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howden

HEALTH AND WORK

EEF HEALTH AND WORK SURVEY 2018

Sparks, taken by Terry Livesey at Conveyor Units Limited in Stourport-on-Severn, shortlisted in the professional category of the EEF Photography Competition 2017.

CONTENTS

1. Introduction **4**

2. Howden viewpoint **6**

3. Key findings **8**

4. Long-term sickness absence **9**

5. Work-related ill health **14**

– Work-related musculoskeletal disorders (WRMSD) 17

– Occupational lung disease (OLD) 19

– Work-related stress (WRS) 22

6. Occupational health **26**

7. Key messages for policymakers **31**

1. INTRODUCTION

It has long been recognised that the right work is beneficial for employees, bringing about health and well-being, improved status, economic security and enhanced social support. It is also beneficial to employers when a company invests in both the health and the well-being of its workforce. The converse is also true: those who are workless suffer from poorer physical and mental health and financial outcomes.

It is essential that employers take what steps they can to support and assist employees suffering from long-term ill health problems, particularly ill health that is caused by work, so that they can remain at work and enjoy all the benefits of continued employment.

We know that a fit and healthy workforce is a productive workforce. Helping people to remain in work will reduce the cost to the benefits system and the burden on the NHS. It is therefore important that both the Government and employers take steps to help employees who have been off work because of ill health to get back into work. We recognise that prompt intervention reduces the number of days lost to unnecessary sickness absence and prevents absence becoming long term, with the possibility in some cases that employees will never return to work.

EEF had anticipated that the Government's Industrial Strategy would (a) recognise benefits to the economy of a healthy workforce in terms of improving productivity – an eleventh pillar; and (b) provide assistance to employers by incentivising schemes that would enhance health and well-being. The Industrial Strategy: Building a Britain fit for the future,[1] was published in November 2017 and, while people is a key theme within the strategy, EEF is disappointed to note that health is only mentioned in the context of healthy ageing. No reference is made to a fit, healthy and productive workforce. We see this as a missed opportunity.

Since publication of the 2017 EEF Sickness Absence Report, the Fit for Work assessment service has been closed, largely because it was not marketed properly, particularly to GPs. It did not achieve the success in assisting people back to work that was envisaged. The outcome of the Health, Work and Disability Consultation[2] was published in November 2017 and highlights many of the societal pressures that employers are facing, not only to ensure that their workplaces are safe and without risk to health, but also to enhance general employee health and well-being which may or may not be connected with work.

[1]HM Government Industrial Strategy: Building a Britain fit for the future, November 2017:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/664563/industrial-strategy-white-paper-web-ready-version.pdf
[2]Department of Work and Pensions and Department of Health and Social Care, Consultation outcome: Work, health and disability green paper: improving lives, 30 November 2017
https://www.gov.uk/government/consultations/work-health-and-disability-improving-lives/work-health-and-disability-green-paper-improving-lives

The Health and Safety Executive's (HSE) Go Home Healthy campaign is concentrating on workplace health in relation to work-related musculoskeletal disorders (WRMSD), occupational lung disease (OLD) and work-related stress (WRS). EEF was keen to explore the extent to which these causes of ill health are an issue for UK manufacturers. We designed our survey questions in conjunction with HSE and have gained some early insights into how EEF members are managing these particular workplace risks.

This is the fifteenth EEF annual survey looking at sickness absence, health and work issues. It provides an up-to-date snapshot of the state of health and work among EEF members in 2018. The survey questionnaire was sent to manufacturers across the UK. We received 165 responses, and SMEs with up to 250 employees comprised almost nine-tenths (88%) of the responses received. The respondents were representative of the whole EEF membership by region and by manufacturing sub-sector.

2. HOWDEN VIEWPOINT

In January of this year, the number of workers in the UK over the age of 50 reached a record 10 million.[3] Longer careers means manufacturers need to adapt their business strategies to keep their employees healthy and able to work for the duration of their working life.

Many business leaders we speak to ask how they can deliver on their corporate responsibilities in a way that is commercially viable, particularly in manufacturing, where there is tough competition for skilled workers, and a greater need to retain them.

This report goes some way to suggest some businesses are already taking a proactive approach to occupational health but there are some key areas that need to be addressed, including whether their employee health strategy is actually working.

The increase of mature workers has been driven by a number of factors: no statutory retirement age means people are likely to continue working as they get older. This in turn means mature workers are more likely to fall ill whilst still in employment, and because of the skills gap there is pressure on employers to ensure these workers are able to return to work. Medical advancements have helped, meaning that previously life changing illnesses are treatable and individuals might chose to return to employment. These changes to the workforce and work environment have encouraged employers to focus on the health and wellbeing of their employees.

This report highlights that medical investigations and/or surgery are the most common cause of long-term sickness absence for manufacturers, which is not surprising. Pressure on the NHS and GP waiting times are widely reported, and in March 2018 only 87% of NHS patients had a waiting time of less than 18 weeks.[4] To decrease long-term sickness absence businesses are now requiring more focused and bespoke medical services for their employees. Businesses need to understand how these should be applied, as buying off-the-shelf medical benefits could be an expensive mistake if they aren't what is needed for the workforce.

It is encouraging to note that 99% of manufacturing companies implement some kind of solution to help reintegrate employees back into work. This shows that the health of employees is clearly high on business agendas. However, detailed and systematic evaluations of these measures are more difficult to track as different reintegration techniques and their impact on individuals varies dramatically. This is echoed in the report findings, with 37% of companies not knowing whether the measures they put into place to manage Musculoskeletal Disorders (MSD) risks have any impact on the number of MSD cases in the business. This creates an unknown outcome for businesses who have no idea whether their processes are successfully combating ill-health.

[3]https://www.ageing-better.org.uk/news/number-over-50s-uk-workforce-10-million
[4]Referral to treatment (RTT) waiting times statistics for consultant-led elective care report, NHS England, June 2018

Manufacturers are evidently making use of occupational health services and have identified specific problem areas to target relating to the industry (the most common type of health surveillance is audiometry, followed by lung function tests and skin checks). Also encouraging is the use of wider, broad-ranging occupational health services, with 38% adopting an employee assistance programme (EAP) to help combat work related stress. An independent government review has highlighted the successful return of investment of workplace mental health interventions, £4.20 being the average return for every £1 spent.

Whilst employee wellbeing and rehabilitation services are high on industry agendas it is apparent that businesses need to best utilise their benefit spend both internally and externally. They need to ensure that they are both engaging with employees to find out which services are best suited and making sure that employees are in turn engaging with what is available. Externally, third party providers should have specialist knowledge of the industry they are working with and the risks they face to ensure they are sourcing the best benefits available and most fitting for the workforce structure.

Glenn Thomas
Managing Director, Employee Benefits,
Howden UK

3. KEY FINDINGS

Long-term sickness absence not recorded in a third of companies

– Although just over half of companies (56%) record levels of long-term sickness absence (20 working days or more), almost a third (29%) do not.
– Median long-term sickness absence is running at 3.5%, rising to 8% for companies with 251+ employees.

Sickness absence caused by work is a small proportion of total sickness absence

– Just under one-third (29%) of companies identify work-related sickness absence levels, but just under two-fifths (37%) of companies do not.
– Mean sickness absence attributable to work is 4%.

Main cause of long-term sickness absence unchanged in almost 10 years

– The most common cause of long-term sickness absence for just under two fifths (37%) of companies is a result of employees waiting for medical investigations and/or recovering from surgery.

Rehabilitation after long-term absence is implemented by almost all companies

– Almost all companies implement measures to help reintegrate employees back into work. Larger companies offer the greatest number and variety of rehabilitation measures.

WRMSD and WRS work-related ill health is an issue for the majority of companies

– Almost three-fifths (58%) of companies in respect of OLD, almost a quarter (25%) for WRMSD and just under a quarter (23%) for WRS said these health risks did not affect workers in their business.

OLD, WRMSD and WRS risks are managed but health outcomes unclear

– Almost half (45%) of companies in respect of OLD, almost two-fifths (37%) for WRMSD and just over two-fifths (43%) for WRS are unaware whether their risk control measures have an impact on the number of cases of ill-health.

High take-up of occupational health services in the manufacturing sector

– Just over four-fifths (81%) of companies have access to occupational health (OH) services and the most common utilised OH services for just over three-quarters (76%) are task fitness assessments.
– Audiometry is the most common type of health surveillance for just over four-fifths (82%) of companies.

4. LONG-TERM SICKNESS ABSENCE

Introduction

The Government recognised the importance of managing long-term sickness absence when it established its Fit for Work service in order to reduce the length of time employees would be absent from work and to reduce the number of workers who might become incapacitated for work and have to rely on state benefits. It was, from EEF's perspective, a very important initiative which deserved wide support.

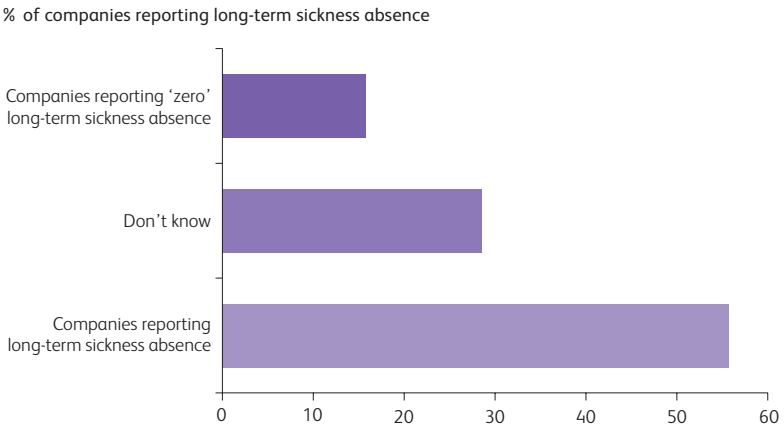
Now that the Fit for Work assessment component of the service has been disbanded, it is important that the issue of long-term sickness absence is not forgotten but effectively dealt with using a different approach. The financial benefits to the Government, to employers, to employees and to the economy as a whole still vastly outweigh a 'do nothing' option.

