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Work and Pensions Committee

The Work of the Health and Safety Commission and Executive

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Volume III

Written evidence

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The Work and Pensions Committee

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Written evidence

Memorandum submitted by CO-Gas Safety

A. Introduction

1. Stephanie Trotter became interested in safety some time after 1991 when her older son, Alex, then aged 12, had an accident while on his first residential sailing course. Alex Trotter suffered a clot on the brain. Trotter accepted that the injury had been caused by an accident. However, she was disturbed by the fact that the centre administered the wrong First Aid (Trotter was not notified and Alex was put to bed and left unattended for several hours). Trotter suspected that there were no persons trained in First Aid on the premises at the time. This would mean that there were no trained sailing instructors present at the time of the accident. (MPs might like to know that thankfully, after a year off school, Alex recovered completely.)

2. Being a barrister, Trotter researched the law but found there was no real control on children's activity centres. Trotter wrote to her MP, but received only information about guidelines (ie mere advice). After the canoe tragedy, (four teenagers drowned in Lyme Bay), Trotter wrote an article published in the *New Law Journal* advocating licensing of children's activity centres (*New Law Journal* April 1994 page 454, 455, enclosed, "CO-Gas Safety 1"). Trotter knew one of the barristers, Kiernon Coonan, who was representing a defendant, Peter Kite at the trial of OLL Ltd. OLL Ltd was the company which ran the canoe course during which the four teenagers drowned. Coonan told Trotter that this article was read as background by counsel and the trial judge, Mr Justice Ognall. Trotter's recollection is that the judge in his speech recommended that the government regulate these centres. David Jamieson, MP for the canoe parents, came second in the ballot for private members' bills and children's activity centres are now licensed—Activity Centres (Young Persons' Safety) Act 1995.

3. During this campaign, Trotter was assisted by Molly Maher, president of Consumer Safety International, an independent registered charity working to reduce deaths and injuries on holiday. In 1985 Maher had lost her only son in Tenerife to carbon monoxide poisoning from an illegally installed gas water heater. Molly's daughter, Sheree was seriously injured in the same incident and is still confined to a wheelchair. Maher had been campaigning in Spain but was told by the Spanish authorities that the UK was also in need of improvement with regard to gas safety.

4. Maher founded CO-Gas Safety with Nigel Griffiths MP, then Shadow Consumer Affairs Minister and David Jenkins of RoSPA. Trotter agreed to head it on a voluntary basis. CO-Gas Safety was launched at the House of Commons on 25 January 1995 and is an independent registered charity. CO-Gas Safety now has a very small office, a website (copies enclosed—"CO-Gas Safety 2") www.co-gassafety.co.uk, a database, is on two HSE Work Groups and has finally been appointed (after three years of asking) to the HSC Gas Safety Sub-Committee.

CO-Gas Safety now has nine years of experience of helping accidental gas and CO victims and lobbying Government for change.

The charity is mainly funded by the Department of Health (£16,000 pa) although it has had some funding from some of the fuel companies, in particular Centrica (although no longer), Transco and more recently contributions from EDF and Powergen (£5,000 each, one off payments).

CO-Gas Safety operates on a shoestring budget and has no paid full time employees. Trotter has worked full time for CO-Gas Safety for nine years in a voluntary capacity.

5. For many years Trotter has been interested in all aspects of health and safety, particularly how to change the law to encourage better practice and to reduce totally unnecessary and preventable deaths and injuries. Since 1991, Trotter has written many articles about this—mainly published in the *New Law Journal* with some published in *The Times*.

B. General Points

Aim of Health and Safety at Work Act 1974

6. The aim of this Act, which set up the HSC/E, is to prevent deaths and injuries, ie to reduce victims.

Commissioners of the HSC

7. Although the aim of the H & S at W Act is to reduce victims, there are no Commissioners for victims. There are also far too many Commissioners representing industry. Even the Trade Unions are not, in CO-Gas Safety's experience, very interested in safety. CO-Gas Safety is concerned that Trade Unions are put under pressure to agree to pay deals which compromise safety or at least do not put safety as the top priority it should be.

