Health and Safety Executive Board			HSE/12/19
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IMPROVING HEALTH AND SAFETY IN THE HEALTH AND SOCIAL CARE SECTORS

Purpose

1. The Board previously discussed a paper 'Improving health and safety performance in the health and social care sectors – next steps?' The Board requested a revised intervention strategy that:

- provided a model for effective stakeholder and co-regulator engagement;
- ensured that commissioning for safe services played a major part;
- considered what work in these sectors could be delivered through current mobilised or additional resources; and
- covered both employee and patient and service user safety.

2 Since the 'next steps' paper was presented, much has happened that has introduced uncertainties and made producing and progressing the revised strategy, as originally envisaged, difficult. This paper:

- sets out what we think we can realistically do, given the present uncertainties;
- touches upon what more we could do, dependent on resource, once regulation of patient and service user safety is clarified, and;
- seeks Board endorsement for our current approach.

Background

Uncertainties

3 Factors that have, or could lead to change in these sectors include:

- The Mid Staffordshire NHS Foundation Trust Public Inquiry (Mid Staffs. Inquiry) and the government's response to its recommendations, which may significantly change the patient and service regulatory landscape in England.
- The Vale of Leven Hospital Inquiry, into a major Clostridium Difficile outbreak, which may affect HSE's involvement in infection control and healthcare more widely – especially in Scotland.

- Legislation changing the way health and social care services are commissioned in England, with the establishment of a NHS Commissioning Board and clinical commissioning consortia.

4 Factors that affect our approach include:

- The 2010 spending review, which has resulted in major, and ongoing, restructuring of many of the stakeholders we need to influence;
- The DWP Paper 'Good Health and Safety, Good for Everyone' (GHSGFE), which states that proactive inspection in health and social care is 'unlikely to be effective and is not proposed'. Our approach recognises that alternative and more effective approaches are therefore needed;
- Increasing delivery of social care in domestic settings; and
- the devolution of health and social care, resulting in different approaches to, for example, commissioning and regulation across GB.

Health and Social Care sectors - structure, size, accident and enforcement data

5 These sectors employ more than 12% of the GB workforce. The way services are commissioned, delivered and regulated is changing. This includes an increase in personalised budgets[1]; the abolition of Strategic Health Authorities and Primary Care Trusts in England; and major changes in Scotland and Wales.

6 Analysis of 2010/11 data showed that:

- 4.7 million working days were lost due to work related ill health or injury. This equates to 1.6 days per worker – higher than any other sector;
- almost 90% of the lost days were due to ill health, with rates of stress in particular being significantly higher than the all industry average;
- approximately 52% of all reported injuries to workers involving physical assault occurred in these sectors;
- approximately 46% of all EPIDERM reported cases of dermatitis were to workers[2] in these sectors; and
- there were 37 deaths to non-workers, with an average of 39 reportable deaths a year over the last five years.

7 The majority of unexpected deaths to patients and service users are not reportable, because they happen whilst the person is under 'medical supervision'. The National Patient Safety Agency estimates that there are around 3000 'serious untoward incident'[3] deaths a year, the vast majority of which are not reportable.

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[1] A personal health budget allows people to have more choice, flexibility and control over the health services and care they receive. At the heart of a personal health budget is a care plan, the agreement between the primary care trust and the individual that sets out the person's health needs, the amount of money available to meet those needs and how this money will be spent.

[2] According to EPIDERM data there were an average of 801 cases reported to dermatologists per year between 2008-10. 368 of these were in health and social care.

[3] Definition of a serious untoward incident requiring investigation can be found in the NPSA publication - National Framework for Reporting and Learning from Serious Incidents Requiring Investigation. Found at http://www.nrls.npsa.nhs.uk/resources/?entryid45=75173

Annex 1 describes our policy on investigating deaths, which includes investigation of some deaths that are work related, but not reportable.

8 In 2010/11p, these sectors accounted for:

- 306 enforcement notices, approximately two thirds of which were in social care. This represents 2.8% of all notices issued by HSE.

- 21 prosecutions (2.3% of the total prosecutions taken across HSE). Many of the prosecutions were high profile, attracting major fines.