Long-term sickness absence

We know that long-term sickness absence is considered to be absence that extends beyond four weeks (twenty days). EEF has monitored the levels of long-term sickness absence in all our previous sickness absence surveys, and we were interested to find out whether the trends of long-term sickness absence have changed from previous years.

In Chart 1 we can see that just over one-sixth (16%) of companies told us that none of their sickness absence is a result of employees being absent for four weeks or more. However, almost one-third (29%) said that they do not know their levels of long-term sickness absence.

Chart 1: One in six companies have no long-term sickness absence



Source: EEF Health and Work Survey 2018

1/3 OF COMPANIES DO NOT KNOW THEIR LEVELS OF LONG-TERM SICKNESS ABSENCE

It is disappointing to find such a large number of respondents who appear not to have basic absence data at their fingertips. It is crucial that information about long-term absence and ill health is gathered to enable employers where necessary to (a) intervene and rehabilitate people back into work; and (b) put measures in place to help prevent and manage long-term sickness absence.

Chart 2 illustrates the level of long-term sickness absence for those companies who record long-term sickness absence data and excludes those companies who said they don't know.

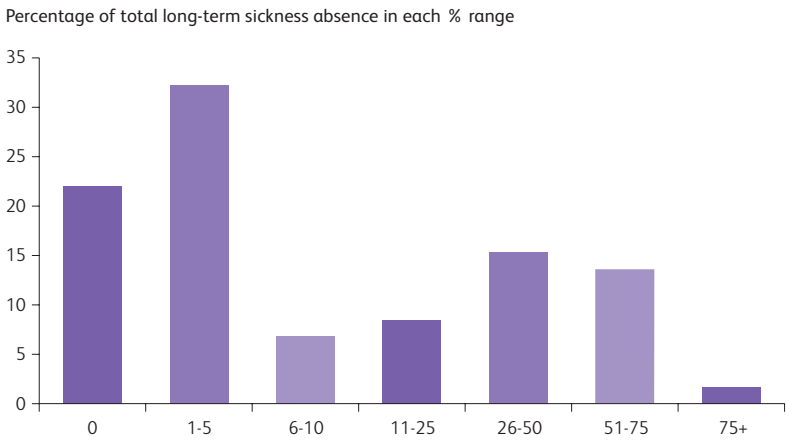
If we also exclude companies with zero long-term sickness absence the median long-term absence percentage is 3.5%. Chart 3 tells us that larger companies have much higher median percentage levels of long-term sickness absence. For companies with 251+ employees, the median is 8%.

Median long-term sickness absence is running at 3.5%, rising to 8% for companies with 251+ employees.

Companies with fewer than 250 employees have the lowest long-term sickness absence; such companies also have (as we will see in Chapter 6) the lowest access to occupational health services.

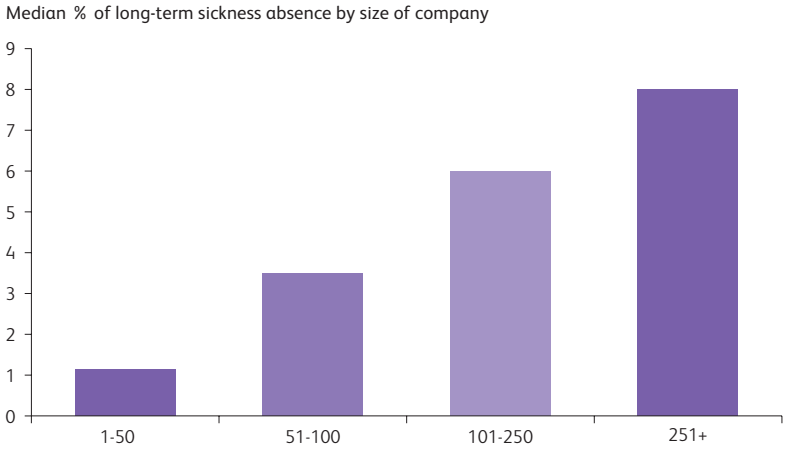
Why do larger companies have greater levels of long-term sickness absence? Is it because they are more likely to employ individuals with pre-existing health conditions or to continue to employ individuals when they develop long-term health conditions? Do larger organisations have greater difficulties tracking their employees, especially companies whose staff travel between or work in multiple locations? Is it because employees are less likely to fall out of work with a long-term condition in a larger company, or is it simply that the reporting of long-term sickness absence is better? Is it ineffective absence management?

Chart 2: Between 1% and 5% of sickness absence is long term



Source: EEF Health and Work Survey 2018

Chart 3: Larger companies have more long-term sickness absence



Source: EEF Health and Work Survey 2018

Most common cause of long-term sickness absence

Survey respondents were asked to identify the most common cause of long-term sickness absence. Chart 4 tells us that surgery or medical investigations/tests came out in first place, accounting for just under two-fifths (37%) of long-term sickness absence. This was followed by stress/mental health problems (22%) and MSD (18%). If we examine EEF trend data between 2009 and 2017 in Chart 4, we can see that the most common cause of long-term sickness absence has increased over that period.

The most common cause of long-term sickness absence for two fifths of companies is employees waiting for medical investigations and/or recovering from surgery.

If we look at the most common cause of long-term sickness absence by company size two-fifths (40%) of all firms employing up to 250 employees ranked surgery/medical investigations as the most common cause of long-term sickness absence, whereas just over two-fifths (44%) of companies employing more than 250 employees ranked MSDs as the most common cause. This is consistent with the trends we have found historically in our survey data.

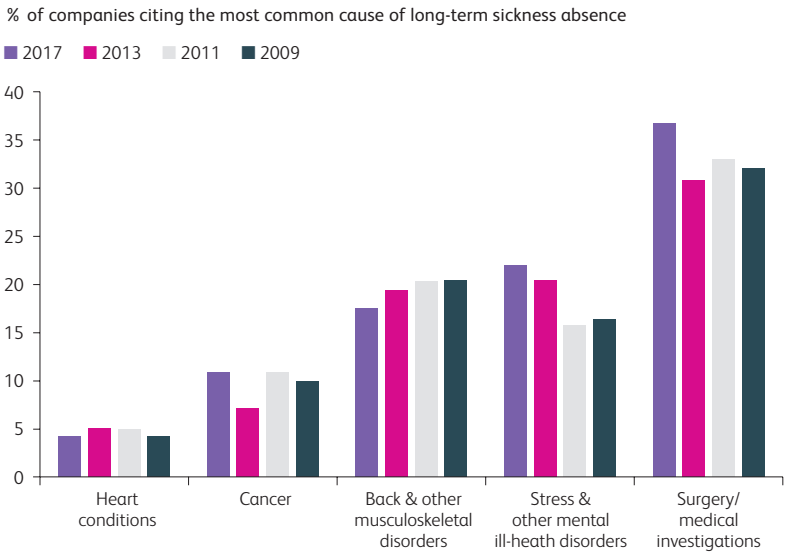
Management of long-term sickness absence

Companies were asked what measures they have applied in the last twelve months to reintegrate their employees into work following a period of long-term sickness absence.

Chart 5 reveals that employers proactively use a number of mechanisms. Looking at the top three most common interventions:-

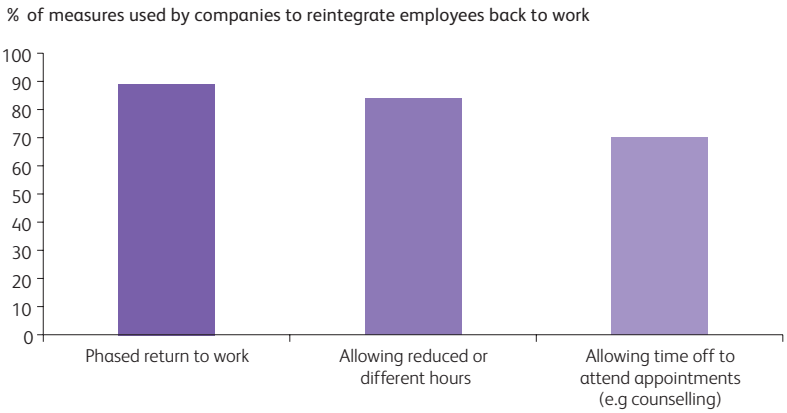
– almost nine-tenths (89%) implement phased returns to work,
– just over four-fifths (84%) apply reduced or different hours, and

Chart 4: Surgery/medical investigations most common cause of long-term sickness absence



Source: EEF Health and Work Surveys 2010 to 2018

Chart 5: Employees most likely to return to work by a phased return



Source: EEF Health and Work Survey 2018

– just over two-thirds (70%) allow time off for medical appointments.

