# The changing landscape of OSH regulation in the UK

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Research Report

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## Final report for the Institution of Occupational Safety and Health

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# Executive Summary

This report presents key findings of a research project on the changing landscape of OSH regulation in the UK. Understanding the changing landscape of OSH regulation and standards and its implications are of central importance for ensuring that OSH outcomes are not compromised and the needs of different types of organisations are met. This project examined the landscape of OSH in the UK since its origin and in particular looked at how regulation of OSH has evolved over time. It considered both policy and practice issues as well as the role of key stakeholders in this process with a view to identify how the right balance can be achieved to promote health and safety going forward. To achieve its aims, a qualitative methodology was implemented in five stages: a. a literature and policy review, including a comparative analysis with other countries; b. case study analysis; c. stakeholder interviews, d. stakeholder workshops including focus groups; and e. research output synthesis.

The term *regulation* is nowadays not exclusively used in relation to legislation. It is seen by many stakeholders as relevant to different types of policies and initiatives – all aiming to regulate health and safety standards in different ways. Perhaps a more appropriate term to include these various approaches would be *policy*. Policy instruments have typically been differentiated between *hard law*, based on the concept of legalization, and *soft law* referring to policies that rely primarily on the voluntary participation of non-governmental actors in the construction, operation and implementation of a regulatory arrangement. These have been explored extensively in relation to OSH in the current project.

Our analysis shows that the OSH landscape is not independent of wider influences, including social, economic and political. These do not only define how OSH is dealt with but also the nature of work itself and working practices that stakeholders are often too slow to respond to. The more complex the landscape becomes in terms of the influences it receives (and their outcomes) and the actors that emerge, the more flexibility is introduced in the system in terms of control, evidenced by the increasingly diverse forms of regulation that have been implemented over the years. In reviewing the changing landscape of OSH regulation in the UK, it is evident that while OSH regulation used to be prescriptive and rigid, it has evolved into being goal-setting and risk-based, with many voluntary forms of regulation emerging in addition to legislation. At the same time, more stakeholders are now active in the OSH landscape than ever before playing an important role and promoting their own approaches to OSH regulation. It is also apparent that history repeats itself in many ways. Examples in the case of OSH would be the definition of priorities, such as reducing the burden on businesses and especially SMEs, and deregulation in all its forms, from reviewing and rationalising legislation to more indirect forms such as budget cuts and their effect on relevant government agencies.

To address changes in working life and their associated influences and outcomes, several policy initiatives have been developed and implemented by OSH stakeholders. Our case study analysis of fifteen such initiatives showed that key drivers for their development were legislation, regulatory reviews and meeting industry/market needs, while key challenges included resource availability, perception, measurement, and meeting demand. Initiative success depended on several factors including: whether the policy initiative had to meet an identified need and its legitimacy in meeting this need (in terms of support from a credible source or the evidence base); ownership of and commitment to the initiative by recognised stakeholders (such as the government, social partners, trade or sectoral bodies); consultation with various stakeholders and raising awareness in relation to the initiative; whether it balanced different stakeholder interests depending on social, economic and political influences; resource availability; and whether it was implemented through a structured process including clear objectives, responsibilities and evaluation methods that allow learning, knowledge transfer and future initiative development. However, policy evaluation was found to be dramatically lacking in most cases which questions the legitimacy of actions taken to tackle pertinent OSH issues.

Interviews and workshops with key stakeholders explored the current OSH landscape, changes and their impact, associated challenges and constraints as well as opportunities. Particular issues discussed included political influences and whether evidence-based policy making is a reality, the associated trend towards deregulation even when it is not substantiated or supported - even by businesses, addressing the needs of SMEs, raising awareness on OSH and issues such as risk-based vs hazard-based approaches, and high vs low hazard sectors on the basis of current evidence,

the role of the media in shaping OSH legitimacy, and educating key stakeholders and the public; and the need for a multi-policy proportionate approach and long-term thinking.

Ten key facets of the optimal OSH landscape were also identified, including: evidence-based, proportionate and enforceable regulations; adequately resourced, independent, transparent and competent regulators; the need to elicit a wider range of stakeholder views during consultation; a responsive multi-level policy approach which adapts to changes in the business landscape; competent, open leadership and empowerment and education of management; integration of OSH in business thinking; active involvement and engagement of the workforce; access to competent and verifiable OSH support; flexible OSH communication plans which are tailored for different audiences; and more celebration of OSH successes and the promotion of positive messages to the public.

In line with the research findings, five key priorities have been identified to enable the promotion of health and safety going forward: Re-iterating OSH legitimacy; raising further awareness on OSH and engaging key stakeholders; the need for better regulation, and not just deregulation; the consideration of occupational health in OSH policy initiatives and action; and finally the need for working in partnership and learning from the past. On the basis of these priorities, recommendations are offered for the role of IOSH and its members in the future of OSH regulation in order to move closer to the optimal OSH landscape.

# 1. Introduction

## 1.1 Background

In October 2010, Lord Young published his 'Common sense, common safety' report on the state of health and safety in the UK which dismissed exaggerated claims about the impact of litigation and occupational safety and health (OSH) regulation. IOSH in its formal response raised a number of concerns, especially in relation to the potential impact of the report on OSH legislation and standards while ensuring the protection and promotion of workers' health and safety. A key issue for discussion concerned the definition of 'low hazard workplaces', especially given the nature of health and safety concerns in the modern workplace. The Young report largely ignored the health dimension in health and safety which indeed represents a concern since of the overall 28.5 million working days lost in the UK in 2009/10, 23.4 million were lost due to work-related ill health (work-related stress and musculoskeletal disorders being the highest reported illnesses) and 5.1 million due to workplace injury (HSE, 2010). In this context, IOSH was concerned with the promotion of a better professional and public understanding of the changing world of work and the future role of its members within it. Understanding the changing landscape of OSH regulations and standards and its implications are of central importance in ensuring that OSH outcomes are not compromised and the needs of different types of organisations, and especially of small and medium-sized enterprises (SMEs), are met.

Although embedded in norms and traditions unique to its context, the changing landscape of OSH regulation in the UK is not unique. In many countries around the world and in Europe, over the past decades, there has been a notable move to balance 'hard' policy in health and safety such as legislation with 'softer' forms of policy such as guidance and stakeholder initiatives (Leka et al., 2011a). A number of reasons have led to this new landscape in health and safety, which include budget cuts, a lack of manpower and expertise in formal government bodies as well as increased social partner interaction and business initiatives (EU-OSHA, 2009). This new landscape can be observed, in varying forms, both at the European Union (EU) level and in many of its member states. However, it is interesting to note that with the exception of some comparative reports across European countries and some evaluation reports examining the implementation and impact of government, European Commission (EC) and social partner initiatives, studies evaluating the changing OSH policy landscape and its implications are lacking.

In the framework of a large scale policy-oriented research programme with a focus on the changing nature of OSH and emerging risks funded by the EC, Leka et al. (2011b) examined different sources and types of standards applied in the area of psychosocial risk management at the European and international levels as well as some EU member states. This research programme included a series of reviews, surveys, interviews and focus groups with different stakeholders in the OSH arena and addressed both 'hard' and 'soft' policy, its implementation and key actors involved (see for example, Ertel et al., 2010; Iavicoli et al., 2011; Jain et al., 2011; Leka et al., 2010). These studies showed that there is increased complexity in the area of OSH as concerns both policy and practice. Although a number of actors such as OSH regulatory bodies, standard-setting and certification bodies, social partners, business networks, NGOs, insurers and consultants are active, there is still a gap between policy and practice and enterprise needs are not addressed adequately. This concerns especially the needs of SMEs and dealing with new and emerging risks to workers' health and safety. In addition, in a Europe-wide policy oriented survey, ESENER, explored key drivers and barriers for OSH management in European enterprises, considering support provided by different actors. It was found that even though in some countries, such as the UK, OSH management appears to be embedded in the organisational context, enterprises and especially SMEs require more support to put in place appropriate procedures and measures to assess and manage health and safety hazards (EU-OSHA, 2012).

A Risk and Regulation Advisory Council survey on health and safety in small organisations to identify key factors influencing health and safety practices, indicated that there are various influences on health and safety practice in SMEs that can cause confusion if they are not consistent (RRAC, 2009). To address this challenge the RRAC suggested that a holistic approach that tackles the influences of all stakeholders or 'the risk actors', stretching beyond traditional government boundaries is needed. To achieve this, it is essential to understand the motivations and the interactions between all the actors within the 'risk landscape' (RRAC, 2009). A similar approach was also suggested many years ago by noted economist W. Kip Viscusi (1989) who said that to create an effective risk reduction

system it was important to consider the complexities arising from the overlap of market forces, tort law, social insurance and government regulation on health and safety. Such an analysis of complexities and overlaps and finding an appropriate mix of market incentives, tort liability, insurance and regulation requires a thorough understanding of the role played by each 'risk actor' in the policy process as well as of their motivations and interactions. Addressing this complexity in the OSH landscape in the UK, the role of various stakeholders, and how to achieve a balance in policy and practice were the broad aims of the current IOSH funded project.

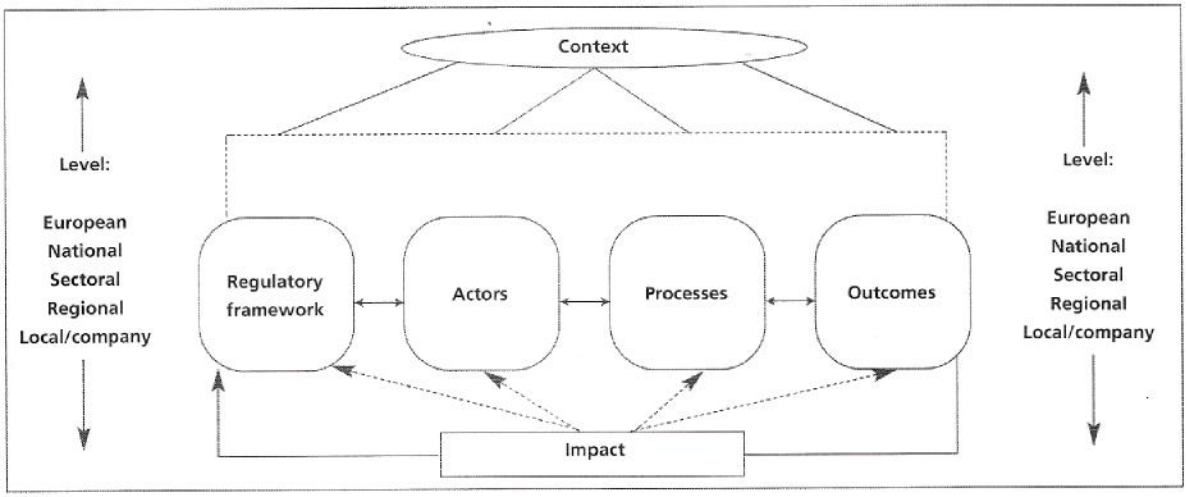
## 1.2 Aims

This report presents key findings of a research project on the changing landscape of OSH regulation in the UK. The project aimed at mapping the OSH landscape over the years with a view to identifying how the right balance between different types of initiatives can be achieved at the policy and practice levels. In line with this primary aim, this project had eight research objectives:

1. To investigate different sources of authority and key actors in the changing OSH landscape
2. To map different types of initiatives promoted by these key actors, how they are implemented in practice and their impact
3. To conduct a comparative analysis with other countries where a similar changing OSH landscape is evident and draw key conclusions
4. To investigate whether actors are being granted space to devise locally relevant strategies for achieving OSH goals or whether they find themselves constrained in different ways
5. To explore how potential external constraints are being generated and managed by actors in local OSH systems and how they are changing with the industrial structure
6. To investigate the implications of the changing OSH landscape for OSH standards and OSH practice, especially as concerns SMEs
7. To explore the role of IOSH professionals against this changing OSH landscape and key priorities to be addressed to ensure they are able to promote the health and safety of the workforce effectively while dealing with the implications of the situation
8. To provide recommendations for the role of IOSH and its members in this changing OSH landscape

The research project adopted the policy analysis framework presented in Figure 1.

**Figure 1: Policy review and analysis framework**




*Adapted from: Weiler (2004)*

To achieve an effective mapping across the categories presented in the framework, a qualitative methodology was implemented in five stages:

a) literature and policy review, including a comparative analysis with other countries
b) case study analysis
c) stakeholder interviews
d) stakeholder workshops including focus groups
e) research output synthesis.

## 1.3 Key concepts in this research

OSH is best understood through the definition reached by the Joint International Labour Organization and World Health Organization Committee on Occupational Health at its first session in 1950 and revised in 1995. Occupational health and safety should aim at: the promotion and maintenance of the highest degree of physical, mental and social well-being of workers in all occupations; the prevention amongst workers of departures from health caused by their working conditions; the protection of workers in their employment from risks resulting from factors adverse to health; the placing and maintenance of the worker in an occupational environment adapted to his physiological and psychological capabilities; and, to summarize, the adaptation of work to man and of each man to his job (ILO/WHO, 1950).

OSH regulation is not a new societal concern (Henshaw et al., 2007). Originating from the law of King Henry (1068-1135), masters were responsible and liable for servants' injury or loss of life due to negligence (Rabinowitz, 2002). The rationale behind this was that masters, in the small work units that existed before the industrial revolution, often had a greater knowledge of workers' tasks, and therefore the risks involved.

In the nineteenth century, the industrial revolution changed the way the English workforce worked. Factories and mills emerged in swaths across the midlands and northern England, bringing with them dirty and dangerous working conditions (Warburton, 2012). People shifted from working in small family sized business, often in homes, to working in large factories carrying out larger-scale activities. Mechanisation and the increasing size of industry, meant workplace conditions became more crowded and complex. The employers' knowledge of the workplace diminished as they were no longer able to oversee all elements of the working environment. Furthermore, the interface between machine and man was not common. All these factors combined led to common industrial accidents (Henshaw et al., 2007) with young children working extremely long hours in hazardous conditions. During this period, reality outpaced the law and there was no regulation of working conditions (Warburton, 2012).

These changes first brought questions of occupational health and safety before Parliament and the law courts (Barrett & Howells, 1997). Free market theory, which had underpinned the theory for early regulation, suggests that those who do not manage health and safety properly will suffer economically, to the extent that their business will no longer be profitable (Dawson et al., 1988). However, this theory assumes that compensation is rightly and adequately provided by the employer. The industrial revolution had instilled a culture of profit orientation (Dawson, et al., 1988), and one could argue the industrial revolution was greatly aided and abetted by the absence of OSH legislation as fast expansion required low overheads in order for employers to be competitive (Crombie, 2000). Parliament intervened, with the only route they perceived viable: legislation. As it will be discussed in this report, this early landscape evolved in several ways as the world – and the world of work – changed. As a result different approaches were implemented to advance OSH standards, underpinned by different perspectives from diverse stakeholders.

As it will become evident in this report, the term *regulation* is nowadays not exclusively used in relation to legislation. It is seen by many authors as relevant to different types of policies and initiatives – all aiming to regulate health and safety standards in different ways. Perhaps a more appropriate term to include these various approaches would be *policy*. Policy instruments have typically been differentiated using the 'hard' and 'soft' dichotomy however the definitions for these categories vary greatly throughout the literature (Kirton & Trbilcock, 2004). *Hard law* is generally defined as a policy relying primarily on the authority and power of the state in the construction, operation, and implementation, including enforcement, of arrangements at international, national or sub-national level (Kirton & Trbilcock, 2004). Hard law, based on the concept of legalization, is used to refer to legally binding obligations that are precise and that delegate authority for interpreting and implementing the law (Abbott & Snidal, 2000). Statutes or legislations in developed national legal systems are typical elements of hard law.

Contrasting to this, *soft law* refers to policies that rely primarily on participation and resource of non-governmental actors in the construction, operation and implementation of a regulatory arrangement (Abbott & Snidal, 2000). There is a voluntary participation in the construction, operation and

continuation of the initiative and a strong reliance on consensus-based decision making. In these instances, a participant is free to adhere to the regime or not, without invoking the sanctioning power of a state (Ikenberry, 2001).

Both state and non-state actors can achieve many goals through soft law. In many cases such an approach may be preferable. Soft law provides a basis for efficient international 'contracts' and it helps create normative 'covenants ' and discourses that can reshape international politics (Abbott & Snidal, 2000). These policy instruments range from treaties, to non-binding or voluntary resolutions, and codes of conduct, to statements prepared by individuals in a non-governmental capacity, but which lay down international principles. They also include voluntary standards designed and adopted by businesses and civil society to guide their shared understanding (Chinkin, 1989; Kirton & Trebilcock, 2004).

Hard law and soft law each have their advantages and disadvantages. Hard law offers the legitimacy, guaranteed resources and strong enforcement mechanisms that soft law often lacks. Governments acting alone can produce high standards with clear and durable solutions. In contrast, where there is a broader array of stakeholders and interests, soft law arrangements can deliver less stringent standards (Kitron & Trebilcock, 2004). Soft law offers advantages in that initiatives can be brought about when governments are stalemated. These benefits are particularly important at a time when the demands of intensifying globalisation may outstrip the capacity of national governments to respond (Kitron & Trebilcock, 2004). However, a disadvantage to such an approach is the compromise that may be required to satisfy all stakeholders in the process (Chinkin, 1989). An over use of soft law initiatives can lead to uncertainty as competing standards struggle for dominance, and as actors remain unclear about the costs of compliance or its absence, and about when governments might intervene to impose a potentially different mandatory regime. As will be discussed in this report, these various modes of operation have been used throughout the history of OSH – in the UK and elsewhere.

Understanding the changing landscape of OSH regulation and standards and its implications are of central importance for ensuring that OSH outcomes are not compromised and the needs of different types of organisations, and especially of SMEs, are met. This project examined the landscape of OSH in the UK since its origin and in particular looked at how regulation of OSH has evolved over time. It considered both policy and practice issues as well as the role of key stakeholders in this process. Before a historical review of this landscape is presented, it is important to discuss some key elements in the policy making process.

To date, various models and approaches in studying the policy process have been proposed. Dunn (1994) divided the policy process into five stages: agenda-setting, policy formulation, policy adoption, policy implementation, and policy assessment. Even though it is acknowledged that multiple theories and frameworks have offered important insights into the policy process (Nowlin, 2011), this research uses a stages heuristic framework to examine the policy process. At the same time it is recognised that in practice the policy process seldom occurs in a neat step-by-step sequence and these stages often occur simultaneously, each one collapsing into the others (Dye, 2010).

A stages framework was deemed useful in this research as it allowed the research team to analyse the policy process, including the enablers, barriers and the role of stakeholders. Such analysis is essential to understand and contextualise the development of specific policy initiatives. Moreover, the purpose of this research was to explore perceptions and actions of policy makers in relation to the development and implementation of policy initiatives, rather than the validation of a given theoretical approach. The stages approach was particularly useful as each stage is also easily understood by wider audiences as well as those not familiar with policy research.

### 1.3.1 The policy process

According to Lindblom and Woodhouse (1993), policy making is a complexly interactive process without beginning or end. Howlett and Ramesh (2003) point out that it is important to recognise the role of policy actors and institutions in the policy process although one may be more important than the other in specific instances. Dye (2010) proposed six main steps in the policy process, which along with the typical activities and stakeholders in each step and how they relate to the systems model are presented in Table 1.

**Table 1: Steps in the policy process**

| Stage | Step | Activity | Stakeholders |
|---|---|---|---|
| **Inputs - Policy demands** | Problem Identification | Publicising societal problems<br>Expressing demands for government action | Mass media, interest groups, citizen initiatives, public opinion |
| | ↓ | ↓ | ↓ |
| | Agenda Setting | Deciding what issues will be discussed, what problems will be addressed by government | Social partners, civil society, political and societal elites |
| | ↓ | ↓ | ↓ |
| **The political system - Policy decisions** | Policy Formulation | Developing policy proposals to resolve issues and ameliorate problems | Experts and think tanks<br>Government agencies<br>interest groups |
| | ↓ | ↓ | ↓ |
| **Policy outputs** | Policy Legitimisation | Selecting a proposal – Regulation impact assessment<br>Developing political support<br>Enacting it into law | Government agencies, courts, interest groups |
| | ↓ | ↓ | ↓ |
| | Policy Implementation | Organising departments and agencies<br>Providing payments or services<br>Levying taxes | Government agencies and departments, social partners |
| **Policy outcomes** | ↓ | ↓ | ↓ |
| | *Policy Evaluation* | *Reporting outputs of government programmes*<br>*Evaluating impact of policies on target and non-target groups*<br>*Proposing changes and 'reforms'* | *Executive department and agencies, mass media, experts and think tanks, social partners* |

*Source: Adapted from Dye (2010)*

#### 1.3.1.1 Inputs – Policy demands

There are several steps required to develop the evidence relevant to informing policy and practice. The first is recognising a need for intervention, where 'intervention' is interpreted as any policy or public service practice that may affect other people's lives (Oliver et al., 2005). The need for intervention arises out of the need to solve societal problems in specific or multiple domains and the demand for 'government' action expressed by civil society, social partners, interest groups and other such stakeholders. Government action here refers to any type of policy intervention. Once the problem is identified, various stakeholders are involved in discussing which problems can be addressed at the policy level to set the agenda for policy action (Dye, 2010).

In the next stages of the process, this is followed by efforts to develop feasible interventions that are acceptable to potential recipients; and finally developing strategies to support appropriate implementation and evaluating the effects of interventions. Designs and methods for the different types of primary research needed at each of these steps are well developed (e.g. Boruch, 1997; Campbell & Stanley, 1966; Haines & Donald, 1998; Hawe et al., 1990).

Studies on the policy process have pointed out the crucial role of actors and institutions in the process.

Howlett and Ramesh noted that "individuals, groups, classes, and states participating in the policy process no doubt have their own interests, but the manner in which they interpret and pursue their interests, and the outcomes of their efforts, are shaped by institutional factors" (2003, p.53). Considering this perspective of the policy process, policy, in this research, is viewed as a product of the interactions among policy actors and institutions. The term 'policy actors' refers to state and societal actors who are involved in the policy process while 'institutions' refers to the structures and organisations of the state, society, the EU and the international system which constitute the larger context of a policy subsystem, or what is called the policy universe, which may directly or indirectly affect the policy process (Birkland, 2005; Howlett & Ramesh, 2003).

#### 1.3.1.2 The political system - Policy decisions

"The extent to which government will be able to influence the provision of goods and services, taking into account the self-regulating powers of the systems concerned, will depend on achieving coordination and control among disparate actors" (Hanf & O'Toole, 1992, p.167). Judgments regarding the possibilities of governmental guidance, or steering and control, must be based upon an examination of the institutional modes of coordination within the public sector, and coordination of multiple actors as an important precondition for increasing the capability of government to perform a more active part in the desired transformation of society (Kaufmann, 1986).

Benson (1975) suggested that the inter-organisational field should be viewed as a political economy. This formulation emphasised the distinction between substructure and superstructure. At the level of substructure, differentially powerful organisations interact in pursuit of the scarce resources of money and authority, in this case, the actors at the national level. Power in these interactions is said to derive from different sources: (1) network structures or patterns of direct linkage between agencies in a specific network, and (2) extranet work structure or patterns of linkage between network agencies and organisations, officials, and publics in the network environment - in this case, ties of the Health & Safety Executive (HSE) to important interest groups in the society, e.g. Confederation of British Industry (CBI), etc.

Benson (1975) further suggested four general strategies for changing network relations on the basis of the political economy view. These are: (1) cooperative strategies in which change is sought through agreements and joint planning; (2) disruptive strategies in which resource-generating capacities of agencies are threatened; (3) manipulative strategies in which the supply of, and sources of, the resources money and authority are tactically altered; and (4) authoritative strategies in which network relations are precisely fixed by prescriptive action of resource controlling agencies, offices, or bodies.

#### 1.3.1.3 Policy outputs – measures and instruments

In the last decades there have been paradigmatic changes concerning hard law. Modern states face important challenges when governing and promoting the welfare of citizens in complex, open, diverse and interconnected societies and economies (Kirton & Trebilcock, 2004). From the attempts to deepen the understanding of the nature of regulation and deregulation in the 1970s, during the 1980s and 1990s, the core work of governments, especially in the OECD countries, was focused on regulatory management and reform. More recently, the goals have been set on a more complex forward-looking agenda with the aim of improving regulatory quality and developing consistent regulatory policy. Regulatory policy tools such as administrative simplification, alternatives to regulation (soft law) and regulatory impact assessment (RIA) are used to make policies more efficient and to improve regulatory quality and good governance. Such improvements can give more stability, trust and strength to governments, private sectors and civil societies (OECD, 1997).

Feasibility studies allow policy makers to make informed choices on whether or not to implement a policy intervention and also which policy instrument to select if an intervention is being implemented. Non-intervention is an important policy choice that governments can use as a policy instrument. It implies that the government leaves the policy implementation to market mechanisms, civil society and households (as they provide the foundation for the emergence and maintenance of social norms) and let the outcome depend on what the individual decides to do (Vedung, 1998). The government or 'state' policy actors may then support civil society, social partners, or market mechanisms to implement policy instruments to address certain policy issues. When governments choose to implement an intervention, they may use: structured options where they create programmes which individuals are

then free to use or not as they see fit; biased options where the government devises incentives and deterrents so that individuals will be guided voluntarily, toward the desired ends of public policy; and lastly regulation, where government set up constraints and imperatives for individual action backed by the coercive powers of government (Anderson, 1977; cited in Vedung, 1998).

#### 1.3.1.4 Policy outcomes – implementation and evaluation

Following the implementation of a policy, the next step in the policy process is ascertaining its 'success or failure'. Marsh and McConnell (2010) report that popular instances of 'policy success' appear in media pieces assessing the success/consequences of policies, claims by government and government agencies of policy successes, either in the media or in official documents, reports by interest groups or voluntary organisations, assessments/claims about policy successes, blogs on policy outcomes and academic articles assessing policy success, usually in the form of evaluation studies. According to them, both political actors, whether politicians, bureaucrats or interest group leaders; and observers, whether academics, journalists or bloggers, 'assert', even if they don't demonstrate, the 'success' of policy initiatives. However, the key problem is that these claims/assessments about policy outcomes do not establish any systematic criteria for assessing success or failure.

Much of the evaluation literature is produced from within government but rarely, if ever, moves beyond the assumption that success equates with meeting policy objectives or producing 'better' policy (for example, Davidson, 2005; Weimer & Vining, 1989). Most of it is also highly quantitative as well as highly normative, given its assumption that the purpose of evaluation and policy analysis is: 'client-oriented advice relevant to public decisions' (Weimer & Vining, 1989).

Drawing on the relevant literature, Marsh and McConnell (2010) suggested a framework for assessing policy success, with three dimensions - process, programmatic and political - and identified the indicators which can be used to measure success in relation to each of the dimensions and, then, the evidence which would be appropriate in relation to each of these indicators. The 'process' of policy formation, as presented in this report, is an important, but often unacknowledged, element in any consideration of whether a policy is successful or not. Processes are important, in both practical and symbolic terms. For example, a policy which is produced through constitutional and quasi-constitutional procedures will confer a large degree of legitimacy on policy outcomes, even when those policies are contested (Marsh & McConnell, 2010).

'Programmatic' success is often seen as synonymous with policy success as in the contemporary focus among most Western democracies on evidence-based policy making where the assessment of success is outcomes-based and judged by 'the evidence' (Parsons, 2002; Sanderson ,2002). 'Operational' success occurs if a policy is implemented according to objectives laid down when it was approved. Policy implementation is generally a much more complex affair than it was, especially given the growth of multi-level governance, public sector fragmentation through agencies, non-departmental public bodies, privatization and outsourcing (Exworthy & Powell, 2004). 'Political' success is the final benchmark for policy success. In particular, from the perspective of government and the governing party, a policy may be successful if it assists their electoral prospects, reputation or overall governance project.

Keeping in mind the complexity of the policy process and the various angles from which it can be looked at, mapping the changing OSH landscape in the UK while identifying the role of key stakeholders and drawing conclusions to move towards the optimal OSH landscape necessitated the use of a methodology that allowed the collection and synthesis of rich data that grasped these various elements. The next section details how this was achieved at each stage of the research process.

## 2. Methodology

This research was exploratory in nature and aimed to detangle the changing OSH landscape and the OSH policy making process, including drivers, barriers and success factors of various policy initiatives promoted by different stakeholders. A qualitative approach is suited to exploratory research studying process issues, and how they evolve over time (Lee Mitchell & Sablynski, 1999). In addition, in light of changing developments within the policy arena, a qualitative approach can study dynamic processes and document sequential patterns and change. As Lee et al. (1999) note this reflexivity is one of the strengths of qualitative research. Thus, as data collection and analysis co-occur, contextual factors are identified as they relate to phenomena allowing the researchers' focus to shift accordingly as the research responds to local situations, conditions, and stakeholders' needs.

Engagement of key actors and stakeholders was key for the success of this research programme. To ensure this, a project Advisory Board was formed in the beginning of the project which included IOSH and other key stakeholders. The Advisory Board served both as a steering group to the project, providing support and critical feedback, and a mobilisation group to ensure participation of additional stakeholders in all stages of this research. The following organisations were represented in the project Advisory Board: IOSH, Health and Safety Executive, Association of British Insurers, Chartered Institute of Environmental Health, Confederation of British Industry, Health & Safety Committee - British Standards Institution, Association of British Certification Bodies, British Safety Council, OSH Practitioner, OSH Academic Expert.

### *2.1 Stage 1 – Examining context: Historical review and comparative analysis*

The first stage in this research was a literature and policy review. A number of sources were used for the review including: 1. journal articles, books and dissertations; 2. publications and reports of various interest groups; 3. government publications and research documents; 4. the internet. The search was broken down covering both the academic and grey literature.

The academic literature search was conducted in two parts.

- Electronic searches were performed using the following online databases for relevant published articles (including internet based searches): ABI/INFORM Global, Business Source Premier, Science Direct, Web of Knowledge/Science, Zetoc, Applied Social Sciences Index and Abstracts, Health and Safety Science Abstracts, Medline, PsycINFO.
- Searches of the University of Nottingham's library catalogue and Google Scholar were conducted to identify relevant books.

Regarding the grey literature search, websites, the publications contained within and their reference lists were reviewed for relevance. Examples of websites searched include the Health and Safety Executive, Institute of Occupational Safety and Health, the UK Government, the European Agency for Safety and Health at Work, European Union Law, the European Trade Union Institute, and the Trade Union Congress. In addition, several databases were used to retrieve retrospective media reports (Factiva, Nexis), company information (FAME) and off the shelf industry reports (Mintel). A number of online alerts (Google) and newsletter subscriptions (e.g. alerts@osha.europa.eu) were set up during the review period to keep abreast of current news and breaking developments.

The following keywords were used throughout the search: Occupational health and safety, Occupational health and safety management systems, Health and safety stakeholders, Policy*, Social policy, Legislation*, Law*, Regulation*, Trade unions*, Employers*, Social partner, Social partner agreements, Insurance*, Consultant*, Consultation*, Guidance*, Guidelines*, Business networks, Compliance*, Standard*, Risk assessment, Risk management, Gap*, Practice*, SMEs, Professionals*, Practitioners'*, Impact assessment, Impact statement, Health and Safety Work Act 1974, Management of Health & Safety at Work Regulations 1999, Approved Code of Practice, Framework Directive 89/391/EEC, Deregulation*, Fee for intervention, Cost recovery*, OHSAS 18001, Burden*, Pre-qualification scheme, Evaluation*, Landscape*, OSH knowledge, Safety representative, Worker representative, Certification*, Business case*, CSR*, Trade associations, Regulatory engagement, Regulatory culture, Risk communication*, OSH governance, Risk tolerance, Risk aversion, Code of practice, Better regulation, Local authorities, Competencies*, OSH compensation, Compensation culture, Liability*, Employer representative, Employer's liability, Public liability, General liability, Chambers of commerce.

These search terms were checked and commented upon by the project Advisory Board. The search terms were flexible to accommodate the needs of the project including breaking news, spelling differences, and term differences. Sources were screened for relevance based on the abstract or executive summary, where possible. Studies were selected that had originated from credible sources (published journal articles, books, stakeholder websites and reports, and practitioner journals). The reference lists of any relevant source were further searched for subsequent references.

## *2.2 Stage 2 – The policy process and the role played by stakeholders*

A flipside to the flexibility in qualitative research noted above is a criticism that qualitative approaches have too many unconscious biases operating (Lee et al., 1999) and that compared with quantitative methodologies the results are more easily influenced by the researcher's personal biases and idiosyncrasies. In addition, organisational stakeholders could attempt to manipulate the researcher's focus of the study for their own gains (Johnson & Onwuegbuzie, 2004). To avoid bias and ensure the data accurately represents the issues identified, a case study approach was employed in the second stage of the research. This aimed at exploring the policy process by focusing on specific stakeholder initiatives, including documentation review and semi-structured interviews.

A case study is an intensive analysis of an individual unit stressing developmental factors in relation to context (Yin, 2009). Case study methods involve an in-depth examination of a single instance or event: a case. They provide a systematic way of looking at events, collecting data, analysing information, and reporting the results. As a result the researcher may gain a sharpened understanding of why the instance happened as it did, and what might become important to look at more extensively in future research.

Policy initiatives were identified through the previous literature and policy review which investigated and mapped the different sources of OSH authority and actors and the types of initiatives they had developed. Following the identification of policy-level interventions during the literature review phase of the project, interventions were reviewed and assessed against 7 inclusion criteria agreed by the project Advisory Board. These were as follows:

- initiated, developed and implemented in the UK;
- focus on specific OSH issues;
- promoted by concrete stakeholders who bear responsibility for the initiative;
- could be relevant to SMEs;
- have defined target, goals and outcomes;
- evaluation has been conducted;
- address different types of OSH issues and risks.

Initiatives had to meet all 7 criteria to be considered for inclusion onto a policy matrix grid (see Annex 1). The policy matrix grid included a range of legislative (i.e. 'hard') and non-legislative (i.e. 'soft') policy-level interventions and a range of stakeholders (for example, from government, trade associations, employer associations, standardisation bodies) who were responsible for their development. Circa 50 interventions were mapped and from these 15 were selected for further study, as outlined below in Table 2.

**Table 2: Selected policy initiatives for case study analysis**

| Title | Principle developer | Type | Brief description |
|---|---|---|---|
| Managing health and safety in construction (CDM2007) | Health and Safety Executive | Approved Code of Practice | The ACoP provides practical guidance on complying with the regulatory duties set out in the Construction Design and Management Regulations (2007), (HSE, 2007a) |
| Control of substances hazardous to health (COSHH) | Health and Safety Executive | Legislation | COSHH provides the legal framework for controls on exposure to hazardous substances arising from work activities (HSE, 2005) |

| | | | |
|---|---|---|---|
| Fee for Intervention (FFI) | Health and Safety Executive | Legislation | FFI is a cost recovery model whereby the HSE can recover its costs for carrying out its regulatory functions from those found to be in material breach of health and safety law (HSE, 2012). |
| Statement of Fitness for Work (Fit Note) | Department for Work and Pensions | Legislation | Using the Fit Note GPs can classify individuals as either 'not fit for work' or (unlike the Fit Note's predecessor, the Sick Note) 'may be fit for work' (Lalani et al., 2012). |
| The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) | Health and Safety Executive | Legislation | Through using RIDDOR 'the responsible person' informs the enforcing authorities about deaths, injuries, occupational diseases and dangerous occurrences (HSE, 2011a). |
| Making the Market Work (MTMW) | Association of British Insurers (ABI) | Guidance | MTMW work was a mechanism through which the ABI assessed trade associations' health and safety schemes and delivered this information to Employers Liability insurers (ABI, 2003). |
| Safety Passport | Client Contractor National Safety Group | Accreditation | The Safety Passport ensures a basic knowledge of health and safety for all site personnel to enable them to work on site more safely (Sreenivasan, Benjamin & Price, 2003). |
| C3HARGE | Health and Safety Executive (and tripartite partners) | Advisory committee | C3HARGE represents the cement, ceramics/heavy clay, concrete and glass sectors and supports trade associations within those sectors in meeting targeted initiatives (HSE, 2009a). |
| The Contractor Health and Safety Scheme (CHAS) | The Association of London Government Health and Safety Forum | Pre-qualification scheme | CHAS provides assessment criteria that safety professionals can use for the OSH element of a prequalification application (Fidderman, 2007). |
| Occupational Health (OH) Advice Lines service | Department for Work and Pensions | Guidance | The service is a free, 'one-stop shop' for OH advice and provides immediate access to support for employers, employees and GPs (Sinclair, Martin & Tyers, 2012). |
| Leadership Actions for Directors and Board Members' | Institute of Directors and Health and Safety Executive | Guidance | The guidance sets out an agenda for the effective leadership of health and safety, and is designed for use by all directors, governors, trustees, officers and their equivalents (Local Government Association, 2009). |
| The Management Standards for Work-related Stress | Health and Safety Executive | Guidance standard | The Standards cover the primary sources of stress at work and define the characteristics of an organisation in which the risks from work-related stress are being effectively managed (Edwards & Webster, 2012). |
| OHSAS 18001 (2007) | British Standards Institution | Standard | OHSAS 18001 (2007) is an assessment standard for occupational health and safety management systems. |
| Professionals in Partnership (PiP) | Institution of Occupational Safety and Health | Guidance | The guidance highlighted the importance of preventing work-related illness and the added value of rehabilitation and workforce health promotion, and the role IOSH members can play (IOSH, 2003). |

| | | | |
|---|---|---|---|
| Workers' Safety Adviser Challenge | Health and Safety Executive | Grant scheme | The WSA fund gave funding to groups of organisations who wanted to increase involvement in health and safety. This was achieved via a Worker Safety Advisor (WSA) who visited participating organisations (HSC, 2006). |

Following the aforementioned mapping exercise, stakeholders who have (or had) responsibility for the initiatives' development (or were knowledgeable about their development) were approached to voluntarily participate in the case study stage of the project through semi-structured interviews. These individuals were identified, primarily, from the literature review previously conducted and through the use of desk research. If stakeholders either could not be identified or their correspondence details could not be retrieved, the assistance of the project's Advisory Board was sought, who duly assisted with and facilitated this process.

Fifteen semi-structured interviews were conducted in total – one corresponding to each initiative included in the case study analysis. The aim of the interviews was to elicit the views of key stakeholders who either were or currently are responsible for the initiatives' development, so as to achieve a more in-depth understanding of the development, implementation and impact of various policy initiatives.

Due to the explorative nature of the research, semi-structured interviews were deemed appropriate (Denscombe, 2010). The merits of this approach is that it facilitates the probing of respondents (where necessary) to check understanding and to allow for more in-depth responses (Zikmund, 2003). In addition, semi-structured interviewing allows for hitherto unidentified or perceived 'unimportant' issues to be broached by the participant (Rudestam & Newton, 2007).

Initial contact with the potential participant was made via email. This communication included the following details: the name of the University, the title of the project and the identity of the researchers, and the aim of the research 'to identify, map and then elicit the views of key stakeholders from various backgrounds to gain a more in-depth understanding of the initiative's development, implementation and impact'. The email closed with respondents invited to participate at their own discretion and the researcher's contact details were provided so the recipient could confirm/decline or request further information.

Once respondents had expressed an interest in participating in the study, they were sent a standardized information sheet which detailed in more depth the aims of the research project, the aims of this specific stage of the project, the research team's obligation towards participants (in terms of research ethics) and the logistical information around the research (e.g. the likely duration of the interview, its telephone based delivery, and the recording of interviews for transcription purposes). The respondent was also provided with the general list of questions (listed below) that were sent to all respondents ahead of the interview for them to familiarise themselves with.

During the interview, participants were initially thanked for their participation and a short prose was read which contained the following (summarised) information: that participants had read and understood the information sheet, that the research was voluntary and anonymous and that participants had the right to withdraw at any time. Before the interview commenced the interviewer double-checked that the participant consented for their interviews to be audio recorded.

Following this prose, the general and specific probe questions were asked to participants. For consistency purposes, and so to avoid misinterpretation of data, interview data was audio recorded and transcribed accordingly (Saunders et al., 2007). The interview closed with the interviewee thanking the participant for their participation, the ethical considerations were reiterated, the interviewee was informed of the next stages of the research and was asked if they had any questions.

