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HEALTH AND SAFETY COMMISSION

EVALUATION OF THE HEALTH AND SAFETY (FIRST AID) REGULATIONS 1981 – PROPOSALS FOR CHANGE

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Issue

1. For the Commission to note the results of the discussion document (D/D) on the Health and Safety (First Aid) Regulations 1981 (FAW), and agree proposals for concluding work on the review and effectiveness of the Regulations.

Timing

2. Below the line for information and approval.

Recommendation

3. That the Commission
   - notes the high level of goodwill and moral duty that is evident in an active first aid community;
   - notes the results of the D/D concerning the shape of FAW regulatory regime;
   - agrees the main recommendations of HSE's response set out in the argument below; and,
   - notes that HSE will inform key stakeholders and the public on the outcome of the review at the earliest opportunity.

4. The responses to the discussion document were analysed fully in arriving at the recommendations and argument proposed in this paper.

Background

5. Regulations covering the provision of first aid in the workplace were introduced by the Health and Safety (First-Aid) Regulations 1981 (FAW). They place a general duty on employers to ensure adequate equipment, facilities, and personnel are provided to deliver

immediate and initial management, i.e. first-aid, to their employees. The supporting ACOP and guidance have been revised twice in tidying–up exercises.

6. This is the first full review and evaluation of the Regulations since they were introduced. The review has explored what form legislation will take in this area in future and asked employers, first aiders, training providers, and other stakeholders how they view the implementation and maintenance of FAW, and the provision of first aid at work in the future. Much change has taken place in the interim since 1981. For example, in the economy - the reduction in large, heavy and hazardous industry; the rise in small and medium sized businesses, self-employment; and change in approaches taken to safety regulation from one of prescriptive measures to the encouragement of good safety management through assessment and control of workplace risks.

7. An encouraging 550+ responses to the discussion document (D/D) phase of the review were received evenly spread across role, industry and region. We were told that dialogue was well overdue and that the D/D captured every key issue and point of concern.

Argument

8. The overall message is that there is no need for major revisions to the current form of the regulatory framework. While there has been some call for changes to regulation or the ACOP as exist at present, they are mostly minority views, or are the responsibilities of other government departments e.g. provision for school-age children, members of the public. These findings complement the positive findings of prior research reviewing the effectiveness of FAW conducted for HSE by Casella Winton (HSC/03/73 annex 2). They also concur with the informal soundings that we have received and accepted from face-to-face meetings with key players of the first aid industry during the consultation period.

9. There was evidence of a high level of goodwill and moral duty amongst the first aid community, and support for FAW in its present form. This provides us with scope to consider whether the commitment of trained first aiders might be harnessed to promote proactive health and safety practices. For example, first aiders may present a ready conduit for the spreading of good health and safety messages in workplaces and there is evidence that first aid training in itself can improve safety behaviour and may contribute to accident prevention (e.g. in support of the HSC priority on slips, trips and falls etc.). There is also evidence of specialist first aider roles having a good effect too. We are awaiting the final results of a short piece of research into the current number of certified UK first aiders that will help in developing the feasibility of tapping into these ideas further. Preliminary analysis of the replies that we received back from about a third of those companies contacted demonstrates that there is at least one half to one million workers who are certified first aiders at present in the UK. It would appear that an encouraging number of first aiders (70 000 plus) are active in the difficult-to-reach small and medium sized enterprises (SMEs).

<u>Regulatory Framework</u>

10. In the short to medium term, FAW should not be integrated into other health and safety regulations e.g. MHSW. They are valued in their own right and merger would reduce the visibility and focus of a tried and tested regime and may result in a drop in compliance and provision. The time and effort involved in working up new legislation

would outweigh any possible benefits. New burdens on business issues would also be raised.

11. Additional guidance had been requested, however, in the following areas:

- the content and flow of the first aid needs assessment required of employers when deciding on the level of first aid provision, with illustrative examples included;
- the roles and responsibilities involved, particularly the ‘appointed person’;
- first aid training course content and standards;
- proportionality of requirements between low and higher risk work settings;
- other developments e.g. new equipment available, and writing in minor amendments to FAW in industries where an employer is dealing with his or her employee (new requirements passed on standard workplace signs and symbols, access and identification of first aid rooms).

12. There was demand for guidance on the provision of first aid for members of the public who are not at work, for example, pupils in schools, residents and visitors in care homes, and other areas. However, this is is not covered by FAW and is provided separately by OGDs. HSE guidance should make this clear.

13. More generally, extending provision of first aid to members of the public was rejected, albeit by a narrow margin, persuaded by the argument that there was already a good voluntary response especially in sectors where interface with the public and visitors was commonplace – retail premises, transport. Employers raised the impracticality of having to cater for every visitor. First aiders were concerned about possible litigation and would reconsider volunteering if obliged by the law to offer first aid attention to the public.