Phased returns and reduced hours are the most popular intervention by some margin and have been established as good practice for a number of years. The least popular reintegration options mean that:-

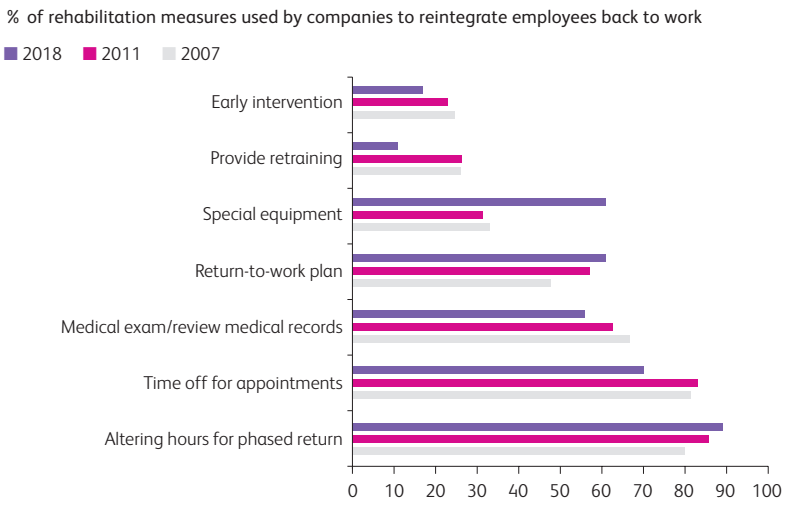
– just over one-tenth (11%) of companies provide retraining (11%)
– just under one–fifth (17%) said that they have early interventions in place in order to prevent acute illness becoming chronic, e.g. physiotherapy.

Almost all companies implement measure(s) to help reintegrate employees back into work after long-term sickness absence.

It has been possible to make a comparison with rehabilitation arrangements implemented by companies in previous years from previous EEF surveys. Chart 6 illustrates three different survey years and clearly shows increases over this time period in the provision of special equipment for employees, greater use of return-to-work plans and a small increase in altering hours of work to allow phased returns to work. The use of early intervention measures such as physiotherapy or counselling (which potentially have the greatest impact) to facilitate earlier employee return to work has, however, declined.

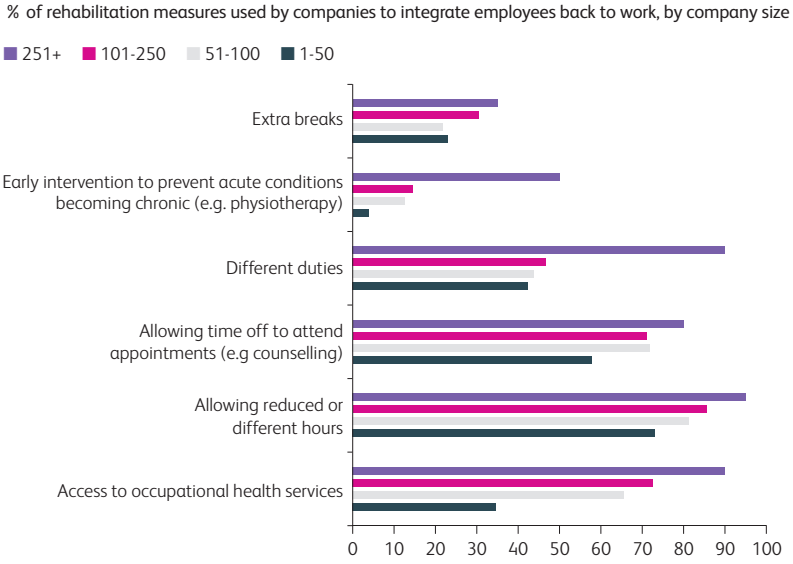
In terms of employee reintegration measures and company size, Charts 7 and 8 show us that use of occupational health services increases with company size, from up to nine-tenths (90%) for the very largest organisations down to just over one-third (35%) for companies with 1 to 50 employees. This is likely to be a reflection of the resources available to larger firms to invest in employee health and a perception of how they value getting employees back to work more quickly.

Chart 6: Most employers provide a phased return to work for employees



Source: EEF Health and Work Survey 2008, 2012 and 2018

Chart 7: Return-to-work plans most popular with largest companies



Source: EEF Health and Work Survey 2018

When all the reintegration interventions are considered, their application increases with company size, apart from provision of workplace adjustments and reduction of workload. It was disappointing to see that few firms, regardless of size, engage in early intervention to prevent acute conditions from becoming chronic. Interventions of this nature have proved successful in the long term. Tackling employee health and sickness absence early can prevent acute conditions becoming more long term and chronic.

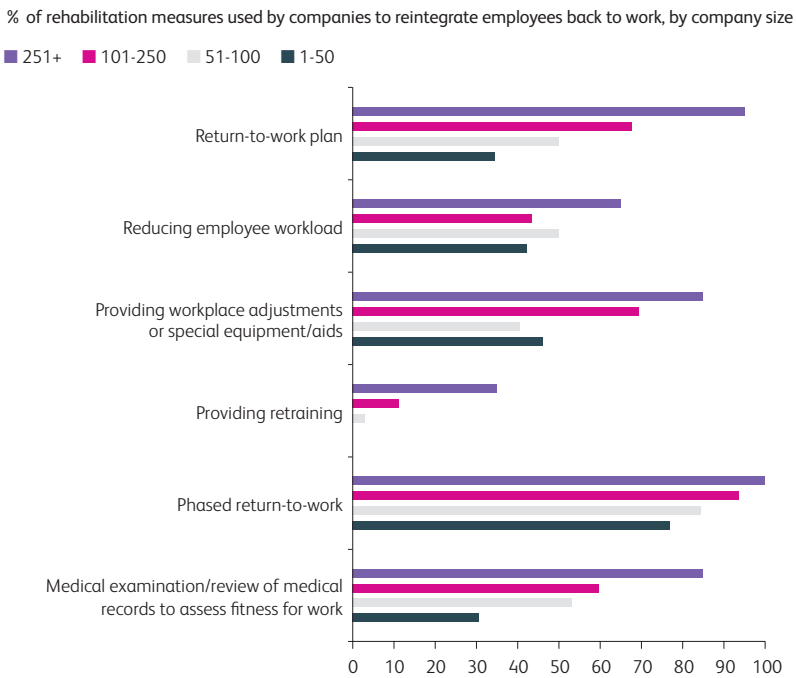
Long-term sickness absence – what now?

EEF has stated in many of its sickness absence survey reports over the years that reductions in long-term sickness absence will only be achieved once the Government recognises that fiscal incentives are likely to be the route that will secure SME engagement in the funding of medical interventions, rehabilitation or workplace adaptations without reliance on the NHS.

EEF members have told us that the following measures should be considered to incentivise companies to pay for employee health (including people with longer-term health conditions) and well-being programmes. They are:

- Employer/Government matched funding;
- Health tax credits for employers;
- Lower National Insurance rates;
- Income protection and private medical insurance incentives;
- Employer allowable business expenses;
- Lower VAT rates on health and well-being expenditure.

Chart 8: Phased returns to work most popular with smallest SMEs



Source: EEF Health and Work Survey 2018

5. WORK-RELATED ILL HEALTH

Work-related ill health and HSE

HSE figures[5] show that work-related ill health is estimated to cost the economy more than £9 billion, with 26 million working days being lost, each year. This has now become a priority for HSE, which effectively operates as the Government's chief occupational health adviser.

On 18 September 2017 the Health and Safety Executive launched its health priority plan. This followed criticism of HSE by industry for ignoring the work-related ill health agenda for several years and for the effective dismantling of its Employment Medical Advisory Service (EMAS). HSE-funded research[6] also found that almost half of Britain's industry leaders did not feel enough was being done across industry to tackle cases of work-related ill health.

In addition, the HSE research found that more than two-fifths of businesses are reporting a rise in cases of long-term ill health, with the majority (80%) stating that tackling this growing problem is a priority within their organisation.

HSE identified three key health issues. Unsurprisingly, the priority areas chosen are lung disease, work-related stress and musculoskeletal disorders as together they are the most significant causes of occupational ill health and death in the UK.

Following the launch of HSE's health priority plans, HSE announced its new national campaign: 'Go Home Healthy'. EEF works in partnership with HSE and has made a number of commitments to HSE in supporting its campaign, especially in the area of OLD and MSD.

The lung disease priority plan covers chronic obstructive pulmonary disease (COPD), including lung cancer, pneumoconiosis and mesothelioma. Lung diseases account for around 12,000 deaths per year. The Labour Force Survey (LFS) suggests that 36,000 people have suffered from breathing problems caused by or made worse by work. It is estimated that there are around 14,000 new cases a year, resulting in around 400,000 lost working days.

To reduce the toll of disease and death as a result of lung disease, HSE has proposed the prevention and management of exposure in high-risk industries through cross-sector leadership, product manufacturers providing advice on exposure reduction and educating employees on what 'good' looks like.

MSDs account for 41% of all cases of ill health and 34% of all working days lost because of ill health. It is estimated that MSD cost the UK economy more than £2 billion per annum. HSE estimates that in 2015–16, 8.8 million working days were lost, with 539,000 cases each resulting in an average of 16 days lost. Of this figure, it is estimated that 176,000 were new cases that year.

HSE is encouraging the implementation of control measures to seek the elimination of MSD risks by automation and mechanisation and job design, rather than reliance on manual handling training to reduce the risk of injury.

[5]Health and safety at work: Summary statistics for Great Britain 2017 – HSE (November 2017)
[6]https://www.phoenixhsc.co.uk/blog/not-enough-being-done-to-tackle-work-related-ill-health-say-gbs-business-leaders.html, accessed on 27/10/2018.

Work-related stress is the third priority area and represents the second most commonly reported cause of ill health in the UK. WRS accounts for 37% of all ill health cases and 45% of days lost because of ill health. In 2015–16 it was estimated that stress was responsible for 11.7 million working days lost, with an average of 23.9 days per case. In the same year it was estimated that 224,000 of the 488,000 cases were new.

HSE's approach is similar to their previous strategies to reduce of the impact of WRS. Great emphasis is being placed on the application of HSE's management standards, with more HR and safety professionals being competent to apply the standards within their organisations. HSE also recognises that addressing workplace stress impacts the wider mental health agenda and provide a balanced view on the responsibilities of the employer and the responsibilities of the employee.

