



House of Commons

Committee of Public Accounts

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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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**Forty-second Report of  
Session 2002–03**





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Session 2002–03**

*Report, together with formal minutes,  
oral and written evidence*

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## The Committee of Public Accounts

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## Summary

The National Health Service (NHS) employs more than one million people. Maintaining the health, safety and wellbeing of this workforce is essential, is a statutory requirement, and makes good economic sense. Staff accidents and other health and safety issues impose substantial costs, through sickness absence payments, staff replacement, ill health retirement, compensation payments, fines and higher insurance contributions. A lack of attention to health and safety can affect staff recruitment and retention and can have wider detrimental effects on the quality of service and on trusts' ability to deliver the NHS Plan.

In 1997 our predecessor Committee highlighted their concerns about the burden of accidents on the NHS, and the lack of information on the extent and costs.<sup>1</sup> In response the Department of Health (the Department) took action to promote incident reporting, disseminate good practice and publicise specific health and safety issues. In 1999, the Government set national improvement targets for the NHS to reduce the level of staff sickness absence, accidents and incidents of violence and aggression by 20% by 2001 and 30% by 2003. However, the number of reported accidents has increased and the Department is unlikely to meet the 2003 target.

On the basis of a Report by the Comptroller and Auditor General we took evidence from the Department on the need to evaluate the extent and costs of accidents to staff, the case for a national occupational health and safety strategy, improved health and safety training, and the importance of managing the risks to contractors, agency and locum staff.

We draw the following main conclusions from our examination:

- There is a need for a national health and safety strategy to co-ordinate existing and new health and safety initiatives. As part of this strategy, the Department should clarify the roles, responsibilities and accountabilities of NHS organisations; they should set standards for training; and provide advice and guidance on occupational health services provision and the management of health and safety risks to contractors, agency and locum staff.
- Although there is evidence that NHS trusts have improved their accident reporting systems, there is a lack of consistency in identifying and recording accidents. The Department should develop strengthened national reporting criteria and encourage trusts to adopt reporting systems that provide better and more complete information about the type and nature of accidents, by drawing on the experiences of those trusts that have introduced good practice reporting systems. They should also work with trusts to improve compliance with the statutory requirement to report all incidents resulting in three or more days' absence to the Health and Safety Executive under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations.

1 2<sup>nd</sup> Report from the Committee of Public Accounts, *Health and Safety in NHS Acute Hospital Trusts in England* (HC 350, Session 1997–98)

- The Department should review the appropriateness of the national improvement targets and through strategic health authorities, should agree targets for reducing accidents with individual trust chief executives with a clear understanding of how these will contribute to a revised national improvement target. The emphasis should be on encouraging trusts to adopt a health and safety management strategy which identifies and addresses the most serious risks, with strategic health authorities being responsible for monitoring and benchmarking trusts' performance.

# 1 Measuring the extent and impact of accidents to NHS staff

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1. In 1997 our predecessor Committee's Report on *Health and Safety in NHS Acute Hospital Trusts in England* highlighted the need to improve the recording of health and safety incidents in the NHS, including staff accidents. They were concerned that staff accidents imposed a significant burden on resources which could be better spent on patient care. They found it unsatisfactory that many hospitals did not have robust accident recording systems, that there were very wide differences in accident rates, and difficulties in making comparisons because of under-reporting. They recommended that chief executives and boards should take a stronger lead in encouraging staff to report all accidents promptly.<sup>2</sup>

2. In response the Department launched a number of initiatives, including issuing guidance to NHS Trusts to put in place policies and procedures to record, monitor and assess the causes and costs of accidents, sickness absence, ill health retirements and occupational ill health for all health and safety risks. The Department emphasised that trust chairs and chief executives should make health and safety a priority area.<sup>3</sup>

3. One key initiative, launched in September 1998 by the then Secretary of State for Health, was *Working Together Securing a Quality Workforce for the NHS*. This 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. Subsequent guidance issued in April 1999 set national improvement targets for reducing sickness absence, accidents and violence and aggression by 20% by 2001 and 30% by 2003. The targets were subsequently incorporated in the *Improving Working Lives* standard, launched in October 2000, which all acute, mental health and ambulance trusts were required to put into practice by April 2003.<sup>4</sup>

