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PSA DELIVERY PLAN

Issue

1. To achieve the PSA targets for occupational health and safety.

Purpose

2. In June 2000 the Government and the Health and Safety Commission published Revitalising Health and Safety Strategy Statement which set out national PSA targets for occupational health and safety:
 - a) Reduce the number of working days lost per 100,000 workers from work related injury and ill health by 30% by 2010;
 - b) Reduce the incidence rate of fatal and major injury incidents by 10% by 2010;
 - c) Reduce the incidence rate of cases of work-related ill health by 20% by 2010 ; and
 - d) Achieve half the improvements under each target by 2004 against a baseline of 1999/2000.**
3. The purpose of this plan is to set out the critical elements of work to achieve 'd' which is the PSA target:

Accountabilities

Minister for Health and Safety, Department for Work and Pensions (DWP)	Rt Hon Nick Brown MP	Owens PSA targets and held accountable to the Prime Minister and Parliament
Chair, Health and Safety Commission	Bill Callaghan	Accountable to Ministers for implementing and delivering HSC Plans to deliver PSA targets.
Director General, Health and Safety Executive	Timothy Walker	Accountable to HSC for ensuring HSE makes the necessary arrangements to deliver the PSA Targets.
Deputy Director General (Policy)	Kate Timms	Delegated responsibility to make sure that the right detailed plans are in place within HSE to underpin delivery of the PSA targets

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Department for Work and Pensions (DWP)	Gareth Williams	Responsible for giving Ministers the confidence that progress and work streams are robust to meet aims of PSA delivery programme
DWP/HSE Project Board	Gareth Williams Kate Timms Linda Derrick Jane Willis Phil Scott	Responsible for developing a PSA Delivery Plan

Headline Statistics

Graph 1: fatalities and major injuries (ANNEX 13 to be updated with 2001/02 figures);
 Graphs 2 and 3 will represent number of working days lost and incidence of work-related injury and ill health; these will be available from EMSU late October.

Roles and responsibilities

4. Kate Timms, Deputy Director General (Policy) has delegated responsibility from the DG for oversight of the work to deliver the PSA targets. She is responsible for the preparation, development and monitoring of the Delivery Plan. This includes:
 - Challenging programmes of work
 - Identifying deficiencies in delivery
 - Understanding the progress made
 - Learning lessons/share experiences
 - Bringing issues/progress to the attention of the Board

Those also responsible for the work streams contributing to the programme for delivering the PSA targets are:

Board – corporate responsibility to the Commission

5. Richard Hillier / Vivienne Dews – Corporate services, including resources
 Sandra Caldwell – Change Management
 Sandra Caldwell and Peter Graham - Baseline monitoring for reporting publicly on PSA targets

Priority Programme Managers, responsible through their line managers:

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- Agriculture – Linda Williams (Adrian Ellis)
- Construction – Kevin Myers (Adrian Ellis)
- Health Services – Murray Devine (Adrian Ellis)
- Stress – Elizabeth Gyngell (Sandra Caldwell)
- Musculoskeletal Disorders (MSD) – Elizabeth Gyngell
- Workplace Transport – Bill Gillan (Nick Starling)
- Falls from height – Bill Gillan
- Slips/Trips – Phil Scott (Justin McCracken)

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| 6. Providing support to Kate Timms | Linda Derrick |
| Monitoring including performance indicators | Tony Mulhall |
| Research including evaluation | Alan Brown / |
| Paul Davies | |
| Quality Assurance | DWP |

Strategy

7. In June 2000, the Government and the HSC published a Strategic Statement for Revitalising Health and Safety. This provides the strategic framework for delivering ten-year national health and safety improvement targets for the first time. The Spending Review 2000 PSA targets require the achievement of half of these improvements by 2004. Success requires everyone in the health and safety system to contribute.
8. In October 2000 the HSC selected eight priorities that would make a major contribution to the targets. The priority areas for action are:
 - Construction, agriculture and the health services sectors
 - Falls from height
 - Workplace transport
 - Musculoskeletal disorders (MSD)
 - Stress;
 - Slips, trips and falls in local authority enforced sector

[Annexes 1 – 8 provide a summary of the contribution each priority programme will make to the PSA target].

9. Each of these priorities have their own targets and if met, would ensure achievement of 60% of the accident target, 75% of the ill health target and 87% of the days lost target. The strategy for delivery is to concentrate on these eight priorities. MSDs and slips and trips, in particular, appear to be those with the potential to deliver the greatest contributions to meeting the targets because of the numbers involved.
10. Resource provision to these priority programmes is fundamental to the success of the Delivery Plan. It needs to be addressed so that there is a clear understanding about the level of resources

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allocated and how they will be managed from the outset. This is a difficult issue as it impacts on the resourcing of work in other priority areas and has major implications for HSE's current systems. The HSE Board needs to discuss and decide how it wishes to take this forward, not just in relation to the delivery of the PSA targets but in the broader context of its change programme.

11. Some other activities may yield high results from a small amount of resource and are thus worth including as part of the delivery plan. Examples are:

- Challenging the Top 350 companies to report on health and safety annually, appoint a director responsible for health and safety and share good practice
- Through insurance companies
- Corporate governance

HSE will need to prioritise this work to secure improvements either by sector, particular companies or by innovative ways of tackling health and safety issues. Plans for other activities that could contribute are not included in this plan but mentioned at Annex 10.

12. In addition, Government needs to demonstrate its commitment to improving health and safety in the Civil Service. Without this clear commitment, the HSE cannot gain the necessary commitment of others to delivering the PSA targets. The credibility of the delivery plan will be undermined. Work to improve health and safety in the Civil Service is therefore essential to the delivery plan and is at Annex 9.

Success indicators

Fatal and major injuries

- Validated statistical data available every Autumn
- Quarterly based fatalities data
- Develop indicators based on numbers of accidents reported, by sector and hazards and region

Working Days lost

- Currently rely on self-reporting (LFS and SWI) – 3 year cycles
- Need to develop innovative additional sources of information (much shorter timescales e.g. narrow target surveys in particular industries, regions, populations etc.

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Work-related ill health

- High level progress based on assessments from different data sources
- Need to develop innovative sources of information e.g. occupational diseases and exposures

13. All projects also expect to use “surrogate” measures identified in relation to specific activities and initiatives that will be identified when the activity is begun and used for monitoring.

Putting delivery into action

14. Subject to resources being available, HSE will deliver this plan. Milestones will be set and monitored. The plan will be regularly reviewed. [Mechanism needs to be specified?]

Quality assurance

15. [HSE must ensure the delivery plan is both internally and externally quality assured].

Stakeholder engagement

16. A draft stakeholder engagement plan is at Annex 10. This has identified the five current key groups of stakeholders – central and devolved government; the media; insurance companies; local authorities; and, tripartite/ representative groups such as industry advisory groups. The next step is to evaluate their contribution against possible new stakeholders and get corporate agreement to the key stakeholders.

