but unable to fulfil their full duties. Many employers refuse to allow a worker back until such time as they are 'signed back on' by their GP. This is often because of fear of compensation claims if the person becomes injured again. In addition, a worker who does return to work part-time can often find that their benefits are withdrawn. The removal of the Reduced Earnings Allowance made this position worse.

In reality, many workers would choose to come back on a gradual basis – either on reduced hours, or a reduced workload – following a long period of absence. The TUC believes this should be encouraged. Unfortunately, such a system would also be open to abuse by employers. Employers may attempt to force a worker to return to work before they feel confident to do so. Any moves for an early return to work on a reduced basis should always be initiated by the employee. In addition, there is a danger that where a worker returns to a work environment that was responsible for their injury or illness in the first place, then this could lead to a relapse. This is particularly the case with MSDs and psychosocial disorders.

There is also some confusion over the health benefits to the employee of returning to work early. Guidelines on the management of back pain are quite clear that, in most cases, some activity can play a major part in rehabilitation. That has been interpreted by some as meaning that it is in the employee's best interest to return to work as soon as possible. This thinking has been applied to other MSDs by some employers. In actual fact there is little evidence that a return to work, as opposed to moderate physical activity, has a positive role in assisting recovery of any MSD, including lower back pain. An additional factor is that if a person is asked to return to work in an environment that may have led to, or made worse, an MSD, then this could either make a relapse more likely or delay recovery.

Activity – Rehabilitation policies

Aims

To help you:

▶ review existing standards in rehabilitation policies

▶ establish trade union guidelines for rehabilitation policies.

Task

1. Do you have a written rehabilitation policy?

   If yes, work in a group and answer these questions:

   ▶ Was there any input from the trade union side?

   ▶ Is the rehabilitation policy part of the safety policy?

   ▶ What strengths does your rehabilitation policy have?

   ▶ What weaknesses does your rehabilitation policy have?

   If no, work in a group to decide:

   ▶ the arguments you could use to obtain one

   ▶ some key points that should be part of a rehabilitation policy.

Using the resources in the book and in your group outline the main features of a good rehabilitation policy.

Report back

A flipchart will be passed around the room with the heading 'Trade Union Rehabilitation Policy Guidelines'. Each group will be asked to contribute a point until all ideas have been added.

Activity – Rehabilitation in practice

Aims

To help you:

- ▶ identify examples of good and bad practice
- ▶ apply the Disability Discrimination Act to get people back to work.

Task 1

Think about people who have been off work with ill health. Did they have a disability covered by the DDA and, if so, was anything done to accommodate them? If your group has examples, put them into good or bad practice categories.

Task 2

Your group will be allocated two of the conditions from the table below. Decide whether the conditions described could be covered by the DDA and give examples of the types of adjustment that could be possible.

Condition	Is it a disability under the DDA?	Give examples of possible 'reasonable adjustments'
Arthritis		
Asthma		
Cancer		
Depression		
Epilepsy		
Hand-arm vibration syndrome		

Condition	Is it a disability under the DDA?	Give examples of possible 'reasonable adjustments'
Heart attack		
Noise-induced hearing loss		
Tenosynovitis		
Any other relevant to your workplace		

Report back

Choose a reporter to:

- give one example of a good and a bad rehabilitation practice

- indicate how the DDA could be applied for two conditions.

Activity – Sickness absence management

Aims

To help you:

◗ review how sickness absence is managed

◗ develop guidelines on sickness management procedures.

Task

In groups compare how sickness absence is managed in the workplace.

Discuss:

◗ whether you have a sickness management procedure

◗ the role of occupational health

◗ whether the 'Bradford Factor' or another type of trigger factor is used

◗ how issues of confidentiality are dealt with

◗ how absence due to disability is treated

◗ the role of the union.

Compare your procedures with the advice in the HSE pamphlet *Working Together to Prevent Sickness Absence becoming Job Loss: Practical advice for safety reps and trade union reps* found at www.hse.gov.uk/pubns/web02.pdf

Use any ideas from the above to produce a checklist for safety reps on sickness management procedures.

Report back

Appoint someone to report back on your guidelines.

5. Strategies for occupational health

- **Social inequalities in health**

- **Government agenda**
  - Securing health together 2000–2010
  - HSC strategy for workplace health and safety to 2010 and beyond
  - Workplace Health Connect
  - Community-based services
  - The Health, Work and Well-being Strategy
  - Is work good for your health and wellbeing?
  - Welfare and benefit reforms

- **International agenda**
  - European Union strategy 2007–12
  - World Health Organisation Global Plan of Action 2008–2017

- **Trade union initiatives**

- **The TUC view on social security benefits and health**
  - The relationship between health and work

- **Activity – Influencing the trade union agenda**

- **Activity – Action plan**

Social inequalities in health

Inequalities in health are marked by social class. This view was expressed by the Government chief scientist Sir Douglas Black who chaired the Inequalities in Ill Health Research Working Group. The Group produced the *Black Report* in 1980 which highlights the importance of class as a factor in determining things like life expectancy and infant mortality, as the extract below illustrates:

The Black Report 1980

Most recent data shows marked differences in mortality rates between the occupational classes, for both sexes and at all ages. At birth and in the first month of life, twice as many babies of "unskilled manual" parents (class V) die as do babies of professional class parents (class I) and in the next 11 months four times as many girls and five times as many boys. In later childhood the ratio of deaths in class V to deaths in class I falls to 1.5–2.0, but increases again in early adult life, before falling again in middle and old age. **A class gradient can be observed for most causes of death, being particularly steep in the case of diseases of the respiratory system**. Available data on chronic sickness tend to parallel those on mortality. Thus self-reported rates of long-standing illness (as defined in the General Household Survey) are twice as high among unskilled manual males and 21 times as high among their wives as among the professional classes.

An example from the report shows that a construction labourer is more than five times more likely to die before the age of 65 compared to a construction manager.

Poor health standards at work are made worse by other socio-economic factors like poor housing, diet and access to healthcare. All of these factors are influenced by social class and the class of parents. People in Social Class V or those that are unemployed are more likely to experience feelings of low self-esteem, which can be expressed in health-related behaviour such as addiction and risk of dependence, stress, worse health outcomes and violence. It can overlap with psychosocial factors experienced at work.

A review of the report in 2005 showed that differences in life expectancy and infant mortality between working class and middle class people had widened.

The Whitehall Studies

The Civil Service also researched the relationship between class, job and ill health. The first Whitehall Study (the Whitehall I Study) investigated social determinants of health, specifically the cardio-respiratory disease prevalence and mortality rates among British male civil servants between the ages of 20 and 64. The Whitehall I Study was conducted over a period of ten years, beginning in 1967. A second phase, the Whitehall II Study, examined the health of 10,308 civil servants aged between 35

and 55, of whom two thirds were men and a third women. A long-term follow-up of study subjects from the first two phases is ongoing.

The initial Whitehall Study found lower grades were clearly associated with greater propensities for significant risk factors, including obesity, smoking, reduced leisure time and physical activity, more baseline illness, higher blood pressure, and shorter stature. The studies found a strong association between grade levels of civil servant employment and mortality rates from a range of causes. Men in the lowest grade (messengers, doorkeepers, etc.) had a mortality rate three times higher than that of men in the highest grade (administrators).

