Health and Safety Executive Senior Management Team Paper			SMT/09/91
Meeting Date:	2nd September 2009	**FOI Status:**	Open
Type of Paper:	For discussion	**Trim Ref:**	2009/334030
FoI Exemptions:			

HEALTH AND SAFETY EXECUTIVE

Senior Management Team

Improving health and safety performance in the health and social care sectors – next step?

A Paper by Rosalind Roberts, Steve Scott and Amanda James

Cleared by Kevin Myers on 24th August 2009

Issue

1. To consider and comment on the attached Board paper so that it can be amended and cleared for the Board meeting on 23rd September 2009.

Timing

2. Urgent - the Board asked for the attached paper six months ago and are expecting it at their September meeting.

Recommendation

3. That the SMT:
   a) support the proposal that an enhanced engagement strategy be developed to galvanise improvement to the health and safety performance in the health and social care services sectors;
   b) comment on these proposals so that they can be sharpened; and
   c) consider if an SMT "champion" for this work is needed, and if so, who?

Background

4. A statistical presentation was made to the Board at their February 2009 meeting. One of the graphs (now figure 1 in the attached paper) showed an apparent rising trend in major injuries in the health and social care services sectors. The Board questioned this and asked for further information.
5. More recently, individual members of the Board have asked that the paper also cover the health and safety of patients and service users. This is a significant separate workstream with scheduled SMT discussions on 2nd December 2009 and 3rd February 2010. Following which a presentation to the Board should be made although no date has yet been set.
6. The interim Boorman report on *Health and Well-being* in the NHS released on 19th August said:
   - Annual NHS sickness levels of 10.7 days per year per employee were higher than the rest of the public sector and fifty per cent higher than the private sector (6.4 days);
   - Stress, musculoskeletal problems and mental health were the most common problems suffered;
   - Eight out of ten staff said that health and well-being issues were affecting care.

Argument

7. These are not the most hazardous sectors regulated by HSE. The accident statistics show a plateauing where in other sectors major injury rates are falling. On reported injuries alone these sectors would not attract special interest. However, the numbers employed are huge (11 per cent of the working population and rising) and lost time as a consequence of work-related illness is significant, estimated to cost the services and the public purse around £2 billion per year (2007/08)and may be affecting the standard of care given.
8. HSE has had a number of successes in tackling hazards in these sectors. However, overall, our approach has been piecemeal and we have only really chipped away at the problems with a number of worthy initiatives. We could continue in this manner, however, given the projected growth of these sectors and their increasing complexity and fragmentation, continuing with our tried and tested methods may not continue to yield the individual successes of the past. We therefore believe that the time is right to take stock of what we have achieved and to re-invigorate our strategy and engagement plans for these sectors. As ever, the trick will be to use our limited resources for maximum effect.
9. We believe that we will achieve most in these sectors by top-level engagement with the “movers and shakers” across the three departments of health (Wales, Scotland and England) and that such engagement must be lead by those at the top of HSE. We therefore invite the SMT to consider the proposals in the attached paper and to advise us on next steps.

Consultation

10. In relation to the attached paper – across HSE. The views of external stakeholders were also sought.

Presentation

11. None at present although a reinvigorated engagement strategy for these sectors will need an accompanying communications plan.

Costs and Benefits

12. If the SMT and Board agree to a new engagement strategy for these sectors then we will work with our economists on an impact assessment.

Financial/Resource Implications for HSE

13. Our proposals require senior level engagement which may mean that senior colleagues have to drop other commitments if they decide to lead this work. Some additional or re-directed resource would be needed within the Public Services Sector team to support this work. As we work up our proposals, some addition and potentially significant communications spend may be necessary, and there would eventually need to be some follow through and assessment by field inspectors to ensure that commitments made at the top were being implemented. However, we do not envisage committing any field resource to follow-up activities until at least 2012/13.

Action

14. That the SMT act as per the recommendations above.

Health and Safety Executive Board			Paper No: HSE/09/
Meeting Date:	23 September 2009	**FOI Status:**	Open
Type of paper:	Above the line	**Exemptions:**	
Trim reference:			
IMPROVING HEALTH AND SAFETY PERFORMANCE IN THE HEALTH AND SOCIAL CARE SECTORS – NEXT STEPS?			

Purpose of the paper

15. Requested analysis of injury and ill-health statistics, an overview of current health and safety performance and HSE's activities within these sectors. Proposals for an enhanced strategy to enable the Board to steer the direction of future work.

Background

16. The Board originally saw the major injury graph, which prompted this paper, as part of a wider statistical report. This graph (figure 1 below) showed a steady rise in the rate of major injuries since 2001, reflecting a change to the coding of accidents which has now been corrected and the graph "remapped" (Annex A). The remapped rate of major injuries shows a fairly constant rate in contrast to falling major injury rates in other sectors over recent years.

17. When compared against the other main industry sectors, the health and social care services sectors have lower rates of reported 'major' and 'fatal' injuries to workers. 'Over 3 day injury' rates are also lower than other main industry sectors, except for services sectors and agriculture. However, because of the huge numbers employed in health and social care the total number of over-3 day injuries is large (103,074). Reports made under RIDDOR provide only part of the picture, as the main concern is ill health. The rate of self reported work-related illness is higher in these sectors than the average for other industries. (Annex B)

Ill health and lost time data

18. An estimated 5.1 million days were lost to work related ill health or injury within these sectors in 2007/08, a rate of 1.9 days per worker - higher than the 1.2 days per worker for all industries[1]. These absences and the costs associated with them, approximately £2 billion per year, pose significant challenges for health and social care service delivery.

19. The main causes of work-related ill health in the health and social care sectors are musculoskeletal disorders, stress and dermatitis. Prevalence rates of self-reported work-related stress and musculoskeletal disorders were higher in these sectors than the average for all industries. In 2006/07, stress accounted for over 30 per cent of sickness absence in the NHS, estimated to cost around £300-£400m.

20. Dermatitis incidence rates for 2005-2007 were above the all industry average, according to THOR[2] surveillance data. EPIDERM[3] data shows that these sectors account for 25 per cent of all work-related dermatitis.

[1] 2007/08 Labour Force Surveys & Self reported Work-related illness (SWI) www.hse.gov.uk/statistics/industry/healthservices/index.htm
[2] reports of work-related ill health seen by specialists gathered in surveillance schemes run by The Health and Occupation Reporting network (THOR)

21. Needle stick and sharps injuries are a significant concern to employee representatives due to the worry of possible infection. RIDDOR reports show small numbers of incidents (325 dangerous occurrences between 2002/03 - 2007/07) because only injuries involving an infectious agent are reportable and under reporting is significant. Actual numbers of needlestick injuries are not known, however the RCN estimates there to be around 100,000 per year[4].

Major injuries

22. In 2007/08, the major injury rate was 74.3 per 100,000 employees in health care and 87.5 in social care, compared to an all industry average of 98.2.

23. **Trends:** The health care and social care services sectors show different trends in reported injury rates since 2001/02:

- **Health care:** stable major injury rates and recently falling over 3 day injury rates; and
- **Social care:** significant rise in major injury rates. An increase in over 3 day rates up to 2007/08, but remapping indicates more recent stability.