4. On the basis of a follow-up Report by the Comptroller and Auditor General we took evidence from the Department to determine the extent to which the national improvement targets have been met and the impact that accidents have on acute, mental health and ambulance trusts; the adequacy of the strategic management of health and safety risks, including the management of risks to agency and contract staff; and the effectiveness of training and other actions aimed at reducing the extent and impact of accidents. Our earlier Report, *Protecting NHS Hospital and Ambulance Staff from Violence and Aggression (39<sup>th</sup> Report, Session 2002–03)*, considered the related issue of the accuracy of the measurement of

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2 2<sup>nd</sup> Report from the Committee of Public Accounts, *Health and Safety in NHS Acute Hospital Trusts in England* (HC 350, Session 1997–98)

3 C&AG's Report, *A Safer Place to Work: Improving the management of health and safety risks to staff in NHS Trusts* (HC 623, Session 2002–03) para 1.10

4 *ibid*, paras 1.11–1.12 and Appendix 2

violence and aggression, and the effectiveness of actions taken to improve the protection and support given to healthcare staff.<sup>5</sup>

## Failure to achieve the Working Together targets

5. In 2000–01 there were 108,743 reported accidents, a 10% decrease compared with the number reported in 1998–99 when the Working Together initiative was launched. However, the number of reported accidents in 2001–02 increased to 135,172 and as a result the national improvement target of a 20% reduction by March 2002 has not been met. Indeed there has been a 24% increase over the 2000–01 baseline figure (Figure 1).<sup>6</sup>

Figure 1: 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 (NHS 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 (iv)
Ambulance	38	21	28
Community/mental health	21	15	N/A(iv)
Mental health/learning disabilities	26	11	18
<b>All NHS Trusts</b>	19	13	18
<b>Total number of accidents</b>	<b>120,474 (i)</b>	<b>108,743 (i)</b>	<b>135,172 (ii)</b>
<b>Staff accidents reported to the Health and Safety Executive (iii)</b>	<b>7,112</b>	<b>6,732</b>	<b>5,992</b>

Source: National Audit Office Report<sup>7</sup>

Notes:

- (i) Information derived from Department of Health surveys conducted in 1998–99 and 2000–01. 2000–01 being the baseline for measuring the national improvement targets against.
- (ii) NAO and Department of Health census of all acute, mental health and ambulance trusts to assess the position at the first milestone.
- (iii) Information provided to the Health and Safety Executive on incidents that resulted in more than three days off work. While the figure for 2001–02 is a provisional figure, like the other figures provided it is likely to be an underestimate as in general only 42% of all incidents that should be reported to the Health and Safety Executive are reported.
- (iv) Multi service trusts and community/mental health trusts are no longer a designated type of trust as services have been re-configured into either a mental health trust or a primary care trust.

5 Q1; 39<sup>th</sup> Report from the Committee of Public Accounts, *A Safer Place to Work: Protecting NHS Hospital and Ambulance Staff from Violence and Aggression* (HC 527, Session 2002–03)

6 C&AG's Report, para 2.8

7 *ibid*, Figure 4 and Appendix 3, Table 1

6. Overall, only 23% of trusts met the 20% improvement target and, in each of the different types of trust, the number of accidents per 1,000 staff has increased compared to the 2000–01 baseline level, with ambulance trusts having the highest level of accidents per 1,000 staff. Understanding the reasons for the increase between the baseline and 2001–02 is complicated by a number of confounding factors. Some NHS trusts have seen a fall in the number of reported accidents, due to improved training and practices, while others have recorded an increase, due to increased awareness and compliance with reporting requirements. Over a fifth of trusts identified staff shortages and increased workloads as leading to poor compliance with good practice, resulting in an increase in accidents.<sup>8</sup>

7. The Department acknowledged that it is difficult to be precise about the reasons for the increase but believed that it was mostly due to improved reporting. They drew attention to the decline in the number of major accidents, which must by law be reported to the Health and Safety Executive.<sup>9</sup>

