

A Safer Place to Work

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



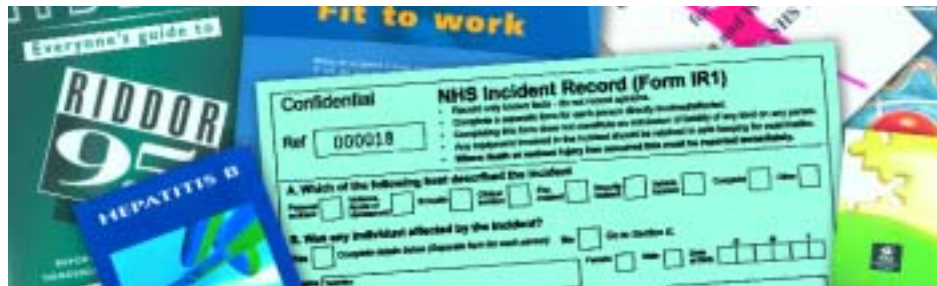
REPORT BY THE COMPTROLLER AND AUDITOR GENERAL
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executive summary

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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 centⁱ 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.

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.

- 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 Plan¹³ (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 Standard¹⁵ 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 systems⁹ 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 Serviceⁱⁱ 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 Inspection¹⁷ 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 System¹⁸ 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 System¹⁸ 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.

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 Standard¹⁵ 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 Standards¹⁹ 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.