The interview schedule was developed by the members of the research team and was cross-checked and agreed by the project Advisory Board. Following this process the following questions were asked to all participants:

1. Why this type of initiative and why was it launched?
2. What were its aims and were they achieved?

3. Who were the key stakeholders involved in its promotion/implementation?
4. How was it received by businesses (including SMEs) and safety practitioners?
5. Did any unintended/unexpected outcomes emerge?
6. What were the internal and external success factors/challenges?
7. Under what conditions does it work best?
8. Are there plans to develop this or other initiatives further?
9. What lessons would you share?

Specific probe questions unique to each initiative were also asked during each interview.

Thematic analysis was used to analyse the interview data (Braun & Clarke, 2006). It was used to categorise topics into themes, explore common themes, and to elicit similarities and differences within and between initiatives. The research followed the six broad thematic analysis phases identified by Braun and Clark (2006):

1. Familiarisation with the data (transcripts were repeatedly read and annotations were made)
2. Initial code generation (annotations were compared across transcripts and initial codes were formed)
3. Theme searching (informed by the projects prior reading and the first two steps themes were searched for)
4. Theme reviewing (once elicited themes were checked within and across transcripts and with the academic and grey literature for consistencies and contrasts)
5. Theme defining and labelling (themes were labelled to succinctly capture the content within them)
6. Report production with a concise, logical and coherent story from the data (the themes elicited in conjunction with the findings from empirical and grey literature informed the content of the report).

Emerging themes were identified across all initiatives. A thematic grid was produced through the following process. Interview transcripts were reviewed in detail to familiarise the researchers to their content and then develop a set of 'open codes', specifically summarizing the content of short sections of the text in a few words. Transcripts were read repeatedly to identify the key themes and categories for coding. The collection of generated open codes was discussed and reflected upon by three other researchers, and subsequently grouped into broader categories established by consensus. To ensure inter-rater reliability, three researchers reviewed the collected emergent themes, and the coded data. This is considered a strength because obtaining multiple opinions on the same data by different people increases the reliability of the interpretation (Lee, Mitchell & Sablynski, 1999). Consensus was reached through discussion. The collection of categories was used to develop the initial coding frame, which was used to identify emergent themes. The template was viewed as a continuously evolving template and where if information was found not to fit into the existing framework, the template was further refined and developed. Theoretical saturation was achieved once the final coding frame was developed and all relevant first- and second-order themes were identified. The researchers reviewed the collected emergent themes and examined relationships among the way themes co-occurred. An independent researcher reviewed the emerging themes and adjustments were made in collaboration. Lastly, patterns, associations, concepts, and explanations in the data were identified and interpreted. The final thematic framework is presented in Annex 2.

## *2.3 Stage 3 – Stakeholder perspectives on changes in the OSH landscape*

On the basis of the stakeholder map developed in the previous stages of this research, a number of stakeholders were identified (Annex 3). Forty semi-structured interviews were conducted in total reflecting the breadth of stakeholder groups involved in OSH. The aim of the interviews was to elicit the views of key stakeholders on the changes in the current OSH landscape so as to understand the nature and implications of these changes.

The interview schedule was informed by the first stage policy and literature review and the findings of the second stage of the research. The items were developed by the members of the research team and the interview schedule was cross-checked and agreed by the project Advisory Board. The questions focussed on understanding what stakeholders perceived as the biggest changes in OSH and the opportunities and constraints presented by these. Stakeholders were also asked to consider

whether these changes would affect the role of their organisation, as well as the implications on OSH outcomes, and for SMEs and practitioners. The final area of interest focussed on the future of OSH policy, including recommendations and key areas which required balance.

Thematic analysis was conducted using NVivo 10. The transcript of each interview was entered into NVivo 10 and an initial coding was conducted, establishing many specific preliminary themes. These were discussed with the research team and grouped together to form higher order themes arranged in a thematic framework (Annex 4). The coded material was then recoded to fall in line with the established framework. To ensure inter-rater reliability, all four members of the research team reviewed the collected emergent themes, and the coded data. Once the coding was completed, NVivo was used to produce all coded material relevant to a specific theme to aid the authors in appreciating which were the key issues among coded data that stakeholders had discussed.

## *2.4 Stage 4 – Looking at the future: identifying an optimal OSH landscape*

Two stakeholder focus groups were conducted, exploring stakeholder perspectives on how to secure the optimal OSH landscape in the future. Stakeholders identified as key actors in the OSH arena throughout the prior stages of the research project participated in this study. As wide a representation of stakeholders as possible was sought. To be able to effectively facilitate discussion and accurately reproduce the discussion for analysis, participants were limited to approximately 10 stakeholders per focus group. A list of stakeholder groups represented, and number of participants attending (for example: the HSE, the Health and Safety Laboratory, the Office for Rail Regulation, Local Authorities, IOSH, the Chartered Institute of Environmental Health, British Ceramics Confederation, and the University Health and Safety Association) is given below (Table 3).

**Table 3: Stakeholder groups represented and number of contributors**

| Stakeholder group | Number of contributors |
|---|---|
| Government agencies | 7 |
| Professional associations | 3 |
| Consultants | 2 |
| Insurance | 2 |
| Trade associations | 2 |
| Employer association | 1 |
| Trade unions | 1 |

The schedule of the two focus groups was identical. First, the facilitator introduced the topic area and briefed participants on the research project, as well as key findings thus far. The facilitator then offered the following four statements/questions one by one, inviting discussion:

- Prime Minister David Cameron referred to killing off the health and safety monster: Is OSH illegitimate?
- Better regulation is not just deregulation.
- Common Sense Common Safety, Reclaiming health and safety for all: What happened to health?
- Are OSH practitioners part of the problem or the solution?

A second exercise involved participants noting down what they believed to be three key elements of the optimal OSH landscape. These were collated and discussed to reach consensus on important elements to strive towards in the future. Participants were then asked how far they perceived the current landscape to be from the optimal landscape that had been conceptualised through this exercise.

The audio recordings were transcribed by a third party, ensuring all data that could identify participants was excluded. The transcripts were then checked by members of the research team to ensure accurate transcripts had been produced. The data was then analysed using framework analysis following the key stages reported by Krueger (1994) and Ritchie and Spencer (1994). The analytical framework was informed by previous stages of the research, as there were direct links to the current data. Data was examined to evaluate the extent to which it fit key themes identified in the previous stages of the research, indicating a very good fit. Hence data from the current stage of the

research which fit under those themes was coded as such. This further validated many of the prior emergent themes. This was built on with the new focus on the future of the OSH landscape in the UK. Several new themes emerged using the analysis process described by Braun and Clarke (2006). Relevant extracts were collated and grouped into emergent themes. The data was then re-assessed refining the emerging themes. The final thematic framework was then assessed by all members of the research team to ensure the validity of the themes (see Annex 5).

All studies in this research were reviewed and given a favourable opinion by the Division of Psychiatry and Applied Psychology Research Ethics Committee. Participation in each study was entirely voluntary with participants free to withdraw from the study at any time without giving a reason. The identity of the participants and the information they provided was kept anonymous and treated in confidence to comply with UK Data Protection Laws. Only members of the research team had access to participants' personal and study data. The identity of participants will remain confidential in any published results of the study.

# 3. Examining context: historical review and comparative analysis

The history of OSH in the UK begins with rigid and specific, ad hoc approaches struggling to keep up with the changing pace of work and technology, to goal and risk-based regulation which targets the involvement of several stakeholders. A concise timeline of the history of OSH in the UK is presented in Annex 6.

## *3.1 The early years of OSH regulation in the UK*

The first piece of OSH legislation in the UK was introduced in 1802 by Sir Robert Peel. The Health and Morals of Apprentices Act targeted those employed in cotton mills and other factories. It restricted the working day to 12 hours and envisioned a phased elimination of night work (Callaghan, 2007). This was followed by the Factory Regulation Act of 1833, later amended through the Factories Amendment Act 1844.

It is interesting to note that in this period there was apprehension towards prosecuting employers for OSH issues, on the basis that they provided jobs to society (Johnstone & Carson, 2002). Linked to this point is the fact that no official inspectorate was established to ensure compliance. Karl Marx noted "Parliament passed 5 labour laws between 1802 and 1833, but was shrewd enough not to vote a penny for the requisite officials" (1867, p.264).

At around this time, forward thinking employers such as Robert Owen, put forward the utilitarian argument that protecting workers would make them more productive, and thus this could be seen as the origins of the modern business case for OSH. When broaching the subject of working hours in his evidence to Sir Robert Peel's Committee, Owen stated: "Such conduct to work people is the most likely to make them conscientious, and to obtain more from them than when they are forced to do their duty" (as cited in Callaghan, 2007, p.5).

After 1832, industrial and social reform did lead to the establishment of an inspectorate. This appointment of inspectors, however, was no guarantee of the observation of legislation (Bartrip, 1983). Although many scholars have claimed the 1833 Act to be the "first effective factory act", Bartrip (1983) doubts whether this is the case as only four inspectors and two poorly paid superintendents were initially appointed to enforce the Act throughout the whole of Great Britain and Ireland. A large driver for this legislation were large manufacturers who had introduced shorter working hours voluntarily, and feared that an unfair advantage could be gained by competitors choosing not to similarly reduce working hours (Marvel, 1977). However, according to Johnstone and Carson (2002), this Act was also difficult to enforce. Prosecutions were time-consuming and costly; and over time, the ratio of inspectors to factory premises reduced significantly. Furthermore, it was initially assumed that only the minority would commit offences. However it was soon found that contraventions were widespread and intrinsic to the production system. As a result, prosecution of all offenders was impossible, and enforcement shifted towards an advice and persuasion approach with prosecution reserved for the worst cases, where there was evidence of willful employer disregard for the legislation (Johnstone & Carson, 2002). This suggests that the system of OSH regulation was not designed with prosecution envisaged as a main driver for improvement, and that practical issues drove enforcers into an advisory role, a role that is increasingly being used in modern enforcement today.

Subsequent legislation developed in a reactive manner to specific situations; for example, major accidents in coal mines, the identification of occupational diseases or the emergence of new hazards as a result of technological developments, for example, electricity (Rimington, McQuaid & Trbojevic, 2003). Regulations and associated bodies were formed in an attempt to protect workers from each hazard as they arose, and therefore this appears to be the origins of a hazard-based approach founded on the 'precautionary principle' (Löfstedt, 2004; Rimington et al., 2003). Rimington et al. (2003) suggest that an ad hoc response to OSH issues may have endured because of a lack of understanding of the concept of risk in this area.

Despite employer pressure, due to an increase in major railway accidents, and the increased prevalence of environmental damage due to industrial emissions, further regulatory bodies were introduced (e.g. the Mining Inspectorate, the Railway Inspectorate and the Alkali Inspectorate) whose concern widened to include the protection of the public and the environment (Rimington et al., 2003).

This can be seen as the origins of the perception that OSH forms an element of a much broader public health and environment agenda.

The TUC first met in 1868 and the first item on their agenda was the Factory Acts Extension Bill, 1867, the necessity of Compulsory Inspection, and its application to all places where women and children were employed (Callaghan, 2007). Between 1888 and 1918, trade union membership grew faster than at any other time together with the demand for an eight hour working day.

For a large proportion of the nineteenth century, factory regulation only affected a minority of those engaged in manufacturing industry. Thus, following a royal commission investigation, a consolidating measure, the Factory and Workshop Act, 1878, was passed which, with later amendment in 1901, gave Ministers powers to pass ad hoc regulations to deal with hazards in certain industries (Callaghan, 2007). Throughout the last two decades of the century the Trades Union Congress and sections of the press repeatedly voiced their concern that the factory inspectorate was proving inadequate to enforce the factory Acts (Bartrip, 1983).

The 1930s onwards, saw the Labour political party make the extension of social benefits for all, 'from the cradle to the grave', a top campaigning priority (Davis, n.d). In 1931, the Asbestos Industry Regulations were enacted, illustrating that health-related issues were recognised (Lyddon, 2012). In 1946 the National Insurance Act provided for sickness, unemployment benefit and insured all workers who had paid in the necessary contributions against workplace accidents. The TUC fought tirelessly for its enactment and also for the National Health Service Act 1946.

In a similar vein, in 1946, the Gowers Committee on Health, Welfare and Safety in Non-Industrial Employment, was formed, illustrating a broadening focus towards non-industrial occupations (Lyddon, 2012). The Committee recommended that the provisions of the Factories Act should be extended and adopted in shops and offices. However, with the exception of the Shops Act 1950 (which limited the working hours for under 18 year olds), the progress in which the Gowers Committee's findings were implemented was extremely slow, with governments using the excuse of lack of parliamentary time to discuss them (Lyddon, 2012).

By the 1960's the piecemeal approach to OSH had resulted in over 500 pieces of OSH legislation (Fairman, 1994). An attempt to update and consolidate them occurred through the enactment of the Factories Act 1961 which aimed to provide more overarching and comprehensive legislation applicable to all types of industry. In 1960, an Offices Act was passed extending the reach of OSH that was followed by the Offices, Shops and Railway Premises (OSRP) Act 1963 (Lyddon, 2010). As a consequence, millions of previously unprotected employees had some protection for the first time. However, premises such as hotels, restaurants, pubs and entertainment; transport operations; postal and telephone services; educational establishments; and hospitals were excluded by the Act (Lyddon, 2012).

In line with the school of thought that economic incentives were critical to ensuring OSH compliance, in 1969 the Employers' Liability (Compulsory Insurance) Act was enacted. This required most employers to take out Employer's Liability Insurance to cover the cost of injuries to employees or former employees should they try to claim compensation (HSE, 2008a).

Up until 1974, UK health and safety legislation had been characterised by a limited scope, a partial coverage of the workforce and slow progress (Lyddon, 2010). The pre-1974 period was also characterised by a large and highly unionised politically active industrial sector since, in 1970, trade union membership had reached 10.6 million, meaning 1 in 2 salaried employees were represented by a union (Beck & Woolfson, 2000). In addition, there was a raft of over-regulation and over-complication in the legislative system. Existing Acts were accompanied by hundreds of Statutory Instruments with a multitude of agencies overseeing the system (Crombie, 2000). An important evaluation of the system of legislation at the time was provided by the Robens Committee appointed in 1970 and chaired by Lord Robens, Chairman of the National Coal Board, and former trades union official and Labour politician (Rimington et al., 2003). The Robens Committee was formed by the Labour government of Wilson, in response to the fact that despite the plethora of legislation, the number of accidents within the workplace was not falling. The Committee reported that there were several flaws in the existing system and there was a need for change.

## 3.2 The introduction of the Health and Safety at Work Act 1974

The main outcome from the Robens Report on Safety and Health at Work in 1972 was that a radical change in attitudes to health and safety was required. Thus, Robens made a number of recommendations, in which the responsibility for action fell upon industry rather than government (Rimington et al., 2003). Over 150 years after the first OSH legislation emerged, the UK passed the 1974 Health and Safety at Work Act (HSWA) in an attempt to rectify many of the flaws of the existing OSH legislation. The passing of the Act coincided with the major explosive accident at Flixborough, at the Nypro chemical plant which left 28 dead and 36 seriously injured. The timing of the Act was also said to coincide with the European Community's burgeoning interest in OSH (Rimington et al., 2003). The HSWA established legislation for the general application of health and safety provisions in every workplace in Great Britain (excluding Northern Ireland) (Barrett & Howells, 1997). As an enabling or framework Act, this legislation set up a system for dealing with problems but created only broad rules and allowed for more specific regulations and Approved Codes of Practice (ACoPs) to be made under it. Although ACoPs existed before the 1974 Act in certain sectors, the Act formally introduced them more widely. ACoPs do not impose legal duties and failing to comply with a provision of an AcoP is not in itself an offence. However, if a statutory requirement is not satisfied in some other way, then one could be found guilty of contravening the regulation or sections of the HSWA (Fairman, 1994).

The revised legislation and any subsequent additions were meant to be goal-setting rather than prescriptive, changing the focus to prevention rather than compensation (Barrett & Howells, 1997). This shift in policy was seen as a way to rectify the issue of 'apathy' that was identified by Robens, and to ensure risk was dealt with by those who created it (Dalton, 1998). Importantly, the general duties under the Act are qualified by the phrase 'so far as is reasonably practicable'. This instils a philosophy that there will always be a trade-off between safety and factors such as cost and feasibility (Fairman, 1994). This philosophy can be seen as the origins of a risk-based approach to OSH, despite several authors stating that risk appeared in OSH regulation towards the 1980s (Hutter, 2005). Carrying out what is reasonably practicable requires an understanding of the necessary risks in order to weigh up the cost of action relative to inaction (Bearfield, 2009). Indeed, Callaghan (2007) notes that, through introducing the concept of risk, Robens anticipated the better regulation agendas of successive governments.

The 1974 Act provided for the establishment of the Health and Safety Commission (HSC) and Health and Safety Executive (HSE). The Act also significantly expanded the available sanctions to both the HSE and local authority inspectors (Lyddon, 2012). It allowed both parties to issue prohibition notices (where a dangerous activity was ceased until it had been made safe) and improvement notices (where an employer had a set time to comply). One of the first actions of the newly commissioned HSC was to declare that passing regulations for safety representatives and committees was of prime importance, though this transition was slow due to disagreements between the Confederation of British Industry (CBI) and members of the TUC.

Three years following the 1974 Act, the Safety Representatives and Safety Committees (SRSC) Regulations were passed (Goldman & Lewis, 2004). These regulations arose through the bargain struck between the Labour government and organised labour during 1974-79, referred to as the Social Contract (Eurofound, 2009). They extended the duty described in the HSWA for employers to provide their employees with information necessary to ensure health and safety at work; and to require employees in union recognised firms to appoint OSH representatives who could call for the establishment of OSH committees, investigate potential hazards and complaints, access information about OSH matters, and have paid leave to carry out these tasks (Robinson & Smallman, 2006). Thus, for the first time, partly through the HSWA 1974, but largely through the subsequent SRSC 1977 Regulations, worker involvement entered legislative duties for employers. With the SRSC Regulations in situ, 1978-79 saw 30,000 safety representatives go on the TUC 10-day-release courses (Lyddon, 2012).

The HSWA looked to reduce the inefficiencies of health and safety, removing unnecessary elements while striving to increase the protection of workers, through shifting responsibility to employers (Aalders & Wilthagen, 1997; Genn, 1993). In many ways this can be seen as a deregulatory agenda which was a radically new approach. Similarly, the 1977 SRSC regulations brought a culture change through the inclusion of workers. The period can be characterised by government (both Labour and Conservative) adopting a new approach to OSH where employee protection was based on employee

status rather than on the premises in which the employee worked (Lyddon, 2012). What Robens did not or perhaps could not foresee was that the expansion of the 1974 Act away from the premises approach laid health and safety open to the development of the civil liability phenomenon. In addition, the Robens report and the 1974 Act could not have foreseen the effects of the transfer of law-making power to the European Union, and the particular effects of regulation making in the field of health and safety post the Madrid Summit of 1986 (Rimmington, 2009).

## 3.3 The turbulent Thatcher years

The Thatcher Government, established in 1979, brought new fundamentals to the governance of the UK which heralded regulation through the 'free market' in a model that became known as 'Thatcherism' (Tombs, 1996). As a result, many policy areas with established regulation, such as OSH, witnessed attempted deregulation (Baggot, 1989). In the mid-1980's, two White Papers were published, *Building Businesses Not Barriers* (Department of Employment, 1986) and *Lifting the Burden* (Department of Environment, 1985), both of which called for reductions in the general regulatory 'burden' on business. *Building Businesses Not Barriers* also for the first time proposed a systematic review of OSH regulations in order to identify where the 'burdens' lay. The economic recession of the early 1980's had created a need for the government to drive business, however, during both of these reviews, the UK's health and safety legislative and regulatory systems remained unscathed. Dalton (1991) notes a major reason behind this was that one of the supposed chief beneficiaries of deregulation, small firms, did not find OSH law burdensome. Furthermore, considerable public concern (Dalton, 1992), and opposition against government proposals, including opposition from employers (Department of Environment, 1985; Department of Employment, 1986), forced the government to take a more subtle approach to its deregulation agenda (Tombs, 1996).

In 1980, the government introduced the 1980 Employment Act. Under this Act, provisions made through the SRSC Regulations, and the Employment Protection Act 1975, were repealed. It also removed the employer from the full burden of proof of reasonable action in cases of dismissal for unfair reasons (including safety-related dismissal). Similarly, tribunals were required to take the employer's size and resources into account in deciding cases of unfair dismissal. Trade union membership declined in the 1980's as did industrial action (with the exception of the 1984-85 coal miners' strike).

During this period, the broad duties of the 1974 Act were supplemented by specific regulations, many of which placed absolute duties on duty holders leading to a significant increase in legislative output (HSE, 2004). In 1982, the Notification of Installations Handling Hazardous Substances (NIHHS) regulations were passed. In 1984, these were followed by regulations on the Control of Industrial Major Accident Hazards (CIMAH) which brought the Seveso Directive intro force in the UK. The CIMAH Regulations were designed to prevent or mitigate the effects of major accidents both on people and the environment (HSE, n.d.a.). A year later in 1985, the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) were passed. These regulations require a 'responsible person' to notify the enforcing authority in the event that: a fatality occurs; a person sustains any injuries or specific medical conditions; or where a dangerous occurrence takes place in connection with a work activity. Importantly, this reintroduced the requirement to report incidents that lead to over three days of absence from the workplace (Dawson et al., 1988). In 1986 the Sex Discrimination Act was enabled while 1989 saw the introduction of the Electricity at Work Regulations and the Noise at Work Regulations, the former taking a prescriptive approach while the latter being more goal-setting in nature.

1988 also saw the introduction of the risk tolerability doctrine through the publication of the document 'The tolerability of risk from nuclear power stations' by the HSE. This established the HSE's three tiered approach to risk, defining where organisations should implement OSH initiatives. The document sets out the principle of 'as low as is reasonably practicable' (ALARP) as the foundation to this risk approach (Kemp, 1991). Although many advocate the use of the risk-based approach, it should be noted that some authors have commented this approach goes hand in hand with a deregulatory agenda. Bain (1997) argues that using a risk-based approach gives the government a rationale to ignore some hazards arguing that they do not pose a sufficient risk to justify the expenditure in dealing with them.

The HSE/C were also affected in this era. Between 1975/76 to 1990/91 the proportion of HSE expenditure which came directly from the government fell from 98% to 76%. Unsurprisingly, these cuts affected the HSE's ability to influence OSH at the enforcement level through inspections. Dalton (1992) comments on data which showed that one in five of the workplaces the HSE was responsible for, had not received a preventive inspection for five years or more.

However, towards the end of the 1980's several factors combined to pressure the government into giving OSH regulation a higher priority. Firstly, there had been an increase in 'major' injury rate for 18 of 19 industry groups between 1981 and 1985 (HSE, 1985a). Secondly, with the introduction of using employee data to gauge OSH working conditions, the 1990 Labour Force Survey (LFS) found that 1.5 million people reported work-related injuries in the previous year, 2 million people suffered from an illness that they believed to have been caused by or made worse by work, and work-related injuries and ill-health were linked to approximately 29 million lost working days annually (ten times more than those lost through strike action) (Dalton, 1992). Thirdly, and perhaps more importantly, there had also been a number of highly publicised private and public disasters which had led to a number of fatalities and injuries including: the Herald of Free Enterprise sinking; the Clapham rail crash; the Kings Cross fire; major incidents at the Hillsborough and Bradford football stadiums; Flixborough and Piper Alpha. These disasters focussed attention on the issues of risk management and commitment from top level management to OSH issues (Ellis, n.d). Indeed, the HSC's first chair, Bill Simpson, is quoted as saying: "It is a sober fact of health and safety matters that awareness is kindled by catastrophe and our experience shows there is nothing like actual events for moving public opinion and political action" (HSE, 2004, p.11). Towards the end of the decade the most strident anti-unionism of the Thatcher government seemed to dim, while a changed economic situation also saw workers' movements increase in confidence (Tombs, 1996).

## *3.4 The increasing influence of the European Union*

This period saw the development of a critical influence on the UK's OSH system through European Union (EU) regulation. Until 1987, the introduction of EU health and safety law into the UK was slow and piecemeal (Dalton, 1998). This changed with the passing of the Single European Act and a move towards Directives which specified general duties and minimum standards with the aim of harmonisation across EU member states. In June 1989, the Framework Directive on the introduction of measures to encourage improvements in the safety and health of workers at work, which was followed by a number of individual Directives (Barrett & Howells, 1997), was adopted. The Framework Directive 89/391/EEC is focused on systematic risk assessment and internal competence. In its preamble, it is stated that health and safety at work is an objective which should not be subordinated to purely economic considerations (Dalton, 1998). It establishes the principle that the employer has a duty to ensure the safety and health of workers in every aspect related to their work. Crucially the Directive broadened the scope of health and safety with the inclusion of issues such as the organisation of work, and social relationships. Individual Directives were designed to supplement the Framework Directive by tailoring its principles to specific issues.

On the 1st of January 1993, the Framework Directive and five subsidiary Directives were implemented in the UK by six new regulations (The 'Six Pack'). However, along with this new legislation, any laws pre-dating the 1974 Act were also revised (e.g. provisions of the Factories Act 1961) (Barrett & Howells, 1997). This allowed the simplification of approximately 40 items of legislation (Facilities, 1993). Other notable regulations that were also passed under EU influence were the Control of Substances Hazardous to Health (COSHH) Regulations, implemented in 1989 (later updated in 2002).

Another influence EU legislation has had is in the arena of worker involvement. In 1996, the Health and Safety (Consultation with Employees) Regulations were enacted to give protection to employees who are not Union members, entitling them to elect their own health and safety representatives, and through them to consult with employers about health and safety issues (Goldman & Lewis, 2004). These regulations stemmed from concerns that representation of only union represented organisations, conflicted with Article 11 of the Framework Directive (which required all workers to have such rights) (James & Walters, 1997). The Management of Health and Safety at Work Regulations 1999 (MHSW) are also particularly relevant as they furthered the self-regulation agenda through a focus on health and safety management rather than structural problems, and a risk-based approach (Dalton, 1998).

In this period, social dialogue also increasingly influenced the development of OSH policy, as social partners obtained the right to be consulted by the Commission on all initiatives and to negotiate and conclude framework agreements which could be adopted as EU law. As a result of this new legitimacy, three framework agreements were signed by social partners at European level on: parental leave in 1995, part-time work in 1997, and fixed time work in 1999 (Branch, 2005). These were then implemented as Directives and transposed into national legislation. The gradual creep of European law was noted in the Davidson Review (2006) which found that between 1984 and 1993 more than half of the OSH regulations laid before Parliament were European in origin. This would lead to resistance against Europe in the coming years.

Parallel to these developments in the EU, the UK OSH policy arena also developed substantially. In 1990, Sir John Major took over as Prime Minister of the UK, and in October 1992 he launched a 'deregulation initiative' aimed at removing unnecessary red tape from business (Bain, 1997). Under the auspices of the Department of Trade and Industry (DTI), eight Business Task Forces were set up to report to a Deregulation Task Force. All these task forces were composed entirely of big British business representatives. In January 1993, the HSC was also instructed to conduct their own review of all legislation with a view to lessen the burden on business (Bain, 1997).

The first interim report of the DTI Deregulation Task Force was published in January 1994. One of the key proposals was a demand for the introduction of impact assessments (weighing the costs and the benefits) for regulatory reforms which would affect business, and for any such measures to be signed off by Ministers. The report stated: "Deregulatory reforms of primary legislation can now be implemented by a special 'fast track' procedure… we expect that power to be used extensively" (Cabinet Office, 1995, p.3). The government, simultaneously, brought forward the Deregulating and Contracting Out Bill, which gave the Secretary of State for Employment the power to repeal legislation, including health and safety (Bain, 1997).

The HSC published their own internal review in which 18 sets of regulations were identified as no longer addressing significant risks; while 20 more were identified as having repeated existing requirements. The review also highlighted the confusion on the purpose of ACoPs, even though most consultees supported their use. The government accepted the findings of the HSC report including limiting the use of ACoPs to specific cases, the removal of seven pieces of primary legislation and 100 sets of regulations, with any EU based legislation being unaffected (HSC, 1994). In 1995, public funding to train union health and safety representatives, available since the SRSC Regulations in 1977, was ended (Bain, 1997).

Furthermore, a growing discontent for European influence legislation had led to the establishment of measures to reduce the subsequent influence of the EU. A UK/German business representative group was established to scrutinise European regulation (Bain, 1997). In September 1994, the European Council of Ministers had set up a review body to examine the broad field of social policy, including health and safety legislation. This 'Molitor group' called for the removal of burdensome and unnecessary legislation calling for a review of health and safety Directives, a decrease in administrative expenditure for trade and industry and a strengthening of the competitive position of businesses within the EU (Plomp, 2008).

Despite the focus on reducing the 'burden' of health and safety, markedly the trend of considering health matters continued. Following the findings of Health Risk Reviews in the 1980's which highlighted work-related stress to be a significant issue (Mackay et al., 2004), the HSE provided guidance for employers regarding work-related stress in 1995 (Spiers, 2003). This was the first time that employers were explicitly advised it was within their duty to assess the risk of work-related stress. A potential explanation to the introduction of this guidance, somewhat against the flow of deregulation, could be the data that was emerging on the widespread prevalence and impact of work-related stress.

In line with a non-regulatory approach, the HSE in 1996 produced a policy statement which outlined the heightened prominence and importance of standards as a form of guidance in promoting health and safety and articulated its commitment to standard making where there was justification to do so and when resources permit. Recognising the need for an international management standard for OSH, BSI Management Systems, a management systems registrar, collaborated with OSH experts from around the world to create the OSHAS 18001 series (O'Connell, 2004).

The HSC and HSE continued to be affected in the 1990's. The role of chairing the HSC was made part time, the budget was cut by 2.6% with a further reduction of 5% in 1995-1996 (Bain, 1997) and further reduced by 9.2% between 1996-2000 (Dalton, 1998). This in tandem with staff cuts meant the HSE was struggling to keep up with inspections. The number of planned inspections fell by a third between 1995 and 1996 and it was suggested that workplaces were being visited once every ten years (Bain, 1997).

Overall, in the 1990's, the government's 'deregulation' agenda coincided with Europe becoming the main source of new OSH legislation, with 'risk assessment' as the key approach to managing health and safety. Since then many have been concerned that the membership of the EU and the influence on OSH legislation has been a significant burden to the UK. The 1990's continued to see the HSE's resources cut and its powers as a regulatory inspection and enforcement agency weakened. Somewhat in line with the government's stance on legislation, softer forms of policy were beginning to develop momentum with the concept of standards as a tool for regulation emerging in this period. This trend would continue in the following decade.

## 3.5 The new millennium

The 2000's saw a number of health and safety strategies issued by the HSE/government. In 2000, the HSC and the government launched the 'Revitalising health and safety' strategy. This was partly driven by the number of working days lost figures not falling for a decade. It contained the first ever target approach for UK's OSH system. Within this strategy, financial incentives were acknowledged as playing a key role in improving firms' OSH performance (Wright & Marsden, 2002): "The compensation, benefits and insurance system must motivate employers to improve their health and safety performance....the Government sees a case for reforming the arrangements for employers' liability insurance in pursuit of these goals" (p. ix). The Strategy noted that many consultees had advocated the use of auditable management standards, loading and discounting premiums and offering free risk management advice as part of a consultancy package. In addition consultees raised the point that smaller firms and firms in lower hazard sectors are disproportionately burdened by Employer's Liability Compulsory Insurance (ELCI) and consideration should be given to the way premiums are adjusted for such parties (Wright & Marsden, 2002). In 2003, the British government undertook a review of ELCI which concluded that too many businesses paid premiums that failed to reflect their health and safety record (Elsler, 2010). This has led to criticisms and the perception that a compensation culture has been developed in OSH for which insurers and OSH consultants are widely responsible.

The year 2000 also witnessed 'Securing health together', the government's 10 year occupational health strategy led by the HSC, which, like the 'Revitalising health and safety' strategy was target-driven, aiming to reduce occupational ill health and related absence. The 'Revitalising health and safety strategy' was built on and subsumed by the HSC's 2004 'A strategy for workplace health to 2010 and beyond'. This strategy was not target based but instead set out a new direction, calling for a more effective self-regulatory OSH system and clarifying the roles of the HSC, HSE and Local Authorities. It also included a call for a more evidence-based approach to the system and a more balanced approach to living and working with risk. The HSC/E's Simplification Plan outlined the agency's progress in reducing the administration burdens of OSH as laid out in the strategy. It reported the discontinuation of over half of HSE forms, the increased use of the website listing primary and secondary legislation and a simplified reporting regime for accidents and incidents (HSE, 2006). A follow up strategy was launched by the HSE in 2009 called 'The Health and Safety of Great Britain: Be Part of the Solution' which aimed to instil the responsibility of all stakeholders for managing OSH. The 2009 Anderson Review estimated that uncertainty regarding how to comply with legislation cost over £880 million annually – recommended the simplification of legislation for easier interpretation by business

Specific initiatives also developed in the 2000's. In order to meet the targets for reduction of occupational ill health and absence in the UK, the HSC recognised that tackling work-related stress should be a priority (HSE, n.d. b). Instead of introducing an ACoP, the Management Standards for work-related stress were introduced in 2004, based on a framework of agreed standards of good management practice in this area. Another initiative to combat work-related stress developed by the British Standards Institution was PAS1010, a voluntary psychosocial risk management guidance

standard which can be incorporated into existing OSH management systems such as BS OHSAS 18001, ILO OSH-MS and ANSI 2 10 and also works in conjunction with the HSE Management Standards for Work-related Stress (Leka et al., 2011b).

The Construction (Design and Management) (CDM) Regulations were launched in 2007, while on 6th April 2008, the Corporate Manslaughter and Corporate Homicide Act 2007 came into force. With this Act, an organisation will be guilty if the way it manages or organises its activities causes a death and amounts to a gross breach of a duty of care to the deceased. The Health and Safety (Offences) Act 2008 came into force in 2009, increasing the fines and actions that could be considered a health and safety offence from £5,000 to £20,000 and additionally increasing the range of offences for which an individual can be imprisoned.

In August 2007, the Department for Work and Pensions started a consultation on the merger between the HSC and the HSE. This took place on the 1st of April 2008, and the HSC as a body ceased to formally exist (HSE, n.d. c). As noted, the previous eras saw a decrease in the budget allocated to the HSE. This continued in the 2000's and more recently the DWP's spending review for 2008-2011 proposed that the HSE have 5% year on year cuts (Occupational Health, 2007). This repeated reduction of resources led to cuts in HSE services and also affected inspectors and the number of inspections that could be carried out. In 2006-07 there were 41,496 HSE inspections, a reduction from 65,000 in 2002-03 with evidence suggesting the average workplace falling within HSE jurisdiction would be visited on average once every 14.5 years (Taylor, 2010). However, this period saw many attempts to improve the effectiveness of local authority enforcement and coordination with the HSE.

Developments also occurred simultaneously at the European level. The European Commission formed two strategies which were launched over this period addressing the negative effects of occupational ill health. The EU influence on UK OSH legislation continued with a significant addition being the REACH (Registration, Evaluation, Authorisation and Restriction of Chemicals) Regulations, which came into force in the UK in June 2007. This created a new approach to the control of chemicals by shifting the responsibility for substance risk assessment from the regulator to manufacturers and importers. The 2000's also witnessed a culmination of the EU social partners' social dialogue efforts with the broadening of their autonomy and the conclusion of three autonomous agreements on: tele-work, 2002; work-related stress, 2003; and harassment and violence at work, 2007 which were not transposed in legislation (Leka et al., 2010).

Deregulatory agendas in the EU also took a significant step in this period. The 2000 Lisbon European Council set the goal for the EU to become the most competitive and dynamic knowledge-based economy in the world by 2010. To achieve this, the Lisbon European Council asked various EU departments to "set out by 2001 a strategy for further coordinated action to simplify the regulatory environment, including the performance of public administration at both national and Community levels" (Mandelkern Group on Better Regulation, 2001, p.8) reflected by the use of regulatory impact assessments for all proposed regulations. Wright (2008) and Neal (2004) suggest that the European position on OSH policy has since changed markedly towards a deregulatory agenda. The authors argue that, as suggested by Löfstedt (2004), there has been a marked move towards the reclassification and reordering of existing Directives, a move towards updating earlier Directives to ensure consistency with technical progress, and a move towards 'soft law' solutions.

In summary, in this period, a series of HSE/governmental and EU strategies were launched to reduce the number of working days lost due to ill health and to address existing and emerging psychosocial risks in the workplace. A series of soft law approaches followed, primarily through standards in the UK and through autonomous agreements achieved via social dialogue at EU level. The UK strategies increasingly called for greater participatory involvement from all OSH stakeholders to reach improvement targets, with a back drop of finite public resources and the continued cuts to the HSE. The government would subsequently further explore cutting the volume of statutory instruments with the Young review in 2010 and the Löfstedt review in 2011.

## *3.6 Recent developments in OSH in the UK*

The current coalition government has commissioned two major OSH reviews. In 2010, Lord Young's 'Common Sense-Common Safety' Review on legislation and the (alleged) compensation culture surrounding OSH was published. The 2011 Löfstedt review aimed to consider the opportunities for

reducing the burden of OSH legislation while maintaining the progress the UK has made in improving OSH outcomes. These reviews took place in a wider deregulatory context, as the 'Red Tape Challenge' initiative aimed to reduce the number of legislation on its statute books. As part of this Challenge, the HSE was also involved in a Star Chamber Review, having to find cost savings of 35% by 2014/15 (Safety & Health Practitioner, 2010).

The Young review (Young, 2010) found that businesses have issue with the interpretation, rather than the content, of legislation and that the compensation culture surrounding OSH was "perception rather than reality" (p.19). The review also raised the notion of classifying workplaces according to their level of risk (although ignoring the impact of occupational health concerns in this classification and directly questioning the notion of evidence-based policy making), and recommended that the UK "takes the lead in cooperating with other member states to ensure EU health and safety rules for low risk businesses are not overly prescriptive, are proportionate, and do not attempt to eliminate all risk" (p.40). Two additional key recommendations were that the RIDDOR reporting period for employees absent from work following an accident or injury at work be extended from three to seven days; and that the level of professionalism for OSH consultants increases by requiring them to hold a qualification with a professional body. As a result of this recommendation, The Occupational Safety and Health Consultants Register (OSHCR) was set up in 2010 (IOSH, 2010a).

In a similar vein to the Young (2010) review, Löfstedt (2011a) found no evidence for radically altering OSH legislation and acknowledged the previous deregulatory actions resulting in 46% less OSH regulation than there was 35 years ago. However, he did recommend the consolidation of sector specific legislation by 35% and that the HSE review all 53 ACoPs with a view to simplification. The review also made some recommendations that have been raised as contentious by some stakeholders such as the exemption of the self-employed and those working from home and whose work activities pose no potential harm to others from health and safety legislation, and the revision of the CDM Regulations (2007) and their associated ACoP.

The guiding overarching principle behind the Löfstedt review was that regulation should be risk-based rather than hazard-based. With this orientation in mind, and with an acknowledgement of the EU's considerable growing influence over the UK's OSH system, the review recommended the formation of a European Parliamentary Committee to build on the progress made in EU risk-based policy making and to further assist EU regulators and policymakers to regulate on the basis of risk and scientific evidence. Consistent with the 2010 review, the 2011 review concluded that the issue businesses have with OSH is largely not with the regulations per se, but rather the way they are interpreted and applied, inconsistent regulatory enforcement activity, and negative influence of third parties which encourages the generation of unnecessary paperwork and a focus on health and safety activities which go above and beyond the regulatory requirements.

The government's overreaching of the recommendations and their proposed timescale for enacting them has since been criticised by many stakeholders (Wustemann, 2011). Also controversial has been the HSE's newly introduced fee-for-intervention scheme whereby duty-holders who materially breach OSH law will be charged £124 per hour for the HSE's intervention, in an extension of the cost recovery principle. This essentially has shifted the role of HSE inspectors towards a consultancy model.

In reviewing the changing landscape of OSH regulation in the UK, it becomes apparent that history repeats itself in many ways. Examples in the case of OSH would be the definition of priorities, such as reducing the burden on businesses and especially SMEs, and deregulation in all its forms, from reviewing and rationalising legislation to more indirect forms such as budget cuts and weakening relevant government agencies (such as the HSE).