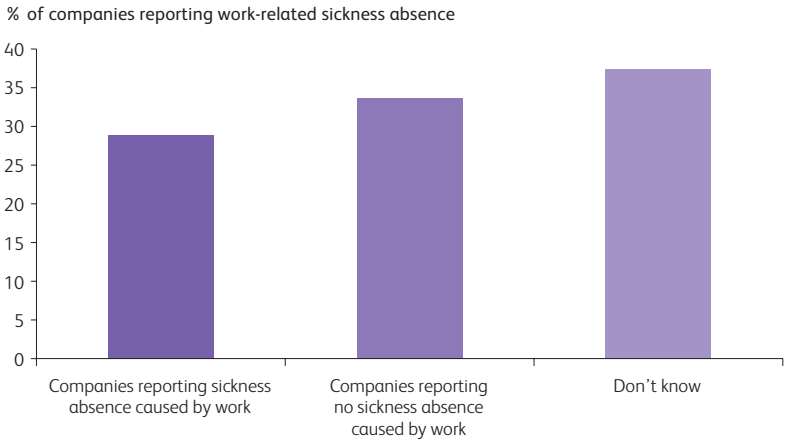
Data from the LFS estimates that, annually, around 80,000 manufacturing workers in Great Britain suffer from an illness they believe was caused or made worse by their work.
Of these:

- 43% (34,000 cases) are musculoskeletal disorders (MSD), of which around one-third are new conditions;
- 28% (23,000 cases) are cases of stress, depression or anxiety, of which about half are new conditions;
- 29% (23,000 cases) are other conditions (such as skin or respiratory conditions), of which around half are new conditions.

Absence caused by work

Companies were asked what percentage of their total sickness absence days are caused by work, including resulting from ill health conditions such as work-related stress or musculoskeletal disorders. This means that the survey responses covered work-related sickness absence attributable both to ill health and to accidents.

Chart 9: One in three companies have no work-related sickness absence



Source: EEF Health and Work Survey 2018

1/3 OF COMPANIES IDENTIFY WORK-RELATED SICKNESS ABSENCE LEVELS, BUT 2/5 OF COMPANIES DO NOT

Chart 9 tells us that just over one-third (37%) of companies were unable to say whether any of their sickness absence was attributable to work. This is not dissimilar to the findings in Chart 1, where just under one-third (29%) of companies told us that they do not know their levels of long-term sickness absence. This may suggest that the investigation and attribution of the causes of sickness absence (whether attributable to work or not) is not particularly well managed. For those companies who recorded work-related absence, the mean percentage of sickness absence caused by work was 4%.

When the same data is interpreted in relation to company size, Chart 10 demonstrates that the companies with the highest reported mean for work-related sickness absence are those employing between 51 and 100 people, at 7.4%. This is more than double the rate for the next highest: 3.6% for those employing between 101 and 250 people. Chart 10 could suggest that companies with 251+ employees are either better at recording sickness absence attributable to work or that their health and safety management systems are more effective in reducing levels of sickness absence caused by work.

Ill health priority areas

To establish their significance for EEF members, respondents were asked to what extent, if at all, did the three ill-health priority health areas affect their business.

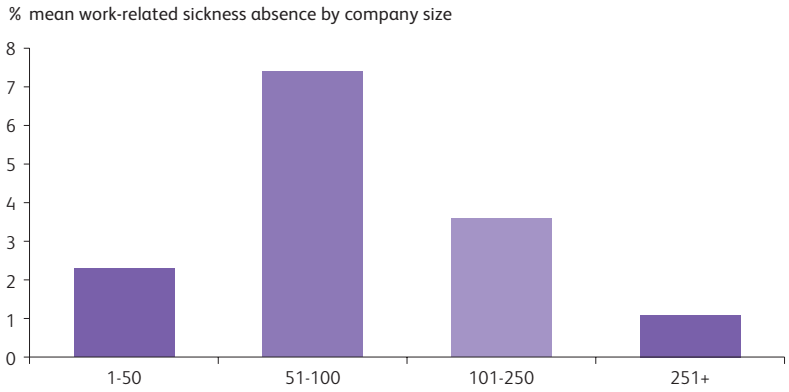
Chart 11 reveals a number of surprising outcomes to this question. A significant number of respondents reported that they do not know whether these particular health issues have any impact on their business (7% for MSD, 9% for lung diseases and 13% for WRS). We think it is important that employers take thorough steps to investigate and record causes of absence to determine whether or not there is an occupational origin or component. An unexpected finding was that:-

- almost three-fifths (58%) of companies in respect of OLD,
- almost one-quarter (25%) in respect of WRMSD,
- just under one-quarter (23%) in respect of WRS

said that these health risks do not affect workers in their business.

3/5 OF COMPANIES SAID THERE WERE NO OLD HEALTH RISKS AND 1/4 SAID THAT THERE WERE NO MSD OR WRS RISKS AFFECTING THEIR WORKERS

Chart 10: Companies with 51–100 employees have highest work-related sickness absence



Source: EEF Health and Work Survey 2018

Chart 11: A quarter of employers have no WRS or WRMSD problems

Source: EEF Health and Work Survey 2018

What does this tell us? It can mean many things. It could mean that in those particular companies that these health risks are generally well managed. It could mean that these health risks do not manifest themselves at work (especially longer-latency lung diseases or non-work-related MSD), especially where employees move frequently between jobs. It could also mean that employers do not have OH health surveillance in place, or procedures and processes that allow them to accurately attribute sickness absence to work or non-work-related activities.

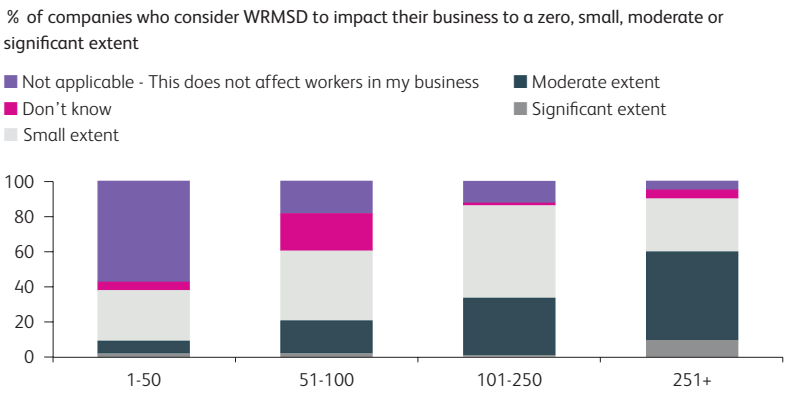
All in all, there is a disconnect between the extent to which WRMSD, WRS and OLD appear to be a problem among our survey cohort and the levels of self-reports we see recorded under the Labour Force Survey for manufacturing workers in Great Britain who say they are suffering from an illness they believe was caused or made worse by their work. This suggests that there may be a high level of under-reporting of work-related ill health at employer level, or alternatively that the Labour Force Survey estimates for work-related ill health are over-estimates.

None of the survey respondents believes that OLD or WRS are significant issues for their business. Almost half (49%) of companies said that WRS, just over two-fifths (41%) said WRMSD and just under a third (30%) said OLD present problems to a small extent. Clearly, companies are aware of these potential health risks but do not view them as significant.

Work-related musculoskeletal disorders (WRMSD)

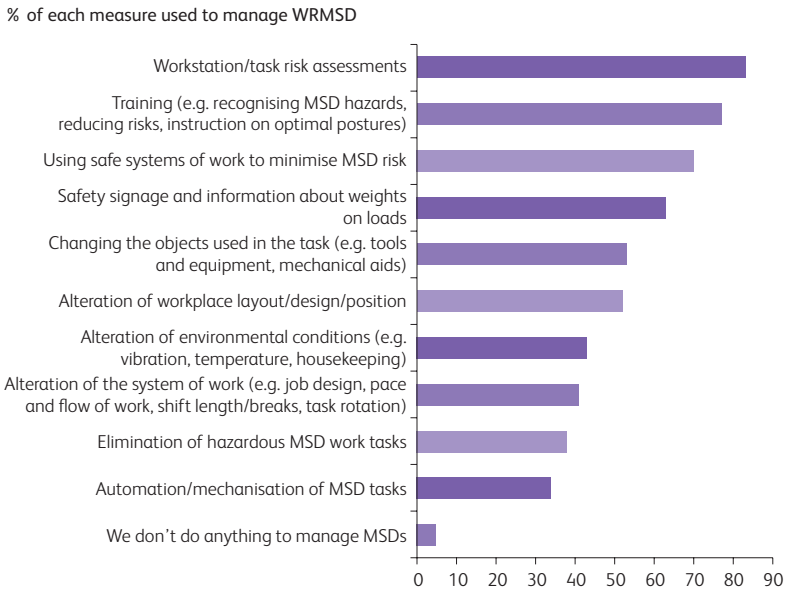
If we look at WRMSD by company size, we can see in Chart 12 that it is more of an issue with larger businesses and, conversely, the smaller the company the more frequently WRMSD was reported as not being an issue. It seems unlikely that ergonomic risks are not an issue in smaller firms. It may simply be that smaller firms have a lower incidence of WRMSD because they have fewer employees, or perhaps they do not have robust WRMSD internal reporting systems in place (placing reliance on GP fit notes), or perhaps they do not understand MSD risks.

Chart 12: WRMSD considered more of a problem in larger businesses



Source: EEF Health and Work Survey 2018

Chart 13: Four-fifths of firms carry out WRMSD risk assessments



Source: EEF Health and Work Survey 2018

Management of WRMSD

Companies were asked what they do to manage WRMSD in their organisations. A variety of options were given and respondents were asked to indicate all interventions used. See Chart 13.