WHO has studied how employment and working conditions contribute to social inequalities in health. A 2007 report highlighted the strong association between labour market inequality and "unfavourable health outcomes". This is particularly pronounced in the rapidly growing 'informal' and contracted-out sector.

WHO also gives a strong encouragement to union action on OH:

> "Voluntary measures by employers/corporations have a role to play but are too fragmented and weak to reshape employment conditions and lift standards generally. Historically, it has been government action, often in response to community pressure, that has set social standards. The combination of union and community pressure plays a vital role in ensuring government action. We hope that this report helps communities and unions, as well as interested governments, to make steps towards the realisation of fair employment for all workers, independently of their place of origin, their class, their gender, their age or their ethnic origins."

www.who.int/social_determinants/resources/articles/emconet_who_report.pdf

Government agenda

Securing health together 2000–2010

In this document the HSC states that OH is its "priority theme". The Government is committed to working with interested parties to achieve the ill health elements of its Revitalising Health and Safety Strategy. It contains a number of targets, including:

- a 20 per cent reduction in the incidence of ill health
- a 30 per cent reduction in the number of work days lost due to work-related ill health
- everyone currently in employment but off work due to ill health or disability is, where necessary and appropriate, to be made aware of opportunities for rehabilitation back into work as early as possible

◗ everyone currently not in employment due to ill health or disability is, where necessary and appropriate, made aware of opportunities to prepare for and find work.

The strategy has five elements:

1. **Compliance** – to improve the law in relation to OH and compliance with it. One of the aims is "increasing the involvement of health and safety representatives to promote compliance with the law".

2. **Continuous improvement** – designed to promote a culture of partnership. Again, safety reps are referenced:
   "increasing involvement of employees or their representatives in decision-making processes and implementation schemes".

3. **Knowledge** – collecting data to inform the strategy. The aim linked to safety reps is:
   "employers and workers collaborating to decide data needs within individual workplaces, to help them understand what problems need to be tackled".

4. **Skills** – increasing opportunities for people to gain necessary skills. There are no specific worker/union aims but the examples given refer to trade union training projects organised by the GMB and UCATT.

5. **Support** – improving access to OH support by taking forward the recommendations of the Occupational Health Advisory Committee report. Some of these initiatives are detailed below.

HSC strategy for workplace health and safety to 2010 and beyond

This was overhauled in 2004 and is now based around two core 'strategic delivery programmes': Fit for Work, Fit for Life, Fit for Tomorrow (Fit3) and Major Hazards. Supporting these are four 'strategic enabling programmes' covering partnership with local authorities, worker involvement, business involvement and enforcement. Initiatives in the ill health reduction block of Fit3 have included stress, MSDs, disease reduction, noise and hand-arm vibration and OH through Workplace Health Connect.

Workplace Health Connect

Workplace Health Connect was launched in 2006 as a two-year pilot project. It is based on a model for occupational health, safety and return to work (OHSR) support, developed by the HSE following work undertaken within the Securing Health Together programme. The HSC has endorsed the model and this programme of work to extend access to OHSR support. Workplace Health Connect provides:

◗ a confidential service designed to give free, practical advice on workplace health, safety and 'return to work issues' to smaller businesses (with five to 250 workers) in England and Wales

- an advice line (telephone: 0845 609 6006) and a supporting website at www.workplacehealthconnect.co.uk giving tailored practical advice to callers – both managers and workers – on workplace health, safety and return to work issues

- a service that aims to transfer knowledge and skills directly to managers and workers, enabling them to tackle and solve future workplace health issues themselves

- a service that tests free, problem-solving workplace visits in five separate areas (Greater London, North East, North West, Wales, West Midlands) across England and Wales

- a service that complements Safe and Healthy Working (www.sahw.co.uk), an existing service for small companies in Scotland.

In January 2007, the Institute of Employment Studies (IES), which is evaluating Workplace Health Connect for the Health and Safety Executive, prepared a second Progress Report at www.hse.gov.uk/workplacehealth/whcreportjan07.pdf According to the report, there has been low take-up of the advice line, and only one in ten calls received has been about workplace health. As it is presently structured the service is incapable of dealing with the OH gap in the UK.

Community-based services

Another approach to providing workers and ex-workers with the OH support they need has been developed in a number of occupational health advisory services (OHAS) working in GP surgeries.

In Sheffield, Rotherham, Leeds, Bradford and Liverpool, GPs or patients themselves can refer to an OH adviser for help with preventing a problem at an early stage, working out how to remain in work or how to leave work on the best financial terms if the health problem is more severely limiting, or how to find work if the patient has a disability. There are many advantages:

- The advice is impartial, and can often be given long before an OHS would step in.

- It is available to everyone because nearly everyone has a GP.

- It is linked in to medical records so that any underlying problems can be clearly understood – but it also entirely confidential.

- Advisers can sometimes see emerging patterns in the workforce in the town they are working in.

- Advisers can provide reps with full support if they need it.

- The service fits well with the NHS commitment to reduce health inequalities.

The OHASs have a long record of supporting workers, organising city-wide initiatives on particular health problems, and identifying problems previously not picked up by HSE and local authority inspectors.

The Health, Work and Well-being Strategy

Launched in 2005 and led by Dame Carol Black, the national director for Health at Work, the strategy is a partnership between Government (the Department for Work and Pensions, Department of Health and HSE), employers and healthcare professionals. Its main themes are engaging stakeholders, improving working lives and healthcare for working age people. The report stated:

"Many people work in organisations with little or no access to good quality occupational health advice – advice that can be essential in helping employers to manage risk and protect and promote the health and well-being of employees. Our strategy will increase the number of people whose workplaces have access to occupational health support aimed at reducing the number who suffer from work-related ill health."

Is work good for your health and well-being?

This was the title of an independent review, commissioned by the Department for Work and Pensions in 2006, which has proved controversial with its claim that work can be intrinsic to health and wellbeing, boosting self-esteem and quality of life. The trade union response has been that some work is intrinsically bad for you – if it is the reason for becoming ill in the first place.

The report came at a time when the Confederation of British Industry (CBI) criticised GPs over the cost of attending appointments in work time. A 2007 CBI report quoted independent research by Boots, which showed that some 3.5 million working days are lost each year because of time spent at GP surgeries. The British Medical Association (BMA) responded vigorously by saying: "If its (CBI) members think their staff are seeking medical appointments without any real cause, that seems to point to the need for a better occupational health service. Many employers seem to regard

A 2007 CBI report quoted independent research by Boots, which showed that some 3.5 million working days are lost each year because of time spent at GP surgeries.

their sick employees' time as their own. It isn't. NHS general practice is there to treat patients and their care is what comes first and last."

A report from the Work Foundation says workers with back pain and arthritis need to stay in work as much as possible. The report said being able to work helps people with MSDs recover more quickly, and claims many GPs wrongly believe they must be "100 per cent well" before returning to work. The TUC has responded by saying: "This advice is at best simplistic – and at worst dangerous. What we need is more access to rehabilitation for MSDs with further research into what interventions work and at what stage."

