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A Safer Place to Work

Improving the management of health and safety risks to staff in NHS trusts

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A Safer Place to Work

Improving the management of health and safety risks to staff in NHS trusts

John Bourn   National Audit Office
Comptroller and Auditor General   **22 April 2003**

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This report can be found on the National Audit Office web site at www.nao.gov.uk

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1 Maintaining the health, safety and wellbeing of the National Health Service (NHS) workforce is essential; it is a statutory requirement and makes good economic sense.

2 The NHS employs more than 1 million people. Yet the biggest constraint facing the NHS is staff shortages. In 2001-02 there were some 8,390 nursing (3.1 per cent) and 1,320 consultant (3.7 per cent) vacancies. In 2001-02, the NHS spent around £17.7 billion on staff salaries and wages and £1.2 billion on agency staff to cover vacancies and staff absences.[1]

3 A major reason for staff absence is sickness. In 2001-02 this was running at an average of 4.9 per cent[i] across all NHS trusts, compared with an average of 3.7 per cent for all public administration, education and health employees.[2] While there are no reliable estimates of the full costs of sickness absence to the NHS, the Department of Health (the Department) estimates that the annual cost is around £1 billion.[3]

4 Staff accidents and other health and safety issues, such as violence and aggression against NHS staff, are major factors in staff absences. They result in time off work due to minor injuries, stress and temporary or permanent disability. They also incur substantial costs, for example sickness absence payments, staff replacement costs, staff turnover, ill health retirement and compensation payments, fines and higher insurance contributions.
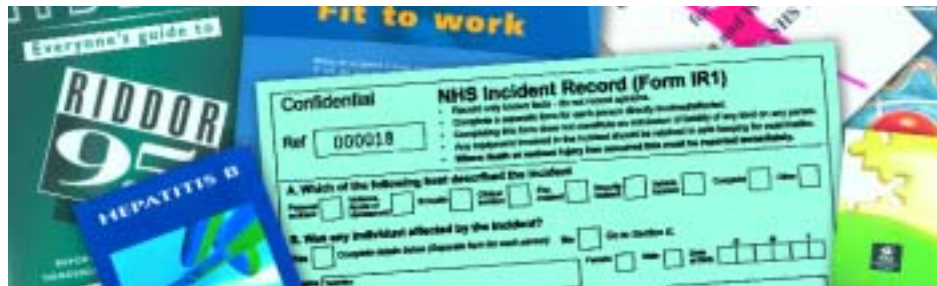
5 In 1999, the Government set National Improvement Targets for the NHS to reduce incidents of violence to staff, accidents to staff and the levels of sickness absence, by 20 per cent by 2001 and 30 per cent by 2003.[4] However, average sickness absence rates remain above target. Moreover, in 2001-02, the overall numbers of recorded incidents of violence and aggression increased by 13 per cent and recorded accidents by 24 per cent against the 2000-01 baseline.

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i   *Sickness absence is measured as the time staff are absent from work as a proportion of time available.*

6   Against this background, we looked at action taken by the Department and NHS trusts in response to our 1996 report on *Health and Safety in NHS Acute Hospital Trusts in England*,[5] and the subsequent recommendations by the Committee of Public Accounts.[6] **Appendix 1** summarises our study methodology, including membership of our Expert Panel. The full details, including the survey questionnaires and a detailed report on progress against the 1996 recommendations, are contained on our website www.nao.gov.uk.

7   We have produced two reports. Our report on *A Safer Place to Work: Protecting NHS Hospital and Ambulance Staff from Violence and Aggression* was published on 27 March 2003,[7] and looks at progress made in preventing violence and aggression against NHS staff. In this report, we look at progress in reducing the extent and costs of accidents to staff (Part 2); and improving the management of specific health and safety risks (Part 3).

8   While our 1996 report covered the health and safety of patients, staff and visitors, in view of the creation of the National Patient Safety Agency in July 2001,[8] we have deferred evaluating progress on improving the health and safety of patients, until the changes have bedded down.

Main findings and conclusions

9   All employers are required, by law, to ensure as far as possible the health and safety of their staff.[9] Poor attention to health and safety issues affects staff recruitment and retention and can have wider detrimental effects on the quality of services, staff morale and public opinion of the NHS.[10]

10   Following our 1996 report,[5] the Department took a wide range of initiatives to improve the management and monitoring of health and safety risks to staff (summarised in **Appendix 2**). A key initiative was the launch in 1999 of *Working Together, Securing a Quality Workforce for the NHS*, which included targets for creating healthy workplaces (paragraph 3).[4] Despite this and an initial 10 per cent fall in the number of recorded staff accidents between 1998-99 and 2000-01,[11] the number of reported accidents rose in 2001-02 to 135,172. As a result, the National Improvement Target of a 20 per cent reduction by March 2002 has not been met. Indeed only 23 per cent of NHS trusts reduced the number of accidents by 20 per cent or more, with 64 per cent reporting an increase. There were also wide variations between similar types of trusts in the number of accidents per 1,000 staff.

11   These raw statistics mask a complex position where in some NHS trusts the number of accidents had fallen due to improved training and practices, in others there had been an increase due to improved awareness and reporting, while in all trusts there remained a significant problem of under-reporting of accidents. Over a fifth of trusts identified staff shortages and increased workloads as leading to poor compliance with good practice and as a result an increase in accidents. Five trusts were unable to provide any information on numbers of accidents.

12   We found a mismatch in around 36 per cent of NHS trusts between the information on accidents that was provided to the Department by the human resource directorates (responsible for monitoring the *Working Together* targets) and the information we collected from health and safety leads who maintain the trust accident and incident reporting systems. This highlighted a lack of communication and collaboration between the different parts of the trust that have a role to play in managing health and safety risks, including occupational health and estates.

13   Furthermore the range of national initiatives on health and safety are produced and monitored by different parts of the Department (for example, the Controls Assurance Unit, Employment Policy Branch and NHS Estates). There is no central co-ordinating function for health and safety that would allow the Department to produce an NHS-wide occupational health and safety strategy such as that developed for the NHS in Scotland.

14   The Health and Safety Executive (HSE) is responsible for enforcing the *Health and Safety at Work etc Act.*[9] Accidents to NHS staff that result in more than three days' absence, and which by law are reportable to HSE,[12] have decreased by 25 per cent over the last five years (around five per cent of all reported accidents in the NHS are reported to the Executive). While the number of HSE Improvement Notices served on NHS trusts has fallen, there has recently been an increase in the number of prosecutions. HSE considers that despite improved general compliance with health and safety legislation, the gap between the best and worst trusts is widening and the NHS is failing to ensure consistent minimum standards and to disseminate good practice **(Appendix 3).**

15   In 1996 we highlighted the fact that few NHS trusts had robust incident reporting systems.[5] Most trusts have since put the systems in place to facilitate improved recording and reporting of accidents and used training and other initiatives to try and reduce accidents. However under-reporting, differences in systems and inconsistencies in classifying, recording and reporting within and between trusts, mean there is scope for further improvement.

16   Moving and handling, needlesticks and sharps injuries, slips, trips and falls and exposure to substances hazardous to health remain the main types of accidents, but work-related stress has emerged as a serious issue, with over two-thirds of NHS trusts reporting an increase in the last three years.

17   In 1996 there was very little information on the cost of accidents.[5] Despite Departmental initiatives to encourage NHS trusts to introduce procedures for assessing the costs of accidents, little progress has been made. Published research tends to focus on qualitative or non-financial impacts and any estimates, such as those produced by HSE, have a number of limitations.

executive summary

18 Our analysis suggests that the direct cost of work-related accidents is at least £173 million, based on a crude estimate of the cost of work-related sickness absence, and estimates of permanent injury benefits, ill health retirements and payments out of court as a result of staff accidents. This is a very conservative estimate and the overall cost is likely to be much higher if staff replacement costs, medical treatment costs and court compensation awards were to be included. It also excludes the substantial human costs, such as low productivity and increased staff turnover and their impact on delivering the NHS Plan[13] (paragraphs 2.24-2.26).

19 In 1996, we found that standards of health and safety management were variable with a number of NHS trusts failing to meet their statutory obligations, and recommended areas for improvement.[5] In response, the Department issued guidance setting out the actions trusts needed to take.[14]

20 Since then, NHS trusts have made improvements and there is evidence of much good practice in managing risks. However, progress has been patchy and there is considerable scope for more trusts to learn from, and implement, good practice. For example we found that:

■ While there has been considerable improvement in compliance with the statutory and operational responsibilities for managing health and safety risks, staff surveys have found that employees are often unaware of their health and safety policies. We also found inconsistencies within and between trusts in the way that compliance with the Health and Safety Controls Assurance Standard[15] was assessed (paragraphs 3.3-3.7).

■ Trusts have generally improved their overall approach to risk management but the types and quality of risk assessments vary and only 12 per cent of trusts include risk assessment in their induction training. While there are acknowledged benefits in having an integrated risk management framework, just under half of all trusts identified constraints due to having different reporting routes to the Board for clinical and non-clinical risks. Central initiatives like the Clinical Negligence Scheme for Trusts and the new National Patient Safety Agency reporting systems[8] may also militate against trusts developing an integrated reporting system (paragraphs 3.8-3.12).

■ Ninety five per cent of trusts had appointed a competent person(s) to lead on health and safety matters with the remainder of trusts carrying a vacancy. However, qualifications, experience and the resources available vary widely. While 17 per cent of health and safety leads considered that their staffing resources were less than adequate for maintaining an effective health and safety environment, 44 per cent considered their resources were more than adequate (paragraphs 3.14 -3.17).

■ While all trusts provide health and safety induction and refresher training programmes, there is no prescription as to the content and length of these courses. As a result there is a lack of consistency between trusts in the training provided. The numbers and types of staff attending also varies. In particular doctors are the least likely to attend, and staff shortages and increasing workloads were identified as barriers to take-up for all groups of staff (paragraphs 3.18-3.27).

■ All trusts provide staff with occupational health services but the quality and accessibility varies and the provision is largely reactive. The scale of services differs widely, in part due to a scarcity of trained staff, with around three-quarters of trusts identifying staffing and other resource constraints. Indeed, the resources available within trusts vary, from a part-time occupational health nurse to a dedicated directorate with a team of occupational health nurses, doctors and managers. While there are clear incentives for trusts to ensure effective and speedy rehabilitation of staff, for example fast track access to treatment such as physiotherapy, this can be contentious and trusts' interpretation of what is permissible varies widely (paragraphs 3.28-3.40).

■ In order to improve staff wellbeing, all trust occupational health departments provide access to some counselling services, but only 14 per cent operate a fast track referral system to ensure staff receive assistance at the earliest possible moment. Only eight per cent of trusts' occupational health leads and seven per cent of health and safety leads have identified stress as one of their top three priorities. Staff representative bodies have identified the need for risk assessments to target interventions to control stress (paragraphs 3.41- 3.44).

■ While the NHS increasingly uses contractors to deliver certain healthcare and support services, over a third of trusts believe that they have limited control over their contractors' health and safety. Also, the numbers of HSE prosecutions and Improvement Notices relating to contractors have increased (paragraphs 3.45-3.51).

Recommendations

21 We therefore make the following recommendations:

(a) Improving information on the extent and impact of accidents

22 The Department should:

a) issue further guidance on the need for a more consistent approach to identifying and recording accidents with measures for tackling under-reporting, drawing on the experiences of those NHS trusts that have introduced good practice reporting systems;

b) ensure that the new clinical accident reporting system being developed by the National Patient Safety Agency and the decision to transfer responsibility for reducing violence and aggression to the new Counter Fraud and Security Management Service[ii] do not undermine progress in developing integrated risk management systems;

c) use the opportunity presented by the new performance monitoring arrangements under *Shifting the Balance of Power*,[16] to encourage the new Strategic Health Authorities and Workforce Development Confederations to work with NHS trusts to set priorities and local targets for reducing accidents to staff, based on agreed definitions;

d) encourage the new Commission for Health Audit and Inspection[17] to include questions in its national staff survey on staff's experience of health and safety, including the support provided and to disseminate the results and examples of good practice;

e) help NHS trusts prioritise actions for reducing accidents, by ensuring that the new NHS Electronic Staff Records System[18] is developed to capture information on reasons for work-related staff sickness absences and turnover; and

f) work with the NHS Litigation Authority and HSE to support the development of a robust costing methodology for assessing the financial impacts/outcomes of accidents. Full appreciation of the impacts and costs should help NHS trusts prioritise actions and develop sound business cases for investment in interventions.

23 NHS trusts should:

g) review their health and safety policies to ensure they support a clear, unambiguous reporting culture in which staff understand the need for, and are confident in making, accurate and timely accident reports;

h) review their accident reporting systems to ensure that information requirements are properly defined, and staff are clear as to why the data are being collected and how they will be used;

i) ensure that staff surveys include questions about health and safety management issues and the constraints to reporting and then feed the results into action plans;

j) ensure exit interviews identify cases where staff leave due to concerns about, or experience of, poor response to health and safety issues and identify any action needed;

k) use the opportunity presented by the new NHS Electronic Staff Records System[18] to ensure that information on the extent and reasons for work-related sickness absence are captured, including absence due to health and safety accidents, and interventions are prioritised accordingly; and

l) set up a system to monitor the cost of work-related ill health retirements, legal fees incurred and compensation awards due to health and safety accidents and report this information to the Trust Board at least once a year.

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ii   *From 1 April 2003 responsibility for all policy and operational matters relating to the management of security in the NHS, including leading work on reducing violence and aggression, will be passed to a new Special Health Authority - The Counter Fraud and Security Management Service. This is covered in our companion report A Safer Place to Work: Protecting NHS Hospital and Ambulance Staff from Violence and Aggression.[7]*

(b) Improving the management of health and safety risks

24 The Department should:

m) consider developing a national health and safety strategy to co-ordinate existing and new initiatives, including the work of the Employment Policy Branch, the Controls Assurance Unit, NHS Estates, Strategic Health Authorities, Workforce Development Confederations and relevant Special Health Authorities;

n) review the approaches taken by NHS trusts to evaluate compliance with the Health and Safety Controls Assurance Standard[15] and consider the need for a more consistent approach to evaluation;

o) encourage NHS trusts to integrate their strategies for managing health and safety into their risk management arrangements and provide good practice guidance on integrating clinical and non-clinical risk management;

p) commission and disseminate evidence-based guidelines, including lessons learned from other public and private sector service industries, that could help NHS trusts improve the management of health and safety risks and the impact of interventions on stress, sickness absence and staff retention;

q) provide guidance on the expected content and coverage of health and safety induction and refresher training, and consider whether this is something that the NHS University could take on board, and at the same time consider the merits of adopting the health and safety training passport, being piloted in Wales;

r) liaise with Workforce Development Confederations to ensure that they commission sufficient training places to meet the needs of the NHS for appropriately trained occupational health professionals and encourage the wider employment by NHS trusts of trained health and safety professionals;

s) review the resources available to occupational health and consider whether there are more cost effective ways of providing the service, including evaluating the operation of NHS Plus and the extent to which income is being re-invested in occupational health services; and

t) remind trusts of their responsibilities under health and safety legislation for all staff on their sites and commission research to determine the main challenges and solutions in managing contractors with a view to promulgating guidance on managing the interface between trusts and contractors.

25 All NHS trusts should:

u) review their policies on health and safety risk management to ensure they reflect the views of staff and staff-side representatives and consider the extent to which clinical and non-clinical risk assessments could be integrated, including a single reporting line to the Trust Board;

v) ensure that they have an appropriate number of competent persons with expertise in health and safety to assist the trust's compliance with health and safety legislation, and that they have the training, knowledge and experience to equip them for the role;

w) adopt a strategic approach to induction and other training and development based on an annual training needs analysis for all clinical and support staff, and ensure that responsibility for maintaining staff training records is clarified and that records are kept up to date;

x) measure compliance with the Occupational Health and Safety Service Standards[19] and ensure that there is a documented long-term strategy, supported by annual plans with priorities for action;

y) review their strategies for managing work-related stress and for providing counselling and other support to staff, with any arrangements reflecting Departmental guidance on good practice. The option for fast tracking should be fully explored and a clear, unambiguous strategy implemented; and

z) develop a robust system to ensure that contractors have appropriate arrangements for training their staff in health and safety and risk management, and to record and monitor contractors' health and safety performance. They should also assure themselves that they are complying with health and safety legislation in relation to people working on their premises.

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Executive

REPORT
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Mind Matters

A HIDDEN DANGER IN YOUR WORKPLACE

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CONSULTING EMPLOYEES
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Work-related stress

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NHS Incident Record (Form IR1)
- Record only known facts - do not record opinions.
- Complete a separate form for each person directly involved/affected.
- Completing this form does not constitute an admission of liability of any kin
- Any equipment involved in the incident should be retained in safe keeping
- Where death or serious injury has occurred this must be reported im

A. Which of the following best described the incident

Personal accident | Violence, Abuse or Harassment | Ill Health | Clinical Incident | Fire Incident | Security Incident | Vehicle Incident | Complaint

B. Was any individual affected by the Incident?

Yes | Complete details below (Separate form for each person) No | Go to Section E.

Female | Male | Date of Birth

Staff/patient No

Grade | Employing management unit

Occupation

Full time | Part time | Was/Will staff member be absent from duties? Yes | No

person receive any attention (eg treatment, advice counselling, etc?)