14. Two-thirds of respondents saw no need for more guidance on the costing of first aid provision. Costs were variable from company to company and any estimates would require frequent update to be useful, and run the risk that employers would assess only in terms of cost.

First Aid Training Arrangements

15. The discussion document suggested that to meet the differing needs of employers the current arrangements for certified first aider training of an initial 4-day course and subsequent refresher at the end of every 3-year period could be replaced by the option of attending:

- **Either** a 6 hour emergency first aid course, with annual refresher training (3-4 hours) and a 6 hour requalification course every 3 years;
- **Or** an 18 hour first aid at work course, with annual refresher training (3-4 hours) and a 12 hour requalification course every 3 years
- **The role of appointed person retained** as basic requirement (formal training still not required.

16. There was a high level of support for these practical changes to the training arrangements. Employers would have the option of one-day emergency first aid courses or 3-day first aid at work courses and individuals successfully completing either course will become certified first aiders. There was some support for all workplaces having at least

one certified first aider but this was considerably less than the support given to the option outlined above.

17. It is clear from these responses that the first aid community, training providers and employers would welcome improvements to the existing arrangements.

18. We also received a great deal of enthusiastic comment, notably from first aiders and small and low risk premises, on how course content, and guidance, could be added to or improved e.g. the use of Automated External Defibrillator equipment. As HSE does not lead on this policy area providing such guidance could best be effected by providing links from HSE's website to specialist websites, reviewed on a regular basis for currency.

Training Standards

19. The D/D responses here were less clear-cut. Under current procedures, HSE accepts only those standards set by external bodies (the UK/European Resucitation Councils, voluntary aid societies, medical and other scientific research). There was a small majority of responses in favour of no change. However, the number in favour of HSE extending the list of specific standards to include, for example, ambulance authorities and medical Royal Colleges was not far behind.

20. The majority of large training organisations appears to believe that the first aid industry is mature enough to serve its own needs by self-regulating and developing its own standard setting body and recommended competencies and skills. The smaller independent training organisations would support this idea provided that all players could work collaboratively on a level playing field, and no group (e.g. the larger voluntary aid societies) was allowed to dominate. However, the advantage of the present system is that training organisations must defend the standards that they use rather than HSE having to take prescriptive decisions for them.

21. One clear message in this section was that poor understanding exists in the industry of the standards that are accepted presently by HSE. To mitigate this misunderstanding, we would, in the absence of an industry body to set standards, have to set out in clearer terms what the agreed status quo position of accepting a range of alternative standards entails. It is proposed that we continue the current system of requiring **first aid training course standards** that are in accordance with currently accepted first aid practice, but with clearer guidance available on our website on the range of standards we accept to reduce the number of queries we receive. In the medium to longer term, we will encourage the first aid industry to set out and maintain its own standards collaboratively as opportunities for doing so arise.

Approvals

22. Regulation 3 (2) of FAW requires HSE approval of training and qualifications for those appointed as first aiders at work. Historically, HSE has effected this by approving training organisations rather than the training itself. However, we believe that a more natural reading of reg 3 (2) would be for HSE to limit the approval process to the content and syllabus for first aid training courses, rather than the existing system of approving the

suitability of the training provider organisations themselves. Advice from Solicitors is that there is no legal bar in FAW to such a change in policy on approvals.

23. The D/D initiated a debate and invited comments on whether we should move to approval of course content and structure. A small majority of replies (of whom 10% only were training providers) was in favour of remaining within the present system of HSE approving training providers, primarily because they were concerned that the larger training providers would over-influence the industry if HSE was not in control. However, the biggest training providers (Voluntary Aid Societies and the larger independent Training Providers) are in favour, as explained in meetings with us, of a move to HSE approving only the content and structure of training courses. These organisations represent a large majority share of the first aid at work training industry. Informal discussions with providers in recent months indicate that this development would be acceptable to the first aid training industry. Since the publication of the D/D, one favourable development is that the first aid industry is adopting a more co-ordinated approach to representing its interests and managing its affairs. Such a first aid training providers group will be mature enough and best placed to operate the new system. We will be eager to work with them on transitional arrangements and the setting up of a new external body that will lead on the monitoring and publicity for first aid activity.

24. It is clear that any changes to the current arrangements would require considerable work to put in place an equitable and robust system. This would include the setting up of a nationally agreed qualification/register for first aid at work trainers and assessors. A majority were in favour of this development and a majority also indicated that more detailed guidance would be required particularly in view of the changes that may occur. To ensure success, approval of the content and syllabus by HSE would go hand-in-hand in engaging in the development of this new monitoring body and a national register of trainers. However, this would require a commitment from HSE to facilitate the process over the medium to long term. Moreover, changes to the Health and Safety (Fees) Regulations and a Regulatory Impact Assessment might be required to reflect any changes to the approvals system.