Welfare and benefit reforms

The Government has introduced a range of reviews and reforms designed to:

- encourage people to work longer by retiring later
- introduce work capability assessments to reduce the number of people claiming incapacity benefit (IB).

In 2008 a new IB test was introduced. The mental health charity Mind expressed concern about its impact:

"We are worried that the new test raises the bar for claiming incapacity benefit too high and will force people with mental health problems back to work before they are ready… too many people will fall foul of the IB test and will instead be coerced onto Jobseeker's Allowance, which does not offer the same degree of specialist support. They will find themselves in a devastating cycle where they are turfed out of their new job and back onto benefits. This won't be good for the individual's health or for the economy."

The TUC is concerned that changes are not simply made in an attempt to cut the welfare bill by forcing people back into inappropriate jobs.

International agenda

European Union Strategy 2007–2012

This is set out in a document entitled Improving Quality and productivity at work. The strategy quotes from the fourth European survey of working conditions, which found **that 35 per cent of workers on average feel that their job puts their health at risk**. As with the HSE there are targets, although some confusion as to what is being targeted. The press release talked about reducing work-related accidents and occupational diseases by 25 per cent by 2012. This is an even more ambitious target than that of the HSE. However, the document itself only links this figure to accidents, which play a small role in work-related health damage. The strategy is short on specific proposals. It does, however, refer to the need to:

- take account of those aspects of health and safety that particularly affect women

- deal with social and demographic change by developing strategies for women, migrant, young, and older workers, in particular by "applying reliable ergonomic principles more effectively to the way in which workplaces are designed and work is organised"

- undertake more research into prevention measures for certain types of occupational illness like MSDs and illnesses and infections associated with psychological stress.

The strategy makes specific reference to problems over the implementation of Article 7 of the Framework Directive with regard to the **quality, coverage and accessibility of prevention services**.

Marc Sapir of the European TUC (ETUC) sums it up by saying:

"Getting any kind of fresh impetus for community health and safety at work policies probably depends on how much the trade unions can step up their health and safety at work activities to hammer home the full importance of health and safety at work in our societies."

World Health Organisation Global Plan of Action 2008–17

The Global Plan of Action on Workers' Health was launched in 2007. It noted that:

- Only 10–15 per cent of workers have access to a basic standard of OHS.

- The cost to a country of occupational accidents and ill health is approximately 4–5 per cent of Gross Domestic Product (GDP).

It moves on to forward a five-point plan focusing on prevention and rehabilitation. It states:

> "Core institutional capacities should be built at national and local levels in order to provide technical support for basic OHS, in terms of planning, monitoring and quality of service, design of new interventions, dissemination of information, and provision of specialized expertise."
>
> (Global Plan of Action on Workers' Health 2008–17)

The plan and the WHO Occupational Health Newsletter (GOHNET) can be found at www.who.int/occupational_health/en/

Trade union initiatives

Unless trade unions take this on as a priority issue, the UK will continue to lag behind the rest of Europe. Action is required at workplace, local/regional and national level.

Workplace level – Unions must use their consultation rights on the appointment of competent persons far more effectively than they have done up to now. Where OH services exist they have in most places been set up with little or no consultation with trade unions. This is a breach of the Safety Representatives Safety Committees Regulations 1977.

Local/regional level – Links need to be made at local/regional level to identify networks and support. This could lead to the development of partnerships to support preventive services.

National level – Unions and the TUC will continue to campaign to reverse the cuts in OHS provision. A comprehensive state service will require a major overhaul in current thinking and policy direction.

International level – Effective liaison and campaigning within the international trade union movement will maximise the prospects of the EU and WHO strategies being implemented at workplace level.

There are some good examples at home and internationally that illustrate how unions can be proactive on this.

Case study 1:

TUC Congress 2007

The health of the public sector workforce

The Society of Radiographers successfully moved the motion below:

Congress notes with concern the negative effect that constant organisational change, the threat of redundancy, vacancy freezes and working in a target-driven environment is having on the health and welfare of NHS employees.

Congress notes that stress, bullying, violence and musculoskeletal disorders are rife in the NHS which, unsurprisingly, correspond with high levels of sickness amongst NHS employees.

Congress recognises that the health and well-being of the public sector workforce is central to the effective delivery of public service reforms.

Congress notes the DWP strategy Health and Wellbeing – Caring for our future, which aims to reduce sickness absence and give all employees access to competent occupational health advice and support.

Congress believes that the NHS should have exemplar occupational health services that set the benchmark for other services.

Congress calls on the General Council to campaign for proactive, accessible, well-staffed and holistic occupational health services that promote preventative strategies and effective rehabilitation in order to best serve the health needs of public sector workers.

And finally…

The HSC Performance Report 2007, 'The Way Ahead', states in the last section, 'Challenges for the Future', "Ill health is a topic where more time and sustained effort is required".

The TUC is also concerned that aspects of the benefits system, including the qualifying period for many benefits, often acts as a disincentive to return to work, or forces people to return to work before they should.

The TUC view on social security benefits and health

There is a certain degree of confusion in public debate between a number of different issues that relate to the rights and responsibilities of sick and disabled people. These include the claim that engaging in paid work can be good for one's health; the claim that there are large numbers of disabled people whose preferred option would be paid employment; the argument that disabled people who are capable of paid employment should be required to look for it and to accept job offers; the claim that a significant number of people claim benefits who are not really sick or disabled.

The TUC does not dispute claims that well managed work (paid or unpaid) in an environment where hazards are controlled can be good for individuals' health, compared with inactivity. We do not object to using the benefits system to underline this message. But it is also true that there are times when work is not a reasonable expectation. Most people can understand that workers with infectious diseases should not be expected to return to employment, but it is also true that working with a debilitating condition or returning to work when one is no longer infectious but still not fully recovered can lead to long-term performance problems. Working when suffering from pain or fatigue can cause or exacerbate chronic conditions, forcing workers into less productive jobs or out of employment altogether. No one should be forced to work when this would cause them pain, excessive fatigue or loss of mental acuity, would exacerbate these problems. Most workers lack financial independence and occupational sick pay – supported by the benefit system – should protect them from feeling that they do not have the option of sick leave.

The Government often emphasises the fact that there are a million disabled people who say they want jobs. A million people is a large group, but it is worth bearing in mind that there are two million working age disabled people who do not want paid work, and the TUC would strongly oppose any attempt to require them to be available for employment. Some of these disabled people may have concluded that their condition rules out paid work.

An even higher proportion of IB claimants who do not want jobs may also have decided that their experience of discrimination and exclusion indicates that, in practice, they are unlikely to get jobs. This is not unreasonable; in 2005 the CIPD found that, when recruiting, 33.1 per cent of its members excluded people with a history of long-term sickness or incapacity, even though such a policy would almost certainly leave employers very exposed should a disappointed applicant use the Disability Discrimination Act against them.

