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Target Audience:
All FOD Inspectors with Responsibilities for Health Services

MANAGEMENT INSPECTIONS OF NHS TRUSTS AND LARGE PRIVATE HOSPITALS

This SIM gives guidance on the preparation, conduct and reporting of inspections of NHS trusts and private hospitals.

BACKGROUND

1 The inspection of trusts has been part of the strategic plan for health services inspection for a number of years and was planned to be a rolling programme of inspection of all NHS trusts and hospitals. Such work is now central to the Health Services Priority Programme. The main objective of the management inspections is to secure the drafting and implementation of action plans to improve standards of health and safety, and to address non-compliance with legislation in NHS bodies (acute, primary care, specialist and ambulance trusts and their equivalents in Scotland and Wales) and private hospitals. ([SIM 7/2003/18](#) gives guidance on the inspection of ambulance services).

2 Inspection should focus on the risks that present serious problems in health care. These are laid down in the Health Services Inspection Programme (see [SIM 7/2003/21](#)):

- (1) management of manual handling; and
- (2) management of the risks from workplace violence.

Other risks such as stress,asthmagens and slips and trips should be covered in line with instructions in the RHS Inspection Topic Pack. Other matters of concern may be identified during visits, eg risk of scalding from hot water/burns from hot surfaces and falls from windows.

CONTROLS ASSURANCE AND CLINICAL GOVERNANCE

3 Inspectors carrying out management inspections should be aware of the controls assurance and clinical governance initiatives and the requirements that they impose on

trusts in England and Wales. In particular, inspectors need to be aware of the controls assurance risk management system and the standard for health and safety management. The NHS Executive (NHSE) produced a CD-ROM that contains guidance and the current controls assurance standards. A copy of this CD-ROM has been distributed to File 357 in office libraries. Further information on controls assurance is contained in [SIM 7/2000/15](#), and on clinical governance in [SIM 7/2000/14](#).

TRAINING FOR INSPECTORS

4 Guidance on inspecting health and safety management is contained in the current FOD Guide *Assessing health and safety management systems*. Inspectors who lead inspection teams should have completed the FOD training course. Further training on the structure of health services, and the key risks in the sector is available from the Health Services Unit technical training course.

5 Inspectors should be familiar with the contents of the FOD Health and Safety Policy, in particular Supplement 00, General approach to site visits and 01, Health Services supplement.

PREPARATION FOR THE MANAGEMENT INSPECTION

6 A 'lead' or coordinating inspector should be chosen, who should have completed the 'Assessing Health and Safety Management Systems' training course. Consideration should then be given to the number and composition of inspection teams.

7 A contact in the trust should be identified who can facilitate the organisation and execution of the inspection. This is usually the health and safety manager, risk manager or human resources manager. The inspection will need to be timetabled to ensure the availability of the relevant people. This is best arranged through the trust's main point of contact.

8 The Commission for Health Improvement (from April 2003 becomes the Commission for Healthcare Audit and Inspection, CHAI) conducts reviews of clinical governance (see [SIM 7/2000/14](#)) in England. Reviews are resource intensive for trusts; inspectors should ensure that an HSE inspection will not coincide with a CH(A)I review. Details of planned reviews are posted on the CHI website at www.chi.gov.uk under Clinical Governance Reviews.

9 Chief Executives and Board members should be engaged in the inspection. This may be done for example by:

(1) holding a seminar to outline what HSE will be looking for and expecting, and inviting all those who are going to be inspected to attend;

(2) an early introductory visit involving the chief executive and/or executive and non-executive board members. Consideration could be given to a PI or Band 1 making such a presentation;

(3) a letter explaining the process or, if there is already a good relationship, a

telephone call.