8. The Department had put in a large amount of effort into reducing major accidents, in particular the reduction of serious accidents due to moving and handling. (Figures provided by the Health and Safety Executive confirm that moving and handling injuries have fallen steadily since 1998). There were a number of reasons for this decrease, including targeted work by the Department, such as their *Back to Work* campaign; the fact that the Health and Safety Executive had concentrated on this issue during inspection visits; and that initiatives by the Royal College of Nursing and the National Back Exchange, had helped raise the profile of this issue.<sup>10</sup>

9. Nevertheless the March 2002 target has not been met and the Department agreed that they were unlikely to meet the March 2004 target. The Department conceded that these were stretching targets. They were also aware that there would be methodological problems because of the inadequacies of NHS trusts' reporting systems.<sup>11</sup>

### Variations remain in the quality and comprehensiveness of information

10. Despite evidence that trusts have taken this topic quite seriously, with improvements in the levels of reporting and 94% of trusts investing in computerised data recording systems, the performance of trusts still varies considerably in terms of the comprehensiveness of reporting of accidents and the consistency in what is reported. In particular evidence from staff surveys and other research indicates that:

- Only 42% of those accidents which trusts are required to report by law to the Health and Safety Executive are reported. The Department told us that this under-reporting

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8 C&AG's Report, paras 11, 2.9–2.14 and Figures 5a–5c and Figure 6

9 Qq 2–3, 41, 165

10 C&AG's Report, pp 18–25, Appendix 3 para 6 and Table 1; Qq 2–3, 35, 47

11 C&AG's Report, para 2.8; Qq 126–133

related to the less important health and safety accidents, though they have not obtained any hard data on this issue.

- NHS staff are often reluctant to report because reporting forms are “tedious and longwinded”.
- Some groups of staff, particularly doctors, and especially those in training who rotate through hospitals, are known to be particularly poor at reporting health and safety accidents.<sup>12</sup>

11. The Department assured us that the introduction of monitoring as part of the Improving Working Lives standard and the Controls Assurance process, which for example requires health and safety to be reported to the board on a regular basis, is starting to improve reporting standards. Some trusts, like the Hammersmith Hospitals, use a simple form on the Intranet which makes it easy to record accidents, and most trusts have review mechanisms in place to try and identify where non-reporting is taking place. Professional bodies also encourage staff to report accidents. Trusts can use their local disciplinary procedures against staff who repeatedly fail to report, but this would be seen as a last resort and the Department did not know of any specific instances where this has been used.<sup>13</sup>

### **Few trusts have a robust understanding of the impact of staff accidents**

12. Following our predecessor Committee’s Report in 1997, the Department issued guidance to trusts asking them to evaluate and improve their understanding of the costs and impacts of accidents. Few trusts have made any progress in quantifying the human and financial costs. Only 24 trusts (9%) had attempted to estimate their costs and of these only 17 provided any cost information. In the absence of robust data the NAO estimated that the annual direct cost of health and safety accidents in 2001–02 was at least £173 million.<sup>14</sup> The new Electronic Staff Record, which the Department expects to have in place very shortly, would give more information about staff and provide trusts with more effective access to the details of staff absence and related information.<sup>15</sup>

13. The only published Departmental cost estimate on staff sickness absence is the cost of injuries through manual handling which accounts for 40% of NHS sickness absence costs or in the region of £400 million a year. One in four nurses has taken some time off work with a back injury sustained at work and for some it has meant the end of their careers. Manual handling issues is one of the biggest, most serious issues for NHS staff because of the amount of lifting that is done. The availability of cost information on back pain is one reason why the Department have been able to give it priority, tackle it and as a result see a reduction.<sup>16</sup>

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12 C&AG’s Report, paras 2.2–2.7, Appendix 3; Qq 36–37, 41–45, 86

13 Qq 25–33, 37–40, 46

14 C&AG’s Report, paras 2.22–2.26 and Figure 11; Qq 166–168, 209

15 Qq 5, 34–35, 166–167

16 C&AG’s Report, para 2.24; Appendix 3 (para 6); Qq 3, 35, 47

14. Needlestick injury is one area where attempts have been made to quantify the cost-benefits of interventions to reduce accidents through the introduction of safer needles. Such injuries occur mostly to nurses, doctors and ancillary staff. Over a third of nurses and half of agency nurses have been stuck by a needle/sharp at some point in their career, with 7% being stuck more than once in the last 12 months. The Department explained that staff needed to receive improved training, particularly in disposal. A reduction in needlestick injuries also depends on proper surveillance and reporting procedures; a range of preventative measures and safer working practices; and the adoption of safer needles in higher risk areas. We asked the Department for reassurance that this was being dealt with properly.<sup>17</sup>