It is simply not the case that large numbers of benefit claimants are fraudulent. We have already addressed the myth of the 'sick note culture'. Far from having trivial or mild conditions, researchers have found that, when the impairments of claimants of incapacity benefits were ranked on a severity scale ranging from zero to ten, over half had a severity score of five or higher. The survey also found that 64 per cent of the participants stated that their condition had been affecting their ability to do paid work for more than five years, and 90 per cent expected their conditions to last for at least another year. There is a very low level of IB fraud, as the official benefit review of IB noted:

> "Due to the small number of confirmed fraud cases found during the review, it is not possible to produce a robust central estimate of the total annual value of benefit overpaid due to fraud for short-term IB and long-term IB. However, an indicative upper limit has been produced. It is estimated that the amount of overpayment is less than £19 million, i.e. less than 0.3 per cent of all expenditure on cases in receipt of these rates of IB. Similarly, it is estimated that the percentage of all IBST(H) and IBLT cases that are fraudulent is less than 0.5 per cent."

The TUC is also concerned that aspects of the benefits system, including the qualifying period for many benefits, often acts as a disincentive to return to work, or forces people to return to work before they should. This also applies to the absence of, or extremely short time set for overrun of, benefits on return to work, which leaves people without any income for up to several months. The TUC hopes these issues will be considered by the Government in its review of benefits.

The relationship between health and work

There has, in recent years, been some discussion on the relationship between physical causes of illness and psychosocial ones. Work-related MSDs may, to a certain extent, be divided into those that occur as a result of a specific incident at work, such as a manual handling injury, and those which occur slowly over time and become chronic, although some MSDs fall in the middle. There is some evidence that many long-term chronic MSDs that develop over time, as opposed to those which are caused by an immediate injury, are not only a result of physical activity or a lack of good

ergonomics but are also related to the general working environment, including workplace organisation, culture, overwork, and management techniques.

A number of studies have confirmed that modern management methods are often responsible for the development of permanent debilitating health problems and that the general work environment can be a major factor in both health and productivity.

Much has been made of the mantra that 'work is good for you'. The reality is that this is not the case. While it is true that, for most people, being actively engaged is less likely to lead to serious long-term illnesses than unemployment and inactivity, being in work is, at best, less harmful that not being in work, and even then only when it is properly organised, risks are properly managed, and staff are engaged in the work process.

The reality for too many workers is that work makes people physically or psychologically ill. Looking back we now know the long-term damage to the health of those who worked in mining, shipbuilding, asbestos industries, heavy engineering and stone working. However that does not mean that modern workplaces are, in the long term, necessarily safer. It may just be that we do not yet realise the dangers facing those who work in call centres, electronics factories, IT, and so on. The risks from potential hazards such as electro-magnetic fields (EMFs) and nanotechnology, and simply modern working methods, may take many years to be fully understood.

To seriously reduce the level of long-term sickness absence there first has to be an understanding of what 'good work' actually is. There then has to be a framework to ensure that employers which do not operate to that standard are taken to task for damaging the long-term health of their employees. That requires a completely different approach to our understanding of workplace risk, and also the enforcement of health and safety regulations.

The TUC also believes there is a role for rewarding good practice as well as penalising bad practice. We believe that employers that take positive action and provide a safer working environment should be rewarded through reduced insurance premiums. This may require the development of certifiable standards that employers have to meet to be fully effective, but simpler models based on indicators like risk assessments and injury rates could be introduced much earlier. A system has been developed in Demark for use with the state insurance scheme that has the support of both employers and trade unions.

In addition, employers that provide quality OH provision and access to rehabilitation should not be penalised through the tax system, as they are at present. The TUC believes the Government should revise the current tax system on OH and rehabilitation and even consider tax breaks for employers that meet a certain standard. Mandatory self-assessment or auditing could again be linked to incentives and disincentives.

Activity – Influencing the trade union agenda

Aims

To help you:

◗ raise membership awareness of OH issues

◗ contribute to a strategy for increasing the profile of the union on OH.

Task

Where possible you will be allocated to a group with members of the same union and/or sector.

Look at the example of a motion in Case Study 1 (see page 133).

Draft up a motion for your branch outlining how you can progress union involvement in OH. This could be a motion on:

◗ a policy position on your employer's OH provision

◗ a response to government initiatives like 'Return to Work'; or lifestyle issues

◗ initiatives related to branch organisation on specific OH issues like stress and MSDs.

Report back

Agree who will propose and second the motion.

Present your motion to the rest of the group, who will act as branch members.

Activity – Action plan

Aims
To help you:
▶ summarise your priorities on OH
▶ plan for action.

Task

Review the notes you have made and the work you have done on OH.

Use the headings below to indicate how you intend to prioritise your future work in this area.

Topic	Action required	By whom and when
Finding information from your employer		
Finding out OH issues from your members		
Improvements in employers' OH provision		
Work on specific OH issues		
Improvements in rehabilitation services		
Improvements in sickness absence procedures		
Links with local or national campaigns		
Links with local OH support groups		
Raising branch/member awareness		
Any other		

Report back

When you get back to work explain your plan to a meeting with other reps and/or your members.

Appendices

▶ Appendix A – Glossary of terms

▶ Appendix B – Contacts and resources

Appendix A – Glossary of terms

ABI	Association of British Insurers
ACAS	Advisory, Conciliation and Arbitration Service
ACDP	Advisory Committee on Dangerous Pathogens
ACM	asbestos-containing material
ACoP	Approved Code of Practice
AFOM	Associateship of the Faculty of Occupational Medicine
ANHOPS	Association of National Health Occupational Physicians
BMA	British Medical Association
BMI	body mass index
BMJ	British Medical Journal
BOHRF	British Occupational Health Research Foundation
BSI	British Standards Institution
CBI	Confederation of British Industry
CDM	Construction (Design and Management) Regulations
CHAS	Contractor Health and Safety Assessment Scheme
CHIP	Chemicals (Hazard Information and Packaging for Supply) Regulations
CIPD	Chartered Institute of Personnel Development
COSHH	Control of Substances Hazardous to Health
dB	decibel
DDA	Disability Discrimination Act
DIY	(research) do-it-yourself
DPA	Data Protection Act
DRC	Disability Rights Commission
DSE	display screen equipment
DSEAR	Dangerous Substances and Explosive Atmospheres Regulations
DTI	Department of Trade and Industry
DWP	Department for Work and Pension
ECJ	European Court of Justice
EH40	Environmental Hygiene Series No. 40
EHO	environmental health officer
ELCI	employers liability compulsory insurance
EMAS	Employment Medical Advisory Service
EMF	electro-magnetic field
ERO	European Risk Observatory
ETS	environmental tobacco smoke
ETUC	European Trade Union Confederation
EU	European Union
G&OSH	gender and occupational safety and health
GMC	General Medical Council
GMO	genetically modified organism
GP	general practitioner
GUF	Global Union Federation
HASAWA	Health and Safety at Work Act
HAVS	hand-arm vibration syndrome