First Aid | Seen by resident doctor | Occ Health | A&E | Advised to see own GP

gnature, where appropriate

Yes | No | Signature of Relative/Guardian

ve person suffer physical injury, health or ot

Complete details below

part of the body was affected eg back, left shoulder, right eye, neck, etc (refer to pick-list 2)

nature of injury was sustained? eg abrasion, bruising, laceration, in/strain, needlestick, fracture, etc (refer to pick-list 3)

ntify nature of ill health or adverse effect eg skin trouble, cramp, adache, stress, backache, infection (specify, etc (refer to pick-list 4)

r adverse effect? eg lifting nce, fall from height (specify r clinical cause choose Other.

occur?

Part 1

Background

1.1 The NHS employs more than 1 million people. Yet the biggest constraint facing the NHS is staff shortages, for example in 2001-02 there were some 8,390 nursing (3.1 per cent) and 1,320 consultant (3.7 per cent) vacancies. In 2001-02, the NHS spent around £17.7 billion on staff salaries and wages and £1.2 billion on agency staff to cover vacancies and staff absences.[1]

1.2 A major reason for staff absence is sickness. As **Figure 1** shows, in 2001 this was running at an average of 4.9 per cent across all NHS trusts, compared with the average of 3.7 per cent for all public administration, education and health employees.[2] While there are no reliable estimates of the full costs to the NHS, the Department estimates that the annual cost is around £1 billion.[3]

1.3 Accidents involving staff can also result in time off work due to minor injuries, stress and temporary or permanent disability. They can also incur costs, for example staff replacement costs, compensation payments, fines and higher insurance contributions. Again, there are no robust estimates of the cost of work-related sickness absence.

1.4 All employers are required, by law, to ensure as far as possible the health and safety of their staff.[9] Poor attention to health and safety issues affects staff recruitment and retention and can have wider detrimental effects on the quality of services, staff morale and public opinion of the NHS and on trusts' ability to deliver the NHS Plan.[13]

1.5 In 1999, the Government set targets to reduce the level of sickness absence, incidents of violence and accidents to staff in the NHS, by 20 per cent by 2001 and 30 per cent by 2003.[4] However, as Figure 1 below shows, the average sickness absence rates remain above target. Moreover, the overall numbers of reported violent and aggressive incidents have increased by 13 per cent (see our report *A Safer Place to Work: Protecting NHS Hospital and Ambulance Staff from Violence and Aggression*).[7] The numbers of reported accidents have also increased.

Since our 1996 report the Department has taken a range of measures to improve the management of health and safety in the NHS

1.6 In November 1996, our report,[5] and the subsequent Committee of Public Accounts report,[6] on *Health and Safety in NHS Acute Hospital Trusts in England* highlighted concerns about the burden of accidents and incidents of violence and the lack of information on their extent and costs.

1.7 Our report suggested that in 1995 there were likely to have been between 450,000 and a million accidents in NHS acute hospitals, of which a quarter were accidents to staff. Rigorous cost estimates were not available, but based on figures provided by four trusts, we estimated that the immediate costs of accidents to staff and patients (such as staff time lost and patient treatment costs) were likely to have been some £12 million, or £154 million if longer-term costs, such as compensation payments, were included.[5]

1   The average sickness absence rates across NHS trusts for 2000 and 2001

Target/Outturn	All NHS Trusts	Acute Trusts	Mental Health Trusts	Ambulance Trusts
2000 Target	4.6	4.3	4.9	5.7
2000 Outturn	5.1	4.8	5.4	7.1
2001 Target	4.3	4.1	4.5	5.3
2001 Outturn	4.9	4.5	5.1	6.8

Source: National Audit Office survey of trusts

1.8 Overall, we found that standards of health and safety management were variable with a number of NHS trusts failing to meet their statutory obligations. Inadequate investigation of accidents meant that employers were unaware of the true costs of failing to follow best practice in health and safety and occupational health. We concluded that trusts needed to develop a more proactive approach, including developing hospital-wide strategies to minimise the number of accidents. These strategies needed to be supported by effective reporting arrangements to assess trends, and be informed by comparisons of best practice in health and safety management.[5]

1.9 The Committee of Public Accounts was concerned that the large number of accidents imposed a significant burden on resources which could be better spent on patient care. The Committee found it unsatisfactory that many hospitals did not have accident recording systems which provided accurate and timely information and was concerned that there were very wide differences in accident rates and difficulties in making comparisons because of under-reporting. The Committee concluded that NHS trusts needed to have accurate and up to date information to assess health and safety risks, identify areas for action, and minimise the costs involved. It also looked to chief executives and Boards to take a stronger lead in encouraging staff to report all accidents promptly.[6]

1.10 The Department agreed with the Committee's conclusions, but noted that "some degree of risk was unavoidable in a service which operates 24 hours a day, serves more than 150 million people and is dangerous by its very nature".[20] The Department issued guidance requiring NHS trusts to develop strategies, supported by effective reporting arrangements, to assess trends and identify best practice in health and safety management. In particular trusts had to put in place policies and procedures to investigate, record, monitor, review and assess the causes and costs of accidents, sickness absences, ill health retirements and occupational ill health. They also asked trust chairs and chief executives to make health and safety a priority area.[14]

1.11 The Department launched a number of initiatives to improve the management and monitoring of health and safety risks to staff (Appendix 2). Full details of progress against the Committee's recommendations, are published on our website: www.nao.gov.uk. The main actions taken were:

- the promotion of improved accident recording and reporting through circulars and other guidance and the running of a series of regional roadshows to offer advice and encouragement and to disseminate good practice;[14,20]

- the Department and HSE (Appendix 3) worked with individual NHS trusts to help them improve their management of health and safety;

- the introduction of new arrangements to sharpen trusts' understanding of the legal framework, and re-emphasise their responsibilities; [15]

- the launch of *Working Together, Securing a Quality Workforce for the NHS*, and the subsequent setting and introduction of arrangements for monitoring targets for reducing the levels of sickness absence, incidents of violence and accidents[21,4] (paragraph 1.5); and

- the running of high profile campaigns to address specific health and safety issues such as the *zero tolerance zone*[22] to help reduce violence and aggression and the *Back in Work* campaign[23] to reduce musculo-sketelal problems.

The *Working Together* initiative was aimed at reducing the number of staff accidents and sickness absences by 20 per cent by 2001

1.12 In order to monitor progress against the *Working Together* targets, the Department conducted a survey of all NHS organisations during 1998-99.[4] This found an average sickness absence rate of 4.6 per cent and 7 incidents of violence and 19 accidents per 1,000 staff per month. Five per cent of accidents were reported to HSE under the *Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995* (RIDDOR)[12] (these are accidents which resulted in more than 3 days' absence from work - see Appendix 3).

1.13 The survey also identified continued under-reporting of incidents of violence and accidents and differences in the definitions used by employers. The Department therefore promulgated standard definitions for reporting (Figure 2).[4]

1.14 A further survey, published in July 2002, showed that the total number of accidents in 2000-01 had fallen by 9.3 per cent, from 120,474 cases in 1998-99[4] to 108,743.[21] The number of accidents per 1,000 staff per month also fell from 19 to 13. However, our survey of the position in 2001-02 showed that this fall had been reversed. The number of accidents had risen to 18 per 1,000 staff per month, with an overall total of 135,172 (Figure 4, Paragraph 2.8). In all three surveys, NHS ambulance trusts had the highest numbers of accidents per 1,000 staff. They also had the highest number of serious accidents per 1,000 staff reportable to HSE, under RIDDOR.[12] HSE also confirmed our finding that under-reporting, whilst improved due to greater awareness, was still a problem (Appendix 3).

2 **Standard definitions to be used in recording and reporting incidents of Violence, Accidents and Sickness Absence**

Violence - " any untoward incident where staff are abused, threatened or assaulted in circumstances relating to their work, involving an explicit or implicit challenge to their safety, wellbeing or health" - *European Commission DG-V1997- measured on a financial year basis.*

Accidents - " any untoward or unexpected event which results in injury to or adverse effect on the physical or mental health of an individual member of staff" - *Health and Safety at Work etc Act 1974 - measured on a financial year basis.*

Sickness Absence - " the time staff are absent from work as a percentage of staff time available" - included in the balanced score card element of the 2000/2001 NHS Performance Ratings for NHS Acute Trusts - *measured on a calendar year basis.*

Source: Department of Health[4]

In 2000, the Department introduced proposals to improve reporting of accidents and 'near misses' involving patients

1.15 Although *Working Together*[4] required NHS trusts to report details of staff accidents, similar requirements have not applied to patients. In June 2000, an expert group chaired by the Chief Medical Officer published *An Organisation with a Memory*[24] highlighting the need for the NHS to develop unified mechanisms for reporting and analysing patient accidents. It identified the need for "an open culture in which errors or service failures could be addressed; mechanisms to implement change once lessons had been identified; and a wider appreciation of the systems approach in dealing with errors".

1.16 In April 2001, *Building a Safer NHS for Patients*[8] set out a blueprint for a national reporting system and established a National Patient Safety Agency from July 2001. The Agency was given responsibility for establishing and operating a centralised system to collect, code, classify, analyse and provide feedback on clinical and non-clinical adverse events affecting patients. A progress report on the first eighteen months of operation is at **Appendix 4.**

Statutory and management responsibilities for health and safety

1.17 NHS trusts have been subject to the full requirements of health and safety legislation since they were set up in 1991 (Appendix 2). The *Health and Safety at Work etc Act 1974*[9] places a legal duty on employers to provide for the health and safety of their employees. These duties were extended under the *Management of Health and Safety at Work Regulations 1992 (further amended in 1999)*[25] which require employers to assess risks to the health and safety of their employees and make arrangements for implementing a comprehensive system

of safety management, including providing adequate information and training.

1.18 In 2000 the Department introduced the Health and Safety Controls Assurance Standard to help NHS organisations understand the legal framework more effectively. The Standard states that "there is a need for a managed environment which ensures as far as is reasonably practicable the health, safety and welfare of patients, staff, visitors, contractors and all others who are affected by the activities of the organisation". It also provides a framework for measuring NHS trusts' compliance with good practice.[15]

1.19 NHS trust chief executives have overall statutory responsibility for managing health and safety risks and establishing clear lines of accountability throughout their organisation.[15] While all NHS staff have a duty to take reasonable care for the health and safety of themselves and any other persons who may be affected by their acts or omissions at work, trusts are likely to have key individuals with responsibility for specific aspects of health and safety management:

■ a human resources director, responsible for all aspects of human resource management including continuing professional development, sickness absence etc and also for monitoring compliance with the *Working Together*[4] targets;

■ a health and safety lead who is responsible for all aspects of health and safety management including recording, monitoring, reviewing and assessing the root cause of incidents, and facilitating heath and safety training;

■ an occupational health manager who organises pre-employment checks and access to support, including physiotherapy and counselling, to help expedite a return to work; and

■ a director of estates/facilities who ensures the maintenance and safe upkeep of the buildings and environment.

1.20 All NHS trusts have established a Health and Safety Committee as the main forum for dealing with health and safety management issues. The Committee is also used to meet the statutory requirement to consult staff-side representatives on health and safety issues. However, membership and line management responsibilities vary from trust to trust. For example, in many trusts the Health and Safety Committee reports via the Clinical Governance Committee to the Trust Board, in others it can be part of the estates and facilities directorate and reports through the Risk Management Committee and in others reports direct to the Board. In many trusts there are also different reporting lines to the Board for clinical and non-clinical risks.

1.21 An overview of NHS trusts' self assessments against the Controls Assurance Standards can be found on the Department's website.[26] This shows that for 2001-02, trusts on average met 74.6 per cent of the Health and Safety Standard, compared to 85.3 per cent compliance with the Human Resources Standard. Overall compliance with the Standards has improved year on year.

There are a number of external organisations with responsibility for evaluating health and safety in the workplace

1.22 There are three key inspection bodies with responsibility for the monitoring and reporting on compliance with the statutory health and safety and Controls Assurance requirements:

■ **The Health and Safety Executive** - responsible for the enforcement of the *Health and Safety at Work etc Act 1974*.[9] Inspectors carry out planned inspections of health and safety standards in health care premises and can also consider complaints about health and safety and investigate accidents to workers and patients. Since 1996, inspections of NHS trusts have focussed on a number of key risks, one of which is manual handling. In 2001, the Government launched a 10 year strategy (*Revitalising Health and Safety*[27]) to reduce the incident rates of accidents, causes of work-related ill health and number of working days lost. The Health Services were designated as one of the priority areas of action and a strategic programme to target poor performers and address key risks was established. Operational activity has initially focussed on violence and aggression and manual handling incidents. Appendix 3 provides an overview of the last six years of inspection activity.

■ **The Commission for Health Improvement** - has statutory powers to help improve the quality of patient care in the NHS by carrying out reviews of clinical governance, including the corporate view of non-clinical and clinical risk and confirming that risk assessments are carried out. Their reports can be accessed on www.chi.gov.uk.

■ **The NHS Litigation Authority** - handles claims and indemnifies NHS bodies in respect of both clinical negligence and non-clinical risks. The Authority also requires NHS trusts to have risk management programmes in place against which they are assessed. Some of the assessments that include non-clinical risk management programmes have yet to be completed and there was no over-view on the management of non-clinical risks available at the time of our investigation.

The scope and methodology of the study

1.23 We focussed our work on following up the action taken by the Department and NHS acute trusts in response to our 1996 report and the recommendations by the Committee of Public Accounts.[5,6] Because of evidence from the Department's surveys that ambulance and mental health trusts have a higher incidence of accidents, we included these trusts.

1.24 Appendix 1 summarises our study methodology, including membership of our Expert Panel. The full details, including the survey questionnaires, are contained on our website www.nao.gov.uk.

1.25 In this report, we look at progress in:

■ reducing the extent and costs of health and safety risks to staff (Part 2); and

■ improving the management of specific health and safety risks (Part 3).

1.26 A separate report, which examines the progress made in preventing violence and aggression against NHS staff, *A Safer Place to Work: Protecting NHS Hospital and Ambulance Staff from Violence and Aggression*, was published on 27 March 2003.[7]

1.27 The results from our surveys have been shared with the Department and all NHS trusts that took part are being given individual feedback reports covering violence and aggression and accidents to staff.

1.28 In view of recent developments on patient safety (paragraphs 1.15 - 1.16 and Appendix 4), we focussed on staff safety, and plan to review progress in relation to patient safety when the changes have bedded down.

Part 2

The extent and costs of health and safety risks to staff in NHS trusts

2.1 NHS acute, mental health and ambulance trusts provide services 24 hours a day, 365 days a year. The scale and nature of these services makes delivering health care a risky business. Health and safety accidents have serious consequences for the staff involved, affect trust productivity and cost the NHS millions of pounds. This part of our report examines the extent and impact of staff accidents and whether NHS performance targets are being met.

All NHS trusts have accident reporting systems but the effectiveness, completeness of information and definitions used still vary

2.2 In 1996 few NHS acute trusts had robust incident reporting systems.[5] In response to our report, the Department required trusts to develop strategies, supported by effective reporting arrangements, to assess trends and identify best practice in health and safety management. They also expected trusts to have in place policies and procedures to investigate, record, monitor, review and assess the causes.[14]

2.3 All NHS trusts have now adopted or developed some sort of accident recording system and most have taken action to encourage staff reporting, including fostering a 'just and fair' or 'blame free' culture. Around two-thirds are also providing training (induction and refresher) on reporting, and other initiatives to encourage staff to report accidents. These include:

- a documented policy that encourages reporting (49 per cent of trusts);

- revamped accident reporting forms or procedures to make reporting easier (30 per cent);

- active promotion of the need to report through the use of posters, presentations, and workshops (26 per cent); and

- providing feedback to staff (including managers) about action taken to address accidents to show that reports are taken seriously (20 per cent).

3   Assessment of the appropriateness of NHS trust incident reporting systems

Trust rating (where 1 is poor and 10 is very good)	1-3	4-5	6-7	8-10	Don't know	Average Score
(i) Effectiveness of the incident reporting system	1%	10%	31%	56%	2%	7.5
(ii) Completeness of data collected	3%	14%	40%	41%	2%	6.9
(iii) Effectiveness of IT resources available	3%	13%	32%	52%	-	7.3

NOTES

1. Of the 270 trusts who responded to the questionnaire, 253 use a computer based system (34 per cent use SAFECODE and 28 per cent DATIX).

2. Questions (i) and (ii) were responded to by all 270 trusts who completed the questionnaire (n= 270). However for question (iii) - 20 trusts either did not use a computer based system or did not have access to IT and therefore did not answer the question on IT resources (n=250).

Source: National Audit Office survey of trusts

2.4 Ninety four per cent of NHS trusts have invested in computerised systems over the last few years. Trusts that have used an integrated reporting system (around 80 per cent of the trusts) believe that having one system, with one form, increased staff's familiarity with the system and has encouraged reporting. However four per cent of trusts still operate solely paper-based systems.

2.5 Overall, over four-fifths of NHS trusts' health and safety leads now rate the effectiveness of their reporting systems, the completeness of the data and the effectiveness of the IT resources available as above average, with around half rating them at least 8 out of 10 **(Figure 3 on previous page)**.

2.6 In contrast to these assessments, evidence from staff surveys and other research indicates a mixed picture. For example:

■ HSE's analysis of statistics of accidents to employees in health services between 1996-97 and 2000-01 found that only 42 per cent of reportable injuries were reported. They also noted difficulties in comparing NHS trusts' performance because of the different systems and variable levels of reporting[28] (Appendix 3).