17. A major group of critical stakeholders are other Government Departments. HSE will need to advance joined-up/cross cutting government working, already started by initiatives such as High Level Forum, by:

- Demonstrating the business case for the proper treatment of H & S on OGD agendas both in terms of their business activities and also in terms of their role as employers/procurers of services
- Focusing on encouraging priority OGDs (selected as critical stakeholders) to give H & S proper treatment as above
- Investigate and introduce effective cross cutting and cross silo thinking and working - for example peer review and benchmarking of Business delivery plans in the Treasury/ Cabinet Office Business Planning Strategists network.

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Communication plan

18. A draft communications plan is at Annex 11. The internal PSA delivery communication plan needs full support from the HSE Board [corporately and individual Directors] in communicating information to staff on what their contribution and role will be in delivering the PSA targets. It needs to clarify other activities that will contribute to achieving the PSA targets, beyond the Priority Programmes. The communication plan will also explain how the PSA targets fit into HSE's other work and ways of motivating staff.

Reporting

19. HSE will report annually on progress against the PSA targets in the HSC Progress Report. The reporting process will be single-line, require only relevant information and avoid the need for multiple reporting. The timing will have to cohere with the planning and reporting systems. This will use the intelligence provided in the following documents:
20. Further explanation of the three key PSA targets for fatalities and major injuries, work-related ill health and working days lost was given in Achieving the Revitalising Health and Safety Targets at <http://www.hse.gov.uk/revitalising/baseline.pdf>
21. The principles which HSE will use when assessing progress against the PSA targets were set out in Achieving the Revitalising Health and Safety Targets: Statistical note on progress measurement at <http://www.hse.gov.uk/statistics/statnote.pdf>
22. A first report on progress, based on provisional data up to 2000/01, has been published as Statistical Note on Progress Measurement: Update based on data published in Health and Safety Statistics 2000/01 at <http://www.hse.gov.uk/statistics/snoct01.pdf>
23. The HSE Board will report to the DWP on a regular basis. HSE will also report on achievements, lessons learnt and possible new priorities in the *State of the Nation* Report every two years to inform future spending reviews.
24. HSE will review performance indicators using the Balanced Scorecard method. The Balanced Scorecard gives a focus for management and departmental target setting and will therefore provide some structure to the intermediate performance indicators that relate to the PSA targets.
 - The scorecard is a structured approach to using performance measurement information to:

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- Help set agreed performance goals and priorities
- Change policy or operational direction to meet those goals if necessary, and
- Communicate expectations and report on the success

Evaluate/value for money

25. HSE will assess the impact of our activities using the RHS Evaluation Framework and existing HSE methodology.
26. HSE need research to support the whole delivery programme in particular to improve the indicators available to assess progress against ill health and days lost targets. Further work will underpin individual priority programmes.

Managing the delivery: meeting the challenges

27. A draft risk register is at Annex 12. This includes risks to the achievement of the PSA Targets and to the individual priority programmes. This will need further work to make sure it is comprehensive and to indicate how risks are to be managed.

Change the way we work

28. HSE's Change Management Programme will put in place structures, systems and ways of working to support delivery. Implementation of organisational change necessary are planned to take place between October 2002 and the end of March 2003. Some changes will need to take place more quickly to enable progress toward delivery of the targets.

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ANNEXES

Annex 1	Priority Programme – Agricultural sector
Annex 2	Priority Programme – Construction sector
Annex 3	Priority Programme - Health Services sector
Annex 4	Priority Programme - Work related stress
Annex 5	Priority Programme - Musculoskeletal disorders
Annex 6	Priority Programme - Workplace Transport
Annex 7	Priority Programme - Falls from height
Annex 8	Priority programme - Slips and Trips
Annex 9	Improving health and safety in the Civil Service
Annex 10	Draft stakeholder engagement strategy
Annex 11	Draft internal communications strategy
Annex 12	Draft Risk Log (based on RHS Unit and Priority Programme Teams' views)
Annex 13	Graph showing progress against the targets for reducing the incidence of fatal and major injuries

<p>Priority programme</p>	<p>Agriculture</p>
<p>Contributions to achieving the PSA targets</p>	<ul style="list-style-type: none"> • The sector's most significant contribution to the PSA targets promises to be to the incidence rate of fatal and major accidents. For 2000/01 the combined fatal rate to workers/major rate to employees fell from 228.9 to 211.6 (meeting our current sector target for 2003/4 of 217.5). The fatal injury rate rose from 7.7 to 10.2 (in 2000/01) reflecting perhaps the economic and other pressures (eg Foot and Mouth Disease) experienced by the self employed and small farms in particular. It is too early to judge whether this overall fall in the combined incident rate constitutes a real trend. The number of major injury accidents obscures the identifiable trends for fatalities (upwards for the self employed and currently downward/static for the employed) and may possibly provide the most reliable indicator of future trends. If we roughly extrapolate graphical plots of major accident data since 96/97 (changes in RIDDOR) we may tentatively predict: <ul style="list-style-type: none"> - A fall in actual numbers to 600 by 2001/2, 587 for 2002/3, 575 for 2003/4 (+/- 5% in each case) and - Either a static incidence rate averaging 216 per year (+/- 5%) or a fall to 200 by 2001/2, 191 by 2002/3, 184 by 2003/4 (+/- 15%) • We can offer to make no contribution to the other PSA targets. The AIAC felt unable to set targets for the industry in the areas of working days lost and a reduction of cases of work related ill health because of gross inadequacies in levels of reporting within the industry such that they lacked confidence in the ability to set baselines.

Strategy	<ul style="list-style-type: none"> • Against the background of: Foot and Mouth disease outbreak; profound economic impacts; proposed changes to the structure of the industry; the results of an internal review of accident and incident rate data; and the findings of HSE sponsored research into the underlying causes of fatal accidents, the sector has already embarked upon a major revision of the strategic plan which will be completed by the end of 02/03. This will include revised/updated RHS targets and baselines and will provide a more strategic focus, identify new actions and secure greater commitment/contributions from the field and main stakeholders. The overall objective is to secure in the longer term a step change in the culture of the industry. Analysis of fatal accident trends and causation and other behavioural research indicates that different intervention approaches will be needed for the self employed and employed sectors. • The strategy will include: <ul style="list-style-type: none"> - Working with key stakeholders/others who can exert influence. - Extending the knowledge, skills and competencies of those in the industry. - Stimulating action amongst the self-employed and family farms by raising awareness of risk and the practical demonstration of health and safety solutions. - Developing with key stakeholders/OGD's new approaches to eliminating deaths to children/young people. - Deliver a planned, targeted inspection programme and identifying other intervention strategies. - Influencing safety and design for machinery and other equipment. - Promoting OH/rehabilitation provision encouraging take up by the farming community.
Key activities	<ul style="list-style-type: none"> • To build H&S into the agenda of OGD's (principally DEFRA) e.g.: demonstration farms; cross compliance; whole farm plan/audit. • Blitz inspections • Develop a voluntary electronic self-assessment form • Work with key intermediaries to deliver RHS targets • Safety Awareness Day's • Audit inspections • Publicity of priority topics and themes • Occupational health pilot projects • Continue with research and use results to inform this programme.