15. The Department told us that there were 23,000 needlestick injuries reported in 2001–02 compared with 250 million such devices used. The General Accounting Office has produced an evaluation of needlestick injuries which suggested that as many as 25% of accidents reported in the United States of America were potentially preventable because needle use was unnecessary. Therefore this type of accident might also be reduced by confining the use of needles to procedures where there is no alternative.<sup>18</sup>

16. Further evidence, submitted by the Safer Needles Network, also drew attention to the risk of healthcare workers becoming infected following a needlestick injury. Health Protection Agency data shows that in the UK there have been five healthcare workers who acquired HIV occupationally, four of whom are now deceased, and a further 12 healthcare workers who have probably acquired HIV occupationally. The Department said that they were unaware of any cases where HIV had been transmitted through needlestick injuries in this country and that the five cases we raised with them had occurred overseas. The Department has subsequently accepted that these cases happened in UK hospitals.<sup>19</sup>

17. In relation to the costs of needlesticks injuries to the NHS, we noted that UNISON had negotiated a deal with employers whereby claims against NHS trusts for certain needlestick injuries are immediately settled by the trust £2,000. The Department explained that the amount of the compensation had emerged through a series of case studies where there had been a demonstrable case of mental stress. It was not an automatic payment, and employers needed to balance the cost of settling with that of being taken to an employment tribunal and the attendant legal costs.<sup>20</sup>

## Compensation and ill health retirement

18. Accidents can result in compensation costs arising from litigation, as evidenced by the examples given in the National Audit Office's Report (reproduced below as **Figure 2**). In order to help people to manage these costs, they had brought staff accidents into the remit of the

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17 C&AG's Report, pp 20–21, para 2.28 and case example 6; Q 199; Ev 25–26

18 Qq 199, 207

19 Q 208; Ev 23–25

20 C&AG's Report p20; Qq 199–206

NHS Litigation Authority and their risk pooling arrangements, which resemble those through which clinical negligence is handled.<sup>21</sup>

**Figure 2: Compensation payments awarded by the courts to employees injured in the course of their duties**

<ul style="list-style-type: none"> <li>• 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.</li> </ul>
<ul style="list-style-type: none"> <li>• 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.</li> </ul>
<ul style="list-style-type: none"> <li>• 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 that the hospital was deemed to have given inadequate lifting training.</li> </ul>
<ul style="list-style-type: none"> <li>• 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.</li> </ul>
<ul style="list-style-type: none"> <li>• In October 2001, a nurse who had a mental breakdown because of stress and overwork, in the aftermath of a traumatic pregnancy, won £140,000 compensation. 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.</li> </ul>
<ul style="list-style-type: none"> <li>• 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.</li> </ul>
<ul style="list-style-type: none"> <li>• 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.</li> </ul>

Source: National Audit Office Report<sup>22</sup>

19. However, the Department did not think that there was significant abuse of ill health retirement on the grounds of a work-related accident as they had a very sophisticated system of checking and a great deal of occupational health expertise available to them. In addition, the NHS Pensions Agency had conducted a review two to three years ago which resulted in revised guidance for trusts on the handling of cases of this nature. The number of ill health retirements in 2001–02 was 4,507 which is already below the Treasury's target of 3.96 per 1,000 employees by 2005. The Department consider that their guidance "*Managing ill health retirement in the NHS: guide for human resource and occupational health service*", which was published in November 2001, has tackled any possible incentive to retire early on ill health grounds.<sup>23</sup>

21 C&AG's Report, para 2.23 and Figure 10; Qq 6, 7, 75

22 C&AG's Report, Figures 7, 10

23 Qq 136–138; Ev 23 (ref to Qq 137–138)

## 2 Improving the management of health and safety to reduce risks to NHS and contract staff

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20. Our predecessor Committee's Report in 1997 found that standards of health and safety management were variable with a number of trusts failing to meet their statutory obligations. We therefore looked at what progress had been made in improving the strategic management of health and safety risks at the national and local level, including the role, responsibilities and accountabilities of the Department, NHS trusts and other stakeholders.