■ The Commission for Health Improvement's reports on their inspection visits to trusts over the last two years show that there are still concerns about inconsistencies between reporting systems and evidence that staff are still reluctant to report accidents because reporting forms are "tedious and longwinded".[29]

■ Various research studies and staff surveys all show that doctors rarely report health and safety accidents.[30]

■ Our report *A Safer Place to Work: Protecting NHS Hospital and Ambulance Staff from Violence and Aggression* found a high and varied level of under-reporting of around 39 per cent.[7]

2.7 Furthermore, the National Patient Safety Agency cited differences between NHS trusts' data recording systems as a key reason for the problems experienced in its pilot exercise on reporting patient incidents. The Agency has therefore commissioned consultants to develop a new national computerised patient incident reporting system, which may risk introducing further barriers to reporting staff accidents by having yet another trust incident recording system.

The total number of accidents has increased by 24 per cent with only 23 per cent of NHS trusts achieving the *Working Together* 20 per cent reduction target

2.8 Regional Offices collected baseline details of accidents for 2000-01.[4] However, due to the NHS reorganisation under *Shifting the Balance of Power*,[16] from April 2002 Regional Offices ceased to exist and information on 2001-02 incidents was not collected by them. We therefore undertook a separate survey, in parallel with the Department. **Figure 4 on page 16** shows that while the total number of reported accidents fell between 1998-99 and 2000-01, they have risen again in 2001-02. As a result the National Improvement Target, of reducing accidents to staff by 20 per cent by March 2002, has not been met and indeed overall there has been a 24 per cent increase over the NHS baseline figure.

2.9 Understanding the reasons for the increase between the baseline and 2001-02 is complicated by a number of confounding factors and reflects a complex position where some NHS trusts have seen a fall in the number of reported accidents, due to improved training and practices, and others have recorded an increase, due to increased awareness and compliance with reporting requirements.

2.10 We also found a mis-match between the accident data that we collected from trust health and safety leads, responsible for maintaining the trust accident and incident reporting systems, and the information collected by the Department. The latter was generally provided by the trusts' human resources department, as they are responsible for the *Working Together* targets. In total we identified anomalies in 36 per cent of trusts. Further verification work to try and resolve this issue revealed a lack of 'joined-up' working within these trusts, with evidence of poor communication and collaboration on health and safety matters. Five trusts were still unable to provide any information without undertaking an extensive data collection exercise.

2.11 Following the data verification exercise, we established that there were a total of 135,172 accidents in NHS acute, mental health and ambulance trusts in 2001-02. In each type of trust, the number of accidents per 1,000 staff has increased compared to the 2000-01 baseline level. Ambulance trusts had the highest level of accidents per 1,000 staff. **Case example 1** details how one ambulance trust has reduced its level of reported accidents.

Case example 1: London Ambulance Service NHS Trust - action plan to improve the organisation's policies and manual handling

Situation: In April 2001, an HSE audit found that health and safety responsibilities were not being implemented adequately and an Improvement Notice was issued, focussing on the Trust's organisational policy and manual handling procedures.

Action taken: The Trust drew up an Action Plan that resulted in the issue of a revised organisational policy that identified:

- the health and safety responsibilities for each management role and other employees, which were included in revised job descriptions;

- the health and safety management performance standards, which were included in the objectives of managers; and

- the membership of, and key agenda items for, local health and safety groups, which included risk assessments, incident reporting and industrial injury absence levels. Outcomes from the groups are fed into the Trust's Corporate Health and Safety Group.

In implementing the revised policy:

- over 300 copies of the Trust's revised Health and Safety Manual were distributed across the Service and the Safety and Risk team visited all sectors to inform staff about the HSE Improvement Notice and resultant Action Plan; and

- emphasis was placed on the need to adopt a proactive approach to health and safety, including risk assessments. The expectation was that health and safety would be part of day-to-day management rather than a reaction to external requirements.

On manual handling:

- the Trust commissioned, in February 2002, an independent Manual Handling Audit that estimated the cost of musculo-skeletal illness and injuries to be around £4 million (based on occupational sick pay, injury allowances, early pension payments, recruitment of replacement staff and legal claims);

- based on the audit recommendations, a three-year Manual Handling Improvement Programme was funded by the Trust and implementation is in progress. Also included is the appointment of a Back Care Adviser to provide advice and expertise on best practice, training in lifting and handling and specific vehicle/equipment design;

- a Manual Handling Sub Group of the Vehicle and Equipment Working Group was established in August 2002 to review and evaluate existing and proposed patient handling equipment and vehicle design. The Trust is already committed to invest in patient lifting air cushions and hydraulically operated trolley beds and is evaluating the use of a stair descending chair transporter. In addition, and as part of the Service's standard 5-6 year rolling ambulance vehicle replacement programme, 130 ambulances with tail lifts have been ordered;

- the Trust is reviewing its patient treatment guides to encourage patients to walk/help/lift themselves where clinically acceptable. The existing fitness/lifting assessment, within the selection procedures for operational staff, is also under review;

- the DATIX incident reporting system has been introduced to improve data collection, help identify problems or trends and prioritise actions;

- an initial four-day Manual Handling Risk Assessor course was held in October 2002 for identified operational team leaders; and

- detailed manual handling procedures have also been introduced along with a generic risk assessment process to encourage staff at all levels to take ownership of assessing and controlling foreseeable manual handling risks.

Outcome: In view of actions taken by the Service and its ongoing commitment to implementing the Manual Handling Improvement Programme, HSE lifted the Improvement Notice in April 2002. As a result of the actions taken the overall number of reported manual handling incidents has decreased by 12 per cent in the last year.

Source: National Audit Office survey of trusts

4   Reported accidents to staff in 2001-02 compared with 1998-99 and 2000-01

Type of NHS trust	1998-99 Estimated number of reported accidents per 1,000 staff per month	2000-01 Number of reported accidents per 1,000 staff per month (baseline)	2001-02 Number of reported accidents per 1,000 staff per month (first improvement target)
Acute	16	12	17
Multi-service	17	14	N/A
Ambulance	38	21	28
Community/mental health	21	15	N/A
Mental health/learning disabilities	26	11	18
All NHS trusts	19	13	18
Total number of accidents	120,474 [(i)]	108,743 [(ii)]	135,172 [(iii)]

NOTES

(i)   The total figure for 1998-99 was obtained by extrapolation from a sample of 391 NHS trusts.[4] Five percent of these accidents to staff were reported to HSE.

(ii)   Based on information (including null returns in brackets) from 312(8) NHS trusts, 28(5) primary care trusts, 83(69) health authorities and 5(3) special health authorities. Some community and mental health trusts were unable to supply the information because of NHS re-configurations.[11]

(iii)   Using information from both the NAO and Department surveys we obtained data on 98 per cent of all NHS acute, mental health and ambulance trusts. Five trusts were unable to provide any information and four mental health trusts were unable to supply complete information because of NHS re-configurations. As the focus of our investigation is NHS hospital and ambulance staff, we did not cover health authorities or primary care trusts in our survey, but based on the above and initial data from the Department this might add a further 8,000 to the 2001-02 total.

Source: Department of Health and National Audit Office surveys of trusts

2.12 A detailed trust by trust comparison of 179 NHS trusts for which we have comparable data for 2000-01 and 2001-02, shows that 23 per cent met the improvement target with reductions in reported accidents of 20 per cent or more, 13 per cent recorded reductions of 10 to 20 per cent, while 64 per cent recorded an increase in accidents.

2.13 Pages 18-19 detail the key facts about accidents due to moving and handling, including **Figure 5a** which shows the number of reported accidents per trust per month per 1,000 staff and a good practice example of how one trust has reduced moving and handling accidents **(Case example 2)**. Pages 20-25 provide the same information for each of the other main types of accidents: needlesticks (pages 20-21, **Figure 5b** and **Case example 3**); slips and trips (pages 22-23, **Figure 5c** and **Case example 4**); and exposure to substances hazardous to health (pages 24-25, **Figure 5d** and **Case example 5**).

2.14 Some of the variations illustrated by Figures 5(a) to 5(d) represent differences in practices, while others are due to varying success in getting staff to report. In order to try and understand more clearly what was happening in individual NHS trusts we asked trust health and safety leads their views on changes to the main categories of reported accidents to staff. **Figure 6 opposite** summarises the scale of the changes and the perceived reasons for the change.

6 Some of the reasons given for the perceived increase or decrease in reported accidents to staff

Proportion of accidents compared with 1996(i) and trend over last 3 years	Reasons given for decrease	Reasons given for increase
Moving and handling ■ Overall proportion has increased from 17% to 18% ■ 28% of NHS trusts have seen an increase ■ 33% a decrease ■ 31% stayed the same ■ 7% didn't know	■ Most trusts have introduced clear policies - 3% have adopted a 'no lift' and 5% a minimal lifting policy. ■ 56% have increased the provision of or attendance at moving and handling training. ■ 39% have invested in equipment. ■ 47% have employed manual handling specialists. ■ 10% of acute trusts use dedicated lift teams.	■ Increased awareness has improved reporting in 23% of trusts. ■ Most hospitals cite increased workloads, staff shortages and heavier and more dependent patients. ■ Ambulance trusts have concerns about hospitals and care homes which have 'no lift' policies. ■ Lack of compliance with safer patient handling policies, limited resources and reliance on old or unsuitable equipment.
Needlesticks/Sharps ■ Overall proportion reduced from 19% to 17% ■ 20% of NHS trusts reported an increase ■ 33% a decrease ■ 42% stayed the same ■ 5% didn't know	■ Trusts have given priority to this area by involving infection control teams and/or working with occupational health on improved re-training. ■ 8% have targeted training at medical staff. ■ 21% have improved the type and/or location of sharp boxes. ■ 14% of acute and ambulance trusts are trialling the use of alternative needles.	■ 25% improved reporting, due in part to doctors' increased awareness and general concerns about HepB/C and HIV. ■ 21% cited poor working practices, particularly by doctors. ■ Increase in bed numbers and staff workload. ■ Growing concern about the risk of permanently locating sharps bins near patients.
Slips, trips and falls ■ Overall proportion of accidents is down from 19% in 1996 to 13% ■ 30% of NHS trusts reported an increase ■ 21% a decrease ■ 45% stayed the same ■ 4% didn't know	■ 41% of hospital trusts reported better use of hazard signs and warning cones and improved housekeeping. ■ 23% have used staff training, 11% reduced clutter and 7% enforced their footwear policy more strictly. ■ 15% have increased the use of formal risk assessments. ■ 21% have improved responses to requests for upgrading floors.	■ 37% reported increased awareness. ■ Emphasis on 'just and fair' reporting culture means that accidents that were not reported are now reported. ■ Low staffing levels leading to more rushing around, poor skill mix, and poor housekeeping. ■ Risks on non-trust premises are less easily minimised for ambulance and community workers.
Sensitisation/ Control Of Substances Hazardous to Health ■ Overall the proportion of accidents has increased slightly from 3% to 4% ■ 10% of NHS trusts reported an increase ■ 28% a decrease ■ 45% stayed the same ■ 17% didn't know	■ More robust compliance with improved COSHH regulations. ■ 70% of hospitals and 87% ambulance trusts attribute improvements to powder free gloves and other latex free products. ■ 27% have tightened policies and procedures, reflecting recent legal judgements. ■ 18% of trusts have reduced or eliminated the use of gluteraldehyde.	■ Improved reporting, training and media coverage of litigation cases have increased awareness (35%). ■ Overall increase in numbers of staff with sensitivity to latex. ■ Despite clear guidance on latex allergies, still increased tendency to use gloves, often inappropriately - due to fears of infection. ■ 23% of ambulance trusts reported more incidents of exposures to chemicals such as CS spray and carbon monoxide, at the scenes of accidents.

NOTE

(i)   Our 1996 report showed the frequencies of the main types of accidents, including physical assault. In order to compare like with like we excluded assaults and recalculated the proportions.

Source: National Audit Office survey of trusts

Moving and Handling

Back and other injuries as a result of manual handling may occur due to a single accident or reflect the cumulative effects of years of lifting. They may be directly related to an accident at work, or work may exacerbate the problem. In 1996 the Institute of Employment Studies noted that some 80,000 nurses hurt their backs each year and 3,600 were invalided out of the NHS as a result.[31] The NHS Pensions Agency data indicates that although the number of ill health early retirements due to musculo-skeletal conditions has reduced, the proportion of this type of pension award has remained fairly constant at around 40 per cent.

KEY FACTS

Back Facts from the Department show:[23]

■ 24 per cent of NHS staff regularly experience back pain;

■ 30 per cent of domestic, portering and catering staff in the NHS experience back pain regularly;

■ 35 per cent of ambulance workers experience regular back pain;

■ Manual handling accidents cause a third of all reported injuries that lead to three or more days off work;

■ One in four nurses has taken time off work with a back injury sustained at work;

■ 5 per cent of NHS staff surveyed had more than 20 days off work in a year due to back pain; and

■ 46 per cent of NHS staff interviewed had not been told how to report a manual handling problem.

5a **Number of accidents involving moving and handling reported by trusts in 2001-02**
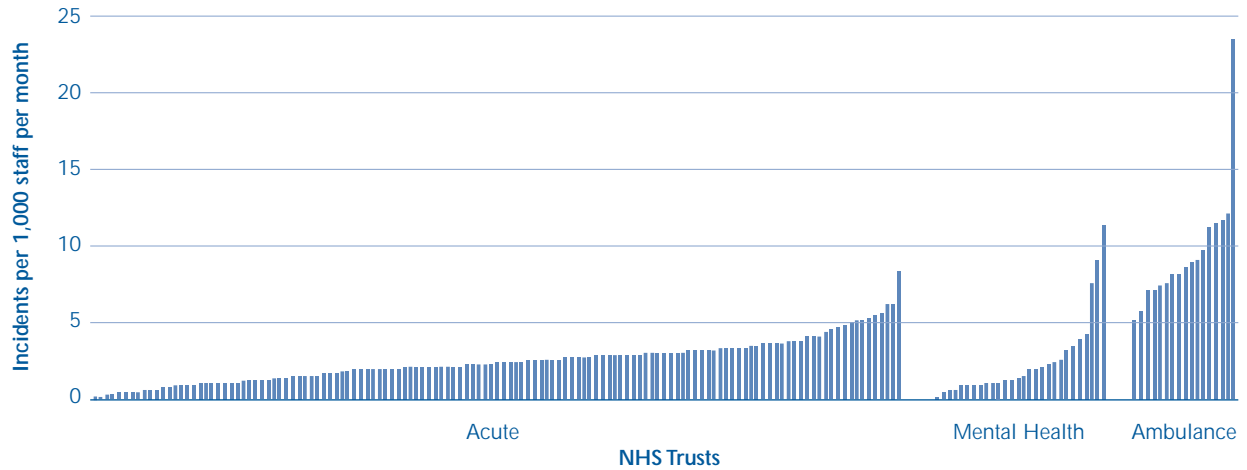
Source: National Audit Office survey of trusts

Case example 2 : Westcountry Ambulance Services NHS Trust - Moving people - safer patient handling for ambulance personnel

Situation: In 1999 manual handling incidents accounted for the majority of accidents at work and for the majority of ill health retirements from the Westcountry Ambulance Services. HSE expressed concerns about the Trust's manual handling performance.

Action taken: At a manual handling event organised specifically for ambulance services by the NHS, trusts were invited to be involved in an initiative to improve manual handling performance. The Trust's Personnel and Employment Director expressed an interest in developing and funding a video based manual handling training system, specifically designed for ambulance services. Subsequently the project was taken forward in partnership by Westcountry Ambulance Services NHS Trust, The Association of Professional Ambulance Personnel and Merlin Communications.

Merlin Communications provided some initial written material based on their work with residential nursing homes. The Trust's lead developed this by writing new modules and adapting work already undertaken on manual handling techniques and equipment by the Health and Safety Manager. Merlin's screen script was reviewed by the Trust's multi-disciplinary editorial group, consisting of the Trust's lead, the Training Manager and two Paramedic Supervisors/

Manual Handling Instructors, and the video used volunteer Trust staff, their relatives and friends and retired ambulance personnel. This has meant that there is ownership of the product. Hospital scenes were shot in Plymouth Hospitals with their kind agreement.

It has been necessary to have 'champions' with absolute commitment to the project, due to the time and effort required for a product of this type, but when finalised the pack was used as the basis for all manual handling training for operational staff, including Paramedics and Technicians within the Trust. The training was and is delivered by local and central manual handling instructors.

The development and use of the pack was only one part of Westcountry Ambulance Services' strategy to reduce manual handling incidents; others included procurement of special equipment and improved design of ambulances.

Outcome: As a result of these activities manual handling accidents reduced from 199 in 1999-2000 to 99 in 2000-01, a reduction of over 50 per cent. Manual handling accidents continue to fall. The Department funded the distribution of the packs to ambulance services under the NHS Health at Work initiative. HSE has acknowledged the quality of the work.

Source: National Audit Office survey of trusts

Needlesticks

Needlestick and sharps injuries occur mostly to nurses, doctors and cleaning staff, and typically occur when proper procedures are not followed. They can arise before or during use, while the instrument is being prepared or during and after disposal. Such injuries can cause anxiety and stress. UNISON have negotiated a deal with employers whereby claims against NHS trusts for certain needlestick injuries are immediately settled by the trust for £2,000.

The Royal College of Nursing (RCN) *Working Well* survey found that over a third of nurses, and half of agency nurses, had been stuck by a needle/sharp previously used on a patient at some point in their career, with seven per cent being stuck more than once in the previous 12 months. Twenty three per cent had not reported the incident.[32] Since July 2000 the RCN has been conducting a surveillance project into needlestick injuries using the EPINet software package.