Most companies recognise that they need to manage WRMSD, which is very encouraging. The top three most popular interventions see:-

– just over four-fifths (83%) of companies implementing work station/task risk assessments,
– just under four-fifths (77%) implementing training,
– and just over two-thirds (70%) implementing safe systems of work.

The interventions likely to have the biggest impact in terms of eliminating or reducing hazards are considered less frequently. Just under two-fifths (38%) eliminate hazardous MSD work tasks and just over one-third (34%) implement automation/mechanisation of MSD tasks. Clearly this indicates that there is some work to do with EEF members to move them from providing manual handling training to elimination of the hazard in line with HSE's MSD policy.

When looking at the number of intervention measures implemented by companies to manage WRMSD, just under one-sixth (13%) use at least six measures and one-tenth (10%) use up to ten measures. This seems to suggest that WRMSD health risks are considered in more depth than the other health issues identified in the survey. Multiple approaches and measures for the management of WRMSD are common.

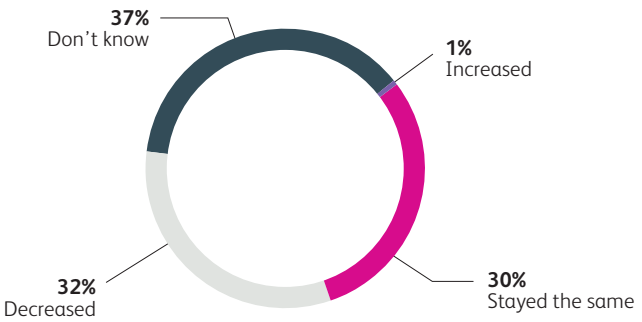
Again, reflecting on HSE's ambition to move towards risk elimination, it appears to be the midsized companies (51–100 and 101–250 employees) that are most active in applying intervention measures within their organisations. Elimination of WRMSD risks are being applied by just under half (45%) of survey respondents and automation in just over one-third (37%). As commented above, this good practice needs to be spread across companies of all sizes.

Effectiveness of management interventions in reducing WRMSD

It is important to determine whether the measures introduced have had an impact upon the number of cases of WRMSD in the workforce. Responses to the survey question (as shown in Chart 14) were largely inconclusive. They indicate that:-

Chart 14: Impact of WRMSD interventions not known in almost two-fifths of companies

% of companies reporting changes in the number of WRMSD cases following workplace interventions



Source: EEF Health and Work Survey 2018

– just under two-fifths (37%) do not know whether the number of WRMSD cases has increased or reduced,
– just under one-third (30%) said the number of cases has remained the same,
– and just under one-third (32%) said they have reduced.

The number of 'don't know' responses probably reflects the difficulty EEF members have in differentiating whether an MSD is attributable to work or not.

2/5 OF COMPANIES DO NOT KNOW WHETHER THEIR WRMSD RISK CONTROL MEASURES HAVE AN IMPACT ON THE NUMBER OF CASES OF MUSCULOSKELETAL ILL-HEALTH

If we look at the impact of the individual interventions on the number of WRMSD cases, the two most successful interventions for almost two-thirds (63%) of firms is automation and mechanisation and safe systems of work. See Chart 15. This is an expected outcome in that automation and mechanisation clearly remove the need for manual handling, and safe systems of work should introduce safer manual handling operations. It does appear that survey respondents are clear about what really works in reducing cases of WRMSD.

Occupational lung disease (OLD)

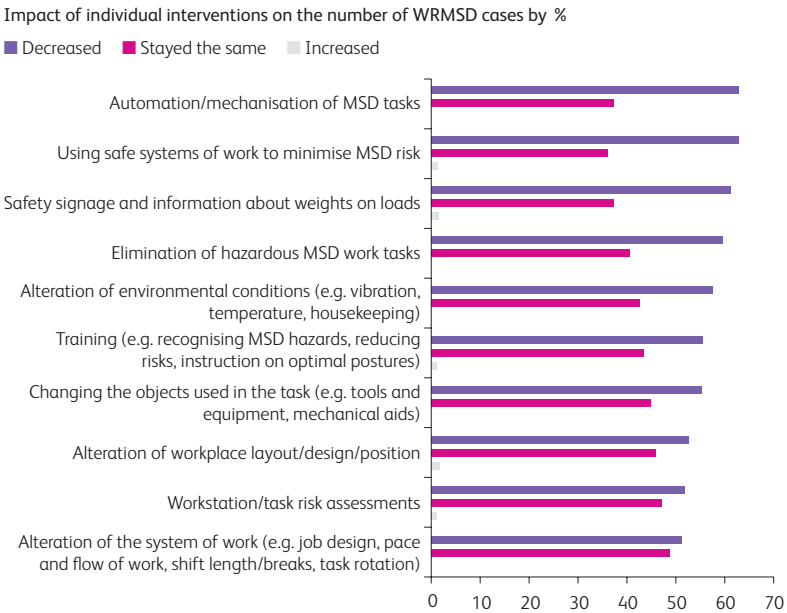
Work-related lung disease appears to be much less of a problem for our survey respondents. Almost three-fifths (58%) reported that it is not applicable to their business, and an analysis of company size tells us that there is a direct relationship between company size and whether OLD is an issue. Almost four-fifths (79%) of companies with 1 to 50 employees do not consider OLD to be relevant for them. See Chart 16. There could be a number of reasons for this, the most likely being that firms with a small number of employees are less likely to see cases of employees with OLD and therefore it is not identified as a problem. It is also more likely that smaller firms do not have access to occupational health services which provide respiratory health surveillance, especially if they do not perceive a risk in the first place

It should be recognised that, although larger companies report that OLD impacts them only to a small extent, more employees may be affected proportionately owing to the size of their workforce. The fact that no large company reported OLD to have a moderate or significant impact on their business could also suggest that they consider exposure to agents that may cause OLD to be under control.

Management of OLD

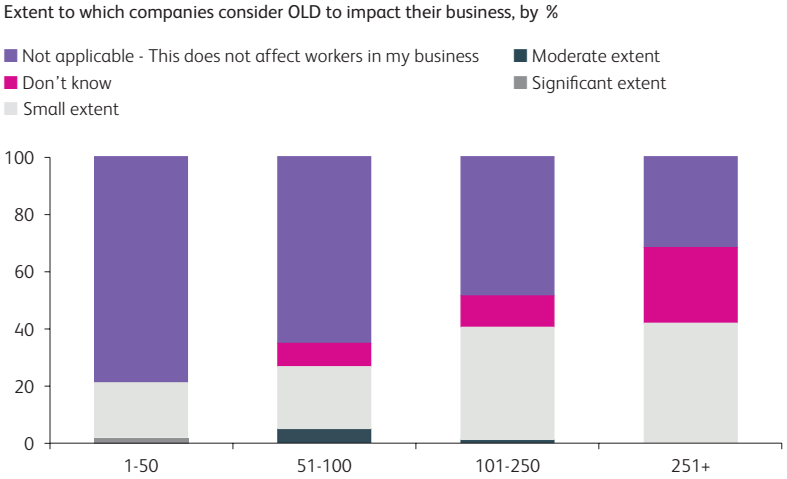
Companies were asked what they do to manage OLD in their organisations. Eleven control measures were suggested and respondents were

Chart 15: Automation/mechanisation has greatest impact on reducing WRMSD cases



Source: EEF Health and Work Survey 2018

Chart 16: Occupational lung disease (OLD) not an issue for small employers



Source: EEF Health and Work Survey 2018

asked to indicate which ones they implement in their workplaces. See Chart 17.

Although two-thirds of companies said that OLD are not an issue for their business, most are actively implementing measures to manage OLD risks in some way. Only one-tenth (10%) said they are not doing anything to manage exposure to hazardous substances.

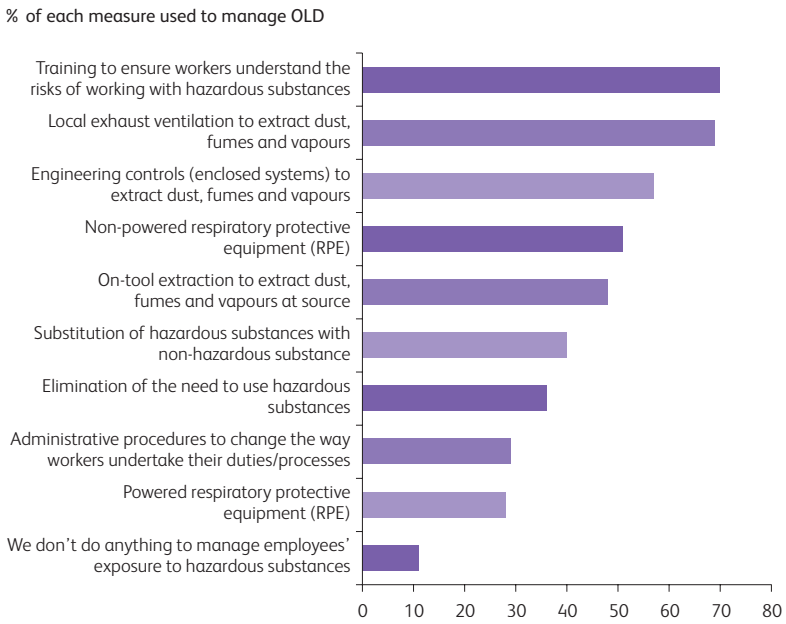
The top three interventions see:

- more than two-thirds (70%) providing training to ensure that workers understand the risks of working with hazardous substances,
- more than two-thirds (69%) installing LEV
- and just under three-fifths (57%) providing enclosed engineering controls.