There is a Commissioner for Consumers but CO-Gas Safety has not found the interests of consumers and victims to be the same. Indeed the Commissioner for Consumers has no experience of helping victims. Victims are a valuable source of information and CO-Gas Safety has found their contributions to be invaluable. CO-Gas Safety suggests that if there were several Commissioners for victims appointed or perhaps one with a good staff, Commissioners could try to assist victims. In this way, valuable information would be gained and passed on to all the other Commissioners.

CO-Gas Safety also suggests that the Commissioner for victims should organise events where victims could address all the Commissioners in order that the other Commissioners gained this information on a first hand basis. Even twice yearly events, would in the charity's opinion make a huge difference to the way the HSC is run.

Please note that although CO-Gas Safety clearly represents victims the charity is often treated as "consumers" or, when we started, as housewives! (See enclosed—"CO-Gas Safety 10"—letter from Nick Starling dated 8 May 2002 page 2 where he states "CO-Gas and other consumer organisations").

Appointment of Health and Safety Commissioners

8. Commissioners are appointed by the Minister.

Are these positions even advertised so that those who may be suitably qualified, but perhaps would otherwise be overlooked, could at least apply for the posts?

Is it healthy for an "independent" body to have its Commissioners appointed by a government minister?

Composition of HSC/E's Committees and Work Groups

9. These are largely composed of government and industry. For example the Gas Safety Sub-Committee recently was made up of 28 members, nine government, one regulator, two local authorities, one TUC, one training body, 13 industry (46%) and one consumer (Energywatch, arguably a government body) until CO-Gas Safety finally obtained a place after three years of asking.

Even now, the balance is hugely weighed in favour of government and industry.

It is often said that it is extremely difficult to find consumer and victim organisations to fill places on such committees and work groups. In that case, why did CO-Gas Safety have such difficulty being appointed to GSSC and other HSE Work Groups?

CO-Gas Safety's experience has been that it has been extremely difficult to obtain information and make its voice heard. Why?

Consensus kills

10. Please read the excellent booklet written by the late and great Alan Dalton, (enclosed—"CO-Gas Safety 7"). CO-Gas Safety's experience with regard to dealing with HSE on gas safety has been very similar to that experienced by Alan Dalton. It was only through Alan's admirable work (Alan persuaded the HSC/E to have some open meetings) that CO-Gas Safety was able to ask to become a member of the HSE's Gas Safety Sub-Committee in two open meetings. Trotter encloses the speeches she made at both open meetings (see enclosed—"CO-Gas Safety 10")—CO-Gas Safety still cannot understand why the charity was not asked to become a member many years ago. Furthermore, CO-Gas Safety cannot understand why CO-Gas Safety was refused membership on the first application. The attitude that led to this decision by HSC/E is worrying.

Resources

11. Has the HSC/E sufficient resources? CO-Gas Safety has assumed until recently that HSC/E has insufficient resources and this is the reason there are insufficient inspections, spot checks and prosecutions. However, recently others have pointed out to CO-Gas Safety that the resources of HSC/E may be being used for new buildings etc rather than for the core activities of HSC/E. CO-Gas Safety suggests that a full inquiry into the resources of the HSC/E be carried out.

It would be helpful to compare the resources and achievements of the HSC/E to some other similar body whose work is very satisfactory.

The HSC/E could undertake more inspections and undertake more spot checks.

12. Trotter is hoping that David Potter (who lost his son in a construction industry incident) will be making a submission. Potter has had 30 years of experience in the construction industry. Potter said recently to Trotter, "for ordinary visits, the HSE normally gives around two days notice. During that time things are tidied up and workmen are taken away from dangerous parts of a site. When HSE officers do turn up, they normally spend around two hours but most of that time is taken "taking tea with the managers in the

office" and then they do a quick drive through the site". Please could the Select Committee conduct an investigation into this allegation? CO-Gas Safety submits that such an investigation would need input from ordinary employees not only from Trade Unions.