KEY FACTS

The EPINet results show:[33]

■   42 per cent of these accidents happened to nurses; 23 per cent to medical and dental staff; 11 per cent to health care assistants; four per cent to domestics and porters; and 20 per cent to other healthcare workers;

■   26 per cent of injuries occurred during use of the device; 30 per cent after use but before disposal; eight per cent during disposal; 13 per cent result from an inappropriate disposal of the device; and 23 per cent occur at other times; and

■   40 per cent of healthcare workers who were injured were not the original user.

5b Number of accidents involving needlestick injuries reported by trusts in 2001-02
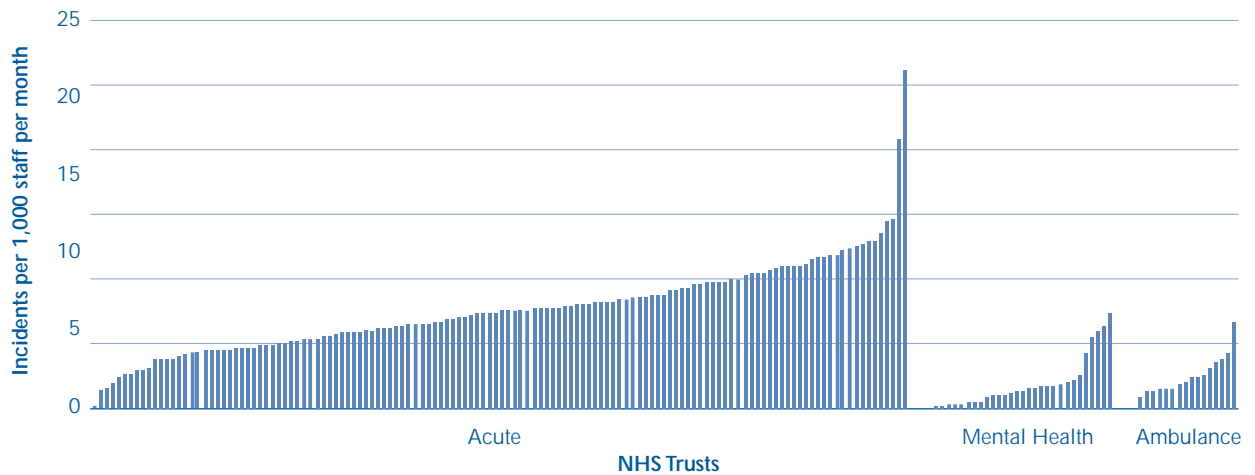
Source: National Audit Office survey of trusts

Case example 3: Rotherham General Hospitals NHS Trust - Reducing needlestick injuries through better management of sharps containers

Situation: The Trust identified that there were some cases where patients were gaining access to used needles from sharps bins in the Accident and Emergency Department. Also some doctors placed used needles from the cannula on the blanket covering the patient while completing the procedure, which then required the doctor to remember to pick up the needle and dispose of it afterwards.

Action taken: The Trust contacted its regular supplier of sharps bins and was able to obtain a tray incorporating a sharps bin as an alternative product free of charge. Staff carry the tray to the patient and can dispose of sharps at the point of use. All sharps bins were removed from patient rooms and now the trays and sharps bins are stored in supervised central locations.

Outcome: The trays have been well received by nursing and medical staff. These changes have resulted in a 42 per cent decrease in the number of reported needlestick incidents and there is a perceived reduction in the potential for injuries.

Source: National Audit Office survey of trusts
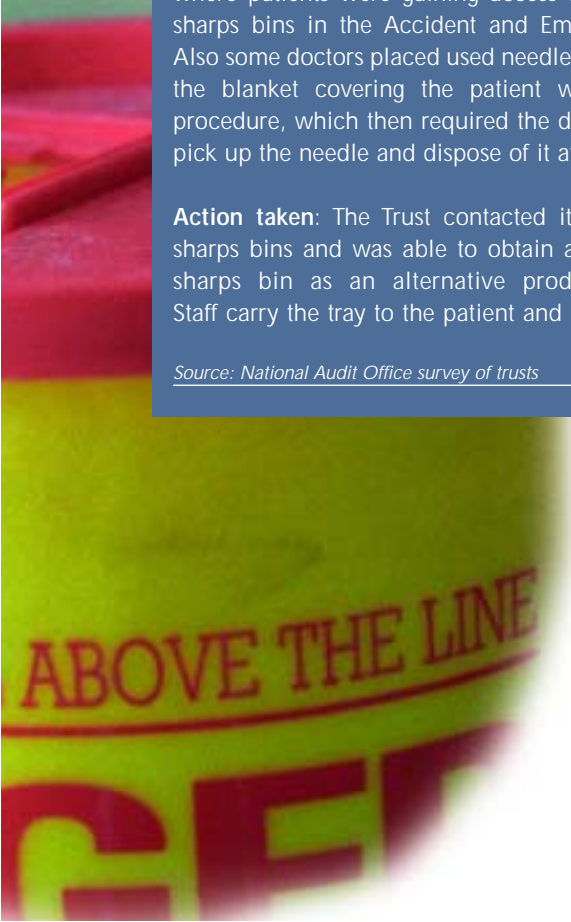
Slips and Trips

Slipping and tripping accidents account for 48 per cent of major injuries.[28] The principal causes of these injuries were poor cleaning techniques, slippery surfaces or failure to mop up liquid spillages quickly and poor working practices, such as trailing electrical cable leads across floors. Some accidents are unavoidable because of difficulties in anticipation. Although HSE have produced guidance for the Food and Drink industries and conducted slip and trip awareness campaigns, there have not been any specific initiatives in the Health Services.

A TUC survey of nearly 800 health and safety representatives found that 44 per cent of slips and trips were in the health sector, and that there were four times as many incidents as in workplaces generally.[34]

KEY FACTS

HSE's reported data from the health sector over five years shows:[28]

- 22 per cent of slips were due to slippery substances and surfaces and a further 15 per cent due to wet surfaces;

- 17 per cent were due to trips over obstructions and 10 per cent on an uneven surface;

- 68 per cent involved on-site transfer, whilst 10 per cent of slipping and tripping injuries occurred in nursing processes; and

- 25 per cent of major slipping and tripping accidents happen to nurses.

5c   Number of accidents of slips and trips reported by trusts in 2001-02
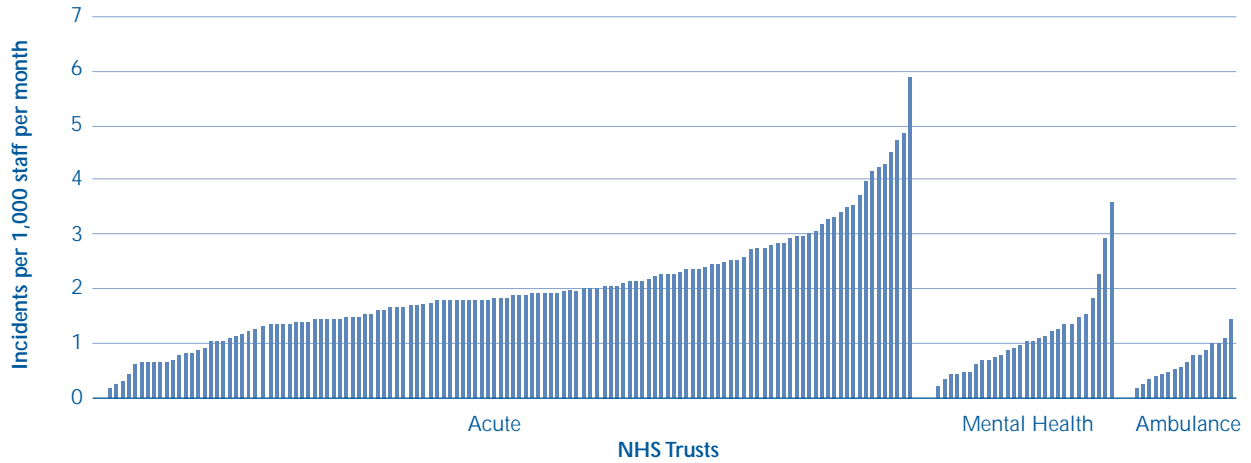
Source: National Audit Office survey of trusts

Case example 4: Isle of Wight NHS Trust - Use of risk assessments to improve prevention of slips and trips

Situation: Trust incident recording systems treat slips and trips as a single category, but the causes are generally different. To assist in avoiding repeat incidents, the Trust needed to manage the hazards and associated risks better and take appropriate remedial action.

Action taken: The Health and Safety Department improved the quality of the slips and trips risk assessments within the Trust and raised the staff's general awareness of the issue. Occupational Health were involved in workplace assessments and pre-planning. Warning signs are used when

floors are being washed and cleaning schedules were altered so as not to coincide with the peak activity times. Working environments were improved. The quality of the floor surfaces and the standard and timeliness of the cleaning is now considered to present minimal risk of slipping and tripping to staff.

Outcome: There has been a 40 per cent decrease in the number of reported incidents of slipping and tripping over the two year period since April 1999.

Source: National Audit Office survey of trusts

Sensitisation and COSHH

Hospital employees make use of a wide range of chemicals which might be hazardous to health. Hazardous substances usually have at least one of these characteristics - toxic, corrosive, harmful, sensitising, biological or carcinogenic - and they could enter the body by inhalation, skin or eye contact, injection or ingestion. Medicines and clinical waste are included but not lead, asbestos and radiation.[35]

HSE inspectors continue to find deficiencies in NHS trusts' handling and storage of clinical waste and in systems of infection control which have led to Improvement Notices.[27] They also note that the use of gluteraldehyde, for which a number of trusts have received Improvement Notices in the past, is now being well controlled and that employers are generally aware of the risks from latex and have policies or procedures in place. The NHS Purchasing and Supply Agency has removed powdered and high protein natural latex rubber gloves from their catalogue.

KEY FACTS

■ In 2000 a Royal College of Nursing survey of members revealed four per cent of respondents had been diagnosed as allergic to latex, a rise of three per cent from their 1999 survey.[32]

■ Latex Allergy Support Group survey of its members found 50 per cent of ambulance trusts had no latex free gloves.[36]

■ TUC report and Latex Summit suggests that 8-17 per cent of all healthcare workers may already be sensitised to latex.[37]

5d   Number of accidents involving sensitisation and COSHH reported by trusts in 2001-02
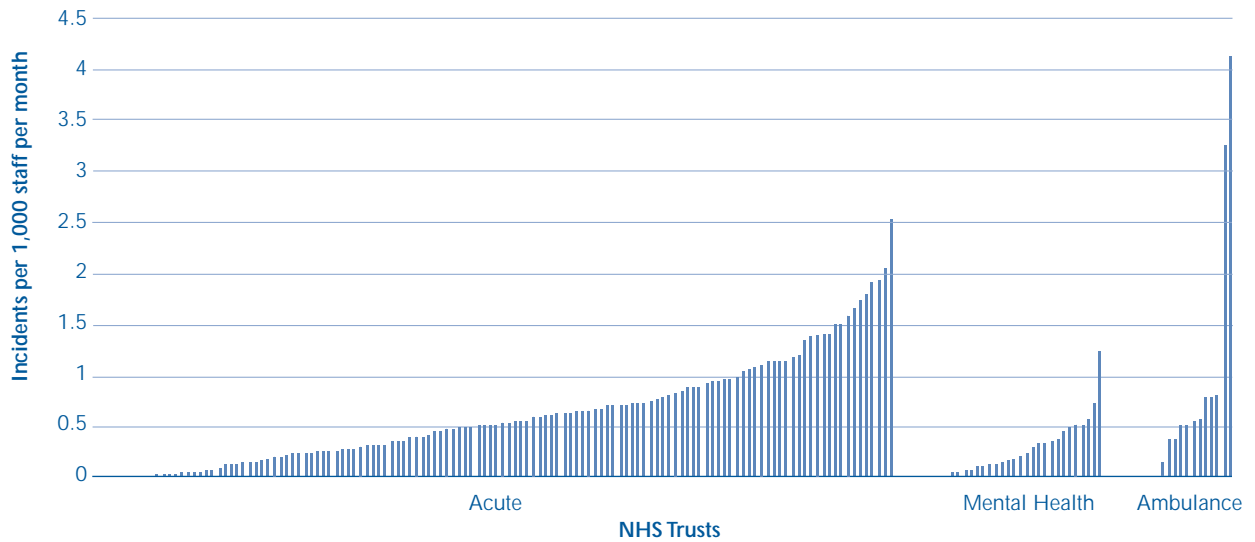
Source: National Audit Office survey of trusts

Case example 5: North Bristol NHS Trust - Creation of a safe environment in response to HSE Improvement Notice

Situation: In August 2001, HSE issued a Latex Improvement Notice for non-compliance with its guidelines on use of latex.

Action taken: Extensive systems for the management of latex, developed over a number of years by the Latex Advisory Group, were already in place at the Trust, but the receipt of the Improvement Notice focussed attention on the issue of accessibility of information and training to all levels of staff. The Trust's policies, procedures, protocols and training were reviewed and updated as appropriate and existing latex trainers subsequently cascaded further training to staff. The programme consists of study days and glove selection guides. All directorate trainers are provided with educational toolkits, relevant literature and presentation tools, which are reviewed on an annual basis.

As a consequence of the Improvement Notice the Latex Advisory Group became a formal sub-group of the Trust Health and Safety Committee and provides bi-monthly reports to the Committee.

Outcome: The awareness of 8,500 employees was raised and basic information has been distributed to every member of staff through their pay packets. HSE's follow-up visit determined that the Trust had successfully created a latex safe environment for all staff and the Improvement Notice was lifted.

Source: National Audit Office

Since our 1996 report the issue of work-related stress has had an increasingly high profile

2.15 Our 1996 report did not cover work-related stress. Since then this issue and the implications for the NHS have been raised in a number of high profile publications:

- In 1998, a report by the Nuffield Trust, which was based on an extensive literature review, drew attention to high levels of psychological distress in the main groups of NHS employees, for example: stress in health service staff was substantially higher than in other UK employees (studies found high levels of psychological disturbance in 21-50 per cent of doctors and in 29-48 per cent of nurses); NHS managers were twice as likely to be above the threshold for psychological distress as other British managers; factors causing stress in doctors included long hours and workload pressures, whilst for nurses it was high workload coupled with staff shortages. New stressors such as the perceived risk of violence to staff and fears of contamination by HIV/Hepatitis B and C had emerged.[38]

- A literature review carried out in 2000, found that over 20 reports consistently showed that between a quarter and a half of all NHS staff were reporting significant levels of stress and that many stressors were unique to healthcare.[39]

- In June 2001 a Policy Studies Institute report, commissioned by the Department, found senior nurses were being stressed by concerns about how to staff busy wards, competency levels among agency nurses, long hours, recruitment and retention problems and cleanliness of wards. Nurses blamed organisation and management factors beyond their control for spiralling stress levels.[40]

- The Royal College of Nursing's 2002 *Working Well* survey used a psychometric questionnaire to determine the psychological health of members. This showed that 11 per cent of nurses had a similar profile to people deemed to be in need of NHS psychological therapies. But only half of these staff were receiving counselling or other treatment. These nurses also report twice the level of sickness absence as other nurses in the survey.[32]

- In February 2002 the Trades Union Congress reported a twelve-fold increase in work-related stress personal injury claims.[41] This has significant cost implications for NHS trusts if the courts continue to make significant awards to stressed workers **(Figure 7)**.

7 **Compensation awarded to nurse following mental breakdown due to stress and overwork**

A nurse who had a mental breakdown because of stress and overwork, in the aftermath of a traumatic pregnancy, won £140,000 compensation in October 2001. The NHS trust was ruled to have grossly dishonoured the arrangement that had been made to protect her health and welfare upon her return to work and the trust should have foreseen the substantial risk that she would suffer psychiatric injury. Excessive hours, lack of administrative assistance and covering for absent or sick colleagues were contributory. She has retired on the grounds of ill health.

Source: National Audit Office literature review

2.16 HSE defines work-related stress as "the adverse reaction people have to excessive pressures or other types of demands placed on them". Work-related stress is not an illness in itself but if prolonged or particularly intense it can lead to physical or mental ill health. There is no specific law dealing with stress but key regulations for protecting staff are the *Management of Health and Safety at Work Regulations 1999*, based on risk assessment.[25]

2.17 We found that around two-thirds of NHS trusts believed that work-related stress had increased over the last three years. But many trust occupational health managers could not produce hard data to support their view and others did not know the trends in their trusts **(Figure 8)**.