Stakeholder Engagement	<ul style="list-style-type: none"> • Work with key stakeholders (DEFRA, NFU, TGWU, AEA, CPA and others) to deliver the overall revitalising targets, to identify vulnerable groups, to encourage individual target setting where appropriate and to deliver the developing strategy outlined above. • To encourage key stakeholders to incorporate agricultural H&S into their agendas and plans.
Outcomes, baselines and methodology for progress measurement	<p>Outcomes:</p> <ul style="list-style-type: none"> • Reduction in incidence rate of fatal and major injuries to employees by 5% by 2003/4 • Reduction in the average rate of new assessments of WRMSD per 100,000 employees to 1.0 per 100,000 by 2003/4 • Reduction in the incidence rate of reported major injuries to employees in agriculture to 210 by 2004/5 • Reduction in the number of workplace transport and related fatal and major injuries involving employees by 5% by 2003/4 • Step change in the culture of the industry. <p>Baselines:</p> <ul style="list-style-type: none"> • Fatal accidents average incidence rate for employees between 1997-2000 at 7.3 per 100,000 • Major injury rate for employees 221.8 per 100,000 in 1999-2000 • Number of transport related fatal accidents – 22 in 1999/2000 • Number of child accidents - 4 in 1999/2000 • Average rate of new assessment of WRMSD 1.2 per 100,000 employees in 1999/2000 <p>Methodology for Progress management: Yearly figures on the incidence rate of accidents will help to inform the programme manager how the programme is going. Other indicators could be progress report on delivery of the plan and prioritisation of inputs</p>
Milestones	<ul style="list-style-type: none"> • Publication of revised strategy and revised/updated targets and baselines by March 2003 • Continue with delivery of key activities listed above during 2003/4 • Complete identification of key stakeholders and engagement strategy by April 2003. • Complete the development of the electronic risk assessment project and develop it as a compliance tool for H&S conditionality for grants under the proposed reformed Common Agricultural Policy (CAP) by first quarter of 2004. • Periodic monitoring of progress with delivery of targets/outcome/success indicators

<p>Key risks</p>	<ul style="list-style-type: none"> • Failure to secure adequate political will amongst OGD's/stakeholders • Not having experienced HSE staff in the right place at the right time • No specific priority programme budgets (eg for publicity, research) • In comparison with Construction priority programme there is limited (Chief Inspector) directional / managerial control over field resources • Limited ability to monitor field resource activity • No in-year, accruing incidence rate data to allow regular monitoring of progress towards bottom line (only becomes available some nine months into the following year) • Difficulty to identify surrogate performance indicators (eg swingometer to indicate extent of cultural change) achieved to help proved balanced scorecard.
<p>Evaluation</p>	<p>The parts of the plan selected for evaluation are those that are significant, either because they are new techniques or newly applied in agriculture and evaluation is necessary to decide future use.</p> <p>Topics for evaluation:</p> <ul style="list-style-type: none"> • Overall RHS plan for agriculture • Safety Awareness Days • Blitz Inspections (Construction lead) • H & S Training in Agricultural College • Audit Inspections • Self – assessment forms • Sizes of bags in agriculture • Occupational Health pilot projects • Machinery ring Safety Awareness Days
<p>Report on Progress</p>	<p>Activity in 2001/2 distorted by Foot and Mouth outbreak: reduced activity possibly reflected in the statistics.</p>

Priority programme	Construction
Contributions to achieving the PSA targets	
Strategy	<p>The strategy for delivering the Construction PP recognises that there are a number of factors that are crucial to its successful delivery.</p> <ol style="list-style-type: none"> 1. The targets for improvement in the construction industry will not be achieved unless HSE at large succeeds in delivering the 10-point strategy and 44 action points under RHS as a significant number of them impact directly or indirectly on construction. 2. A strategy that focuses on sites – or on what happens on sites- will not achieve the improvements required in the industry. The key to success will be the targeting of all the key stakeholders, including clients and designers as well as contractors, supported by effective legislation, clear guidance on acceptable standards and a coherent, strategic and comprehensive intervention strategy. 3. All parts of HSE must work together to deliver the improvements we seek, in particular, the RHS Action Points and the PP's for falls from heights, workplace transport, MSD and stress as well as those parts of HSE who regulate construction clients. 4. The strategy is for the wider construction industry, HSE cannot succeed alone: it needs to positively engage and encourage all the stakeholders involved with the industry to play their part. 5. SME's make up some 95% of the industry. Health and safety improvements must be made by this hard to reach group.
Key activities	<ul style="list-style-type: none"> • To deliver the 2002/3 elements of the Construction Intervention Strategy set out in SIM 02/2002 01 & 02, including the contribution from FOD's geographical Divisions • To continue to champion the delivery of the Construction Priority Programme internally and externally through the Strategic Forum, CONIAC and other key intermediaries and stakeholders; reporting progress regularly to Ministers, HSC and others • To meet the Output Performance Measures set out in Appendix 1 of the FOD Planning Guide [can you briefly explain what these targets are] • To contribute to the London pilot and Prosecution Pilot

<p>Stakeholder Engagement</p>	<p>Engagement with the key intermediaries, stakeholders and other enforcing authorities to achieve a cultural change in the industry, in particular to develop an expectation of compliance and continuous improvement that involve partnerships between those who create, manage and are exposed to risk.</p> <p>The intervention strategy will focus on the following stakeholders:</p> <ul style="list-style-type: none"> • Government as a client • CDM duty holders: <ul style="list-style-type: none"> Key clients Key designers Key planning supervisors Designers – the top 50 • SME's and sole traders • Reaching out to workers • Manufacturers • Building occupiers and maintenance safety. <p>The ConPP will be supported by:</p> <ul style="list-style-type: none"> • Working well together initiatives • A communications strategy developed in conjunction with DIAS.
<p>Outcomes, baselines and methodology for progress measurement</p>	<p>Outcomes:</p> <ul style="list-style-type: none"> • A reduction of incidence rate of fatal and major injuries by one third by 2004/05 and by two thirds by 2009/10 • A reduction of incidence rate of cases of work-related ill-health of employees by 20% by 2004/5 and by 50% by 2009/10 • A reduction in number of working days lost per 100,000 workers from work-related injury and ill-health by 20% by the end of 2004/5 and by 50% by 2009/10. <p>Baselines:</p> <ul style="list-style-type: none"> • The industries baselines were announced at the February 2001 Construction Summit. For fatal and major injury injuries a rate of 270 per 100,000 for all workers. • In 1995/6, over 1.2 million working days were lost as a result of work-related ill-health and over 0.6 million as a result of work-related injury, a total of nearly 1.9 million lost days. • However, more work is required to improve the robustness of the data on incidence rates for cases of work related ill health of employees ad the number of days lost. SASD leads in securing this information. This work is essential to both informing targets and evaluation the programmed <p>Methodology for Progress Measurement</p> <ul style="list-style-type: none"> • Risk control indicators when up and running possibly use as lead indicator. • Accidents could be key indicator but with health warning that they are lagged because need data on underreporting before get a measure.

