

Sustainability of the Health and Safety Agenda

Nattasha Freeman CFIOSH, RMaPS, LL.B (Hons), CIWEM
Immediate Past President IOSH

BOHS Conference – Harrogate April 2010




How do you recognise a pandemic?

- Is it when people start to exhibit similar symptoms and stay away from work for long periods?
- Is it when its on the 10 o' clock news?
- Is it when the Client's start asking you for your policy?
- Is it when you realise it could be YOU next?

....and who deals with the work when the number of casualties grow?

The most common causes of workplace absence are..

- ▶ MSD's ~ approx. 330,000 claiming incapacity benefit
 - ▶ Stress/depression/anxiety ~ approx. 1/3rd working days lost which accounts for approx. 40% of the claim on incapacity benefit
 - ▶ Inhalation/respiratory illnesses
 - ▶ Skin disorders including dermatitis
- 

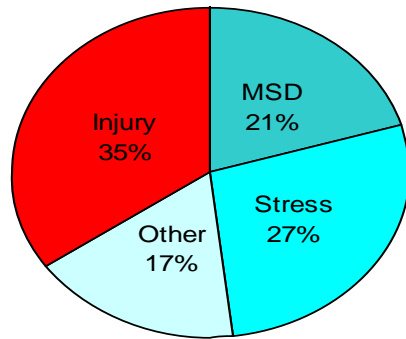
Research tells us

If the employee is absent from work for:-

- ▶ 6 months => 50% chance of a return to work
- ▶ 1 year => 25% chance of a return to work
- ▶ 2 years => practically 0% chance of a return

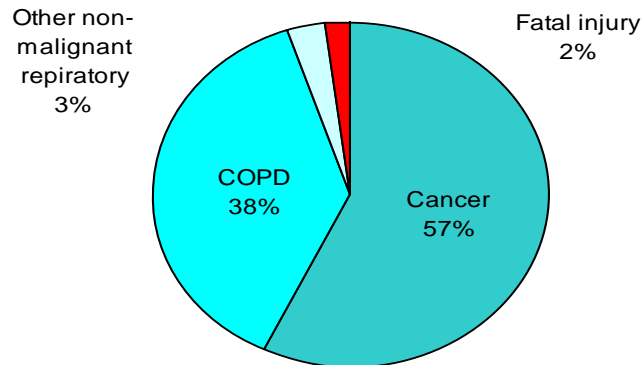
HSE Statistics 2007/8 – Work related absence

Comparison of work-related incidents of ill health and injury, 2007/08



65% absence attributed to ill health

Comparison of work-related ill health and injury fatalities



98% fatalities attributed to ill health

Ill health and the impact on the economy

- 2.2 Million people suffer from work related ill health
- 2.65 Million people claim incapacity benefit
- 40 Million working days lost each year


Cost to UK economy is £12.5 Billion

- Absence due to sickness/ and health related worklessness

Cost to UK economy is £100 Billion > the cost of running the NHS

- Total costs to UK tax payer in terms of benefits and foregone tax revenue are gauged at over £60 billion a year

The Financial Cost of Work Related Ill-Health

- ▶ Overall costs of working age ill-health in UK exceeds £100 billion per year
 - ▶ Around 172 million working days were lost to sickness absence in 2007, at a cost to the economy of over £13 billion (*CBI*)
 - ▶ ‘Presenteeism’ due to mental ill health is estimated to cost £15 billion per year.
- 

The Social Cost of Work Related Ill-Health

- ▶ “If people are not healthy enough to work – or are inadequately supported through ill health to make a return to work possible – it is not just the individual or the business which is affected. The bottom line is often the impact on his or her family and children.”

(Lane Lecture, University of Manchester, Nov 2007)

- ▶ **Children in workless households suffer higher rates of psychiatric disorders** (Working for a Healthier Tomorrow, Dame Carol Black Report)

The Cost to the Employer of Work Related Musculoskeletal Disorders

- ▶ In 2008/9 average days lost per worker = annual loss of 0.39 days per worker, affecting about twice as many people as 'stress'
- ▶ Cost to society estimated to be £5.7 billion in 1995-96 (HSE1999), equivalent to £7 billion in 2007 prices
- ▶ In EU countries, MSDs account for about half of all work-related disorders, and almost 50% of absences from work of three days or more and 60% of permanent work incapacity, costing between 0.5% and 2 % of GDP.