HPA	Health Protection Agency
HSC	Health and Safety Commission
HSE	Health and Safety Executive
HSENI	Health and Safety Executive for Northern Ireland
HSG	Health and Safety Guidance series
IARC	International Agency for Research on Cancer
ICFTU	International Confederation of Free Trade Unions
IES	Institute of Employment Studies
IIDTW	Independent Inquiry into Drug Testing at Work
IIP	Investors in People
ILO	International Labour Organisation
IOSH	Institution of Occupational Safety and Health
IRR	Ionising Radiations Regulations
IRS	Industrial Relations Services
Kgm	kilogram metre measurement system
kHz	kilohertz
LA	local authority
LEV	local exhaust ventilation
LFS	Labour Force Survey
LRD	Labour Research Department
MS	Medical Series
Ms²	metre second squared
MAC	manual handling assessment chart
MFOM	Membership of the Faculty of Occupational Medicine

MHSW	Management of Health and Safety at Work
MHSWR	Management of Health and Safety at Work Regulations
MSD	musculoskeletal disorder
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
NIHL	noise-induced hearing loss
NOCN	National Open College Network
OEDA	Occupational and Environmental Diseases Association
OH	occupational health
OHAC	Occupational Health Advisory Committee
OHS	occupational health services
PD	prescribed disease
PIN	Provisional Improvement Notice
POOSH	Professional Organisations in Occupational Safety and Health
PPE	personal protective equipment
RCN	Royal College of Nursing
REPPIR	Radiation (Emergency Preparedness and Public Information) Regulations
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
RIPH	Royal Institute of Public Health
ROES	representative of employee safety
ROSPA	Royal Society for the Prevention of Accidents
RPA	radiation protection adviser

RPE	respiratory protective equipment
RSI	repetitive strain injury
RSR	roving safety representative
RTW	return to work
SARS	severe acute respiratory syndrome
SART	sickness absence recording tool
SBS	sick building syndrome
SME	small and medium-sized enterprise
SOHAS	Sheffield Occupational Health Advisory Service
SRSC	Safety Representative Safety Committee
SSP	statutory sick pay
SWORD	surveillance of work-related occupational respiratory disease
TAEN	The Age and Employment Network
TSO	The Stationery Office
TUC	Trades Union Congress
UIN	Union Inspection Notice
UKCC	United Kingdom Central Council for Nurses, Midwives and Health Visitors
VDU	visual display unit
VRA	Vocational Rehabilitation Association
VTHC	Victoria Trades Hall Council
WBV	whole-body vibration
WEL	workplace exposure limit
WHO	World Health Organisation
WRULD	work-related upper limb disorder
WSA	worker safety adviser

Appendix B – Contacts and resources

TUC

Senior Health and Safety Officer,
TUC, Congress House, Great Russell Street,
London WC1B 3LS
Tel: 020 7636 4030
Email: healthandsafety@tuc.org.uk
www.tuc.org.uk

TUC organising pages

www.tuc.org.uk/hsorganisation

Priced TUC health and safety publications, all available at www.tuc.org.uk/publications, or by phoning 020 7467 1294, include:

Hazards at Work: Organising for safe and healthy workplaces (2007)
342pp, £18 for TUC member unions

Keeping Well at Work: A TUC guide (2001)
Published in association with Kogan
Page 200pp, £8.99

What Works is What Matters: Rehabilitation and retention (2002)
16pp, £5 (£1 for unions)

Clean Up With COSHH 2000 (2000)
52pp, £20 (£5 for unions)

Tackling Stress at Work (1998)
24pp, £5 (£2.50 for unions)

Beat Bullying at Work (1998)
30pp, £20 (£10 for unions)

Working Women (2005)
128pp, £30 (£10 for unions)
This has chapters on health and safety, violence and bullying.

TUC Hazards at Work Chapter 51
TUC web resource page on rehabilitation and OH services www.tuc.org.uk/h_and_s/index.cfm?mins=260

Rehabilitation and Retention:
The view from the workplace
www.tuc.org.uk/h_and_s/tuc-5266-f0.pdf

Essential information for safety representatives. Keep up to date on health and safety by reading *Risks*, the TUC's weekly e-bulletin for safety representatives at www.tuc.org.uk/h_and_s/index.cfm

TUC workSMART

The TUC workSMART website is a tool for all working people, which includes a large section on health and safety
www.worksmart.org.uk

TUC Education

Liz Rees
Trade Union Education Manager
TUC, Congress House, Great Russell Street,
London WC1B 3LS
Email: lrees@tuc.org.uk
www.tuc.org.uk

Scotland

Harry Cunningham
Regional Education Officer
4th Floor, John Smith House,
145–165 West Regent Street,
Glasgow G2 4RZ
Tel: 0141 221 8545
Email: tucedscotland@tuc.org.uk

Northern

Ian West
Regional Education Officer
5th Floor, Commercial Union House,
39 Pilgrim Street,
Newcastle upon Tyne
NE1 6QE
Tel: 0191 232 3175
Email: iwest@tuc.org.uk

Yorkshire and Humberside

Trevor Sargison
Regional Education Officer
Yorkshire & the Humber Regional
Education Officer,
3rd Floor, 33 Park Place,
Leeds LS1 2RY
Tel: 0113 242 9296
Email: tucednyh@tuc.org.uk

North West

Pete Holland
Regional Education Officer
Suite 506–510,
The Cotton Exchange, Old Hall Street,
Liverpool L3 9LQ
Tel: 0151 236 7678
Email: tucednorthwest@tuc.org.uk

East and West Midlands

Peter Try
Regional Education Officer
24 Livery Street, Birmingham B3 2PA
Tel: 0121 236 4464
Email: tucedmidlands@tuc.org.uk

Wales

Julie Cook
Regional Education Officer
Transport House,
1 Cathedral Road, Cardiff CF1 9SD
Tel: 029 2034 7010
Email: tucedswwales@tuc.org.uk

South West

Marie Hughes
Regional Education Officer
Ground Floor, Church House, Church Road,
Filton, Bristol BS34 7BD
Tel: 0117 947 0521
Email: mhughes@tuc.org.uk

Southern and Eastern

Rob Hancock – Regional Education Officer
Angela Perry – Regional Education Officer
Congress House, Great Russell Street,
London WC1B 3LS
Tel: 020 7467 1238
Email: tucedse@tuc.org.uk

Trade union information

Contact your own trade union for
information, advice, networking and
publications. The website addresses of all
trade unions are on the TUC website at
www.tuc.org.uk/tuc/unions_main.cfm

Hazards magazine lists the health and
safety pages of most trade unions at
www.hazards.org/links/ukunionlinks.htm

Many unions provide guidance on OH
services. Contact your union or visit your
union's website to find out if it produces
any guidance on OH services. For example,
UNISON produces an information sheet on
OH schemes at www.unison.org.uk/safety/doc

Health and Safety Executive (HSE)/Health and Safety Commission (HSC)

HSE priced and free publications

*Managing Sickness Absence and Return to
Work: An employers' and managers' guide*
HSG249 2004, £9.95

*Best practice in rehabilitating employees
following absence due to work-related*

stress RR138 HSE Books 2003 (HSE Research Reports are downloadable free from the HSE website. www.hse.gov.uk

Occupational Health Services in Higher and Further Education HSG257 2006, £9.50. This is the only detailed sector guidance. It contains some very useful model policy statements, checklists and case studies.