Most interventions relate to the control of exposure rather than removing the hazard through elimination and substitution. Clearly, it is more difficult to eliminate or substitute hazardous substances in a manufacturing environment subject to Good Manufacturing Practice (GMP) and exacting quality control standards, but it is encouraging that almost two-fifths (40%) of firms have implemented or are considering implementing these control solutions. These survey results suggest that the COSHH hierarchy of controls are proactively considered by many companies.

When looking at the number of intervention measures implemented by companies to manage OLD, just under one-fifth (19%) use at least six different control measures. This tells us that OLD health risks are managed in depth and that a combination of the different control measures found in COSHH legislation are being implemented. Multiple approaches and measures for the management of OLD reflect the nature of the risks posed by exposure to hazardous substances. It is not possible to infer from the survey data the most effective combination of measures for the control of exposure to hazardous substances by inhalation, but it is encouraging that employers are choosing to implement elimination or substitution as a means of controlling employees' exposure.

Chart 17: Over two-thirds of firms provide hazardous substance training



Source: EEF Health and Work Survey 2018

For the smallest companies, it is not surprising to see that the control measures most often employed include training, LEV and non-powered respiratory protective equipment (RPE). What is encouraging in respect of larger organisations is greater use of on-tool extraction systems and enclosed engineering control systems. This suggests that exposure prevention for respiratory risks is being taken seriously, but this approach needs to filter down to companies with 1 to 50 employees.

Effectiveness of OLD management

It is important to determine whether the measures introduced have had an impact upon the number of cases of OLD in the workforce. See Chart 18. It would appear that these interventions are effective, as no survey respondents reported an increase in occurrence

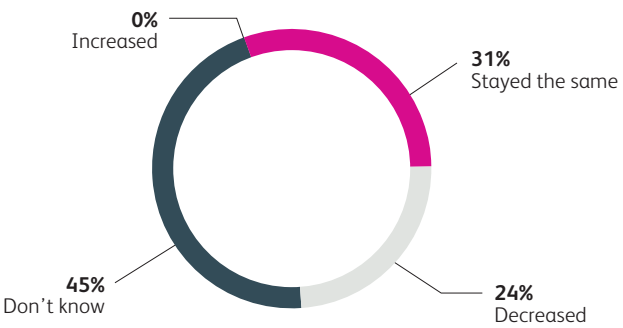
after implementation. Almost one-third (31%) said the number of cases remains unchanged, and almost one-quarter (24%) said that the number of cases has decreased. What is surprising is that almost half (45%) said that they do not know the impact of the control measures. This is concerning, as companies could be spending money on measures that are having little or no impact on the incidence of lung disease. It may also suggest that employers are not monitoring their control measures to determine whether or not they are effective and whether or not they are meeting workplace exposure limits (WEL).

1/2 OF COMPANIES DO NOT KNOW WHETHER THEIR OLD RISK CONTROL MEASURES HAVE AN IMPACT ON THE NUMBER OF CASES OF RESPIRATORY ILL-HEALTH

If we look at the same survey data by size of company we find that the larger the company, the larger the reported decrease in lung disease. However, larger companies also reported the highest level of 'don't know' responses about the impact of the control measures, at almost three-fifths (59%).

Chart 18: Impact of interventions on OLD cases unknown in 45% of companies

% of companies reporting changes in the number of OLD cases following workplace interventions

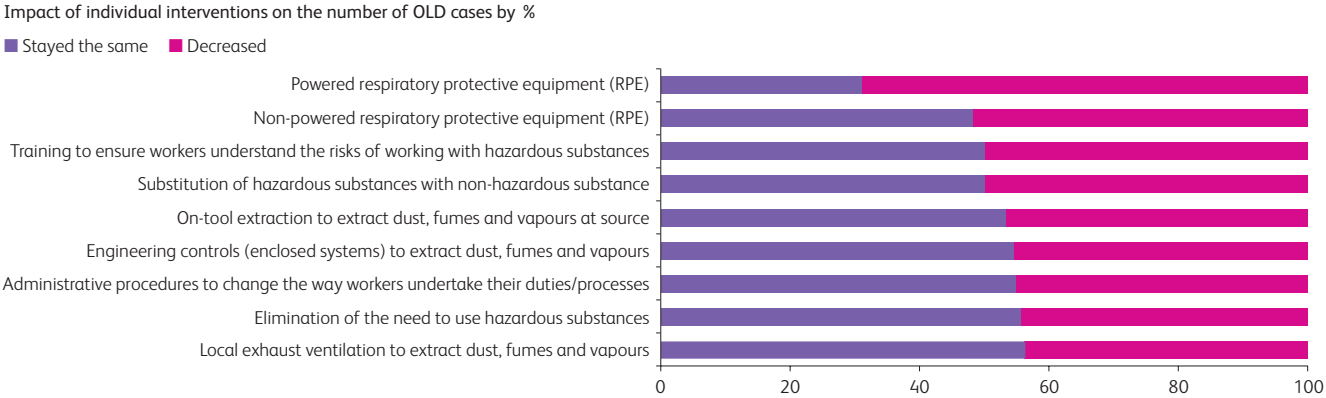


Source: EEF Health and Work Survey 2018

The intervention that demonstrates the highest level of effectiveness in reducing lung disease is powered respirators, with just over two-thirds (69%) seeing a decrease. Half (50%) of companies said that substitution and hazardous substance risk training has had equal impact. See Chart 19. As substitution is reported as being only the second most successful intervention, EEF needs to encourage its members to apply the COSHH hierarchy of control.

Chart 19: Powered respiratory protective equipment (RPE) has greatest impact on reducing OLD cases

Impact of individual interventions on the number of OLD cases by %



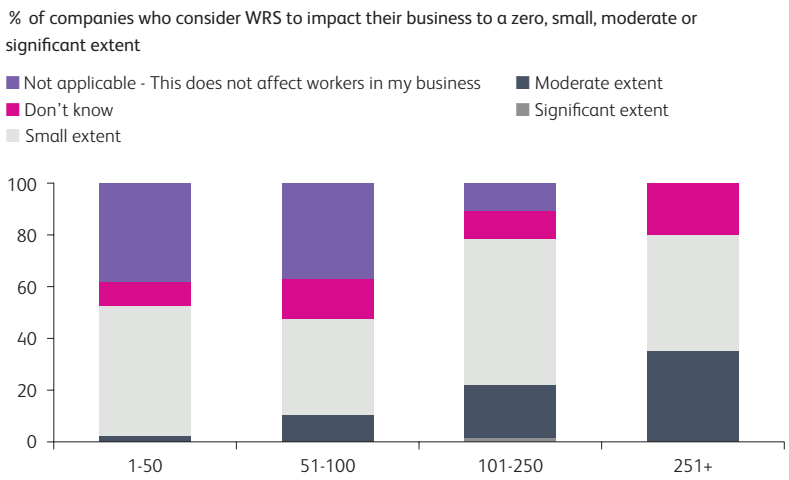
Source: EEF Health and Work Survey 2018

Work-related stress (WRS)

Overall, WRS appears to be a less significant health risk for EEF members than WRMSD.

If we look at WRS by company size, we can see from Chart 20 that as companies get larger, stress becomes more of a problem. In the largest companies (251+ employees), just over one-third (35%) reported that WRS impacts their business to a moderate extent. This may reflect the complexity of larger organisations, the extent to which they identify it as a workplace risk which requires effective management, and the simple fact that larger companies have more employees. It may also reflect a lack of knowledge about the importance of managing WRS in smaller companies.

Chart 20: WRS considered more of a problem in larger businesses



Source: EEF Health and Work Survey 2018

Management of WRS

Companies were asked what they do to manage WRS in their organisations. See Chart 21.

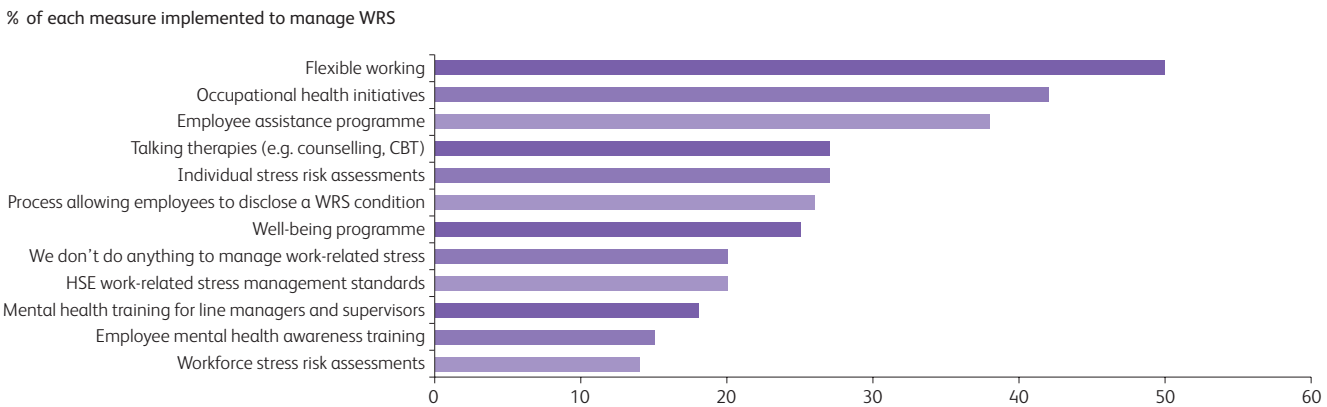
The top three most popular interventions see:-

- half (50%) of companies adopting flexible working,
- just over two-fifths (42%) introducing occupational health initiatives,
- and almost two-fifths (38%) embedding employee assistance programmes.

HSE will be disappointed to see that its work-related stress management standards are used by only one-fifth (20%) of the respondents and ranked as the seventh most popular intervention.