Milestones	
Key risks	<ul style="list-style-type: none"> • An under resourced plan will not deliver i.e if not get extra staff • The quality of RIDDOR, ICC accident data • Failure to deliver on RHS strategic aims and other programmes.
Evaluation	<ul style="list-style-type: none"> • An evaluation protocol/strategy to underpin the ConPP to be developed • This will take account of both the process and the outcomes (impact) and evaluation of the ConPP as a whole, will consist of evaluation of some of the key component parts and by use of some BOMEL influence network so as to capture cultural change through leading indicators. • The evaluations will have two main thrusts: firstly by statistical analysis of RIDDOR and secondly from stakeholders engaged in operational interventions (cross sectional comparison). • Where possible, confounding factors, which may have influenced the outcomes, will be identified and quantified. • It is acknowledged that a full impact assessment may not be appropriate until after 2004.
Report on Progress	

Priority programme	Health Services
Contributions to achieving the PSA targets	<p>The Health Services Priority Programme is heavily directed towards achieving the PSA targets of:</p> <ul style="list-style-type: none"> ▪ Reduction in working days lost from work-related injury and ill health by 15% by 2004 ▪ Reduction in the incidence of major injury accidents by 5% by 2004; and ▪ Reduction in number of cases of work-related ill health by 10% by 2004.
Strategy	<p>The intervention strategy is intended to engage all significant stakeholders, and not just duty holders to maximize outcomes in a resource efficient manner:</p> <ul style="list-style-type: none"> • The 3 Departments of Health and the National Health Services in England, Scotland and Wales through their new and existing programmes to make a substantial contribution to reducing health and safety failures; • Other statutory bodies with inspection/audit functions in health care; • Site contact with larger organisations and other more resource efficient ways with smaller Primary Care Trusts; • The independent care sector through the trade bodies as well as site visits. <p>Concentration on those hazards that give rise to the highest proportions of injury, ill health and resultant working time lost i.e. MSD, stress, violence, asthmagens and slips and trips.</p>

<p>Key activities</p>	<p>Central and Regional initiatives</p> <ul style="list-style-type: none"> • Support the 3 Departments of Health central initiatives to reduce health and safety failures; • to seek new levers within the NHS England following further devolution of control and monitoring functions; • Work with NHS Estates on safety by design and extend to Scotland and Wales, and with Purchasing and Supply Authorities on supply chain initiatives • Continue work with the Care Bodies to promote joined up working and the application of consistent standards • Work with the Trade Bodies in the independent sector to assess baseline data and set action plans to meet targets <p>Inspection of NHS employers and private hospitals</p> <ul style="list-style-type: none"> ▪ Assess risk management systems for control of MSD, violence, slips and trips, stress, glutaraldehyde and latex
<p>Stakeholder Engagement</p>	<p>Key stakeholders are:</p> <ol style="list-style-type: none"> 1 Department of Health 2 Scottish Executive 3 National Assembly of Wales 4 Individual NHS trusts 5 Professional bodies & Trade Unions <ul style="list-style-type: none"> ▪ The HSIP will be publicised jointly by HSU and DIAS in line with the DIAS Health Services PP Communication Strategy. Health services TUs on HSAC have offered to provide advance publicity to their members. ▪ high level meetings with Health Department officials to ensure commitment to RHS and SH2 ▪ operational support at B2 & B3 level for Health Department/NHS initiatives ▪ contact to all CEs by appropriate high level within HSE e.g. by letter and individually at inspections ▪ meet TU organisations via HSAC to gain commitment to RHS and SH2 and their engagement in PP planning process and evaluation; ▪ Opportunities involving journal articles and other media will be maximised by the Sector/ operational teams during the course of the plan, and this will include publicity for new or revised HSAC guidance.

<p>Outcomes, baselines and methodology for progress measurement</p>	<p>Outcomes: To secure effective risk control systems for MSD; Reduction in incidence of major and over 3 days accidents and measurable reduction in RIDDOR reportables; To ensure a coordinated strategy for H&S in the devolved bodies;</p> <p>Baselines: Determination of baseline data is beset with difficulties arising from underreporting under RIDDOR, the variable willingness of employers to self-report data voluntarily to their NHS, and the factors described in the Labour Force Survey and the Self-reported Work-related Illness survey. HSE intends to use four sources of data as a baseline measures to try and even out inaccuracies.</p> <ol style="list-style-type: none"> 1. The Labour Force Survey 1998/9 (LFS) gives an incident rate for non-fatal injuries of 1570/100k employed, which includes employed and self-employed for health and social work. The Labour Force Survey calculates that health and related workers are 2.1 times more at risk of injury than clerical workers; Figures are not given for health care alone. Ill-health data will be available early 2002. 2. Rate of self reported work-related illness (SWI) is 6.6% compared to an average of 4.7% for all industries. Nursing was amongst the occupations with the highest reported rate of MSD: approx 5.8% compared to an average of 2.5% 3 HSE receives around 12,000 reports annually of injury and ill health to workers. Incidence rates 5-year average is 805 per 100k employed. Around 1900 accidents to MOPs are reported to HSE each year with 28 being fatal 4 Data collected by the three health services is being used internally by them as a baseline for initiatives to reduce accident and ill-health levels. <p>Methodology for progress management</p> <ul style="list-style-type: none"> • Progress indicator could be the number of cases of MSD's reported as this is felt to be the most reliable indicator
<p>Milestones</p>	<p>Intermediate targets were agreed centrally: Trusts need to adopt these independently.</p>

Key risks	<ul style="list-style-type: none"> • The changing structure of the NHS. It is being planned to move from a centrally run set-up to a more devolved one with NHS trusts who gain three stars being responsible for their own money/ initiatives/ priorities as Foundation Trusts; • The changing structure could cause difficulties in targeting all the trusts with the same message; • If the new structure goes ahead it will bring about a need for a new strategy for the HSPP in England; • What the National Audit Office report on..... says
Evaluation	<ul style="list-style-type: none"> • Evaluation will be carried out on both the process and the outcomes (impact). Evaluation of the plan will consist of evaluation of some of the key component parts. • The evaluation will have two main thrusts: firstly by statistical analysis of impact of RIDDOR, DoH accident and ill-health data; LFS and SWI (experimental technique) and secondly from stakeholders engaged in operational interventions (cross-sectional comparison). • Where possible confounding factors, which may have influenced the outcomes will be identified and quantified.
Report on Progress	<ul style="list-style-type: none"> • In the first 12 months of the programme there has been a reduction in RIDDOR reported MSD injuries of 4.25% • Shirley to add some more headlines here if we have them ▪ Interventions at senior level with Departments of Health in Wales and Scotland have been successful in securing commitment to meeting the objectives of RHS, and providing impetus to internal initiatives; ▪ Work with central NHS organisations in England is generating outcomes to improve supply chain involvement; ▪ Planned inspections of NHS and independent sector organisations have been carried out with increased numbers of enforcement notices being served on MSD, indicating concentration of effort on HSC priorities; ▪ The incidence rate and number of RIDDOR reported incidents continue to show steady decline