8 **The views of NHS trust occupational health managers on the extent to which work-related stress has increased, decreased or stayed the same in the last three years**

Type of NHS trust	Increased	Decreased	Same	No Response
Acute	**67%**	3%	16%	14%
Mental Health	**60%**	0%	9%	31%
Ambulance	**65%**	7%	14%	14%

Source: National Audit Office survey of trusts

The human and financial costs of work-related accidents are acknowledged to be high but there is little quantifiable data

2.18 The human and financial costs of accidents at work can be substantial[5] and **Figure 9** illustrates the range of potential impacts. Published research tends to focus on qualitative or non-financial impacts. These show that the impact will depend on its severity and range from:

■ a minor accident which does not require staff to take any time off work; to

■ accidents that result in costs associated with sickness pay, short-term replacement staff, and training to avoid similar incidents occurring; to

■ more severe impacts involving ill health or early retirement or staff turnover. Research on behalf of the London Workforce Development Confederations show that for staff who experience a serious accident there is a high probability that they will leave the NHS.[42]

HSE and others have produced guidance to help employers estimate the cost of accidents in their organisation

2.19 HSE have publications on the *Cost of Accidents at Work*.[44,43] In 1993 they estimated that accidents could cost an average NHS trust £397,140 or five per cent of its running costs per annum, based on a total loss approach.[43] The limitations of this work were acknowledged and, although ground-breaking at the time, it had little practical value to managers. They subsequently revised and updated this in 1997, including a literature review of investigative tools[44] and piloted a new methodology in an NHS setting. These results, based solely on direct costs, suggested that the average total cost of accidents in a trust were £103,152 per annum, although this excluded some significant costs such as staff replacement, medical treatment and compensation payments.[45]

2.20 Subsequently in 2001 under the banner *Good Health and Safety is Good Business*, the HSE developed a Ready Reckoner to help employers cost the impact of health and safety accidents.[46] SAFECODE, one of the computer based incident recording systems, have also issued guidance on costing accidents.[47]

9   **The factors to take into account when assessing the impact of health and safety accidents**

Consequences for employers	Consequences for individuals
Tarnished reputation	Reduced capacity for work
Poor functioning of management teams	Reduced quality of life
Delayed service delivery	Need for redeployment
High staff turnover	Need for re-training
Loss of key, experienced staff	Reduced earning capacity
Unplanned managerial time spent reacting to incidents	Temporary disability
Court fines	Permanent disability
Legal costs	Early retirement
Compensation claims	Affect on staff morale
Increased insurance contributions	Death

Source: National Audit Office literature review

10   Compensation payments awarded by the courts to employees injured in the course of their duties

- In 1998, a health authority paid an out of court settlement of **£465,000** to a junior doctor who developed a psychiatric illness following a sharps injury, even though the incident did not lead to any physical infection.

- In 2000, an occupational therapy assistant won **£600,000** in compensation for injuries sustained at work. In March 1990 she slipped on a wet vinyl floor fracturing her right ankle. She continued to suffer considerable pain and disability in the knee and ankle, requiring numerous operations, and her employment was terminated on ill health grounds in 1992. In May 1997, she had to have her right leg amputated below the knee.

- In February 2000, a former intensive care nurse accepted **£800,000** compensation in an out of court settlement after injuring his back at work. The incident happened in 1992, when the nurse lifted a patient with just one other colleague, although the NHS trust policy recommended that staff should use a hoist, or a minimum of four members of staff should lift a patient. The award was made on two counts: the lack of a mechanical hoist and the hospital was deemed to have given inadequate lifting training.

- In June 2001, a former staff nurse was awarded **£347,000** for a back injury caused by repetitive strain while working in a hospital which allegedly lacked suitable equipment to help move patients. She had suffered back pain from 1994 and was retired from Queen's Medical Centre, Nottingham, in 1996.

- In 2002, a healthcare worker received an award of **£58,000** for a needlestick injury received in 1997. While assisting a consultant anaesthetist a Senior Operating Departmental Assistant was injured when a tray of needles flipped over. One stuck in his arm, and in attempting to shake it off it penetrated his toe, through his shoe. The needle was contaminated and the assistant suffered severe shock and trauma.

- In October 2002, the High Court awarded **£420,000** compensation for a nurse who was forced to retire in 1998 after moving patients without adequate arrangements. Patients of up to 12 stone in weight had to be manually lifted because the mechanical hoist was shared with another ward and staffing levels were poor. Newham Healthcare NHS Trust also faces legal expenses of **£400,000**.

Source: National Audit Office literature review

Few NHS trusts have robust information on the costs of health and safety accidents

2.21 In 1996, we found that none of the hospitals surveyed could provide information on costs of accidents, although working with four hospitals and extrapolating the results, we calculated that the immediate costs of accidents to staff, patients and visitors was some £12 million, and £154 million if longer-term costs were added.[5] In response the Department required NHS trusts to put in place "policies and procedures to investigate, record, monitor, review and assess the causes and costs of accidents, sickness absences, ill health retirements and occupational ill health".[14]

2.22 Although the Department has re-iterated this requirement in successive guidance, in response to our survey, only 24 NHS trusts (9 per cent) had attempted to estimate their costs and of these, only 17 (6 per cent) provided any cost information. The basis of the costing and the assumptions made varied widely, demonstrating the significant problems that trusts have in determining robust cost estimates and the need for guidance, including a framework for costing accidents.

2.23 While only a small proportion of incidents result in claims being pursued through the courts, a number of high profile compensation awards have highlighted the potential costs to the NHS of failing to ensure the health and safety of their staff **(Figure 10)**.

In the absence of NHS data we estimate that the direct cost of health and safety accidents is at least £173 million

2.24 The only published Departmental cost estimate on staff sickness absence is the cost of manual handling accidents, which accounts for 40 per cent of NHS sickness absence costs, or in the region of £400 million a year. NHS trusts with an annual budget of £100 million and the average sickness absence rate of 4.6 per cent are likely to be paying £1.25 million for staff that are unable to work due to back injuries.[23] While this data does not identify the cost of work-related accidents, it notes that one in four nurses has taken some time off work with a back injury sustained at work and that for some it has meant the end of their careers.

2.25 We therefore attempted to assess the broad direct cost to the NHS of accidents to staff. Using information from one NHS trust that we judged had made the most robust attempt at assessing costs; from the NHS Pensions Agency on permanent injury benefits and work-related ill health retirements; and from the NHS Litigation Authority on potential claims and actual payments of claims in excess of £10,000, for post 1 April 1999 events. Our methodology is summarised in Appendix 1. We calculated that the annual direct cost of health and safety accidents in 2001-02 would be at least £172.8 million **(Figure 11)** and could be as high as £265 million if different assumptions are made about the levels of work-related sickness absence (see Appendix 1). The total cost is likely to be much more as these figures exclude a number of relevant costs such as staff replacement costs, which are substantial but cannot be readily quantified.

2.26 This cost estimate also excludes the human costs, such as low productivity, low morale and increased staff turnover and their impact on delivering the NHS Plan.

There would be clear benefits from NHS trusts having more robust information on costs

2.27 The lack of high level information on the cost of accidents means that few NHS Trust Boards or chief executives are aware of the impact of health and safety on their productivity or on the cost-effectiveness of specific initiatives or countermeasures. This makes it difficult to prioritise expenditure on interventions. Research undertaken on behalf of HSE has found that workers' compensation arrangements in countries such as Canada, the United States, Germany and Australia positively motivate the management of health and safety and, in some cases, rehabilitation due to the link between cost of the claims and the duration of absence.[48]

2.28 One area where attempts have been made to quantify the cost-benefits of interventions to reduce accidents is in relation to needlesticks and the introduction of safer needles **(Case example 6)**.

11 Estimate of the annual direct cost of NHS staff health and safety accidents in 2001-02

Cost Factor	Basis of Estimate	£m
Sickness absence	Using data from one NHS trust which we judged to have the most robust information on costs, extrapolated to all trusts. However the estimate of work-related sickness absence at 7.6 per cent is acknowledged as very conservative and data from other published sources suggest it is more likely to be between 10 and 15 per cent (Appendix 1).	88.0
NHS trust liabilities	Data from the 50 per cent of trusts who provided information - grossed up to the population as a whole - Temporary Injury Allowance (£3.3 million), industrial injury claims (£12.1m) and payments out of court (£7.1m).	22.5
Permanent Injury Benefits	Information provided by NHS Pensions Agency	43.6
Ill health retirements	Information provided by NHS Pensions Agency	13.0
Compensation payments	Information provided by the NHS Litigation Authority on claims in excess of £10,000	1.5
Legal and Insurance Costs	Includes contribution costs from the NHS Litigation Authority	4.2
Total [i]		**172.8**

NOTE

(i)   This is a conservative estimate as it uses a low estimate of work-related sickness absence and excludes staff replacement costs, treatment costs and the cost of claims settled through the courts (some examples of which are detailed in Figure 10).

Source: National Audit Office

Case example 6 - Cost-benefit analysis of introducing safer needles by the Chelsea and Westminster NHS Trust

Problem: The Trust wanted to evaluate the potential cost savings of introducing safer devices against the initial costs of implementation.

Solution: The Occupational Health Department monitored body fluid exposures in the Trust over 12 months. The statistics revealed that the majority of 'sharps' injuries happened during use of the device, but 40 per cent occurred after the procedure or disposal. From this data a prediction of the number of 'low' and 'high' risk sharps injuries (i.e. Hepatitis C and HIV risk) likely to be experienced by F grade nurses and specialist registrars was made. Potential costs of the time staff spent away from work, locum staff, occupational health input and treatment, but excluding management time, were then calculated. If the number of needlestick injuries to clinical and non-clinical staff could be reduced there was the potential to make cost savings of up to £55,000.

Outcome: Although the purchase price of safer devices (around £136,000 based on current market prices), is more than the predicted potential savings, the Trust's Risk Management Committee also considered the unquantified impact of sharps injuries in the evaluation. These included raised levels of anxiety in the injured individual, which may lead to lowered performance; fines for breaches of health and safety legislation and potential litigation costs, which could be as much as £500,000. In view of the fact that injuries from IV cannulas tend to carry a higher risk of transmission of Blood Borne Viruses and the cost difference is not as great as with other 'safer devices', it was agreed that a trial of retractable cannulas should go ahead in the acute wards, Accident and Emergency and theatres. The Trust's Clinical Skills Trainer and Occupational Health are to ensure that all staff involved are trained in the correct use of the devices and criteria from the NHS Purchasing and Supply Agency will be used to evaluate the trial.

Source: National Audit Office survey of trusts

Part 3

Improving the management of health and safety risks

3.1 In 1996, we found that standards of health and safety management were variable with a number of NHS trusts failing to meet their statutory obligations, and recommended areas for improvement.[5] In response, the Department issued guidance setting out the actions trusts needed to take to improve the effectiveness of their health and safety management.[14]

3.2 This part of our report examines progress in:

- ensuring compliance with the statutory and operational responsibilities for managing health and safety risks, including developing a clear written health and safety policy (paragraphs 3.3-3.7);

- implementing appropriate risk management strategies/systems (paragraphs 3.8-3.13);

- appointing competent persons (properly trained health and safety advisors) to promote compliance with health and safety legislation (paragraphs 3.14-3.17);

- ensuring a comprehensive approach to health and safety training for staff (paragraphs 3.18-3.27);

- providing good quality, confidential and accessible occupational health services (paragraphs 3.28-3.40);

- introducing counselling and other strategies aimed at improving staff wellbeing, including measures to tackle stress (paragraphs 3.41-3.44); and

- improving the management of health and safety risks to contractors (paragraphs 3.45-3.51).

A Most NHS trusts now comply with the Department's requirement as regards the structures needed to manage health and safety risks

3.3 Following our 1996 report, the Department, together with the NHS Confederation, held a series of regional roadshows to offer advice and encouragement and to disseminate good practice. These were targeted specifically at chief executives, chairmen and directors and were attended by over 600 delegates. Those attending received advice on the legal aspects of health and safety management, together with examples of health and safety risk management policies and how to implement them. The Secretary of State for Health also sent a letter to NHS Trust Board chairmen encouraging greater participation in managing health and safety.[20]

3.4 Initially few senior managers expressed an interest in attending the roadshows, preferring instead to send junior staff. However a 'landmark' prosecution of the Swindon and Marlborough NHS Trust by HSE, in the month before the first roadshow, brought home to chief executives and Board Members that they were legally responsible for health and safety compliance. As a result, around 80 per cent of those attending the first series of roadshows were Board level representatives.

3.5 Subsequent guidance (Appendix 2), revised legislation (for example the *Management of Health and Safety at Work Regulations 1999*[25]), the Health and Safety Controls Assurance Standard[15] and speeches by Ministers have contributed to maintaining this profile.

3.6 We found that:

- around 80 per cent of NHS trust chief executives have personally reviewed their health and safety arrangements in the last 12 months;

- almost all trusts have appointed a Board member with responsibility for health and safety matters, but although 71 per cent of trusts discuss health and safety at least every six months, in 12 trusts (four per cent), health and safety is not discussed at Board level;

- almost all trusts have a separate Health and Safety Committee which meets at least every six months and includes staff-side representation;

- ninety eight per cent of trusts have a written policy on general health and safety management and two per cent are in preparation; and

- ninety per cent have a policy on health and safety risk assessment in the work place and 10 per cent are in preparation.

3.7 That said, NHS trust staff surveys show that many staff are unaware of their trust's policies or where to find them. Some trusts have addressed this problem by putting their policies on their intranet site.
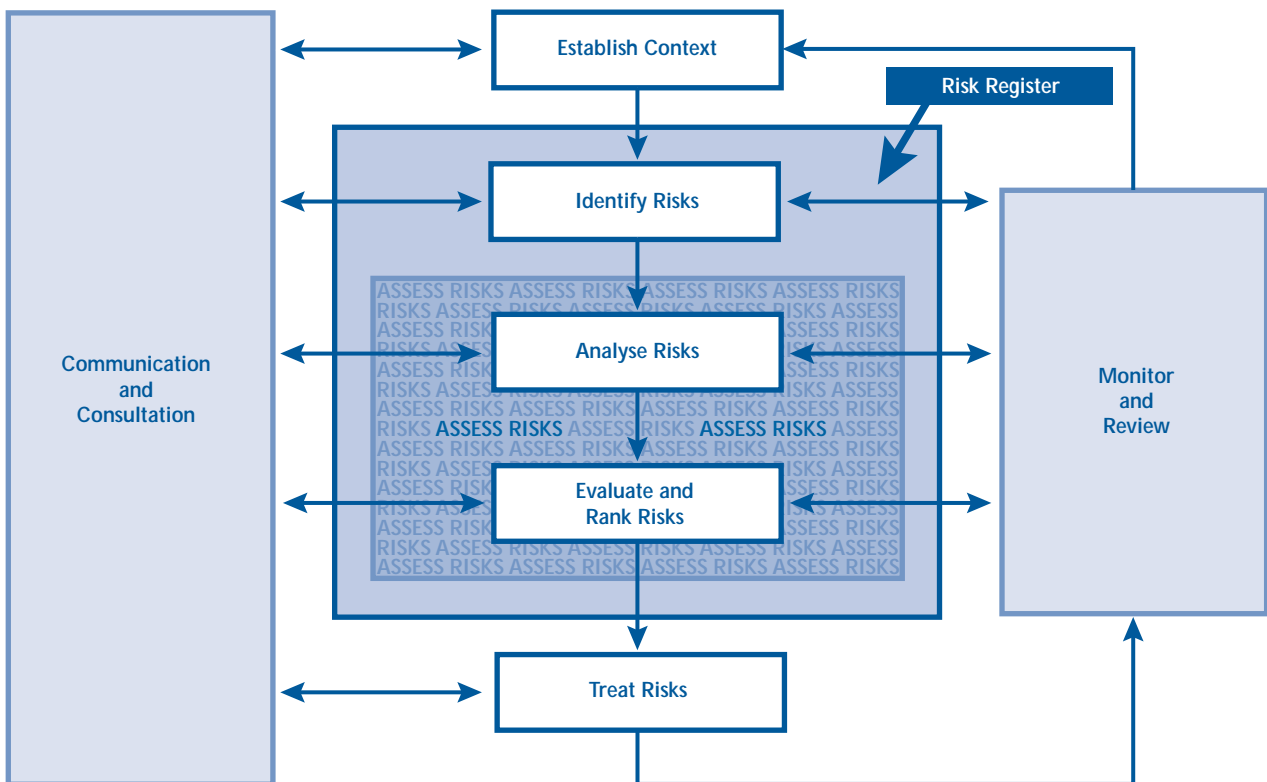
B Most NHS trusts have integrated health and safety risk management within their trust risk management framework

3.8 In response to our 1996 report, the Department agreed it was essential that health and safety was integrated into NHS trust's risk management framework and planned to develop a risk management tool in conjunction with NHS Estates, to help trusts improve the management of health and safety risks.[20] In the event the development of this tool was overtaken by plans to develop and maintain a comprehensive 'control framework', comprising detailed risk management and organisational controls standards and assessment criteria,[49] including the introduction of the Department's Controls Assurance Risk Management Standard.[15] This standard encouraged trusts to develop an integrated risk management framework covering both clinical and non-clinical risks and to use a risk register to store information and rank risks in order of priority **(Figure 12)**.

3.9 In practice, NHS trusts should already have had equivalent arrangements in place to comply with HSE's *Management of Health and Safety at Work Regulations 1992 (further amended in 1999)*.[25] Departmental guidance containing a specimen risk register, risk treatment schedule and action plan and a basic risk register database was posted on the Controls Assurance Unit website (www.doh.gov.uk/riskman.htm).

3.10 We found that most NHS trusts have improved their overall approach to health and safety risk management, but the picture is by no means consistent and some trusts have scope for further improvement. This picture is supported by HSE's findings, which show a general improvement in compliance with health and safety legislation but a growing gap between the better performing and worst performing trusts (Appendix 3). HSE noted that where trusts appeared to be making improvements the commitment and active support of the Chief Executive and senior staff was a key factor.

12 The Department's Risk Management Process

Source: Department of Health

3.11 While most NHS trusts have now integrated their health and safety risk management within the trust overall risk management framework the types and quality of risk assessments vary. Eighty four per cent of trusts carry out health and safety risk audits. Almost three-quarters undertake audits on a cyclical basis, and a third of these do so at least once a year. However, seven per cent audit each department less than once every three years. Moreover, trust chief executives have concerns about the reliability of some of their risk assessment activity, and in particular whether staff have received appropriate training to undertake effective health and safety risk assessments. Only 12 per cent of trusts include training on risk assessments in their induction programmes. HSE have been working with the Department to target poorer performing trusts, and with the NHS Litigation Authority and the Department to help trusts improve their systems.