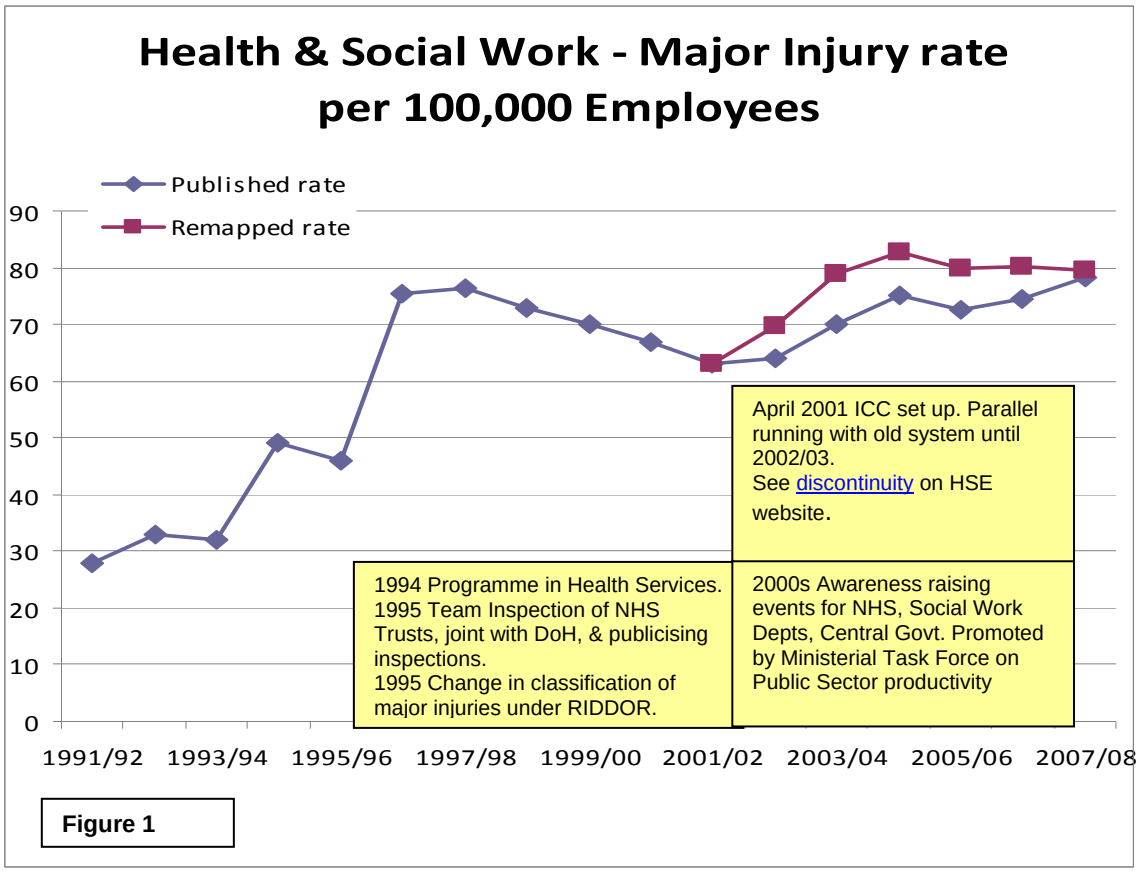


Figure 1

Fatal Injuries

[3] EPIDERM is a voluntary surveillance scheme under which dermatologists report new cases of work-related skin disease.
[4] http://www.nursingtimes.net/whats-new-in-nursing/acute-care/eu-legislation-will-mean-safer-needles/5002435.article

24. The number of RIDDOR reported fatalities to workers in these sectors is small compared to other sectors, with 15 fatalities during the period 2001/02 to 2007/08. The number of RIDDOR reported fatalities to patients and service users is significantly greater, with 309 reported deaths in the same period. This figure does not, however, include deaths from healthcare associated infections or other non-reportable deaths to patients/service users. HSE's role in working with others to regulate patient and social care service user safety is a substantial issue and the subject of another work stream to be presented at a future Board meeting.

25. The causes of these 15 fatal accidents are sadly predicable. They include three deaths as a result of slipping/tripping, four from falls, two from contact with machinery, and four as a result of physical assaults. The deaths from assault reflect the fact that the staff in these sectors deal directly with the most vulnerable in society and those acting violently under the influence of prescribed/illicit drugs and alcohol.

The main causes of injuries

26. In both the health care and social care services sectors, slips and trips are the main cause of major injuries, followed by handling accidents and physical assaults. Handling is the main cause of over 3 day injuries in both sectors, followed by slips and trips and physical assaults. (Annex B).

Main Occupations affected

27. In terms of total numbers of RIDDOR reported injuries, the majority (across both sectors) are to nurses, care assistants and nurse auxiliaries. This is expected given the numbers employed. However, domestic/kitchen staff and porters are also involved in a significant number of reports and given their smaller populations may be targets for future action. Ambulance staff and paramedics account for 8.4 per cent of all healthcare employee RIDDOR reports, perhaps due to their non-routine work in uncontrolled environments.

Previous work by HSE to improve health and safety performance in these sectors

28. HSE's work in these sectors, whether policy development, inspection or enforcement, is driven by reactive work, which is dominated by our efforts to protect non-employees affected by work activities as required by section 3 of the Health and Safety at Work etc Act 1974. That said we have, over the past 5 years, within the Fit 3, Public Services and Healthy Workplace Solutions programmes, sought to improve worker health and safety using the full range of intervention techniques. (Annex C)

29. Campaigns on sickness absence management and reducing ill health and injury included: secretariat support to the Ministerial Task Force on Health, Safety and Productivity; partnership work with stakeholders; seminars with public sector organisations; provision of relevant tools and advice for duty-holders; publishing guidance; and inspection and enforcement campaigns. (Annex C).

30. Successes include raised awareness of key issues amongst duty holders (e.g. stress management and slips and trips); engaging with and influencing a wider range

of stakeholders; and that we now have a better understanding of how these sectors operate, although we have yet to significantly influence the “movers and shakers”.

Description of these sectors and the challenges they face

31. The health care and social care services sectors, although sharing similar health and safety risks and being brigaded together for health and safety statistical purposes, are nonetheless two very separate and distinct sectors particularly in their employment profiles, funding arrangements and potential levers for change. Both sectors are growing, currently employing three and a quarter million, around 11 per cent of Great Britain’s workforce. Consequently they are a major component of GB’s overall health and safety performance.

32. In developing strategies and plans to improve the health and safety performance in each of these sectors, we need to take into account:

- *Devolution*: health and social care services are devolved matters and differing policy and funding regimes across England, Scotland and Wales could potentially affect worker health and safety – a reserved matter;
- *Regulators*: there is potential to work with other regulators in recognition that patient/service user and worker safety are often aligned;
- *Funding arrangements and commissioning regimes:* have the potential to significantly affect standards of health and safety;
- *Safety of patients and service users:* poor health and safety practice has a major impact, both directly and indirectly, on patient and service user care, outcomes and safety; and
- *Changes in the general population:* increasing demands of providing services to an ageing and increasingly obese population creates risks to workers.

Social care

33. Funding and commissioning in social care are largely publicly controlled, however the sector is dominated by micro and small employers (87 per cent). As a result of government policy on “Direct Payments”, numbers employed by domiciliary care service users are growing. These are harder to reach and potentially more vulnerable workers. All of which suggests that to improve health and safety performance in this sector we need to develop strategies to engage SMEs and those who commission services.

Health care

34. The health care services sector is dominated by the NHS. The NHS is becoming increasingly fragmented, with Boards and Trusts gaining more autonomy, operating like individual businesses despite being driven by central performance targets.

35. To improve health and safety performance in the NHS, we need to develop strategies to influence those in the three Departments of Health who set policy and

performance targets; engage better with the increasingly autonomous Boards/Trusts; and influence relevant regulators and stakeholders.

Argument

36. These are not the most dangerous sectors regulated by HSE, but because of the prevalence of certain risks and the large numbers employed, they have been a priority for HSE for some years and subject to a number of initiatives including a Ministerial Task Force. However, the injury and ill health statistics show that we are only chipping away at their health and safety performance.

37. Given the projected growth and challenges faced by these sectors (Annex D) our prognosis is that their health and safety performance is likely to dip further and that we need to review our current work plans (Annex E) and decide how best to use our limited resources for maximum effect. The impetus provided by the new Strategy and the Boorman Review[5] on NHS Health and Well-being provides the opportunity and mechanisms to do so.

A revised strategy for the health and social care sectors

38. Our revised strategy needs to take into account the profile, characteristics, influences and challenges of these sectors as described above, which have led us to conclude that there are five major blocks of work:

- **In the health care services sector** – which is largely driven by clinical and financial targets, we need to complement our existing plans and stakeholder engagement work, with senior level engagement with the "movers and shakers" in the three Departments of Health across Great Britain with the aim of influencing policy at a high level; and

- We need to capitalise on the findings of the review of NHS Health and Well-being interim report (published 19 August 2009) which highlights the need to: secure Board commitment, leadership and staff engagement; embed staff health and well-being in the core business; properly resource health and well-being services to deliver long term savings; and develop agreed and consistent measures of health and well-being programmes.

- **In the social care services sector** – In addition to high level engagement with other "movers and shakers", given the growth of SMEs, the self-employed and harder to reach groups, we need to help the industry improve its health and safety knowledge, competence and risk management performance. We propose to do this through current conventional methods that we know work including guidance, roadshows, communications activities, inspections and work with key stakeholders.