25. Because knowledge of additional procedures are expected for those in the offshore and diving industries, separate legislation i.e. the Offshore Installations and Pipeline Works (First-Aid) Regulations 1989 (OFAR) and the Diving at Work Regulations 1997 (DWR) apply. As in FAW the approval of training and/or qualifications depends upon the organisation or employer satisfying certain criteria. Any changes to FAW approvals and training course structure and content that may impact upon the approvals process for OFAR or DWR will be taken into consideration.

First Aid Equipment and Medications

26. Opinion supports our favoured option that current arrangements are retained whereby HSE provides guidance and advice, but no prescription. There was, however, a strong demand for more detailed practical guidance, possibly with the help of supporting examples based on case studies. Several other supportive suggestions were received.

27. There was a firm rejection of the suggestion that first aiders should take responsibility for over-the-counter-medicine e.g. paracetamol should be introduced. That view is in line

with our thinking and advice taken from the Medical and Healthcare Products Regulatory Agency (MHRA).

<u>Key recommendations and resource implications</u>

28. The high level of support for FAW in its present form that **the Regulations and the ACOP should not be changed** reinforces our view that further regulatory work in relation to FAW is not necessary. Overall, the regulations are regarded as a cost effective framework for the delivery of first aid provision, although further work falling short of regulation would be required to improve understanding of the existing system and update the way it operates. HSE should also consider exploring **novel approaches and opportunities** on the back of the goodwill and commitment expressed by workplace first aiders. This may gain leverage in spreading positive health and safety messages, and help to prevent accidents further.

29. There is a need to undertake limited work to ensure that our guidance meets the needs of respondents who have asked for a significant amount of **new material and clarification in guidance** of particular aspects e.g. on making an assessment of need, clearer definitions of roles/responsibilities, and advice on new topics and developments such as automated external defibrillators and training course standards. **We will update the guidance currently available on HSE's website,** primarily to address those issues which generate the highest numbers of queries, making links to other specialist websites where appropriate.

30. We propose to **change the structure of certified first aid training courses** proceeding along the lines outlined in paragraphs 15 & 16 above. We will work up a more detailed proposal for discussion with key stakeholders before finalising the changes and issuing revised supporting guidance. We do not envisage that this valuable work aimed at modernising the present system will turn out to be particularly resource-intensive.

31. As outlined in the D/D, **our preference is to limit the approvals process in future to the content and syllabus for first aid courses**. We believe that this would not require any legislative change. This would involve first aid training providers setting and maintaining its own industry body collaboratively through a membership system. However, we recognise that this would require HSE to support the industry through a transitional period to ensure that a system could be put in place to allow us to move away from the existing arrangements. **We recommend that further exploratory scoping work be undertaken on the feasibility and resource implications of this before putting any firm proposals to the Commission.**

Consultation

32. The D/D was circulated to voluntary aid associations, first aid training providers, employers, health and safety experts, and others with an interest in first aid. It was openly advertised on the HSE website, and First Aid Café website. Relevant parts of HSE and OGDs including DoH have been consulted.

Presentation

33. No implications from this paper. A summary of the D/D findings and HSE's response will be published on the first aid pages of HSE website. Copies of the responses are available to read in our info centres, as is standard practice.

34. Our decisions will be of interest primarily to first aiders, training providers and occupational health professionals. There will be much interest from employers too as we are proposing major changes to the training schedules, partly in response to employer feedback in the Casella research and other direct approaches made to them in considering the way forward on first aid training. First aid also generates a considerable amount of HSE website hits. A news release to accompany publication will be considered.

Costs and Benefits

35. We believe that changes to training arrangements short of legislative changes will be largely cost neutral for industry in terms of indirect costs (time lost for training) to employers. It is too early to estimate how the training industry would price the new style courses. Over a period of several years, the number of training days required for the current and proposed first aid at work courses would be similar even though, under the proposals, two interim refresher courses will be required over each 3-year cycle. We do not know at this stage what costs will be involved.

36. There would also be possible cost implications for training providers. Many can see business opportunities in the new proposals whereas a few are predicting loss of business. This would depend on their size, location and clientele. Revision of guidance, consulting the industry, and exploring extended roles from first aiders etc would require further resource input from HSE.

37. The present approvals system is intended to be a self-financing charging regime and currently generates income for HSE. Work to change the approvals system and contribute to the creation of an alternative would however require a commitment from HSE to support the industry through the transition period. However, as noted at paragraph 31 above, more detailed scoping work on the feasibility and resource implications is required.

Financial/Resource Implications for HSE

38. The estimated full cost of the work proposed at paragraphs 28 to paragraph 31, (including a preliminary scoping exercise, all overheads, travel and subsistence) is in the region of £154K.

Action

39. **The Commission is asked to agree the recommendations set out above.**