HSC/E largely intended to be confined to the workplace

13. The workplace is no longer confined to factories and offices. People work from home and from and in their cars etc. Rail travel is covered but not other travel unless it is "work". Gas is covered but not solid fuel yet both can give rise to accidental CO poisoning. It is surely illogical that HSC/E is so confined, basically to the workplace, in 2004.

Independence

14. HSC/E is put forward by Government as independent. Yet the HSC/E is overseen by a Minister (Department of Work and Pensions), its budget is entirely provided by Government and its Commissioners are appointed by a Government minister. Nevertheless, it is presented to the media as an independent investigator, which looks after everyone's safety. The status of the HSC/E should be clear, either it is entirely a government body (CO-Gas Safety submits that it is) or it is given true independence.

Very few prosecutions of directors or managers under s37 of H & S at W Act 1974

15. Attention has been drawn to this by David Bergman of the Centre for Corporate Accountability, who gave evidence at the last Select Committee into the work of HSC/E. The reason that matters have not improved more than they have is probably because it is so difficult to prove knowledge on the part of directors. Directors should have safety duties and the appointment of a Safety Director would mean that minutes would be kept (see below para 35 (b)).

HSC/E needs to be pro-active

16. HSC/E have produced some excellent leaflets and research about the saving to industry of good health and safety. CO-Gas Safety and Trotter cannot understand why industry does not take more notice of these findings and why the HSC/E cannot do more to persuade bodies such as the CBI and Institute of Directors to take more notice.

HSC/E's information about the Select Committee

17. Trotter only heard about the Select Committee because she was in correspondence with Alan Osborne (Alan Osborne resigned in protest as the HSE's Director of Rail Safety at Her Majesty's Railway Inspectorate). Otherwise, Trotter might well not have known about it in time to make a submission.

When Trotter telephoned the Gas Safety Policy unit, the civil servant she spoke to did not know about the Select Committee but said it was probably because s/he (the civil servant) was "too lowly". Trotter tried HSE's information line as suggested but could not get through. The HSE Press Office and the person who answered were, frankly, hostile. Trotter thought it might be because CO-Gas Safety is perhaps, infamous at HSE. However, she overheard the person who answered her saying in a very angry and loud voice to someone else, "this woman claims. . . " so Trotter is sure it was nothing personal! Trotter had been saying who she was and about the Select Committee. After that, another civil servant came on the telephone and perfectly pleasantly told Trotter to contact Parliament, which she did. Please note that everyone Trotter spoke to in relation to the Select Committee in Parliament has been incredibly helpful.

Trotter asks the Select Committee to ask HSC/E, did they inform any person or body about the Select Committee? If so, whom did they inform? If not, why not? Why did the HSC/E not inform CO-Gas Safety of the Select Committee?

Please note that CO-Gas Safety had no notification of the last Select Committee into the work of HSC/E and only heard about it from the Centre for Corporate Accountability after being given notice that David Bergman had been called to give evidence to the Select Committee (see paragraph 15 above).

Research

18. HSE uses Advantica to undertake gas research. We have been informed that Advantica gives HSE reduced rates. CO-Gas Safety has been told that other research establishments would be much cheaper—admittedly by another research establishment, the Building Research Establishment. Furthermore, because research is undertaken with funds from gas supply companies and transporters, such as Transco, much of the work is confidential, at least while it is being undertaken. This has caused CO-Gas Safety great difficulty

as, if we are given documents which set out the intended research, we are told that these are confidential. It is therefore very difficult for us to object publicly to the fact that the intended research is not the correct research that should be being undertaken.

HSC/E ought to be able to fund its own research and not have to be beholden to the stakeholders that fund its research. This creates an impossible position for HSC/E.

Access to HSC/E lawyers

19. Although Trotter has been told that legislation in relation to the duty of the gas emergency service, Transco, was not drafted as HSE intended, CO-Gas Safety has found it extremely difficult to get through to HSE lawyers to suggest other improved versions.