WRS may be the condition that affects the widest array of companies, but it is also the condition with the least measures implemented to combat it. One-fifth (20%) of the survey respondents said that they take no action to manage WRS, even though one-fifth (20%)

Chart 21: Half of firms apply flexible working to manage WRS



Source: EEF Health and Work Survey 2018

reported that WRS is a moderate problem for them.

When looking at the number of measures implemented by companies to manage WRS, just under one-fifth (18%) of companies use only one measure, and one-sixth (15%) use two measures. This again suggests that WRS may not be as big an issue as the other health issues identified for EEF members. Multiple approaches to the management of WRS appears to be uncommon.

Across all company sizes, apart from the very largest, flexible working is the most popular intervention measure. This is likely to be because it is reasonably inexpensive and the easiest to introduce and manage. Employee assistance programmes (EAP) can be more expensive, and that is probably why they are used by the largest employers who are likely to have more resources available to invest in the health of their employees.

Effectiveness of WRS management

It is important to understand what works when putting in place measures to manage WRS. Companies were asked what change they have seen in the number of WRS cases as a consequence of putting in place WRS interventions.

Responses, as shown in Chart 22, were largely inconclusive and indicate that:-

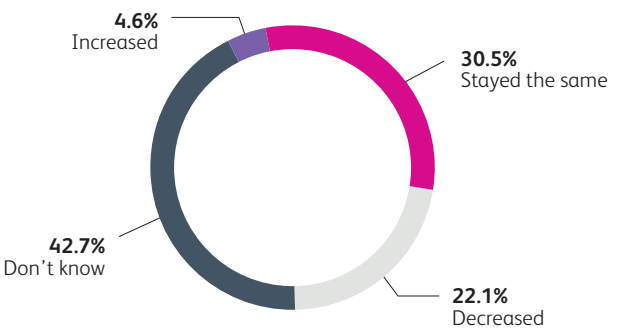
- just over two-fifths (43%) do not know whether the number of WRS cases has increased or reduced,
- just under one-third (31%) said the number of cases has remained the same,
- and just over one-fifth (22%) said they have seen a reduction.

The number of 'don't know' responses probably reflects the difficulty EEF members have in managing and measuring the issue in the workplace.

2/5 OF COMPANIES DO NOT KNOW WHETHER THEIR WRS RISK CONTROL MEASURES HAVE AN IMPACT ON THE NUMBER OF CASES OF MENTAL ILL-HEALTH

Chart 22: Impact of WRS interventions not known in two-fifths of companies

% of companies reporting changes in the number of WRS cases following workplace interventions



Source: EEF Health and Work Survey 2018

Chart 23: OH and EAP have greatest impact on reducing WRS cases

Source: EEF Health and Work Survey 2018

If we look at the impact of the individual interventions on the number of WRS cases, Chart 23 suggests that for these interventions there have been either no or just small improvements for most companies in the number of WRS cases. The only interventions that appear to have reduced the number of WRS cases for some companies are EAP and occupational health WRS initiatives. The picture is confused as to what really works in reducing cases of WRS.

Next steps

This is the first opportunity that EEF has had to find out from its members how they are managing three key ill health risks.

It would appear that many companies do not see these health risks as a significant problem in their particular workplaces, although many recognise WRS as being something that presents a moderate risk to the health of the workers in their business.

What is striking is the difficulties companies are having in attributing whether ill health is caused by work or not, especially for stress and MSD. Companies are also generally unaware whether or not the implementation measures they have in place to manage risks are effective.

EEF has set up a small working party which is in the process of developing work-related key performance indicators (KPI) for health and well-being in the manufacturing sector. We hope to continue working with HSE to develop a guide which will help manufacturers (a) to decide whether ill health is work-related, and (b) to assess the effectiveness of control measures to reduce the risk of exposure to WRS, OLD and WRMSD.

Color_Steel-0666, taken by Steve Morgan at TATA Steel in Shotton, shortlisted in the professional category of the EEF Photography Competition 2017.

6. OCCUPATIONAL HEALTH

Introduction

Access to occupational health (OH) is the backbone of a healthy workforce. EEF supports the call of the Society of Occupational Health (SOM) for universal access to occupational health[7,8] – because all employees might at some point need help.

Good occupational health is relevant for all: employees, businesses, healthcare payers and society in general. We all gain from seeing improvements in employee health and reductions in absenteeism, presenteeism due to poorly managed chronic health conditions and healthcare costs.

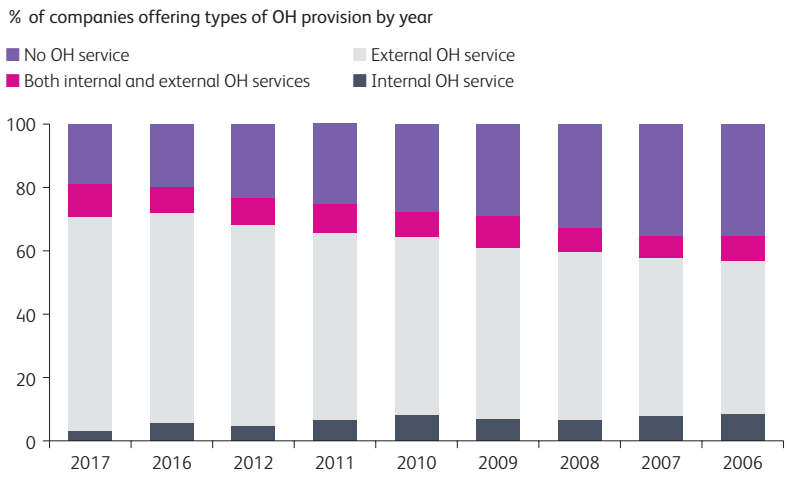
As EEF has said before, the missing pillar in the Government's Industrial Strategy is workplace employee health. Keeping people fit and healthy keeps them in work, and is fundamental for employers and the wider economy in terms of overall productivity and economic growth.

Types of occupational health services

Often it is a company's occupational health service that underpins an employer's approach to the management of occupational ill health. It is essential to ensure that the type of service and the level of provision are balanced with the actual occupational health risks and workplace needs.

Companies can provide internal occupational health services, engage external providers or have a mix of the two. The trend over time, supported by the latest EEF survey data as shown in Chart 24, is that just over two-thirds (68%) of companies now have external OH contracts, one-tenth (10%) have a mixture of external and mixed provision, and a handful of companies still retain their internal OH service. Just under one-fifth (19%) of companies told us that they do not have access to OH services; this compares with just under two-fifths (35%) in 2006. We are pleased that a significant majority of our survey respondents recognise the importance of and need for occupational health provision.

Chart 24: Four in five companies have access to OH services



Source: EEF Health and Work Survey 2007-2013, 2017 and 2018

4/5 OF COMPANIES HAVE ACCESS TO OCCUPATIONAL HEALTH (OH) SERVICES

[7]Occupational health: The Value Proposition, SOM, May 2017
[8]Occupational Health: The Global Evidence and Value, SOM, April 2018

The picture is different when we look at occupational health provision by company size. Not surprisingly, the smallest companies are least likely to have OH support. Chart 25 shows that just over two-fifths (44%) of firms have access to OH services. Larger companies are more likely to retain their internal OH service, although they are a dying breed.

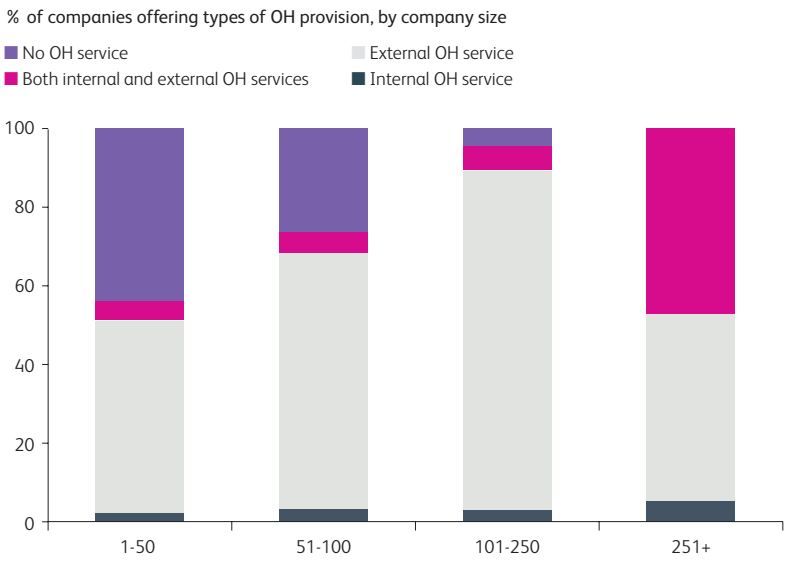
Occupational health services

Companies were asked which services they currently receive from their occupational health provider. See Chart 26.

The most common response, from just over three-quarters (76%) of survey respondents, was task fitness assessments. Just over two-thirds (70%) cited advice on workplace adjustments and health surveillance, and just under three-fifths (58%) cited advice on chronic conditions and disabilities. This is encouraging, as it is these types of intervention that will be needed to enable an ageing work force suffering from chronic health conditions to remain in the workforce for longer.

3/4 OF COMPANIES USE THEIR OH SERVICE TO CARRY OUT TASK FITNESS ASSESSMENTS

Chart 25: SMEs with 1–50 employees less likely to access OH services



Source: EEF Health and Work Survey 2018

Chart 26: OH most likely to provide fitness-to-work service

Source: EEF Health and Work Survey 2018

What is also immediately apparent is the variety of OH services on offer and the extent to which they are used by our member companies. Where OH services are paid for through external contracts, companies are likely to pay for what they think they can afford. It is not clear that they pay for the services they really need, the services that reflect the OH risk profile of the companies and their workforces.