9 Common areas for enforcement include: control of Legionella, bedrail safety, asbestos, hazardous substances, violence and aggression, moving and handling of people, lifting equipment, scalding and falls from windows.

Argument

Strategy

10 The health and social care sector strategy is a part of the broader Public Services Sector strategy. The strategy and HSE's intervention plan for these sectors have had wide internal consultation. Formal external consultation on the specific plans has not yet taken place, although most of our key stakeholders have been engaged bilaterally and are aware of, and understand, our proposed approach. The plans acknowledge the uncertainties, as described in paragraph 3, and make it clear that they are subject to change. The key features of the plans are summarised in Annex 2.

11 Our strategy, and consequently the intervention plans, follow the same rationale. Specifically that most accidents and ill health arise from a lack of knowledge of widely recognised minimum standards, or failure to implement them. The strategy recognises the importance of securing competence and good leadership in preventing failures. It also recognises the importance of working with our co-regulators and key stakeholders, including worker representative bodies.

Intervention plans

12 Our plans seek to secure improvement in competence and leadership and consequential decreases in accidents and ill health. Key work-streams, described in the plans, include:

- Providing information via our website and published guidance; and where necessary establishing, with others, appropriate standards.

- Providing guidance for employee health and safety in healthcare, via standards published jointly with the Partnership for Occupational Safety and Health in Healthcare (POSHH).

- The intention to improve leadership by providing a series of events, ideally run jointly with our co-regulators, and targeted at chief executives and boards. Board support for these events would be very well received.

- Developing the 'lead inspector' scheme in independent health and social care, where influencing a relatively small number of large providers should have significant impact.

- Using targeted interventions where intelligence indicates evidence of poor performance.

13 HSE will continue to investigate fatal and very serious accidents to employees and members of the public, in accordance with our published policies and procedures. Where these indicate widespread failure in management or leadership, we will consider wider interventions with the duty holder.

Work with co-regulators on patient and service user safety

14 We are not the only regulator in these sectors. There is overlap with others[4] and a considerable amount of work is ongoing, to clarify our respective roles and responsibilities.

15 However as well as overlap, there are regulatory gaps in the current framework. For example, in England CQC do not currently have powers to prosecute following patient or service user deaths, even where these arise from clear failures to meet appropriate standards. HSE has provided a clear policy and guidance in terms of what it will and will not investigate in this area. This is referred to in Annex 1.

16 In its evidence to the Mid Staffs. Inquiry, HSE acknowledged the regulatory gap; and that this is unsatisfactory. The solution lies either in giving more comprehensive powers of prosecution to CQC and HSE withdrawing from this area, or in HSE clearly being given the responsibility for prosecutions across a much wider range of health and social care activities. The latter option would inevitably result in a substantial increase in the number of complex investigations and prosecutions that would fall to HSE.

17 We are currently working with CQC on an agreement on information sharing and associated training to help ensure we receive early notification about appropriate patient or service user incidents.

18 Despite the uncertainties, we have continued to work with regulators in the devolved administrations and have provided some training for them. All parties are keen to develop further working arrangements.

19 There is also a bank of technical knowledge and services available from within the Health and Safety Laboratory (HSL), which may also be of benefit to our co-regulators.

Commissioning

20. The Board raised commissioning as a potential lever for securing improvements, if commissioners set clear contracts and monitor them.

21 Health and social care commissioning is complex and changing. According to the Department of Health, commissioning is 'the process of ensuring that the health and care services provided effectively meet the needs of the population'.

[4] Information on other regulators is given on our web page 'Who regulates health and social care?': http://www.hse.gov.uk/healthservices/arrangements.htm

Responsibilities include assessing population, prioritising health outcomes, procuring products and services and managing service providers.

22 Because health and social care is devolved, very different arrangements apply across Great Britain. However, across GB the NHS commissions healthcare and Local Authorities commission social care, although there is also some integrated commissioning.

23. Commissioning has the potential to improve employee as well as patient and service user safety. This is because of the links between them. For example, if a commissioner is required to find a care home place for an adult who requires extensive manual handling, selecting a home that has adequate equipment and training to meet those needs should also reduce risks to employees.