Today, 30 January 2004, Trotter telephoned to check to make sure the law has not been changed in relation to mentioning the injury in the charge under H & S At W Act 1974 and, having mentioned the Select Committee, actually got through to the legal department of HSE. However, Trotter was told they never give out legal advice but when she persisted, she was given an email address to write to*. Dialogue with the HSE lawyers would be extremely helpful and if they are concerned about their advice being quoted Trotter suggests that a disclaimer could avoid this.

Please could the Select Committee ask HSE if it is their policy to refuse people access to their legal department—even bodies that have been around for many years, such as fuel supply companies and charities such as ourselves?

*Trotter has since received a helpful response. However, is this only because of the Select Committee?

Lack of a body to help accident related gas and CO victims and their families

20. Despite Ofgem, Energywatch, CORGI and the HSE, CO-Gas Safety seems to be the only body that is there for victims. Yet CO-Gas Safety is run on a shoestring with no full time paid staff. Victims need someone to contact immediately who looks at things from their point of view. The Centre for Corporate Accountability and Inquest are the only other bodies that are there for victims of workplace deaths or injuries. In the era of "counselling" for everything and anything it is wrong that victims and their families are so badly served and treated when their problems are so much more immediate and real than most people who receive "counselling". In Trotter's experience, what families need most is practical advice and access to good experts as soon as possible after a death or injury so that evidence can be gathered correctly.

Incident investigation and report

21. There has been an improvement in liaison between HSE and the police in recent years. However, CO-Gas Safety and Trotter still hear of cases where the police do not take a work death seriously. There are several other problems. Initially the family assumes that the HSE is there to help them, not to merely investigate to see if there has been a breach of a statutory duty, which requires prosecution. HSE field officers do not tell families exactly how limited their remit is. HSE field officers often mistakenly tell families that they will receive the report of the investigation into a death. This lulls the family into allowing the investigation to be undertaken without the presence of their own expert investigator. Often the investigation itself prejudices evidence (eg a gas appliance is taken apart to be examined) and the evidence is lost. The family should be told that it can obtain and instruct its own expert (and given a suitable list of independent experts) to investigate along with the HSE. This is virtually never done in our experience.

The family is usually the last to receive the HSE report, or indeed may never be allowed to see it. However, the HSE report may be the only way the family can find out how or why their loved one died. The report is privileged but despite many suggestions about how this difficulty could be overcome or got around (eg releasing the report to the family's lawyers—please find enclosed—"CO-Gas Safety 14" including letter dated 9 October 1995 to Les Philpott HSE, page 2—top), it seems to us that no progress has been made in nine years. This is just wrong.

Over many years, since 1998, Trotter has tried to persuade HSE to inform the bereaved about this issue by suggesting changes to the bereavement leaflet (see enclosed "CO-Gas Safety 14"). Although some changes have been allowed, information telling the bereaved to instruct their own experts because they may never receive the investigation report has not been allowed. See enclosed "CO-Gas Safety 14" letter dated 1 January 1999 to Tony Gissane and also material relevant to the leaflet. Why is this misinformation allowed to continue? It is surely not part of the remit of the HSE to mislead people?

Qualifications of investigators

22. CO-Gas Safety is extremely concerned at what we consider to be an appallingly low standard of investigation presumably caused by the poor training and experience of investigators. Please see enclosed letter from Harry Rogers to HSE dated 25 November 2003 (enclosed—"CO-Gas Safety 15"). We know of cases where the HSE has failed to measure for CO—Harry Rogers can give evidence of this. CO-Gas Safety is also concerned that CO measurements are not taken when the appliance is still *in situ* and yet it is often the installation and the flue that causes the problem with CO.

Lack of independence of investigators—query training of investigators

23. CO-Gas Safety is also very concerned that investigations into gas incidents are undertaken by gas companies, which seem to have a vested interest in claiming that gas is always safe and that incidents were caused by the weather. 99% of investigators into gas and CO deaths and injuries are employed by Centrica, (ie British Gas). Chris Bielby of Centrica told Trotter and Don Neal (another director of CO-Gas Safety and father of a CO victim) this recently.