- **In both these sectors** - there is a need to influence commissioning policy and to provide guidance on what is expected from commissioners of services in integrating health and safety into contract setting and monitoring. In this area our interest is primarily to ensure the health and

[5] http://www.nhshealthandwellbeing.org/InterimReport.html

safety of service users/patients. However, good commissioning practice also improves worker health and safety; and

- as part of the Better Regulation Agenda, we need to continue our engagement with other regulators of patient/service user safety so that we capitalise on improvements to worker health and safety that could arise from their work, for example in relation to manual handling and violence and aggression.

39. In delivering all of the above there is a need to ensure that our plans:

- capitalise on the skills and competencies within HSE from Board level down;
- maximise our excellent existing stakeholder networks and if needed build new ones;
- ensure worker involvement in line with the Board endorsed strategy[6] HSE/09/43;
- provide a multiplier effect to all our efforts through communications activities; and
- are underpinned, when and where necessary and appropriate, with inspection and enforcement activities.

40. Annex F provides further details on some of our ideas and proposals that, given Board support, we can distil and develop into an enhanced engagement strategy and plan for these sectors. However, before doing so we seek the Board's views and steer, particularly in relation to resources as we recognise that these are finite and the trick is to do fewer things better. Even so, our proposals do require senior level engagement, which may mean senior colleagues dropping other commitments to lead engagement in these sectors. A modest amount of additional or re-directed resource may also be needed to support those leading this work and some additional (and potentially) significant communication spend may be necessary.

Action

41. We recognise that our detailed proposals are ambitious and therefore before attempting to develop our ideas further we ask the Board:

- should HSE develop an enhanced strategy and plan for engaging with these sectors or simply carry on chipping away at these sectors or even withdraw from them;
- if we do develop an enhanced strategy and plan, should it be based around the five blocks of work outlined above (paragraph 24);
- if so, is the Board content for us to develop our ideas further;
- and what further involvement do the Board wish to have?

Paper clearance

42. By Kevin Myers on 24th August 2009 and the SMT at its meeting on 2nd September 2009.

[6] http://www.hse.gov.uk/aboutus/meetings/hseboard/2009/290409/p-apr-b09-43.pdf

Annex Contents

Annex A: RIDDOR[7] INJURY DATA RECORDING

1. Reported Injury Data

Statistics on injury and ill in the health and social care sector are drawn from the activity standard industrial classifications (SICs) 85.1 'Human Health Activities and '85.3 Social Work Activities.

Human Health Activities, referred to as 'health care sector' for the purposes of the paper, includes hospitals, nursing homes, medical and dental practices and 'other' human health.

Social Work Activities, referred to as 'social care sector' for the purposes of the paper includes all social work or social care activities, both with and without accommodation.

2. Remapping

The graphs in this paper show re-mapped injury data. Remapping removes discontinuity in the data which occurred due to industry coding changes in incident reports to the Incident Contact Centre (ICC) in 2001/02.

The largest effect on HSE's statistics relates to the coding of council workers. Between 2003/04 and 2007/08, these workers were generally coded to SIC 75 (Public Administration). Prior to 2003/04 these workers had been more precisely coded to the activity they were engaged in, for example education, social care, refuse collection, etc.

From the start of 2007/08, the ICC changed their coding practice for council workers to be more closely aligned with the previous practice, and workers are now coded to the activity they are engaged in, which introduced a discontinuity.

Remapping has the effect of reducing the number of injury reports assigned to Public Administration and increasing them in other industries, particularly Health and Social Services.

3. Other Coding Information

The paper and accompanying Fact Sheet (Annex B) show comparisons with other main SIC Industry sectors. Where such comparisons are made, health and social care activities have been removed from the overall services totals. Examples of some of the other forty-plus activities in Services SIC include motor vehicle repair, retail & wholesale trade, transport, post and telecommunications, financial services, Education, public administration and defence.

[7] Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995, http://www.hse.gov.uk/riddor/

Annex B

Fact Sheet

Health and Social Care Services Sectors – Worker Health and Safety

Employment in the health and social care services sectors

1. The health and social care services sectors employ over 3¼ million workers in Great Britain and the size of the workforce is forecast to continue increasing*.

Year	GB Employment Numbers in Human Health and Social Work Services Sectors (SIC 85)
2000/01	2,764,671
2001/02	2,847,755
2002/03	2,927,492
2003/04	3,018,821
2004/05	3,120,811
2005/06	3,216,290
2006/07	3,256,154
2007/08	3,286,546

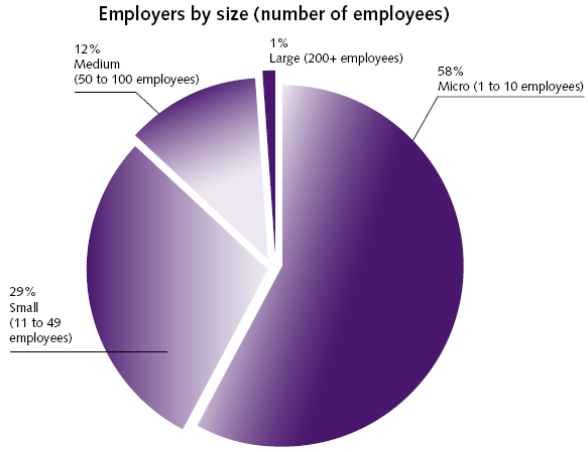
*Adult social care is one of the fastest growing sectors of the economy. In social care an additional 1 million employees is forecast to be needed by 2025[1]

2. The health care sector is dominated by the NHS with a total of 415 NHS Trusts in England, 14 NHS health boards in Scotland and 9 NHS Trusts in Wales (soon to reduce to 6 in Wales).

3. The annual NHS staff census[8] showed staffing levels reached a peak of 1,368,200 in September 2008, a 2.8 per cent increase on the previous year and a 27.7 per cent increase compared to 1998.

4. Private healthcare is segmented. It is dominated by the NHS, which commissions the largest number of beds with the biggest five private healthcare companies also accounting for a significant proportion. .

5. The social care system is made up of a large number of different types and sizes of service commissioners and providers; including public, private, partnership and voluntary organisations, SMEs and the self-employed.



- Employment in the social care sector is dominated by micro and small employers.
- Local authority directly-employed staff numbers are falling as commissioning of home care from the independent sector increases.
- The numbers employed via Individuals in receipt of direct payments is growing (estimated 152,000 in 2008 compared with 113,000 in 2006-07).

Source: Department of Health 'Working to put people first'[9]

[8] Source: NHS Information Centre: www.ic.nhs.uk
[9] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_098481

6. The majority of the social care workforce are employed in community and domiciliary care services (47% in 2007/08). The remaining 42% of the workforce work in residential care, 6% for agencies and others not directly employed, and 5% in day care.[10]

Injury and ill health data

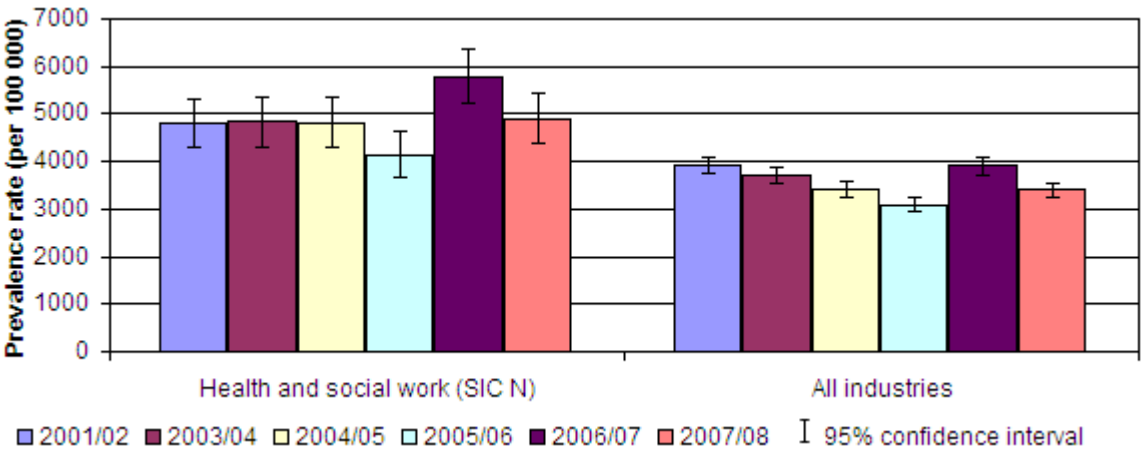
7. Days lost due to injuries and ill health

An estimated 5.1 million days were lost to work-related ill-health or injury within the health and social care services sectors 2007/08, a rate of 1.9 days per worker, higher than the average for all industries of 1.2 days per worker.