However, the OSH landscape is not independent of wider influences, including social, economic and political. These do not only define how OSH is dealt with but also the nature of work itself and working practices that stakeholders are often too slow to respond to. The more complex the landscape becomes in terms of the influences it receives (and their outcomes) and the actors that emerge, the more flexibility is introduced in the system in terms of control, evidenced by the increasingly diverse forms of regulation that have been implemented over the years. While OSH regulation used to be prescriptive and rigid, it has evolved into being goal-setting and risk-based, with voluntary forms of regulation emerging (soft law) in addition to legislation (hard law). Indeed the OSH policy mix is now

more interesting than ever before. At the same time, more stakeholders are now active in the OSH landscape than ever before playing an important role and promoting their own approaches to OSH regulation. The question then becomes one of balance in order to achieve desirable outcomes and standards.

While, the UK is acknowledged to have one of the best OSH records in the world, cross-national comparisons of public policy can serve as a useful tool for evaluating the current policy landscape (Mossberger & Woolman, 2003). Comparative public policy is particularly useful in expanding policy options and learning from what might have worked elsewhere (Harrop, 1992). Furthermore, policy-making in liberal democracies can no longer be examined in isolation from other states and policies must be studied comparatively because that is the context in which an increasing number are formed (Harrop, 1992). As discussed previously, the international (European) environment and the inherent dependence and collaboration between states form much of the context of national policy making. The next section therefore examines the OSH landscape in the Netherlands and presents a comparative analysis with the UK.

## *3.7 The case of the Netherlands*

Within the EU, the Netherlands is well-known for its experiences with the introduction of soft law for OSH. This section provides an overview of the historical background and recent developments in OSH policy in the Netherlands, focusing in particular on major policy developments in the late twentieth century brought in by the introduction of privatisation and market regulation in OSH policy. Present priorities in OSH policy development are then discussed and challenges for the future are identified before a comparative analysis with the UK is presented.

### 3.7.1 Historical background: introduction of privatisation and market regulation in OSH policy

The very first development towards more market regulation in OSH took place in the mid-eighties when the Ministry of Social Affairs decided that the Labour Inspectorate should focus on inspections (enforcement of compliance of minimum OSH standards) and leave their consultancy role to 'the market'. At the same time, the Ministry effectively created a substantial market for OSH consultancy, by making it mandatory for all companies to have a contract with a (certified) OSH service[1], which had to provide four basic services, including the approval of the company's risk assessment. A consequence was that from that time, OSH services, that were up till then non-commercial agencies, became commercial services; many new commercial OSH services were started up, followed by a battle for greater market share, through acquisitions, mergers and competition on costs (not quality).

In 1994, the Dutch government started a project to stimulate market regulation, deregulation and quality of legislation (in Dutch abbreviated as MDW). The general idea was that governmental regulation was too high a burden for society and that too much regulation was sometimes counter-effective in reaching its goals. A 'smaller government' became the overarching aim. As part of this broader effort, OSH regulation was critically evaluated, and more room for initiatives from the social partners or 'commercial parties' was encouraged. The review led to a proposal (Committee Kortmann) to strongly reduce public regulation for OSH, and replace it by systems of certification and civil legislation. After fierce debates, this proposal was rejected, but nevertheless it changed the thinking about OSH legislation in the Netherlands.

In the early nineties, there were two major (economic and social) problems related to OSH: 1. a high percentage of sickness absence – with absence rates up by around 10%, and 2. the rapidly increasing number of people that became dependent on social security arrangements for disability to work. As a response, in 1994 the government introduced an economic incentive for employers to reduce sickness absence. An obligation for employers to pay the wages of employees that are absent from work, irrespective of the cause of their (sickness) absence, was introduced, initially for six weeks, but extended to 52 weeks in 1996. This was actually the first example in the OSH domain where former governmental responsibilities were transferred to the social partners and 'the market' and worker compensation was transferred to private arrangements and private insurance.

[1] This obligation was skipped several years later for a variety of reasons

In 1998, economic incentives for employers were introduced, to prevent people to become dependent on social security arrangements, while the relevant social security arrangements were shifted to private insurers. The more employees of a certain company were shifted to social security arrangements, the higher the premiums. In 2002, employers got new responsibilities to prevent long-term sickness absence and to stimulate early return to work (The gatekeepers law), triggered by additional significant economic incentives. Since the nineties, several policy initiatives were taken to develop a better balance between market and governmental regulation. The further development and proliferation of soft law was a major focus of the Dutch OSH policy - and the central theme of an EU Conference during the Dutch Presidency in 2004 (SZW, 2004).

Another initiative, which ran until 2006, was the Dutch inter-Ministerial programme called 'dealing rationally with risks'. The basic premise of this programme was that a more rational approach to policy making about risks (in general) would offer great opportunities to increase effectiveness and efficiency of regulation, including opportunities for 'smarter' regulation. After the analysis of a series of cases studies delivered from a variety of Ministries, a governmental working group identified five dilemmas that were very persistent, and seem inherent in any risk based governmental policy.

- *The societal division of responsibility and accountability:* What responsibilities and accountabilities should remain with the government? What responsibilities and accountabilities should be attributed to other agencies or agents?
- *Rationality versus risk perception:* How to deal with scientific rationalities versus the risk perception of the (general) public)? Policies that are only made on rational grounds can easily be undermined by the behaviour of various actors and stakeholders.
- *Certainty versus precaution:* To what extent is scientific certainty a necessity for governmental policy? What degree of uncertainty is acceptable? When is precaution to be used, to avoid unacceptable delays in policy making?
- *Generic versus tailor-made policies:* The advantages of a generic (or universal) governmental policy are unambiguous and there is a level playing field for all. The advantages of tailor-made governmental policies (e.g. sector specific) are practical applicability and user friendliness.
- *Rational policy making versus politics:* There are inherent constraints between the rationalities of policy making and the drive of policy making by politics. Governmental policy makers can develop a well-balanced rational policy, but when suddenly there is a real (no longer a hypothetical) problem in society, it is almost certain that some politicians will plea for new and more detailed regulation, stricter enforcement, etc. This phenomenon has been called the risk-regulation reflex (Better Regulation Commission (UK), 2006).

### 3.7.2 Recent developments in OSH policy making – concrete initiatives

The EU Framework Directive puts emphasis on risk assessment as a necessary activity for OSH management. In the Netherlands this was initially turned into a relevant legal obligation for all organisations, independent of sector or size, whereby (commercial and certified) OSH services had the mandatory duty to be involved and approve the risk assessment, or to carry it out for the companies. The idea was that the expertise of the OSH services would guarantee the completeness and quality of risk assessments for all organisations. While this worked for larger companies, it turned out to be problematic for SMEs, especially for micro enterprises. As OSH services could only 'approve' the in-company-made risk assessment after assessing the risks again, many companies complained about the lack of added-value of the costs of contracting an OSH service. The balance between added-value and costs was especially problematic in small and micro enterprises. As a result, the government wanted to exempt certain categories of micro and small enterprises from the obligation, but this was regarded only acceptable when it would not lead to lowering OSH standards.

The problems with societal acceptance of a possible exemption to make mandatory risk assessments were often compensated by the development and availability of new, reliable, user friendly tools. The first example was the risk assessment tool for employers with only one employee (1997), and this was followed up by a series of sector wise tools. Over time, the government stimulated the development of various risk assessment tools which are nowadays all web-based (which makes it relatively easy to have a comprehensive tool which is user friendly and leads to a tailor-made risk assessment). Easy to use tools for SMEs in sectors – developed by TNO In cooperation with the Ministry of SZW and the

social partners – now form the basis for the European set of tools initiated by the European Agency for Safety and Health at Work (OiRA) (www.oiraproject.eu). During the development of risk assessment tools in the Netherlands, there was a clear shift in focus from only risks (often perceived as problems) towards risks and practical solutions. This better serves the needs of SMEs who are more interested in solutions than in the identification of problems.

The OSH Covenants (arboconvenanten) (Blatter et al., 2008; Veerman et al., 2007) refer to agreements between the social partners in a sector and the Ministry of Social Affairs and Employment. The agreements were focused on the main risks in the sector, and especially on the reduction of risks and their negative impacts. The underlying goal was to reduce the transfer of workers to social security arrangements, especially those for worker disability. These agreements, and the measures needed for the realisation of their (quantitative and measurable) goals, were subsidized by the Ministry. As a result, many sectors participated, with generally positive results. In total, 69 Covenants were agreed (reaching 53% of the Dutch workforce), and the Ministry's investment (in subsidies) was €251 million. Certainly, their impact was that OSH came high on the agenda of the social partners, both in sectors where Covenants were agreed as well as in many other sectors. More (but not that much more) preventive measures were taken in the sectors with Covenants compared with other sectors. Nevertheless, the positive health impact was rather limited, and not significantly differen t from those in other sectors.

As a follow up of the Covenants, since 2007, OSH Catalogues have been developed (Heijnk & Oomens, 2011). The basic idea of OSH Catalogues is to have catalogues of good practices per sector. The OSH Catalogues are thought to complement OSH regulation. While new OSH regulation is increasingly focussing on the goals to be achieved, the OSH Catalogues give guidance for the means to be used. Heijink and Oomens (2011) evaluated 142 OSH Catalogues, relevant for 60-70% of the Dutch workforce. The availability of relevant information is certainly successful. The remaining challenges concern (a) the implementation of the good practice described, and (b) the periodic updating of the Catalogues.

As many enterprises in a sector face the same or similar types of hazards and risks and have similar types of jobs, it might make sense to combine forces in the sector, and develop OSH solutions which are useful for every enterprise in that sector. In a few significant sectors (i.e. Construction, Road transport, Agriculture, Industrial Cleaning, Roofers), this has also led to the institutionalisation of specific OSH knowledge centres, created by the social partners. Their activities vary, but all of these aim to have sector specific tools for risk management, to provide tailor made tools, and all deliver or organise various OSH services to the companies in their sector.

As a complement to the various sector wise activities, the Ministry of Social Affairs and Employment has managed programmes to stimulate individual companies to improve in OSH, most notable in the area of occupational safety (culture). Examples include the Programme Strengthening Occupational Safety (2003-2008) (see K+V, 2008), followed up by the Action plan for occupational safety (2009-2012), and occupational hygiene (2003-2008) (see TK, 2008).

### 3.7.3 Current priorities in OSH policy development

On the basis of the latest vision on the system for healthy and safe work (De Krom, 2012), the government sees as its three core tasks:

- Legislation (more goal requirements, less prescription of means), based on international (EU) regulation
- Provision and exchange of relevant OSH information as a basis for the control of OSH risks
- Governmental supervision and enforcement: serious enforcement in case of non-compliance.

The key focus of the Dutch government has been and currently remains on increasing self-regulation via 'market mechanisms' (i.e. through the 'invisible hand' of economic self-interest, triggered by economic incentives), to strengthen the role of the social partners, and to organise focused and stringent (risk based) inspections. While, implicitly this means stimulation of deregulation, legislative reform will focus on goal requirements replacing detailed prescriptions of means, and leaving it up to the social partners to define the adequate means to reach these goals, offering opportunities for tailor made approaches per sector.

The Dutch agenda for policy reform until the end of 2015 for the Netherlands can be summarised as a transition from a focus on OSH means towards a focus on OSH goals; less rules, but higher fines for non-compliance, and still pro-active inspections whereby priorities are risk-based; expanding OSH regulation to also protect the growing group of the self-employed; greater responsibilities for the (individual) employees as behaviour of employees is of growing importance for good OSH and facilitation of a better connection between OSH services and the general healthcare system.

EU legislation is the core of Dutch OSH legislation and forms a key part of the Dutch agenda for policy reform. Most Dutch legislative requirements on top of EU legislation are already skipped. This implies that, presently, there is little room for further deregulation in OSH legislation in the Netherlands. As there is the conviction that OSH regulation is still too detailed and prescriptive, the Ministry's policy objective has been to stimulate reforms in EU OSH legislation and to bring EU legislation more in line with Dutch regulation, policies and ambitions.

At EU level, a clear distinction should be made between general and detailed legislation. The Dutch preference is that details and means should be the responsibility of the individual Member States. The general EU legislation should become more goal-oriented and less prescriptive. The Dutch intention thereby is not to lower the level of OSH requirements in the EU, but to go for 'smarter regulation'.

### 3.7.4 Challenges now and in the future

The main challenge in the Netherlands is to stimulate sustainable employment in an ageing (working) population. Having a healthy and productive workforce is regarded as a key economic factor, and with the view to the ageing population, this requires policy makers, social partners and individual workers to take care of long term impacts on sustainable employment (which also comprises issues like life-long learning and regular updates of professional qualifications – besides OSH related issues). Indirectly this relates to the financial sustainability of social security arrangements and of pensions.

Other relevant challenges are new forms of work where time and space are no longer determined centrally by the employer. The proliferation of 'flexicurity' arrangements, whereby employment is flexible and temporary, and its impact represents another challenge. The main policy challenge is to develop an OSH system that drives itself (not driven by legislation), and corrects itself when necessary. An important strategy hereby is to make use of 'parallel interests', interests of employers, employees and various stakeholders who may primarily pursue other goals (e.g. employers who strive for productivity gains or insurers who want to reduce healthcare costs) while their goals and good OSH can create synergies. This offers opportunities for alliances with such agents and proactive initiatives from such stakeholders.

One of the challenges is to create better incentives for (primary and secondary ) prevention, as the strong economic incentives for sickness absence reduction and the resulting demand from employers to lower sickness absence has reduced the attention from employers to primary prevention. OSH services and occupational physicians (who are paid by the employers) followed this development in market demand. As a result the latter group of OSH experts is only very minimally involved in prevention, which seems to be a threat for the future of the profession.

Another challenge is to tune policies from the Ministry of Health – to stimulate health promotion in 'the work setting' and OSH. The division of 'spheres of influence' is mirrored by different intermediary organisations (OSH services versus health promotion providers); while in organisations, responsibilities are often divided between human resources (health promotion) and prevention workers or external OSH Services.

There is a clear need for more knowledge about (success factors for) the options for self-regulation in OSH. The Ministry intends to initiate research into ways to stimulate and achieve self-regulation. Hereby, learning from other areas like environment and sustainability will be very relevant, as there are only a few self-regulation initiatives that focus solely on OSH, but there are many such initiatives in related areas, that sometimes also refer to OSH as a sub-issue (Tien organisatieadvies, 2011). An example is the certification for the CSR Performance ladder which is inspired (among others) by the ISO 26000 standard for Corporate Social Responsibility – in that scheme 'occupational health and safety' is one of the 33 areas that should be managed systematically (plan, do check act), where performance indicators should be defined, and where dialogue with stakeholders is required.

### 3.7.5 Comparison with the UK

On the basis of the review presented in this report and the overview of the situation in the Netherlands, it appears that the OSH landscape in the two countries presents both similarities and differences.

In terms of similarities, in both countries, trends towards deregulation can be observed with the introduction of initiatives aiming at a 'smaller government' and 'smarter regulation' with softer forms of regulation being on the increase. Similar initiatives towards the introduction of web-based tools have been explored and introduced, although in the Netherlands at a larger scale and with clearer ownership by the social partners that appear to have a longer tradition of collaboration (although not without disagreement). In both countries there has been emphasis on a better connection between OSH and the general health system with initiatives of educating GPs on early identification of OSH-related problems. In addition, systems of certification have been promoted. At the same time, there appear to be efforts in both countries to influence reforms of EU regulation within a smarter regulation agenda and a goal-setting approach. Important issues in OSH are similar in both countries and relate to SMEs, sickness absence, the aging workforce and sustainable employment, the self-employed, and new forms of work and associated challenges.

However, there also appear to be several differences between the two countries. Civil law and liability is less important in the Netherlands as discussed before in relation to the UK. Economic incentives are another since in the Netherlands economic incentives were introduced through which a large part of worker compensation has been transferred to private insurance paid by employers (up to 52 weeks). Another point of diversion is the role of inspectors. While in the Netherlands inspectors have moved away from a consultancy role, leaving that to the market with a proliferation of OSH services, in the UK the role of inspectors has recently been revamped with the introduction of the 'fee for intervention' scheme, essentially extending the role of HSE inspectors to include a consultancy aspect. However, in both countries there is a focus on more serious enforcement in case of non-compliance. While in the Netherlands, the general perception appears to be that there is little room for further deregulation of OSH, in the UK there have been continuous debate and initiatives aiming at reducing OSH regulation. However, in both countries, the image of OSH is perceived to be poor, due to regulatory burden and associated costs. Another point of difference relates to high risk jobs. In the Netherlands, psychosocial risks had a strong relevance to discussions on what constitutes high risk jobs and whether these types of jobs can be eliminated. However, despite the fact that in the UK several initiatives on psychosocial risks have been introduced (perhaps even at a greater scale than in the Netherlands – with the introduction of the Management Standards for Work-related Stress), current discussion on high risk jobs and high risk sectors broadly focus on traditional issues of safety. In both countries, there appears to be a similar OSH knowledge infrastructure with similar stakeholders, with insurers identified as a strong newer stakeholder. The notion of greater responsibility by businesses (including CSR) as well as by employees is also relevant in both countries. Finally, in the UK, well-being at work is a topic that is high on the agenda.

The above issues are further considered in the Discussion section of this report that discusses overall issues that pertain to the changing OSH landscape in the UK.

# 4. The policy process and the role played by stakeholders

The literature and policy review carried out in Stage 1 of this project highlights the role different sources of authority and key actors have played in the changing OSH landscape in the UK. It is evident that the political climate, major industrial accidents and exposure to various occupational risks, have increasingly highlighted the importance of health and safety amongst organisations and their stakeholders and, consequently, have had a significant impact on the actions taken by them. Stakeholders are persons or groups who are directly or indirectly involved and affected by the activities of the enterprise, either positively or negatively. They may include locally affected communities or individuals and their formal and informal representatives, national or local government authorities, politicians, civil society organisations and groups with special interests, the academic community, or other businesses (IFC, 2007).

Most research in the area of health and safety has generally focused on the role of traditional stakeholders such as government agencies, trade unions, employer organisations and, to some extent, researchers and academics. However, it is also important to examine the role played by 'new' stakeholders such as insurers, professional associations, standardisation bodies that are increasingly active in the changing landscape of OSH regulation in the UK. Key stakeholders in OSH management and examples of their stakes are presented in Table 4.

**Table 4: Stakeholders in OSH management and their main stakes**

| Stakeholders | Main stakes |
|---|---|
| **Employers** | Good OSH management is of primary importance to ensure that workers remain healthy and productive. Employers also have a legal obligation to provide safe and healthy workplaces. |
| **Employees** | Good OSH management is of primary importance to employees for their own health and productivity (staying economically active). They share the legal obligation with employers. |
| **Government agencies** | Develop and implement OSH regulation. Monitoring, inspection, and ensuring compliance with national OSH regulations and standards. Provision of basic OSH services, for example through primary health care system. |
| **Researchers and academics** | Development of OSH management tools. Examine the link between exposure to occupational risks and health and sharing this information with practitioners. |
| **OSH services** | Implement OSH management initiatives and tools. |
| **Social security agencies** | Good OSH management may reduce the burden of disease and help to reduce rising costs healthcare on social security arrangements (for workers compensation, societal costs of disabilities and associated unemployment). Social security agencies have a clear stake in prevention. |
| **Health insurers** | Good OSH management may reduce the rise of health care costs for treatment of occupational diseases. Health insurers have a clear stake in (primary and secondary) prevention. |
| **Health care institutions** | The prevalence of occupational health problems is a challenge and burden to the health care systems and institutions. Increasing treatment activities may trigger greater interest in prevention. |
| **Customers/clients** | In many jobs people work with clients. If workers suffer from illnesses, this is likely to affect the way they work which may also reduce customer satisfaction. |
| **Shareholders** | Occupational ill-health can lead to high levels of sickness absence. In companies with severe problems, it may also be more difficult to attract talent. As a result the productivity and competitiveness of the company may be affected, implying reduced shareholder value. |

| | |
|---|---|
| **NGOs/Civil Society** | NGOs represent civil society groups. Several civil society groups may have an interest in good OSH management by companies. This may include expectations of social benefits to be generated as a result of the hosting of the business activities (e.g. access to employment, improved livelihoods). Potential change in communicable disease patterns (spread of diseases from workers to members of wider community or vis-a-versa). Threat of injury of violence (for example as a result of the inappropriate use and training of security personnel, poor practices in managing site safety, etc.). |
| **Universities, business schools and vocational institutes** | Good OSH management clearly has a link with good business practice. This is important for the education of present and future business leaders and workers. OSH management should therefore be integrated in the curricula of universities, business schools and vocational institutes. |
| **Employment agencies** | Occupational disorders (particularly psychosocial disorders) are increasingly relevant as a cause of reduced work ability and rising unemployment. Recent literature shows that (re)activation of long term unemployed persons is more successful when it is combined with work than in the traditional model of treatment and cure before people start working. This implies that employment agencies are having a clear interest in tertiary prevention. |
| **Human resource departments and officers** | Within companies, OSH issues are relevant for accident prevention, well-being at work, company climate, employee satisfaction and the retention of existing employees. Though coming from another tradition compared to OSH experts, HR officers are increasingly involved in the management of OSH issues particularly psychosocial issues at work. |
| **Media** | OSH management is a societal issue with even growing impact. It is important to many people (workers, their families etc.). As a result the issue is of growing importance to mass media (journals, TV, internet, etc.). |
| **Actors of (in) the judiciary system** | OSH risks are increasingly having economic implications both for companies and their workers. This is likely to lead to a boost in legal cases, on liability issues. This may form a burden to parts of the juridical system but might be a source of potential income to lawyers. |
| **Business consultants** | As OSH risks are increasingly having business impacts, advising on these issues will probably not remain the exclusive domain of occupational health and safety services. Business consultants are likely to develop a growing interest in this area. |

*Source: Adapted from Zwetsloot, Leka & Jain, 2008*

Stakeholders are major forces of change (Grundy, 1997) and, therefore, identifying key stakeholders and establishing the link between OSH and their needs is essential for examining various policy developments and identifying how the right balance between public and private initiatives can be achieved at the policy and practice levels. However, in practice, this is not without dilemmas; pertinent challenges include interpretation of:

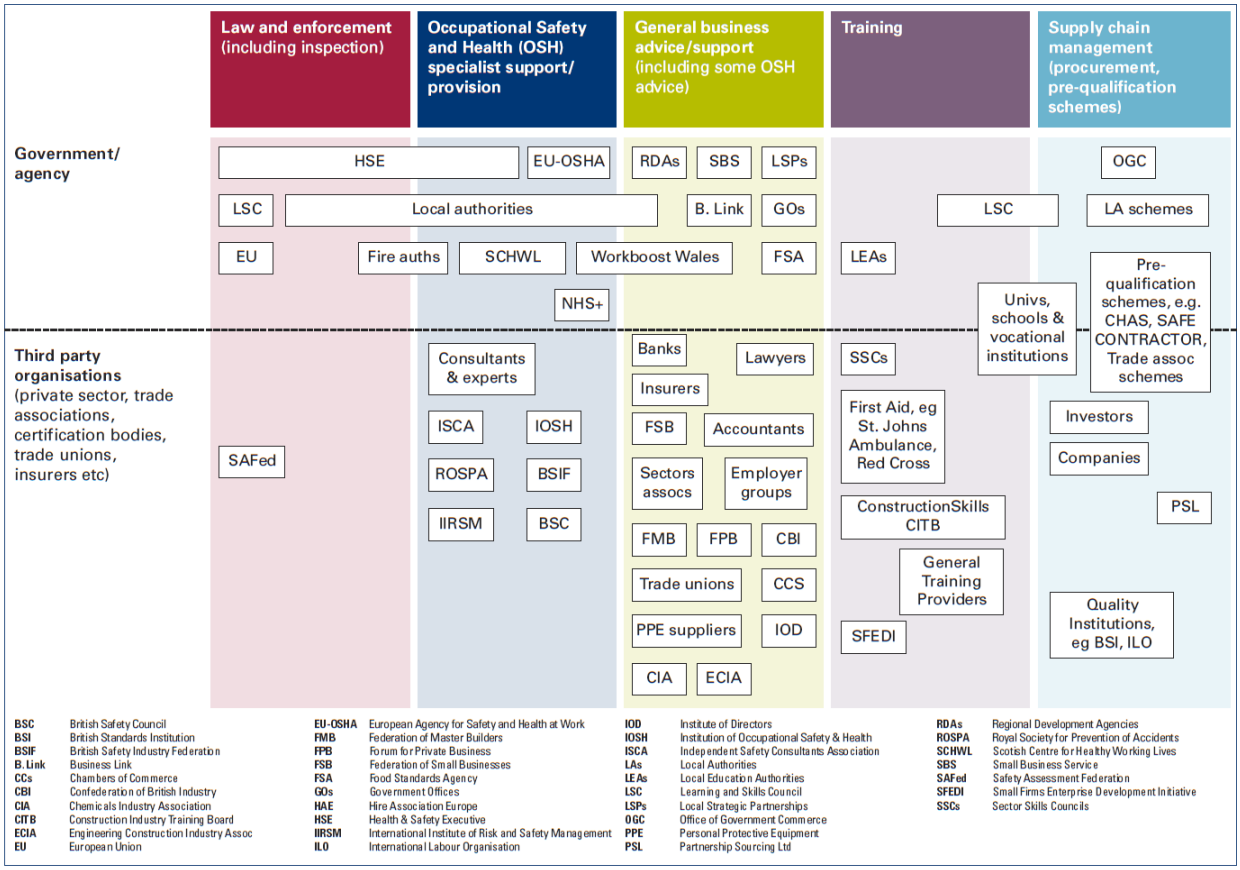
- scientific evidence versus practical situations and/or risk perceptions
- workplace interventions and determinants outside work
- conflicting interests of workers and employers
- negative social or legal impacts of addressing health and safety risks
- prevention of shifting consequences
- negative health and safety impacts versus other organisational priorities.

## *4.1 Key OSH stakeholders in the UK*

The key message of the national OSH strategy in the UK titled 'Health and Safety Strategy for Great Britain - Be Part of the Solution' is that everyone has a role to play in improving the country's health and safety performance. It states that to bring about improvements in health and safety performance, there is a need for all stakeholders to work together towards a set of common goals. For that to become a reality, each stakeholder within the health and safety system has to understand their role and become better at executing their responsibilities. The stakeholders identified in the Strategy

include: employers and their representative bodies; the self-employed; workers and their representative bodies; Government, through its departments and agencies (Health and Safety Executive, local authorities etc.); professional bodies; voluntary and third sector organisations (HSE, 2009b). There is a complex network of sources of health and safety support, advice and information available to both employers and workers which are largely outside the direct control of either the HSE or local authorities which together form the national OSH landscape in the UK (BRE, 2008). Figure 2 presents this landscape and highlights the key actors.

**Figure 2: The OSH landscape in the UK and the key actors**




*Source: Better Regulation Executive (BRE) (2008)*

### 4.1.1 Law and enforcement

The Health Safety at Work etc Act 1974 and related legislation are primarily enforced by the HSE or local authorities, according to the main activity carried out at individual work premises. The Health and Safety (Enforcing Authority) Regulations 1998 allocate the enforcement of health and safety legislation at different premises between local authorities and HSE (HSE, 2009c). Under the Health Safety at Work etc Act, the HSE has been set up in order to support the Government's strategic aims and current targets for health and safety at work. According to the Act, the main statutory duties of the HSE are to:

- propose and set necessary standards for health and safety performance;
- secure compliance with those standards;
- carry out research and publish the results and provide an information and advisory service;
- provide a Minister of the Crown on request with information and expert advice.
- To perform these duties the HSE seeks to:
- influence people and organisations – duty holders and stakeholders – to embrace high standards of health and safety;
- promote the benefits of employers and workers working together to manage health and safety sensibly;
- investigate incidents, enquire into citizens' complaints and enforce the law.

HSE is the primary delivery agent for the UK government's Department for Work and Pension's strategic objective of improving health and safety outcomes. The Secretary of State for Work and Pensions has the principal responsibility for the HSE (HSE, 2009d). Certain areas of risk or harm directly or indirectly related to work activity are covered by legislation other than the Health Safety at Work etc Act and are not dealt with by HSE. These include disability discrimination, consumer and food safety, fire safety, marine, railway, and aviation safety and most aspects of environmental protection (HSE, 2009b; BRE, 2008)

Local authorities enforce health and safety law mainly in the distribution, retail, office, leisure and catering sectors. HSE liaises closely with local authorities on enforcement matters through the HSE/Local Authorities Enforcement Liaison Committee (HELA). Partnership teams (comprising HSE and local authority staff) and an enforcement liaison officer network in HSE regional offices across Britain also provide advice and support. HELA provides a strategic oversight of the partnership aiming to maximise its effectiveness in improving health and safety outcomes – including enforcement priorities for local authorities. A Local Government Panel, comprising local authority councillors, was also established in 2006 and regularly meets the HSE Board for a strategic dialogue on local, central and devolved government issues that impact on health and safety regulatory functions. It also reviews the effectiveness and performance of the partnership between the two enforcing authorities (HSE, 2009b).

### 4.1.2 Occupational safety and health specialist support/provision

The Management of Health and Safety at Work Regulations 1999 require employers to appoint 'one or more competent persons' to help them meet their duty to control risks at work. Many employers can get or develop this help in-house which they are required to use when it is available or seek external help or advice if in-house help is inadequate, or use a combination of both. There are a number of different sources of external advice available to employers. These include:

- the HSE
- local authorities
- consultants registered on the Occupational Safety and Health Consultants Register
- health and safety experts
- specialist health and safety groups (e.g. Faculty of Occupational Medicine, Institute of Ergonomics & Human Factors etc.)
- professional bodies

There are a number of OSH professional bodies actively engaged in promoting the field of health and safety in the UK, many of which are also active internationally. Some key bodies include:

- Institution of Occupational Safety and Health (IOSH)
- British Safety Council (BSC)
- Royal Society for the Prevention of Accidents (RoSPA)
- Independent Safety Consultants Association (ISCA)
- International Institute of Risk and Safety Management (IIRSM)
- British Safety Industry Federation (BSIF)
- Chartered Institute of Environmental Health (CIEH)

It is estimated that more than 1,500 specialist health and safety consultancy firms in the UK – not including general business or financial service consultancy firms - provide health and safety support to employers (BRE, 2008). Employers are advised by the HSE to select external help carefully (HSE, 2011b). Both providers of health and safety services (both internal and external) should be able to help employers manage risk sensibly, i.e. focussing on reducing real risks, both those which arise more often and those with serious consequences. As the provider, they must be competent, give a good quality service and deliver help that is 'fit for purpose'. The HSE and a network of professional bodies and stakeholders have been working in partnership to develop the Occupational Safety and Health Consultants Register (OSHCR). OSHCR provides an up-to-date list of general health and safety advisers who have a qualification recognised by the professional bodies participating in the scheme. Together, this partnership has agreed that a minimum standard should be set for consultants to join the register. This has currently been set at a degree level qualification, at least two years' experience and active engagement in a continuing professional development scheme. All consultants who join the register are bound by their relevant professional code of conduct and are committed to

providing sensible and proportionate advice. Employers seeking general external health and safety advice can search the register for a consultant by industry, topic, county or keyword (HSE, 2011b).

### 4.1.3 General business advice and support (including some OSH advice)

Under the provisions of the Employers' Liability (Compulsory Insurance) Act 1969, most employers are required to insure against liability for injury or disease to their employees arising out of their employment. The Act ensures that employers have at least a minimum level of insurance cover (£5 million) to cover the cost of compensation for employee injuries or illness whether they are caused on or off site (with certain exclusions). The HSE enforces the law on employers' liability insurance and HSE inspectors can check that an employer has employers' liability insurance with an approved insurer. The inspectors may also ask to see the certificate of insurance and other insurance details. If an employer does not have suitable insurance they can be fined up to £2500 for any day which they are without insurance. If the certificate of insurance is not on display or not made available to HSE inspectors if requested, the employer can be fined up to £1000 (HSE, 2008a).

Insurers and insurance brokers play a significant role in the health and safety system where in order to manage their exposure to risk, they may take on a number of roles that are similar to those of a regulator (BRE, 2008):

- they stipulate conditions on employers which, if not met, may lead the insurer to charge more, or in extreme cases to withdraw or invalidate their cover;
- they may require employers to demonstrate compliance through completion of forms and submission of evidence before they agree to provide cover;
- they provide personalised advice to firms after visiting, through the use of risk advisors and brokers; and
- they provide general advice and guidance on health and safety issues

Employer associations (e.g. Confederation of British Industry, Institute of Directors, Federation of Small Business, CEEP UK), trade unions (e.g. Trades Union Congress), lawyers/legal experts and sectoral associations also act as key sources of general advice and guidance on health and safety issues for their members in addition to playing a role in shaping policies relating to OSH in the UK (Broughton, 2008).

### 4.1.4 Training

The Safety Representatives and Safety Committees Regulations 1977 and the Health and Safety (Consultation with Employees) Regulations 1996 require that employers provide or arrange for appropriate training for in-house occupational safety and health specialists functioning as health and safety representatives either appointed by trade unions or elected by employees.

According to the regulations, employers must give appointed health and safety representatives the paid time necessary to carry out their functions, and paid time as is necessary to undergo training in those functions, as is reasonable in the circumstances. The Trades Union Congress or the trade union concerned will offer training to trade union health and safety representatives and usually meet the costs. Trade unions offer online training courses, so health and safety representatives may not always have to leave the workplace, but may simply require access to online training within the workplace and time to complete the course. In the case of elected representatives, employers must ensure that elected representatives receive the training they need to carry out their roles, as is reasonable in the circumstances, and pay any reasonable costs to do with that training, including travel and subsistence costs, give them paid time necessary to carry out their functions (HSE, 2011b).

For those working as external consultants and those not in OSH specialist roles, the Management of Health and Safety at Work Regulations require that any help to manage OSH risks is competent. Being competent is recognised as having:

- relevant knowledge, skills and experience;
- the ability to apply these appropriately, while recognising the limits of your competence; and
- the necessary training to help you acquire and maintain this.

The Regulations, however, do not outline how service providers achieve competence, nor do they specify the relevant set of skills or qualifications. Rather, they set these competency criteria as a goal for OSH service providers to achieve, as what will be considered competent will depend on the context and particular help being provided. How a service provider achieves competence is up to their discretion. Being a member (at the appropriate level) of a professional body which sets competence standards for its members, and prescribes levels of qualification and schemes of continuing professional development, is one way health and safety service providers undertake voluntary training and achieve competence (HSE, 2007b).

In the UK, voluntary training is provided by a number of organisations such as the Health and Safety Laboratory (HSL), the Chartered Institute of Personnel and Development (CIPD), the British Psychological Society (BPS), the Institution of Occupational Safety and Health (IOSH), the Royal Society for the Prevention of Accidents (RoSPA), the British Safety Council (BSC), UK trade unions, employer associations, universities and vocational institutes. The training is relevant for managers, supervisors and staff from all types of organisations responsible for health and safety. Some examples include qualifications awarded by the National Examination Board in Occupational Safety and Health (NEBOSH) and the British Safety Council.

NEBOSH was formed in 1979 as an independent examining board and awarding (certification) body with charitable status. It offers a comprehensive range of globally-recognised, vocationally-related qualifications designed to meet the health, safety, environmental and risk management needs of all places of work in both the private and public sectors. Courses leading to NEBOSH qualifications attract around 35,000 candidates annually and are offered by over 500 course providers, with exams taken in over 100 countries around the world. Their qualifications are recognised by the relevant professional membership bodies such as IOSH and IRRSM. NEBOSH examinations and assessments are set by its professionally qualified staff assisted by external examiners, most of whom are Chartered Safety and Health Practitioners operating within industry, the public sector or in enforcement.

### 4.1.5 Supply chain management (procurement and pre-qualification schemes)

In addition to being important sources of health and safety support, third parties are increasingly imposing their own health and safety requirements on business. More and more often, procurers, and insurers demand adherence to certain standards, compliance and/or forms of pre-qualification from clients that want to work with them (BRE, 2008).

Pre-qualification schemes assess health and safety standards in firms when tendering for work with clients. These assessments look for evidence of contractors' basic health and safety credentials. But while pre-qualification schemes can help drive up health and safety standards overall, such schemes can also add to the bureaucracy firms face and can also serve as a barrier to some – especially smaller firms – bidding for work and safety standards required. Moreover, they can lead to a number of different standards being applicable and an associated uncertainty about the appropriateness of different standards/schemes for different clients/sectors (BRE, 2008).

In addition, a number of voluntary standards in the area of OSH have been developed by the British Standards Institution (BSI), the national organisation responsible for the development and publication of standards in the UK. Since its foundation in 1901 as the world's first standardisation body, BSI has grown into a leading global independent business services organisation providing standard-based solutions in more than 140 countries. BSI develops private, national and international standards, certifies management systems and products, provides assessment, certification, and testing of products and services, and provides training and information on standards and international trade. BSI developed the first used standard on occupational health and safety management systems, BS 8800 which went on to become the OHSAS 18000 series standards – the most widely used OSH standard globally.

## *4.2 Stakeholder approaches*

A number of approaches to manage and promote health and safety have been developed and implemented by various stakeholders. A few examples of such initiatives are provided below.

### 4.2.1 The Contractors Health and Safety Assessment Scheme (CHAS)

CHAS is a form of pre-accreditation for suppliers, predominantly used in the Construction sector (Fidderman, 2007) though also used in jobs ranging from care services to demolition contractors, designers and consultants in the UK (The Contractors Health and Safety Assessment Scheme, n.d). Set up in 1997, in a collaboration between health and safety procurement professionals and the Association of London Government (ALG), CHAS has founder member status with the HSE supported Safety Schemes in Procurement (SSIP) and is certified to ISO9001 and ISO14001 standards (The Contractors Health and Safety Assessment Scheme, n.d).

The scheme's purpose is to reduce duplicated safety applications for both suppliers and buyers and save time and resources in the supply chain when contractors are aiming to demonstrate competence to potential clients/buyers in the first stage of Construction Design and Management (CDM) regulations criteria. Once the supplier has achieved compliance, they are approved to work for all CHAS buyers. In addition, CHAS provides suppliers with information about any weaknesses in their safety management and gives guidance on how they can improve (The Contractors Health and Safety Assessment Scheme, n.d).

There is also a version for organisations with less than five employees which reflects the revised CDM Regulations. This differs from the standard version in that, by law, policy and arrangements do not have to be in writing, though firms are still required to demonstrate competence to a potential client and are, like larger firms, required to make provision for competent advice. In addition, tailored versions are available for CDMC and designers that are slanted towards assessing training and qualifications (Fidderman, 2007).

### 4.2.2 Making the Market Work (MTMW)

A scheme by the Association of British Insurers (ABI), Making the Market Work provides trade associations and trade bodies with guidance about the kind of best practice employer liability insurers would like to see member firms adopt (Fidderman, 2007). To be in the scheme, organisations must adhere to the following stipulations: be members of the trade association's health and safety scheme; meet the recognised health and safety standard and have an up-to-date policy; an assessment tool; training; and collection of statistics. The Better Regulation Executive (2008) also notes that duty holders have to demonstrate they have met HSE guidance in addition to meeting minimum standards. Once the assessment process is complete, the ABI sends details of the trade association scheme to its entire Employers' Liability providing members, with the decision to offer discount or not made by the individual insurer. There are no mathematical mechanisms in place for risk-based premiums and no guarantee members will receive a discount (Wright et al., 2005).

The British Printing Industry Federation's (BPIF) health and safety 'health check' scheme was the first trade association scheme approved under the Making the Market Work initiative (Fidderman, 2007). The health check is a self-report questionnaire which covers 22 areas, each of which comprises 10 sections. After completion, the applicant's answers generate a report which is compared with OSH legislation and industry good practice, and makes recommendations for actions. An applicant receives full marks for best practice and legal compliance, 75% for legal compliance only and 50% for best practice only, with the answers in each area ranked. The check is performed annually which allows member companies to revisit insurers annually to demonstrate improvement (Fidderman, 2007).

The BPIF has a block insurance arrangement with the Royal Sun Alliance, where a score of 70% generates a 10% reduction on the overall premium. The health check is based solely on the applicant's answers given during the BPIF visit and no attempt is made to verify these, the only exception being when the health check is part of a government funded training contract. In these cases "essential" items are audited (Fidderman, 2007).