3.12 For many NHS trusts there are constraints to adopting an integrated approach to risk assessment as they often have different routes for reporting to the Board for clinical and non-clinical risks. External pressure from organisations like the NHS Litigation Authority that assess the appropriateness of clinical risk management systems, can also militate against trusts developing an integrated risk assessment process. And the new National Patient Safety Agency's proposal to introduce a separate system for reporting patient incidents and 'near misses' (Appendix 4), may focus attention away from maintaining or developing an integrated approach. **Case example 7** shows how North Tees and Hartlepool NHS Trust has adopted an integrated approach to risk management.

Strategies to improve the physical and environmental risks have a bearing on NHS trusts' abilities to provide a safe workplace

3.13 One key area where risk assessment can have a significant impact is in the evaluation of physical and environmental risks. Ninety two per cent of NHS trust facilities/estates departments reported that they had introduced initiatives to reduce health and safety risks within the hospital. Most of these initiatives were justified on the basis of a risk assessment. Government statistics show that backlog maintenance to the value of £362 million is needed to achieve health and safety code B, that is sound, operationally safe, and exhibiting minor deterioration.[54] Clearly improving the safety of the environment will reduce health and safety risks.

Case example 7: Closing the loop - Using risk assessment to determine appropriate action and resource requirements in the North Tees and Hartlepool NHS Trust

Action taken: The Trust policy is that a complete assessment of clinical and non-clinical risks is carried out in every ward and department by a cross- section of their staff at least annually. They use a series of standard forms for hazard identification, risk assessment and risk treatment and the sessions are facilitated by the risk management department. Managers are encouraged to compare the risk category before and after any proposed action to demonstrate the expected benefit and to nominate a person to deliver the plan by the set deadline. To ensure consistency, standard definitions are used based on identifying the likelihood of an event (rare to almost certain) and the impact (none to catastrophic) then using a risk matrix to identify the risk category (simplified into four-colour traffic lights).

Each directorate management team reviews these assessments and the resultant action plans and adds any organisational or strategic risks before passing them to the risk management department for inclusion in the Trust-wide risk register. The Head of Risk Management produces reports for the Controls Assurance and Risk Management Committee with recommendations to be passed to the Board for ratification.

Directorates are expected to review their risk assessments at their monthly meetings and notify changes to the risk management department, which monitors progress with action plans. The Head of Risk Management includes any non-compliance in his reports.

Outcome: By using a common technique it is possible to compare the relative priorities of disparate risks. This facilitates the creation of business plans based on addressing the key issues first. It also informs decision making in relation to capital bids and gives clear focus to funding discussions with purchasers. Staff can see that their concerns are being addressed in a fair and equitable manner and are reassured that the organisation has a clear picture of its risk profile.

Source: National Audit Office

13 **Number of health and safety staff employed by trusts in 2001-02**
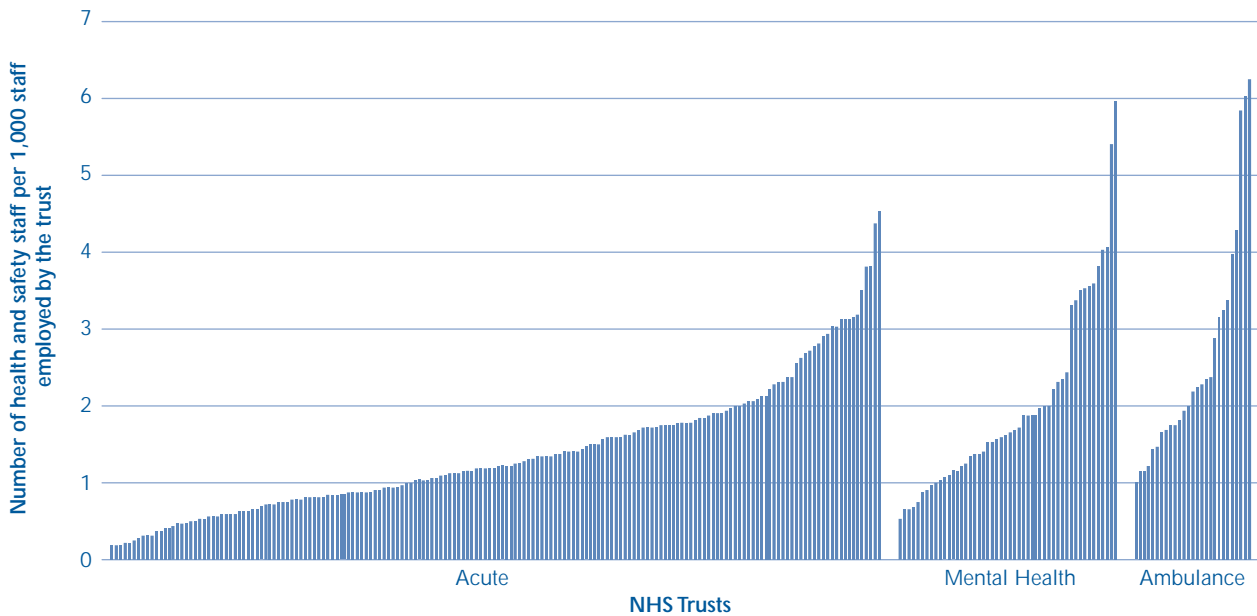
Source: National Audit Office survey of trusts

C Ninety five per cent of NHS trusts have a health and safety lead but their qualifications, experience and the resources available to them vary

3.14 The *Management of Health and Safety at Work Regulations 1992* (*further amended in 1999*)[25] and Departmental guidance[14] require NHS trusts to appoint a competent person(s) to assist them in complying with health and safety legislation, that is someone having sufficient training, experience and knowledge to enable proper assistance to be given. The appointed persons should ideally be employees or can be independent health and safety experts. Membership of appropriate professional institutions is recommended but, unlike most other health professionals working in the NHS, it is not a pre-requisite.

3.15 Ninety five per cent of NHS trusts have appointed lead health and safety advisors but five per cent were carrying a vacancy during 2002-03. The qualification and experience of the health and safety lead varies. For example, 43 per cent are members of the Institute of Safety and Health (MIOSH), 16 per cent have a general certificate in health and safety (NEBOSH) and six per cent an NVQ in Health and Safety Management. While 17 per cent held some other health and safety related qualification, 18 per cent do not appear to have any formal qualifications. The average length of time that leads have worked in health and safety management is around nine years with an average of seven years in the NHS.

3.16 In addition to lead advisors, 89 per cent of NHS trusts have other designated health and safety staff in operational areas. Overall, however, there are wide variations between trusts in the health and safety management resources available per member of staff **(Figure 13)**. Overall, 17 per cent of health and safety leads considered that their staffing resources were less than adequate for maintaining an effective health and safety environment, whereas 44 per cent rated their staffing resources as more than adequate.

3.17 The financial resources available to the health and safety department also vary. Just under half (48 per cent) of NHS trusts have a dedicated health and safety budget, although 18 per cent of these did not know the value of the budget. Of those that did know, the average budget for 2002-03 was £53.51 for each member of staff. Of the 145 trusts without a dedicated budget, 109 (75 per cent) were unaware of the resources available for expenditure on health and safety. The remaining 36 trusts estimated that their average budget was around £20,000.

D NHS trusts' provision of health and safety training varies widely

3.18 Under legislation, the general duties of employers include "the provision of such information, instruction, training and supervision as is necessary to ensure, so far as is reasonably practicable, the health and safety at work of his employees".[9]

3.19 Most Departmental and HSE guidance on health and safety management emphasises the importance of training. Furthermore, the Department's response to our 1996 report states "NHS employers must ensure that all

staff are given appropriate health and safety training on recruitment and when exposed to new or increased risks, whether due to changing responsibilities or the introduction of new equipment".[20] The guidance recognises that the training needs of staff vary depending on their particular duties but stresses the need for induction and refresher training and for training records to be maintained and audited on a regular basis.[14]

3.20 The Department has not prescribed the types of training needed or their content, in contrast to Wales where the Welsh Assembly has recently launched a revised training strategy, which includes standardised health and safety training courses customised for particular members of staff. Staff will be given a training 'passport' which is transferable between NHS organisations. This approach means that staff are trained to the same level of competence whichever NHS trust they work for, and avoids duplication by individual trusts.[51]

3.21 The lack of a recommended model in England has led to wide variations in the health and safety training provided to staff, for example NHS trusts' induction programmes **(Figure 14)**. The Commission for Health Improvement is also concerned that variations in the length of induction programmes limited some trusts' ability to cover adequately the statutory requirements for health and safety induction training.

3.22 Provision of courses and attendance at induction training also varies:

■ nurses are the most likely staff to attend health and safety induction training;

■ doctors are the least likely to attend: re-enforcing the Commission for Health Improvement's findings in their Clinical Governance Reviews that attendance at training by consultants, junior doctors and locum doctors was deficient;

■ 90 per cent of NHS trusts provide induction training on moving and handling to nurses, allied health professionals, managers and ancillary staff but only 50 per cent to new doctors. Furthermore, take-up varies: our survey of accident and emergency departments found that only 54 per cent of their staff had received manual handling training at induction; and

■ only 12 per cent of trusts provide training in risk management to any of their staff.

3.23 A number of NHS trusts highlighted problems with timing of training courses and that staff shortages and increasing workloads meant that it was increasingly difficult to release staff for training. In 2001, the Audit Commission found that access to training, including health and safety training, varied between trusts and they expressed particular concerns about access for part-time staff, night workers, those on non-day shifts and bank and agency staff. They also found that in the majority of trusts that they visited one third of nursing staff had not had any refresher training in moving and handling.[52]

3.24 In our report on violence and aggression we found little evidence of risk assessment of training needs, wide variations in the level and types of training and in the numbers of staff receiving the training. Furthermore, 80 per cent of accident and emergency managers and 68 per cent of ambulance service operational managers believed that the level and coverage of induction training their staff received was inadequate and that some staff rarely receive appropriate training.

14 The main elements of a health and safety induction programme and the percentage of NHS hospital trusts that provide this induction training averaged across all staff groups

Subject	NHS Acute Trusts	NHS Mental Health Trusts
Occupational Health	84%	78%
Needlesticks	83%	72%
Manual Handling	81%	79%
Substances Hazardous to Health	69%	58%
Violence and Aggression	69%	80%
Slips and Trips	63%	53%
Sensitisation	43%	27%
Risk Management	13%	12%
Other Health and Safety Training	51%	51%

Source: National Audit Office survey of trusts

3.25 **Case example 8** highlights how NHS trusts in the North West are ensuring that health and safety training is targeted at more of their staff.

3.26 While 82 per cent of NHS trusts' health and safety leads told us that they maintained records of health and safety training, the responsibility for this varied between trusts. The Commission for Health Improvement identified trusts where it was not clear who was responsible for maintaining records and they therefore had difficulties in demonstrating compliance with, or determining the need for, mandatory training. HSE has issued two trusts with Improvement Notices, one for failure to provide adequate health and safety training for department managers and Executive Directors and another for failure to provide evidence of training records for maintenance workers using equipment held for work at heights.

3.27 Assessment of training courses rarely includes evaluation of what happens in the workplace as a result of the training. Evaluations have generally been limited to post-course questionnaires which elicited feedback for adjusting the content or delivery of the training programme.

E All NHS trusts provide some occupational health services but this is largely reactive and the quality and accessibility varies

3.28 Occupational health services fulfil a number of important roles from health surveillance and screening, health education and counselling, assessments of individual employees' fitness for work, and the rehabilitation of staff into work following an injury or illness, to planning and implementing health improvement measures in the workplace.

3.29 Our 1996 report noted that, whilst the Department issued detailed guidance on occupational health services for NHS staff in 1994,[53] few NHS trusts routinely analysed data to identify potential problems and none could provide information on trends in occupationally related ill health among their staff.[5] In response, the Department issued further guidance requiring trusts to improve NHS occupational health services, identify and reduce work-related illness and injury and provide necessary support.[54]

Case example 8: Use of Open Learning Programmes to facilitate Health and Safety Training

Situation: Following inspections by HSE, NHS trusts in the North West identified the need to deliver a large volume of health and safety training to their staff.

Action taken: Twelve trusts met with Manchester College of Arts and Technology to discuss a project to respond to HSE's concerns. The Health and Safety Advisors at Central Manchester Healthcare, Bury Healthcare and North Manchester Healthcare worked in partnership with the College to produce a paper-based distance learning package. The materials explore key aspects of health and safety in healthcare settings and the programmes are validated by Edexcel. The programme is designed for all levels of employees within NHS trusts and it involves using workbooks and attending practical sessions to evaluate real life situations. Support tutors are easily accessible via email or telephone.

Employees with no experience of health and safety training generally take four to six months to complete the course and produce a portfolio of evidence. Managers are required to complete the main programme, which is pitched at National Qualifications (NQF) level 2, along with their staff in order to develop a framework and a greater awareness of their staff's responsibilities for health and safety in the workplace before progressing to the Management Programme at NQF level 4.

Outcome: The materials have been available for one year and the majority of the pilot cohorts have attained the required standard. The Management level is in the final stages of being approved by Edexcel and will be piloted in the near future. The partners are in discussion with the Postgraduate Deans to complete the development of "Safety in Healthcare - A guide for doctors".

Source: National Audit Office

3.30 In December 2001, the Department issued *The Effective Management of Occupational Health and Safety Services in the NHS*,[19] setting out for the first time the range of occupational health and safety services which should be available to all staff working in the NHS. It also describes responsibility for provision and sets a number of standards for their delivery. This guidance, together with targeted campaigns and initiatives from organisations such as HSE[55] and the Health Education Authority,[56] has helped raise the overall profile of occupational health.

3.31 At the same time the Department launched NHS Plus, enabling NHS trusts to provide occupational health services to other NHS organisations and private sector employers and to use the resultant income to provide improved occupational health services for NHS staff. Details of this scheme can be found on the NHS Plus website (www.nhsplus.nhs.uk). The Department expected this to encourage trusts to invest in their occupational health services.[57] However, since the launch of NHS Plus, the number of trusts signing up has levelled off. In addition a number of trusts noted that the resources generated were not being invested in improving the provision of services.

There are wide variations in occupational health provision between NHS trusts

3.32 All NHS trusts confirmed that they provide a range of occupational health services for their staff, but that this is usually only available during normal office hours. Only 50 per cent of trusts had arrangements for staff who require services out of hours. Eighty two per cent of acute trusts provide occupational health services with dedicated in-house staff, but only 30 per cent of mental health trusts and 17 per cent of ambulance trusts have in-house provision. The remainder contract the service from another trust (35 per cent), another non-NHS provider (three per cent) or use a combination of in-house and contracted in services (five per cent).

3.33 Over three-quarters of NHS occupational health leads identified constraints to providing occupational health services:

  ■ just under half, with in-house provision, identified significant problems in recruiting suitably qualified staff;

  ■ seventy two per cent of ambulance trusts, 46 per cent of mental health trusts and 41 per cent of acute trusts using contracted out services, highlighted their concerns that a lack of resources for investing in occupational health services was a key constraint; and

  ■ around a third of occupational health leads identified that problems with their accommodation or the geographical location of the service provision was a constraint.

3.34 We found that occupational health staffing resources varied widely, from a part-time occupational health nurse to a dedicated in-house team of doctors, nurses, managers and support staff.

3.35 Only 13 per cent of NHS trusts have undertaken any form of cost-benefit analysis of their investment in occupational health services, partly because the records maintained by trusts are not sufficiently comprehensive or accurate. Without this, it can be difficult to convince senior management of the value of providing more resources and/or introducing more occupational health measures. However, we found some correlation between higher levels of spending on occupational health and lower levels of sickness absence (Figure 15).

15 Occupational health spending compared with sickness absence
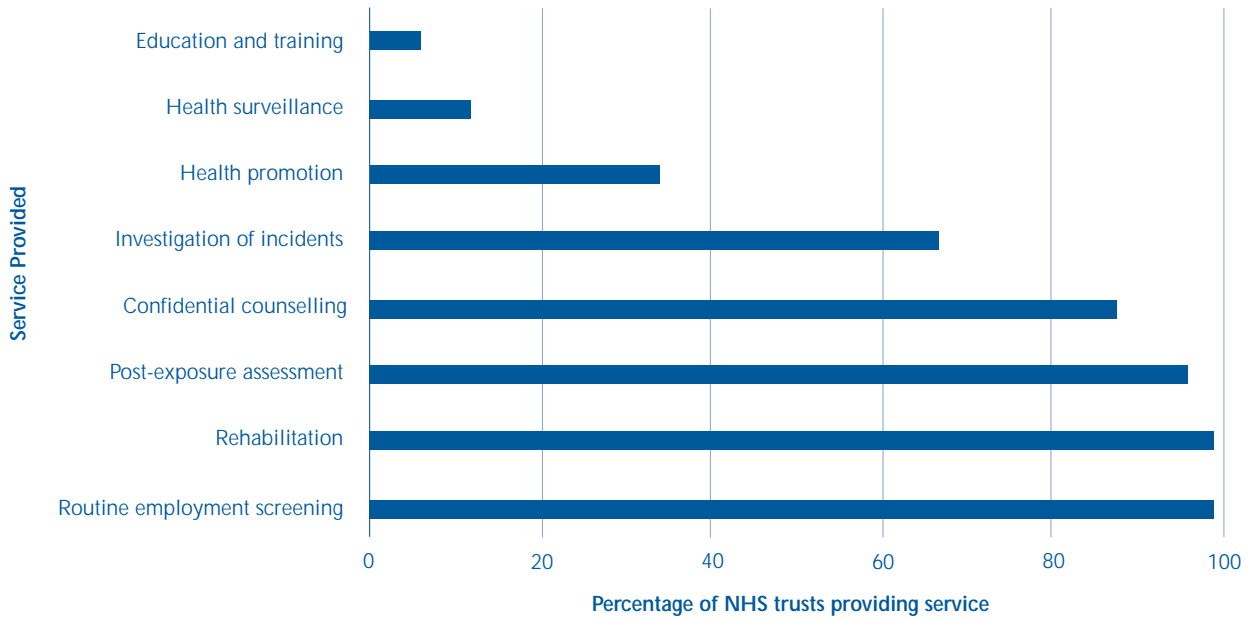

Key □ = an NHS trust
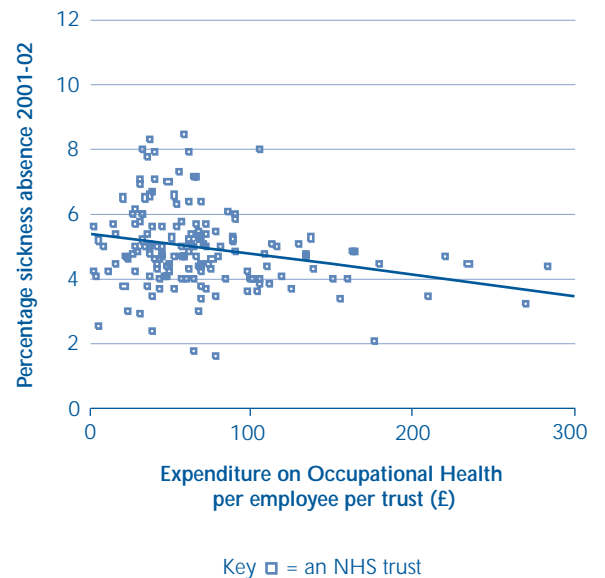
NOTE

This shows that the level of sickness absence falls as expenditure on occupational health increases.