10 Relevant paperwork should be requested in advance of the visit. Consideration should be given to limiting such requests to:

- (1) the trusts overall safety policy and risk assessments;
- (2) assessments and policies from priority areas and departments which you intend targeting in the inspection, eg manual handling, violence. Copies of the relevant assessments and policies form a useful baseline comparison for the inspection;
- (3) minutes from recent board meetings, safety committee meetings and infection control committee meetings, where health and safety matters were discussed;
- (4) an analysis of recent accident and ill-health statistics;
- (5) a copy the controls assurance statement from the annual report (see [SIM 7/2000/15](#)); and
- (6) reports on any other recent audits relating to health and safety.

THE INSPECTION PROCESS

11 The use of selected priority areas of risk, ie the key indicators described in para 2 above, will form the basis of the assessment of the strengths and weaknesses of the management of health and safety.

12 Strengths and weaknesses should be judged in respect of:

- (1) how well health and safety are integrated into the management systems (using the headings in HSG 65);
- (2) availability of information on the incidence and costs of work-related accidents and occupational ill-health and its use in risk based decisions (see controls assurance risk assessment standard).

13 The information gathering process can be structured by using either question sets or an aide-memoire. Whatever method is chosen it should ensure that each member of the inspection team is able to make a useful and meaningful contribution to the overall findings. Question sets may be too rigid for experienced inspectors, but would prove useful for those with less experience. Following requests from the field, HSU has a small library of questions sets that have been successfully used by operational colleagues. They can be made available on request to Robert Hampton VPN: 508 4284. The Sector does not suggest that these must be used, however they could be modified to suit individual inspections. The [appendix](#) gives some suggested aides-memoires of approaches and areas to explore.

14 It is helpful for the inspection team to liaise daily (perhaps at lunchtime) and to feed

back to the main contact from the trust so that any immediate action points can be raised.

INSPECTION OUTPUTS

Reporting back to the Chief Executive/Board

15 An oral report back and/or presentation needs to be given shortly after the end of the inspection (within 1-2 days), summarising key findings and concerns. Emphasis should be given to particular strengths. This should, if possible, involve the same people who were involved in the introductory meeting, particularly the Chief Executive.

16 Consideration should be given to using the PI/Band 1 to lead the report back, involving team inspectors as appropriate to provide essential evidence/detail. It is crucial that the report-back is seen to be convincing and make an impact, otherwise the affect of the inspection can be dissipated.

Written reports

17 Reports of the inspection should note not only weaknesses but also strengths found, so that trusts can learn from them and develop similar approaches elsewhere. They should be working documents both for the trust and for inspectors to check on progress. The main aim should be to enable the trust to agree the report and produce and implement its own action plan.

18 Inspectors will find it helpful to structure their reports along the lines of HSG65. It is recommended that the report contains an executive summary of the key findings and a list of recommendations, **including any enforcement action**. These should be kept as concise as possible. Where detailed information on specific topics/departments is required, this should form appendices to the main document.

19 To keep up the impetus of the inspection, the final report should be submitted as soon as possible after the visit, preferably within 4-6 weeks.

FOCUS reporting

20 Inspectors are asked to complete **one form IRF1**, marking the scoring matrices for **all** RHS priority topics inspected. The comments field should contain a description of the overall standard of health and safety management at the trust.

21 Where manual handling forms part of the inspection, one contact report should be made containing the information requested in [SIM 7/2003/06](#).

22 For violence, a separate FOCUS contact should be made, including opinions on: (1) policies; (2) risk assessments; (3) controls; and (4) training.

Enforcement

23 **Notices:** should be served where there are inadequately controlled risks and where

there are significant specific failures in assessments. Where there are broader issues, such as minor deficiencies in management or risk assessments, the report should specify the areas of deficiency. To enable the notice to be cleared easily, the notice and schedule might relate to a specific area or topic, whilst the accompanying letter should make it clear that the trust needs to take similar action in other areas. Notices should be served as soon as practicable after the visit and referred to in the report.

24 Prosecution: should be considered where failings in health and safety management arrangements are significant, and previous advice has been given. If significant breaches are revealed during the inspection, it will normally be appropriate to terminate the management inspection and concentrate on collection of evidence for legal proceedings.