(Musculoskeletal Disorders and Labour Market Participation, The Work Foundation 2007)

The Cost to the Employer of Work Related Stress/ Mental Health Problems

Total cost to employers of mental ill-health at work is ~ £29.5 billion per annum ⁽¹⁾


- ▶ Stress from work per annum costs employers ~ £3.7 billion ⁽²⁾
- ▶ 13m working days are lost ⁽³⁾
- ▶ **Total cost of Incapacity Benefit per annum is £12 billion** ⁽⁴⁾
- ▶ Nearly 40% of people drawing Incapacity Benefit have a mental health condition = £5 billion

- ▶ **Cost of stress in the workplace results from a wide range of sources such as:**
 - Presenteeism
 - Sickness absence
 - Labour turnover
 - Premature retirement
 - Health insurance
 - Treatment for consequences of stress


(1) Sainsbury Centre for Mental Health (2008); (2) CBI (2005)

(3) HSC (2004); (4) DWP (2006) Foresight Report: Government Office for Science


Sobering thoughts.....

- ▶ In 2024, 50% of the population will be over 50 years old
 - ▶ The government aims to reduce the number of people dependent on long term sickness benefit by 1 million over the next 10 years
 - ▶ Dame Carol Black (DWP) forecasts that by 2046 there may be a rise in the pension age to 68, which makes worse the fact that currently a million people work beyond pension age
 - ▶ By 2050 it's been estimated that 90% male and 80% female British adults could be obese
- 


Occupational Health Practitioners and GP's are struggling to cope...

- ▶ Typical appointment time is 7-10 minutes
 - ▶ Later involvement
 - ▶ Ignorance of task/workplace
 - ▶ Liability concerns
 - ▶ Limited options and limited access
 - ▶ Limited opportunity to influence
 - ▶ Harder to persuade Employers
- 


Barriers to return to work and healthy working...

- ▶ No proactive intervention ~ lack of knowledge
 - ▶ The “attitude” of the person suffering
 - ▶ The treatment focus
 - ▶ Returnee behaviour
 - ▶ Returnee isolation
 - ▶ The hostile workplace
 - ▶ Recession and no incentive
 - ▶ Cheap labour (the ghosts of Christmas future!)
- 

The Response to the Dame Carol Black Report

- ▶ Electronic Fit note due for implementation ~ 6th April 2010
 - ▶ Fit for work service pilots
 - ▶ Education and training initiatives
 - ▶ Regional co-ordinators of health, work and well-being
 - ▶ Government strategy for Mental Health and Employment
 - ▶ Public sector as exemplar - review of health of NHS staff
 - ▶ Occupational Health help-line for small/medium enterprises (SMEs)
 - ▶ HWWB Challenge Fund for SMEs launched 7th December 2009
 - ▶ Business Healthcheck tool
 - ▶ National Standards for providers of OH
 - ▶ Council for Work and Health
 - ▶ National Centre for Working-age Health and Well-being
- 

The reason **why** IOSH needs to respond to the Government ...

- ▶ 1,500 Occupational Physicians
 - ▶ 2,195 Members of the Society of Occupational Health Nurses
 - ▶ But approx. 37000 members of IOSH: mostly health and safety practitioners
- 

IOSH initiatives

IOSH response to the HSE “revitalising health and safety”:

Publications:

“[Creating a Healthier UK Plc](#)”

“[A Healthy Return](#)” – good practice guide to rehabilitating people back to work

“[A Wellbeing Guide](#)”

Website Help:

[Occupational Health Toolkit](#)

Campaign Support:

[Men’s Health Week](#) and the [Council for Work](#)

Course Creation:

“[The Proactive Intervention Course](#)”

Proactive Intervention – Support for Occupational Health Practitioners Course

Course Aim:


To better equip the H&S Practitioner to support

- The Individual
- The Employer
- The Occupational Health Practitioner dealing with the case
- The GP