Priority programme	Work Related Stress
Contributions to achieving the PSA targets	<ul style="list-style-type: none"> • No targets have been set for 2004 as the stress programme relies on long term achievement of targets in 2010. • It is expected that numbers of cases will initially increase as awareness grows and individuals become less reticent in concealing the nature of this illness.
Strategy	<ul style="list-style-type: none"> • Conduct a publicity drive to inform employers about what they can already be doing to prevent work-related stress. • Develop standards of good management practice for preventing a range of stressors; • Better equip enforcement officers to be able to handle the issue routinely; • Encourage a more comprehensive approach to preventing work-related stress;
Key activities	<ul style="list-style-type: none"> • Working with stakeholders to develop the Management standards • Developing baselines • Identifying and developing effective interventions • Promoting guidance and best practice
Stakeholder Engagement	<ul style="list-style-type: none"> • Working closely with businesses who volunteer to pilot the Management standards to monitor, record and evaluate experiences. • Engaging with other Priority Programmes where there are synergies and mutual interest • Using the Government High Level Forum network to promote improvements in stress management across Government. • Develop and use links with Local Authorities and NHS Trusts to ensure effective sector coverage. • Promote awareness and best practice through company Human Resource channels. • Develop Stress web pages on HSE and HELA websites to engage and widen audience, encouraging the sharing of best practice. • Encourage the development of stress partnerships and stress clubs • Promote and support effective networking of technical specialists to anticipate and respond to technical challenges.

<p>Outcomes, baselines and methodology for progress measurement</p>	<p>Outcomes:</p> <ul style="list-style-type: none"> a. a reduction in the incidence of work-related stress-related illness of 20% by 2010 b. a reduction in the number of working days lost from work-related stress of 30% by 2010 c. a significant proportion (to be specified) of employers complying with management standards on stress by 2010 d. a significant reduction in levels of exposure to key stressors (to be specified) (including the number of people exposed) by 2010. • Awareness of the issue of stress should increase the number of cases reported. <p>Baselines and progress measures: To achieve a reduction by 2010 of 20% in the incidence of work related stress; and to reduce the number of working days lost from work related stress by 30%</p> <p>Progress Measurement: Management information required to see if the programme is on course is:</p> <ul style="list-style-type: none"> • The evaluation of the management standards pilot • The number of people voluntarily taking up the guidance.
<p>Milestones</p>	<ul style="list-style-type: none"> • Consultation on first phase of Management standards August 2002 • Pilots of first phase Management standards begin end 2002 • Qualitative evaluation on guidance published in 2001 completed end 2003 • Evaluation of fist phase of pilots early 2004 • Training materials for managers of health and safety representatives on how to carry out stress risk assessments published on web site by end September 2002 • Focus on work related stress on European Week of Health and Safety 2002, highlighting the practical action that managers can take. • Consultation on second phase of Management standards • Pilots of second phase of Management standards • Evaluation of second phase of Management standards

Key risks	<ul style="list-style-type: none">• External Stakeholders disrupt the execution of this plan because its outputs are unfavorable to their preferred outcome• Key opinion formers, single issue groups and pressure groups hijack plan for their own ends or use spoiling tactics to cause reactive work, e.g. through the media.• Delays through the need for iteration in decision making to allow stakeholders' anxieties or uncertainties to be explored.• Changes in knowledge negate the approach being taken• Inadequate resources through:<ul style="list-style-type: none">(a) lack of staff(b) insufficient priority devoted compared to other issues(c) Staff across the organisation not sufficiently skilled• Insufficient attention paid to management of change in HSE• Internal stakeholders unable to deliver outputs to time and quality• Work to improve access to occupational health support and to develop a framework for effective rehabilitation not progressed adequately
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<p>Evaluation</p>	<p>Following HSE guidance. Evaluation will fall into two main blocks:</p> <ul style="list-style-type: none"> (i) work to evaluate the success of the programme against the Outcomes; and (ii) specific key elements of the programme <p>Evaluation against outcomes a and b will take place through already planned projects to measure the incidence of work-related ill health and its impact on sickness absence. It is expected that, as we are successful in raising awareness, the number of cases of stress reported will initially increase.</p> <p>Evaluation against outcome (c) will be by means of a specially commissioned research project at an estimated cost of £100k. A baseline will be set for this evaluation when the first phase management standards are drafted, and will be repeated at approximately 2-year intervals.</p> <p>Evaluation against outcome (d) will be by means of a repeat of elements of the survey carried out for Contract Research Report (CRR) 265 at an estimated cost of £100k. CRR265 will form the baseline for the evaluation.</p> <p>The criteria for selecting key elements for evaluation will be:</p> <ul style="list-style-type: none"> • business need • practicability • reasonable cost <p>The key elements of the programme selected for evaluation are:</p> <ul style="list-style-type: none"> • compliance: management standards • knowledge: research portfolio • skills: revised guidance for inspectors • support: the publicity drive (baseline already established - see CRR 322)
<p>Report on Progress</p>	<p>Programme established to deliver targets in 2010</p> <p>First consultation on draft Management standard undertaken with stakeholders August 2002. Training materials for managers available on web site with effect from the end of September 2002</p> <p>Second draft of framework of management standard and development of stress climate tool available November 2002.</p>

Priority programme	Musculoskeletal Disorders (MSD)
Contributions to achieving the PSA targets	<p>The contribution of the MSD priority programme to the overall targets can only be properly assessed once the statistical methodology for the target assessment has been determined. However as a working assumption it will be reasonable to use the following figures based on SWI data.</p> <p>Incidence: the MSD priority programme's target for a 12% fall in the incidence of MSD's by 2004 would reduce the overall incidence of work-related illness by around half the PSA target reduction of 10%. This includes MSD cases falling within the sector priority programmes.</p> <p>Days lost: the MSD programme's targeted fall of 15% in the number of working days lost due to MSD's by 2004, would also reduce the overall working days lost due to work-related illness by around half the PSA target reduction of 15%. Again, this includes MSD cases falling within the sector priority programmes.</p>
Strategy	<ul style="list-style-type: none"> • To stop people being made ill by work. Where people do get ill (because not all MSD's can be prevented) to help to get them back to work as quickly as possible. • To be achieved by promoting a holistic approach involving all stakeholders through partnership working and extending across all five elements of Securing Health Together: Compliance, Continuous Improvement, Skills, Knowledge and Support
Key activities	<ul style="list-style-type: none"> • Manage the MSD PP by ensuring products/projects in the programme, most of which are the responsibility of other Divisions/Directorates are delivered. • Continue to target inspection and enforcement activities where there is significant MSD risk. • To aid the above produce a practical workplace manual handling assessment tool to identify hazardous operations and ensure compliance. • Continue to promote a holistic approach to better workplace and clinical management of acute MSD, including sector based ergonomic intervention programmes. • Total revision and republication of Display Screen Equipment (DSE) guidance. • Formulate, manage and monitor a revised MSD research agenda supporting this priority issue and based on a revised MSD research strategy.