8. ill health

An estimated 178 000 people whose current or most recent job in the last year was in the health and social work sector, suffered from an illness which was caused or made worse by work, according to the latest survey of self-reported work-related illness (SWI) carried out in 2007/08. The associated prevalence rate, 4 900 per 100 000 people (4.9%) working in the last year, was higher than that for all industries (3 400 per 100 000 people, 3.4%).

Estimated prevalence rates of self-reported illness caused or made worse by the current or most recent job, per 100 000 people working in the last 12 months



The main causes of work-related ill health in health and social care services sectors are **musculoskeletal disorders, stress** and **dermatitis**. Whilst verbal assaults are not reflected in RIDDOR statistics, empirical evidence suggests that these too impact upon staff health and can contribute to stress-related ill health with 23% of respondents in the NHS staff survey 2008 stating they had experienced bullying, harassment and verbal abuse from patients[11].

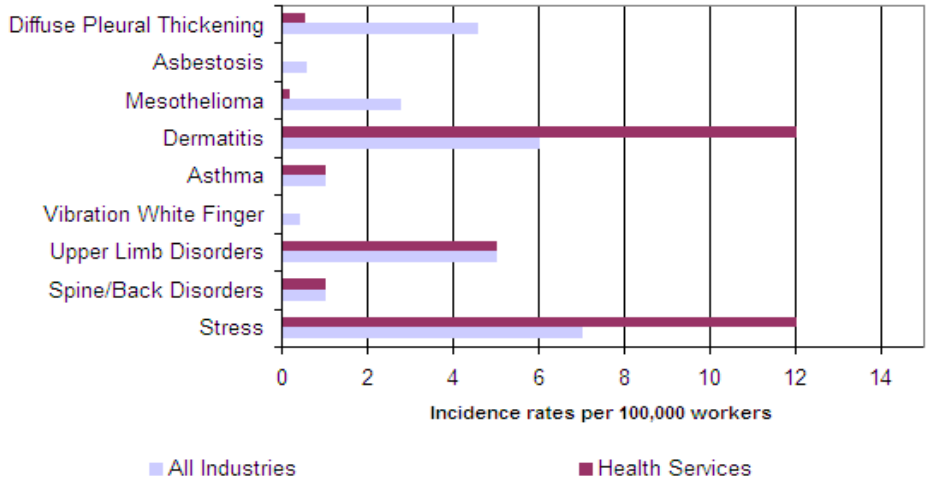
More detailed prevalence data by type of illness are not yet available from SWI 07/08. However, the SWI 2006/07 survey showed that the prevalence rate for musculoskeletal disorders, stress, depression or anxiety disorders in the health and social work sector was statistically significantly higher than the average rate across all industries.

[10] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_098481
[11] Care Quality Commission.NHS Staff Survey 2008, key findings. http://www.cqc.org.uk/publications.cfm?fde_id=11001

This is further borne out by the THOR-GP surveillance scheme which collates data on occupational diseases from doctors and physicians. For the period 2005 – 2007 it shows incidence rates for **stress** and **dermatitis** in the health services to be substantially above the average for all industries.

Stress is believed to account for over 30 per cent of sickness absence in the NHS - costing the service £300-400 million per year. The Healthcare Commission's 2008 NHS staff survey found that 28 per cent of staff questioned said they had felt unwell because of work-related stress in the previous 12 months[12].

Annual average incidence rates of occupational diseases seen by disease specialist doctors and occupational physicians in the THOR surveillance schemes; 2005-2007



Dermatitis: EPIDERM data shows that 25% of all cases of work-related dermatitis occur within health and social work occupations; the incident rate amongst nurses since 2004 has remained more than 6 times higher than the all-industry average[13].

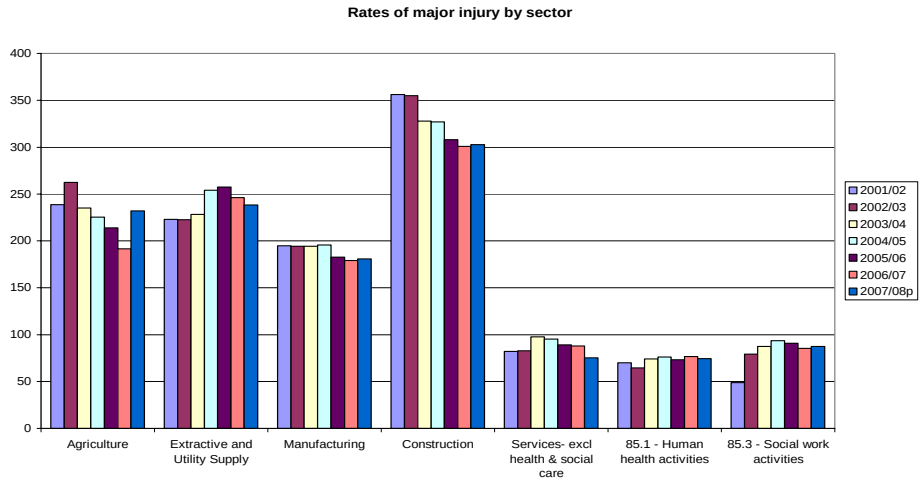
During 2008/09 HSE specialist Occupational Health Inspectors visited 44 Trusts/Boards in Scotland, England and Wales and interviewed more than 550 employees. Emerging findings indicate that nearly 50% of interviewed workers reported work-related skin problems.

Needlestick injuries: Needle stick and sharps injuries are a significant concern to employee representatives due to the worry of possible infection. RIDDOR reports show small numbers of incidents (325 dangerous occurrences between 2002/03 - 2007/07) because only injuries involving an infectious agent are reportable and under reporting is significant. Actual numbers of needlestick injuries are not known, however the RCN estimates there to be around 100,000 per year

9. Major Injuries

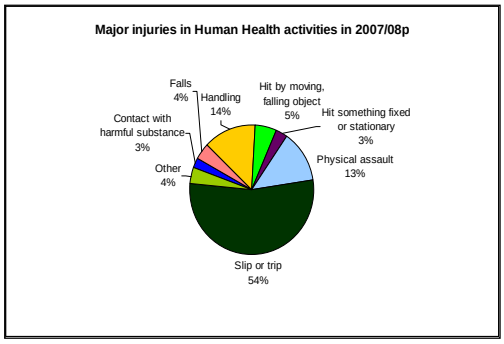
The health and social care services sectors show different trends in RIDDOR reported injury rates to workers since 2001/02. Health care shows stable major injury rates (74.3 per 100,000 employees in 2007/08). Social care major injury rates have risen since 200/01 to 87.5 per 100,000 employees in 2007/08. (Compared with an all-industry average of 98.2)

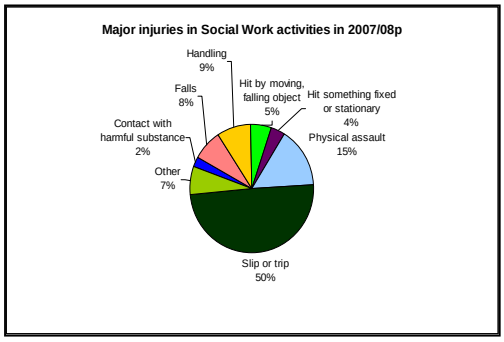
[12] As above.
[13] (http://www.hse.gov.uk/statistics/tables/thors05.htm).



Major injury rates shown are per 100,000 workers.

The main causes of reported major injuries to workers in health and social care are **slips and trips, physical assaults** and **handling activities** (including people handling).