### 4.2.3 OHSAS 18001 (2007)

OHSAS 18001 is a standard that describes the requirements for an organisation's OSH management system. It can be used for certification/registration and/or self-declaration purposes. Fidderman (2007) summarises the main requirements of OHSAS 18001 as follows: policy; planning (hazard identification, risk assessment and determining controls); implementation and operation (including

resources; appointment of a senior manager responsible for OSH; competence, training and awareness; communication, participation, consultation and, and representation; and emergency preparedness); checking (performance monitoring, incident investigation and internal audit).

BSI states that in the 2007 version there is the much greater emphasis on health rather than just safety, greater alignment to ISO 14001:2004, and improved compatibility with ISO 9001:2000. These improvements enable organisations to develop integrated management systems. An organisation may wish to demonstrate conformity with the standard to make a self-determination and self-declaration about their OSH management system; to seek confirmation of the said self-declaration by an external party to the organisation; to seek certification/registration of its OSH management system by an external organisation; or to seek confirmation of its conformance by parties who are interested in the organisation's business (e.g. customers) (Fidderman, 2007).

### 4.2.4 The Management Standards for Work-related Stress

The Management Standards were developed by the HSE in 2004 and are a form of guidance developed to assist employers, employees and their representatives manage and reduce levels of work-related stress (Mackay, Cousins, Kelly, Lee & McCaig, 2004). The HSC decided to address this issue through soft-regulation in the form of guidance (HSE, n.d. b). Therefore, although the Standards reflect the legislative framework of the HSWA (which requires UK employers to secure the health (including mental health), safety and welfare of employees while at work) and the MHSWR (which require employers to carry out a suitable and sufficient assessment of significant health and safety risks, including the risk of stress-related ill health arising from work activities, and take measures to control that risk) the Standards are not legally enforceable (Mackay et al., 2004).

Six key areas of work design are included in the Standards that, if not properly managed, are associated with poor health and well-being, lower productivity, and increased sickness absence (HSE, 2007c): job demands, control, support from management and peers, relationships at work, clarity of role and organisational change. The methodology of the Standards involves each of the six areas having a threshold (expressed as a percentage) and an accompanying platform statement 'the states to be achieved' for each standard. This approach allows organisations to gauge their performance and to encourage continuous improvement with meeting the threshold criteria indicating that an organisation's management practices conform to good practice with regard to preventing the occurrence of work-related stress (Cousins et al., 2004).

On the basis of the case study analysis of 15 stakeholder initiatives, including 15 stakeholder interviews, conducted in the second stage of the research, six key thematic areas emerged in relation to the policy development process of these initiatives. These included Drivers behind initiative development, Influences on initiative type, Constraints on the initiative, Challenges around the initiative, Success Facilitators, and Success Indicators. These are described in the following sections and substantiated by the research findings (see also Annex 2 for a summary).

## *4.3 Drivers behind initiative development*

What drove a policy initiative to be formed, revised, or consolidated was a key theme in the analysis. Three main drivers were identified: legislation, regulatory review and industry need.

### 4.3.1 Legislation

Several of the 'hard' legislative initiatives were reported to be at their origins driven by the requirements of the European Commission (EC). In the case of 'soft' regulatory initiatives, the EC was mainly noted as influential in a stakeholder capacity rather than being a direct driver behind them. Interestingly however, in the case of OHSAS 18001 the guidance which preceded it "BS8800, which was published in 1996" was partially driven by the EC requirements as the respondent explained: "we wrote this guidance ... to help organisations manage risk as per the new regulation that came out from Europe in 1989". With many of the 'hard' regulatory initiatives being driven by the EC, many of both the 'hard' and 'soft' regulatory initiatives were either direct outcomes of, or heavily influenced by regulatory reviews.

### 4.3.2 Regulatory review

Many of the initiatives analysed were revised iterations of original initiatives, with the driver for the amendment emanating from one of the UK government's various reviews of OSH regulation, as was the case with RIDDOR (HSE, 2013): *"We were asked following on from various reviews that had been carried out, particularly the one which related to this was the one which was labelled Common Sense Common Safety ... We were asked very specifically to look at this one area of amending one part for changing the provision of the trigger for reporting over three-day injuries".*

Government reviews of OSH and related impact assessments were also the driving force behind several of the non-legislative (i.e. soft) policy initiatives with the 'softer' regulatory option often being the 'vehicle' for policy makers to meet the government's numerous quantitatively target driven strategies. "*The force behind the development of the Management Standards*" and "*the initial motivation for it*" was, for example, "*when the then government came up with some revitalising health and safety targets, which were ten-year targets*". These targets were, namely, to: reduce the incidence of work-related illness by 20% by 2010; and to reduce the number of working days lost due to work-related illness by 30% by 2010 (HSE, n.d. b).

Another example is the Fee for Intervention initiative. The government's 2010 Strategic Spending Review drove the inception of Fee for Intervention (2012), although similar charging models where already in situ in certain HSE sectors, for example "*the nuclear inspectorate... are funded by a business levy and the high-hazard industries... are charged for their time under the Campbell Regime*". As it was reported, "*as part of that settlement we (HSE) were allowed or encouraged to look for other ways of financing ourselves... And one of those of course was what is now known as Fee for Intervention*". In addition, the literature states that one of the measures suggested in the Government's 2011 review 'Good Health and Safety, Good for Everyone' (2011) was a cost-recovery model (Department for Work and Pensions, 2011). However, drivers also arose from other sources; a key one being that the initiative was a response to market needs.

### 4.3.3 Market needs

Across several of the 'soft' regulatory initiatives the driver behind their inception and formation was to meet a market need which had been identified by stakeholders/clients within the market. The Association of British Insurers (ABI), for example, stated that they *"... came up with the Making the Market Initiative ... because in 2003, we (the insurance industry) had a hard part of the cycle of the market which meant companies, employers were not able to get any insurance or the premium was too high for them to pay*". Thus there was a reactive need for the ABI to address a need which had been identified and pushed for by clients within the market.

Just as the self-identified needs of the market helped drive the initiative formation at their inception, these forces also influenced their subsequent revisions. For example, industry clientele drove the CCNSG Safety Passport: "*it was born out of the...high hazards industry*", again to meet a reactive need at that point in time: "*around that time there was a couple of reasonably serious incidents*", "*the people who owned and operated the sites ... the oil companies ... suddenly realised that they wanted to do more about ...securing the basic health and safety and health awareness of the contractors who worked on the site*".

## *4.4 Influences on initiative type*

A second major theme relates to how specific types of initiatives came to be and what influenced the type of policy initiative chosen to address particular issues. Within this theme, the main sub-themes are the multi-faceted nature of the policy process itself, meeting changing industry needs, and the fit of the particular initiatives with others, and with prior empirical research.

### 4.4.1 Policy process

The structured nature of the policy process was a strong influence on how an initiative came to be. This was manifested in numerous ways, for example, the preordained periodic reviews of policy; the 'typical' personnel involved in initiatives' formation and development and the 'typical' outlets through

which the personnel's views are gathered and disseminated; consultation with stakeholders; and how often pre-testing of an issue's prevalence or demand for its presence influenced the subsequent form the initiative took upon full implementation. In addition to the influence of government reviews hitherto noted on initiative development, a further influence on the type of initiative chosen was the cyclical nature of policy process reviews.

Both 'hard' and 'soft' policy initiatives were subject to policy reviews with due diligence being performed to ensure that they were still 'fit for purpose' and there was not a dilution of standards, as expressed by the RIDDOR interviewee. Allied to the structured cyclical timing of policy making, the stakeholders involved in the formation and monitoring of several of the initiatives were often members of a designated structured body, committee, or steering group. For example, as previously relayed in C3HARGE's case the "advisory committee that was borne out of a formal industry advisory committee", whereas with the CDM ACoP, committees were used to inform the initiative's development in terms of reaching the necessary personnel.

Having the opportunity to elicit the views and input from a diverse and appropriate range of stakeholders was also identified as a key component of the policy process. Having either a tripartite approach or structure to work was a key component to facilitate the expressing of views, sharing of expertise and an aid to effective working, with this point being epitomised by the Management Standards' respondent: *"Through all the intervention if you like, we always tried to come up with this tripartite type social partners approach. Because we believe it only works if you have you know, the unions, staff, management on board".*

Regardless of whether or not the structure of the initiative was overtly tripartite or committee based in nature, the importance of having a plethora of viewpoints across the spectrum of stakeholders was recognised. For the majority of initiatives trade associations/bodies were a critical stakeholder. As the C3HARGE respondent succinctly details: "*one of the groups that you'd liaise with would be the trade body because you can influence a large number of organisations and therefore a large number of people through their membership*".

Links with employers' representatives were also identified as being evident, and these parties were acknowledged as being both proponents of some initiatives, and active contributors to it, with, for example, in the case of Making the Market Work they were acting as an intermediary in terms of relaying the concerns of businesses to the government. Trade Unions were also seen as a key driver behind the formation and development of initiatives. Trade Unions were also viewed as being an important outlet through which to disseminate the initiative's key message. Governmental departments with their multi-faceted nature and cross workings were also identified as a key stakeholder during the nascent stages of policy development and consultation. In several of the initiatives, the developers were governmental arms who, depending on their remit, had to liaise with civil servant colleagues. The RIDDOR interviewee noted the importance of the process during the nascent stages of drafting policy: "*you have to have within that process the opportunity for those who have a stake in this to be able to make known their views. So in that timetable you need to be able to have some appropriate consultation*". Following due process in this case went further than being a facilitator; as the following quote shows, it was an imperative: "*You can talk about policy development but you'll not get it in without the policy process we have to go through*".

Revisiting the structured thought process behind policy making, in many cases the initiative was either an outcome from a pilot study which aimed to test the demand for its services, or for the prevalence of the issue it addressed. For example, in the WSA Challenge Fund's case a previous pilot study informed its inception: "*there was a pilot that was undertaken in I think 2002 to 2003 ... which was largely selected trade unions going into SMEs... in about three or four different sectors... going in there to engage the workforce on health and safety matters. That pilot worked very well and so from there we decided that we would take it forward into the Challenge Fund*". Incidentally, the Challenge Fund was also a pilot study which over three years saw a £2.7 million investment from the government into partnerships - including trade unions and employers' groups – that tested innovative ways to encourage worker involvement in OSH in SMEs, with advisers visiting companies (Fidderman, 2007).

The DWP's Occupational Health Advice Line service was also a pilot study, which emanated from a government commissioned review to test demand for a service the review had identified. Likewise in

the case of Fee-For-Intervention, mock studies of the initiatives roll-out and its expected internal and external impact were conducted: "*as part of the dry run and shadow run evaluations, we've... interviewed internal but we've also done a random sample of duty holders where we phoned them up and sort of asked their opinion*". The interrelated nature of initiatives was also a feature in influencing the form an initiative took. 'Fit' in terms of compatibility (or not) with preceding, current or expected future iterations of initiatives was an important contributory factor.

### 4.4.2 Initiative fit

A contributory influence on the form a revised initiative took was its 'fit' with what had preceded it and other related initiatives. Fit was also in terms of familiarity of a particular target group with specific initiative types. It was, for example, an important consideration in changing the Sick Note to the Fit Note, familiarity not only in terms of the former's legislative position, but also the familiarity it had built up with relevant stakeholders: *"By changing an existing piece of legislation rather than creating a new piece, it was something that everyone in the healthcare world, in the employer world but also in the individuals' world would know".*

There were multiple reasons as to why a specific type of initiative was chosen. In some cases it was to address the issues that legislative (i.e. hard) initiatives either 'could not' reach (in the case of Making the Market Work) or 'would not' reach. Thus, in this case, the initiative aimed to "*improve the information flow... to make the product more accessible*" and thus could be considered as a supplement to hard legislation. The supplementary nature of initiatives in relation to 'hard' legislation was also evident in the case of the Workers Safety Adviser Challenge Fund, where a 'softer' approach was viewed as an aid to existing legislation, which had little material impact.

The relation of 'soft' to 'hard' initiatives was also apparent in the case of the IoD, with the development of the guidance coinciding with the development of statute law: "*at the same time that the guidance was being produced, the Home Office, then Ministry of Justice, was working up its corporate killing laws for corporate manslaughter and corporate homicide law*" and the 'soft' guidance was used to assist in identifying the culpability of duty holders in meeting the legislative requirements.

Interestingly, in the case of the IoD guidance the 'type' of initiative it was originally intended to be and the type it practically became changed over time. For example, the Management Standards have, over time, taken on a quasi-legal status as the respondent explained: "*I think if you go to court judgments that have happened in the intervening period, although it is guidance, it's almost taken on an ACoP type stance, in that the courts seem to be saying well there is guidance from HSE and you need to demonstrate you're doing at least as much as that guidance describes, which if you like is almost de-facto ACoP*". Prior empirical research was also important in bringing an issue into focus and thus influenced the initiatives formation.

## *4.5 Constraints on the initiative*

Constraints and challenges were two key themes identified across several of the initiatives, the differentiation between the two being that the former (typically) posed a direct constraint on the initiative during its delivery, whereas challenges were more long term and often more intangible in nature.

### 4.5.1 Implementation

The implementation of many initiatives at the practice level (i.e. post-development) appeared to constrain their impact. With the CDM ACoP, the interpretation of the guidance was identified as a hindrance to its appropriate implementation: *"The chance of the owner of that business ... understanding it and crucially saying to himself I can now see what that means for my construction site, my construction business, is very, very slim indeed".*

The implementation of initiatives (more precisely their principles) by 'official' training and auditing partners was a cause of concern. For CHAS, the issue initially was that training partners were not progressing beyond the superficial checking of clients' practice. With the CCNSG Safety Passport, the training element is also a key facet of the initiative: "*There are about 100 or so training providers that*

*deliver the training... and it's a case of making sure that you get a consistency of quality... that is one of the challenges that we have to make sure that we face up to*".

For OHSAS 18001, interviewee concerns were abound about the quality of auditing across the OSH sector which could compromise the validity of regulatory initiatives: "*I've seen elsewhere; there's a comfort zone with auditors to go in and look at the paperwork and look at straightforward things... they don't think (about asking the question) that really needs asking, which is a high-level question about tell me what the real issues are and what are you doing about them*".

With several original and unoriginal (i.e. extended/revised initiatives), poor off-the-shelf consulting was a severe issue in initiative implementation. This was expressed, for example, in the case of the CDM ACoP *"It has allowed a cottage industry to flourish... who sell businesses off-the-shelf solutions….Our inspectors do see... repackaged, generic material that in many cases either directly copies or paraphrases the ACoP being sold back to businesses, giving them the mistaken belief that buying this so-called consultancy package somehow protects them from the law".* However, constraints were not only reported to arise from 'external' sources. Some were internal and directly relevant to the initiatives themselves.

### 4.5.2 Initiative structure and content

In some cases the initiative's structure and content impeded its impact. This was raised by the WSA Challenge Fund respondent, the structure severely compromised one of the initiative's core principles which was that WSAs were employed to promote partnership between workers and employers to identify and manage risks together, but not to be the means by which worker involvement occurred (Sanger & Woodrow, 2006). However this effect did not materialise: "*they'd had a great impact in terms of health and safety performance but they hadn't generated the kind of worker involvement that had been envisaged. So in one respect it had been a great success but in other respects it hadn't delivered in the way that was wanted…because of the turnover of bids from round one to round two, it was never entirely clear, apart from those bids that had gone through every year successfully, whether they'd developed a groundswell and whether they were having genuine long-term sustainable change*" and it also adversely affected inter-project collaboration: "*Because of the Challenge Fund structure, it was difficult to translate learning points and best practice from project to project*".

The content of the CDM ACoP was also identified as a major constraint to its understanding and therefore its use: "*it's felt to be far too long, its reading age is far too high for what is, in general, a comparatively uneducated workforce compared with the working population as a whole*". Another important constraint in many cases is relevant to bureaucracy associated with many initiatives.

### 4.5.3 Bureaucracy

Internal and external bureaucracy was a big burden for many of the initiatives. Internal bureaucracy was evident within the WSA Challenge Fund from an-going operational perspective: "*The bureaucratic structure of the Fund itself was in some respects its own worst enemy and in terms of day-to-day administration*". With OHSAS 18001, external bureaucracy and red-tape was identified as being more problematic than the initiative's content: "*The biggest issue is getting over people's politics... It isn't the technical issues; they're not a problem... The barrier is very much political about stopping it...I've had very little technical arguments, they've nearly all been political*".

SME perception of the initiative as 'another' piece of bureaucracy was raised by the Fit Note respondent: "*anything that's a bureaucracy they find slightly harder*". So in this case the perception of any initiative which requires administrative change at the beneficiaries' end presented an initial potential constraint on its effect. Finally, personnel attrition also impacted initiatives negatively. This was mostly due to over-reliance on certain people.

### 4.5.4 Personnel attrition

In several of the initiatives, over-reliance on select individuals was a constraint, C3HARGE being a case in point: "*Each of the industry initiatives is run by the industry, it's usually run by a scheme*

*champion from one of the trade bodies and that's both a success and a failure really*". Likewise in the case of the WSA Challenge Fund, the input of key personnel was critical to its operation and ultimately therefore its success: "*because the bids were predicated around two or three people having a role... So if you took any one of those three individuals away, by the time their replacement came up to speed, it was almost the end of the project round*".

Similarly the COSHH respondent identified how internally high staff turnover can be troublesome from a policy development perspective: "*So HSE as an organisation a number of years ago sort of lost a lot of expertise when the head office moved up to Merseyside and... that policy group of people sort of left the organisation*". Likewise organisational restructuring within the regulator was identified as an internal constraint by the C3HARGE respondent: "*at a time of reducing resource and fewer people in HSE ... those that are left being stretched and having to do more - that is a significant internal challenge*". The following theme details the numerous challenges that initiatives faced, often more long term and intangible in nature.

## *4.6 Challenges around the initiative*

Five key aspects were identified as challenges: time, measurement, perception, engagement, and supply and demand.

### 4.6.1 Time

Time represented a challenge in terms of attempting to get the initiative's policy makers/developers (and its intended recipients) to apply it themselves. In the case of CCNSG, the releasing of employees by their employers to attend the compulsory training component of the initiative was a challenge, since in the eyes of the employer time equates to money which is a somewhat short-term orientation.

Having patience with the process the initiative follows and then patience for it to deliver its anticipated benefits was also initially problematic. The nature of the issue and the time required to address it adequately was typified by the WSA Challenge Fund. Conversely the superiors of the Fit Note's developers and implementers (potentially informed by Dame Carol Black's review) were more receptive and appreciative that the issue at hand (identifying the positive links between work and health) would take a longitudinal approach: "*my directors have a view and a feel that it will take probably ... five or so years to kind of really get where we want to get, with the use of the Fit Note*".

An allied challenge associated with time, was measurement, in terms of: attempting to prove the longitudinal effects an initiative had had, matching the method of measurement to the nature of the issue, and attempting to measure latent health issues.

### 4.6.2 Measurement

A major challenge across initiatives was measuring their impact and effectiveness; particularly when trying to evidence causation at the practice level. This issue was succinctly captured in the CDM ACoP: *"In terms of delivering outcomes from the industry, we get into areas of difficulty here of establishing cause and effect".* The hazardous nature of the substances COSHH addresses was also noted as being conducive to long-term measurement: *"I don't think we can fully appreciate the impact (of the regulations) because of the latency of the diseases involved*".

Attempts to measure the effects of an initiative on occupational health were also identified as troublesome, with the views on tangibility and latency being recognised by the C3HARGE participant: *"If the policy was to secure improvements in ill-health…it takes longer to realise the benefit, especially with a chronic disease like silicosis... So there's always this argument about the incidents that we've got now is a result of historical exposure you know, sort of 20 years, which is partially true*". Similarly, the difficulty of measuring the initiative's impact on this topic was also mentioned by the Management Standards' respondent: *"I think it's a very difficult one to get good data on...we have quite a lot of local success, i.e. at the organisational level, but when you're dealing with national data, it doesn't always come through; it gets lost."* In addition to trying to quantify or qualify an issue and capture the effect of an initiative, often an initial obstacle was the perception of stakeholders and the intended recipients towards either the initiative, the issue it attempted to address, or a combination of the two.

### 4.6.3 Perception

The perceptions of relevant stakeholders such as policymakers or developers towards the issue(s) at hand in terms of the credence and credibility they gave it, was a challenge in some quarters. As illustrated in the cases of the Management Standards (initially) and Fee-For-Intervention, respectively, the HSE's Field Officer Directorate (FOD) Inspectors were resistant towards the initiatives' principles: *"Certainly at the time we started there was a great deal of resistance from our field force that they did not believe that HSE should be dealing with this issue ...because it was in their eyes a soft issue, you couldn't take prosecutions and therefore not necessarily a suitable topic for HSE inspectors to inspect on."* However, the FOD's stance on the 'soft' issue softened somewhat: "*that attitude has changed significantly as inspectors got experience of working with organisations... inspectors came to understand the relationship between psychosocial risk factors and other health and safety issues, mainly accidents"*. However, in the latter case of Fee for Intervention it did not*: "A number of them have already voted with their feet and gone".*

The credence given to the issue the initiative was attempting to address was also an issue externally among parties upon which it was aimed and upon whom its success largely depended on. In some circumstances these parties opined that the issue was not within the scope/remit of their role. In the Institute of Directors' case, the major issue was trying to get OSH on Directors' radar: *"perhaps their perception of health and safety was one that they hadn't thought about in a leadership context"*, most probably because of their perception of occupational health and safety *"which they thought was technocratic and boring".*

Similarly, for many of the intended beneficiaries of the initiatives (i.e. the clients), attempting to get these parties to both register and ingest the initiative was a challenge, as the CHAS respondent explained: *"(the challenges) still exist today, …changing mind-sets particularly with safety professionals is quite or can be quite difficult to ask... the mind-set of many health and safety professionals was 'I've always done it this way, so why do I need to change?'".*

Clients' perception of not only the issue but also the issuer was a further challenge in some cases. For example, when trying to roll out the WSA Challenge Fund among SMEs, "*the perception of HSE was not necessarily very high within the SME sectors... in some cases... they had had no understanding of who HSE were and what their role was. In many cases the best that they knew of HSE was in relation to the large-scale rail accidents".* Conversely, however, in some cases the perception of the issuer and the initiative's 'brand' appeared to facilitate its success. With C3HARGE, the forum's alliance with the HSE gave it a certain prestige among trade association members: "*They all value HSE's involvement and name on the finished document... if they can get HSE's name somewhere on that document, then they've cracked it as far as they're concerned".* This was also evident in the case of the DWP Occupational Health Advice Line where the respondent revealed a similar initiative, Workplace Health Connect, had received a preferential reception from users because of its connections: *"one of the benefits that was associated by users of that service was the fact that it was linked and supported by Government".*

However perception was found to be only part of the picture, often even if awareness of the issue/initiative had been raised and stakeholders 'bought in' to its premise, getting these individuals to engage with it was a further challenge.

### 4.6.4 Engagement

Trying to secure engagement among an initiative's intended recipients was an issue for many of the initiatives, particularly when the recipients were SMEs. As the interviewee on the DWP Occupational Health Advice Line noted: *"small businesses particularly, for the first two years of their life, if not longer, are purely focused on survival".*

Other challenges identified when trying to engage with this group were their dispersed nature. This viewpoint was raised in the CDM ACoP interview: *"The difficulty we have is that the problem with engaging with SMEs for a regulator is quite acute when it comes to the construction industry, because the industry is very fragmented".*

The interlinked web between awareness and engagement was touched upon by both the CDM ACoP and the DWP Occupational Health Advice Lines Service interviewees in terms of SMEs not being aware of the initiative and having no engagement with it until there is an expressed need for them to be engaged. A final challenge, related to initiatives' usage, was supply and demand, where in some cases the initiative was a 'victim' of its own success.

### 4.6.5 Supply and demand

A more minor but still noteworthy challenge identified was that an initiative's previous performance or output had raised subsequent expectations about its future delivery which, in light of restricted resources, could be problematic, COSHH being a case in point: *"as a regulator and as an organisation, we've tried to be too helpful, ... we've almost given people too much guidance"*, and this was identified as being a future challenge: *"HSE simply doesn't have the resource to keep updating and amending either legislation or in some respects the guidance".*

Allied to this point, in C3HARGE's case, previous high performance can bring challenges, with impressive past performance an indication of future delivery in the eyes of some clients: *"Another challenge to someone like me is that a time comes when their demand far exceeds anything that you can supply".*

Having identified and discussed several challenges, the last two themes focus on aspects of success, in terms of what facilitates success and associated indicators in terms of what constitutes success.

## *4.7 Success facilitators*

Various factors were identified as facilitating the appropriate delivery of a policy initiative, its on-going development and ultimately whether it effected the change in the target group envisaged and facilitated its success. These included top-down support, responsibility, dialogue and dissemination.

### 4.7.1 Top-down support

Support from superiors was a key facilitator - from both politicians with governing power and from the senior management of government bodies. Political backing, for example, facilitated the launch of the WSA Challenge Fund: *"it does require not only the political will to make it happen but to put the resources behind it"* with the respondent identifying support for it at both at the macro level of the powers that exist: *"The Labour Party and the government at the time ... were very keen to see it go forward"* and from a prominent and influential stakeholder within the health and safety 'arm' of the government: "*The HSE Chair at the time was Sir Bill Callaghan who was very keen to see it succeed".*

Following this facilitator through it was evident how political will can sway the future direction of many initiatives: *"It's much more about delivering the government's priorities and that's largely around better regulation than it is about looking genuinely at improving workforce engagement".*

As with the issue of worker involvement, a governmental change in orientation away from the issue of work-related stress clearly had repercussions for the future of the Management Standards: "*The change in administration clearly is one reason why this area is no longer a top priority", "We can't ignore the political perspective and obviously policy tends to react to political aims and objectives that are set for the organisation, the strategies... the stress priority programme sort of petered out in 2010".* A shifting culture and general attitudes towards health and safety in government was also evident across several initiatives, with a deregulatory agenda being alluded to. This was encapsulated by the following responses of the WSA Challenge Fund and the CDM ACoP interviewees: *"The political will of the time, the government had moved from this kind of proactive, revitalising health and safety approach, which was very much let's target new ways of doing things, let's try and get into small businesses... Towards much more of a better regulation, reducing burdens on business approach".*

However, interestingly, in the case of some initiatives, the government's 'better regulation' viewpoint was not shared or endorsed by the recipients/beneficiaries of initiatives. For example, as the C3HARGE respondent explained: *"the current administration laid into health and safety big time, saying it's a burden and you know we want deregulation and all of the rest of it. In fact, a lot of... well I*

*think virtually... all the industries represented in C3HARGE had a completely opposite view. As far as they're concerned you know, go away government and just let us get on with it because what we're doing we're doing because of a legitimate reason for doing it... it's not red tape as far we're concerned, it actually yields a real benefit".*

Seeing the potential benefits of an initiative and then actually following through and making those benefits materialise was also an important facilitator.

### 4.7.2 Ownership

Having personnel with appropriate knowledge and commitment was identified as being imperative both at the developer level and at the practice level (within the target group).

Being responsible and committed was of paramount importance internally among stakeholders. Shared responsibility and ownership for conveying the message and principles of the Management Standards were a pre-requisite among its intended beneficiaries: "*You know, if you're going to do this effectively it's got to become part of everyday management and not a sort of standalone initiative"*. Similarly in the CDM ACoP's case among the recipients, it has to be promulgated *"as part of your business management rather than it being a bolt-on".* Thus, it was evident from participants' responses that internalisation and ownership of the initiative, rather than superficial compliance with it, brought benefits. The ethos of several parties being actively involved and communicating with one another was also evident as a facilitator, within the subtheme of dialogue.

### 4.7.3 Dialogue

As noted within the 'influences on policy type' theme, appropriate consultation and due diligence is a key constituent part of the policy process, in some cases being a mandatory requirement for the initiative to happen. In other cases where consultation was not obligatory, the dialogue which emanated from parties facilitated the success of an initiative.

For example, in relation to CCNSG, at the developer/implementer level having an appropriate forum in which to consult and air views was identified as a key lesson for the Safety Passport's on-going growth: *"we've got the CCNSG, the Client Contractor National Safety Group that meets 3 or 4 times a year and its vital to have that avenue where people can cooperate with each other".*

Likewise, the consultative structure of C3HARGE was conducive to facilitating its on-going development as it provided a platform whereby the forum developers could openly have dialogue with the scheme's clients. Consultative working was generally considered to be advantageous in terms of both working practices and the output delivered. However, conversely, it was also identified as a potential constraint to the end product: *"But we've also got examples of where ... and I think the CDM ACoP is one of them; we had too many fingers in the pie".*

Allied to the previous point around the plethora of parties involved in the policy process, the Fit Note respondent also revealed an insight into effective policy planning from the outset: *"It's important to think of all the parties that you need to involve from the beginning. So just don't think of it internally only or don't think of it in terms of government-only but think of everyone who will be impacted in terms of a policy change".* The fourth and final success facilitator was, as expected, the initiative developers' openness to its dissemination.

### 4.7.4 Dissemination

An important facilitator identified was that often one initiative alone cannot achieve its aims and may require supplementary assistance and openness to possible dissemination avenues. This was highlighted in the case of the Management Standards: *"we took the decision early on not to exclude them (consultants). In fact, we encouraged them to use our material within their own businesses... And the rationale for them we believed was it was an amplifying factor in that yes, they're out there making money but they're also propagating our message... that I think was again a key lesson for HSE that you can use external consultants constructively... in this particular initiative I think it's quite a success the way we use them to our own advantage".*

Likewise in the case of Professionals in Partnership, in addition to promotion via the IOSH official magazine and website; to relevant universities; and also at the IOSH and BOHS conferences, the representative from IOSH noted the body's other wide ranging and successful dissemination activities, for example, *"Presenting a paper on the initiative at the International Congress on Occupational Health (ICOH) at Iguassu Falls in Brazil in 2003", "Registering and posting the project on the government website (SH2)"* and *"Publishing an article on the initiative in 'Occupational Health Review'",* as being a success.

Related to the factors which assist an initiative in being successful, a main theme emerged around 'what does success look like?'.

## *4.8 Success indicators*

There was a plethora of differing views across initiatives about what constitutes success. From the perspective of those developing or implementing initiatives, the following indicators were regularly raised: targets, uptake and satisfaction, acceptance, internal impact, working partnerships, and bottom line benefits.

### 4.8.1 Meeting targets

As the drivers theme outlined, several of the initiatives by nature of their inception were target driven, with success being quantifiable and thus open to objective measurement. Therefore, in numerous cases when the respondent was probed about the success of an initiative, the answer equated with the meeting of targets. However, participants aired caution about using aims as the sole barometer to ascertain whether an initiative could be deemed a success.

Within C3HARGE, the respondent identified that the reliance on using targets as a solitary success indicator was flawed: *"the easy gains have been made now...it's always you know, sort of when you're left with the last 20%, that's the most difficult bit to tackle".* In addition to the meeting of internal targets, the reception an initiative got at the recipients' end was also considered by respondents to constitute a partial success.

### 4.8.2 Uptake and satisfaction

The level or volume of uptake among the target audience was also used as a measure of success. When questioned about the successes of the CCNSG and CHAS schemes respectively, respondents stated: *"I think why CCNSG has worked so well ... there are about 42,000 people a year who go through CCNSG at the moment, that figure has been quite consistent for some time"* and *"now we have 500 over 550 buyers with 8,000 registered contractors".*

In other cases, the end users' satisfaction with the service delivery approximated success. For CHAS, this was in the form of quality control (a quality-control process is in place that checks between 5-7% of approved applications. In other cases, the mere prolonged existence of an initiative was often considered a constituent success proxy.

### 4.8.3 Acceptance

Again, from the viewpoint of those developing/delivering the initiative, the longevity of an initiative (particularly in light of adverse contextual factors) was often viewed as indicative of success. Related to longevity, in many cases an initiative's existence and regular usage, meant often it had become institutionalised into an organisation's 'way of doing business', as highlighted with the CCNSG Safety Passport: *"I think overall it's (CCNSG) just regarded as a standard practice, it's like you know it's like HGV drivers have got to have certain types of licenses and different people have got to have different types of qualifications to do different things, it's just one of those things that part of the working landscape".*

Acceptance 'within industry' was also considered to constitute a success for the Management Standards: *"it was successful in terms of it has almost become a de-facto standard in the UK".* Allied

to this point, and another success indicator in the eyes of the stakeholder interviewed was its imitation: *"Others have learnt from us and are adopting the approach, as you probably know ...".* Toderi et al. (2012) found that the Italian version of the Indicator tool is strongly consistent with the UK version and may be used for the screening of psychosocial risks in Italian workplaces.

Though potentially an unintended success indicator, across many of the initiatives, the impact the initiative had in terms of internal change (i.e. attitudinally or behaviourally) was considered to be a barometer of success.

### 4.8.4 Internal impact

Several of the initiatives were considered internal successes, in terms of widening the developers' (and their superiors') perspective on a particular issue. In the WSA Challenge Fund for example, the respondent argued: *"I think it gave us (the HSE) a much better understanding of what we meant by worker involvement... some of the lessons that came out, some of the good practice that came out from WSA was quite influential in working out what worker involvement meant for small and medium-sized businesses".* In this case, although the Fund ceased operation in 2007, the views of the respondent demonstrate that it did meet with some success in terms of having wider positive implications for the HSE.

In the case of the Occupational Health Advice Line, "*There's a greater recognition in DWP and across government about the importance of intervening early"*. Similarly, Making the Market Work was considered an internal success, because it acted as a catalyst for the Association of British Insurers to think more widely about dissemination activities to SMEs: *"the amount of interest from trade bodies, and just the general desire for more information to be out there on insurance products which we probably hadn't identified previously".*

In C3HARGE's case, the success indicators raised were not concerned with the outcomes it originally intended to affect but its wider reach across the HSE: "*I think the benefit is that through it, it enables a low amount of HSE resource to produce a disproportionately large impact…Through C3HARGE and similar bodies like it, you can actually sound out people and get views, which can help form policy".* The reciprocal nature of initiatives was also considered to be a success indicator when it assisted in developing working partnerships.

### 4.8.5 Working partnerships

A success outcome and indicator which emanated from some of the initiatives was that some acted as a vehicle or 'bridge' to improve relationships between the initiative developer and other related parties. In the case of the Directors' guidance for example, it helped improve existing relationships: "*Perhaps it improved the reputation and dialogue between IOD and HSE at that time".*

Whereas with regards to the WSA Challenge Fund as already alluded to, the success of the fund was in terms of social partnership. An additional by-product of these relationships was that the parties on either side had a more informed and educated view of one another's roles and responsibilities. Again staying with the WSA Challenge Fund: *"One of the things it did do was give a degree of what one might call demystification for both sides. So the trade unions for the first time got to see the pressures that some of these local groups are under, got to see how the PCTs were operating, got to see what initiatives and what pressures local authorities had to deal with. At the same time, a lot of these social partners got an understanding of how trade unions operate, got a feel for what the drivers were, got to see people working up close".* The final success indicator subtheme was the degree to which the initiative yields a benefit (often material) for its intended recipients.

### 4.8.6 Bottom-line benefits

The success outcomes for the intended beneficiaries of the initiatives (i.e. the clients) were often considered in operational terms. For example, with OHSAS 18001, *"Implementing the policy and standards has been very, very useful and productive and has given great benefits…making the people who run an organisation...take ownership of the risks and establishing the policies for those".* Similarly in the following case the business benefits which emanated from the proper use of the

initiative were expressed: *"The Management Standards approach worked at an organisation level, certainly organisations that used the approach and used it well made significant improvements in their management and as a consequence (had) reductions in absence, turnover, etc.".*

The financial benefits clients derived from using an initiative weighed against their initial outlay was also considered to be a success factor for the initiatives' users. With CHAS, a success indicator was not only the cost savings the scheme produced in isolation but also how those savings have been escalated more widely, as the respondent explains: *"The CHAS principles, ethos process has now been embraced within an umbrella organisation called Safety Schemes in Procurement; that is a huge success whereby now we are not just talking about CHAS making savings we are talking 25-26 different schemes all doing that, so that's a huge success".*

Having explored the history of the OSH landscape in the UK, the emergence of various types of stakeholders and policy initiatives and the drivers, barriers and success factors of these initiatives, it is time to turn to the current OSH era to explore constraints and opportunities within it and the views of stakeholders on the optimum OSH landscape and how to achieve it.

# 5. Stakeholder perspectives on changes in the OSH landscape

From the 1972 Robens report onwards, the UK OSH arena has witnessed a step-change away from a purely legislative approach towards shifting responsibility to employers and other parties. As the preceding stages of this research have highlighted, it is clear that the political climate (e.g. better regulation and resource constraints), the impact of austerity (e.g. measures taken as a result of two recessions), major industrial accidents (e.g. Flixborough) and the emergence of various new risks (e.g. psychosocial risks) have elevated the importance of OSH among enterprises and their stakeholders and thus have significantly impacted on the actions taken by these parties.

In addition, it is clear that there is a mix of what could be deemed 'traditional' stakeholders (e.g. government agencies, trade unions, employer organisations) and 'new' stakeholders (e.g. insurers, professional associations, standardisation bodies) who are active in the OSH arena, highlighting the breadth of stakeholders and the multiplicity of their interests.

Thus the next stage of this research aimed to explore stakeholder perspectives on recent changes in the OSH landscape in the UK, following the two major reviews of Young and Löfstedt and subsequent reforms; and to explore the views of a range of stakeholders with regards to whether, and how, recent developments in OSH in the current era have had an impact on OSH stakeholders and OSH standards. The findings presented in this section are based on forty semi-structured interviews conducted with various stakeholder groups involved in OSH in the UK, and two stakeholder workshops (for a summary of key findings, see Annexes 4 and 5).

## *5.1 Changes relating to OSH*

The theme changes relating to OSH described both broad factors that had an impact on OSH, and specific changes within OSH, the motivation for these changes, issues regarding the process of change, and the immediate outcomes of changes.

### 5.1.1 Broad macro factors

Many broad factors influence OSH at both the policy and organisational level, including social, political, and technological changes. Many stakeholders referred to these issues, indicating their importance. As a determinant of many of these factors, it was unsurprising to often hear of the change in government. For example when asked about the biggest changes in OSH, a training body interviewee commented: *"Probably the change in government. With the way the Conservatives view health and safety… is not in a good light really. It has more political influence on it than it had in previous years, which links to funding. And the cutting back of the HSE inspectors and all things like that".*

The influence of the changing nature of work was also discussed. A member of a trade association suggested that labour force dynamics had implications for OSH management: *"globalisation and cultural aspects within the workforce […] you get immigration and cross border movements within the EU, that's your workforce. At a certain level it's far more diverse and that has effects with it in terms of how that sector of the workforce accesses ill health and also their training".*

Perhaps the most commonly mentioned issue was the current economic climate and the impact that this has on OSH standards. A standardisation and certification body interviewee suggested that a shortage of resources would negatively affect people's decision making in relation to OSH issues: *"The austerity […] and the effect on people working and how they will work and what jobs they will take on, and how they will do them".* Possibly as a result of the economic climate and a government orientated towards economic growth, changes were also noted in labour related legislation, which impacted OSH. As one employer representative mentioned: *"The changes to employment law actually are having much more impact on issues around health and safety, and health and safety legislation, than [changes to] health and safety legislation. Yes, things like flexible working, means that shift patterns and so forth are more difficult for business to accommodate*".

These broader level factors have in many cases had a direct impact on governments' policy decisions regarding OSH.

### 5.1.2 Changes in OSH policy

Many interviewees discussed changes that had happened in OSH policy making. These included: the government's agenda to reduce red tape; government spending reviews and associated reduction in budget to HSE; the fee for intervention initiative to address this shortfall; the review of ACoPs; and the focus on high risk sectors (prioritisation).

Commenting on the government's general deregulatory agenda one academic noted *"the key change […] is the government policies to reduce red tape".* These policies resulted in a number of changes including budget cuts to HSE, as described by a government official: *"when the current administration came into power they carried out a spending review […] That had significant repercussions on HSE as a regulator in as much it slashed their budget by about 35%... which obviously has repercussions on the number of staff it employs".* In response to these budgetary constraints, the government has implemented certain tools for the HSE to make up this shortfall, including the fee for intervention initiative (HSE, 2012) whereby companies pay a fixed rate to HSE if a material breach is found in relation to their business activities.