Managing the Causes of Work-related Stress HSG218 2007, £10.95

Essentials of Health and Safety at Work (fourth edition) 2007, £10.95
HSE research 'An assessment of migrant workers health and safety risks' 2006 Working Lives Research Institute

For all the latest documents on OH services go to www.hse.gov.uk

Alternatively, obtain a free copy of the latest HSE Books catalogue, CAT 34, by telephoning 01787 881165

HSE Operational Circular
'Provision of OHS to employers' OC244/5. This OC describes the legislation, scope and range of OH assistance available, the various means of assessing competence and the actions to be considered by field inspectors. www.hse.gov.uk/foi/internalops/fod/oc/200-299/244_5.pdf

HSE Workplace Health Connect website
The HSE has a specific webpage that draws together HSE information on Workplace Health Connect at: www.hse.gov.uk/workplacehealth/index.htm

HSC Occupational Health Advisory Committee (OHAC)
Report and recommendations on improving access to occupational health support. Available at www.hse.gov.uk/aboutus/hsc/iacs/ohac/

HSC Securing health together from HSE books Misc 225
▶ HSC Health and Safety statistics available from the HSE website

In the 'Diseases' section of the HSE website there are links for statistics on the following causes and kinds of disease:

▶ Asbestos-related
▶ Cancer
▶ Deafness
▶ Infections
▶ Lead exposure
▶ Lung-related
▶ Musculoskeletal disorders
▶ Skin disorders/dermatitis
▶ Stress
▶ Vibration-related disorders
▶ Violence at work

Construction Occupational Health Management Essentials (COHME)
Launched in February 2008, COMHE is a web-based tool to help contractors understand and manage OH risks more effectively. It covers seven priority risks; hand-arm vibration; MSDs; dermatitis; noise; stress; respiratory diseases and asbestos. It contains examples, case studies and links to other websites. www.hse.gov.uk/construction/healthrisks/index.htm

HSE managing sickness absence and return to work website

The HSE has a specific webpage that draws together HSE information on return to work in one place at www.hse.gov.uk/sicknessabsence/index.htm

HSE publications on managing sickness absence and return to work

For all the latest documents containing general standards and guidance on return to work, go to the HSE webpage: www.hse.gov.uk/sicknessabsence/resources.htm

HSC/IOD Leading health and safety at work:Leadership actions for directors and board members. INDG417 (Oct 2007)

The guidance, written by directors for directors, offers straightforward practical advice on how to plan, deliver, monitor and review health and safety in the workplace.

www.hse.gov.uk/pubns/indg.417.pdf

POOSH – Professional Organisations in Occupational Safety and Health

POOSH exists to promote the continuous improvement of the practice of occupational safety and health through education, communication and the encouragement of co-operation between all persons and agencies involved in the provision of a healthy and safe working environment. www.poosh.org

Some of the organisations represented in POOSH are:

Association of Occupational Health Nurse Practitioners (UK)

AOHNP (UK) is a professional organisation for OH nurse practitioners. The Association was founded in 1992 to increase representation and raise the profile of occupational health nurses in the UK www.aohnp.co.uk

British Occupational Hygiene Society

The British Occupational Hygiene Society (BOHS) is the voice of occupational hygiene, which focuses on controlling health hazards at work. BOHS provides access to specialist information and consultants, runs seminars and offers a range of qualifications in occupational hygiene and allied subjects. www.bohs.org

Chartered Institute of Environmental Health

The Chartered Institute of Environmental Health (CIEH) is an independent professional body and registered charity representing those who work in environmental health and related disciplines. Their primary function is the promotion of knowledge and understanding of environmental health issues. www.cieh.org

Ergonomics Society

The Society was formed in 1949. Ergonomics is the science of human interaction (both physiological and psychological) applied to the design of objects, equipment, systems and environments for optimum human usage. www.ergonomics.org.uk

Faculty of Occupational Medicine

The Faculty of Occupational Medicine was founded in 1978 to advance occupational medical knowledge, develop education and training in the specialty and ensure the highest standards of professional competence and ethical integrity. www.facoccmed.ac.uk

Institute of Risk Management

IRM is risk management's professional education body. A not-for-profit organisation, it seeks to represent an increasingly broad and diverse set of stakeholders. Governed by practising risk professionals, it works closely with specialist institutes and associations and has strong links to universities and business schools worldwide. www.theirm.org

International Institute of Risk and Safety Management

The IIRSM is a professional body for health and safety practitioners. It was created to advance professional standards in accident prevention and OH throughout the world. As an independent registered charity, the institute works closely with other health and safety organisations, including the British Safety Council, to offer members a comprehensive range of benefits. www.iirsm.org

Royal Environmental Health Institute of Scotland

The Institute, which is incorporated by Royal Charter, is a recognised Scottish charity established to promote the advancement of environmental health for the benefit of the community. It is the awarding body for environmental health officers in Scotland and also provides a range of qualifications including health and safety. www.rehis.org

Royal Institute of Public Health

The Royal Institute of Public Health is a leading independent body that protects and promotes public health through education, training and policy development. www.rsph.org

Royal Society for the Promotion of Health

The aim of the Society is to promote continuous improvement in human health worldwide through education, communication and the encouragement of scientific research. www.rsph.org

Safety and Reliability Society

SaRS is an internationally recognised professional body that brings together and represents engineers and scientists working in the fields of safety and reliability technology and engineering risk management. www.sars.org.uk

Society of Occupational Medicine

SOM is a forum for its membership that aims to stimulate interest, research and education in occupational medicine. It has wide-ranging contacts with government departments and professional bodies and responds with its views to consultative documents relevant to the speciality. www.som.org.uk

Other contacts and resources

Action on Smoking and Health (ASH)

102 Clifton Street, London EC2A 4HW
Tel: 020 7739 5902
Email: enquiries@ash.org.uk
www.ash.org.uk

Alcohol Concern

Waterbridge House,
32–36 Loman Street, London SE1 0EE
Tel: 020 7928 7377
Email: contact@alcoholconcern.org.uk
www.alcoholconcern.org.uk

Andrea Adams Trust

Hova House, 1 Hova Villas, Hove,
East Sussex, BN3 3DH
Tel: 01273 704900
www.andreaadamstrust.org/

Association of British Insurers

www.abi.org.uk

Association of Chartered Physiotherapists in Occupational Health and Ergonomics

Email: jslsda@aol.com

Association of Noise Consultants

www.association-of-noiseconsultants.co.uk

Asthma UK

Providence House,
Providence Place, London N1 0NT
Tel: 020 7226 2260
Email: info@asthma.org.uk
www.asthma.org.uk

Back Care

The Charity for Healthier Backs,
16 Elmtree Road, Teddington,
Middlesex, TW11 8ST
Tel: 020 8977 5474
Email: website@backcare.org.uk
www.backcare.org.uk