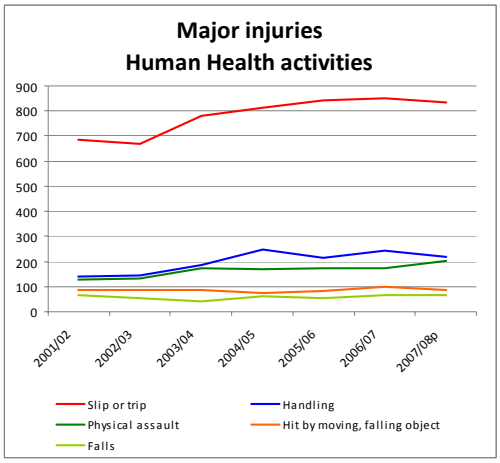


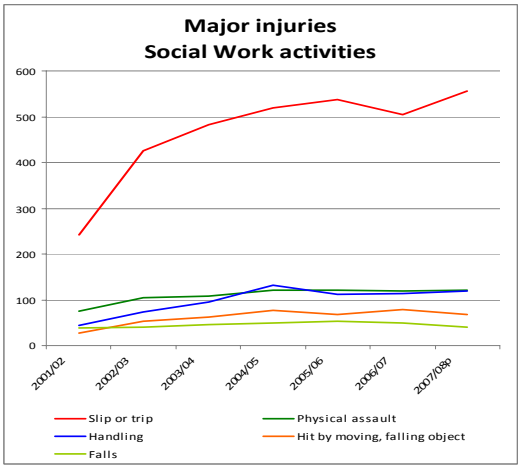


The comparatively small number of major injuries from **handling** is as expected given the definition of a major injury. The large numbers of handling injuries reported in health and social care, including those from moving and handling people, are better represented in the reported over 3 day injuries (see section 8) and often involve long absences from work.

The trends in the main causes of major injuries show the rise in reported social care major injuries is largely attributable to **slips and trips**, which are a common risk in health and social care sectors due to frequent cleaning of smooth floors, work in uncontrolled environments and spillages/other floor contaminants.

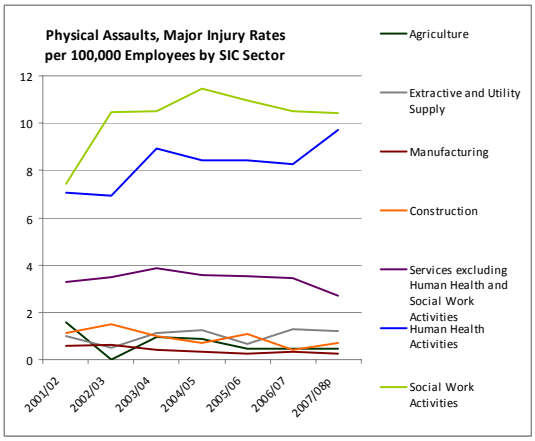
Major Injury Rates by Kind, per 100,000 employees





Health and social care staff deliver care to the most vulnerable in society, those with challenging behaviour and people acting violently under the influence of prescribed and illicit drugs and alcohol. The number of **physical assaults** is high compared to other main industry sectors as seen in this graph:

In 2007/08 there were 324 major injuries to workers in health and social care from physical assaults (35% of total physical assault injuries for all sectors.)

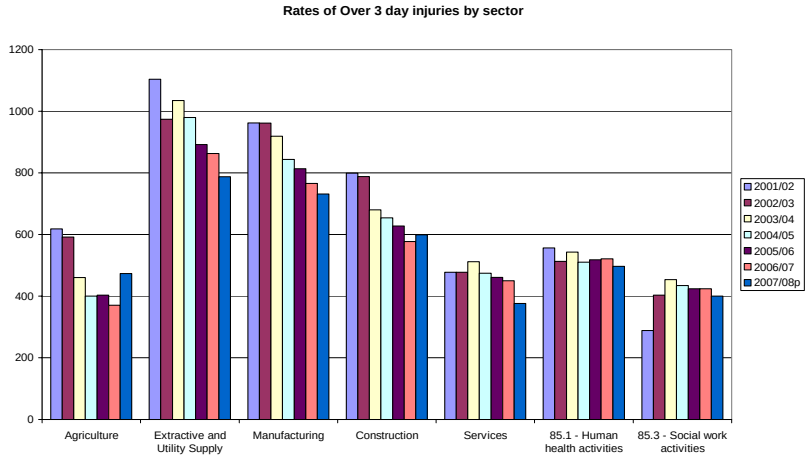


The majority of all reported injuries in health and social care are to nurses, care assistants and nurse auxiliaries which is expected to be given the numbers employed. However, domestic/housekeeping, kitchen staff and porters are also involved in a significant number of reports.

Ambulance staff and paramedics account for 8.4 per cent of all health care employee RIDDOR reports reflecting the nature of their work in uncontrolled environments and the amount of manual handling they undertake.

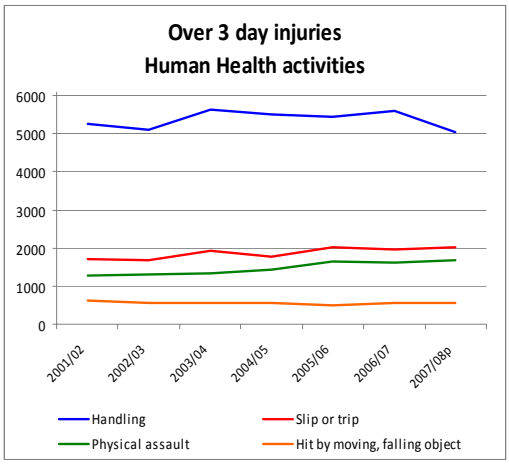
10. 'Over 3 day' RIDDOR reported injuries

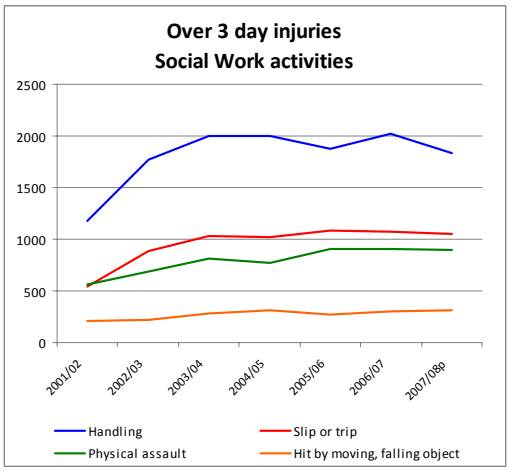
Trends in over 3 day injuries show recently falling rates (per 100,000 employees).



The main causes of reported over 3 day injuries are **handling, slips and trips** and **physical assaults**

Over 3 day injury rates by kind per 100,000 employees





The high rate of reported work-related over 3 day handling injuries in these sectors is reflected in NHS data that nearly half of all absences by NHS workers is due to musculoskeletal disorders.[14]

11. Fatal Accidents

Numbers of fatal accidents to workers are low in comparison with other sectors. During the period 2001/02 to 2007/08 there were 15 fatal accidents to workers: 3 caused by slips/trips; 4 by falls; 2 by contact with machinery; 4 physical assaults and 2 others.

[14] http://www.nhshealthandwellbeing.org/InterimReport.html

Annex C

Previous work in the health and social care sector

1. Over the past 5 years the FIT 3, Public Services and Healthy Workplace Solutions programmes generated a huge amount of work in health and social care. Campaigns on sickness absence management and reducing ill health and injury included: high level engagement on the Ministerial Task Force; partnership work with key stakeholders; seminars with public sector organisations; provision of relevant tools and advice for duty-holders; and follow-up inspections.

2. HSE collaborated with other stakeholders and regulators to avoid duplication, target resources and agree working protocols/Memoranda of Understanding (MOU). HSE also worked with stakeholders to influence their standards, guidance and inspection criteria, particularly on violence and aggression, MSDs, stress and slips and trips.

3. In 2008 HSE worked with the Partnership for Occupational Safety and Health in Healthcare (POSHH) in England, to produce Occupational Health and Safety Standards guidance for the NHS.

4. In social care, HSE, in partnership with others, successfully ran over 33 events attended by 2600+ managers/owners of care homes across the UK. Topics covered included slips, trips and falls, manual handling and Section 3 risks.

5. FOD and LA inspection campaigns in care homes are now underway. Early findings from Wales and W/SW regions, who have completed inspection blitz's', include 31 improvement notices issued during visits to 28 homes in Wales on manual handling, bed rail safety, slips and trips, asbestos management, hot water control and legionella.

Musculoskeletal disorders

6. During 2007/08, as part of the 'Better Backs' campaign, HSE collaborated with the NHS across England, Scotland and Wales, to raise awareness of the benefits of electric profiling beds (EPBs) in reducing manual handling risks. HSE is currently working with others, including the WLGA All Wales Manual Handling Group on a series of workshops, on the application and benefits of EPB's in reducing risks in the community and care homes.

7. In 2003 (revised 2008[15]) a manual handling 'Passport Scheme' was developed by the All Wales NHS Manual Handling Steering Group with HSE support. This was followed by the All Wales Local Government Manual Handling Training Passport and Information Scheme. The schemes provide consistent standards for manual handling training and risk assessment and enable employees to transfer skills between employers within the NHS and social care sectors. Trusts have been audited against the standard.