One of the key areas of debate around the reviews has been the revision of ACoPs, proposed in the Löfstedt review. This was discussed by interviewees as one of the biggest changes. Other issues were also discussed however by a fewer number of interviewees. These included efficiency of the HSE and: *"the idea of focusing resources on so called high risk sectors"* (academic); challenging the role insurance and compensation claims have had in deteriorating the standing of OSH in public perception: *"the last thing I think that is happening and everyone is trying to fight it a bit, is the continued growth of no-win, no-fee legal suits"* (trade association interviewee); and: *"the decision to increase the days required of absence for reporting under RIDDOR from over 3 to over 7"* (academic).

### 5.1.3 Motivation for change

With substantial discussion of different changes enacted by policy makers, stakeholders were keen to discuss potential motivations for these actions. This subtheme describes the key perceptions offered by interviewees including two broad strands: whether the changes were evidence based and whether the changes aimed to alleviate a burden on business.

A central subtheme was whether these changes were in the best interest for OSH, and therefore evidence based. Many stakeholders suggested that the actions of government sent contradictory messages, indicating at first glance that proposals were not supported by strong evidence. For example, a trade association representative argued that despite a statement that guidance needed to be improved to make it more useful to business, government had reduced the amount of guidance available: *"where they start reducing 50 pages down to 11, again it seems to be a reverse logic. People are then going to go to a guidance document expecting to find well-structured guidance, only to find that it's been watered down, and is even more ambiguous. How does that work?".*

There is of course a debate around better regulation, and whether less regulation can be used as a way of achieving policy goals. However, interviewees were quick to point out that the government's agenda did not look like it was removing requirements after detailed consideration. As one professional association interviewee noted: *"There is certainly no harm in looking through what we've got and what we do. That's a very healthy and positive thing. But the government took their own spin on that and did what they wanted to do on that, rather than looking more objectively and basing it on evidence".* This view was also shared by union officials: *"the fact that [there was a proposed] health and safety framework which talked about a change in regulation, preceding Professor Löfstedt's review, that in our view substantiates our perception that this is very much a sort of deregulatory dogmatic approach rather than looking properly at the evidence".*

This argument stood alongside the proposition that a conservative orientated government would seek to deregulate because of its political ideology, rather than the provision of evidence. One consultant supported such a view: *"I think it's political, […] when the elections happened there was a clear push to deregulate and strip the place of regulation. Some of that's not a bad thing … but if you're kind of rushing into things just for the sake of it, because of political ideology, then it's not evidence based, and it's not the best thing".* An employer's representative added: *" I don't subscribe to that problem*

*that health and safety is just a series of cheap shots in the media… There's an ideological movement against regulation and health and safety is one area that is getting it in the neck".* Indeed the view was raised that *"…health and safety is core to the politics of this country"* (government agency). An academic also shared this perspective: *"incredible that one of the first things that the coalition did was to set up the Young review, that's in I think 4-5 weeks of forming government which is quite astonishing really*." This trend was noted by a second academic: *"every time a conservative government has come into power, reducing red tape has been a priority. When Thatcher came in in 1979 the recruitment to HSE was frozen for 4-5 years, this has happened always. I think that health and safety has been particularly vulnerable"*.

Linked to the politicisation of OSH is the notion that OSH policy has developed a reputation for being excessive, and being seen to tackle the issue is likely to garner public support. As such, these changes could be understood as an attempt to alter the public perception of OSH rather than any legitimate issues with the system. A representative from an employer's association supported such a notion: *"a lot of reforms […] it's not about improving health and safety performance, reducing the number of injuries in the workplace or work-related ill health. Actually it's about improving the public perception of health and safety"*. Despite these arguments, interviewees pointed out that it was unlikely that government would undertake changes without some form of backing. One academic suggested that the government may be getting its evidence from close lobbying circles rather than relying on objective evidence: *"It is evidence based because of the industrial and the SME people that conservative politicians meet on their daily round. The objective evidence is actually somewhat different".*

While the need for evidence based policy was universally expressed, several stakeholders were quick to point out the significant gap in robust evidence and the difficulty in making these decisions. An employer's association interviewee commented: *"the quality of the impact assessments has been woeful, […] and I don't think that's the fault of the economist, I think the economist has to work in a very difficult environment, and so many of those impact assessments, you're reading the economist saying 'well basically we've got no idea as to what the cost and benefits are likely to be"*. Much of the policy literature explored in the previous stages of the research also reached similar conclusions suggesting there is a real need for higher quality research.

Many of the messages from government in the build-up to some of the aforementioned changes, referred to OSH as a burden on business (Young, 2010; Löfstedt, 2011a). The main premise of the argument states that stringent OSH requirements are resource intensive and inhibit much needed growth. As such, the government's ambition for these changes is to free businesses of these burdens. However, there was a notably mixed response from stakeholders regarding whether this proposition is valid.

An insurance organisation interviewee responded that they were unaware of any organisation to report OSH as being burdensome: *"We have never had it put to us that it is a burden, and even when we expressly asked about it".* A government agency stakeholder added: *"all the industries that I have had dealings with, those who were sort of thinking ahead, didn't see occupational safety and health as a monster. They actually saw it as a benefit to their business".* Indeed another government agency official suggested that business may actively disapprove of the removal of inspections as inhibiting their ability to compete: *"I know those industries cried out and said 'hang on a minute, we don't agree with that [reduction in inspections] and we want inspectors to continue to visit to ensure we are all on a level playing field […] when it comes to complying with the law'. I thought originally they'd be over the moon when they said 'we're not coming around to you', but quite the reverse was the case".* While a professional association participant argued: *"We still live in a society where I'd hope that if you spoke to 99.9% of the population and asked them if they want to work in a workplace that is healthy and safe, they would say 'yes'".*

Indeed evidence suggests that organisations do not view OSH as a burden, as noted by one consultant: *"if you look at sort of business survey type information that was published, it [concerns with OSH regulation] generally came a long way down the list, as one of the issues that was affecting industry*". Indeed one employer association representative noted that where cost savings had been identified, they were close to insignificant: *"I think the RIDDOR reform worked out at saving us something like £3 a business, and the self-employed change something like £2-3 savings for business and the economy. Well, in my view, that's not necessarily reducing burdens on business".*

Given these opinions, it is interesting to consider where the perception that OSH is burdensome derives from. One trade union interviewee was of the opinion that, as in the above subtheme, it was traditional beliefs that went unquestioned: *"[on the view that OSH is a burden] Well what's your [government's] evidence for that, because it's not obvious to us that that's a correct statement. And these government ministers can't produce any other reason other than the BCC or the CBI says it's true. And you say to them well what's their evidence, and they can't produce any evidence".*

Thus, it appears while many stakeholders believe that OSH legislation is not burdensome, there is a perception that it is. A misunderstanding of legislative requirements could account for this discrepancy since these misunderstandings persist and lead to the negative perception of health and safety: "*there's a lot of hot air about it and sometimes there's a lot of repeated misconceptions. For example the myths, a lot of it is just recirculating old myths and keeping them in the public eye and it becomes reinforcing rather than saying this is a myth and it isn't really like this in the real world. You hear this story, what the myth was, and it's so ridiculous in the head, and people still think that health and safety is being stupid"* (consultant interviewee).

In relation to this, many stakeholders felt that the media had been instrumental in preserving that image, as a representative of government agencies noted: *"certainly health and safety gets a bashing from certain parts of the media. The majority of that is ill-informed*". An employers' association interviewee also shared this view noting: *"public perception is primarily driven by what gets written in the Daily Mail".* As one insurer noted: " it is created to some extent, I wouldn't say to a large extent, but to some extent by the media, because scare stories, exaggeration, incorrect perceptions, sell copies". Another argument as to why the perception that OSH was burdensome was maintained, was that, at first glance, it would seem that investing resources in something which is mandated by law may be perceived as unnecessary: *"it has a very common sense appeal because you know OSH law requires employers to do something which they might otherwise not do […] the common sense logic to saying that also entails costs for employers"* (academic interviewee).

While these arguments would suggest that OSH requirements were not considered burdensome, some stakeholders disagreed with the above notions. One perspective was that while large organisations might cope with these requirements, smaller organisations would struggle: *"large businesses tend to have well supported advice and health and safety departments. In that regard, the sort of perception that health and safety is a burden isn't necessarily the view held within the organisation. They would actually view it as an essential component of a successful business. Perhaps the perception of safety being a burden and the need for change, was from SMEs and small businesses".* A government agency representative sympathised with these comments however rejected the term burden: "*certainly from a local authority perspective working with small businesses, they do see them as a burden […]. I think the word burden is political […] it's unfortunate that that word burden has been there".* Although, one consultant disagreed with the view that OSH regulation is a considerable burden on SMEs, stating that research showed SMEs to be open to regulatory activity: *"there are other studies around that say that small business quite like regulators come and tell them what they should be doing, you know sometimes it's viewed as a help".*

Another interesting perspective shared by a government agency representative was that whether OSH was perceived as a burden depended on how it was approached: *"if you just look at it though as a tick box then it will always be a burden, […] you have to make some investment before you realise a benefit. I think a good business that's run well, that looks after its people properly, that has proper processes and procedures in place to manage its plant etc., shouldn't have too much of a problem complying with health and safety law. If a business is badly run, doesn't look after its people, has a terrible approach to general housekeeping etc., then it probably will find it difficult to comply. But that's not because health and safety is a burden - that's because they're a badly run business".*

It is important to bear in mind however, that OSH legislation is for the most part implemented because it serves an important goal. As noted by one trade association interviewee: *"regulation does not just come about because somebody has a hunch. It comes about because people perceive there is an issue that needs to be addressed, and what emerges out of long periods of consultations with stakeholders, trade unions, the manufacturing industry, [and the] health and safety industry, is that actually 9 times out of 10 it's well worth having".* Thus, perhaps the primary criteria to evaluate OSH policy should not be whether it is burdensome, but whether it is useful in protecting society.

### 5.1.4 Process of change

Several interviewees referred to the process of change in OSH, including issues with regards to how changes had been conceived, devised and implemented.

Much was said regarding the reviews which were instrumental in beginning a series of changes (Young 2010; Löfstedt, 2011a). It was felt that these reviews were politically driven, and their validity was questionable, as one commentator from an employer association noted: *"Lord Young's report was […] nonsense, was very very partial, it was informed by a piece of research […] on behalf of Policy Exchange which was very very badly researched, poorly researched. The evidence that he used and cited was very very select, and it was politically driven"*. Similar comments were made regarding the subsequent Löfstedt review, with many stakeholders finding it to be lacking substance.

While the reviews themselves were questionable, so was their application. Stakeholders reported concerns that the reviews were being misquoted, as one union representative noted: *"The difficulty with the Löfstedt report is the way that the government has interpreted it and gone beyond it really. So the government attempted to use the Löfstedt report to justify the government's desire to make cuts in health and safety that Löfstedt hadn't actually suggested"*. Furthermore, it was suggested that government had a track record of ignoring government commissioned reviews. A member of the judiciary and legal services commented on Dame Carol Black's 2008 review: *"generally I'm very much in favour of what the Black review said. I think it was a highly competent inquiry […]. What worried me was that these things were not really taken up by government, to the right extent"*.

A second emerging area is a concern over the government's apparent disregard for recommendations from consultations. For example, a member of a trade association argued: *"certain parts of central government are making this up very quickly, and [there are] conflicting messages. They consult say the health side, and the medical side, and the professional safety practitioner side, and probably to a certain extent the HSE, [and] then seem to come out with a totally opposite view…the consultation exercises are a complete sham. They've [the government] decided what to do, and they will make the consultation responses fit the bill… and the process is deeply flawed"*.

An additional concern were attempts to change the policy making process, in areas such as consultation. The motivation behind these changes was unclear, with some stakeholders suggesting that it was to be able to pay lip service to the process of consultation while pushing through already established agendas. As one professional association representative noted: *"in the consultations for example we usually get 3 months to consult with our members and create our response to submit. So now that's changing. The HSE no longer have to consult for 3 months. I've seen them do very much reduced ones. Because there are so many, they are having to get them through as fast as they can. So we worry that the value of the consultation process is massively decreased, and wonder whether really the consultations are a tick box exercise, where the decisions have already been made."*

Perhaps a comment by a consultant best sums up concerns of the process of change: *"at the end of the day I think it's quite right to review ACoPs and to make sure they're fit for purpose, I haven't got an issue with that […]. But when you see the way in which it's being done and the speed at which it's being done, and you look at the response to the consultation, you wonder if it's being done in a way that's objective"*.

### 5.1.5 Outcomes of change

This subtheme related to immediate outcomes of the current changes and discussions around change, including the scope of changes, uncertainty created by changes, inconsistency created by the changes, increased ambiguity into the system, and, finally, the increased burden which had been created by these changes.

Regarding the scope of change, many stakeholders suggested that the impact of the changes was limited. A trade association stated the changes were not as severe as first anticipated. In line with these views, the immediate impact of changes, in terms of OSH, also appeared to be minimal. A

separate issue was the notion that these changes had created a great deal of uncertainty, as many proposals are yet to be finalised. As one trade association interviewee, commenting on their opinions on the greatest impact of the change process, noted: *"the uncertainty of the changing landscape and the conflict and competing agendas that the changes seem to be related to"*. Much of this uncertainty can be traced down to a lack of clarity at the policy level, perhaps in relation to the lack of clear evidence.

A third issue related to outcomes, was the inequalities which stakeholders felt had been created. For example, one trade association interviewee discussed the discrepancy between enforcement bodies in that enforcement by the HSE would have cost implications whereas enforcement from LAs would not. A less mentioned issue, although seemingly important, was the fact that changes were introducing sources of ambiguity into the system of regulation, incidentally one of the reasons for the changes in the first instance. For example, an academic noted: *"this business of low and high risk industries. I mean I don't even know how you would identify a high and a low risk industry"*. Similarly a consultant mentioned there was considerable uncertainty about how things would work in the future: *"I don't think the explanation about what is a risk area, what is a risk business, has been that well documented. And I think that has created a lot of confusion for small companies like me"*.

The final issue brought up in relation to outcomes was the fact that a substantial amount of work had to be carried out by all involved to become accustomed to the new system. This may, in fact, detract from the purpose of the regulations which is to keep people safe. For example, a consultant noted: *"just keeping up to date with what's happening with deregulation, its impact on a company, is quite a big job. […] just looking at the scale of all the proposals, it's quite mind boggling really […]. When they are updated, it'll be a big job to do and there is a bit of bureaucracy involved in that, around updating all the procedures and documents to make sure that they have the correct references, which is a bit bureaucratic"*.

A professional organisation interviewee also expressed similar concerns, noting: *"There has been a piece of research on this which says with all the changes occurring and the government selling it as cutting the red tape. In actual fact it will have a huge and very financial time resource burden on the types of business that the government is trying to help. Because if they change an ACoP or merge an ACoP together, then businesses have to reinvest in finding out what those changes are and how they affect them. So, in actual fact, we're creating much more work. Whereas the reality is a lot of these ACoPs are actually being dissolved or consolidated with others, rather than the actual fundamentals changing. So it's not a good thing to burden businesses"*.

## 5.2 Emerging opportunities

With a number of proposals being discussed as well as on-going changes, one of the key areas of concern for this research was whether this would present opportunities for OSH and in particular to stakeholders. This theme, therefore, reflected emerging opportunities which stakeholders felt they could take advantage of, either during the changes or as a result of the changes. Interestingly many stakeholders reported the absence of any opportunities, often commenting that the opposite was true. However, four aspects emerged which could be considered opportunities: time to critically evaluate the OSH system; increased efficiency and effectiveness of the system; new strategic partnerships; and changing the culture of OSH.

### 5.2.1 Time to critically evaluate the OSH system

Stakeholders felt that having a focus on reform had brought increased attention to OSH, allowing for a critical appraisal of what needed to be improved. As one government agency representative noted: *"often you do need something like this to create the shift in thinking that ultimately delivers a better health and safety system for the UK. I think you could carry on doing the same old stuff year after year, improving it little bit by little bit, without taking a fundamental step back from it to say 'actually with fewer resources and a different approach we can still deliver a competitive yet healthy and safe economy'"*. Another government agency participant added: *"I think it was one of Obama's advisors who said, 'Don't waste a good crisis', and you know, innovative thinking will come from having to do things differently. And the changing landscape creates that opportunity"*. However, evaluation of the system does not necessarily translate into improvements. One academic shared the perception that there was a period of focus on health and safety, but they feared that perhaps the opportunity had not

been taken.

### 5.2.2 Increased efficiency of the system

In spite of the fears voiced above, some stakeholders commented on changes that were resulting in some positive outcomes. A representative of government agencies felt the reviews had enabled a more comprehensive and effective OSH system to emerge, removing some of the absurdities seen previously: "*Löfstedt's review has enabled a more systematic and comprehensive review of information, guidance, regulations, etc., which has to benefit the health and safety system in the UK".*

The reduction of the HSE's budget, although largely seen as a negative outcome throughout the interviews, was also commented upon as an opportunity in certain respects. As one consultant noted, this had forced the HSE to consider other ways in which to communicate information, namely improving their website: *"One of the positive things around shrinking HSE's approach to doing visits, it means they've had to beef up the internet side of things. So there's been a push to put information into a format that's more readily accessible and useful by business. That's quite good".* This approach to reduction in budgets was also shared by other stakeholders, although not all the operational changes were perceived as positive. For example a government official mentioned: "*the scale of the cuts is so big that [the HSE is] not left with a viable service. So it's forcing [them] to be more strategic, to look at other options; so joint working, shared working, even outsourcing of the work. I hesitate to say that all of that is positive, some of it is positive and new ways of working to meet new circumstances is obviously sensible".*

Fee for intervention was also perceived as an opportunity, in that it would add a deterrent for companies to motivate them towards better OSH management. As one union official noted: *"Another opportunity […is] the extension of cost recovery into field operations. The fee for intervention, we see that as creating, I suppose, a common desire to keep the regulator away, to not have the regulator visit, because of the potential costs if they, material breaches, are established. […] We are certainly using or trying to use the opportunity to say, 'look, we must […] make sure that health and safety problems are nipped in the bud promptly, resolved quickly, to everybody's satisfaction', so that the internal systems are stronger and more effective".*

### 5.2.3 New strategic partnerships

One of the consequences of changes in OSH reported by interviewees was a need for greater collaboration among them. As one union official noted, a common goal had been created which stakeholders shared and could use as a basis for working together: *"one of the developments that we think is positive is that, actually, it is provoking stakeholders from quite a wide range, that previously might have been regarded as, maybe, a disparate group, or not necessarily had some common goals. I think there are possibilities for new relationships that have been generated on the back of the common mutual concern about a deregulation that isn't evidence based".* This was noted by a government agency representative suggesting that partnership had always been a part of their work, however the changes had accelerated this process.

Stakeholders also discussed the proposed alignment of LAs under the HSE. This particular strategic partnership was thought to potentially lead to significant benefit in terms of OSH standards through prioritisation: *"the environmental health officer aspect of the enforcement, which is run by local councils, will come under the HSE. I think there is a benefit to be had from that. In that there will be a more focussed approach and it will be more evenly measured across the board"* (government agency interviewee). However, interestingly as described below, this new partnership was also seen as a potential constraint.

### 5.2.4 Changing the culture of OSH

The final subtheme emerging in this area, despite being mentioned less than other subthemes, represented a significant opportunity, namely addressing the culture of OSH. Related to the notion that OSH was perceived as a burden, due to factors such as the media, a few stakeholders commented on initiatives to alter this perception. A representative of government agencies noted that bringing a sense of proportionality to the OSH system would inhibit the idea that OSH was a barrier to

organisational growth: *"Prioritisation of health and safety, and, if you like, changing the national culture of health and safety as a consequence; so rather than being seen as the organisation that stops everything, being seen as an enabling organisation. So putting things in, like the myth busters panel etc., helps just to make it very clear that sensible health and safety is about running good businesses".* However, some stakeholders debated to what extent misconceptions around OSH really needed to be directly addressed. As a trade association representative argued: *"I think by paying too much attention to it, we give a credence it doesn't deserve. And this is why I was a little bit critical of the HSE for putting this 'Myth of the month' out, because that's actually responding to the flip flap in the Red Tops and I don't think it deserved the attention HSE gave it frankly".*

However, some respondents felt that with the increased publicity around OSH, this presented the industry with an opportunity to be proactive in voicing its success stories and historic achievements. As one insurer noted *"I am reminded to think about Monty Python and what the Romans do for us and what did Health and Safety do for us? And it took us from the Industrial Revolution to where we are now. And so if we are looking at how many lives were saved progressively, as new acts, new regulations came along etc. Even if you only go back to the Second World War, there must be a fairly significant reduction in the number of fatalities per year, but we don't celebrate that".*

## 5.3 Emerging constraints

Similarly to emerging opportunities, this research sought to understand whether the proposals, or on-going changes, had resulted in constraining factors for key stakeholders and organisations. As discussed, most stakeholders felt that there were more negative than positive outcomes emerging from changes in OSH in recent years. These largely focussed on two somewhat overlapping areas: stakeholder autonomy, and lack of resources.

### 5.3.1 Stakeholder autonomy

This subtheme related to whether stakeholders' freedom to make decisions (i.e. developing their own strategies to tackle perceived problems) had been inhibited by the changes taking place. The general trend was that those stakeholders associated with government were restricted in that they felt compelled to follow government strategy. This appeared to affect the HSE particularly negatively as one professional organisation mentioned: *"they [HSE] are really struggling and I think politically they're having their strings pulled quite a bit, which really ties their hands on what they can do and what they can provide. And it's a massive shame because it doesn't help anyone".*

The aforementioned alignment between HSE and LAs was also discussed, as it was perceived that LAs would have some of their autonomy compromised by being placed under the HSE. As one consultant noted: *"when you look at the local authority and HSE working in partnership, it seems to me that one result of the Löfstedt review was that he was quite keen for HSE to direct local authorities […]. To my mind, it's a retrograde step because it's made LA a junior partner in what had become a nearly equal partnership, which was working quite well five or six years ago".* Interestingly however, the opinion of an LA interviewee was that there was little impact as yet, although this may be due to the short space of time since the changes: *"None at all. The changes haven't put any constraints on us. …But it's too early in that process".* Employer representatives also discussed potential constraints, although these were largely indirect. One argument was that changes had increased the implicit boxes that needed to be ticked in order to be competitive, thus somewhat restricting autonomy: *"Constraints will be things like tendering, where there's more and more things to tick off and comply with, like the FFI, and that just makes it more difficult and time consuming, and difficult to progress".*

The degree to which stakeholders are able to exert autonomy in their everyday activities was identified as being a potential future constraint. For example, one insurer noted: *"I think another snag with regulation unfortunately, is there's a Bill published yesterday, de-regulation Bill, which talks about all non-economic regulators having to take growth into account when they make regulatory decisions. So I don't quite know how you do that, when you wander around – if you ever do – and find something wrong somewhere, and think some action should be taken about this, but hang on I've got a statutory duty to take growth into account".* The extent to which regulatory changes represented a constraint for stakeholders depended on whether these changes were at a policy or practitioner level, as one government agency representative noted *"The question will be whether your organisation as a regulator has to take growth into account in its policies, or whether individual decisions by an inspector at a point in time, have to take growth into account. Because if it is the first we can do it. If it*

*is the second, that is much more difficult".*

The extent to which practitioners are constrained within the OSH system was also identified by several stakeholders. However, this was more in relation to what is currently happening and largely centred around the autonomy such practitioners are afforded. This was noted for example, by a representative from a government agency: *"Is it that some practitioners are part of the problem? Or that some chartered practitioners are part of the problem? And the reason I say that is because actually it is not so much about the person, their competence building, but what it is that they have been brought in to do".* The same view was espoused by a trade union attendee: *"An awful lot of consultants will be brought in by companies, and their brief will be: What do we need to do to meet the law? What do we need to do to stop an inspector coming in and accusing us of not doing this or that? So that will be the brief they have got... So part of the problem that the practitioner has is to do with the brief he has been given, or she has been given, by the client, the employer".*

There was also discussion of constraints at the individual worker level with one trade union representative arguing that there might be some constraints felt on the ability to blow the whistle on OSH issues: *"if you create a culture where health and safety is taken less seriously, I think it makes it much harder for people to speak out about health and safety concerns, because they are seen as somebody who is standing in the way of growth and progress so forth. So from that point of view, it can be negative at a local level".* As mentioned, there were also stakeholders who noted that their autonomy was unaffected due to their independence, as one professional association noted: *"We don't have our strings pulled by anyone. So in terms of what we genuinely believe are the right ethical policies, procedures, practices to go down, we will still shape our path down those avenues".*

### 5.3.2 Lack of resources

Several stakeholders mentioned issues related to resources, and in particular financial limitations, which inhibited stakeholders' ability to pursue desired goals and objectives. For example, an interviewee representing professional associations stated: *"The landscape is changing massively because of the spending cuts. […]. Clearly that's a constraint; if there are not the right number of regulators to do the work, it's not going to be possible to cover all the work, and there again you run the risk of leaving things undone that should be done, and that potentially puts public protection at risk".*

Trade unions also felt that financial pressure was leading to reduced OSH standards through impairing the impact of union representatives, as one union interviewee noted: "*trade union reps are under constant pressure because of cost cutting, our work in promoting workplace health and safety has been undermined all the time. It's a constant battle for health and safety reps to have the time to do what they need to do, having the time to do risk assessments, having facility time to represent members, having time to go to training courses, having time to talk to specialists, all that has been whittled town, though, in effect, austerity and the cuts".* At a broader level, a training body suggested that austerity might have a more subtle effect on generic OSH standards through reduced training: *"Probably less people going on the [OSH] courses as a result of the cost of training. Not only the monetary cost but the cost in lost time".*

Organisations that did not seem to suffer from resource constraints were funded through ways which were protected in times of austerity. For example, a specialised government agency noted: *"we're in a different place from HSE because we are funded directly by industry through a levy. […The] 30% cuts that HSE was forced to do, combined with HSE reclaiming its costs through fee for service, is not something that we have had to tackle and I think that would've been incredibly difficult and disruptive had we had to".* Therefore, it appeared it was mostly government agencies which were directly affected by resource limitations, although there would be a subtle effect through limitations on opportunities for OSH development such as training, and through union influence.

## *5.4 Implications of the changes*

The themes discussed thus far have focussed more on either developing issues or immediate outcomes. However, of particular interest were the longer term implications of the changing landscape. Thus, this theme differs from the earlier discussion of outcomes of changes in that it considered stakeholders' predications for the long term future. Five themes emerged: uncertainty of the future; the changing role of stakeholders; in particular, practitioners; the effect on organisations,

particularly SMEs; and, finally, standards of OSH.

### 5.4.1 Uncertainty of the future

When focussing on the implications of the changing landscape, an almost universal reaction was the difficulty of forecasting how the changes would affect the complex and dynamic system that is OSH. As an employer association interviewee put it: *"I think it's very difficult at this stage. We're too close up at the moment to actually understand how the reforms that were put in place as a result of Lord Young's review or the recommendations that were contained in the Löfstedt report, I think it's far too early to say what the impact of those will be".* Despite this hesitation to suggest what might be the future for OSH, four subsequent themes emerged with tentative suggestions, as well as theoretical predictions.

### 5.4.2 The changing role of stakeholders

This subtheme discussed how the changes in the OSH landscape might alter the role of certain stakeholders. The HSE's role was discussed extensively; there was a belief that resources would affect provision of advice. This impact on the HSE had stimulated discussions in other stakeholders' organisations. Indeed a representative of a standardisation and certification body mentioned this decline in advice had prompted discussions about whether they could address this gap: *"if the HSE are going to have reduced resources and also there's lot of stuff that needs to be guidance written or done, [we] could have a very significant role and I've pointed this out in [our] strategic policy".* Other stakeholders also noted their roles could change as a result of a changing HSE. For example, one consultant mentioned that consultancy services may be required more now that advice from the HSE was being cut back: *"Certainly [if there is] lack of clarity because it's not there in the ACoPs, then people will want to know from consultants what they should do. They will use it as an insurance policy".* Some stakeholders mentioned that they had already noticed a change in their role: *"we are being approached more and more for advice, in terms of occupational safety and health […] because of the decline of the health line that HSE used to supply"* (trade association interviewee).

However, it is important to note that not all of the functions of the HSE are transferable to other stakeholders. As noted by an insurance interviewee, stakeholders do not have the same powers as the HSE and, therefore, can do no more than provide advice: *"we have been asked many times over the years, just by governments of different political persuasions, whether insurers should become more involved in health and safety. But it's a difficult issue for us because we are not policemen, we haven't got the powers that the HSE and other regulators have. Our power is more commercial and economic […] but we certainly see that, probably in the future, it may be a role for insurers and other bodies to be providing advice to people to fill any gaps where the regulators pull out".*

Somewhat separate from the impact of the HSE's role, trade unions were also concerned about the implications of changing labour dynamics on trade union membership. One union representative noted that the recent period had made it even more challenging for union representatives to fulfil their responsibilities: *"the current climate is one that is making it difficult for us to ensure our reps are as active as we would like them. But I think that's just austerity, you know, being released from your day job to fulfil what is a voluntary role; it's a very harsh climate. I think also a constraint is the capacity to recruit more health and safety reps so if you think at the moment because of redundancies which are happening in public and private organisations, we are losing members, where amongst those members we are losing reps. I think we're going to have difficulty maintaining our numbers of OSH reps. So that's a big challenge for us".*

There was specific concern for LAs as they had been subject to severe cuts and the reforms had not been yet finalised. One representative of government authorities noted: *"the worst scenario is that regulation goes central and it's not a LA matter, but I'm not sure it will go that far, […] but I can see less work being done by LAs […]. There will be a lot less people and a lot less OSH will be done".*

### 5.4.3 The changing role of practitioners

Practitioners have a central role to play in the field of OSH, especially as there have been questions over whether practitioners contribute to some of the issues the reforms are attempting to address.

Thus, it was unsurprising for interviewees to discuss the impact of the changes on practitioners.

There did seem to be consensus around the fact that the issue of consultants had required addressing. For example, one consultant noted that the opinions of colleagues at workshops left a lot to be desired: *"when we did a 'round the table' thing, the views of some of the people who were there as independent consultants were shocking"*. Another stakeholder from a standardisation and certification body mentioned that the older generation of consultants had failed to make the switch to modern risk based approaches: *"you will find there is a block of people who have been in this game for many years and they would not recognise the OHSAS approach or this approach [based on risk assessment] as the way they would want to do things. These people are very risk averse or hazard focused".* An academic also shared this perspective: *"there are 40,000 people allegedly in the Institution of Occupational Safety and Health, of which I am a Fellow. And I suspect most of them don't understand what reasonable practicability means, and yet they're supposed to be the professionals".*

One of the key concepts was the Occupational Safety and Health Consultants Register (OSHCR), the aim of which as perceived by stakeholders was to address some of the aforementioned issue through providing businesses with a recognised assurance of quality. However, a number of stakeholders were concerned that the OSHCR might not be an adequate solution to these issues, questioning its ability to adequately filter out some of the consultants that were providing poor advice: *"there is a huge challenge […] here of course. You want to be inclusive but you need to have a degree of rigour and I think that's the bit that's tricky. […] It's a good start but it needs some fine tuning"* (professional association interviewee).

Furthermore, there were concerns over the practitioners who weren't on the register who would still be practicing. As one representative from an employers' association argued: *"it's just a very small fraction of the number of people who are either directly or indirectly [involved with] health and safety. So I think there's 2,000 consultants on the register but in terms of health and safety… there must be easily 100,000 people out there who've got health and safety as a substantial part of their job, and there is a question over whether they should be regulated".*

Apart from OSHCR, many comments were made about the need for practitioners to develop broader perspectives. One representative from a professional association commented on the soft skills required: *"leadership skills and communication skills. If you're going to get the senior management within an organisation to manage risk as they should be doing, they may well need somebody to lead them, actually point them in the right direction, and influence them".* The same stakeholder also discussed the ability to produce a business case for OSH: *"What a lot of OSH practitioners don't actually understand is the business context in which they are expected to work. And we need to think of new ways of actually getting the message over. […] money is the language that senior management talk in, and we need to be able to talk their language".*

Indeed one representative from government agencies noted that the law should be used sparingly in the context of organisations. Discussing the feedback received at a performance appraisal the interviewee stated: *"feedback I got from that […] was that I reached for legislation far too early in the discussion and I hadn't used the cost-benefit analysis angle, the moral angle. And I'd gone far too quickly for the legal angle".*

Another element of competence was the need for awareness around civil law, because as one insurer noted, insurers are interested in more than just regulatory issues: *"we would probably have criticism of some external bodies who just go out and are only ever looking at regulatory issues. Because we think that's only half the issues, because they've probably got little or no competence in terms of understanding the civil law side of things and to some extent we think they're doing a disservice, because we've had, and this has been a fairly regular issue raised with us, we might take on a risk, we might go and survey it, and we might then get a remark sometimes, 'well you've picked up something that the HSE have never picked or we had a consultant in here and he never picked it up'. And you say no that's because they are purely regulatory issues; what we are talking about is beyond that, it's risk based issues".*

It seemed many stakeholders demanded more of practitioners, however, one trade association representative expressed concern that broadening the scope too much could result in a dilution of

expertise as OSH practitioners would struggle to comprehend the broad nature of the job: *"Some of negatives that I think are happening because of the economic climate is more and more of these guys are getting lumbered with more and more of these jobs. You know, not only now are they the safety expert, they also have to become the environmental protection manager, and the facilities manager, and the whole range of other things. And if we're not careful, I think that's just going to dumb the whole field down a bit".*

### 5.4.4 Impact on organisations, including SMEs

As noted above, one of the main objectives of these changes is perceived to be the alleviation of burdens on businesses. As such, implications for organisations, particularly SMEs, were a key talking point of stakeholders. One notable concern was the perception of culture around OSH and the implications that would have for organisations. One trade union interviewee noted: *"In the long term I can't see what the benefit is to any employer in creating a culture where health and safety isn't taken seriously".* This culture was deemed as particularly damaging to SMEs; for example, a government agency representative speaking of the changes stated: *"If it makes things simpler and easier for people to follow, one would hope they would do so. But experience tells me that sort of small firms have so many other competing demands that unless something is done to keep health and safety in their sight, then it just gets pushed to one side and forgotten about until something happens".*

Further commenting on the lack of drivers for engagement, one employer representative, noting that there is a difference between SMEs, argued that the larger organisations within the group might have other drivers for compliance, but the micro organisations would seem to suffer the most: *"SMEs covers such a wide range. I think I'd split it between the micro ones, and my concern would be the micro level that people just think health and safety is not an issue that I have to concern myself with, that would be my concern. For the bigger SMEs, when you're getting into the 20 employees and above, my concern is a little less there because I think other factors begin to come into play […], they have to probably make sure they're doing things right, they find themselves on procurement lists for tier one suppliers for things. So they know that they may have to satisfactorily answer questionnaires from other companies who wish to deal with them".*

For those organisations that were driven to manage OSH, the changes to the OSH system might also make it harder for them to access guidance. As noted by one consultant: *"there's less opportunity to get advice from regulators […]. At the end of the day, for businesses that are looking to have good health and safety, they'll continue to pay consultants or they'll employ people within their organisation who are capable of giving them advice".* However, as one professional association interviewee noted: *"the problem is a lot of the SMEs don't necessarily have the resources that the larger organisations have".*

It was interesting that stakeholders presented this largely negative view, given that one of the drivers for these changes was for the benefit of business. However, some argued that these changes might be positive for SMEs. For example, a government representative noted: *"it probably has removed some of the burden for SMEs, given the nature of things. Hopefully the advice and guidance that's actually appearing on the HSE website will be of more value to SMEs".* Although struggling to see the overall positive outcomes, another government agency representative agreed with the notion that there could be less work for SMEs: *"[there is] not going to be a massive benefit for SMEs at the moment. I suppose you could argue that in terms of reporting, if we stick with that, then they're not perhaps having to do so much paperwork, and reporting incidents, so there's a benefit there".* Despite this, some noted that, in the long term, this might prove to be more costly. Thus, overall, the benefit (if any) for business, and particularly SMEs, appeared short term, and perhaps at the detriment of long term benefit.

### 5.4.5 Impact on OSH standards

Perhaps the most important long term implication of the changes related to whether or not these would directly influence OSH standards in terms of outcomes such as work-related ill health, sickness absence, injuries and accidents. The view was proposed that the recent economic climate could worsen bias in the statistics by fuelling underreporting, for fear of losing one's job. As one standardisation and certification body representative mentioned when discussing major problems in

reporting: *"I think the underreporting in small businesses […]. If I work for a company and injured myself and I knew that if I reported I'd have the health and safety people around and they might close us down and it's my job as well as the gaffers job. Yeah I may want to claim off him for losing the end of my finger. But it might be better to keep it quiet, and I've got a feeling, I think people are too frightened".*

An issue within this was the debated changes to RIDDOR. These included a change to the number of days an employee had to be absent before reporting of the incident was compulsory, and certain elements (especially in relation to health) removed from the reporting requirements. One professional association was sceptical about the proposals of the government: *"when government said 'oh we no longer need to look at certain areas or we wanted to remove certain occupational disease reporting because the HSE gets its data from elsewhere'… but it didn't say where they were actually getting that data, and a lot of commentators' eyebrows were raised".*

However, some stakeholders could not foresee any down side to the RIDDOR changes. For example one government agency representative noted: *"Well, I think the stats will reduce in terms of the numbers, obviously because they've lengthened the RIDDOR time, when it needs to be reported. I think it's quite a sensible move to be honest".* However, stakeholders also felt that this change could add an element of bias to the statistics.

Taking these caveats in mind, interviewees tentatively predicted what they believed future OSH standards would look like. One trade association respondent suggested that a combination of government changes as well as macro changes would lead to increases in ill health: *"you live in a more uncertain world. Changes in terms of contracts of employment, or improving the employers' ability to dismiss people, surrounded by all the other varying components, you would anticipate that stress and ill health from …obesity and an ageing workforce, which is going to have an associated increase in musculoskeletal issues, you would draw the conclusion that those figures are going to go up".*

A government agency representative felt that performance would be dependent on how duty holders responded to the increasing responsibility being placed upon them. However, other stakeholders were more certain that the changes would negatively impact OSH standards. As one union representative noted, commenting on the mechanism by which this might happen: *"if there are forces that diminish the effectiveness and the involvement of the safety reps, and if there is less consultation and less dialogue, less partnership work, we are certain that we will see a reverse of the positive developments that have happened in the UK in terms of accident rates and ill health. So we would expect accident rates to start going up again, and ill health is already going up and up and up, mainly stress, depression and anxiety".*

Another perspective on the mechanism of how changes could influence organisational practice was that a perception that OSH is not important, would lead to less engagement from business: "*if they [business] actually see any information in the press about a reduction in inspections etc. That won't lead them to go out of their way to make sure things are hunky-dory in their firms, I don't think. So [if] the idea of getting a visit was reduced, they'd probably put in less effort than they do now, not that they put a lot of effort in now".*

Ill-health in particular was mentioned as particularly worrying, although this was often down to broad macro factors. A standardisation and certification body interviewee noted that the economic climate would lead to a decrease in health: *"I think for health things, psychosocial risk will increase I believe because people will have five employees and they really need seven, they'll try and get the five to do the seven's work. And this will mean somebody will fall over from doing too many hours or whatever".*

While most of the predictions were that performance would decrease, a few stakeholders (notably from the employer perspective) offered an alternative opinion: "*In theory, things like FFI should reduce poor practice and, therefore, likelihood of accidents and injuries, because they're getting charged for it which they weren't before, so there's a cost".*

Thus, differences in opinion did exist, however one insurance interviewee noted that, in actual fact, it would be very difficult to attribute any change in performance to any specific change in the landscape: *"it would be very very difficult for us to ever to make a cause and effect, because there are so many*

*things happening".*

## 5.5 Achieving balance in the future

The final theme which emerged from the interviews reflected subthemes in relation to what was required in the future to reach the optimal balance in terms of OSH policy, practice and outcomes. Given the broad nature of the question, stakeholder answers were varied, however seven emerging subthemes were: the perceptions and understanding of risk, health in OSH, engaging business, a multi-policy proportionate approach, long term independent thinking, working in partnership, and education.

### 5.5.1 The perception and understanding of risk

How risk is perceived and understood by stakeholders both within and outside of the OSH system was a key issue. In addition: how society perceives OSH risk in comparison to other types of risk; how risk differs internationally in other countries and cultures; how risk is context dependent; and how risk is viewed by and should be positioned to business, were all key discussion points.