Source: National Audit Office survey of trusts

16 **Range and frequency of services provided by NHS trust occupational health departments**

Source: National Audit Office survey of trusts

Management of occupational health services needs to be more proactive

3.36 Fifty per cent of occupational health leads told us that they had a documented annual plan or programme for improving the health and safety of staff, but only 27 per cent had a documented long-term strategy. In mental health NHS trusts the re-organisation of services affected the infrastructure that had been in place and as a result only 21 per cent had a strategy and 30 per cent a plan. Overall, the types of services provided are largely reactive **(Figure 16)** and there is considerable scope for more trusts to be more proactive in surveillance, health promotion and education.

3.37 **Case example 9** shows how one NHS trust has expanded its services through becoming an NHS Plus provider and has clearly demonstrated reductions in staff sickness absence.

3.38 Part of the reason for NHS trusts being more reactive than proactive is the legal, but time consuming, requirement to provide occupational health checks, especially when these checks have to be repeated if staff move to another trust. The Department plans to introduce an Occupational Health Smart Card Scheme[iii] by March 2004 which will help standardise health checks and improve the quality and speed of pre-employment checks. Initially, this will only apply to junior doctors, followed by locum doctors, but there is the possibility of extending the scheme to other NHS staff.[58] In time, this should release resources for more proactive occupational health activities.

Providing staff with early access to rehabilitation services can mean a speedier return to work

3.39 Staff absence has a direct impact on the ability of NHS trusts to treat patients, and can increase costs through the use of bank or agency staff. There is therefore a strong incentive for trusts to ensure effective and speedy rehabilitation of staff. Furthermore, research shows that employees should not take long periods of time off work to recover from low back pain as the longer the worker is off, the lower the chances of them ever returning to work.[23] A recent survey of the scope for rehabilitation of workers identified early intervention to prevent acute conditions becoming chronic, for example using occupational therapy, physiotherapy or counselling, as the most important element likely to secure a successful rehabilitation.[59]

3.40 Sixty eight per cent of NHS trusts said that they had developed a fast track treatment programme to try and get staff back to work more quickly **(Case example 10)**. However there is some contention about whether such procedures should be applied to allow staff to be fast tracked for treatment.[60]

iii   *Occupational Health Smart Card Scheme: information on pre-employment checks, occupational health and immunisation status are securely stored within the smart card with access provided to authorised personnel only.*

Case example 9: Sandwell and West Birmingham Hospitals NHS Trust

Situation: In the early 1990s managers at the Sandwell Acute Hospital Trust were concerned about the growing levels of staff absence and their lack of understanding of the reasons for this increase.

Action taken: With support from senior management and an initial investment of £50,000 the Trust supported the Sandwell Occupational Health and Safety Service to further develop the services it provided for the Trust by taking a proactive approach to income generation activities. The initial funding was identified within an occupational health business plan that ensured the services to the NHS were not compromised whilst external services were being developed. Since its inception, the Service has grown in size and now provides a much greater level of support for NHS employees. Employing 33 staff, the Service has helped the Trust to win Royal Society for the Prevention of Accidents gold awards for health and safety, and also a national BUPA foundation award for the provision of occupational health to small businesses. In 2002 the Service also received NHS Plus provider status.

Over the years the Service has collected data on a range of issues including:

■ the reasons for sickness absence;

■ the pattern of referrals to occupational health; and

■ work-related conditions such as stress and back pain.

Using the data collected, the Service has been able to demonstrate the levels and nature of staff sickness to senior management and has obtained agreement to introduce specific programmes to improve the support for staff, particularly in respect of:

■ access to psychological services;

■ treatment of back pain; and

■ faster rehabilitation and support when staff are off work.

Outcome: The Trust has demonstrated that early support for employees suffering from health problems, together with proactive sickness absence management and good rehabilitation policies and procedures, enabled employees to come back to work much more quickly. A recent audit has highlighted the different absence levels between the two recently merged hospital sites. On the site where there are well developed support services and effective rehabilitation programmes, long-term absence levels are nearly half the level as those on the site which does not yet have such access. Efforts are now being made to harmonise the services over both sites with the result that overall absence levels should fall.

Source: National Audit Office

Case example 10: West Suffolk Hospitals NHS Trust - the use of fast track referrals to private physiotherapy services has proved to be cost-effective, reducing staff absences and improving staff morale

Situation: In 2000-01 the direct cost of sickness absence for musculo-skeletal injuries in the West Suffolk Hospitals NHS Trust was £515,819. Indirect costs such as cover, replacement staff, training, recruitment or management time were not evaluated, but the Trust estimated that the true cost of absence was three times the direct cost (i.e. around £1.5 million). The time lost for the same year (2000-01) for musculo-skeletal injuries was 10,049 working days. The hospital wanted to reduce musculo-skeletal injury absence and improve the health of its staff in accordance with government guidelines.

Action taken: The Occupational Health Service negotiated with a local organisation, Bury Physio, to introduce a scheme to fast track referrals following injury to the Trust staff.

The service commenced in September 2001, and by the end of May 2002 (three-quarters of the agreed timespan) a total of 104 members of staff had been referred to Bury Physio for treatment. The introduction of the Partnership coincided with the appointment of a Manual Handling Advisor who had a wealth of experience in training and problem solving.

Results: Of the 104 referred, only one member of staff remained off work and two were referred back to their GP for further advice. The number of days lost during the period of September 2001 to May 2002 was 4,379 which compares most favourably with the comparable period of the previous year with a reduction of more than 40 per cent. The direct costs of musculo-skeletal injuries have been reduced by more than £170,000 at a cost of only £21,000. Patient satisfaction questionnaires returned to the Occupational Health Department, indicate that staff referred to Bury Physio have been greatly satisfied with the service. Furthermore, staff morale has been boosted as staff feel more valued with the introduction of this service.

Source: National Audit Office

F Reducing stress, the provision of counselling and other strategies aimed at improving staff's wellbeing

3.41 The Department, in response to the need to improve staff wellbeing, and in particular concerns about perceived increases in the levels of stress in the NHS (see also paragraphs 2.15 -2.17), issued guidance on the provision of counselling services in the NHS in 2000. Under the Human Resources Framework all NHS staff were to have access to counselling services by April 2000. As a guide an NHS trust could expect to employ one full-time counsellor per 2,000 staff on a single site.[61]

3.42 We found all NHS trusts provided some access to counselling services, with 14 per cent specifically highlighting the fact that they provide a fast track system to ensure staff receive assistance at the earliest possible moment. Trusts are also beginning to introduce psychiatric back-up as part of the service, or through external referrals. Counsellors and occupational health practitioners also run specialist training, such as stress management workshops, counselling skills for managers and developing effective workplace relationships, to break down the perceived stigma attached to admitting that stress is a problem.

3.43 Despite this, and HSE's recently published guidance on preventing and managing work-related stress,[62] few NHS trusts have stress as a health and safety priority and many local initiatives rely on managers' open door policy, regular social events or clinical supervision to mitigate stress factors. Most trusts tackle stress through one or a combination of stress audits, lifestyle campaigns, stress management programmes and employee assistance programmes. Post-incident debriefing is also provided to many accident and emergency staff in acute and ambulance trusts. This recognises that staff need support after traumatic incidents and allows staff individually or in a group to discuss the accident, death or violent incident and talk through their reactions to it in order to come to terms with the incident. A number of trusts noted that the effectiveness depends on who it is for, the timing, the circumstances involved and which therapist conducts it.

3.44 There is also growing support for the use of risk assessment as a means of targeting interventions to control stress at work. UNISON guidance for health and safety representatives on the prevention of stress draws attention to the need for risk assessments as a key way of preventing illness through stress.[63] Good practice guidance, based on research commissioned by HSE, UNISON and the Royal College of Nursing from the Institute of Work, Health and Organisations at the University of Nottingham was published in May 2002. This is based on a longitudinal study in three NHS trusts working with five different staff groups **(Case example 11)**.[64]

G Since our original report the management of health and safety of contractors has emerged as a significant risk

3.45 Since our 1996 report the NHS has increased its use of contract staff. While all parties to a service contract have specific responsibilities under health and safety law, NHS trusts are responsible for protecting contractors and sub-contractors from harm caused by work activities. Likewise, contractors must make sure their employees are trained and clearly instructed in their duties. The party designated as in control of the work is responsible for reporting any incidents.

3.46 Increasing sub-contracting can lead to confusion about the responsibility for delivering information and training on health and safety, for providing equipment and protective clothing or undertaking risk assessments.[65] As a result, temporary staff could be placed in greater danger due to their lack of appropriate knowledge or familiarity with NHS trust policies.

3.47 Indeed, since 1999 there have been a number of HSE prosecutions and Improvement Notices against NHS trusts for failing to protect the health and safety of contractors. Four trusts have been prosecuted for incidents involving contractors on site and fines and costs incurred ranged from £5,674 to £21,737. One trust received an immediate prohibition notice on work in areas that contained asbestos because there were no written risk assessments or safe system of work; and another had to develop a written policy for dealing with the safety of contractors on the hospital site.

3.48 The three most commonly contracted out services within NHS acute, mental health and ambulance trusts were cleaning (140 trusts), security (131 trusts) and catering (90 trusts). In total over 28,708 contract staff were employed by these trusts in 2001-02. Twenty one per cent of the trusts' facilities/estates departments were unable to provide details of the number of contractors working on their premises.

3.49 Installation and maintenance of plant, construction and waste disposal can be particularly risky because they have to be done on sites and in situations which may be unfamiliar to contractors. Accidents often happen because contractors do not know about the inherent dangers on the site, and NHS trust staff do not know that contractors are working nearby.

Case example 11: Review of the impact of interventions based on a risk assessment approach for managing stress at source in an Accident and Emergency Department

Situation: Both clinical and administration staff reported problems with their workload due to time pressures, the slow movement of patients to wards and lack of forward planning for off-duty times. Having to cover for absent colleagues, lack of help at busy periods and lack of training were also issues. There were also a cluster of problems around communication and consultation within the department and the rest of the NHS Trust and concerns about a lack of support for staff involved in distressing situations. Administration staff additionally reported problems with the physical working environment.

Action taken: With the involvement of staff, interventions based on a risk management approach were developed to deal with stress at source. A general wellbeing questionnaire was used before and after interventions to measure worn-out and tense feelings.

Outcome: Interventions, such as the appointment of an administrative co-ordinator and the movement of the psychiatric liaison nurses and an ECG technician into the ward, which allowed nursing staff to free up their time to deliver patient care, were rated as having a significant impact by more than half of the respondents. Similarly raising the number of staff to the complement level and improved organisation of the off-duty rota had positive benefits to between 50 and 60 per cent of the staff.

The overall change in wellbeing was relatively modest but this may be explained by the inability to deal with the slow movement of patients out of the department and the lack of progress in providing support for staff involved in distressing situations. The pattern of results was complex and reflected the fact that the interventions had been implemented in a turbulent and difficult working environment created by the high workload and some persistent problems with work design.

Indicators of wellbeing	Clinical Staff Before intervention	Clinical Staff After intervention	Administration Staff Before intervention	Administration Staff After intervention
Worn-out	22.3	20.5	20.2	12.9
Tense	10.5	10.6	13.0	6.0
Absence - self-reported days	11	7	4	3

Extract from Interventions to control stress at work in hospital staff - by Professor Tom Cox CBE, Dr Raymond Randall and Professor Amanda Griffiths - The Institute of Work, Health and Organisations University of Nottingham.

3.50 HSE recommends that at all stages of the engagement process close attention should be paid to the health and safety performance of contractors, to ensure that their work is properly assessed and managed. While 32 per cent of NHS trust health and safety leads were proactive in ensuring the health and safety of contractors, only five per cent undertook assessments of competence at the pre-contract stage by confirming the existence of health and safety policies and completion of risk assessments.

3.51 Thirty seven per cent of health and safety leads stated that their NHS trust's system for the control of contractors had inadequacies in some or all respects and 11 trusts had this as a priority for the Health and Safety Committee during 2001-02. **Case example 12** details some of the good practice management approaches being adopted to improve the health and safety of contractors.

Case example 12: Examples of good practice in relation to the employment of contractors

Barking, Havering and Redbridge Hospitals NHS Trust has contractor representation on the Safety and Manual Handling Committees.

Isle of Wight Healthcare NHS Trust assesses the hazards the contractors are likely to come into contact with and then provides appropriate internal training to reduce the risks.

Lancashire Teaching Hospitals NHS Trust treats contractors who are within the Trust as a matter of daily routine in exactly the same way as other employees. They receive induction and mandatory annual safety training.

Plymouth Hospitals NHS Trust requires contractors to attend induction and report to the Estates Department on a daily basis.

Source: National Audit Office survey of trusts

Appendix 1 Overview of study methodology

The key features of our methodology

■ An initial survey was conducted between June and September 2002, of all 270 NHS acute, mental health and ambulance trusts in England, to establish information about a range of health and safety issues. The survey sought information on trends in the levels of incidents, the assessment and management of risks, guidance and training given to staff and the support provided to staff who had suffered an injury. The survey was carried out on our behalf by our consultants, Taylor Nelson Sofres Social Research and had a 98 per cent response rate (265 trusts).

■ A follow-up survey of 282 health and safety risk managers to collect 2001-02 incident data (98 per cent response rate).

■ An interrogation of relevant databases, interviews and file examinations at the Department of Health, the Health and Safety Executive, the Commission for Health Improvement and selected NHS trusts.

■ Visits to a number of relevant parties, including public and private sector bodies with experience of managing health and safety risks.

■ Information provided by the NHS Litigation Authority and the NHS Pensions Agency.

■ An extensive literature review and attendance at a number of conferences dealing with health and safety issues.

■ An expert panel, which we consulted throughout the study. A full list of its members is attached at Table A.

Methodology for estimating the cost of accidents at work in NHS trusts

(i) Work-related sickness absence

Only one NHS trust was able to differentiate work-related sickness absence from other sickness absence. It estimated that 7.6 per cent of sickness absence was work-related at a cost of £0.244 million, or £85 per staff member. The Department of Health's employment figures for 2001 indicate that 1,036,370 hospital and community staff are employed. On this basis, a rough estimate of work-related sickness absence costs would be £88 million (this is an extremely crude estimate, but due to the lack of information at trust level it is the best available). Data from other published sources suggest that this estimated level of work-related sickness absence is an under-estimate and that it is more likely to be between 10 and 15 per cent.

(ii) NHS trust liabilities

The data NHS trusts provided on their liabilities and payments for industrial injury claims, Temporary Injury Allowances and payments out of court were extremely patchy:

■ 142 trusts (53 per cent) provided details of payments for industrial injury claims, including 30 with no claims. The total paid out in 2001-02 was £6.3 million - if this pattern was repeated for those trusts who were unable to provide information the total costs would be £12.1 million.

■ 146 trusts provided details of payments for Temporary Injury Allowance, including 11 who made no payments. The total paid was £2.2 million or £3.3 million grossed up.

■ 124 trusts provided details of payments out of court, including 42 with none. The total paid was £4.9 million or £7.1 million grossed up.

Despite variations in the detail provided, we estimate that the total amount paid out by trusts in 2001-02 was £22.5 million and claims lodged during 2001-02, with an estimated value of £19.7 million, were still outstanding. Again this is likely to be an under-estimate.

(iii) Permanent Injury Benefits

All NHS employees are covered by the NHS Injury Benefit Scheme and since April 1997 all costs arising from Permanent Injury Benefit awards are charged back to the employer. On our behalf, the NHS Pensions Agency undertook a review of all 261 claims considered between October 2002 and December 2002. Sixty six per cent were due to musculo-skeletal problems. In 2001-02 the Pensions Agency received 575 applications for permanent injury benefit, a minimum of 183 of which were from nurses. Just under a third (206 applications) were accepted, and 47 per cent were rejected with 94 still on-going. The total expenditure of the Scheme in 2001-02 was £43.6 million.