[15] http://www.wales.nhs.uk/sites3/docmetadata.cfm?orgid=433&id=107187

8. HSE is contributing to development of a similar passport scheme with the health boards in Scotland and to the NHS Employers Organisation (England) 'Back in Work' campaign, which is due for launch this autumn.

Work-related Stress

9. HSE delivered a series of 'Healthy Workplace Solutions' workshops in 2006. Over 230 NHS organisations attended. The workshops aimed to raise awareness and benefits of adopting the Management Standards for work-related stress.

10. HSE Inspectors visited 141 NHS organisations to measure progress on risk assessment and management. Early indications are that the workshops and inspections raised senior managers' awareness. More than half (24) of the 40 organisations receiving a repeat visit were assessed as having progressed to the next stage. One improvement notice was served on an NHS Trust.

11. In 2009 HSE was a partner in the delivery of four stress management workshops run by POSHH for senior HR staff and staff side representatives in Trusts giving them valuable knowledge and practical information about stress management.

Violence & aggression

12. HSE drew up a Concordat Agreement with the Counter Fraud Security Management Service (CFSMS), who also tackle NHS violence and aggression issues in England, setting out how both organisations will work together to reduce injuries to workers from violence. Work has included supporting development and roll-out of a national training programme for frontline staff and promoting competence by ensuring that NHS Trusts designate a director with responsibility for security management (including violence and aggression); and a competent 'Local Security Management Specialist'.

13. An 'All Wales NHS Violence and Aggression Training Passport and Information Scheme' was developed through partnership working between NHS organisations and HSE to provide a framework for the delivery of violence and aggression management systems and training within the NHS in Wales. Auditing of the topic in Wales is planned for 2009/10.

Slips and Trips

14. HSE delivered 23 slips and trips road-shows between 2005-2007 to approximately 900 NHS Trust delegates. The workshops and follow up inspections, successfully raised awareness of NHS and facilities company managers and provided practical advice.

15. Health care was one of the target sectors in the Shattered Lives Campaign (2008/09) aimed at raising awareness of the impact of a slip, trip or fall at work. The 2009 campaign also saw the launch of the Slip and Trip E-learning Package (STEP) which contains a module dedicated to health and social care services sectors.

Dermatitis

16. In the late 1990s the HSE 'Latex and You' publicity campaign and union pressure resulted in the DH initiative to remove powdered natural rubber latex gloves from NHS use. A subsequent drop in latex-related dermatitis and asthma were reported.

17. Given that Health care workers, particularly nurses and dentists, remain at relatively high risk of dermatitis, HSE has recently worked with bodies such as the National Patient Safety Agency (NPSA), on the potential dermatitis risks associated with hand hygiene. Guidance on addressing the risks of frequent hand washing is now incorporated into top level NHS guidance (e.g. NHS Patient Safety Alert on Infection Control; NHS Healthy Workplaces Handbook).

18. During 2009/10 44 Trusts/Boards were visited by Specialist Occupational Health Inspectors (OHI) and over 550 employees including managers, clinical and non-clinical staff interviewed. Emerging findings indicate that nearly 50% of interviewees reported work-related skin problems and that there was poor integration of occupational health into Trusts'/Boards' risk management systems. Further work with the NHS Employers Organisation is planned in light of these findings and the possibility of developing common guidance for hand hygiene products is also being explored.

19. Presentations at national conferences for dental nurses and articles in the British Journal of Dentistry, have raised awareness of dermatitis prevention and management; as have activities in Wales, Yorkshire and the North East, Kent to ensure that those who inspect dental practices (Dental Practice Advisers) look at dermatitis issues during visits.

ANNEX D: Challenges and changes in the health and social care services sectors

NHS

1. ***Fragmentation***: Although we traditionally think of the NHS as one organisation there is increasing fragmentation, with Trusts and Boards operating as individual organisations. In particular as Trusts attain 'Foundation' status they have a large degree of autonomy.

2. ***Commissioning:*** There have also been changes in the commissioning of health services, for example in England this is now the role of primary care trusts who are recently/currently re-organizing. Change and fragmentation can present challenges in achieving consistent health and safety standards and sharing good practice.

3. ***Workforce pressures***: The annual NHS staff census[16] showed staffing levels recovered to reach a peak of 1,368,200 in September 2008, a 2.8 per cent increase on the previous year and a 27 per cent increase compared to 1998. However, there are staff shortages and a reliance on agency workers in some areas. Categories of staff which saw decreased numbers included Nursing assistants whose numbers fell for the 5th consecutive year to 100,400 in 2008, a fall of 6 per cent or 6,400 on the previous year. More than 30 per cent of nursing roles are held by migrant workers who remain a crucial part of the workforce which the NHS needs to retain, despite the recession.

Social Care

4. ***SMEs****:* The number of SMEs in the social care sector is increasing. In particular the home care market consists of a large number of small agencies and Local authority directly employed staff numbers are falling as councils are also increasing the commissioning of home care from the independent sector

5. ***Direct Payments***: Community based care is increasing[17] and there has been a 25% increase in the numbers of carers receiving a Direct Payment in 2006-07. This means that more people are choosing their own services and carers; either from agencies, the self employed or are employing individuals directly to provide their care. Such individual workers are potentially more vulnerable as a harder-to-reach and un-registered care provider group working in uncontrolled environments.

6. ***Workforce pressures****:* An additional 1 million more employees are forecast to be needed by 2025 to meet the growing demand of an ageing population[18]. Empirical evidence suggests that it is common for people to be working in more than 1 job role/ for more than 1 employer in social care. As in health care, workforce numbers have not met demand and there is significant reliance on migrant workers,

[16] Source: NHS Information Centre: www.ic.nhs.uk

"Personal Social Services Staff of Social Services Departments, England" The NHS Information Centre, Adult Social Care Statistics 26 March 2008. from the NHS Information Centre website at: www.ic.nhs.uk/pubs/pssstaffsept08)

[18] The National Skills Academy for Social Care http://www.skillsacademyforsocialcare.org.uk/social_care_is/

Demographic changes affecting both health and social care service sectors

7. ***Mental health services*** – demand is increasing associated with a number of factors including the aging population, an increase in early onset dementia, substance misuse treatment and other mental health conditions. In 2008, the Commission for Social Care Inspection reported an increase in day services and professional support services for those with mental needs[19]. There has been similar pressure on adult mental health services in Wales and Scotland.

8. ***Substance misuse*** - The number in drug misuse treatment (over 202,000 people in 2007/08) has increased by over 60% since 2003 despite the percentage of 16-59 year olds reporting use of class A drugs remaining fairly stable since 2000[20]. The number of young people consuming alcohol has fallen, however those who drink are starting earlier, drugs and alcohol remain key drivers of crime and the health effects continue to pose a challenge[21].

9. ***The average age of the UK population is increasing***. The population of over 65s is projected to have increased by over 30% by 2020 to 12.7 million and the population of over 85s by 50% to 1.9 million[22]. An ageing population will mean greater numbers of people with ill health and other care needs[23]. Increasing demands which can impact on worker safety include increased client numbers, increased dependency/ more assistance required with mobility, provision of equipment numbers of workers and increasing numbers of people with dementia.

10. ***Obesity*** - Almost 1 in 4 adults in England are currently obese and forecasts are that if the current trend continues, by 2050, 9 in 10 adults will be overweight or obese. The effects of this are to create increased demands on health and social care services and challenges in managing risks to workers when moving and handling people.

11. Increased funding pressures associated with these demographic trends and the current financial climate which could affect expenditure on health and safety measures, highlighting the importance of demonstrating the cost savings which can be made through reducing injury and ill health.

Annex E

2009/10 HSE Work streams in the health and social services sectors.

Ongoing and planned work includes:

1. High level engagement and work with other regulators

[19] Commission for Social Care Inspection, annual report 2008.
[20] 'Health Profile of England 2008' Jan 2009, Department of Health, www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_093456
[21] 'Discussion Paper: Realising Britain's Potential: Future Strategic Challenges for Britain' The Cabinet Office Strategy Unit, February 2008
[22] Discussion Paper: Realising Britain's Potential: Future Strategic Challenges for Britain' The Cabinet Office Strategy Unit, February 2008
[23] DH Strategy Unit (2006) Annual Report, Personal Social Services Research Unit 2007, www.dh.gov.uk

- High level engagement and regular liaison to agree working arrangements with the Care Quality Commission and Department of Health on managing health and safety issues across health and social care.