### Roles, responsibilities and accountabilities

21. The *Health and Safety at Work, etc Act 1974* 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) 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.

22. The Department explained that under the Health and Safety Legislation it is the employer on site, the trust chief executive, who is legally responsible for complying with this legislation. In turn, the trust chair and the chief executive were accountable, through local regional directors (now strategic health authority chief executives) to the Chief Executive of the NHS and Permanent Secretary of the Department for the performance of their organisations and through him to the Secretary of State for Health.<sup>24</sup> For the proposed Foundation Trusts, responsibility for health and safety would remain with site management. The Department nevertheless accepted that they were responsible for maintaining a proper health and safety environment within the NHS.<sup>25</sup> In particular they were responsible for making appointments, taking decisions about major investments, about the organisation's structure, and determining how to hold people to account against their key targets. The Permanent Secretary of the Department was also responsible for appointing the trust chief executives as accountable officers.<sup>26</sup>

### Improvements in management of health and safety at the local level

23. NHS trusts are required to appoint a competent person(s) to assist them in complying with Health and Safety Legislation. While 95% have appointed lead health and safety advisors, their qualification and experience varies and overall there are wide variations between trusts in the

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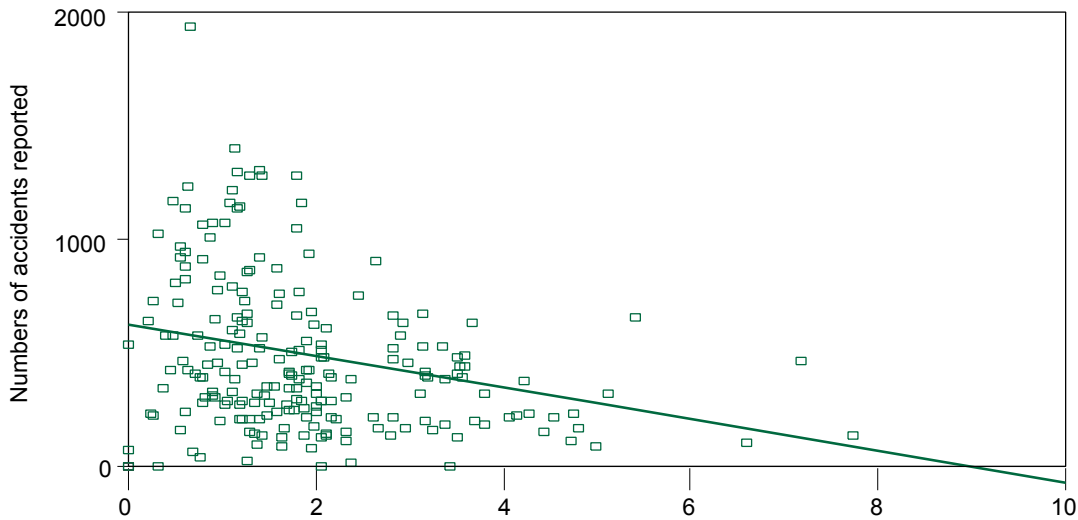
24 C&AG's Report, para 1.17; Qq 64–74, 94

25 Qq 95–100, 107, 117, 178–179; 189–191; Ev 23 (ref to Q 117)

26 C&AG's Report, paras 1.11, 3.3, 3.5 and Appendix 2; Qq 77–78, 103–104, 184–188, 195–197

number of health and safety staff per 1,000 employees. Following the hearing the National Audit Office provided us with a further analysis (**Figure 3**) which suggests that those trusts with a low ratio could improve their management and reduce accidents by employing more qualified health and safety staff.<sup>27</sup>

**Figure 3: The number of accidents reported by trusts compared with the number of health and safety officers per 1,000 staff**



Health and Safety staff per 1,000 staff in trust

The graph shows that as the number of health and safety staff employed per 1,000 staff increases the number of accidents falls

