HSE Health & Safety Executive	**FIELD OPERATIONS DIRECTORATE** **HEALTH AND HYGIENE SPECIALIST GROUP**	**REPORT**

PAPER AND BOARD INDUSTRY ADVISORY COMMITTEE (PABIAC)

Aims & Objectives

1 To gather information on health risks, control measures and occupational health provision.

2 To provide feedback to PABIAC to assist in development of an Occupational Health Strategic Objective.

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Author:

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Inspection Plan

On-site visits to 9 companies proposed: - 3 recovered paper plant, 3 corrugated and 3 mills/tissue. Details of the companies selected for inspection will be based on information provided by PABIAC, Sector and FOD operational groups.

Timescale

The work will be carried out in work plan year 2008/2009. On-site inspections will take place at a maximum of 9 companies.

Resource

The project will be undertaken by Specialist Occupational Health Inspector (Mrs Hamilton) based in Edinburgh

Reporting

The results of the inspections will be presented in a composite report that will be prepared after the visits.
Individual companies will be provided, as necessary, with advice and recommendations to ensure compliance with H&S legislation.

An interim report will be given to PABIAC members in July 2009.

Difficulties encountered in arranging visits were due to personal sick leave, the global financial climate and ongoing interventions by FOD inspectors.

Companies visited:

I have undertaken 6 visits to date. This included

- 1large company in paper manufacture
- 1 Large company in tissue manufacture
- 2 (2 large company & 1 small companies involved in manufacture of paper/cardboard packaging
- 1 company manufacturing labels.

Main hazards to health identified were:-
Manual handling
Noise
Thermal environment
Repetitive tasks
Chemicals
Machinery – Forklift trucks
In all companies visited the company had identified the health risks that could potentially affect their employees. However the controls in place to monitor health varied.

Manual handling
Manual handling risks were generally well controlled with automated systems and good use of lifting aids. One company had contracted an ergonomist report from HSL.

Repetitive manual tasks
In two companies visited I asked if employees reported WRULDS. In both companies risk assessment identified this as low risk. This did not appear to be an issue due to the slow pace, light weights and opportunity for rotation of tasks.

Noise
While noise had been identified as a risk, an assessment carried out and hearing protection mandatory, audiometric screening was not done in two companies.

Thermal
Heat stress was an issue in one company but was well controlled.

Stress
Stress was not identified by sickness absence data as an issue. At each visit I promoted HSE's 'Management Standards for Stress'

Forklift trucks.
Only one company was aware of the medical standards for forklift truck operators.

Occupational Health Provision
None of the companies visited had checked the qualifications/competencies of the OHP.
Only one company had an in-house service and while the nurse was not qualified in occupational health the service provided was good due to her knowledge of the industry, good support from the H&S adviser and extremely good communications within the company. This was the only company where the OH was involved in risk assessments, the health & safety committee etc. In addition sickness absence was very low (< 2%).

Three other companies employed occupational health providers (OHP) on a fee for service basis. The OHPs were not involved in risk assessment and investigation of occupational ill health was limited.
In the fifth company an OHP was used on an ad hoc basis, mainly in relation to sickness absence and return to work issues.

Sickness Absence Data
Only three companies (all with low rates) were using this information as a tool to assist in the identification of health hazards.

Communication
On four of the sites visited, the companies were part of UK/International organisations. However each appeared to have no national/group policies for OH and information on health hazards was not shared.

Litigation
None of the companies visited knew or were aware of the costs of litigation to their company.

Discussion

Policy, Roles & Responsibilities for Occupational Health

The companies did not appear to have clear policy for the management of occupational health. Where there was no in-house provision for OH, the service level agreements did not specify, roles and responsibilities, communication channels and in all cases the OH provider did not provide an annual report to the company. The occupational health staff who were employed in-house were quite clear on their lines of communication and procedures on site. While each of the companies visited had identified the main hazards to their employees, the management of health was not integrated into their management systems.

Managers involved in the procurement of OH provision were not clear on the qualifications and competencies required to provide a competent service. In both companies where there was an in-house service the nurse had no formal qualifications in occupational health. However, in both cases the doctors who were contracted to the companies on a sessional basis did have a qualification in the specialism. The companies who were buying their OH provision had not enquired on the competence/qualifications of the staff providing the service and were uncertain of the competencies required. They had no knowledge of the relevant competencies/qualifications to provide a service to meet the legal requirements of health and safety law. This is somewhat worrying and makes it difficult for them to judge the quality of service.