British Chiropractic Association

www.chiropratic-uk.co.uk

British Occupational Hygiene Society

News and information at www.bohs.org

British Psychological Society

News and information at www.bps.org.uk

British Society of Rehabilitation Medicine

www.bsrm.co.uk

Case Management Society UK

www.cmsuk.org

Centre for Corporate Accountability

Fourth Floor, 197/199 City Road,
London EC1V 1JN
Tel: 020 7490 4494
Email: info@corporateaccountability.org
www.corporateaccountability.org

Chartered Institute of Personnel and Development

www.cipd.org.uk

Chartered Society of Physiotherapy

News and information at www.csp.org.uk

College of Occupational Therapists

www.cot.co.uk

Commercial Occupational Health Providers Association

www.cohpa.co.uk

Confederation of British Industry (CBI)

www.cbi.org.uk

DrugScope

Waterbridge House,
32–36 Loman Street, London SE1 0EE
Tel: 020 7928 1211
Email: info@drugscope.org.uk
www.drugscope.org.uk

Epilepsy Action

New Anstey House,
Gate Way Drive, Yeadon, Leeds LS19 7XY
Freephone helpline: 0808 800 5050
Email helpline: helpline@epilepsy.org.uk
www.epilepsy.org.uk

Faculty of Occupational Medicine of the Royal College of Physicians

www.facoccmed.ac.uk

Hazards **magazine**

PO Box 199, Sheffield S1 4YL
Tel: 0114 201 4265
Email: editor@hazards.org
www.hazards.org

Hazards magazine factsheets

- No. 100: Impaired Thinking – Drug and Alcohol Testing
- No. 99: OHS/SOS
- No. 93: Futile Exercise
- No. 89: Workers' Health Information
- No. 71: DIY Workers' Health Studies
- No. 66: Sickness Absence Policies
- No. 59: DDA and Work-related Ill Health

£1.50 each for union subscribers. £6 for non-subscribers

Hazards **magazine website**

Excellent news and resources on the *Hazards* rehabilitation web resource page at www.hazards.org/rehab and sickness absence at www.hazards.org/sickness

Health and Safety Bulletin (HSB)

Monthly journal. Subscription £249 per year

Institute of Employment Rights

An independent organisation acting as a focal point for the spread of new ideas in the field of labour law

The People's centre

50–54 Mount Pleasant, Liverpool L3 5SD
Tel: 0151 702 6925
Email: ier@gn.apc.org
www.ier.org.uk

Publications:

- Regulating health and safety at work: The way forward (1999)
- Regulating health and safety at work: An agenda for change (2005)

by Phil James and David Walters £30, pp188.

Institute of Occupational Medicine

www.iom-world.org

Institute of Occupational Safety and Health (IOSH)

Professional body for safety and health practitioners. Also represented on POOSH

News and information at www.iosh.co.uk

Publications:

- Monthly magazine
- IOSH 'Supporting health at work: international perspectives on occupational health services' ISBN 978 0 901357397 (2007) £35

International Journal of Occupational and Environmental Health

www.ijoeh.com

International Labour Organisation

Occupational health services at the workplace www.ilo.org/public/english/protection/safework/health/hlthserv.pdf

Joint Council for the Welfare of Immigrants

115 Old Street, London EC1V 9RT
Tel: 020 7251 8708
Email: info@jcwi.org.uk
www.jcwi.org.uk

Labour Research Department

Labour Research Department,
78 Blackfriars Road, London SE1 8HF
Tel: 020 7928 3649
Email: info@lrd.org.uk
www.lrd.org.uk

Resources:

- Rehabilitation £3.15

- Sickness absence and sick pay £4.15

- Workplace Report No 53 Dec. 2007: Work-related ill health

Latex Aware – latex allergy support group

PO Box 27, Filey YO14 9YH
Helpline: 07071 225838
Email: latexallergyfree@hotmail.com
www.lasg.co.uk

National Group on Homeworking

Office 26, 30–38 Dock Street, Leeds LS10 1JF
Tel: 0800 174 095
Email: admin@homeworking.gn.apc.org
www.homeworking.gn.apc.org

National Institute for Mental Health in England

Line manager's resource: A practical guide to managing and supporting mental health in the workplace. Dept of Health 2001. Free of charge: mindout@codestorm.co.uk

NHS Plus

www.nhsplus.nhs.uk

Occupational Road Safety Alliance

Email: furtherinfo@orsa.org.uk
www.orsa.org.uk/home.htm

Pesticide Action Network

Development House,
56–64 Leonard Street, London EC2A 4JX
Tel: 020 7065 0905
Email: admin@pan-uk.org
www.pan-uk.org

Royal Institute of Public Health

28 Portland Place, London W1B 1DE
Tel. 020 7580 2731
www.riph.org.uk

Established for the promotion, practice and protection of standards of public health. Provides training and awards linked to supporting health promotion in the workplace

Royal National Institute for the Deaf (RNID)

19-23 Featherstone Street,
London EC1Y 8SL
Tel: 0808 808 0123
Textphone: 0808 808 9000
Email: information@rnid.org.uk
www.rnid.org.uk

Scottish Chiropractic Association

www.sca-chiropractic.org

Simon Jones Memorial Campaign

PO Box 2600, Brighton BN2 0EF
Tel: 01273 685913
Email: action@simonjones.org.uk
www.simonjones.org.uk

Society of Occupational Medicine

www.som.org.uk

Suzy Lamplugh Trust

PO Box 17818, London SW14 8WW
Tel: 020 8876 0305
Email: info@suzylamplugh.org
www.suzylamplugh.org

Teacher Work-Stress

Email: webmaster@teacherstress.co.uk
www.teacherstress.co.uk

The Age and Employment Network (TAEN)

207-221 Pentonville Road, London N1 9UZ
Te. 020 7843 1590
www.taen.org.uk

UK National Work-Stress Network

9 Bell Lane, Syresham,
Brackley, Northants NN13 5HP
Tel: 07966 196033
Email: iandraper@workstress.net
www.workstress.net

Victim Support

National Office, Cranmer House,
39 Brixton Road, London SW9 6DZ
Tel: 020 7735 9166
Email: contact@victimsupport.org.uk
www.victimsupport.org

Women's Environmental Network

PO Box 30626, London E1 1TZ
Tel: 020 7481 9004
Email: info@wen.org.uk
www.wen.org.uk

World Health Organisation

Department of Protection of Public
Health and Environment, Interventions for
Healthy Environments
20, Avenue Appia,
1211 Geneva 27,
Switzerland
Fax: 41 22 791 13 83
Email: ochmail@who.int

Health and safety support groups and resource centres

The list below is held and kept up to date
by *Hazards* magazine at www.hazards.org.
organisations.htm

Asbestos groups

Asbestos Awareness Wales (Ymwybyddiaeth Asbestos Cymru)

c/o C Cook, 26 St Andrews Road,
Pen y Coedcae, Pontypridd, CF37 1XF
Tel: 07775 815705
Email: help@asbestosawarenesswales.org.uk
www.asbestosawarenesswales.org.uk

Asbestos Related Diseases Association

c/o Tony Huggett,
26 Tollerton Green, Bulwell,
Nottingham, NG6 9EX

Bradford Asbestos Support Group

c/o UNISON office, 2nd Floor,
Auburn House,
Upper Piccadilly, Bradford BD1 3NU
Tel: 01274 393949
Email: hazards@what_bhop.freeserve.co.uk