Source: National Audit Office

## The case for a national health and safety strategy

24. The wide range of Departmental initiatives on health and safety are produced and monitored by different parts of the Department (for example the Controls Assurance Unit, the Employment Policy Branch and NHS Estates) and the Health and Safety Executive. There is no central co-ordinating function for health and safety and, unlike Scotland, no NHS wide occupational health and safety strategy. In response to the recommendation in the National Audit Office report the Department have recently brought together a group to co-ordinate matters and now plan to develop a national strategy.<sup>28</sup>

<sup>27</sup> C&AG's Report, paras 3.14–3.16 and Figure 13; Qq 139–142; Ev 14, footnote 7

<sup>28</sup> C&AG's Report, para 13 and recommendation (m); Qq 124–125

## The provision of occupational health services

25. Occupational health services fulfil a number of important roles from health surveillance. These include screening, health education and counselling, assessments of individual employee's fitness to work, the rehabilitation of staff into work following an injury or illness and planning and implementing health improvement measures in the workplace. The Department's Improving Working Lives initiative requires all NHS trusts to have occupational health services available by 31 March 2003.<sup>29</sup>

26. All acute, hospital and mental health trusts provide a range of occupational health services for their staff but availability and access varies. Occupational health staffing resources vary widely and only 13% of trusts had undertaken any cost-benefit analysis of their spending on occupational health.<sup>30</sup>

27. Occupational health arrangements in primary care trusts (PCTs) are less advanced as historically no national occupational health services were available to GPs or their employees. An NHS Working Group was set up in 1998 to look at what services should be provided and how they might best be delivered. Guidance on the arrangements for commissioning services was issued to health authorities early in 2001. PCTs have been given a year extra to meet the Improving Working Lives target. There has also been a small amount of pump priming money (£21 million over three years from 2001–02, including £8 million in 2003–04). Some PCTs have set up their own small occupational health unit or share one with a neighbouring PCT; others buy services from established local NHS providers or, in rare cases, from a private service provider.<sup>31</sup>

## The legal duty to ensure the health and safety of contractors working in the NHS

28. With increasing reliance on contractors in the NHS there is a risk that trusts might fail in their legal duty to provide for their health and safety. The National Audit Office report pointed out that 37% of trusts' systems for the control of the health and safety of contractors had inadequacies in some or all respects. Fourteen trusts stated that they had no systems for controlling the health and safety risks to contractors. Trusts are responsible for the welfare of contract staff working on their premises and guidance under Improving Working Lives includes a series of measures about the terms of employment for such people within the NHS. The aim was to ensure that contracted staff were at no greater risk of experiencing an accident whilst on trust premises than a trust employee. The Department had no evidence or knowledge of actions taken against contractors on the basis that they had an inadequate record in respect of health and safety.<sup>32</sup>

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29 C&AG's Report, para 3.28–3.30; Q 21

30 C&AG's Report, paras 3.32–3.38 and Figures, 15, 16

31 Qq 11–24; Ev 20–21

32 Qq 101–102, 105–106, 151–155; Ev 11, footnote 3

## Improving the provision of health and safety training

29. In response to our predecessor Committee's Report, the Department required all NHS employers to provide appropriate health and safety training on recruitment and when staff are exposed to new or increased risks. However contractors, agency and locum staff are not universally entitled to or able to take up training opportunities. Doctors were the least likely to participate in health and safety induction training, probably because they move through hospitals on six month rotations so it was difficult to target them.<sup>33</sup>

30. The NHS University, which is to be established from November 2003, has adopted the provision of a core induction programme for all NHS staff, which will include health and safety, as one of its first major initiatives.<sup>34</sup>

31. Standardised health and safety courses and a training passport are being adopted by the Welsh Assembly and the NHS in Wales, which means that staff are trained within a national curriculum to the same level of competence and can then move through the NHS presenting their passport as evidence of what training they have received. The Department were unlikely to adopt this system as the NHS University has been designed to ensure that there would be some standardisation of content of training courses in the future and the new NHS Electronic Staff Records and Occupational Health Smart Card systems would record employee's learning and training experience at all stages of their careers to reduce duplication. The introduction of this "electronic passport" should help to capture more information and reduce wastage of training budgets.<sup>35</sup>

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33 C&AG's Report, paras 3.18 –3.19; Qq 8, 47