The survey data also shows us that the very largest survey respondents offer the greatest range of OH services telling us that larger companies can afford to be more proactive in investing in their employees' health. Smaller companies prioritise health surveillance and prevention OH services and task fitness assessments, whereas larger companies are able to provide more advice on workplace adjustments.

OH and health surveillance

From a workplace perspective, health surveillance is an essential component of any OH service. Those companies that provide health surveillance as part of their OH provision were asked what types of health surveillance are undertaken. The most commonly reported activity, for just over four-fifths (82%) of companies, is audiometry, followed by lung function tests (80%) and skin checks (71%). See Chart 27.

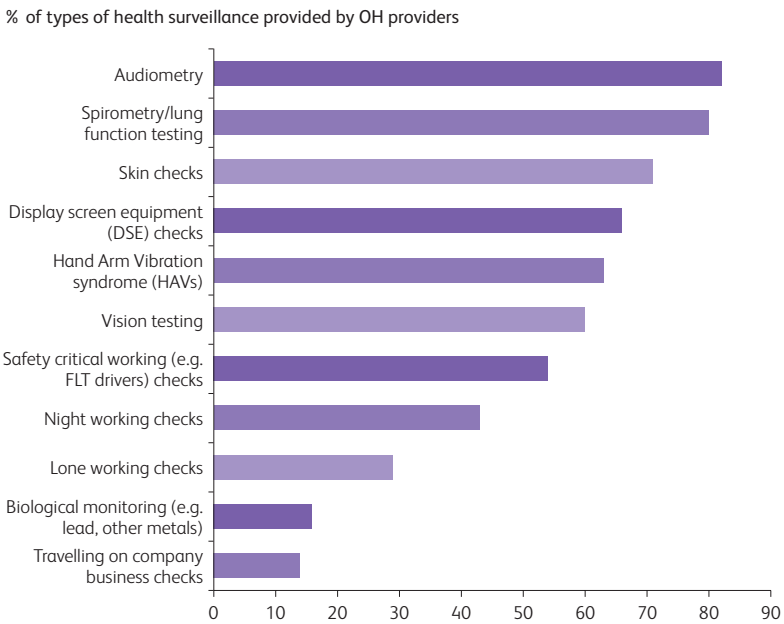
4/5 OF COMPANIES WITH AN OH SERVICE CARRY OUT AUDIOMETRY AS PART OF THEIR HEALTH SURVEILLANCE PROGRAMME

For the manufacturing sector, noise and vibration can be key hazards. Our members tell us that there has been a significant increase in the number of compensation claims made for noise-induced hearing loss (NIHL) in recent years. This may have led to the greater OH service provision for audiometry so that companies are in a position to be able to challenge some of the claims. Indeed, the Association of British Insurers (ABI) warned in 2015 that NIHL claims had become the new whiplash for claimant lawyers following a drop in their income owing to the launch of the small claims portal and its extension to Employer Liability (EL) and Public Liability (PL) claims in 2013.

The health surveillance and health screening services most likely to be used based on company size show how companies with up to 100 employees are most likely to use OH providers for Display Screen Equipment (DSE) assessments, while those with 101+ employees prioritise audiometry.

For some reason, two-thirds (66%) of companies overall employ an OH function to manage DSE checks. Clearly, this depends

Chart 27: Audiometry most requested health surveillance



Source: EEF Health and Work Survey 2018

on what is involved, but is OH involvement really necessary unless it is offering advice for individuals with very specific health needs?

Almost half (49 %) of SMEs contract out their OH provision. Are they buying what they need? Do they know what they need? Is there a danger that some OH companies are selling services such as DSE assessments which companies don't really need and which should largely be managed in-house.Perhaps manufacturing companies should consider SEQOHS (Safe, Effective, Quality Occupational Health Service) accredited OH providers rather than non-SEQOHS services. We should point out however that SEQOHS primarily looks at the governance processes not necessarily the quality of the outcome for the employer.

Universal occupational health provision?

The Government ended its Fit for Work service in March 2018, blaming "low referral rates". The warnings we gave in our 2016 and 2017 sickness absence survey reports were not heeded. Our key message was the lack of awareness and the consequential failure of GPs and employers to refer. In our view, the early demise of the service could clearly have been avoided, if it had been better publicised and GPs incentivised to make these referrals.

So what is going to replace the Fit for Work service? The Government response[9] to the Green Paper, Improving Lives: The Future of Work, Health and Disability, included occupational health in its list of many recommendations.

Ministers appear to recognise that access to and coverage of occupational health services in the UK is uneven and confusing. HSE has produced statistics for 2015–16 (based on the Labour Force Survey), which suggest that occupational ill health costs for the UK that year were around £9.7 billion. The Government said that it was committed to exploring how to shape, fund and deliver effective occupational health services that can support all who are in work. It has formed an expert working group to inform proposals, but the results of the review are not due for publication until 2019.

Sarah Newton, the Minister for Disabled People, Health and Work hinted at the 2018 annual scientific conference of the Society and Faculty of Occupational Medicine that the Government had not discounted placing a legal duty upon employers to provide occupational health support for their employees. From her comments, it is clear that the Government is looking at other countries and their models of delivery of occupational health support to determine what works and what would be best for the UK. She also suggested that occupational health would be crucial to the Government's reform of workplace health. We shall wait to see whether the intended reforms will bring about real and positive change to the provision and spread of occupational health services.

From our research, it is clear that occupational health means many different things. It is important that any OH service which comes out of the Government review is not narrowly focused. It is not just about managing sickness absence. Yes, sickness absence is important, but it is also important that all other key workplace OH services are considered, including:

- Advice on the effects of work on health and health on work;
- Assessment of the fitness of employees to undertake specific tasks;
- Adjustments that may be required in the workplace to support people with disabilities or long-term health conditions to undertake their job role;
- Monitoring the health of employees by undertaking ongoing health surveillance and health monitoring, particularly for employees who work with certain chemicals or materials

[9]Improving Lives: The Future of Work, Health and Disability, Cm9526, DWP/DoH, November 2017

or could be exposed to noise or vibration as a result of work processes;
– Assessment of individual injury and illness cases to develop return-to-work strategies.

Despite the evidence that demonstrates the benefits of supporting health and well-being at work, the UK is still deficient in occupational health support and occupational health practitioners.

We also know that there is a shortage of occupational health practitioners in the UK. If the Government is serious about building up an effective OH capability, it will need to address this. It will be necessary to attract and train the required number of high-calibre occupational health practitioners to meet the predicted occupational health needs. There is currently a particular shortage of occupational health professionals, especially doctors and nurses. It is imperative that investment is made in the profession and that provision of occupational health is not left entirely to the vagaries of the market or providers who do not have suitable qualifications, experience and competence.

If we want some form of universal OH provision then it has to be accessible to all companies who currently do not access such services. We are probably primarily talking about SMEs, who may not know what they need in a workplace context, or indeed what occupational health is. With responsibility for people's health and well-being increasingly falling on employers, occupational health can play a vital role in supporting them to put in place an effective framework.

7. KEY MESSAGES FOR POLICYMAKERS

Long-term sickness absence

– The biggest cause of long-term sickness absence is associated with medical tests, examinations and surgery, and this is mainly prevalent in SMEs. Most of this absence is directly related to the accessibility and availability of NHS services and the lack of knowledge amongst healthcare professionals (HCP) about health and work. It is important that the Government develops occupational health and NHS frameworks which enable early access to treatment for those in work and increase knowledge in HCPs. EEF has repeatedly called[10] for the Government to consider health-related fiscal incentives so that SMEs can be encouraged to invest in both work-related and non-work-related health and well-being programmes.

– We urgently need a replacement for the Fit for Work service to help manage long-term sickness absence. If GPs are not willing to be a part of the occupational health solution, then the Government must facilitate the development and availability of OH networks and/or providers that enable employers to develop effective return-to-work (RTW) plans and reduce levels of long-term absence. There are no benefits to any stakeholder in employees moving out of work on to long-term benefits.

Work-related ill health

– If the UK is to reduce the huge burden of occupational ill health and death in the UK, the Government, through organisations like HSE, must keep up the momentum and continue to prioritise the treatment of work-related ill health. It needs to do this through its health priority plans, inspection programmes and research in conjunction with key industry stakeholders such as EEF.

– Government needs to rebuild its expertise in occupational ill health so that it can more effectively engage with industry. With greatly reduced medical activity, the Government's workplace health regulator has much less intelligence on which workplaces are making their workers ill and how. Organisations like HSE are clearly best placed to rebuild this expertise, perhaps by re-establishing something similar to the old Employment Medical Advisory Service (EMAS). It's not just about what HSE does, it is also about what it knows. This could form a part of the occupational health solution currently being considered by the DWP expert occupational health working group.

[10]EEF, Employee Health: Making Industrial Strategy Work for Britain: EEF Health, Work Well-being and Sickness Absence Survey 2017.

– Our survey shows that employers are not always able to determine the impact of their interventions on workplace ill health. HSE should be encouraged to develop health-related key performance indicators (KPIs) with industry sectors to enable companies to assess the impact that expenditure on OLD, WRS and WRMSD controls and interventions are having on reducing workplace risk and incidences of ill health.

Occupational health

– It is important that any OH service which comes out of the Government review is not narrowly focused. OH includes a range of activities, such as health surveillance, which are extremely relevant to workplace employee health. Occupational health is not just about managing sickness absence.

We know that there is a shortage of occupational health practitioners in the UK. The problem at the moment is one of capacity. There are insufficient occupational health practitioners to provide a service to all employers. Expanding capacity should be one of the Government's ambitions if it wants all employers to have access to occupational health services.

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Looking up, taken by Steve Morgan at EDM Ltd in Manchester, shortlisted in the Professional Category of the EEF Photography Competition 2017.

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