Stakeholder Engagement	<ul style="list-style-type: none">• Working with Department of Health, and Scottish and Welsh equivalents, to promote and demonstrate the partnership and holistic approach to tackling MSD.• Engaging with TUC and TU's to encourage worker involvement in ergonomic interventions.• Encouraging trade associations and employer bodies to set sector targets and initiate interventions.• Continue to develop working relationships with relevant voluntary sector and professional organisations, e.g. Backcare and Ergonomics Society, to promulgate the strategy and key messages of the programme.• Developing MSD web pages on HSE and HELA websites to reach a wider audience with our messages.• Exploring opportunities for partnership working with others with a common interest e.g. BUPA
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<p>Outcomes, baselines and methodology for progress measurement</p>	<p>Outcomes:</p> <ul style="list-style-type: none"> • Reduce the incidence rate of work related MSD (WRMSD) by 12% by 2004, on current figures this means around 22,000 fewer new cases of WRMSD in 2004 than now. • Reduce the number of working days lost per 100,000 workers due to WRMSD by 15% by 2004, on current figures this means around 1.5 million fewer days lost by 2004 than now. <p>But also:</p> <ul style="list-style-type: none"> • A significant reduction in manual handling accidents • A significant increase in employers complying with guidance on Manual Handling Operations (MHO) and DSE Regulations. • A significant increase in the proportion of individuals who receive appropriate early clinical management of their symptoms. • A significant increase in the numbers of duty holders, employees and stakeholders aware of MSD and how to prevent and manage them. • An active, forward looking and joined up revised research agenda addressing the current priority issues. <p>Baselines:</p> <ul style="list-style-type: none"> • In a year an estimated 1.2 million people in Great Britain suffer from WRMSD • This is nearly 60% of all individuals reporting work related ill health, an estimated 180,000 new cases per year. • In a year 9.9 million working days lost as a result of WRMSD <p>Progress Measurement:</p> <ul style="list-style-type: none"> • FOD inspection data showing improvements in average risk control indicator ratings. • Increase in the number of LA's signed up to the DSE Forum • More trade associations and employer's bodies setting MSD targets and implementing sector based initiatives • Sustainability and take up of 'Back in Work' outputs.
<p>Milestones</p>	<ul style="list-style-type: none"> • The improvement of the management of MSD by applying and reviewing a new inspection approach to HSE enforced activities. • The improvement in the level of compliance with the DSE Regulations by promoting revised guidance. • The widespread implementation of revised guidance on the prevention and management of work related upper limb disorders (WRULD). • The dissemination of the results and the lessons learned from 'Back in Work' and other holistic approach initiatives to as many stakeholders as possible.

Key risks	<ul style="list-style-type: none"> • A skills shortage both internally and externally – of people capable of undertaking workplace risk assessments and identifying solutions, and health professionals skilled in rehabilitation. • Failure by D/D to ensure that sufficient resources, especially staff are effectively deployed to priority programme projects/products • The work to increase occupational health support and establish a framework for rehabilitation does not progress satisfactorily.
Evaluation	<p>The priority programme comprises an eclectic mixture of large and small projects, which is still undergoing development. To obtain relevant and reliable information, it is proposed to be selective and concentrate the evaluation effort on the most significant and measurable activities.</p> <p>Evaluate:</p> <ul style="list-style-type: none"> • Programme of visits by FOD. • Evaluation of regulations, guidance and publications. • Number of firms achieving minimum score in inspection rating. • Number of GP's aware of appropriate early management of cases. • Effectiveness of publications. • Cross reference to evaluation of OHAC programme on improved access to occupational health support.
Report on Progress	<p>The priority programme is currently well on course to achieve its targets:</p> <ul style="list-style-type: none"> • manual handling injuries are being reduced as a result of increased enforcement activities; • sector based initiatives are being established, e.g. by the Corrugated Packaging Association and NHS; • research into MSD risks in cleaning tasks has raised the profile of the ergonomic problems, cleaners encounter and resulted in best practice guidance being published; • increased numbers of inspectors being trained in ergonomic enforcement; and • improved guidance on managing WRULD and handling in the home environment has provided stakeholders with increased support.

Priority programme	Workplace Transport
Contributions to achieving the PSA targets	We cannot answer this question until sometime after 10 th September
Strategy	<ul style="list-style-type: none"> Once the discussion document has been commented on, the programme board will decide which way to take the programme [10.09.02]
Key activities	<ul style="list-style-type: none"> Development of CD Rom on workplace transport scenarios Development of websites looking at workplace transport incidents Discussion document on preventing workplace transport accidents, analyse comments and put proposals to commission. FOD visits concentrating on: <ul style="list-style-type: none"> Segregation of pedestrians from vehicles Minimising and controlling reversing Management systems
Stakeholder Engagement	<ul style="list-style-type: none"> Continuing development of external stakeholder action group Use external stakeholder action group to test proposals from Discussion Document analysis Final conference held to share proposals from Discussion Document with external stakeholders
Outcomes, baselines and methodology for progress measurement	<p>Outcomes: To be decided after the 10th September</p> <p>Baselines: To be determined</p> <p>Progress Measurement:</p> <ul style="list-style-type: none"> As each individual project is developed then they will have their own success indicators
Milestones	To be agreed
Key risks	<ul style="list-style-type: none"> Moratorium on research Increased reporting of accidents will need to be taken in to account when the figures are analysed against the PSA and RHS targets. This is an innovative programme and therefore is unpredictable Lack of control over work done by other areas of FOD/HSE
Evaluation	Indicators developed for key activities
Report on Progress	