A common view espoused by attendees was that there remains uncertainty around what OSH risk is, and more specifically how it differs from OSH hazard. For example, as one government agency stakeholder noted this confusion around the two terms is apparent both within some HSE circles and industry: *"I don't think hazards and risks have been well understood anyway. I say that from within HSE as well, because often the two terms are used interchangeably and they have been over for many, many years. And I've worked in industry as well, and seen the same misconceptions there".*

A similar view was expressed by a trade union representative, who noted how the two terms are commonly confused: "*I mean I get it mixed up as well, sometimes you say 'hazard' when it should be 'risk' and so on, everyone does".* However, for the trade union stakeholder this presented challenges for the UK regulatory system which is risk based: *"I think people do tend to look at the hazards. And I think it means also, in our experience also is, that the vast majority of organisations in the UK do not do risk assessments. So the whole law is based, the regulatory system is based, on people doing risk assessments, and most people don't do them. Big companies do, but most others don't."*

Another issue around OSH risk is how society perceives it when compared to other types of risk. For example, one government agency representative noted how there is a general ignorance amongst the general public around OSH risks compared to environmental risks: *"But there's an issue about societal perception of risk isn't there, in terms of environment versus health and safety. The public at large, get more information about, where I come from, are there issues that environmental issues might affect them than maybe about health and safety ones".*

How risk is perceived and understood in other cultures and countries was another key discussion point. As one trade union attendee noted, the EU regulatory framework differs from the UK framework (which in principle is risk based): *"When you get in Europe, the big complaint about European directives is that they are hazard based, and not risk based. That's the general criticism".* With regards to international differences around risk, one stakeholder from a trade association noted the complexities of different types of risk in other countries and how they can potentially affect the regulatory landscape: *"there is a huge international cultural aspect to society perceptions of risk, based around social and economic factors. But if you take nano safety as an emerging area, heavily influenced by Canadian and American science, research etc., and the regulations which will flow from that, will have an impact internationally. So, to a certain extent some of our regulatory approach is out of our government's hands anyway".*

Thus it was clear from attendees that risk is inseparable from context. A common view was that when thinking of risk it is important to take into consideration whether the risk is perceived to be relevant to the macro (i.e. international/national) level or to a more micro level (i.e. industry/workplace). This point was succinctly captured by one government agency representative: *"What is acceptable risk? And that's very much context, dependent". A* government agency stakeholder compared the risks associated with two industries: *"In some aspects hairdressing is a quite hazardous industry in terms of the chemicals that are present, and some of the risks associated with those chemicals. But if you put it in a national context and you are judging against nuclear, you know on a sliding scale, it appears to*

*be very small. So you know, everything is in context".* However, a trade union attendee used the same two industries to give an alternative view: *"with nuclear the hazard is high, but usually they say they have reduced the risk. So the risk of working in hairdressers might be greater than in working in the nuclear industry, actually it probably is".*

Finally, the way risk is presented and portrayed to businesses was an issue. There was a view within the workshops that OSH risk is viewed negatively within industry. As one professional association attendee noted: *"in risk management, you know, there's what they call the up side and down side of risk. But health and safety only has down side risk. And if you manage it well the status quo exists".* The same stakeholder went on to note that a repositioning of OSH risk could potentially alleviate some of the present perception: *"there could be a positive if you start including healthy lifestyles messages in that".*

Likewise, one insurer noted that perhaps OSH stakeholders were taking the wrong approach when talking to businesses about OSH risk. Instead the attendee noted how framing OSH risk as business risk may be a better approach: *"I think what has gone wrong and certainly when we talk to companies, particularly the larger companies, we wouldn't talk in terms of Health and safety. We would talk in terms of business risk".*

### 5.5.2 Health in OSH

Stakeholders felt that OSH had predominantly focused on safety issues, to the detriment of health-related issues. For example, a representative of the judiciary and legal services group noted: *"there needs to be great concentration on the prevention of ill health. I think that's one of the areas in this country that we've not really dealt with properly".* This perspective was shared by an academic: *"one particular area where OSH has failed to do this, is in relation to the 'H' bit, the health bit. […] the TUC, has quite a lot to say about this. And they say that OSH is obsessed at reducing the risk of injury but they're doing it at the expense of occupational health. […] I would echo that. I would say they've also done it at the expense of public health".*

Thus, there was a view that there is a need to engage on occupational health. However, stakeholders supported that the recent reviews had not considered this aspect adequately. As one union representative noted: *"we seem to be taking a backwards step at the moment. And that's reflected in a lot of the government's approach. I mean you look at the Young report. There is very little about health and ill health".* Similarly, looking forward, stakeholders felt that the landscape for those involved in occupational health would be challenging. For example, a second union member mentioned: *"there is a lot of changes that are kind of increasing the gap between safety and health. I'm thinking here of the changes around RIDDOR, the reduced emphasis on health. It could be quite difficult for occupational health people to maintain their… I can see them having to fight to keep their jobs actually. I think the government response to the Dame Carol Black review, I don't think they've done enough".*

More contemporary challenges around occupational health were also identified. These were around: the increasing confusion amongst practitioners and businesses concerning the difference between occupational health and wellbeing; and the current trend witnessed by attendees to move the onus/responsibility for occupational health away from the employer and towards the individual; the need for occupational health policy recommendations to be enacted in practice; and the financial costs associated with occupational health and who pays.

With regards to the wellbeing/occupational health distinction, participants aired caution around using the two terms interchangeably. As a consultant pointed out: *"I think we have to be careful, particularly this Wellbeing Agenda getting mixed up with what should be the health aspect of Health and Safety"*. This view was also epitomised by a trade union attendee who expressed graver concern about muddling the two very separate and distinct issues: *"I think the problem is about what people are calling occupational health. I mean currently we have got a massive problem in that everybody is talking about 'Wellbeing'. It has got mostly very little to do with occupational health, in other words ill health caused by things people do at work"*. However, a stakeholder from a trade association was of the view that the synergies between occupational health and well-being could be used to work in favour of the former: *"the problem with the wellbeing agenda … no one has direct ownership. And I think there is a definite, an opportunity for Health and Safety to align with that, which will take the*

*Health agenda with it".*

Another emerging issue was around the shift participants had witnessed whereby organisations were increasingly framing the responsibility for occupational health upon their employees rather than taking ownership. This point was succinctly expressed by a government representative: *"there has been a huge shift from organisational responsibility for the health of the workforce to individual responsibility".* In the following quote a consultant notes how the use of wellbeing terminology actually facilitates this attitude: "*you have got these new companies setting up about "you need to have your workforce resilient". What does that mean? So it's the individual's fault that they are getting ill. And it's couching this Wellbeing Agenda, rather than what occupational health should be looking at is what is... What is that individual, those employees doing there, in that workforce? Is there something there that's making them ill? If there is, we need to know about it*".

However, as some respondents reported occupational health has not been completely ignored, with many attendees noting the contribution of the 2008 report 'Working for a healthier tomorrow'. For example, one government agency representative noted in his experience: "*From a local government report of view, we are all encouraged to partake in the government's responsibility Bill which has health high on the agenda. Dame Carol Black has had a lot of focus in the last two to three years, around occupational health, absence management, and indeed the responsibility deal links into absence management and occupational health".*

However, the extent to which the recommendations from the report have been enacted was raised by respondents as a cause for concern, as noted by one government agency attendee: "*Essentially Dame Carol's interventions have been slowly watered down. I have sat on various working groups with Dame Carol, and the observation I took away from these, over the years was one from 'we are all in this together' type thing, to 'you are on your own, you fix it'. Very much at the individual level, and that is where we are at. And I think that is happening to health more generally, it is down to the individual, secondary and tertiary interventions".* In addition a government agency representative pinpointed why the recommendations from 'Working for a healthier tomorrow' had not been enacted: *"there's a complete disconnect between what DWP are trying to achieve in terms of health related to the original Carol Black report, and what the Health Service can actually deliver".* Who bears responsibility for paying for the costs associated with ill health at work was a key discussion point. As one government agency representative noted, the onus at present is largely on the state and individuals – not employers: *"I think from a business perspective there's been work done to look, to see who pays for the consequences of workplace, associated with ill health. And I can't remember the exact figures, but it is something like 45% is borne by the state. 45% is borne by the individual; a very small amount is borne by the employer".*

### 5.5.3 Engaging business

Much discussion also surrounded how best to drive OSH in business. Leadership has long been identified as material in the process of creating a safe and healthy workplace. Stakeholders reiterated that need for the future as well. For example, a certification and standardisation body interviewee noted: *"one of the biggest issues, is to make sure that managers, and this is very much in the way that the new standards are being written, that managers have to take the lead and be seen to be taking the lead".* An insurance interviewee took the commitment one step further, suggesting that the board should be involved in OSH, not just managers: *"we always emphasise it should become a board room issue. It's not an issue to say it's someone else's responsibility".*

One of the most discussed issues under this theme was understanding which policies organisations would best respond to, as a precursor to how best to devise policy in the future. Three distinct strands could be identified: the legal drivers, the moral and corporate social responsibility (CSR) related drivers, and the business case.

Regarding the legal perspective, the imperative of having legal requirements was made clear by one stakeholder representing a trade association: *"history repeats itself that sectors left to themselves, horsemeat scandal being the most recent, means that people don't do what they're meant to do. Poor ethics, poor morals, and greed and financial gain are the drivers rather than good health and I think that's just another aspect of work. Actually you need good regulation".* However, even legislative requirements would not mean that a company would be compliant. One government agency

representative noted how legal requirements could effectively be turned into financial cost benefit analyses: *"when lawful action was taken against a small firm who had a load of notices and when we went back to check whether he'd done it, he hadn't actually done anything. Basically [they] said 'when you served me with the notices I looked at how much I was going to be fined if I didn't comply with the notices and I looked at how much I'd be fined if I didn't pay my VAT. And I had so much money, I paid the VAT and didn't do the things you wanted me to. You'll take me to court but the fine you'll give me will be less than the fine the VAT man would have given me'. And that's the choice he made, and that's the stark reality for a lot of small firms I suppose".*

CSR was thus seen by stakeholders as a supplementary approach, with one trade association representative noting that improvements in technology had made the CSR driver particularly salient: *"the other changes […] are around the sort of moral and ethical social responsibility of companies. One of the drivers around that is the use of technology, if an accident happens or a fire happens, people are interviewed live using smart phones, it's all in real time, so people are held far more to account […]. Health and safety is aligned within that setting, there will be a growth within possibly business annual statements and an accountability through that, being driven through moral and ethical governance".* A government agency stakeholder, stated that the motivation for business compliance was solely around reputation, however not necessarily linked to health and safety: *"I remember a few years ago we did a piece of research to understand business drivers around health and safety and all the rest. What that piece of research showed was reputational risk was the biggest driver, not health and safety, not regulation, not business risk, reputational risk".*

However, once again, it was recognised that this approach alone would not suffice, and a combination of measures was required. As one consultant noted: *"The reality is that there are businesses out there which are pretty sort of non-caring organisations, you know, which are not too bothered about people's health or safety, so the reality is that you need some basic core of regulation in the background to make sure that those people are dealt with. […] you've got to have some legal duty that relates to them, that you can make sure you've got some kind of enforcement measures that you can take against them that's effective, so you couldn't just get rid of all regulation".*

As noted above, often the main concern for enterprises is financial considerations. As such, financial incentives could act as significant drivers; this was perhaps best captured by one insurance interviewee who noted that when the cost of employers' liability insurance rose, they perceived OSH to have far higher prominence in organisations because of the financial implications: *"When the cost of ELI rocketed, in the early 2000s, we actually found ourselves dealing with board directors and that had one tremendous advantage, from our point of view it put health and safety on the board room agenda, where it had never really been before […]. Because it was on the board room agenda, things started to happen because of course the boards can control the flow of money into an organisation and what they prioritise becomes more important".*

Indeed the same stakeholder noted that financial incentives can be more salient than legislation: *"For an average big company, I don't think it is that concerned about regulatory compliance. I mean that might change with FFI somewhat, but they're more interested in what influences their insurers, because if their premium goes from £400,000 to £600,000 that's a big budgetary item. Well a visit from your regulator, if you get one at all, is not going to have that sort of cost implication".*

However, one representative of business noted that the business case, as alluded to in the above quotations, might only be effective in larger organisations. When asked whether organisations appreciated that managing OSH would lead to financial benefits, the stakeholder responded: *"Yes and it's very nice to say and you can't argue with that, but if you're particularly an SME and there's twenty of you and you could go under and your business bankrupt, you're not worried about what happens in five years. The bigger guys, you know, yes, they've got the opportunity to think longer term".* The other caveat with business case arguments, as noted above when discussing regulation as a driver, is that when it is not favourable to engage in OSH from a financial perspective, a business case argument might mean that no investment in OSH is made.

As one government agency attendee noted, the optimal approach would be for OSH to be thought of as a key component within business management rather than an adjacent element: *"the quality of health and safety management, I think it is actually a marker of quality of management. And where it works well is when it is integrated into the whole management process, and is not seen as an add on".*

However, the degree to which this aim was feasible and achievable was brought into question. As one representative from a government agency noted this has been an on-going debate for years without a satisfactory resolution: *"And we are back to that argument of they should be built in, rather than built on. And I'm thinking, you know, if it's not well built in by now, and we are still having this debate since 1974, it is not going to happen".*

### 5.5.4 Multi-policy proportionate approach

Following on from the previous subtheme, much of the discussion surrounded what types of policy would be beneficial. Keen to stress that reputational issues and CSR have a role to play, one stakeholder from a certification and standardisation body noted: *"I think we need to raise the profile of safety in what is projected in the reports of big companies and those that aspire to be at the top of the FTSE or the Dow Jones index. So that those who have a good corporate social responsibility in the wider sense, are the ones that you would put your pension fund money in. That would be, I think, one of the greatest changes that could happen".*

Building on what was argued in relation to financial incentives for OSH as a driver for engagement; stakeholders were keen to mention increasing incentives or deterrents. For example, one trade association representative noted: *"I think we might need to investigate whether a certain type of accident should be transferred to insurance companies, as to whether there should be financial incentive […] whether that supplies a better model".*

However, the subject of policy is of course a complex issue and there is no one size fits all approach. Testifying to this, a government agency representative noted that which type of policy was the appropriate driver, including legislation, was highly context specific: *"it depends on the level of maturity of industry you're talking about and the level of risks associated with that industry. So I think in areas of low maturity and high risks, actually regulation is very important to provide the framework for appropriate use of controls, systems, leadership etc. to manage OSH issues. So I think at that end regulation is important. I think at the low risk, mature end, it's probably less important because they're more about culture, continuous learning, improvement etc. So it depends on the maturity of the sector when it comes to OSH as to which approach is more effective".* A similar opinion was noted by a consultant: *"at the end of the day you still need a sort of balance, I don't think there's a one size fits all sort of thing. I think having a balance of regulation, and I mean, there's a place for financial incentives but it depends what the context is really. […] But I think it would be good to have some sort of incentivising around trying to improve standards but it's a difficult topic".*

The notion of a risk-based approach, proportionate to the hazards present, has been a central theme in the current reforms. Stakeholders from the government and employers' perspective were keen to stress this as the way forward, in deciding policy initiatives. Other stakeholders also supported the idea of proportionality. As one employer's association interviewee mentioned: *"health and safety should be an enabler not an impediment, and as a membership organisation we sort of argue hard that health and safety laws and policies have got to be proportionate and sensible".*

Linked to a risk based approach was the notion that regulator activity should be targeted to have the greatest influence. As one government agency representative pointed out: *"One of the key factors from a regulator's perspective is targeting regulatory activity to where it has the greatest impact".* It goes without saying that all of the above comments require a strong evidence base, as one trade association noted: *"if you are going to regulate, and we do say this time and time again, then it's got to be on the basis of good science".*

### 5.5.5 Long term independent thinking

Linked to policy decisions, several stakeholders noted previous and on-going decisions were affected by short term thinking, which had been particularly detrimental to OSH. For example, one interviewee from a professional association noted: *"I would suggest you could see as a fault in government policy, that it looks short term. Therefore the accident and safety statistics tend to drive it, rather than the consideration of the longer term impacts such as the costs to, if you like, the country, of chronic diseases, of stress, of musculoskeletal issues. […]. There is very much, it seems to me, a short term focus to get us out of the mess, rather than a long term consideration of what are the burdens over a longer term. Because governments are only there for say five years. And they tend to focus on short*

*term rather than longer term issues".*

Following on from this, a second stakeholder representing insurance suggested the creation of an independent body to assess major issues in UK policy, independent from government influence: *"it may well be time to actually have a massive rethink of this whole question of regulation or otherwise, […]. Setting up of something like a risk commission in the UK which would be independent of government, but might be able to look at some of these massive issues that are knocking around and try and come up with different answers, rather than just falling along with the usual line of regulation or deregulation because that tends to go with the political whim. […]. Our suggestion is that we need some intelligent thinking going on and there is a lot of stuff there in academia and in industry that wants bringing together […]. We may need to say as a country competing in the future 'how do we manage?', and you can't do that via the political process, because we've still got to vote on that but if we had an independent risk commission of authority people […] that's the sort of body that could look at it and perhaps come up with something sensible".*

### 5.5.6 Working in partnership

Linked to many comments throughout the findings, a key recommendation was the need for partnership work at all levels of OSH stakeholders. One key area was that between regulator and duty holder as noted by a government agency representative: *"I'd go back to that partnership approach, so I think the fact that what are seen as the enforcers has got to be seen as critical friends, and we've got to build that partnership between business and the regulators".* Similarly stakeholders were keen to emphasise that within government: *"there needs to be much more partnership and understanding between people who work for public health and people who work in OSH […]. HSE would know about some of these [work-related antecedents to ill-health], but because they're not properly linking the sort of health and safety side with the Department of Health side, the health practitioners and the OSH practitioners not necessarily working closely together, there are opportunities being missed"* (union interviewee).

The need for closer collaborative working between government and professional associations who represent health and safety professionals was raised by one consultant: *"one of the things is… cross-fertilisation of all those trade bodies and groups getting together with the HSE. What we haven't seen is the formal professional bodies fully get together and promote a way forward, a message from RoSPA, IOSH, and the British Safety Council, to stand together and say, 'Well, no, we represent X thousands of members, of professionals and this is what they're saying'".* However, due to market forces, the extent to which this was a feasible aim was questioned by one trade union representative: *"the BSC and RoSPA have been talking about getting together for years… Ultimately, what happens I think with BSC and RoSPA is that they sort of talk about getting together and they end up having commercial disagreements, because they're in the same market for trade".*

However, the point was raised within one of the groups how there is a working group which brings the interests of various OSH associations together, as one stakeholder from a professional association noted, *"There is a group that brings them all altogether… because I sit on it and it's called POSH which is the Professional Occupations in Safety and Health… they do ask questions about matches of common interest, and it's absolutely what it's about".* However, among attendees there was limited awareness of this group's existence, a point which the professional association representative would raise with POSH: *"Perhaps one of the things I should take away is to say to them 'given all this, what aren't we doing some joint campaigning if that's what it happens to be, looking at how do we align our messages better?".* In addition, there was also a requirement for closer inter-departmental working within organisations, with the responsibility for an issue often sitting within one camp, which due to a lack of communication, was to its detriment. One government agency attendee, for example, explained: *"A lot of the ownership on the health side is sitting with HR, and we are in two separate departments, very rarely do we cross over. So there's a positioning, and there is, probably a skill competency set around that, incorporation of the modern health agenda, certainly in bigger companies".*

### 5.5.7 Education

Finally, as many of the issues related to OSH were identified as deficits in knowledge, it was no surprise that many stakeholders spoke of furthering education in OSH. For example in relation to

health, it was identified that not only is there a need for increased commitment but increased understanding of emerging risks. As argued by one consultant: *"people need to understand. It's all around work-life balance, but what's happened with that process is employers have focused on the route: 'Ok we'll provide gym membership' […]. They're not looking at it as a whole […] the issue of stress, it is holistic. It is about the individual and how resilient they can be and what they do and how they work. But they need to be taught about this […] so there is an awful lot of educational work that needs to be done in that area, definitely".*

Indeed, one employer representative noted that education could begin as young as school, however currently the wrong messages were being sent: *"you could do OSH type training in school so that people take it seriously and say this is not rubbish, this is about not being killed or injured or getting a disease*". Other stakeholders mentioned that a lack of OSH awareness was linked to a general deficit in the knowledge that organisations, particularly SMEs, had access to. As one employer association interviewee noted: *"there needs to be a much bigger education programme, and I don't mean around risk as a concept, but a much bigger education programme which helps small business know and understand where they can go to get advice".*

In addition, the degree to which health and safety knowledge is a priority for educators at a higher education level was brought into question, as one professional association attendee queried: *"I have been on the AMBA website, this is the one that controls the MBA curriculum and there isn't a mention of health and safety anywhere in their criteria".* A similar view was endorsed by a government agency representative who noted that though efforts have been made to include OSH within MBA syllabi the nature of MBAs makes these efforts problematic: "*There are similar activities in business schools, trying to get Health and Safety up onto the syllabus, but as you will appreciate MBA's regulated and influencing those regulations is very difficult".* In addition, the neglect of OSH knowledge was not only an issue for MBA courses. As one professional association representative recollects OSH is also omitted from other postgraduate courses, where an OSH component would be deemed as highly relevant.

Despite these calls for education, stakeholders also discussed barriers to this, with one academic suggesting that there was a lack of awareness regarding this need, and there would be resistance to such endeavours: *"I would say OSH practitioners... they are in need of serious re-education. But I don't think organisations like IOSH and the Institution of Environmental Health officers recognise that yet and I suspect they'll be deeply resistant to re-education".*

# 6. Looking at the future: identifying an optimal OSH landscape

The last focus of the study was around the optimal OSH landscape. Following the collation of respondents' facets of the optimal OSH landscape, the discussion focused on reaching consensus on key facets, and evaluating how far we are from this optimal OSH landscape and how can we get to it. Table 5 shows the ten key facets identified by the participants.

**Table 5: Key facets of the optimal OSH landscape**

| |
|---|
| Evidence-based, proportionate and strong regulations which are enforced |
| Strong, adequately resourced, independent, transparent and competent regulators |
| The need to elicit a wider range of stakeholder views (e.g. sector associations, trade associations, trade unions, professional associations etc.) during consultation |
| A responsive multi-level (i.e. preventive, proactive, consistent and flexible) policy approach which adapts to changes in the business landscape |
| Competent, open leadership and empowerment and education of management, which facilitates a responsible strong top-down culture |
| OSH is integrated into business thinking and actively championed by business (i.e. OSH seen as enabler) |
| Active involvement, engagement of workforce (not just consultation – behavioural and intellectual buy in) |
| Access to competent and verifiable OSH support (e.g. guidance, information and advice) |
| More celebration of OSH successes and the promotion of positive messages to the public |
| Flexible OSH communication plans which are tailored for different audiences (e.g. policy makers, practitioners, the general public) |

Stakeholders were in broad agreement that the OSH regulatory framework is robust and underpins other facets within the landscape. Thus, the regulatory framework needs to be in place and put into practice through effective inspection and enforcement. The group acknowledged that pragmatically this may be easier said than done, in light of continued resource cuts to regulators, though more targeted use of intelligence could help alleviate this.

Participants noted that although the system was fit for purpose, it was not perfect. They felt it could be more proactive in responding to changes within industry that were not present when the original regulatory framework was conceived (for example the influx of more SMEs and renationalised industries). However, with such flexibility came the issue of balance. The system needs to be flexible enough to cater for the needs of duty holders but still retain its fairness and consistency.

Allied to this point, was the need for more pace within the system. Stakeholders felt that new technologies (e.g. Twitter and Facebook) were changing the way people were consuming information and therefore OSH professionals could be more proactive in using social media to both digest and break news. A related point around social media was that this would increase the need for accountability and transparency of businesses, regulators, and practitioners in the OSH sphere.

Although the OSH regulatory framework was generally applauded by attendees, it was felt that the tripartite working practices which had been envisaged under it had become somewhat diluted of late. Stakeholders therefore felt the system needed to be more open to the active involvement of various parties (e.g. trade associations, trade unions, professional associations) throughout proposals to change regulations, though particularly during the consultation phase.

The importance of leaders and managers in extolling the virtues of OSH was noted as a key element within the optimal OSH landscape. Leaders came in many guises, both within the political sphere and within business. Thus stakeholders felt that, ideally, such leaders should internalise and then promulgate the 'value' of OSH (in terms of keeping people alive, safe and healthy). In addition stakeholders have a responsibility to espouse to business the added value of them partaking in good

OSH management (for example increased productivity, enhanced corporate image/reputation). This could be achieved by positioning OSH management as an integral part of business operations (in the same way, as for example, accountancy) rather than an add-on. However, positioning OSH to businesses was not just a one-way relationship. Businesses too have to openly voice the virtues of OSH regulation and assist regulators in doing their job. In addition, stakeholders noted how following the strategic angle of positioning OSH as an enabler of business, in the future, at a more macro level, good OSH management could be marketed as an enabler of the wider global economy.

However, strong leadership should facilitate rather than substitute the need for the active involvement of the workforce and the public in general. It was clear that personal responsibility and accountability was needed from all stakeholders within the system. Although leaders need to instil a strong top-down philosophy of good OSH management, ultimately people are responsible for their own actions, and so should not see OSH in a silo (i.e. as something that happens to somebody else, or as something that somebody else 'does').

Though there was a widespread consensus among participants that the onus was on the individual, stakeholders agreed that the general public and duty holders still needed competent safety assistance and advice. Thus practitioners have a duty of care to provide professional advice as and when required. In addition, the regulatory authorities, as a basic requirement of their regulatory duties, should support duty holders by providing advice and reassurance when needed.

Stakeholders generally felt that the OSH system collectively needed to be more vocal in celebrating its successes (i.e. its impressive safety record in comparison to other developed countries). Some participants felt this would go some way to counterbalancing the negative press OSH attracts. In addition the OSH stakeholder community, and all interested parties within OSH need to be proactive in educating and lobbying policy makers, businesses, and fellow practitioners. However, this was not to say that a blanket 'one size fits all' positive message should be rolled out to all parties. Rather, the type of message needs to be tailored and pushed according to the recipients' various different needs. It was highlighted for example, how the message needs to be framed rather differently at operational and policy levels. In addition, tailored propositions need to be devised accordingly. For example, the drivers for health might be quite different from the drivers for safety.

# 7. Discussion

This research adopted a policy analysis framework based on an analytical model of industrial relations proposed by Weiler (2004) which incorporates all key components of policy evaluation methodologies (see Figure 1). According to this model, any evaluation of OSH policies must begin with an exploration of the context within which these policies are developed and implemented; these relate to the environment that influences the policy process including social, economic and political influences on inputs, systems variables, policy outputs, and policy outcomes.

The context has a direct impact on the regulatory framework for occupational safety and health, the actors who are included or excluded from the development of OSH policies and their perception of OSH risks, the process of negotiation, development and implementation of these policies, and policy outcomes. These have an impact on the actions taken by governments, and companies to promote OSH and to reduce a potential negative impact on workers' health, and safety (e.g. mental and physical health; accidents and injuries) as well as related business outcomes (e.g. absenteeism, presenteeism and human error). This process is applicable at the national, sectoral, regional and company level, and in the case of the UK, also at the European level.

The policy context within the changing OSH landscape was summarised in sections 3 and 4 of this report. It is important to note that up until 1974, UK health and safety legislation had been characterised by a limited scope, a partial coverage of the workforce and by progress being at a 'snail-like' pace with advances often conceded grudgingly (Lyddon, 2010). The period was also characterised by a large and highly unionised politically active industrial sector and in addition to 'traditional risks', a number of new issues arose. There was a raft of over-regulation and over-complication in the legislative system with a multitude of agencies overseeing the system. In addition, incidents such as the 1966 Aberfan coal slurry disaster, which killed 116 children and 28 adults, brought huge media attention to the subject and increased demands for action (Crombie, 2000). In light of the acknowledgement that the system had many flaws, as well as other pressures, in 1974, the Health and Safety at Work Act (HSWA) was enacted. This looked to reduce the inefficiencies of health and safety, removing unnecessary elements while striving to increase the protection of workers, through shifting responsibility to employers (Parmeggiani, 1982; Genn, 1993; Aalders & Wilthagen, 1997). Also significant in the Robens report was the emphasis on a move towards self-regulation and deregulation. The report stated that a principal theme was "the need for greater acceptance of shared responsibility and more reliance on self-inspection and self-regulation and less on state regulation" (1972, para. 114). Similarly, the 1977 SRSC regulations are said to have heralded a culture change at the ground level, through the inclusion of workers (Lyddon, 2012).

Although mixed, the evidence that exists for this period suggests that health and safety standards were improving. Dawson et al. (1988) state that the improvement in OSH figures "can to a great extent be attributed to the Act and to all the associate regulations, discussions, and institutions at every level that followed it" (p.16).

The 1980's saw large scale industrial restructuring, high levels of unemployment and falling trade-union membership, with the coverage and influence of recognised Unions in both the workplace and the policy arena declining significantly. These factors influenced the decrease in OSH standards during that period (Dawson et al., 1988; Nichols, 1990). In tandem with these factors, the government's strategy for OSH is also argued by many to have worsened the situation. As Walters (1994) notes, while the deregulation debate of that period occupied a high profile, a more insidious, sustained and successful effort to limit the regulatory system can be found in the implementation of a series of cuts in public expenditure, a trend that is also widespread in the modern era. Nichols (1990) highlighted that ten years after the implementation of the HSWA Act any OSH improvements had come to an end, which clearly undermines claims that the Act was a success, or, at the very least, means that in order for self-regulation to be effective, certain contextual variables have to be present (e.g. trade union membership), a notion supported by Dawson et al. (1988). However, rather than this signalling a slowdown in self-regulation and deregulatory initiatives, the 1990's would introduce more similar reform.

In the 1990's, the government's 'deregulation' agenda coincided with the Europeanization of OSH policy. The EC Framework Directive 89/391/EEC and its subsidiary Directives were transposed in the UK with the implementation of the 'Six Pack' regulations which led to the simplification of

approximately 40 items of legislation (Facilities, 1993). The Management of Health and Safety at Work Regulations 1992 (MHSW) (replaced by MHSW Regulations 1999) is particularly relevant as it furthered the self-regulation agenda through a focus on safety management and a risk-based approach (Dalton, 1998). During the 1990's the HSE's resources continued to be cut and its powers as a regulatory inspection and enforcement agency weakened. Somewhat in line with the government's stance on legislation, softer forms of policy were beginning to develop momentum with the concept of ACoPs as quasi-legal guidance and the concept of standards as a tool for regulation emerging. This continued in the following decade.

By the start of the new millennium a series of HSE/governmental and EU strategies were launched to meet the growing need to reduce the number of working days lost due to ill health and to address existing and emerging psychosocial risks in the workplace. A series of soft law approaches followed, primarily through standards in the UK and through autonomous agreements achieved via social dialogue at EU level. The UK strategies increasingly called for greater participatory involvement from all OSH stakeholders to reach improvement targets, with a back drop of finite public resources and the continued cuts to the HSE. The government would subsequently further explore cutting the volume of statutory instruments with the Young review in 2010 and the Löfstedt review in 2011.

However, both these reviews reported that the existing UK OSH regulatory system is largely fit for purpose and there was little justification or scope for radical overhaul of the OSH statue book. This was also reported by stakeholders, who participated throughout this research project, who were in overwhelming agreement that in principle the broad regulatory framework set out under the 1974 HSWA and subsequent regulations is robust and fit for purpose. Despite this finding, stakeholders indicated the government was still pursuing a deregulatory agenda via two backdoor routes; better regulation initiatives and cutting the resource of the regulator.

Within this context the next sections discuss the key actors in the changing OSH landscape, the types of initiatives implemented and their impact. The research identified a number of enablers and constraints on actors to devise and implement relevant policies (national and local) for achieving OSH goals. These factors are discussed along with the implications of the changing OSH landscape for OSH standards and OSH practice, especially as concerns SMEs. On the basis of the findings of this research, priorities are identified to enable the promotion of the health and safety in this changing OSH landscape.

## *7.1 Sources of authority and key actors in the changing OSH landscape*

State actors and institutions as well as non-state actors who are involved in the policy process (Birkland, 2005; Howlett & Ramesh, 2003) constitute the sources of authority in the changing OSH landscape.

### 7.1.1 State actors and institutions

"Because electoral controls are too imprecise to determine more than the broadest contours of policy making, direct authority rests largely in the hands of elected functionaries, their appointees and civil servants" (Lindblom & Woodhouse, 1993, p.45). These include governments, bureaucracy, ministerial departments, and political parties.

The government comprises of the legislature who make laws, executive who implement them and the judiciary who rule on them (Bealey, 1999). The nature of, and the relationship between these institutions strongly influences what (and how) policies are made" (Harrop, 1992, p.266). Bureaucrats are active participants in the policy-making process. Administrative actions typically modify or set policy in the process of trying to implement it, and agencies not infrequently are instructed by elected functionaries to make policy (Lindblom & Woodhouse, 1993). An Executive Agency has a degree of autonomy to perform an operational function and report to one or more specific Government Departments, which will set the funding and strategic policy for the Agency, while at an 'arm's length' from a parent or sponsor Department there can be a number of Non-Departmental Public Bodies (NDPBs) (Greve, Flinders, & Van Thiel, 1999). Political parties serve as a powerful organising force in many political systems and give direction to the policy process (Lindblom & Woodhouse, 1993). As elected functionaries, political parties form the political executive and direct the policy process, while in opposition, parties are left free to think up new ideas (Harrop, 1992).

Historically, legislators were identified as critical stakeholders as legislation was seen as the major regulatory tool to safeguard OSH. Magistrates, by their role in the legislative system, were also identified as stakeholders however, Thomas (1948) argues that early legislation was ineffective because magistrates had little interest in factory legislation and were too closely linked to mill owners to enforce the law. The Factories Act 1833 offers the first notion that employers are critical in the regulation of OSH. The creation of a Factory Inspectorate also saw dedicated inspectors become stakeholders for the first time. The passage of the Factories Act of 1937 was also linked to the resurgence of labour organisations from 1933 onwards (Beck & Woolfson, 2000).

Under the 1974 HSWA, the HSC and HSE were established as NDPBs in order to support the Government's strategic aims and targets for health and safety at work. The HSC (now restyled the HSE Board), made and continues to make policy under the 1974 Act (Lyddon, 2012). Tripartite in nature, the HSC proposed Regulations and ACoPs, allowing industrial and trade union representatives a participatory role in OSH policy formation. The HSE is a body amalgamating the powers of central government inspectorates (Fairman, 1994). It is the executive body of the HSC with the responsibility for achieving compliance with the provisions of the Act and the Regulations made under it. Certain areas of risk or harm directly or indirectly related to work activity are covered by legislation other than the HSWA and are not dealt with by HSE. These include disability discrimination, consumer and food safety, fire safety, marine, railway, and aviation safety and most aspects of environmental protection (BRE, 2008).

The Health and Safety (Enforcing Authority) Regulations 1998 allocate the enforcement of health and safety legislation at different premises between local authorities and HSE. Local authorities enforce health and safety law mainly in the distribution, retail, office, leisure and catering sectors (HSE, 2009b). In the new millennium significant changes in the structure of OSH regulation took place. The HSC and the HSE were merged in 2008, and the HSC as a body ceased to formally exist (HSE, n.d. c). This period also saw many attempts to improve the effectiveness of local authority enforcement and coordination with the HSE. The HSE/Local Authorities Enforcement Liaison Committee (HELA) which has been set up to facilitate communication between the HSE and Local Authorities, was reconstituted in 2006, to provide a strategic oversight of the partnership (HELA, 2012). Historically the HSE has worked with Local Authority co-regulators to produce guidance material which aims to promote regulatory consistency.

Over the years, political parties have played a pivotal role in the OSH policy process in the UK. During the period of the Robens review, the majority of the recommendations were formed by civil servants in the Department of Employment and were the basis of a Conservative government Bill (Lyddon, 2012). This Bill was presented to Parliament on 24 January 1974, but fell when the government called a general election for 28 February that year, during the miners' strike. After the Conservative Party's election defeat, the Labour Party formed a minority government, with the Labour Bill on health and safety presented on 21 March 1974 very close to the Conservatives' Bill (Lyddon, 2012). Interestingly the Bill was proposed by a Conservative Government led by Edward Heath but it was actually the Labour Government of Harold Wilson that passed the law through Parliament (Dawson et al., 1988). The main area of difference was in relation to safety committees and representatives, with the result being somewhat watered down duties for employers Lyddon, 2012)

Davies and Freedland (2007) note how over the past three decades, since the election of the Thatcher government in 1979, there has been an on-going theme in British governmental policy discourse that regulatory provisions protecting the employment conditions of workers need to be minimised in order to protect the business needs of employers. James, Tombs and Whyte (2013) highlight in particular that although the Conservative Major Government's Deregulation and Contracting Out Act (1994) was not specific to OSH, it nevertheless placed an institutional mechanism within government which had the net effect of maintaining a deregulatory impetus and to deliver deregulatory reforms, leading to a more implicit and insidious effect on OSH, with the field being ubiquitously ridiculed and becoming synonymous with the term burden, which has been positioned as the antithesis of entrepreneurism (James & Walters, 2005; Tombs, 1996). Tombs and Whyte (2012) further highlight that, deregulation was not restricted to conservative governments, they found that the Labour Government elected in 1997 achieved more in terms of 'deregulation' than their Conservative predecessors had, even though the Labour party rhetoric was couched in terms of 'better' rather than 'de' regulation and rhetorically transcended regulation/deregulation and labelled by the authors as a "third way" of regulation.

The increasing influence of the European Union on the UK's OSH system saw the emergence of European institutions as key actors in the policy landscape. Countries such as the UK that make up the EU (its 'member states') while remaining independent sovereign nations, pool their sovereignty in order to gain strength and influence. Pooling sovereignty means that the member states delegate some of their decision-making powers to shared institutions they have created, so that decisions on specific matters of joint interest can be made democratically at European level (EC, 2011). At the European level therefore, there is interaction between various state actors and institutions with European institutions such as the European Parliament, the European Council, the European Commission, European Courts and specialised agencies such as the European Agency for Safety and Health at Work (EU-OSHA) and the European Foundation for the Improvement of Living and Working Conditions (Eurofound), both of which are tripartite organisations. EU-OSHA works with governments, employers' and workers' representatives across the EU Member States, responsible for commissioning, collecting and publishing new scientific research and statistics on OSH risks as well as disseminating good practice on preventing risks (EU-OSHA, 2008). It works alongside Eurofound, whose role is to provide information, advice and expertise – on living and working conditions, industrial relations and managing change in Europe – for key actors in the field of EU social policy on the basis of comparative information, research and analysis.

### 7.1.2 Non - State Actors

"The freedom to organise, and lobby government is a hallmark of liberal democracy" (Harrop, 1992, p.269). Organised groups typically lobby government for issues specific to their interests; therefore they are referred to as pressure groups or interest groups. Interest group activities are interactions through which individuals and private groups not holding government authority seek to influence policy, together with those policy influencing interactions of government officials that go well beyond the direct use of authority (Lindblom & Woodhouse, 1993). Non-governmental pressure groups can include business associations, employer associations, trade unions, mass media, expert/professional associations/societies etc.

Between 1945 and 1974 the Unions have been termed the most enduring and often most important force for OSH regulation (Lyddon, 2010). The 1977 Safety Representatives and Safety Committees (SRSC) Regulations are said to have heralded a culture change at the ground level, through the inclusion of workers (Lyddon, 2012). Thus, safety representatives and safety committees had emerged as key stakeholders in the regulatory landscape during this period. Worker involvement in OSH became heavily linked with trade unions through the political climate of the 1970's and the Social Contract (Dawson et al., 1988). However, some authors such as Dalton (1992) argued that the Conservative government of the era and those that followed had the aim of "smashing the strength of the trade unions" (p.489). So, on the whole, the role of trade unions became significantly weaker both during and following the Thatcher Conservative government (Crombie, 2000).