... and the Government

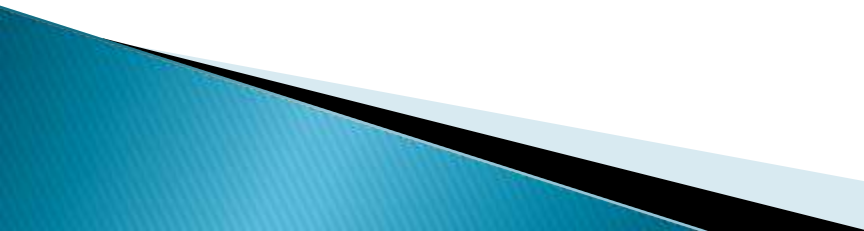
Proactive Intervention – Support for Occupational Health Practitioners Course

Course considerations:

- ✓ Stakeholder representative input - the OH perspective
 - ✓ Course attendees to have a standard base knowledge of H&S
 - ✓ Emphasis on the limitations of the enhanced role
 - ✓ Early referral and where to go
 - ✓ Inclusion of a holistic approach to the wellbeing of employees: impact outside the workplace
 - ✓ How the H&S Practitioner can support OH Practitioners/ G.P's
- 

Proactive Intervention – Support for Occupational Health Practitioners Course

Course objectives:

- Preventative action and early identification
 - Using the workplace for education/training on good health
 - Employers would benefit from informed advice from Safety Practitioners
 - Early referrals ~ reducing long term absence from the outset and better absence management (before 6 weeks)
 - Rehabilitation options ~ staged return to work
 - Agreeing workplans ~ involvement of the absentee
- 


The Course outline includes...

- What health and safety practitioners can do, to support not replace occupational health practitioners
- Absence policies/absence management procedures
- The benefits of early referral and to whom/GP letters
- More specific /clinical information on the main causes of absence and how they present
- Timetables for rehabilitation back into work

...this all supplements what the Health and Safety Practitioner already knows

Feedback from the Course Delegates

OH Interventions implemented fell into 5 categories:-

1. Improving the assessment of health related risks
 2. Enhancing policy/procedure relating to employee health and wellbeing
 3. Taking steps to facilitate a return to work for employees off sick
 4. Undertaking/assisting in the co-ordination of health promotion activities
 5. Implementing activities relating to the education/training of Managers and Employees
- 

Course Delegates Feedback: Case Study 1

“One delegate from a medium sized IT organisation used course skills and tools to develop the company’s return to work programme. This involved the Employer, Employee, HR , the Line Manager and the H&S Mgr, working with an ad-hoc Occupational Health Practitioner.


The exercise brought the people mentioned above together as a Team who are now working more closely together. The Employee feels they can approach any of the Team. Everyone feels more confident both about what they can do and the process”

Course Delegates Feedback: Case Study 2


“One delegate tackled the element of employee risk management on return to their workplace. This delegate also took into account the further obligations that the DDA Regulations require when the Employer needs to consider *reasonable adjustment*.

Through a discussion with the Employee, his Manager, HR, the H&S Mgr and OHP it was agreed that the Employee did not have to drive company vehicles until it was agreed that his condition was being fully managed and controlled. The H&S Mgr whilst waiting for the GP’s report, made arrangements for suitable alternative work. After a period of time he resumed his full duties with emergency callout duties being removed.”

What we can start doing now.....

- ❖ Put in place an **absence and rehabilitation policy**
 - ❖ Put forward a **cost-benefit based argument** for buying in/ getting access to good occupational health services and advice
 - ❖ Suggest that to Employers and Employees that employees with MSD's and stress related conditions be **referred early**
 - ❖ Use the workplace to **promote health initiatives** and give advice on wellbeing that can be “taken home”
 - ❖ Assess whether suggested measures for those returning to work would **benefit those already at work**
 - ❖ Encourage workers **to take responsibility** for their own health
- 

and continue action following absence

- ❖ adopt a **holistic approach**, working with the Employer HR, the absentee and occupational health practitioners
 - ❖ **promote early contact** with regular review meetings
 - ❖ **challenge the myth** that uses H&S as a barrier to return
 - ❖ support Managers carry out **Risk Assessments** on returnees
 - ❖ don't focus on the medical condition when making assumptions on an employee's capabilities : **assess the individual not the illness**
 - ❖ **learn where to get advice from**
- 

Thank you for listening