34 Q 47

35 Qq 48–50, 118–123

## Conclusions and recommendations

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1. The Department's plan to develop a national occupational health and safety strategy is a welcome development and one that should be expedited to ensure efficient and effective co-ordination of existing and new initiatives. In developing this strategy the Department should ensure that the roles, responsibilities and accountabilities for health and safety are clarified, particularly with regard to PCTs and the new NHS Foundation Trusts, and give clear guidance on how their performance will be monitored and managed.
2. The Department should encourage trusts to adopt a comprehensive strategy for dealing with the risk of needlestick injuries. The aim should be for trusts to reduce unnecessary use of needles; to upgrade their training for safer working practices; to evaluate the effectiveness of preventative measures; and to follow appropriate surveillance and reporting procedures.
3. The Department should work with the NHS Litigation Authority and NHS Pensions Agency to monitor the extent and types of compensation claims and requests for ill health retirements due to work-related accidents and where necessary, introduce guidance or other interventions to ensure that such cases are managed effectively with proper controls over the extent of the payments.
4. Healthcare workers need to be fully aware of health and safety risks as early as possible in their careers, so that reporting and compliance with best practice becomes routine. The new induction courses being developed by the NHS University should give due emphasis to managing health and safety risks.
5. The Department should investigate the relationship between the number of health and safety advisors and the level of reported accidents, and between the resources utilised by occupational health services and sickness absence, with a view to developing guidance on the allocation of resources in these areas. The Department should also review the provision of occupational health services by PCTs to ensure that PCT staff have appropriate access to such services.
6. The Department should remind trusts of their responsibilities with regard to training and the health and safety of agency staff and contractors. Trusts which stated that they had inadequate systems for controlling the health and safety of contractors should take early steps to improve their systems.
7. In evidence to the Committee the Department said that they were unaware of any cases in this country where HIV had been transmitted through needlestick injuries, and that the five cases we raised with them had occurred overseas. The Department has subsequently acknowledged that these cases happened in UK hospitals. We emphasise again the importance of accuracy in evidence to Select Committees of the House, and of witnesses being adequately briefed on the issues under examination.

## Formal minutes

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**Wednesday 17 September 2003**

Members present:

Mr Edward Leigh, in the Chair

Mr Richard Bacon  
Jon Cruddas  
Mr Ian Davidson  
Mr Nick Gibb  
Mr Brian Jenkins

Mr David Rendel  
Jim Sheridan  
Mr Siôn Simon  
Mr Gerry Steinberg  
Mr Alan Williams

The Committee deliberated.

Draft Report (A safer place to work: Improving the management of health and safety risks to staff in NHS trusts), proposed by the Chairman, brought up and read.

*Ordered*, That the Chairman's draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 31 read and agreed to.

Conclusions and recommendations read and agreed to.

Summary read and agreed to.

*Resolved*, That the Report be the Forty-second Report of the Committee to the House.

*Ordered*, That the Chairman do make the Report to the House.

*Ordered*, That the provisions of Standing Order No. 134 (Select Committees (Reports)) be applied to the Report.

Adjourned until Monday 20 October at 4.30 pm

## Witnesses

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**Monday 12 May 2003**

*Page*

**Sir Nigel Crisp KCB**, and **Mr Andrew Foster**, Department of Health

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## List of written evidence

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Department of Health

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## List of Reports from the Committee of Public Accounts Session 2002–03