Employers/businesses (often represented by business/trade associations) have always been a critical stakeholder in OSH regulation discussions. Lindblom and Woodhouse (1993) pointed out that important public tasks are delegated to the business sector in societies that employ market economies, these societies can be said to have a second set of 'public officials': business managers, who organise the labour force, allocate resources, plan capital investments and otherwise undertake many of the organisational tasks of economic life as governments award to business managers a privileged position in policy making. This is evident in their representation in the various task forces that were established to review the OSH policy arena, and the government's interest in establishing 'business-friendly' regulation, a trend that has continued until today. For example, in 1996, the HSC decided a concerted push was required to convey the health and safety message at board level and to use this message as a catalyst to improve and maintain OSH performance across organisations. The Institute of Directors (IoD) in collaboration with the HSE, developed new guidance for company directors in 2007, replaced the earlier guidance issued to directors in 2001 (HSE, 2007d). The 2010, Lord Young, a politician, former Executive Chairman of Cable & Wireless PLC and past president of IoD, was appointed adviser to the Prime Minister by the coalition government to review health and safety laws. The report 'Common Sense-Common Safety' focused predominantly on the impact OSH legislation had on business and personal freedom.

Economic incentives have also been used to promote OSH including both financial (e.g. insurance-related incentives, funding schemes, and tax-based incentives) and non-financial (e.g. including recognition schemes such as awards). Insurers and insurance brokers have a significant stake in UK OSH regulation, since they have fairly regular contact with their policy holders tending to visit them at least once a year (Better Regulation Executive, 2008), in comparison to HSE inspection visits of workplaces which occur, on average, every fourteen and a half years, with prosecutions declining over the last few years (Taylor, 2010). The Better Regulation Executive (2008) stated that insurers play a significant role in the OSH system with some respondents to their call for evidence stating they have even become "the main regulators in the regime" (p.42). As previously noted, under The Employer's Liability Compulsory Insurance Act (1969) they take on a number of similar roles to that of the HSE: notably, they stipulate conditions on employers; require employers to demonstrate compliance; and provide both personalised and general advice to employers (BRE, 2008).

In 2005, the Hampton Review 'Reducing administrative burdens: effective inspection and enforcement' was published, as part of the Government's better regulation agenda. The review placed emphasis on standards that regulators should acknowledge during inspection and enforcement (Hampton, 2005). BSI developed the first used standard on occupational health and safety management system BS 8800 which went on to become the OHSAS 18000 series standards – the most widely used OSH standard globally (BSI, 2012) and is now being developed into the International Standard for Occupational Health & Safety Management Systems - ISO 45001. The BSI also developed the first guidance standard on psychosocial risk management in the workplace – PAS1010 (BSI, 2011).

The findings from this research also highlighted the role of the media as a stakeholder. Participants felt the press (particularly tabloid newspapers) perpetuated, but were not solely responsible for, the myth of illegitimacy of OSH and the perception that OSH is burdensome. Fifteen per cent of respondents to the IOSH (2012) salary survey felt their work had been made more difficult by misreporting of health and safety issues and the general bad press OSH receives.) examined The role of the media in the amplification of risk among the public and the impact of self-reinforcing 'circuits' between lay public representations, everyday experience and social conversation has an impact on stakeholder perception and attitudes of OSH (Boden, 1992; Petts, Horlick-Jones & Murdock, 2001) which in turn has an impact on the policy making process though demands placed on elected public representatives (members of parliament, local councillors), enforcement agencies and on OSH practice through demands placed on organisations as well as OSH practitioners.

The Management of Health and Safety at Work Regulations 1999 require employers to appoint 'one or more competent persons' to help them to meet their duty to control risks at work. Many employers can get or develop this help in-house which they are required to use when it is available or seek external help or advice if in-house help is inadequate, or use combination of both. There are a number of different sources of external advice available. These include trade associations, safety groups, trade unions, consultants registered on the Occupational Safety and Health Consultants Register, local councils, health and safety training providers, health and safety equipment suppliers. As the provider they must be competent, give a good quality service and deliver help that is 'fit for purpose'. Competency relates to knowledge, skills and experience of the service provider.

How a service provider (internal or external) achieves competence is up to their discretion. Being a member (at the appropriate level) of a professional body which sets competence standards for its members, and prescribes levels of qualification and schemes of continuing professional development, is one way health and safety service providers undertake voluntary training and achieve competence (HSE 2007). There are a number of OSH professional bodies actively engaged in promoting the field of health and safety in the UK. The key bodies include the Institute of Occupational Safety and Health (IOSH), founded in 1945, is the biggest health and safety membership organisation in the world. IOSH is one of the world's leaders in health and safety training. Other key actors are the British Safety Council (BSC), Royal Society for the Prevention of Accidents (RoSPA), Independent Safety Consultants Association (ISCA), International Institute of Risk and Safety Management (IIRSM), British Safety Industry Federation (BSIF), Chartered Institute of Environmental Health (CIEH) and the National Examination Board in Occupational Safety and Health (NEBOSH).

## *7.2 Types of initiatives, their implementation and impact*

It is evident that the legislative and policy arenas of OSH are complex with multiple stakeholders who

often have discordant priorities and incentives (Tompa, Verbeek, van Tulder & de Boer, 2010). The various stakes of OSH stakeholders make the OSH policy process dynamic (Jain, Leka & Zwetsloot, 2011; Zwetsloot, Leka & Jain, 2008). This dynamism is evident in the types of OSH policy initiatives they have promoted.

The research indicated that a number of legislative (i.e. 'hard') and non-legislative (i.e. 'soft') policy-level of initiatives to manage and promote health and safety have been developed and implemented by a range of stakeholders (for example, from government, trade associations, employer associations, standardisation bodies) who were responsible for their development. These included, legislation, development of national strategy and accident reduction schemes, standards and certification, guidance, classifications and specifications, codes of practice, stakeholder/collective agreements (social dialogue), awareness raising campaigns, economic incentives/programmes, establishing networks/partnerships, performance evaluation and benchmarking tools.

Across the range of initiatives, from the mature to the more nascent, the effects of a changing political context at national and European level were evident on their workings. 'A strategy for workplace health and safety in Great Britain to 2010 and beyond' recognises that HSE resources are finite and limited and that recognising and engaging all the stakeholders involved in health and safety is essential for achieving the desired results (of achieving a world leading workplace health and safety record) (Harrison, 2012). This notion of shared responsibility was also espoused by the UK government's 'Health and Safety Strategy for Great Britain - Be part of the Solution' and was embodied by the tripartite and committee based structures and inter-dependent stakeholder approaches witnessed across several of the initiatives as part of the policy process itself. C3HARGE was an exemplar of this working; although the HSE provided a strategic steer, the initiative is predominantly one of self-regulation by the industries concerned, as initially envisaged by the Robens report (1972).

Within more 'contemporary' initiatives, HSE's role appears to have been more prescriptive in terms of implementation rather than development, with this prescription being an edict from the changing prioritisation of the government (Tombs & Whyte, 2010). For example, in the case of the recent update of RIDDOR, the role of the HSE was evidently more to do with policy legitimisation (i.e. enacting the policy into law via a legislative amendment) and policy implementation. Similarly with Fee For Intervention (which was also a legislative change) although the HSE did have some discretion about how to make efficiency savings, its role was principally an implementation one in terms of enacting the change into law and to levy fees (HSE, 2012). Partly due to these changes, the need to work differently presents an opportunity for the HSE to engage more fully with all OSH stakeholders and to empower and enable workers to play a greater leadership role with regards to their own well-being at work (Harrison, 2012). Shearn (2003) notes that one of the best channels for communicating the 'business benefit' is via business forums. Within the present research, a preeminent stakeholder in this respect was trade associations, who provided businesses with information about the benefits and merits of either their own initiative (for example, C3HARGE) or were a key stakeholder in extolling the virtues of other initiatives (for example, CHAS).

A central and critical question relating to changes in the OSH policy landscape in the UK is whether these efforts have been successful. Indeed much literature explores this notion, and the answer is far from straightforward. The data suggests that between 1974 and 2011, there was a fall in fatal injuries (83% decrease) and non-fatal injuries (77% decrease) (HSE, 2011c). Certain work-related illnesses have also shown decreased prevalence (specifically musculoskeletal disorders). However, statistics suggest the opposite trend since cases of stress, depression and anxiety have all increased (HSE, 2011c). The challenge is determining what to make of this data.

With regards to the dimensions of policy success purported by Marsh and McConnell (2010) several of the success indicators identified in this research could be considered to be or not to be 'process' (e.g. RIDDOR) or 'programmatic' successes. In the case of the WSA Challenge Fund, evaluation studies indicated that while stakeholders agreed that the initiative had been successful, they felt other initiatives to increase worker involvement should be explored. However there was no clear agreement among stakeholders on the best way to achieve this and of the three options offered, no clear consensus emerged (HSC, 2006; Pennie, et al., 2007; Sanger & Woodrow, 2006). As such using the Marsh and MConnell (2010) framework, it can be concluded that the WSA Challenge Fund initiative was not a 'programmatic' success because it did not deliver in terms of three indicators:

i) operational: it did not give sufficient time frames for worker involvement to manifest
ii) outcome: it did not leave behind sustainable change as safety advisors largely remained 'worker representatives' as opposed to 'change agents'
iii) resource: it was not considered to be a cost-effective method to further worker involvement.

Looking at another recent initiative two years after its launch, the OSHCR, the Safety & Health Practitioner (2013) "prompted by a number of less-than-enthusiastic threads on the IOSH discussion forums" (p.33) undertook an investigation of its impact. The research collated the main criticisms registered by scheme members and posed these to some of the organisations involved in the scheme's development and management and the evaluation criteria on which the register is currently being judged upon. Responses from IOSH, the Chartered Institute of Environmental Health (CIEH), RoSPA, the British Occupational Hygiene Society (BOHS), and the Institute of Ergonomics and Human Factors (IEHF) indicated these bodies are confident that the minimum criteria for membership on the register are, as they currently stand, adequate. Initial targets were set for the number of eligible consultants listed on the register, and these were exceeded. However, it remains to be seen whether a general register is the best solution to the diversity of OSH needs among the huge target audience of SMEs.

The findings, however, do shed some light in what constitutes success in policy initiatives. As expected, meeting targets was a key success indicator. However, it should be kept in mind that evaluation of initiatives was not a clear-cut area. In fact, this was the most challenging area for the research team to address due to limited available data. Taylor and Balloch (2005) pointed out that it is important to remember that evaluation itself is socially constructed and politically articulated. Policy evaluations are entwined with processes of accountability and lesson drawing that may have winners and losers. However technocratic and seemingly innocuous, every policy programme has multiple stakeholders who have an interest in the outcome of an evaluation: decision makers, executive agencies, clients, pressure groups (Bovens, Hart & Kuipers, 2006). Uptake of and satisfaction with the initiatives were two such success indicators while another was bottom-line benefits.

Evaluating the effects of OSH initiatives has become a growing concern in both the scientific and public policy arenas (Baril-Gingras et al., 2006; Leka & Jain, 2012). Shearn (2003) analysed a number of OSH case studies and reported the problems of quantifying certain benefits. For example, many of the success indicators were 'softer' issues, for example, improvements in workers' morale, business image or inter-personal communication. Such success indicators were also present in this research. For example, with MTMW one of the success factors for the ABI was the reputational benefits which the organisation accrued as a consequence of the initiative and the subsequent initiatives which emanated from it.

However, as Shearn (2003) notes, such indicators can be problematic because they are not readily translated into quantitative and economic benefits. An additional challenge is that even when 'direct benefits' can be quantified, it is not always apparent whether interventions are the main (or direct) cause of any measured improvements, as there are a range of mitigating factors (Shearn, 2003). Demonstrating impact of policy initiatives, in other words cause and effect, is particularly problematic in policy evaluation. Wolman (1981) argues that this might be because of the design of a programme. In some cases programme design may not meet the test of causal efficacy because objectives have not been adequately specified or simply because the design has not been adequately thought through in terms of the objectives. However, it may also not be possible to design an acceptable programme to solve every problem (Wolman, 1981).

There are also several methodological limitations with the data. One major issue is the inconsistency with which data has been collected over the reporting period. Underreporting poses a significant problem because not only does it misrepresent the OSH situation, but changes in OSH statistics may simply be changes in reporting behaviours rather than changes in actual injuries or fatalities (Dawson et al., 1988). Davies and Jones (2005) highlighted the difficulties the government faced with the 2000 'Revitalising Health and Safety Strategy Statement' in trying to demonstrate that the regulatory regime can have a positive impact on 'bottom line' measures. They state two main reasons for this: the array of regulatory mechanisms (including legislation, standard setting, research and development, campaigns, initiatives, as well as inspection, investigation and enforcement measures) within the system, and the other factors that are within the economic environment but outside of the regulatory system which can influence measures.

The authors note how previous studies (HSE, 1985b; 1991) have failed to make a direct link between the regulatory environment and 'bottom line' workplace injury rates. Instead of using fatality/non-fatal injury data, Davies and Jones (2005) note instead how intermediate outcome measures, for example, level of compliance with legal requirements, number of safety helmets purchased, exposure levels to toxic substances and numbers of workers who have access to occupational health and safety services, have been used as a proxy.

Due to problems in attributing causation between the regulatory environment and injury rates, Davies and Jones (2005) therefore chose to research the effects of the economic environment on injury rates. Analysing RIDDOR data between 1986 and 2004, they found that trying to identify, separate and assess the direct contribution of the regulatory system on 'bottom-line' injury measures above and beyond the various economic, personal, establishment and job-related characteristics is problematic. On the basis of their findings they questioned the logic of whether the government's 'bottom-line' targets are an objective measure against which to judge the performance and impact of the regulatory system. Instead, they recommend that future analysis should focus on establishing level data which considers the various dynamics noted above and, in addition, looks at the timing of regulatory interventions. This method they note would be an improvement on trying to unpick the reasons for injury rate movements from aggregate rates of workplace injury.

In addition, Kendall (2006) notes how international classifications of injury make comparison and attribution of causality between regulatory environments and workplace injury between countries difficult. The author cites an example from the UK where 39% of cases are classified as injuries whereas in the US 94% are called work-related injuries, and discussed how incentives and disincentives to classify injury result in arbitrary divisions that defy meaningful interpretation.

There is relatively little peer-reviewed research on the evaluation of OSH regulatory interventions (Leka et al., 2011a) with issues pertaining to the need for large-scale studies; the lack of control over the intervention, and study design limitations due to ethical and other concerns postulated as reasons (LaMontagne, 2000). In addition, the majority of regulatory intervention research conducted thus far has tended to concentrate on legislative rather than voluntary policies and on occupational safety rather than occupational health policy interventions (LaMontagne, 2003).

An HSE (2005a) report considered models of occupational health support to SMEs (e.g. the HSE's occupational health and safety and return to work support model). An early issue identified was that information published in refereed sources was extremely limited, which the authors criticise suggesting that a greater emphasis on evaluation of these initiatives should be a priority. Furthermore, the report concluded that quantified data was largely missing regarding a number of premises in the models. For example, data on cost benefit or cost effectiveness was entirely missing from most models. Despite this, qualitative data suggested there were many benefits to applying the models. Furthermore, reference material only considered positive outcomes, meaning that effective evaluation was hampered due to a bias in the data. These findings suggest that evaluation efforts are largely ignored whereby they should be a critical element of the policy making process.

Despite its plaudits, the UK's cost-benefit impact analysis model has been criticised for its predominant focus on the economic impact of regulation instead of its social impact, which may lead to important objectives in fields such as safety, social justice or fairness being neglected (Renda, 2006). Ruttenberg (1981) also criticises the economic focus of cost benefit analyses in the realm of social policy with the author arguing that, given the diverse range of variables included in OSH initiatives, with some able to have a monetary value, others quantifiable but unable to have a monetary value attached (for example, the value of life), and others unquantifiable, trying to use a single economic figure to accommodate these various externalities is inappropriate and ineffective.

Hjalte et al. (2003) also question the ethics of balancing health against cost. They describe a health-health analysis, which focuses on a complete assessment of the health impacts of any initiative. This includes considering the other risks affected by the reduction of the target risk (e.g. the effect of increased driver speed due to seat belt legislation on risk to cyclists) as well as the opportunity cost of investing in a particular initiative.

As is being increasingly seen, the dominant feature of the public sector is the relationship between many organised actors with separate interests, goals and strategies. The findings in relation to initiative success indicated that success depended on the extent to which government was able to influence the provision of goods and services, taking into account the self-regulating powers of the systems concerned, and coordination and control among these disparate stakeholders (Hanf & O'Toole, 1992). The findings clearly support that judgments regarding the possibilities of governmental guidance, or steering and control, must be based upon an examination of the institutional modes of coordination within the public sector, and coordination of multiple actors as an important precondition for increasing the capability of government to perform a more active part in the desired transformation of society (Kaufmann, 1986).

Collaboration in most areas of activity (work-related as well as social) is becoming increasingly common. The need in society to think and work together on issues of critical concern has increased (Austin, 2000) shifting the emphasis from individual efforts to group work, from independence to community (Leonard & Leonard, 2001). This was clearly supported in the findings of this research. Goldenhar and Schulte (1994) argue that within occupational health intervention studies a greater focus should be placed on the intervention process and milieu, rather than solely on the outcomes alone. In addition, Baril-Gingras et al. (2006) note that gaining a better knowledge of the necessary conditions and means to ensure the expected outcome of interventions is critical to achieve progress in the field of prevention, especially with respect to guiding public policy. Thus, this research has partly addressed these calls to action, with the process of implementation heavily scrutinised and featuring as a key theme in terms of barriers, facilitators and success indicator themes.

## *7.3 Enablers and constraints on actors to devise relevant strategies for achieving OSH goals*

On the basis of the overall findings of this research, it is possible to identify when OSH policy initiatives are working in practice. Seven key elements appear to be essential for their success. To begin with, the policy initiative has to meet an identified need in an appropriate manner. Linked to this, the specific policy initiative option has to have legitimacy in meeting this need. This might relate to it being promoted by an authority such as the European Commission or experts, or having a strong evidence base to support its implementation. The next key element is ownership of and commitment to the initiative by recognised stakeholders (such as the government, social partners, trade bodies or sectoral bodies). However, ownership of the initiative by specific stakeholders does not appear to be enough for longer term success. Consultation with various stakeholders and raising awareness in relation to the initiative are also key. This consultation should happen in a structured, systematic and transparent process. The initiative will have a greater chance of success if there is the right balance between different stakeholder interests depending on social, economic and political influences. Also important to its continuity is resource availability in terms of finances, personnel and time. Finally, where initiatives have been implemented through a structured process including clear objectives, responsibilities and evaluation methods that allow learning, knowledge transfer and future initiative development, chances of success are much higher.

Perception towards the initiative and engagement with it are issues that are relevant both to its issuers/policy makers and the target audience. Where OSH legislation reform has come from Europe, resistance has been observed in many cases by various stakeholders such as UK policy makers themselves, businesses and the general public (Löfstedt, 2011b). Perhaps due to some of the perceptions of health and safety raised by Lord Young's 'Common Sense, Common Safety' (2010) review "the standing of health and safety in the eyes of the public has never been lower" (p.5). As such, the initiatives were generally and unsurprisingly not raised by quite a few of the respondents as being political successes in terms of raising government popularity directly. However, the popularity of some of the initiatives helped the reputation of stakeholders who developed the initiatives, for example in the cases of Making the Market Work (the ABI) and C3HARGE (HSE).

Similar process issues were apparent in the current research. General attitudes towards health and safety, was an initial issue which drove the formation of the IoD guidance because many Directors did not perceive OSH responsibilities to be within their remit. Attitudinal resistance was also initially uncovered within some factions of the HSE Field Officer Directorate (FOD) during the nascent stages of the Management Standards' roll-out, with some FOD personnel initially perceiving the tackling of 'soft' psychosocial issues to not be in their job description. Resistance to behavioural change was also

a challenge among some of the FOD some eight years later, with Fee-For-Intervention. The widespread roll-out of cost-recovery across the HSE resulted in several FOD inspectors leaving the organisation because they did not agree with the principle of charging duty-holders for their time and services. In a similar vein, Lalani, Meadows, Metcalf and Rolfe (2012) found GPs had difficulty in both embracing the Fit Note as part of their role and opening dialogue with employers about it, so this initiative also presented attitudinal and behavioural challenges.

The findings of this research also resonate with Baril-Gingras, Bellemare and Brun's (2006) findings on organisational level interventions that showed managers and supervisors to have a strong influence on whether changes were executed or not. This concurs with the views of several policy developers within the current study. For example, whether the CDM ACoP was internalised from the outset into the working practices of organisations, rather than just superficially added as a bolt-on at the project's end, was to a large degree dependent upon the role of management. Likewise, the role of managers in the C3HARGE initiative was key. For example, senior management within the HSE were identified as crucial gatekeepers at the policy development stage, at the policy implementation stage via the scheme champions (who acted as the change agents), and among the target group, the trade associations and the companies within the four sectors. Across all of these actors, managers were a key stakeholder in terms of turning intellectual commitment or "buy-in" to enacting behavioural change.

Political will and resources from the issuers' superiors were identified as key success facilitators within the present study, but at the same time the emphasis on deregulation and the use of OSH as a 'political football' was noted by several respondents with a common view being that the perception of OSH as burdensome is driven by political ideology. James, Tombs and Whyte (2013) share this perception noting that within the current coalition government the deregulation discourse has been most prevalent and enthusiastically espoused in relation to OSH, and their approach to the assessment of 'regulatory burdens' excludes from consideration the issue of how far legal provisions are enforced.

A key theme emanating from this research was that various drivers motivate stakeholders to adhere to OSH best practice. Respondents largely identified three key pillars: legal, moral/corporate social responsibility, financial. These findings broadly echo previous research (e.g. Wright, Antonelli, Norton Doyle, Bendig & Genna, 2005; Wright, 1998; Wright, Marsden & Antonelli, 2004) that has found the main drivers to be: enforcement/regulation; reputational risk; the moral case; avoiding cost of accidents; business incentives; and supply chain pressures.

This research concurs with previous studies (e.g. EU-OSHA, 2010) which show that compliance with legislation is a key driver for many OSH interventions which are adopted in order to comply with regulations or to meet contractual arrangements (Wright, 1998). For example, as the findings showed, the requirements of the European Commission (EC) were a key driver behind the formation of many 'hard' initiatives and were a strong influence on numerous 'soft' initiatives, with the said initiatives facilitated to some extent by European policy actors (see also e.g. Gagliardi, Marinaccio, Valenti & Iavicoli, 2011). Indeed, membership to the EU has led to the Europeanisation of national policies of member states with Andersen and Eliassen (2001) noting that this implies a need for a new way of delineating the policy context, one with a wider scope, which includes the interaction between central EU institutions, the European network of national political institutions, and the actors operating at both levels. The trend towards Europeanisation produces more complexity where the central and national-level institutions, interest associations, corporations, regions etc. are brought together.

This changing trend was evident within the present research. Meeting the legal requirements of UK law and fulfilling Member obligations to EC law were found to be co-occurring drivers for multiple initiatives. For example, RIDDOR ensures the UK fulfils its obligations to provide the EC with data on occupational injuries and accidents; COSHH ensures that two EC Directives are transposed into UK law. In addition, other initiatives were driven by the need to assist duty holders in complying with UK legal requirements, as was the case with the Management Standards which assists duty holders in meeting the requirements of the Health and Safety at Work Act 1974 and the Management of Health and Safety at Work Regulations (1999). Similarly, the CDM ACoP, in principle, makes the CDM regulations tangible and actionable through the use of real world exemplars.

Therefore, through either the UK or the EC, regulation was a key driver. Culyer, Amick III and Laporte (2008) note a plethora of reasons for why workplace health and safety regulation and minimum OSH standards are required through government intervention. They note that due to: the absence of full employment; imperfect information; lack of perfect labour mobility across jobs; and the existence of externalities, the market left to its own devices will not yield an optimal level of compensation for risk, and workers would therefore face a higher than optimal level of risk.

Interestingly, Kankaanpää, van Tulder, Aaltonen and De Greef (2008) note that, in principle, a competitive market is supposed to lead to the optimal allocation of resource; however OSH in this respect is an anomaly. The authors note that in developed countries (such as the UK) employers are not always required to handle the negative externalities of production - the costs of ill health and disability - by themselves. This is because the risks of occupational accidents and diseases have been pooled, and the costs of lower than optimal OSH are covered by society. However, despite the assertions of Culyer et al. (2008) and Kankaanpää et al. (2008), a key driver, alongside regulatory influences and reviews, were the needs of the market in driving the formation and future forms of initiatives. Miller and Haslam (2009) state that behind legal reasons, financial and moral reasons (in that order) are the key drivers for businesses to engage in OSH. The 'business case' for OSH was identified in Wright and Marsden's (2005) analysis of survey data from 500 organisations. The results found 73% of employers believed health and safety requirements benefited their business as a whole, while 64% believed they saved money in the long term because of them.

With regards to the business/financial case, it was evident from respondents that the cost of insurance was a key factor in motivating firms (specifically board members) to take their OSH commitments more seriously. Wright et al. (2005) stated that whilst insurance was not an important driver for firms during the 1990s, its importance had grown significantly from 2002 onwards. Indeed their research found that due to increases in cost, the role of insurance, specifically employer's liability insurance, was taking on increasing significance. Wright, Marsden, Turner and Genna's (2003) analysis of survey data in 2002 found that organisations tried to counter steep increases in employer's liability insurance by improving health and safety, and also, to lesser extents, reducing operating costs, contesting claims and switching insurers. Thus, according to Miller and Haslam (2009) this does indicate that UK employers do respond to economic incentives in managing OSH. Similar findings have been reported in European studies, where the business case has been highlighted as particularly important for the management new types of risks in OSH such as psychosocial risks across all EU member states (EU-OSHA, 2012).

Wright (1998) notes that so-called 'softer' drivers work with highly motivated, higher risk firms, with companies operating in major hazard industries implementing health and safety management measures presumably as a matter of principle rather than for potential business benefits. Wright's (1998) assertion appears to be borne out in the present study in the case of CCNSG. In this case, large firms within the petro-chemical industry formed a working group and developed the initiative to address and combat the rising levels of serious accidents and explosions on their sites. However, the link of these incidents with cost cannot be overlooked.

The softer 'market-led' initiatives could also be considered in light of Budworth and Khan's (2000) continuous improvement model. This categorises organisations as follows: those not interested in OSH issues; the compliers; and the advocates. The authors note the first group are likely to be driven by enforcement and regulation, whilst the last group are influenced by reputation and longer-term costs. Some of the 'softer' initiative stakeholder responses indicate that the developers and clients of C3HARGE and the clients of OHSAS 18001 and CHAS could be categorised as advocates. The OHSAS 18001 respondent noted, for example, that clients, rather than standardisation bodies, drove the initiatives' continued development because they themselves wanted recognition for what they had achieved and wanted to differentiate themselves from competitors in the market. In CHAS' case, clients rather than the Safety Schemes in Procurement (SSIP) body drove the assessment cycle because they saw the initiative as offering them a cost-effective annual 'check-up'. With C3HARGE, all parties were reported to participate in the initiative because they saw a genuine benefit in doing so and wanted to go beyond the minimum requirements set by the state.

Regarding the moral driver for OSH best practice, the findings emanating from this research largely showed that corporate social responsibility was of secondary importance (behind legal compliance) and thus should be used as a supplementary aid to the 'stick' approach. Interestingly therefore the

findings aligned somewhat partially with the assertion of Boardman and Lyon (2006) who noted that businesses have a two-fold moral obligation: at a micro level to provide a 'duty of care' to their immediate stakeholders (e.g. employees, customers) and at a wider macro level to respond to societal concerns around OSH (particularly so when these concerns centre around the aforementioned duty of care).

In light of the pillars for engaging businesses, respondents also pointed out the opportunity for CSR to act as a driver for OSH engagement. Research has already illustrated that several companies have begun to cite OSH related interventions in CSR reports (Andreou & Leka, 2013). Furthermore, the publication of guidance has been shown to affect corporate reporting, in that companies' CSR reporting converges to what is included in guidance or standards (Chen & Bouvain, 2009). As such, governments, such as Denmark, have made publication of CSR related communication a legal requirement in the hope that it would stimulate intervention by companies in the direction of existing best practice (Danish Commerce and Companies Agency, 2011). This remains an avenue the UK could explore although it might represent a viable avenue for action following resource challenges facing the HSE. Indeed there has been a call for European wide legislation to make clear the requirements on companies in terms of their non-financial reporting, in an attempt to drive standards (Zandvliet, 2011).

Thus, within the present research it was evident that the legal driver was the primary driver reported by respondents. However, the use of OSH metrics being included within firms' annual financial/company reports were also alluded to as being a potential avenue through which to influence companies' future attitudes to OSH compliance (for example refining the inclusion of OSH metrics within the Global Reporting Index). As Boardman and Lyon (2006) note, there are numerous reputational factors which may influence a firm's engagement with OSH best practice, with the following two being key: the need to protect/enhance company image/reputation and avoid adverse publicity; the need to gain a competitive advantage and differentiate themselves within their sector through good OSH performance/avoid being the laggard within the sector. Similarly Wright et al. (2005) noted in their research how the fear of reputational damage and adverse publicity were emerging as key drivers in motivating firms to comply.

In addition, wider dissemination and open dialogue throughout the life of the initiative leads to initiative success and might increase the ownership of the initiative by both its issuer and the target audience. Dialogue among stakeholders has probably been studied most in relation to social partners' dialogue within the social dialogue literature (e.g. Ertel et al., 2010). However, such aspects are considered good practice elements in all types of interventions a not only those at the policy-level (Leka et al., 2008).

Resource constraints (both in terms of finance and personnel attrition) appeared to impinge upon initiatives. Lack of adequate funding is probably the most frequently cited reason for programme failure, particularly by programme operators and clientele groups. In addition, critics often argue that governments lack the political will to solve problems. Others reply that inadequate funding is usually a suspect argument because it is empirically irrefutable; no matter what the level of funding, it can always be argued that it was not adequate to permit programme success (Wolman, 1981). Resource issues heavily influenced the HSE, and potentially also changed the nature of its involvement in the policy process. For example, in several of the more mature initiatives, HSE appeared to have a greater developmental involvement in the policy process. In the case of the Management Standards, the HSE were involved in what Dye (2010) refers to as policy formulation; with the Standards being developed by HSE in consultation with external stakeholders, business and academia. In addition 'in-house' expertise was used to develop not only the content of the Standards but also the approach to implementation. Similarly, with COSHH, the autonomy the HSE had around the early iterations of the legislation (circa 1988) appeared to change over time due to similar constraints.

Throughout this research, the effect of the changing OSH landscape upon SMEs is of keen interest. Amongst many stakeholders interviewed, a finding that emerged was that for this group OSH was perceived as burdensome and was found to have a relatively low priority. Thus drawing parallels with the research findings of Wright et al. (2005) and Davies and Mckinney (2001) respectively. The issue of the cost of OSH compliance for SMEs was also evident within the present study. The research of Vickers et al. (2003) resonates with this finding. Their research found that the cost of achieving good OSH performance was clearly a demotivating agent for SMEs whereas in larger organisations the cost is more likely to be viewed as an investment.

Cagno et al. (2013) state that many managers see OSH as a matter of rule following and compliance rather than a management value per se. Thus, smaller enterprises prefer a prescriptive approach to compliance with law (i.e. which precisely defines operational procedures) (Micheli & Cagno, 2008). However, Cagno et al. (2013) note that if this is the sole approach taken, then progress will be slow as enterprises will persist in perceiving OSH measures as costly obligations and vis-a-vie fail to appreciate their positive economic value, and thus 'making the case' of OSH economic value for SMEs is of urgent importance.

To facilitate this at a practical level Cagno et al. (2013) outline six main dimensions to motivate SMEs to conduct an economic evaluation: this evaluation should combine measurement of both health and safety and productivity and legal requirements, and it should consist of both quantitative analysis (cost-benefit) and qualitative appraisal. This evaluation process should include an "overall vision" of the OSH process with cause-and-effect relationships between the above metrics extrapolated to facilitate decision making. However, Biddle et al. (2005) observe that SMEs' motivation to conduct such an evaluation differs from larger enterprises since they have less perception of risk, less immediately available data and fewer human and economic resources than their larger counterparts. For Biddle et al. (2005) the need and the benefit of conducting such an evaluation has, therefore, to be conveyed to them by external agents.

Engagement of SMEs has always been an issue in OSH policy initiatives (Taylor, 2010). Engagement has been shown to be more successful in sectoral initiatives as in other countries (e.g. Blatter, van de Bossche, van Hooff, Vroome, & Smulders, 2008) and, in certain cases, where the evidence base is strong or 'mature' (Sanderson, 2002). However, sometimes successful engagement comes with associated challenges as in the case of meeting increased demand when resources are scarce. This relates to what Wolman (1981) calls technical feasibility of an initiative and it is dependent on other key aspects such as political support.

## *7.4 Priorities and recommendations for key stakeholders to enable the promotion of health and safety in the changing OSH landscape*

On the basis of the findings from this research and discussion of the changing OSH landscape, five key recommendations can be made to enable the promotion of health and safety going forward. The first two relate to OSH legitimacy, raising further awareness on OSH and engaging key stakeholders. The remaining recommendations concern the need for better regulation of OSH, the consideration of occupational health in OSH policy initiatives and action, and finally the need for working in partnership and learning from the past.

### 7.5.1 Re-iterating OSH legitimacy

This research has highlighted that the OSH landscape is dynamic. As the landscape has evolved over the years in the UK, so have the perceptions and attitudes in relation to OSH alongside socioeconomic and political developments. The changes in the perceptions and attitudes of the stakeholders identified in this study have had an impact on the legitimacy of OSH and OSH professionals. Perhaps two of the most apparent observations are a trend towards deregulation of OSH and an associated shift in OSH risk perception (as well as sensitivity and tolerability) – within the broader context of what has been called a post-trust society (Slovic, 1993), in which as a consequence of trust failures, relatively minor mistakes may affect the social acceptability of specific risks, including OSH-related risks.

Research reveals that trust plays a major role in shaping public views and risk decisions. The issue of trust has come to the fore as it has become apparent that confidence in industry and government is declining in many countries. Löfstedt (2005) suggests a number of explanations of why the public's trust toward these bodies has decreased dramatically, including:

- The 'sheer number and size' of regulatory action.
- The rise of 24-hour television and Internet, offering alternative non-expert sources of information.
- The increasing concentration of political power.
- Media amplification.

The development of OSH legislation in the UK, at least during certain eras, has been criticized as being haphazard and or reactive (Rimington et al., 2003) to specific situations such as major industrial accidents and disasters, often characterised as regulation reflex or knee-jerk regulation, defined as 'neurotic over-regulation in response to overreaction to risks, accidents and incidents' (Van Tol, 2011). Another issue around regulatory action relates to the enforcement of regulation and the negative impact on stakeholders. Both the 2010 Young review and the 2011 Löfstedt review highlighted the challenges posed by the way legislation is interpreted and applied, and the inconsistent enforcement of OSH regulations and negative influence of third parties such as OSH practitioners/consultants.

The significant role played by the media as a stakeholder in shaping perceptions and attitudes in relation to OSH have been discussed in this report. Petts, Horlick-Jones and Murdock (2001) examined the media's role in the amplification of risk among the public and found that tabloids tended to personalise risk events and editors had a tendency to move the emphasis away from the immediate precipitating causes of risks to their consequences for the individuals and groups they affected. Likewise, Boden (1992) found tabloids drew extensively on personal testimony in the construction of stories. According to the author, this approach produces self-reinforcing 'circuits' between lay public representations, everyday experience and social conversation. Such findings lend support to the argument that tabloid journalism is informed by a strong populist sensibility that seeks to speak to and for the 'man and woman in the street'. Although this is not necessarily problematic, it becomes so when the representation of stories is incomplete or even inaccurate.

This research findings highlighted that stakeholders were of the view that OSH was perceived as illegitimate and burdensome primarily by government rather than by the general public or industry. This finding was contrary to that reported in Lord Young's (2010) report which states that "the standing of health and safety in the eyes of the public has never been lower" (p.5). It is therefore important that efforts are made to address the challenge posed by the perceived illegitimacy of OSH. Academics (e.g. Löfstedt, 2007; Slovic, 1987) have noted how perception within OSH differs widely between experts and the general public. Raising awareness and educating stakeholders and making efforts to streamline legislation (e.g. better regulation initiatives) can therefore help to legitimise OSH for all stakeholders.

It is however important to emphasise that better regulation initiatives should not end up solely as deregulation. When allied to risk-based rationales for enforcement, responsive regulation can allow a deregulatory momentum to develop. Tombs and Whyte (2012) note this rationale is inseparable from and is being used to advocate techniques of 'risk-based' targeting which is a means of allocating ever-decreasing levels of regulatory resources (Tombs & Whyte, 2006). This, according to this research participants, can have a detrimental effect on OSH standards, if not applied appropriately and according to the evidence base. To ensure OSH legitimacy does not suffer because of political or media interests, there is a need to raise awareness and engage all key stakeholders while being more vocal about OSH successes over the years.

### 7.4.2 Raising awareness of OSH and engaging key stakeholders

Engaging key stakeholders was highlighted as a key priority in this research. Participants reported that getting involvement and getting into the business was difficult as there was still a lot of scepticism to overcome, particularly from SMEs. It is important therefore to emphasise and reiterate the value of OSH management and practice to promote not only workers' health and safety but also organisational health, increased productivity, enhanced corporate image/reputation and organisational sustainability. To achieve this, OSH management needs to be positioned and recognised as an integral part of business operations rather than as an add-on. This requires stakeholder engagement at the policy level, where they actively participate in the policy making process and assist the regulators to ensure that policies developed are implemented effectively. This would involve, for example, businesses to openly voice the virtues of OSH regulation and assist regulators in doing their job.

The need for continual training, education and re-education has been a long standing issue throughout this research. Training and education programmes should be targeted not only at managers, health and safety representatives and OSH practitioners but at colleges, universities and business schools. It is important for training and education programmes to clarify the concept of risk and also adequately cover content on new and emerging risks rather than focusing primarily on traditional OSH issues. The concept of risk and its application was found to be a widely recurring

theme in this research. This is perhaps somewhat unsurprising considering that Tombs and Whyte (2012) note how risk based forms of regulation are now ubiquitous across UK regulatory bodies. Indeed, as discussed in this report, regulation is now extending beyond and becoming "de-centred" from the state to various non-state bodies not least operating through market-based relationships and through civil society (Hutter, 2006). There is therefore a need to raise awareness amongst stakeholders on the difference between hazard versus risk based policy approaches, taking into account their advantages and disadvantages and the wider impact on societal objectives. It is also important to note that the two approaches are not mutually exclusive since in order to assess risks, it is necessary to understand existing hazards.

Linked to this issue, is the clarification of the concept of 'low-risk' and how the classification of sectors, activities, areas, businesses, and industries come to be as such. Risk based regulation is one driver for such an approach as well as OSH tradition which primarily focuses on safety concerns. However, often this rationale ignores the current evidence base and taking into account new and emerging risks in the OSH landscape which represent major concerns in modern workplaces (such as psychosocial risks and health-related concerns). In addition, research participants expressed concern that many small and micro businesses which are now labelled 'low-risk' actually face some of the largest health and safety risks. It is therefore important that further awareness is raised across all stakeholders on the notion and severity of 'risk' to reduce ambiguity and promote good practice according to the evidence base.

### 7.5.3 The need for better regulation - not deregulation

The question of balance in OSH policy and practice has been raised repeatedly in this research. One issue of relevance to decision making at both levels is the analysis models used to capture key variables as accurately as possible. However, models used in OSH policy making and OSH practice are traditionally based on economic considerations which, on their own, are unsuitable to concepts such as safety, and even more so health (and certainly not without moral criticism). This research indicated that the preferred mode of action when it comes to OSH regulation over the years has been reactive and deregulatory, often implemented too fast. Or, in short, what actors are used to, depending on their political ideologies, analytical frameworks, and other wider influences. Coupled with the common trend of the evidence base being ignored, or at least ignored in relation to 'uncomfortable issues' (such as, for example, workplace mental health), the extent to which evidence-based policy making is a reality in the OSH arena is questionable.

Better regulation, often characterised by deregulation, has been a key theme since the 1980s that has expanded at EU level (Baggot, 1989; Dawson et al., 1988; Dalton, 1992; Walters, 1994). This change has been evident since the 1970s when the first attempt to consolidate OSH regulation was made with a view to shifting responsibility to employers. Stakeholder consultations and impact assessments (IAs) are now increasingly being considered as essential parts of the policy making process (EC, 2010). Bartle (2008) notes that within the UK through better regulation (and its mechanism, the IA), there appears to be a clear striving by the UK government towards a scientific-technocratic model. Hutter (2005) notes how this model attempts to inject greater objectivity and transparency into the regulatory process (and thus legitimise it) particularly in the eyes of business and industry.