- Agreeing working arrangements with the Medicines and Healthcare Products Regulatory Agency (MHRA) and with the Scottish Commission for the Regulation of Care (Care Commission) and Local Authorities;

- Developing a working arrangements protocol/ MoU on healthcare associated infection (HCAI) with the newly created Healthcare Environment Inspectorate in Scotland.

- Participation in regional risk summits with the Care Quality Commission and other regulators of the NHS in England.

- Agreeing working arrangements and developing MoUs with Healthcare Inspectorate Wales and Care Standards Inspectorate Wales.

2. Communications

- Redesigning and launching new internet and intranet web pages to capture cross sector activities and to provide guidance to stakeholders

- Continuing to build on internal HSE communications and support to field inspectors who are working in the health and social care sectors.

- Continuing work to develop our engagement with the devolved Governments and health departments and to improve HSE's internal mechanisms by which we can share good practice from devolved administrations across the whole of the sector.

3. Topic-based activities

- Developing the enforcement position on work-related stress;

- Developing and publicising the revised ULD/Assessment of Repetitive Tasks (ART) Tool for cross sector work on MSDs.

- A project on work related violence and aggression across the public services sector to gather information on the many intervention techniques and standards used/recommended for differing "client" groups across the whole public services sector.

- In partnership with the NHS CFSMS a project is ongoing looking the cost of violence in the NHS.

- Promoting consistency in asbestos management issues across public

services sector.

- Working with the Social Partners Agreement on prevention of needlestick injuries.

- Review and update of ACDP/HSE guidance on Blood Borne Viruses.

- Research into the impact of different flooring types and slip resistance on cleaning/infection control within the healthcare sector.

- High demands from work on Section 3 issues and policy continue, including reactive issues and facilitating liaison with other government departments, stakeholders and regulators where necessary.

4. Engagement with other stakeholders

- Examples of some of the many other partners HSE engages with on cross cutting health and social care issues include; Health Inspectorate Wales, Care, Social Services Inspectorate Wales (CSSIW), the NHS Employers Organisation (England), Department of Health Estates (England), Health Facilities Scotland, Association of Directors of Adult Social Services (ADASS), Institute of Occupational Safety and Health's Healthcare group, National Association of Safety and Health in Care Services (NASHICS), the NHS litigation authorities, RCN and UNISON. There are many others not named and new bodies emerging, with and through whom we continue seek to improve health and safety standards across health and social care.

5. Operational Activity

- Investigative / reactive work is largely driven by Section 3 HSWA demands

- Planned proactive work, including ongoing stress and Care Home visits and, in Wales, audits looking at Estate Management and Violence and Aggression.

Annex F: Building on HSE's Strategy and the interim Boorman Report:

A draft strategy and plan of work to improve standards of occupational health and safety in the health and social care sectors

Aim: To create healthier and safer workplaces in the health and social care services sectors by driving up standards of occupational health and safety and by doing so to reduce accidents and ill health.

1 Our strategy needs to recognise the challenges facing these Sectors as outlined in the main paper. These include changes in the structure of the Sectors themselves and changes in society that are increasing pressures and demands.

Everyone has a role - involving the workforce – building competence

2 We recognise that everyone has a role. Particularly: employee and employer representative bodies; other regulators; key employers; those that commission; and other stakeholders, such as those involved in nurse and doctor training.

Everyone has a role - Strong leadership

3 In order to make a real difference we need to engage with all of these stakeholders so that we work together to achieve our goal. We need to ensure that duty holders in particular recognise their responsibilities and have the competence to achieve them. This is especially important at Board level.

Everyone has a role - Government

4 We also need to try to influence governments' strategy for these Sectors, so as to minimise any inadvertent adverse impact on health and safety outcomes.

Support for SMEs

5 We also need to ensure that we provide accessible relevant advice, especially for the 'hard to reach' and effectively market it.

In order to achieve the above we need to capitalise on:

- **the impetus provided by the new HSE Strategy;**
- **the findings of the Boorman Review into Health and Well-being in the NHS; and**
- **the competencies and expertise of HSE as a whole and particularly, where top level influencing is required, the SMT / Board.**

6 Our draft overall plan for tackling the priority areas referred to in this paper is to:

- Establish, where necessary, appropriate standards. In some cases, this involves research and in others, it involves joint development, and evaluation of new approaches;
- Provide readily accessible guidance on standards via the website, hardcopy and other means;
- Engage, at all levels, with stakeholders who can make a real difference in ensuring that standards are implemented. For example, with key influences such as the Department of Health, with employee representatives, and with those who commission services;
- Engage, where they can make a difference, with other Regulators, recognising that patient and service user interests are often aligned with worker health and safety;
- Ensure that the Boards of duty holders are fully aware of, and implementing, their responsibilities;
- Back up this approach with proportionate and appropriate inspections and enforcement; and
- Support all of the above with appropriate publicity and other communications activity.

Strong leadership

7 Engagement with relevant stakeholders such as key employers and other Regulators need to take place at all levels but particularly at senior level so that strong leadership for health and safety can be developed. Engagement at lower levels is more effective once those running the organisations are fully 'on board' and effectively directing the process.

8 Engagement with relevant stakeholders has been effective in Wales (for example work with NHS Wales to 'sign up' all Trusts to providing electric beds; and all Wales implementation of passport schemes). However, trying to adopt a similar approach in England is, for many reasons, very much more difficult and will, we believe, require support from the SMT / Board.

9 Securing publicity is also essential. Whilst we have been successful in running conferences and 'awareness days' and engaging with the media we believe that a 'step change' is necessary to make a real difference and to try and reach the less committed.

10 The following paragraphs give more detail about some of our ongoing and proposed initiatives in key areas:

11 Strong leadership

Aim – to encourage leadership, improve ownership and management, including proportionate profiling of health and safety risks in health and social care.

- Encourage better integration of health and safety risks into NHS and local authority risk management systems, including the top 3 risks slips, MSDs and violence, through

    - Communication of the links between patient safety/quality of care and worker health, safety and wellbeing
    - Targeting of LA and NHS risk managers
    - Seek to secure high level engagement with the Health Departments and NHS
    - In areas where we would benefit from more engagement, seek 'health and safety champions' e.g. at DH, at risk director and CEO groups
    - Explore with health departments potential for recognising leaders who promote staff health safety and well being whilst taking to task those who fail
    - Work with new regulator CQC to influence their registration guidance and inspections to include management.
    - Work with the other key regulators and NHS litigation authority who inspect health and social care to include H&S management competency and systems in relevant inspection standards
    - Use the Boorman review as an opportunity to promote our aims and good occupational health and safety management

- Link to current policy work on the framework for delivery of the 'healthier workplaces' and the review of HSG65 to include/supplement with tailored management approaches for large and small public services sector employers, including investigation of various integrated systems approaches currently in use in isolated areas such as "the productive ward", "releasing time to care etc"

- Investigate and develop ways of sharing leadership and risk management practices and networking between health and social care CEOs/directors/Senior management and those from other industries.

- Through stakeholders investigate, develop and encourage initiatives on coaching in the workplace to support line managers in their risk management roles.

Involving the workforce

- Work with POSHH and others particularly worker representative bodies to build on Occupational Health and Safety Standards which have received positive feedback from the field in NHS England and discuss with partners in Wales and Scotland whether they could work on something similar.

- Provide information/guidance to health and social care dutyholders

on what good health and safety management risk management looks like (e.g. management systems and worker involvement), including updating of current guidance;

- Managing health and safety in healthcare,
- Management of occupational health services for healthcare staff,
- Health and Safety in Care Homes,

and develop new guidance for domiciliary care sector

Support for SMEs

- SMEs – Appropriate and simple information on duties and good practice to SMEs and those in receipt of direct payments e.g. working through local authority social care departments and other stakeholders, disability charities etc. in the care sector and investigate ways that SMEs and those in receipt of direct payments can access health and safety advice and information

Building competence

- FOD training and support to FOD in management audit approach E.g. audit packs/guidance similar to with management standards for stress, are likely to be substantially met through the training developed through the Managing for Health and Safety Project, complemented as necessary, by healthcare sector specific briefing material

- Work with LACORS and others to identify any training/information needs for LA inspectors of care homes

- Develop regional/area FOD health and social care Champions

- Set up health and social care e-bulletins to communicate latest information and lessons learned on key risks with dutyholders and stakeholders

- Investigate potential new ways of sharing good practice and communication across the sector e.g. Wikipedia type Q &As

- Through relevant stakeholders (e.g. CQC, NHS Employers organisation etc) investigate ways to encourage better reporting of H&S incidents within trusts/boards to ensure they are treated as a priority under the 'risk register'. (unions suggest a telephone reporting system)

12. Everyone has a role - Commissioning

Aim – To ensure that those who commission health and social care services understand their health and safety duties, are championing health and safety, are managing health and safety risks and driving up standards.