Priority programme	Falls from Height
Contributions to achieving the PSA targets	The FfH programme aims to achieve a 5% reduction in deaths and major injuries from falls from heights by 2004, and a 10% reduction by 2010, in line with the overall Revitalising targets.
Strategy	<p>The Strategy can be summarised briefly below:</p> <ul style="list-style-type: none"> • Stage 1 – gain a better understanding of the problem • Stage 2 – Consider options for tackling the problem; and <ul style="list-style-type: none"> - devise targeted approaches for tackling it; and - test those approaches for effectiveness and cost effectiveness • Stage 3 – devise a method for replicating the successful approaches and embedding them into industry culture and HSE methods.
Key activities	<ul style="list-style-type: none"> • FOD SU's targeted inspection regime will allow for over 60,000 proactive site visits per year to assess performance in addressing this and the other priority hazards in the workplace. Our inspectors will be looking for examples of good practice as well as bad and we will ensure that these good experiences are shared. <p>Activities will be developed on the basis of where the greatest number of falls occur, whether by occupation, activity, agent or economic sector. These are likely to include:-</p> <ul style="list-style-type: none"> • Stairs - apparently the agent of a large number of falls accidents (major injuries rather than fatalities). • Ladders - still one of the major causes of falls, especially high falls. • Maintenance Fitters/Electrical fitters - appear regularly in falls statistics in several sectors. • Engineering/metal/shipbuilding industries - high incidence of falls • Education - surprisingly high numbers of falls in this sector. Accident reports indicate some failures of risk assessment/inappropriate activities by teachers. Require more information on incidence rates - also higher levels of reporting likely than in private sector. • Food industry - several areas within this sector (e.g. bakery) apparently have high numbers of falls • Falls from Vehicles - another major cause of falls in all industries with the drivers apparently being the main victims. <p>These and other activities will continue to be developed during Stage 2 of the Strategy.</p>

<p>Stakeholder Engagement</p>	<ul style="list-style-type: none"> • We shall need to be aware of and work together with other relevant HSE programmes • We will want to develop/ make use of existing links with local authorities to ensure that we include coverage of this sector on the programme. • We need to ensure that all stakeholders are identified and are brought in to what we are doing, relevant OGD's, manufacturers and suppliers of equipment used to facilitate work at height, designers and overlap with the construction PP. • Explore possible opportunities for 'piggy-backing' on campaigns that stakeholders may be undertaking and vice versa.
<p>Outcomes, baselines and methodology for progress measurement</p>	<p>Outcomes:</p> <p>Baselines:</p> <ul style="list-style-type: none"> • On average 80 workers are killed and over 5000 seriously injured each year as a result of falls from height at work. • Alongside Stage 1 work to analyse the data, we need to draw together information from other sources. This may include an even more detailed analysis of RIDDOR and FOCUS data. This could be undertaken by BOMEL as part of their ongoing research project on falls from height. We might also want to use HSL in the future to look at other data in this way. The conclusions of this work should enable the Programme board to clarify the baselines against which the effectiveness of the Programme can be judged. <p>Methodology for progress measurement:</p> <ul style="list-style-type: none"> • Success indicators will be set for each individual project.

<p>Milestones</p>	<p>Milestones for 2001 – 2002</p> <ul style="list-style-type: none"> • The number of targeted inspection visits, and associated enforcement action, exceeded that planned for the year • This work across all FOD enforced sectors aims to deliver a 5% reduction in the incidence rate of fatal and major incidents caused by falls from height by 2004. 10% reduction by 2010. • . • Research was commissioned to look at: recidivist risk takers working at height, designing in safe access for maintenance and repair work at height, the effectiveness of ladder stability devices, the selection and use of fall prevention/protection methods, the effectiveness of prevention and risk control measures for work at height and an evaluation of the use of safety nets.. <p>2002-03</p> <ul style="list-style-type: none"> • Targeted inspection programme put in place for chemicals and offshore industries. • Research projects (above) to be completed and results used to inform further targeted activity. • Progress towards implementation of the Temporary Work at Height Directive.
<p>Key risks</p>	<ul style="list-style-type: none"> • Number of staff working on the PP • Control over the work done by other PPs and areas of FOD • Due to awareness raising of the need to report accidents there has been an increase in figures – will this be factored into the PSA targets and RHS targets when the figures are calculated. • This is an innovative programme and therefore risky. • Reduction in funding for research • Changed strategic priorities for HSC/Ministers

<p>Evaluation</p>	<ul style="list-style-type: none"> • Evaluation of the Programme will be an iterative process within the evaluation of the overall Revitalising initiative planned with IES. It should not be necessary to evaluate each and every activity within the Programme – only those which are deemed to be of major importance or where there is a specific need to learn and to disseminate or replicate the lessons. • A need to establish the division of responsibilities for the evaluation of the various aspects of the Programme which fall to other parts of HSE (e.g. FOD, DIAS) to deliver. Our preference from SPD, not least because it may need to be coordinated with a review of other Programme activities. • The Programme will lack authority unless it faces a rigorous and plausible evaluation of its success, failure or otherwise. The evaluation plan should allow clarification that the Programme is achieving its aim and should allow, if necessary, for reprioritisation of activity and an update or modification of ongoing targets.
<p>Report on Progress</p>	

Priority programme	Slips and Trips
Contributions to achieving the PSA targets	Delivery will contribute: <ul style="list-style-type: none"> • 32% reduction of the fatal/major injury national targets, and half by 2004; • prevention of slips and trips will also contribute to national target for reducing the number of working days lost.
Strategy	To stop people being injured at work.To be achieved by: <ul style="list-style-type: none"> • furthering the understanding of the causes of slips and trips by promoting the simple measures that control risks; • changing attitudes so slips and trips are perceived as a serious issue.
Key activities	<ul style="list-style-type: none"> • management of the slips and trips PP, ensuring all products are delivered on time; • evaluation of critical activities in order to measure the performance and obtain evidence of what works; • make tools available in order to promote a simple and practical approach for controlling the risks of slips and trips; • to encourage and foster a culture that takes slips and trips seriously so that targets are set and action is taken by stakeholders to go beyond compliance.
Stakeholder Engagement	<ul style="list-style-type: none"> • Communication strategy – promulgating the 3 key messages; • Stakeholder analysis for changing attitudes and influencing positive action; • Development of Slips and Trips websites on HSE and HELA websites; • Speaking at conferences etc • Taking opportunities of partnership working with those who can provide levers for achieving the targets and influencing action e.g. with the supermarkets health and safety liaison group and through Revitalising the Lead Authority Partnership Scheme (LAPS).
Outcomes, baselines and methodology for progress measurement	<p>Outcomes:</p> <ul style="list-style-type: none"> • 5 % reduction by 2004 in fatal and major injuries • 10% reduction in all slip and trip incidents by 2010. <p>Baselines</p> <p>Slips and trips account for (1999 – 2000):</p> <ul style="list-style-type: none"> • over 9,087 major injuries to employees each year – 32 % of the total reported; • 27,615 over 3 day injuries to employees – 21 % of the total; • an average of 2 fatalities each year. <p>In the LA enforced sector slips and trips account for (1999 – 2000 (prov)):</p> <ul style="list-style-type: none"> • over 2000 (42%) of major injuries to employees; • 5800 (23%) over 3 day injuries to employees. <p>Progress measurement/indicators</p>