25 More specific guidance on enforcement is contained in the RHS Inspection Pack and [SIM 7/2003/06](#) patient handling and [7/2003/08](#) for violence.

CONTACT FOR FURTHER INFORMATION

26 Health Services Unit contact: Sally Williams 508 4225.

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APPENDIX
(para 13)

SOME SUGGESTED AIDES-MEMOIRES OF APPROACHES AND AREAS TO EXPLORE

1 AIDE-MEMOIRE FOR DISCUSSION WITH CHIEF EXECUTIVE

A useful opening question to steer the interview:

What mechanism(s) does the Board have in place to ensure it receives adequate information to enable it to manage health and safety risks within the trust, and how does the Board use the information to make decisions on competing priorities and for the allocation of resources?

This question could be given to the CE in advance to ensure you get a full answer. It may open up discussion about reporting to the Board, proactive and reactive, H&S Committee, risk assessment, Risk Registers, competent advice, budget allocation, etc.

You can feed in the Business Case (cost of accidents) and stress the Priority Programme message that.... ***Health care organisations will not meet the prescribed standards for delivery of high quality services unless they also effectively manage health and safety risks to ensure they have the staff, equipment and standard of premises necessary to do so.***

2 AIDE-MEMOIRE FOR SENIOR MANAGER/DIRECTOR WITH BOARD
RESPONSIBILITY FOR HEALTH & SAFETY

Example 1:

A. GENERAL ISSUES:

- 1 What is your understanding of the management of health and safety in the trust? Can you describe the arrangements, eg difference between clinical governance committee and risk management group?
- 2 Are you aware of the risk management strategy?
- 3 Have you seen the health and safety policy?
- 4 How do you fit into the overall health and safety management structure?
- 5 Annual safety audits carried out? (Requirement of general safety policy.)
- 6 Six-monthly safety inspections carried out? (Requirement of general safety policy.)

B. USING THEIR SAFETY POLICY AS A BASIS FOR DISCUSSION:

- 1 Explain how health and safety is managed within the directorate.
- 2 Do they have a risk management co-coordinator? If so what is their function?
- 3 Have they received any management of health and safety training?
- 4 Has any one received health & safety training/management training?
- 5 How do they resource health and safety issues/risks identified?
- 6 When a risk is identified what is the process to get it resolved?
- 7 Do they have a risk treatment and action plan or a risk management action plan with targets (as required by the risk strategy)?

- 8 What are the most significant risks in the directorate?
- 9 What is being done to resolve them?
- 10 Has any one from the risk management structure reviewed the health & safety arrangements in the directorate?

11 Discuss arrangements in the directorate safety policy.

C. MANAGING VIOLENCE AND AGGRESSION AND MANUAL HANDLING

- 1 Explain the focus of the inspection and why?
- 2 How are these two issues managed by the directorate?

Example 2:

A. POLICY: Facets to Explore

- 1 Is there an appropriate policy at the level required? Trust wide; Directorate level; department/particular issues.
- 2 What does the policy cover?
- 3 Does policy clearly identify individual's role? How? What is its role?
- 4 Does it clearly identify responsibilities?
- 5 Does it clearly identify the strategy for health and safety management, risk assessments, risk control systems, etc?
- 6 How was policy derived, eg influences/internal/external?
- 7 Is policy workable/achievable/ practical/ understandable? Does it conflict with job?
- 8 Is policy renewed? Is it up to date?
- 9 How is policy communicated to staff?
- 10 What is the role of the competent person(s)? eg producing policy, function stated in policy?

B. ORGANISATION: Facets to Explore

- 1 Do staff know about policy/procedures?
- 2 Are personal responsibilities allocated? Eg health & safety policy/job descriptions/safe working practices? Is there upward/downward responsibility?
- 3 Is health and safety performance rewarded? (Financially, etc).
- 4 How are staff consulted? Effective?
- 5 How is health and safety information conveyed? What are channels for health and safety information flow?
- 6 Are levels of expertise appropriate, eg assessment of training needs, provision of training, Induction?
- 7 Where does competent advice come from, in-house or external?
- 8 What is the mechanism for raising/dealing with concerns?
- 9 What health surveillance is undertaken? How identified?