24. A number of factors need to be borne in mind when addressing this issue:

- The main responsibility to ensure service user safety generally rests with the provider (exceptions may include failure by the commissioner to provide adequate information about a person's needs, or provision of unsafe or inadequate equipment for the provider).

- Our approach must not deflect from the provider's duties under HSWA.

- A sensible, balanced approach is needed that takes account of potential burdens on providers, for example that several commissioners may procure services from one provider and that other bodies assess the quality and standard of care provided.

- Other regulators do not have equivalent (or in some cases any) powers to secure justice.

25 HSE's operational policy focus is on engaging with stakeholders involved in commissioning care home places, because:

- standards are clear in areas such as manual handling, bedrail entrapments, scalding and falls; and

- evidence from investigation and past visits to a range of care homes is that knowledge of, and compliance with, standards we enforce, (for example dealing with manual handling, falls or bedrail safety), is poor.

26 We propose to provide clear guidance for those that commission domiciliary and care home services, setting out their legal responsibilities. In doing so we will consult widely, for example, with the Association of Directors of Adult Social Services (ADASS), the NHS Commissioning Board, appropriate co-regulators and other stakeholders. The guidance should help secure adequate protection for the vulnerable, whilst not detracting from the duties of providers, or placing unwarranted burdens on them. Ideally, this will be guidance jointly authored with relevant co-regulators and appropriate stakeholders.

Implications of current uncertainties

27 The Mid Staffs. Inquiry in England represents the most significant uncertainty in our approach. The Government could agree that one body should be responsible for all aspects of patient and service user safety in England, which would have major implications for our current strategy.

Stakeholder engagement

28 In healthcare, the main forum is the Partnership for Occupational Safety and Health in Healthcare (POSHH). HSE sits as an advisor on this management / union partnership. Many others, for example the Department of Health and NHS Protect, are also represented. POSHH superseded the Health Services Advisory Committee. It has a number of sub-committees dealing with specific issues (for example violence and aggression) and is, we think, effective in producing guidance and advice. It also provides an effective mechanism for distributing guidance, safety alerts etc.

29 However, POSHH only deals with employee safety in healthcare. There is no equivalent comprehensive forum for employee safety in social care. Also, there is no inclusive forum that deals with patient and service user safety in health or social care. However, we do have close relationships with our co-regulators, other stakeholders and representative bodies.

30 The changing landscape has meant that our plan to map and create an engagement strategy for every relevant stakeholder, taking account of their potential influence, has been difficult to complete

Resources

31 HSE's intervention plans for health and social care are delivered almost entirely by Sector staff from HSE's Operational Strategy Division. These are staff who engage with stakeholders, but do not inspect those who deliver the services. However, we do propose some limited work, by field based inspectors, as indicated. This includes resource for the 'lead inspector' and 'leadership' initiatives, or where there is very clear evidence of a failure to meet recognised minimum standards. Reactive work will also continue, but may be subject to change, depending on the outcome of the Mid. Staffs. Inquiry.

32 We will continue to try to mobilise additional resource, for example that of our co-regulators, in addressing key health and safety issues. We will also seek to jointly resource initiatives such as the leadership events, which have received encouraging feedback from our co-regulators.

Action

34 The Board are asked to:

- endorse the approach outlined in this paper; and
- consider whether they can actively support the leadership initiatives outlined at Paragraph 12 and high level engagement with key stakeholders and duty holders.

Paper clearance

Cleared by the SMT on 1/2/2012

Annex 1

Investigation of incidents involving non-workers

1 We have published guidance on investigating deaths to non- workers in these sectors so that we can, as a regulator with finite resources, appropriately prioritise our work. In essence, our policy is to consider investigation where it is clear that established standards have not been followed, because of serious management failure. Such investigations might include patients undergoing medical care, but in general will not include deaths that have arisen from errors in medical judgement by clinicians, or issues relating to patient care, such as hydration.

2 We do not, in general, investigate potential breaches by medical staff, where others (e.g. the General Medical Council or Nursing and Midwifery Council) have regulatory powers (although cannot prosecute).

3 Further information about our enforcement policy is available at:
http://www.hse.gov.uk/enforce/hswact/docs/guidance-for-fod.pdf

4 Situational examples are given at:
http://www.hse.gov.uk/enforce/hswact/docs/situational-examples.pdf