	<ul style="list-style-type: none"> • reportable fatalities/major and over 3 day injuries; • lead indicators could possibly be derived from the FOD inspection returns such as % of organizations that get the rating of 4 v % of organizations in 2004 that get a rating of 4 (poor performers); • no of stakeholders who have set targets and taken action.
Milestones	To be defined
Key risks	<ul style="list-style-type: none"> • planning systems and statistical and research intelligence hinder effective high-level decision making; • inadequate steering arrangement for directing the PP; • no mechanisms for managing/co-ordinating what others areas of HSE and LAs are doing in relation to delivering the slips and trips; • internal under resourcing of PP to deliver the strategy and key outcomes (including research, communication and evaluation); • lack of specific knowledge/expertise of HSE/LA inspectors.
Evaluation	<p>The PP comprises a mixture of small and large projects which are undergoing development. To obtain relevant and reliable evidence, it is proposed to be selective and concentrate the evaluation effort on the most significant and measurable activities e.g.:</p> <ul style="list-style-type: none"> • Establish baseline on culture and attitudes; and working days lost; • Programme of targeted visits by FOD; • Road shows and seminars.
Report on Progress	<ul style="list-style-type: none"> • Programme being revisited to inject clarity of what is critical for delivering the targets, filling any essential gaps; • New FOD inspection system encouraging inspectors to look at slips and trips. • Quarterly exception reports.

Programme	Improving health and safety in the civil service
Contributions to achieving the PSA targets	[Estimate based on total civil service staff numbers against RHS targets]
Strategy	Engage OGDs as employers to improve health and safety for their employees; Engage OGDs as those contracting work, procuring services and giving grants to lead in good practice.
Key activities	Monitoring targeting setting and reporting H&S; Monitoring use of Ministerial checklist and Good Practice Guidance; Work on identified key areas for lost time (possible topics – stress, violence, road traffic accidents).
Stakeholder Engagement	High Level Forum, Policy Sub-group and OH Sub-group work and meetings.
Outcomes, baselines and methodology for progress measurement	Outcomes: reductions in incidents reported and staff absence due to work related ill health and injury. Baselines from Cabinet Office records or individual departments? (possible under reporting). Measurement: annual statistics; against success indicators agreed for individual projects.
Milestones	Annual reporting of H&S Milestones to be agreed for individual initiatives.
Key risks	Lack of engagement (and hence priority) by Ministers, Cabinet Office and HM Treasury. Lack of importance within departmental agendas – no impetus for using good practice guidance; downgrading of representation at HLF. “HSE will do it for us” attitude.
Evaluation	Reduction in time lost and incidents reported year on year; evaluation of effectiveness of other initiatives to be agreed.
Report on Progress	Ministerial checklist and Good Practice Guidance issued; Gov depts. challenged to set targets and report H&S annually. [Future work to be agreed – next meeting of HLF 26 September 2002]

Programme	Stakeholder engagement
Contributions to achieving the PSA targets	Essential part of meeting targets – difficult to quantify as separate activity
Strategy	Tackle newly identified key stakeholders which are <ul style="list-style-type: none"> • Insurance and financial bodies • Top companies • Investors • Those relevant to specific programmes eg drug companies for MSDs ?
Key activities	Continue but review value of current stakeholder contact leading to new ways of working egs IACs, TUs, CBI etc, Trade Associations (follow up stakeholder workshop outcomes). Identify government agendas on which HSE could “piggyback” h&s promotion. Engage govt. depts (High Level Forum) Review media relations and how to make more effective. Insurance and other financial agendas. Partnership initiatives from the Top 350 approach. LA engagement Ways of engaging SMEs
Stakeholder Engagement	Grab any opportunities – watch exploitation by stakeholders (use of valuable time) Co-ordination of activity across HSE to achieve maximum impact.
Outcomes, baselines and methodology for progress measurement	Integral part of meeting all targets – no direct causal link – success by implication if figures reduce. Baselines: as RHS targets. Methodology: need to use surrogates ie milestones and evaluation of particular activities.
Milestones	Identified for each activity eg Top 350 reporting health and safety.
Key risks	Health and safety continues to be seen as a side/non-core issue to business success and a “bad news” story for the press. Little co-ordination of effort – too many approaches with disparate messages. Lack of resources “Too nice” don’t take difficult (hard) decisions Change/distortion of agendas by eg single issue pressure groups Effective operation of proposed HSE Strategy Unit.
Evaluation	Figures reducing; evaluation of surrogates related to specific activities.

Report on Progress	A variety of methods tried with varied degrees of success eg some industry sectors have agreed targets. Continued difficulty in engaging SMEs. Need to follow up outcomes of stakeholder workshop.
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Programme	Internal Communications Strategy
Contributions to achieving the PSA targets	[important to get buy-in from all HSE staff to help achieve the targets – but can we measure it?]
Strategy	To raise the awareness of HSE staff to the need for delivery of the PSA targets (50% of RHS target) by 2004, that Kate Timms is accountable and, linked to the Change Programme, the impact this will have on the way HSE's work and resource allocation are prioritised
Key activities	Baseline survey General awareness raising messages to all staff and key groups; reinforced at key times eg publication of statistics for 2001/02, publication of HSE H&S Report. Articles for express and management briefing as opportunities arise.
Stakeholder Engagement	Target group: HSE staff
Outcomes, baselines and methodology for progress measurement	Outcome: staff commitment to making PSA Target delivery HSE's top priority Baseline: level of awareness of PSA commitment Measurement: surveys of change in attitude to targets over time. Other surrogates – willingness of field inspectors to complete revised inspection form fully for each visit.
Milestones	Timing agreed for messages to staff.
Key risks	HSE does not implement change programme fully. Failure of HSE to operate as though PSA targets are priority. Lack of commitment by senior staff who have the power eg over resources to give priority programmes etc first call on resources. Staff believe "RHS is yet another HSE initiative; something new will come next year"
Evaluation	Inspection returns achieve potential value. Reporting of incidents to HSE staff truly reflect incidence.
Report on Progress	Action taken so far is not believed to have engaged commitment of staff (heresay evidence only)

RISKS LOG (RHS Team and Priority Programme Teams)	
1. Do not deliver the targets	H
2. Inability to get intelligence soon enough	H
3. New Ministers; new priorities or change in policy/policy direction. [DWP strategic review of HSC/E priorities]	H
4. Huge incident therefore fire fighting/distraction/ministerial interest	M
5. Resources not allocated to PSA especially the Priority Programmes – skilled, experienced, knowledgeable staff available in right place at right time	H
6. Lack of communication (understanding ownership/ buy in) with staff	H
7. Stakeholders not encouraged/not doing	H
8. Inspectors driven by outputs – to achieve specified number of contacts, for instance	H
9. Not focussed on 2004; doubt about target period.	H
10. No real external agreement to priorities	M
11. Don't achieve PP targets, particularly slips & trips and MSD which are likely to make major contributions.	H
12. Big gap between targets and achievement if do not achieve PP targets	H
13. No money for evaluation/research/publicity	H
14. Poor monitoring/statistics; lack of adequate indicators; lack of baseline data.	H
15. LA sector not on board or have inadequate resources to deliver	H
16. No HSE delivery mechanism for PSA targets	H