British Asbestos Newsletter (BAN)

c/o Laurie Allen, 9 Tintagel Drive,
Stanmore, Middx HA7 4SR
Email: ban@lkaz.demon.co.uk
www.lkaz.demon.co.uk

Cheshire Asbestos Victims Support Group

3 Fryer Street, Runcorn, Cheshire WA7 1ND
Tel: 01928 576641
Email: cavsg@btconnect.com
www.cavsg.co.uk

Clydebank Asbestos Support Group

8 Crown Avenue, Radnor Park, Clydebank,
Scotland, G81 3BW
Tel: 0141 952 1008
www.clydebankasbestos.org.uk/cag.html

Clydeside Action on Asbestos

245 High Street, Glasgow, G4 0QR
Tel: 0141 552 8852

Construction Safety Campaign

c/o Tony O'Brien, CSC,
PO Box 23844, London
SE15 3WR
Tel: 07747 79 5954
Email: construction.safetycampaign@
canhe.fsnet.co.uk

Greater Manchester Asbestos Victims Support Group

c/o Greater Manchester Hazards Centre,
Windrush Millenium Centre, 70 Alexandra
Road, Manchester M16 7WD
Tel: 0161 636 7557
Email: asbestos.gmavsg@virgin.net

Greenock Asbestos Victims Support Group

c/o J McAlease, Westburn Centre,
Greenock, Scotland

Hull Asbestos Action Group

169 Cranbrook Avenue, Hull HU6 7TT
Tel: 01482 804739

International Ban Asbestos Secretariat

Email: ibas@lkaz.demon.co.uk
www.btinternet.com/~ibas/

June Hancock Mesothelioma Research Fund

c/o Irwin Mitchell, St Peters House,
Hartshead, Sheffield, S1 2EL
Tel: 0114 274 4420

Merseyside Asbestos Victims Support Group (MAVSG)

Suite 32, Second Floor, Oriel Chambers,
14 Water Street, Liverpool L2 8TD
Tel: 0151 236 1895
Email: gfr15@dial.pipex.com
www.asbestosdiseases.org.uk

National Asbestos Respiratory Disease Association

c/o Bill Luck, 5B Wolsely Road Flats,
Wolsely Road, Plymouth, Devon PO7 5EL

Occupational and Environmental Diseases Association (OEDA)

OEDA, PO Box 26, Enfield,
Middlesex EN1 2NT
www.oeda.demon.co.uk

Ridings Asbestos Support and Awareness Group (RASAG)

50b Town Street, Armley, Leeds LS12 3AA
Tel: 0113 231 1010
Email: info@asbestos-action.org

Sheffield and Rotherham Asbestos Group

311 Aizlewood's Mill, Nursery Street,
Sheffield S3 8GG
Tel: 0114 282 3212 or 01709 513587
Email: sarag@asbestos.fsnet.co.uk

West Yorkshire Asbestos Action Group

c/o C Simms, Block 1, Site 8, Whingate
Business Park, Whingate, Leeds LS12 3AT
Tel: 0113 263 2455
Mobile: 07789 936164
Email: c.simms@wyaag-asbestos.freeserve.
co.uk

Local groups

Derbyshire Trade Union Safety Team (TRUST)

c/o Joanne Carlin, 70 Saltergate,
Chesterfield S40 1JR
Tel: 01246 231 441
Email: mail@notusc.u-net.com

Hull Action on Safety and Health (HASH)

c/o Ian Reid, 231 Boulevard, Hull HU3 3EQ
Tel: 01482 213496

Merseyside Hazards and Environment Centre

c/o Ritchie Hunter, Toxteth Town Hall,
15 Hall Park Street, Liverpool L8 8DX
Tel: 0151 727 2648

Portsmouth Area Work Hazards Group

55 Garstons Close, Titchfield,
Hants PO14 4EP
Email: hurt@theworkplace.fslife.co.uk

Potteries Action on Safety and Health (POTASH)

c/o Bill Edmondson, 16 Fieldway, Burton,
Stoke-on-Trent
Tel: 01782 327144

Southampton Area Work Hazards Group

2 Cranberry Close, Marchwood,
Southampton SO40 4YT

South West Action on Safety and Health (SWASH)

c/o Barbara Denning,
16 Woodwater Lane, Exeter

Tyneside Hazards Group

Ken Ternent (Secretary),
TUC Centre Against Unemployment,
4 The Cloth Market, Newcastle upon Tyne
NE1 1EE
Tel: 0191 478 6611

Walsall Action on Safety and Health

7 Edinburgh Drive, Rushall,
Walsall WS4 1HW

Wolverhampton Hazards Group

c/o Kamaljit Rana, 138 Leicester Street,
Wolverhampton WV6 0PS
Tel: 01902 710 801

Resource centres

Bradford Resource Centre

17–21 Chapel Street, Bradford BD1 4PS
Tel: 01274 779003
Email: brc@legend.co.uk

Bradford Workers' Health Advice Team (WHAT)

c/o UNISON office, Auburn House,
Upper Piccadilly, Bradford BD1 3NU
Tel: 01274 393 949
Email: hazards@what-bohp.freeserve.co.uk

Construction Safety Campaign

Tony O'Brien, PO Box 23844,
London, SE15 3WR
Tel: 07747 795954
Email: construction.safetycampaign@
canhe.fsnet.co.uk

Greater Manchester Hazards Centre

Windrush Millenium Centre, 70 Alexandra
Road, Manchester M16 7WD
Tel: 0161 636 7557
Email: gmhazards@hotmail.com
www.gmhazards.org.uk

Keighley Safe Work Project

136 Malsis Road, Keighley BD21 1RF
Tel/fax: 01535 691264
Email: ktuc.ktuc@virgin.net

Leeds Occupational Health Project

Brunswick Court, Bridge Street,
Leeds LS2 7RJ
Tel: 0113 294 8222

Liverpool Occupational Health Project

Tel: 0151 236 6608
Fax: 0151 236 6625
Email: liverpooloh@partnership99.
freeserve.co.uk

London Hazards Centre

Hampstead Town Hall Centre,
213 Haverstock Hill, London NW3 4QP
Tel: 020 7794 5999
Fax: 020 7794 4702
Email: mail@lhc.org.uk
www.lhc.org.uk
Factsheet: *Sick Pay and sickness absence
policies* (Dec 2007)

**Lothian TU and Community
Resource Centre**

Basement, 26–28 Albany Street,
Edinburgh EH1 3QH
Tel: 0131 556 7318
Email: ltucrc@aol.com

Newham Health Works

Alice Billings House, 2–12 West Ham Lane,
Stratford, London E15 4SF
Tel: 020 7655 6679 ext. 4341
Email: healthworks@newham.gov.uk

**Sheffield Occupational Health
Advisory Service**

3rd Floor, Queen's Building,
55 Queen Street, Sheffield S1 2DX
Tel: 0114 275 5760
Email: sohas@sohas.co.uk
www.sohas.co.uk

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