However, there have been a number of criticisms levelled at IAs. For example, Hood, Rothstein and Baldwin (2001) note that the techniques of better regulation, and specifically IAs, are more appropriate for narrow 'regulatory craft' rather than for policy problems and regulatory regimes. In addition, IAs conceal difficult qualitative trade-offs that have to be made. Studies also indicate that IAs are still found to be haphazard, and regulations are at times based on emotions, not science (Löfstedt, 2007). Issues encountered in regulatory reviews and application of IAs include: poorly defined objectives leading to omissions or parts of the policy structure not covered; inadequate use of evaluation techniques; complexity and fragmentation as a result of which too many checklists can cover a bewildering range of issues and reduce the process into a check box ticking exercise; and finally poor integration with consultation processes which limits their practical effectiveness (Löfstedt, 2007; Renda, 2006; Torriti, 2007). Furthermore, not everyone agrees that IAs, particularly cost-benefit analysis, are justified or useful. Such researchers believe that IAs solely focusing on quantification and monetisation is a form of pseudo-science, with the pernicious effect of blinding us to the real values at stake (Ackerman & Heinzerling, 2004). They emphasise that the use of techniques such as cost benefit analysis must be used appropriately during the process of regulatory review and

decisions must be made in a transparent manner.

Bartle (2008) notes that the HSE is one of the government bodies which address risk and uncertainty most explicitly and directly - as outlined in its 'Reducing risks, protecting people: HSE's decision-making process' document (HSE, 2001). Within this document, there is an explicit recognition that risk cannot often be reduced to a 'quantifiable physical reality' (HSE, 2001, p.11) and there are different kinds of risk which emanate from psychological and social perspectives (HSE, 2001, p.25). Societal concerns and human values require judgement, and these are not amenable to be reduced to numbers or to be dismissed as the irrational concerns of the uneducated.

The UK is acknowledged to have one of the best OSH records in the world. At the same time, the recent OSH reviews in the UK have found the regulatory framework to be fit for purpose. However, the actions that followed were still based on economic considerations within a deregulatory framework – as many times before. The questions that then arise are: what the purpose of these reviews is, and whether effort will be devoted to evaluate different policy options using a more robust framework (than just relying on economic considerations), and including all the available evidence. A strong need was identified in our research, to engage in collaboration between stakeholders and to utilise different policy tools in order to arrive at a holistic regulatory package, so as to engage business with appropriate incentives. Related to this was a strong need to improve education of OSH concepts. This would facilitate a more accurate perception of OSH, so that successes can be celebrated, understanding that strong OSH performance saves lives, rather than viewing it as a barrier to business. Going forward more effort must be devoted to a critical appraisal of the approaches taken in the past, in order to learn from them and make a more informed decision on future actions.

### 7.5.4 Reiterating the 'health' dimension in OSH

Reaction to the Young report saw general support from trade associations, employer groups and OSH membership groups for its underlying 'common sense' principles. However, IOSH were critical of the report's ignorance of the 'health' in work-related health and safety and saw the report as a missed opportunity in this regard (IOSH, 2010b). A preoccupation with occupational safety to the detriment of occupational health was also raised by several respondents within the present research.

James, Tombs and Whyte (2012) note that the Löfstedt report acknowledges that occupational health conditions can occur in the kinds of workplaces that are traditionally considered less risky, such as offices and the service industry but the report proceeds with no further commentary on the occupational health issues that workers in such premises face. In addition they note that a further problematic feature of defining workplaces as 'low-risk' is that one of the most dangerous OSH problems UK workplaces face, work-related stress, is health-related. Some respondents were also of the view that the emergence of occupational health was linked to the changing nature of work (particularly in light of the current economic climate) with businesses increasingly requiring employees to 'achieve more with less'. This, ties in with much of the previous literature. For example in a review of psychosocial hazards in the working environment, Leka and Jain (2010) suggest that patterns including downsizing, outsourcing, subcontracting, and globalisation are associated with issues such as demands for workers' flexibility, self-regulated work and teamwork (WHO, 2010).

Dame Carol Black, in her review of sickness absence (2008), recognised the contribution of ill health to sickness absence. Citing statistics from the HSE, Dame Carol Black noted that while injury contributes 4.4 million absence days, work-related ill health contributes five times that amount, at 22 million days. However, Dame Carol Black also put these figures in perspective noting that only one-fifth of the total working days lost to sickness absence stem from work-related sources. These facts have been common knowledge for some time but have not received the attention they deserve through a comprehensive strategy to address them.

In the recent government response to Dame Carol Black's review, it is stated that "the importance of the relationship between work and health is now generally accepted" (DWP, 2013, p.54), and that "The Government is committed to improving the health and wellbeing of the UK workforce" (p.7). It appears to be on the basis of this understanding, and a recognition from government that business also understands this relationship (Young & Bhaumik, 2011), that the government has committed to addressing a range of Dame Carol Black's recommendations including: the provision of a health and work assessment and advisory service; revising fit note guidance for GPs; commissioning further

research on sickness absence management and sick pay regimes in industry; and the removal of systems which created unnecessary burdens or incentives not to manage occupational health.

The majority of participants in this research applauded the Black review (2008) as a rigorous piece of work and noted the recommendations which emanated from it as laudable. However, respondents were not as optimistic that these recommendations had been acted upon. A consensus appeared to emerge that the government is still predominantly focused on the symptoms of occupational ill-health (i.e. absence management). These assertions appear to be borne out by the government's independent review of sickness absence by Black and Frost (2011) which builds on the findings of the Black (2008) report. There is still a lot that needs to be done to integrate 'health' more concretely in OSH policy initiatives.

This research has reviewed and analysed a range of OSH policy initiatives, however most focus on specific hazards, industries or sectors, and only a few comprehensive approaches to promote good practice exist. There is a need to use a more integrated approach to promote OSH. Examples of such initiatives include the WHO Healthy Workplaces Framework (WHO, 2010) which defines "a healthy workplace as one in which workers and managers collaborate to use a continual improvement process to protect and promote the health, safety and well-being of all workers and the sustainability of the workplace by incorporating four avenues of influence: 1) the physical work environment, 2) the psychosocial work environments, 3) personal health resources (health promotion) and 4) Enterprise-Community Involvement (CSR). In the Netherlands an Integrated Health Management (IHM) approach was developed which is defined as the systematic management of the interactions between business activities and (public) health (including occupational health), with the aim of stimulating the health of people and of the organisation (Zwetsloot & Pot, 2004). In the US, NIOSH introduced a similar development using the term Total Worker Health for approaches that integrate occupational health and safety (protection) with workplace health promotion (promotion of healthy life-styles) (NIOSH, 2012).

Piecemeal initiatives in policy and practice will not succeed in furthering the current state of the art in OSH given the several challenges and constraints identified in this research. A comprehensive approach is needed that will be promoted through partnership across OSH stakeholders.

### 7.5.5 Working in partnership and learning from the past

This research supported the view that a participatory approach from all stakeholders within the OSH landscape is required in order for several of the facets of the optimal OSH landscape to be achievable. These views were also shared by Harrison (2012) who notes that in order for the OSH system to make further gains, there is a need for greater partnership working between the regulator, employers and social partners. Just as the present participants noted, the need to work differently presents an opportunity to empower and enable workers to play a greater leadership role, with regards to their own wellbeing at work (Harrison, 2012). Partnership is more important now than ever with the emergence of many non-traditional OSH stakeholders and the role they can play in regulating OSH.

Working in partnership is particularly important to overcome constraints and learn from each actor's initiatives. To do so, it is necessary to critically review further what actions and approaches might work best and under what conditions. As the OSH regulation landscape in the UK is complex and dynamic, various perspectives on various possible policy options and initiatives need to be explored comparatively to achieve a better understanding and make recommendations on the way forward. This research has already identified some key success indicators, but it has also highlighted the lack of evaluation in these efforts. Since as it is evident in this report, certain trends have consistently been repeated in the OSH landscape over the years, a great deal of knowledge can come from examining and learning from the past and from sharing the lessons learned.

# 8. Recommendations for IOSH and its members

The OSH landscape in not independent of wider influences, including social, economic and political. These do not only define how OSH is dealt with but also the nature of work itself and working practices that stakeholders are often too slow to respond to. The more complex the landscape becomes in terms of the influences it receives (and their outcomes) and the actors that emerge, the more flexibility is introduced in the system in terms of control, evidenced by the increasingly diverse forms of regulation that have been implemented over the years. While OSH regulation used to be prescriptive and rigid, it has evolved into being goal-setting and risk-based, with voluntary forms of regulation emerging (soft law) in addition to legislation (hard law). At the same time, more stakeholders are now active in the OSH landscape than ever before playing an important role and promoting their own approaches to OSH regulation.

In reviewing the changing landscape of OSH regulation in the UK, it becomes apparent that history repeats itself in many ways. Examples in the case of OSH would be the definition of priorities, such as reducing the burden on businesses and especially SMEs, and deregulation in all its forms. In the current OSH landscape, legitimacy of health and safety, promoting a holistic view on OSH, working in partnership, and education are vital to the promotion of good practice. It is in these areas where the biggest health and safety membership organisation in the world can take concrete action towards achieving a gold standard in OSH policy.

## *8.1 Recommendations for the role of IOSH*

### 8.1.1 Reiterating OSH legitimacy

A consensus appeared to emerge among the stakeholders that the OSH industry needed to have greater celebration of its successes. These assertions were also largely shared by respondents to the IOSH (2012) salary and attitudes survey, which drew responses from circa 4,000 health and safety professionals. Respondents to the survey opined that the industry should celebrate its consistently low fatality rates, and, focus on positive health and safety messages. One example cited within the survey was the construction of the Olympic stadium in 2012 - the first Olympic in the history of the Games to be completed without a fatality (Waterman, 2013).

Allied to this point was a widely held opinion among participants that the OSH system could be bettered by having a more flexible and dynamic approach by using social media and social marketing more intelligently. As Lavack et al. (2008) note, the use of social marketing within OSH is in its nascent stages. The authors note there is relatively little within the OSH literature about this medium's role in reducing workplace injury and whether specific initiatives have addressed and reduced occupational injuries. However, of the handful of studies conducted (e.g. Spangenberg et al., 2002; Guidotti et al., 2000; Vecchio-Sadus & Griffiths, 2004) into this emerging OSH strategy, it appeared that the chances of successfully facilitating behavioural change are much higher if comprehensive social marketing programmes are sustained over time.

IOSH can play a leading role to reiterate the legitimacy of OSH by widely publicising success stories and launching a dynamic social medium strategy. These are in line with some activities already being carried out by IOSH but there is clearly the need for more action.

### 8.1.2 Promoting a holistic view of OSH

There have been a plethora of new and emerging risks within the UK working landscape which have presented challenges for the regulatory community within OSH. These, for example, relate to changes to the industrial landscape, business management trends, the labour force, and human resource management techniques (Walters, 2011). In addition, new and emerging risks include psychosocial risks which are prominent in the modern OSH landscape with an associated high cost, especially in relation to occupational health problems. However, the research respondents repeatedly highlighted an ongoing preoccupation with occupational safety to the detriment of occupational health, both by policy makers and practitioners. They also criticised how this short-sightedness impacted policy making and the use of evidence, with a frequently cited example being the definition of high vs low risk sectors. They also criticised the knowledge and skills of practitioners in relation to occupational health and highlighted the need to 'put back the h in health and safety'.

IOSH were also critical of the Lord Young report's ignorance of 'health' in work-related health and safety and saw the report as a missed opportunity in this regard (IOSH, 2010). It is therefore recommended that IOSH expand their coverage of occupational health issues in their initiatives, including investments in training and research, and promote a holistic view of OSH according to the evidence-base.

### 8.1.3 Supporting evidence-based OSH policy

Linked to the above point, IOSH stated that the Young review repeatedly confused 'low hazard' with small businesses and this confusion would be to the detriment of businesses trying to interpret and make sense of its recommendations. IOSH went on to note that the two UK sectors with the highest number of fatalities and serious accidents are Construction and Agriculture, both of which are dominated by small businesses (IOSH, 2010b). Within the workshops, a critical yet still unanswered question among participants was how activities within a workplace, sector, or industry, can be labelled low-risk if there is no evidence to support such a label.

Independent evidence based conclusions have been made to governments; however, the research has shown that governments over the years have often overreached in their response to recommendations. The use of evidence in policy making is critical for policy success and IOSH should continue to play in leading role as a provider and resource partner for the provision of such evidence.

### 8.1.4 OSH education

The paucity of UK higher education courses that are either specific to OSH or which contain OSH content was cited as a related key concern by participants in the study. This finding draws parallels with continuing efforts at EU level to promote OSH into education. For example, the 2003 Rome Declaration 'Mainstreaming OSH into Education and Training' aims to prepare and sustain people during their life, engage schools and other professional training institutions in actions providing a safer and healthier workforce in the EU (EU-OSHA, n.d). In addition, the European Commission's Community Strategy 2007-2012 for Health and Safety at Work, reemphasised the importance of integrating OSH into education (EC, 2007). Following these approaches a 'Whole-School Approach' was launched which specifies how the aims of the Rome Declaration will be reached (EU-OSHA, 2013). Löfstedt (2011b) notes that although demand is high, there remains a dearth of supply when it comes to OSH courses within the curricula of higher education in European universities. Hawkins and Booth (1998) reviewed the extent to which OSH is currently taught on MBA programmes to establish the views of MBA course managers and teaching staff about the subject. The findings showed that of the eight courses under review, explicit OSH content was either non-existent or limited.

IOSH is one of the world leaders in health and safety training. It is recommended that IOSH supplements its training activities by promoting collaborations to help in mainstreaming OSH training in schools and higher education institutions. It is important that there are efforts to educate not only business leaders but also practitioners and policy-makers. The aforementioned use of social media as well as lobbying, dissemination of research findings, and working in co-ordination with other stakeholders could be instrumental to this end.

### 8.1.5 Working in partnership

Perhaps the most prominent success factor in OSH policy making, as identified in this research, was working in partnership with other key stakeholders and balancing interests. Collaboration in most areas of activity (work-related as well as social) is becoming increasingly common. The need in society to think and work together on issues of critical concern has increased (Austin, 2000) shifting the emphasis from individual efforts to group work, from independence to community (Leonard & Leonard, 2001).

The policy review and analysis has demonstrated that IOSH has worked collaboratively with multiple stakeholders in the development and implementation of some initiatives (e.g. the recent Occupational Safety and Health Consultants Register, ISO 45000). It is recommended that IOSH continue to work, and strengthen collaborations, with traditional as well as new stakeholders identified in this research. This is particularly important within the political context, to achieve maximum impact and sustainability of efforts and to raise the profile of OSH.

## *8.2 The role of OSH professionals*

It was clear from participants that the role of OSH practitioners has grown in encompassing additional responsibilities (i.e. environmental and quality responsibilities). In addition respondents noted how practitioners' roles are envisaged to grow further in light of the current deregulatory and economic climate. Regarding the role of OSH professionals, Hale et al. (2005) note that the vast majority of empirical research which investigates safety professionals centers around what professionals think their job is or what they believe it should be. However the authors note a paucity of research remains which investigates what the safety professional's job actually entails (with a few notable exceptions in the USA and Canada) and the problematic nature of defining who should be considered a safety professional within Europe. Leka, Khan and Griffiths (2006) investigated future priorities for health and safety practitioners in terms of training needs. They identified that the highest priorities in occupational health were mental health issues and work-related stress. Referring to knowledge gaps in practitioners, the report also identified a need for a better understanding of risk, legislation, and the multifaceted nature of ill health. There were also similarities in terms of skills identified needing improvement: making the business case for workplace health, and soft skills including influencing and leadership.

Another longstanding issue within both this research and the extant literature was the role of practitioners within the OSH arena and whether or not they were part of the 'problem'. A consensus appeared to emerge that this depended, to a large extent, on their level of competence. These views resonate with the views of IOSH (n.d. p.1) who note "Some consultants may overcomplicate health and safety, assess risk poorly or miss important hazards. They can contribute to misperceptions about what is really needed to protect people at work". How practitioners can become more competent was a key issue explored in this research, with the point being made that training alone will not suffice. There is a complex interplay between other individual variables and the context in which competence occurs. These views concur with Leathley's (2013) who notes that training may be a suitable vehicle for providing knowledge and skills. However training and experience are the inputs within the system; with knowledge, and/or skills and abilities being the outputs. Thus, two individuals who attend the same training and are presented with the same opportunities can end up with different levels of competence, due to differences in initial aptitude. Therefore, a qualification is evidence of training not of competence (Leathley, 2013).

The role of the OSH practitioner is therefore to ensure that they are aware of the changes in the OSH landscape and engage in continual professional development. They should advise clients ethically and refrain from being over-zealous when implementing initiatives at the company level. Understanding the needs of their clients and communicating in language that is understandable by non-experts will also assist practitioners to meet the OSH needs of SMEs. Finally, they should be aware of key issues and promote a holistic view of OSH as outlined before.

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# Annexes

## *Annex 1: Policy matrix grid*

| Regulation / Stakeholders | Legislation | National strategy development/ accident reduction schemes | Standards and certification | Guidance, classifications and specifications | Codes of practice | Stakeholder/ collective agreements (social dialogue) | Awareness raising campaigns | Economic incentives/ programmes | Establishing networks/ partnerships | Performance evaluation/ benchmarking tools |
|---|---|---|---|---|---|---|---|---|---|---|
| **Employer associations** | | Ceramic Industry Health and Safety Pledge[5] | | Leading H&S at Work[3] | | Tele-work & WRS framework agreement [2] | | | | CONTOUR[1]<br>SME Indicator Tool[24] |
| **Trade unions** | | Ceramic Industry Health and Safety Pledge[5]<br>LiveWire[5]<br>Making a Difference[6]<br>C3HARGE[8]<br>Safety ports[9]<br>Recipe for Safety[10]<br>GLASS [32] | CHAS[15] | Leading H&S at Work[3]<br>Safety ports[9]<br>Recipe for Safety [10]<br>GLASS [32] | | Tele-work & WRS framework agreement[2]<br>C3HARGE[8] | | | C3HARGE[8]<br>Safety ports[9]<br>Recipe for Safety[10]<br>GLASS [32] | |
| **Government and its agencies** | COSHH [11]<br>RIDDOR [12]<br>The Statement of Fitness for Work[13]<br>Fee for Intervention [44] | Ceramic Industry Health and Safety Pledge[5]<br>LiveWire[5]<br>Making a Difference[6]<br>C3HARGE[8]<br>Safety ports[9]<br>Recipe for Safety[10]<br>Revitalising Health and Safety[14]<br>Concrete Targets[29]<br>GLASS [32]<br>Struck by [42] | Management Standards [7]<br>CHAS[15] | Leading H&S at Work[3]<br>Safety ports[9]<br>Recipe for Safety [10]<br>Workplace Health Connect [16]<br>Occupational Health Advice Lines [17]<br>Estates Excellence[22]<br>Workers Safety Adviser Challenge [23]<br>GLASS [32] | CDM [18] | Tele-work & WRS framework agreement[2]<br>C3HARGE[8] | Asbestos Hidden Killer [19]<br>SHIFT; Action on Stigma [20]<br>Safety Climate Tool [21] | | C3HARGE[8]<br>Safety ports[9]<br>Recipe for Safety[10]<br>Estates Excellence [22]Workers Safety Adviser Challenge [23]<br>GLASS [32] | Safety Climate Tool [21]<br>SME Indicator Tool[24] |
| **Consultants and OSH services** | | | CCNSG [45] | SafeContractor [27] | | | | SafeContractor [27] | | CONTOUR[1] |
| **Insurers** | | | | Estates Excellence[22]<br>Making the Market Work [25] | | | | Making the Market Work [25]<br>HealthCheck [26] | Estates Excellence [22] | Scorecard [28]<br>SME Indicator Tool[24] |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | HealthCheck [26]<br>Scorecard [28] | | | | | | |
| **Health care institutions** | | | | Workplace Health Connect [16]<br>Occupational Health Advice Lines [17]<br>Estates Excellence[22]<br>Mindful Employer [30] | | | SHIFT; Action on Stigma [20]<br>Mindful Employer[30] | | Estates Excellence [22]<br>Mindful Employer[30] | |
| **NGOs/Civil society** | | Safety ports[9] | | Safety ports[9]<br>Estates Excellence[22] | | | Health and Safety Challenge [43] | | Safety ports[9]<br>Estates Excellence[22] | |
| **Researchers and academics** | | | | | | | | | | CONTOUR[1] |
| **Trade associations** | | Ceramic Industry Health and Safety Pledge[5]<br>LiveWire[5]<br>Making a Difference[6]<br>C3HARGE[8]<br>Recipe for Safety[10]<br>Concrete Targets[29]<br>Accident Reduction Charter [31]<br>GLASS [32]<br>Safelec [33]<br>Step Change [34]<br>Zero Accident Potential [35]<br>MPA Hard Target[36] | CHAS[15] | Recipe for Safety [10]<br>Estates Excellence [22]<br>Scorecard [28]<br><br>Accident Reduction Charter [31]<br>GLASS [32] | | C3HARGE[8] | | | C3HARGE[8]<br>Recipe for Safety[10]<br>Estates Excellence [22]<br>GLASS [32] | Scorecard [28] |
| **Professional associations** | | | CHAS[15]<br>Five Star Audit [37]<br>Quality Safety Audit [38] | Professionals in Partnership [39] | | | Going public on performance [40] | | | Going public on performance [40] |
| **Actors of (in) the judiciary system including legal services** | | | | | | | | | | |
| **Standardisation and certification bodies** | | | OHSAS 18001 [41] | | | | | | | |

1. CONTOUR; CBI & White Young Green Environmental Plc
2. Social Dialogue; CBI, TUC, (Prosser, 2011)
3. Leading Health and Safety at Work: Leadership Actions for Directors and Board Members'; IoD, HSE, CBI, FSB and TUC
4. Ceramic Industry Health and Safety Pledge; British Ceramic Confederation, British Chambers of Commerce, HSE and the UNITE, GMB and UNITY trade unions
5. LiveWire; British Steel, EEF
6. Making a difference; The HSE's Paper and Board Industry Advisory Committee (PABIAC), HSE, Unite, GMB, Confederation of Paper Industries (CPI) and the Independent Waste Paper Processors Association (IWPPA)
7. Management Standards; HSE
8. C3HARGE
9. Safety Ports; led by Ports Skills & Safety Limited, brought together government, trade unions (AEUU and TGWU) and employers (http://www.hse.gov.uk/research/rrpdf/rr620.pdf)
10. Recipe for Safety; HSE, food industry trade unions (GMB, USDAW, T&G and BFAWU) and the Food and Drink Federation (http://www.hse.gov.uk/research/rrpdf/rr620.pdf)
11. COSHH
12. RIDDOR
13. The Statement of Fitness for Work; DWP (http://research.dwp.gov.uk/asd/asd5/rports2011-2012/rrep797.pdf)
14. Revitalising Health and Safety; HSE (http://www.hse.gov.uk/revitalising/rhs.pdf)
15. CHAS; The Association of London Government Health and Safety Forum, it is endorsed by the Local Government Association, TUC and IOSH
16. Workplace Health Connect; HSE (http://www.hse.gov.uk/workplacehealth/finalreport.pdf)
17. Occupational Health Advice Lines; DWP (http://research.dwp.gov.uk/asd/asd5/rports2011-2012/rrep793.pdf)
18. CDM ACoP; HSE (http://www.hse.gov.uk/aboutus/meetings/iacs/coniac/130711/m2-2011-2.pdf)
19. Asbestos Hidden Killer; HSE (http://news.hse.gov.uk/lau/2010/01/29/asbestos-hidden-killer-campaign-%E2%80%93-follow-up-activities-for-2010/)
20. SHIFT: Action on Stigma; Department of Health (http://kc.nmhdu.org.uk/viewdocument.php?action=viewdox&pid=0&doc=35021&grp=586)
21. Safety Climate Tool; HSL (http://www.hsl.gov.uk/news/news-archive/2011-archive-/safety-climate-tool-delivers-results-in-first-year.aspx)
22. Estates Excellence; HSE, IoD, FSB and EEF, workers (SERTUC), local authorities and government, major employers including SERCO, Centrica and Southern Water and insurers Zurich & QBE.
23. Workers Safety Adviser Challenge; HSE http://www.hse.gov.uk/consult/condocs/cd207.pdf

24. SME Indicator Tool; HSE (http://www.hse.gov.uk/research/rrpdf/rr393.pdf)
25. Making the Market Work; ABI
26. HealthCheck, BPIF
27. SafeContractor; National Britannia
28. Scorecard; EEF, Travelers Insurance Group
29. Concrete Targets; BPCF, Mineral Products Association, HSE
30. Mindful Employer; Workways, a Vocational Rehabilitation Service of Devon Partnership NHS Trust (http://base-uk.org/sites/base-uk.org/files/news/12-07/mindful_employer_summary.pdf)
31. Accident Reduction Charter; The Environmental Services Association (ESA)
32. GLASS; British Glass Manufacturers' Confederation (British Glass) and the Glass and Glazing Federation and is supported by the HSE, trade unions and industry.
33. Safelec; covers businesses operating in the Electricity Industry (Member Companies of the Energy Networks Association, members of the Association of Electricity Producers, Trade Unions, Electricity Sector Trade Union Council (ESTUC, contractors and HSE) (http://www.hse.gov.uk/research/rrpdf/rr620.pdf).
34. Step Change; three main trade associations, UKOOA (United Kingdom Offshore Operators Association), IADC (International Association of Drilling Contractors) and the OCA (Offshore Contractors Association). http://www.hse.gov.uk/research/rrpdf/rr620.pdf).
35. Zero Accident potential; operated by the Electrical Contractors‟ Association
36. MPA Hard Target; a dedicated OSH scheme that is operated by the Mineral Products Association (MPA)
37. Five Star Audit; British Safety Council http://www.hse.gov.uk/research/rrpdf/rr813.pdf
38. Quality Safety Audit; ROSPA http://www.hse.gov.uk/research/rrpdf/rr813.pdf
39. Professionals in Partnership; IOSH http://www.iosh.co.uk/books_and_resources/published_research.aspx
40. Going Public on Performance; ROSPA
41. OHSAS 18001; BSI
42. ‘Struck by’; HSE http://www.hse.gov.uk/research/rrpdf/rr641.pdf
43. Health and Safety Challenge; MENCAP http://www.mencap.org.uk/node/7157
44. Fee for Intervention http://www.hse.gov.uk/fee-for-intervention/documents/interim-evaluation.pdf
45. CCNSG; Safety Passport http://www.hse.gov.uk/research/hsl_pdf/2003/hsl03-10.pdf

## *Annex 2: Thematic framework – interviews on policy initiatives*

| Main theme | Sub-theme | Description |
|---|---|---|
| **Drivers behind initiative development** | Legislation | To meet a legislative requirement |
| | Regulatory review | To meet the changing needs of government and/or be the vehicle through which change occurs |
| | Market needs | To meet needs identified in the market and changing industry needs |
| **Influences on initiative type** | Policy process | An outcome from a periodical policy review, a policy forum or a preceding 'pilot' test |
| | Initiative fit | The fit the initiative has with existing or other initiatives, or with prior empirical research |
| **Constraints on the initiative** | Implementation | Its implementation by the user, affiliate partner or other third party and the effect of this implementation on the initiative's use and the benefit derived from it |
| | Initiative structure and content | The structure or content of the initiative and its effect on implementation |
| | Bureaucracy | The effect of red-tape, administration and politics on the present and future form of the initiative |
| | Personnel attrition | Over-reliance on key personnel for the initiative to be a success |
| **Challenges around the initiative** | Time | Of the issuer and users (in application terms) towards the initiative and/or the issue; time to sufficiently address the issue; and time for the initiative to yield benefits |
| | Measurement | Demonstrating cause and effect and insufficient measurement timeframes |
| | Perception | The perception of the issuers towards the initiative or its focus; and the users' perception of the focus and the issuer |
| | Engagement | Lack of engagement with and awareness of the initiative |
| | Supply and demand | Previous performance sets a future precedent |
| **Success Facilitators** | Top-down support | Political will and resources from the issuers' superiors |
| | Ownership | Taking sole or joint ownership of the initiative and/or issue from the issuer(s) and users(s) |
| | Dialogue | Having appropriate and open dialogue both pre and post development |
| | Dissemination | Openness to dissemination routes and conveying the right message |
| **Success indicators** | Meeting targets | It met its original targets |
| | Uptake and satisfaction | It was used in sufficient volumes to be considered a success and/or the users of the initiative were satisfied with it and/or its outcomes |
| | Acceptance | It had been in situ for a sufficient period and had gained acceptance from senior stakeholders, colleagues and users |
| | Internal impact | It widened the perceptions of the issuers' colleagues and peers on relevant issues, changed working practices, and facilitated knowledge transfer and future initiative launches |
| | Working partnerships | It strengthened existing relationships between working partners or facilitated the formation of new ones |
| | Bottom-line benefits | It had either a direct or indirect impact on the users' organisational bottom-line |

## *Annex 3: Stakeholder groups and the participating stakeholder organisations*

| Trade Union | Government Agencies | Professional Associations | Trade Associations | Consultants | Academics | Judiciary and Legal Services | Training Body | Employers' Associations | Insurers | Standardisation & Certification Bodies |
|---|---|---|---|---|---|---|---|---|---|---|
| Edinburgh Trade Union Council | Health and Safety Executive | Institution of Occupational Safety and Health | British Ceramic Confederation | Independent Consultants | Aston University | Freelance Legal | Engineering Construction Industry Board | British Safety Council | Zurich Insurance | British Standards Institution |
| Prospect | Health and Safety Laboratory | Chartered Institute of Environmental Health | British Safety Industry Federation | Workable Solutions | Open University | Thompsons Solicitors | | Forum of Private Business | | |
| Unison | Office for Rail Regulation | International Institute of Risk and Safety Management | EEF | Sah Sen Consulting | University of Cardiff | | | CBI | | |
| Unite | Better Regulation Delivery Office | | Universities Safety and Health Association | | University of Middlesex | | | | | |
| | National Health Service | | | | | | | | | |
| | Local Government Tyneside | | | | | | | | | |
| | London Borough of Newham | | | | | | | | | |
| | Merton Council | | | | | | | | | |
| | Cardiff Council | | | | | | | | | |

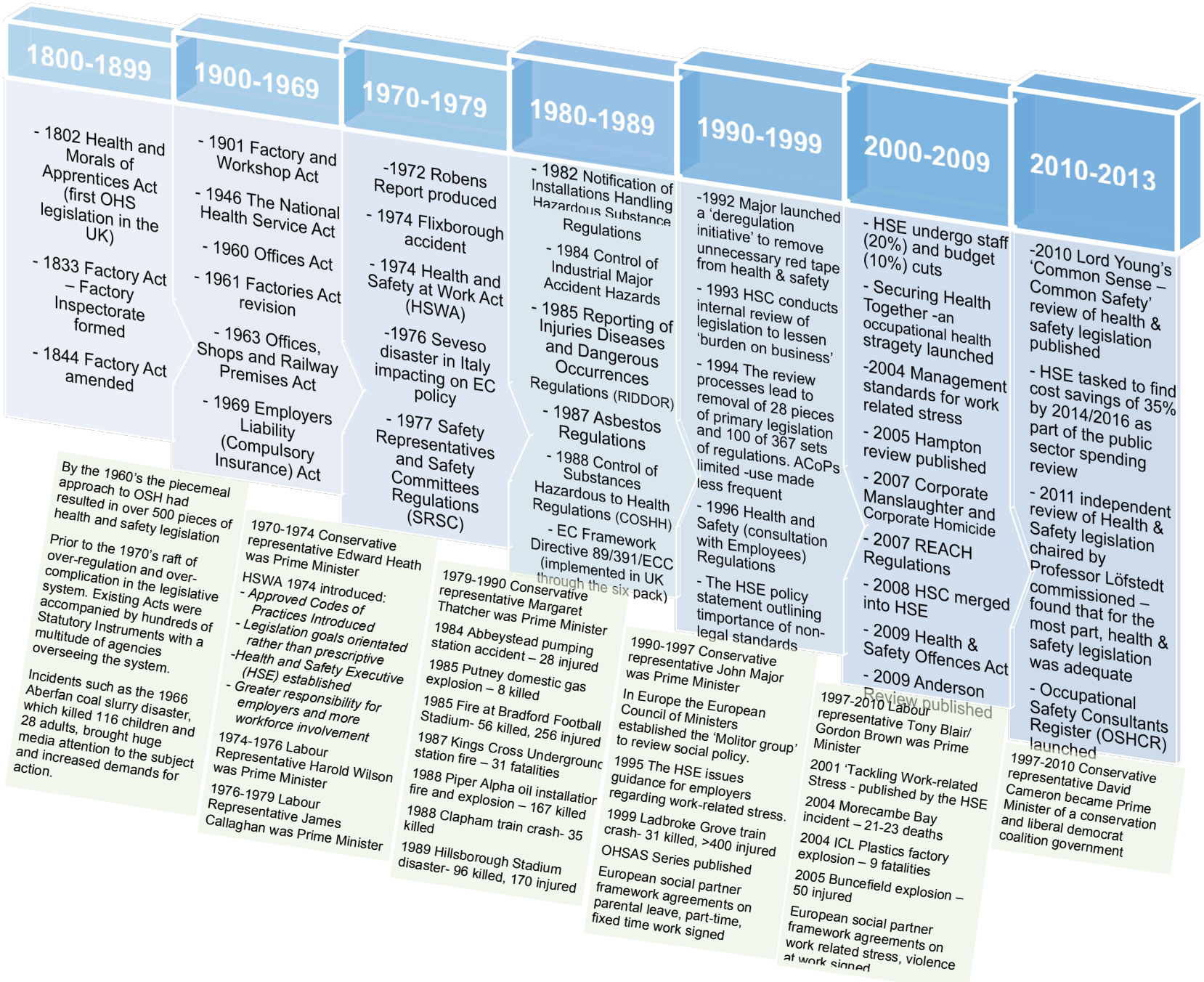
## *Annex 4: Thematic framework – interviews on stakeholder perspectives*

| Theme | Subtheme | Descriptor |
|---|---|---|
| **Changes relating to OSH** | Broad macro factors | Factors operating at a macro level which influence OSH, such as economic climate. |
| | Changes in OSH policy | Specific changes in OSH at the policy level including the government's general deregulatory agenda and subsequent budget reviews. |
| | Motivation for change | Drivers behind government policy, e.g. whether decisions were evidence-based, or designed to alleviate burdens on business. |
| | Process of change | Elements relating to the way in which change was implemented, including questions over the validity of government reviews and whether consultation was adhered to. |
| | Outcomes of change | What the immediate outcomes of the changes, or proposed changes, are, such as increased uncertainty with what is required to be compliant, and the need to update all existing provisions. |
| **Emerging opportunities** | Time to critically evaluate the OSH system | A period of sustained review has offered the opportunity to view the OSH system holistically in an attempt to make system wide positive changes. |
| | Increased efficiency of the system | Stakeholder perceptions that changes would lead to benefits in OSH regulation, such as targeting efforts to high risk areas. |
| | New strategic partnerships | Beneficial partnerships between stakeholders that have arisen out of the changes, due to, for example, new common goals. |
| | Changing the culture of OSH | Changes that had been implemented to address the negative public perception of OSH, such as the myth busters panel. |
| **Emerging constraints** | Stakeholder autonomy | The degree to which stakeholder autonomy was constrained by changes, including LAs being placed under the direction of HSE. |
| | Lack of resources | Whether resources negatively impacted stakeholders' ability to act, such as trade union representatives being able to secure time to carry out OSH activities. |
| **Implications of the changes** | Uncertainty of the future | Difficulty in predicting the long term implications of changes. |
| | The changing role of stakeholders | Whether stakeholders' role has shifted due to changes, such as the HSE's capacity to provide advice. |
| | The changing role of practitioners | How practitioners contribute to OSH problems, and how practitioners need to adapt their role so as to be a driving force for positive change in OSH standards, for example, better engaging business through presenting the business case. |
| | Impact on organisations, inc. SMEs | How these changes will affect how organisations, particularly SMEs, manage OSH, including whether the message that OSH will be less regulated will lead to lesser engagement by businesses. |
| | Impact on OSH standards | Whether outcomes including ill-health and accidents will be affected. |
| **Achieving balance in the future** | Health in OSH | The need to focus on health as well as safety. |
| | Engaging business | Understanding that business responds to legal, business, and ethical drivers. Similarly identifying that engaging leaders in business is critical to OSH. |
| | Multi-policy proportionate approach | The need to have a combination of policy initiatives to regulate OSH such as financial incentives and legislation that are proportionate to the risk posed by each industry. |
| | Long term independent thinking | The need for thinking that is independent from political ideology and is orientated towards long term benefits rather than short term considerations. |
| | Working in partnership | The need for closer working within government as well as between stakeholders. |
| | Education | The need to raise awareness and focus on education activities, like introducing risk education into schooling. |

## *Annex 5: Thematic framework – focus groups on optimal OSH landscape*

| Theme | Subtheme | Descriptor |
|---|---|---|
| **Changes relating to OSH** | Motivation for change/changing OSH policy | Drivers behind government policy, such as whether decisions: i) were based on a political ideology/were a political exercise; ii) were motivated/influenced by a minority of key influential personnel; iii) were evidence based; iv) alleviated a *perceived* burden (business and administrative); or v) a combination of the above reasons. |
| | Process of change | Elements relating to the way in which change was implemented, including questions over: i) the process through which the government's better regulation/deregulation agenda were/are being pursued; ii) how change is really enacted (i.e. backdoor deregulation); iii) the validity of government reviews (and whether they were politically influenced); iv) whether 'proper' due diligent consultation was adhered to. |
| | Outcomes of change | i) Increased uncertainty over how changes within the system will affect regulators' provision to duty holders; and ii) the associated subsequent impact on OSH standards. |
| **Emerging opportunities** | Evaluate and innovate OSH | A period of sustained review offering the opportunity to view the OSH system holistically. |
| | Changing the culture of OSH | Increased publicity around the legitimacy of OSH and the government's deregulatory agenda presenting an opportunity to challenge misconceptions about the OSH system. |
| **Constraints** | Stakeholder/practitioner autonomy and influence | The degree to which stakeholder autonomy is constrained by: i) policy changes (at stakeholder level); ii) the remit practitioners are given and businesses tolerance of their findings. |
| | The OSH 'industry' | The industry becoming a silo, inhibiting its integration into mainstream business practice. |
| **Implications of the changes (in the long term)** | Impact on organisations including SMEs | How these changes will affect the way organisations (particularly SMEs) manage OSH. |
| | The changing role of stakeholders | i) The changing role of stakeholders due to existing political edicts; and ii) predictions on how such future changes may impact stakeholders. |
| | The role of practitioners | i) How practitioners contribute to OSH problems (i.e. competence); and ii) how practitioners need to adapt/upskill in order to be a driving force for positive change. |
| **Achieving balance in the future** | The understanding and perception of risk | i) How risk is perceived and understood by stakeholders both within and outside of the OSH system; ii) How society perceives OSH risk in comparison to other types of risk; iii) how risk differs internationally in other countries and cultures; iv) how risk is context dependent; v) and how risk is viewed by and should be positioned to business. |
| | Health in OSH | i) The historical focus of OSH on predominantly safety issues; ii) increasing confusion between health and wellbeing; iii) complexity/intangibility of health and inconsistencies in its measurement; iv) the need to move the onus/responsibility away from the individual and towards the employer; v) the need for occupational health policy recommendations to be enacted in practice; vi) and the financial costs associated with occupational health and who pays. |
| | Engaging business | i) Understanding that business responds to legal, business, and ethical drivers (the 3 drivers); ii) identifying that engaging organisations' leaders and managers is critical; iii) the need for OSH to be integrated into 'mainstream' management. |
| | Multi-policy proportionate approach | The potential of having a combination of policy initiatives to regulate OSH in the future (e.g. the potential role insurers can adopt in taking some responsibilities away from the HSE). |
| | Working in partnership | The need for closer inter-dependent working: i) within government; and ii) between non-governmental stakeholders. |
| | Education | The need to educate the next generation of business leaders/managers on OSH issues. |

## *Annex 6: Timeline of critical events in the changing OSH landscape in the UK*



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