Risk Assessment

In most companies, large and small, the Health & Safety Advisor, with line managers and supervisors was responsible for risk assessments.
After risk assessments were completed, (in some instances risk assessments were not ‘suitable or sufficient’), the OH provider was asked to provide a

service which in the main was very ‘product’ orientated; for example 10 audiometric tests, 5 pre-employment screenings, xx number of sickness absence referrals. The OH providers, with the exception of in-house providers, did not see the risk assessment documents. In my opinion this is a not only a failing not to utilise the knowledge and skills of the health professional but a failing of the OH service providers to familiarise themselves with the work processes.

In some cases the OH provider did not go on-site and employees were often seen by the OH provider off site. It was difficult to comprehend how the OH provider could give competent advice for pre-employment screening and fitness for work assessments when in some cases the OH provider was given merely a job title and not given a full job description with task analyses so that a comprehensive assessment and judgement could be made.

In some cases where, for example, noise was identified by risk assessment as a hazard, neither baseline audiometric testing nor on-going surveillance was done. Often the health surveillance was not targeted and linked to exposure. For example companies found it easier to do audiometric testing for all employees instead of targeting and linking to exposure.

Sickness absence is an excellent tool to assist in identifying trends, ill heath factors and accident injury rates. Unfortunately only two of the companies visited were using this data effectively to identify work related ill health. These were the companies who had an in-house service and were managing sickness absence. In the others visited the accident injury rate was known but information on ill health was neither collated nor analysed.

Litigation
Companies did appear to link litigation costs, sickness absence, risk management and occupational ill health together.

Communication
Generally companies and sites although part of a larger organisation did not communicate or share best practice between sites. It often appeared that each division of the larger companies was ‘beavering away’ developing policies and procedures in isolation. Each division of a company had its own health and safety policy and occupational health policies. This meant that there was no consistency or standard service provide on health issues. This appeared to me to be very onerous and not cost effective.

Conclusion

Companies had identified their main health hazards but unfortunately did not appear to be managing the health risks cost effectively. Best use of the data and expertise available within the company was not utilised. In the main companies were unaware if the standard of service provided by the OH providers was competent. There appeared to be little consultation with OH providers, with the exception of the in-house services, and this potentially

could lead to misunderstanding of the real risks by the OH provider and the company.
Generally, there did not appear to be standard procedures and clear lines of communication both written and verbal on OH interventions and outcomes. Companies were not aware of the true financial cost of their OH service. They knew the cost of the contract but not if it was cost effective or tailored to their needs.

Recommendations
Good management standards and systems with occupational health truly integrated into the risk management systems will achieve high levels of health, well-being and organisational performance. By integrating Occupational Health into this methodology companies will be able to identify the gap between what is happening in their organisation and will enable them to develop solutions more cost effectively.

1 I recommend that in the first instance that the industry and companies identify a method to communicate more effectively on health issues both within their own companies from site to site and between companies. They could develop a method to share best practice.

2 PABIAC should agree an occupational health –related objective for the paper industries that is aimed at encouraging employers to develop an OH policy that clearly identifies roles and responsibilities, lines of communication for the OH provider (both internal and external) and management of OH.

The objective should help to encourage companies to:

- Have a written record of OHP's qualifications, professional registration number, competence qualifications relevant to the risk i.e. FFOM HAVS course and experience in this industry.
- Have a written contract / service level agreement with OHP which is current & up to date, includes minimum information to be provided to employer and to employee, provision for referral to third party, time scales.
- Identify health risks through risk assessment process; occupational health needs discussed with OHP, occupational health provision in place to address these risks.
- Provide health records that include all relevant information and interpretation of results by the OH provider.
- Differentiate between medical records and health records and make for confidential storage of medical records and safe storage of health records.
- Have a system to ensure that confidential medical information is not passed to management.

If employers in the industry adopt a model for managing occupational health along the lines of HSG 65 or follow, for example, the approach adopted by the construction industry (employers in the construction industry have developed their own web guidance) this would help to deliver improved management of

occupational health and ensure a consistent approach to the topic. Appendix 1 illustrates the elements of an OH management system.

Appendix 1