- Gather information on current commissioning practices, risks and issues in health and social care, and look within the sector and to other sectors for examples of good practice.

- Identify where other regulators/inspection bodies in GB have an interest/compliance role in commissioning and engage with them.

- Work with key stakeholders and those who can influence commissioning practices e.g. Association of Directors of Adult Social Services, LAs, Health Departments, health boards, strategic health authorities and 'Monitor'.

- Design communication campaign to communicate information on health and safety duties and good practice in commissioning.

- Follow-up with operational interventions to health and social care commissioners to provide advice and to check/secure compliance.

- Further, investigate impact of choice and independence agenda, including personalised budgets and direct payments, and ways of influencing those involved higher up the commissioning chain to secure health and safety improvements and compliance.

- Investigate the development/use/promotion of voluntary health and safety standards for health and social care organisations to achieve which could be an indicator for commissioners of care to use.

13. Everyone has a role - Working with other regulators and stakeholders

Aim – To ensure our policies and workstreams take account of wider issues, to influence those bodies who can help achieve our aims and to promote working arrangements in order to aid investigation and secure justice

- Develop engagement strategy and MoU/Concordat agreement with the Care Quality Commission

- Participation in Healthcare 'Concordat' Risk Summits in England with other regulators and stakeholders in order to 'risk profile' NHS Trusts and promote joined up working.

- Agree working arrangements with the Scottish Commission for the Regulation of Care (Care Commission and local authorities

- Agree working arrangements with Nursing and Midwifery Council (NMC) and review/update MoU with General Medical Council (GMC)

- Continue to carry out and monitor current working arrangements and liaison with others that are currently in place

- Learn from and share successful initiatives across the three countries e.g. Wales manual handling passport

- Develop engagement strategies and working protocols with new HAIC inspectorate (Healthcare Environment Inspectorate) and forthcoming healthcare and social care Scottish scrutiny bodies (Healthcare Improvement Scotland and Social Care and Social Work Improvement Scotland)

14. Support for SMEs - Reducing risks to hard-to reach and vulnerable workers

Aim: to reduce the risk of injury by raising awareness of health and safety risks and safe working practices to hard-to-reach and vulnerable workers

- Identify and build liaison arrangements with groups representing vulnerable health and social care workers (e.g. Kalayaan (a charity which supports migrant domestic workers)

- Investigate other ways of accessing/influencing vulnerable workers and those individuals who employ them e.g. via student unions, employment agencies, independent budget schemes etc.

- Influence local authorities and others further up the commissioning line to provide key information to vulnerable workers

- Develop health and social care sector guidance on HSE website for domiciliary workers

15. Building competence – creating healthier and safer workplaces - Focus on core risks to reduce incident numbers and rates across health and social care

15.1 MSDs

Aim – To target key issues to reduce the rates of MSDs across the health and social care s.

- Propose research project to investigate further e the causes of continuing MSDs and to profile risks for targeting activity.

- Continue work with key stakeholders in Scotland and England to achieve standards/principles for manual handling training and assessment in healthcare.

- Communicate advice, reasonably practicable measures and good practice to dutyholders and FOD - Produce a series of information sheets in conjunction with key stakeholders (e.g. national back exchange, NHS Employers, National Ambulance Services Risk Directors) on key MSD risks e.g. bariatric, sonography, hoisting, podiatry & chiropody ambulance services, facilities staff, homecare etc.

- Update of Health and Safety in Care Homes guidance to include information on MSDs, and manual handling.

- Establish contact with higher education training bodies for healthcare staff to investigate people handling training provision and look to develop consistency/standards

- Review impact of EPBs in Wales and other NHS organisations; engage with health departments and stakeholders to continue communicating EPB key messages.

- PUWER/LOLER SIM revision and re-issue

15.2 Slips and Trips

Aim: to reduce the incidence of slips and trips to workers in the sector by targeting key groups and risk factors

- A research project on infection control and flooring in healthcare is underway. Sector will liaise with health departments and other key stakeholders to communicate findings and produce sector specific information in conjunction with slips and trips team.

- In conjunction with Construction Sector, investigate and develop ways of reaching/influencing those involved in new build hospitals/Private Finance Initiatives re. flooring assessment and specification.

- Promote key messages to health and social care such as cleaning techniques and benefits of good floor selection which gives improved slip resistance in wet and dry conditions within NHS estates - which would help reduce risk of incidents to staff, patients and visitors. E.g. through key stakeholders such as NHS Employers

- Develop sector specific guidance for FOD to aid inspection and enforcement around slip and trip risks in health and social care

- Work with unions and health and safety professionals to provide guidance and information on slips and trips factors and assessment to safety reps and health and safety advisors.

15.3 Violence and Aggression

Aim: To grow sector intelligence on the underlying issues causing violence and aggression related injury/ill health and develop targeted plans in conjunction with relevant stakeholders to improve management of the risks and reduce incidents.

- More research on violence and aggression in social care is needed, in particular
    - (i) to understand risks arising from 'challenging behaviour'. And ways of preventing it occurring
    - (ii) to identify various practices and training in physical interventions (including restraint techniques) across the whole of public services, from which we can look to develop consensus/standards/guidance

- Continuing engagement with the Security Management Service in England and other stakeholders to drive up standards in health care.

- Work with partners (e.g. Health departments Estates & Facilities functions and the Security Management Service to raise awareness of the role of building design, in both new builds and refurbishments, in reducing the risks of violence and aggression to NHS staff.

- Evaluation of the Audits planned in Wales on violence and aggression to assess the impact of the passport scheme

- Continuing to seek publicity (e.g. on the upcoming Focussed FM TV channel) about the issues.

16. Other health workstreams

Aim: To reduce incidence of other common ill health risks and those risks which are potentially high impact in the health and social care sector

16.1 Dermatitis

- Work with Skin Disease Reduction Team to communicate findings and key messages from NHS OHI surveys with key stakeholders Employers Organisation and NHS Supply Chain with plans to further embed HSE messages into the hand hygiene agenda.

- Skin Disease Reduction Team are supporting the work of the NHS

Partnership for Occupational Safety and Health in Healthcare (POSHH) in the development of guidance to Health & Safety Representatives on the issues of work-related contact dermatitis in the healthcare sector.

- Identify other stakeholders/vehicles to communicate dermatitis messages to health and social care. Particularly those that assess standards, such as the Dental Reference Service.

16.2 Needlesticks

- Work is ongoing to assess the impact of the Social Partner's Agreement on Needlesticks.

- We are commissioning work on safer sharps technologies to establish the extent to which safer needle devices reduce risk. We know that most injuries are currently caused by a failure to follow appropriate systems of work (e.g. re safe needle disposal).

- We will update our web site, including advice on risk assessment.

- Work with unions to ensure safety reps have appropriate advice and information.

- We will be proposing a proportionate approach to investigating selected needlestick injuries with a view to enforcing where appropriate to embed appropriate standards.

16.3 Stress

- We will continue to work with our Partners to raise awareness of the duties to effectively manage the potential causes of work-related stress in the healthcare setting. Emphasis will be given to embedding the management of work-related stress into general healthcare management systems. Activities will be in line with the proposals of the Managing for Health and Safety Project.

- We will work with colleagues in the Stress Team to develop sector specific case studies on stress management in the healthcare setting.

- Operational training requirements are likely to be substantially met through the Managing for Health and Safety Project, complemented by Health care sector specific briefing material.

16.4 Legionella

- Adapt guidance for Care Home SMEs to aid understanding of requirements through key stakeholders in the care sector and production of a DVD.

16.5 Asbestos

- Ensuring consistency in dealing with asbestos duty to manage issues across public services sector

- Pro-active safety reps with time off to act on the guidance and advice given by HSE

- Proactively seeking examples of poor asbestos surveying work with a view to bringing those that manifestly fail in their duties to account.

- Evaluating the impact of current Estates Management Audits