(iv) Ill health retirements

Under the ill health retirement scheme 29 per cent of accepted applications were work-related and 37 per cent were due to illnesses and injuries that may have been work-related. On this basis annual pension payments totalled some £13 million in 2001-02.

(v) Contribution costs and compensation payments

Under the Liabilities to Third Parties Scheme, the NHS Litigation Authority is responsible for liability claims in excess of £10,000, in respect of staff accidents on NHS trust premises. In 2001-02, contributions paid by trusts totalled £4.162 million and the costs of all claims settled by the Litigation Authority were £1.455 million. As at March 2002, 3,956 claims were outstanding, with an estimated value of £14.084 million.

The full details of our methodology, including the survey questionnaires, are detailed on our website www.nao.gov.uk. The results from our surveys have been shared with the Department of Health. NHS trusts that took part in our survey will be provided with individual feedback reports.

Table A: Membership of Expert Panel

The NAO is grateful to the members of their expert panel who provided advice and guidance throughout the Value for Money investigation.

Dr Robert Ll Davies	Head of Health, Safety and Environment Unit, University of Wales College of Medicine Chair of the Health Care group at the Institution of Occupational Safety and Health
Stuart Emslie	Head of Controls Assurance, Department of Health
Helen Hughes	Director of Operations, National Patient Safety Agency
Ann Macintyre	Director of Human Resources, Barts and the London NHS Trust
Peter McKenna	Senior Nurse Manager in the Accident and Emergency Department, Medway NHS Trust
Lynn Parker	Clinical Nurse Infection Control Specialist, Northern General Hospital NHS Trust Representing the Infection Control Nurses Association
Dr Linda Patterson	Medical Director, Commission for Health Improvement
Jon Richards	Assistant National Officer, Health Care Group, UNISON
Chris Taylor	Principal Inspector, Health Services Unit, Health and Safety Executive
Judy Thurgood	Head Occupational Therapist, Heatherwood and Wexham Park NHS Hospitals Trust Representing the College of Occupational Therapists
Professor Brian Toft	Research Director, Marsh Risk Consulting
Julian Topping	Senior Business Manager, NHS Employment Policy Branch, Department of Health

Appendix 2

Key Department of Health initiatives launched since 1996 aimed at improving the management and monitoring of health and safety risks to staff

1995 reprinted 1996	*Working for Health - A Practical Guide to Developing a Healthy Workplace in the NHS* provided guidance on occupational health and health workplace initiatives.
June 1997	HSG(97)6 *NHS Health and Safety Issues* required NHS trusts to implement the National Audit Office recommendations and to put in place policies and procedures to investigate, record, monitor, review and assess causes and costs of incidents, sickness absence, ill health retirement and occupational health.
November 1997	*Risk Assessment at Work -practical examples in the NHS,* a guide for managers.
March 1998	*Improving the Health of the NHS Workforce*, a report of the 'Partnership on the Health of the NHS Workforce', aimed at developing an evidence-based programme of action to improve the health of staff through better use of existing resources.
April 1998	HSC 1998/064: *The Management of Health, Safety and Welfare Issues of NHS Staff,* updated guidance on the provision of occupational health services and health and safety policies.
September 1998	HSC 1998/162: *Working Together, Securing a Quality Workforce for the NHS,* was launched by Alan Milburn, then Minister of State for Health. It heralded a new approach to the management of human resources in the NHS and gave a commitment to measuring progress against a range of process and outcome targets.
March 1999	*Reviewing attendance in the NHS: Causes of absence and discussion of management strategies* was intended as a guide for managers to better manage the attendance of staff and provide a factual review of sickness.
March 1999	*Survey of Community and Ambulance Trusts,* a 'Health at Work in the NHS' research study, identified health and safety risks and best practice.
April 1999	HSC 1999/079: *Working Together, Securing a Quality Workforce for the NHS* included national improvement targets for the NHS to reduce incidents of violence, accident levels and sickness absence by 20 per cent by 2001 and 30 per cent by 2003.
September 1999	*Improving Working Lives campaign* required NHS trusts to invest in staff training and development; apply zero tolerance on violence; meet *Working Together* targets for reductions in workplace accidents and sickness absence; and provide better occupational health and counselling services.
October 1999	HSC 1999/226: *Campaign to stop violence against staff working in the NHS: NHS zero tolerance zone* developed by the Department supported by the Home Office, the Lord Chancellor's Department and the Crown Prosecution Service, introduced the NHS zero tolerance campaign.
October 1999	HSC1999/229: *Working Together, Securing a Quality Workforce for the NHS: Managing Violence, Accidents and Sickness Absence in the NHS* detailed the performance management process for NHS trusts, including the need for consistent methods of recording incidents and sickness absence for reporting progress against the defined targets.

March 2000	*Our healthier nation* - Work related stress initiatives (set 1-3) provided a number of good practice examples.
July 2000	*The NHS Plan: A plan for investment A plan for reform* proposed a number of staffing initiatives to improve recruitment and retention of staff, and identified a further £140 million expenditure by 2003-04 to provide support for all professional staff to keep their skills up to date.
August 2000	*The Provision of Counselling Services for Staff in the NHS* put forward a set of standards that managers in the NHS could use to measure the quality of their services.
October 2000	HSC 2000/030: *Human Resources Performance Framework* was intended to support the Service in measuring and maintaining progress on *Working Together,* including demonstrating that the NHS is improving the quality of life for staff - a key element of which is delivering the *Improving Working Lives Standard.*
October 2000	*The Improving Working Lives Standard* set a model of good employment practices, including provision of occupational health services, and targets against which the NHS was to be measured.
February 2001	*Taking alcohol and other drugs out of the NHS workplace* included guidance on the rehabilitation of staff.
February 2001	*Controls Assurance Statements* saw the publication of a Health and Safety Controls Assurance Standard to help NHS trusts meet the requirements of good health and safety risk management.
March 2001	*Our healthier nation - a guide to local networks health at work in the NHS* provided information about benchmarking networks.
November 2001	*Effective Management of Occupational Health and Safety Services in the NHS* laid down responsibilities, functions and standards aimed at addressing variations in the extent and quality of, and NHS staff's access to, NHS occupational health services.
November 2001	*Managing Ill Health Retirement in the NHS* was a guide for human resources and occupational health services.
November 2001	*Managing Sickness Absence in the NHS* provided guidance on measuring and monitoring sickness absence including examples of best practice.
March 2002	*Health at Work in the NHS: a case study for ambulance trusts* included health and safety and occupational health good practice examples.
July 2002	*Back in Work* campaign pack, launched the campaign to reduce musculo-skeletal disorders.
October 2002	*Mental Health and Employment in the NHS* was a practical guide to managing the issues raised by staff stress in the NHS.

Appendix 3

The role of the Health and Safety Commission and Health and Safety Executive and their report on activities in NHS trusts since 1996

Background

1   In response to *Revitalising Health and Safety*,[27] the Health and Safety Commission (HSC) published a revised Strategic Plan in 2000. This listed health services as a priority and identified a five year programme concentrating on musculo-skeletal disorders, violence, stress and slips/trips, which are the major causes of injury and ill health in the sector. As, in September 1998, health ministers had already set targets for the NHS under the *Working Together, Securing a Quality Workforce for the NHS*,[4] HSC decided not to impose the national '*Revitalising*' targets on the NHS. HSC judged that when a duty holder had set more stretching targets, it was inappropriate to disturb such better arrangements. HSE's programme also planned to use the existing initiatives such as Controls Assurance and Improving Working Lives (IWL) in the NHS to "embed targets, monitor performance and secure improvements", to improve risk management and support the reduction of accidents, violent incidents and sickness absence.

2   Under a rolling programme of inspections performed by HSE, NHS trusts are assessed against the guidance, *Successful Health and Safety Management*,[66] which is in turn underpinned by the *Management of Health and Safety at Work Regulations 1992*.[25] At least 40 trusts per year receive these inspections or investigations and follow-up visits. In extreme cases, Inspectors can, and do, prosecute for significant breaches of the law, including situations where no injury or ill health condition has occurred.

Performance measurement

3   HSE measures the health and safety performance of the NHS in a number of ways, no one of which is entirely satisfactory. Trusts are required, under legislation, to report all accidents to staff which result in more than three days' absence from work (RIDDOR)[12] and this provides a reasonably consistent measure of certain accident types. RIDDOR, however, provides little data on occupational ill health and nothing on work-related sickness absence. HSE also estimate the degree of under-reporting from separate sources such the Labour Force Survey (LFS) as this provides data on a wider range of accidents and work-related ill health, as well as work-related sickness absence, although in the past it has not distinguished healthcare from social care. It does however, show that this sector had a relatively high rate of under-reporting, i.e. the accident rates from the LFS were much higher than those reported to HSE (estimated level of reporting of 42 per cent).

4   **Table 1** shows the annual totals and main types of reportable accidents under RIDDOR from NHS trusts in England from April 1996 to March 2002.

5   Overall accidents have decreased by between 1 and 18.3 percentage points per year since 1996-97, and the provisional figures for 2001-02 suggest that this is continuing. Recent LFS also confirm this trend.

Table 1: Annual totals and main types of reportable accidents under RIDDOR for NHS trusts in England

Type of Accident	1996-97	1997-98	1998-99	1999-2000	2000-01	2001-02[(i)]
Moving and Handling	3751	3725	3567	3388	3213	2705
Slips/Trips	1347	1223	1264	1327	1278	1229
Struck by an object	893	805	822	726	708	370
Falls (all kinds)	60	69	56	49	53	92
Other	1449	1409	1403	1351	1480	1596
Totals	**7500**	**7231**	**7112**	**6841**	**6732**	**5992**

NOTE

(i)   2001-02 figures are provisional.

6   Figures for moving and handling injuries have fallen steadily since 1998. This is encouraging, not only because they are the most common accidents in healthcare, but also because musculo-skeletal injuries generally are the biggest cause of work-related ill health. The improvement may be attributed to HSE's concentration on the issue during inspections, the role of bodies such as the Royal College of Nursing and the National Back Exchange, and the work of enlightened NHS trust managers. These have led to the introduction by many, but not all trusts of:

■   appropriate patient handling policies;

■   mechanical handling equipment; and

■   staff training and rehabilitation programmes.

Some trusts have managed to reduce their moving and handling injuries and the resulting sickness absence by 30 per cent or more in five years.

7   On the other hand, slips and trips accidents have remained more or less static, and these accidents cause the largest number of major injuries.

8   From evidence and the improved levels of reporting to HSE, it is clear that most NHS trusts now have reasonable systems for collecting information on reportable accidents and ill health conditions. While some trusts use proprietary electronic databases for this purpose, many do not, and the systems used are not consistent between trusts. HSE has identified only a handful of trusts that collect comprehensive data on staff occupational ill health, and can link accident or ill health data to sickness absence records, thereby measuring the resultant costs to the organisation.

9   It has proved difficult for HSE to identify and work with one part of the Department (or an agency) which is responsible for the monitoring and managing the health and safety performance of NHS trusts. Changes to the structure and management of the NHS have also made the use of NHS initiatives by HSE difficult. The demise of the Department's Regional Offices in 2000-01 removed the local mechanism for monitoring performance under Controls Assurance Standards and the new Workforce Development Confederations which are responsible for many human resource functions, including IWL, have no performance management role. The responsibilities of the new Strategic Health Authorities in performance management have yet to be confirmed (November 2002).

Enforcement Activity

10   The level of HSE enforcement action is not necessarily a reliable indicator of overall standards of health and safety performance or compliance. The number of prosecutions of NHS trusts is too small to be statistically reliable and the majority of these relate to patient rather than employee safety. However, the increased number of cases affecting staff in the last two years indicates that some trusts continue to commit serious breaches of health and safety law. Prosecutions relating to employee safety include cases for:

■   inadequate manual handling precautions (2);

■   inadequate management of health and safety generally (1) ;

■   accidents involving falls (3);

■   exposure to hazardous substances (2);

■   unsafe plant and equipment (4);

■   site transport accidents (1); and

■   inadequate precautions against violence to staff (1)

In one of these cases the trust was fined £12,000 plus £14,600 costs, and in another £15,000 plus £2,000 costs.

11   Improvement Notices are much more common than prosecutions. **Table 2 overleaf** shows the number served in the NHS since 1998 and the number served on the more common inspection topics. There are no obvious trends and variations partly reflect the fact that subject matter for HSE inspections alter from year to year. For example in 2000-01 a number of NHS trusts were deliberately re-visited to check if progress was being maintained since their first HSE inspection whereas, in 2001-02, trusts with poor performance in managing risks from manual handling and violence were targeted.

Table 2: Improvement Notices served by the HSE over the last 4 years

Year	Total Notices in the NHS	Notices in NHS served during the inspection programme	Notices served during the inspection programme on:		
			Moving and Handling	Hazardous substances	Managing health and safety(i)
1998-99	133	93	8	7	12
1999-2000	162	84	11	12	25
2000-01	208	65	4	11	12
2001-02(ii)	212	81	14	4	10

NOTES

(i)   Includes such issues as risk assessment, health and safety policy and arrangements, competent advice, and non-specific staff training.

(ii)   2001-2002 figures are provisional.

(iii)   No Improvement Notices have been served on NHS trusts in respect of slips, trips and falls involving staff.

12   The involvement of stakeholders in health and safety management is difficult to measure, and HSE has not attempted this systematically within the NHS. In isolated cases HSE has served NHS trusts with Improvement Notices on the issue of consultation and communication with staff or contractors, but largely, trusts have reasonable arrangements that can effectively engage staff. However, the increasing contracting out of trust activities, and particularly the development of Private Finance Initiatives, has highlighted failures of trusts to engage with and involve other partners. Typical failures include:

■   inadequate monitoring of contractors;

■   failures to communicate health and safety information; and

■   inadequate health and safety input at the design or specification phase of projects.

HSE is addressing these issues with NHS Estates.

Other findings from HSE inspections

13   HSE inspection reports are monitored each year, and since 1999 the general conclusions have been conveyed to the chief executives of NHS trusts in a letter from Health Services Advisory Committee. More examples of good and even exemplary practice are being found with each year, and the key factors in trusts which were successfully managing health and safety were seen to be:

■   commitment from senior management;

■   involvement of staff, and

■   a sound business case based on knowledge of the costs to the organisation of accidents and ill health.

But the same problems, such as poor control of glutaraldehyde, do recur despite widely available HSE or Departmental guidance, and the gap between the best and the worst trusts has been widening. In 1999-2000 four trusts received 27 Improvement Notices between them, out of the 84 for the whole NHS. In 2001-02 another four trusts each received five or more Improvement Notices. Inspectors were still finding trusts with no policies for moving and handling.

14   The main conclusion is that, despite the steady reduction in overall accident figures and the general improvement in compliance with health and safety legislation, the NHS is failing to ensure consistent minimum standards and to disseminate good practice (for example on patient handling). It is therefore not making the degree of progress nationally that has been demonstrated in many individual NHS trusts.

Appendix 4

The role and responsibilities of the National Patient Safety Agency in recording and reducing accidents to patients

1   Research from other healthcare systems and industries indicates that effective reporting systems improve quality and reduce risk to clients. The National Patient Safety Agency (NPSA) was established as part of the Department's commitment to improve the quality of patient care under the NHS Plan. The NPSA manages a confidential national reporting service and works to develop a culture within which staff can report adverse events. It also is developing training support for the envisaged changes.

2   To address the first target in *Building a Safer NHS,*[8] a pilot to identify whether it was possible to capture patient incident information from existing risk management reporting systems was begun across 28 sites in England and Wales. The NPSA has found that the existing NHS trust incident reporting systems are generally based on paper collection forms, using a data input clerk to key the data into their risk management system. There are a significant number of trusts that have either designed their own system or do not have one at all. Six out of the seven major systems used by NHS trusts were covered by this exercise and, as 90 per cent of non-primary care trusts use these, the target of 60 per cent of trusts to be in a position to provide information to the national reporting system by December 2001 was achieved. At the same time, the NPSA issued Pilot Guidance for trusts on how to share information with patients and relatives following an adverse event.

3   The objective of the pilot exercise was to test a potential technological solution. In doing so, the NPSA collected 27,110 notification records. Additionally a separate pilot into obstetric incidents was run and using software from the Australian Patient Safety Foundation (APSF) 500 records were deconstructed and analysed to report on root causes.

4   The technology was thoroughly tested and it was found that while the software from the APSF was able to be used for the purpose intended, the technological solution proposed for connecting the NHS trusts' risk management systems and the NPSA would not function effectively in a national implementation. Only 18 of the original 28 were able to report incidents electronically.

5   It also became clear after the public meetings on 18 June 2002, that there was a need to 'cleanse' the data received during the pilot exercise and to ensure that it was collected completely and was robust. The NPSA has therefore re-collected the data from the 18 pilot sites and will be reporting to the Chief Medical Officer and the general public on this 'cleansed' data. The Head and Deputy Head of Profession for Statistics in the Department have guided the NPSA with regard to the validations and additional checks required to make the data collected more robust. These principles will be applied when designing the new national reporting and learning system.

6   A second pilot (testing and development stage) is being run to test the solution now being proposed for national implementation. This will involve approximately 40 pilot sites across England and Wales, with a higher number of primary care trusts and NHS mental health trusts covered than before. It was envisaged that this would commence early in 2003 allowing for an 18 month phased national roll out commencing after the testing phase in 2003. The NPSA is currently identifying all the suppliers in the risk management system market and the number of risk managers in post.

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