C. PLANNING/IMPLEMENTATION: Facets to Explore

- 1 What are your biggest - hazards?
- risks?
- 2 How are risk assessments done? Are these used as planning tools?
- 3 Contingency plans - (Do any exist? What for? Considered? Practised?)
- 4 What are your three key areas where further control is necessary?
- 5 How are your performance standards - identified?
- used?
- 6 How are non-conformances with policy/SWP, etc - identified?
- 7 Dealt with? Is there an (annual) health and safety plan? - Trust level;
- Directorate level;

- Department level?
- 8 How is health and safety considered before work started?
- 9 Where do you go for advice?
- D. MONITORING/MEASURING: Facets to explore
- 1 How do you know if you meet relevant performance standards?
 - department, personally?
 - active/reactive measurement?
 - is this conveyed upwards/downwards?
- 2 What arrangements are in place for inspections (sample; thorough)?
- 3 What arrangements are in place for investigation (including near misses)? Do they address underlying causes?
- 4 How are records made of inspections/incidents/plant examinations, etc?
- 5 How well do you perform statistics/completion of plans; improvement in risk assessments; training of staff?
- 6 How do you measure losses - financial/sick leave/"downtime"?
- 7 What is system for reporting accidents? Does it include near misses?
- 8 How do you identify high hazard/low probability events?
- 9 Are contingency plans in existence/practised/effective?
- E. REVIEW/AUDIT: Facets to Explore
- 1 How do you know if policies/SWPs, etc are adequate?
- 2 Is there a proactive look at all elements of health & safety management system? (Proprietary audit?)
- 3 Who does "audits" - who/level of experience/depth of coverage/frequency?
- 4 Are inter-departmental issues identified? (Common issues?)
- 5 How are defects taken forward? (Immediate needs/ deferred needs/prioritisation/upward reporting/costing?)
- 6 What are the "top five/ten" outstanding issues?
 - Trust wide
 - Directorate wide
 - Department wide
- 7 How are findings fed back to staff?

3 AIDE-MEMOIRE FOR WARD STAFF

Manual Handling

- 1 Policy
 - Are you aware of manual handling policy? Is it relevant? Do you understand it? What is its purpose? Clear aims and objectives? What is your opinion on strengths and weaknesses of the management of health & safety?
- 2 Risk Assessments
 - Risk assessments for patient moving operations been done? By whom? (Competence?) Were ward staff involved? Are they aware of assessments findings and their implications for practical tasks?
- 3 Access to Competent Advice
 - Has the link nurses role been defined, back care advisers role been defined? Is there an occupational health service? Is it adequately resourced?
- 4 Equipment
 - Moving and handling aids – sufficient, suitable, maintained, examined and tested?
- 5 Patient Care Plans

How are patient handling needs assessed and recorded? Is the information readily accessible in user-friendly format? Has equipment been identified for patient handling available? Are staff trained to use it?

6 Staff Training

Manual handling training? Who identifies (general health & safety) training needs? How? Records? Monitoring effectiveness?

Violence

1 Policy

Are you aware of any policy on controlling risks from violence?

2 Risk Assessments

Have any risk assessment been done, if so, what are the findings?

3 Access to Competent Advice

Has access to competent advice been sought?

4 Equipment

Have risk assessments indicated the need for any equipment? If so, has this been provided?

5 Staff Training

Has the need for any staff training been identified? If so, has this been provided and is it adequate?

6 Other Issues

Have you been exposed to acts of violence and/or aggression whilst at work? Did you report it? Was any investigation done and any action taken? Do you perceive violence as a problem within the Trust in general? Are there any emergency response and security procedures?

General

1 Is there a health & safety committee? Are there safety reps? Has there been dissemination of health & safety information?

2 What single thing would you like done to improve health & safety in your organisation?