First Report	Collecting the television licence fee	HC 118 ( <i>Cm 5770</i> )
Second Report	Dealing with pollution from ships	HC 119 ( <i>Cm 5770</i> )
Third Report	Tobacco Smuggling	HC 143 ( <i>Cm 5770</i> )
Fourth Report	Private Finance Initiative: redevelopment of MOD Main Building	HC 298 ( <i>Cm 5789</i> )
Fifth Report	The 2001 outbreak of Foot and Mouth Disease	HC 487 ( <i>Cm 5801</i> )
Sixth Report	Ministry of Defence: Exercise Saif Sareea II	HC 502 ( <i>Cm 5801</i> )
Seventh Report	Excess Votes 2001–02	HC 503 ( <i>N/A</i> )
Eighth Report	Excess Votes (Northern Ireland) 2001–02	HC 504 ( <i>N/A</i> )
Ninth Report	The Office for National Statistics: outsourcing the 2001 Census	HC 543 ( <i>Cm 5801</i> )
Tenth Report	Individual Learning Accounts	HC 544 ( <i>Cm 5802</i> )
Eleventh Report	Facing the challenge: NHS emergency planning in England	HC 545 ( <i>Cm 5802</i> )
Twelfth Report	Tackling pensioner poverty: encouraging take-up of entitlements	HC 565 ( <i>Cm 5802</i> )
Thirteenth Report	Ministry of Defence: progress in reducing stocks	HC 566 ( <i>Cm 5849</i> )
Fourteenth Report	Royal Mint Trading Fund 2001–02 Accounts	HC 588 ( <i>Cm 5802</i> )
Fifteenth Report	Opra: tackling the risks to pension scheme members	HC 589 ( <i>Cm 5802</i> )
Sixteenth Report	Improving public services through innovation: the Invest to Save Budget	HC 170 ( <i>Cm 5823</i> )
Seventeenth Report	Helping victims and witnesses: the work of Victim Support	HC 635 ( <i>Cm 5823</i> )
Eighteenth Report	Reaping the rewards of agricultural research	HC 414 ( <i>Cm 5823</i> )
Nineteenth Report	The PFI contract for the redevelopment of West Middlesex University Hospital	HC 155 ( <i>Cm 5961</i> )
Twentieth Report	Better public services through call centres	HC 373 ( <i>Cm 5961</i> )
Twenty-first Report	The operations of HM Customs and Excise in 2001–02	HC 398 ( <i>Cm 5961</i> )
Twenty-second Report	PFI refinancing update	HC 203
Twenty-third Report	Innovation in the NHS—the acquisition of the Heart Hospital	HC 299 ( <i>Cm 5961</i> )
Twenty-fourth Report	Community Legal Service: the introduction of contracting	HC 185 ( <i>Cm 5961</i> )
Twenty-fifth Report	Protecting the public from waste	HC 352 ( <i>Cm 5961</i> )
Twenty-sixth Report	Safety, quality, efficacy: regulating medicines in the UK	HC 505 ( <i>Cm 5962</i> )

The reference number of the Treasury Minute to each Report is printed in brackets after the HC printing number

Twenty-seventh Report	The management of substitution cover for teachers	HC 473
Twenty-eighth Report	Delivering better value for money from the Private Finance Initiative	HC 764
Twenty-ninth Report	Inland Revenue: Tax Credits and tax debt management	HC 332 ( <i>Cm 5962</i> )
Thirtieth Report	Department for International Development: maximising impact in the water sector	HC 446 ( <i>Cm 5962</i> )
Thirty-first Report	Tackling Benefit Fraud	HC 488 ( <i>Cm 5962</i> )
Thirty-second Report	The Highways Agency: Maintaining England's motorways and trunk roads	HC 556 ( <i>Cm 5962</i> )
Thirty-third Report	Ensuring the effective discharge of older patients from NHS acute hospitals	HC 459
Thirty-fourth Report	The Office of Fair Trading: progress in protecting consumers' interests	HC 546 ( <i>Cm 5962</i> )
Thirty-fifth Report	PFI Construction Performance	HC 567
Thirty-sixth Report	Improving service quality: Action in response to the Inherited SERPS problem	HC 616 ( <i>Cm 5963</i> )
Thirty-seventh Report	Ministry of Defence: The construction of nuclear submarine facilities at Devonport	HC 636
Thirty-eighth Report	Department of Trade and Industry: Regulation of weights and measures	HC 581 ( <i>Cm 5963</i> )
Thirty-ninth Report	A safer place to work: Protecting NHS hospital and ambulance staff from violence and aggression	HC 641 ( <i>Cm 5963</i> )
Fortieth Report	Improving social housing through transfer	HC 590 ( <i>Cm 5963</i> )
Forty-first Report	Modernising procurement in the Prison Service	HC 676
Forty-second Report	A safer place to work: Improving the management of health and safety risks to staff in NHS trusts	HC 704

The reference number of the Treasury Minute to each Report is printed in brackets after the HC printing number