We are in the process of trying to find out what training and equipment is given to such investigators. So far, Trotter has been informed that the course is under the City and Guilds but that only British Gas runs it and has access to the syllabus. City and Guilds are requesting a copy of the syllabus from British Gas so that this can be sent to CO-Gas Safety.

The weather can be the last straw when an appliance is poorly installed or maintained etc. In our experience, the weather has never been the sole or even main cause.

Some investigations do not seem to include a measurement of CO while the appliance is still *in situ*.

The Sollihull investigation (enclosed—"CO-Gas Safety 16") has been given by HSE to CO-Gas Safety for many years as the case which justified the lack of need for equipment to measure for CO by the gas emergency services because "it was the weather that killed". Yet when CO-Gas Safety eventually obtained a copy of this investigation, it merely showed (to us anyway) that the weather was the last straw. There seem to have been quite a few problems with the boiler in order that 1,000 ppm of CO (and perhaps more) was being emitted. The report does not make it clear where the measurement was taken (eg in the flue or in the house). It may be that there was no measurement taken of the gasses in the flue to see how much CO was being produced that, due to adverse weather conditions, was blown back into the property. In our experience, a flue reversal caused by weather conditions will not cause a fatality unless there is already a problem with the boiler which is, as a consequence, then emitting excessive CO. Harry Rogers would give the Select Committee further details on this. HSE was reluctant to give out the report of this investigation and this report lead to the conclusion, held by HSE for many years, that there was no need for equipment to test for CO. CO-Gas Safety has come to the conclusion that HSE lacks the expertise in gas and CO to make the correct judgment on matters of this kind.

CORGI (Council of Registered Gas Installers) was set up in a way that means it has a disabling conflict of interest

24. CORGI is controlled and licensed by the HSE, CORGI's funds are paid by the gas installers (who are policed by CORGI) and CORGI is also put forward as the public's safety watchdog. CORGI cannot be all things to all parties. CORGI should be funded by a compulsory levy on the gas companies via Government—this would give it some independence from the installers, whom it has to police. If CORGI is to be the public's safety watchdog it should legally owe a duty of care to the consumer which, according to a County Court judgement (Wright v CORGI), it does not. If CORGI is said to be the public's safety watchdog and yet owes no duty of care, the claim that CORGI is the public's safety watchdog is misleading.

Why did the HSC/E allow such a body to be set up in such a way that it cannot possibly fulfill the expectations raised? Having allowed this, surely the HSC/E should at least recommend that changes are made?

C. Recommendations Made by the HSE With Regard to Gas Safety

25. Please find attached a copy of HSE "Fundamental Review of Gas Safety regime, Proposals for Change, Draft report to the Health and Safety Commission" (enclosed—"CO-Gas Safety 8"). The document is not dated but Trotter assumes it is the same document, published August 2000, about which CO-Gas Safety commented, (please find enclosed copy document headed "Main recommendations made by HSE—Published August 2000 CO-Gas Safety's comments in italics—enclosed "CO-Gas Safety 8 B").

Although all the Recommendations are important, we consider that the most relevant are:—

(a) Safety levy—Page 15, Recommendation 7, Paragraphs 54 and 55,

(b) Research and misdiagnosis—Page 18, Recommendation 10, Paragraphs 70-71,

(c) Public Awareness—Page 19 and 20, Recommendation 11, Paragraph 75 and 76, and

(d) Equipment to measure CO for Emergency Service Providers and gas installers—Page 21 and 22, Recommendation 12 and Paragraphs 83–87, Pages 72–74, Recommendation 34, Paragraphs 295–304.

Why are these changes needed?

When Trotter first started working for CO-Gas Safety, hardly anyone would talk to her, apart from victims and their families. The gas supply companies did not want to admit that gas could be dangerous. The HSE was busy and found CO-Gas Safety a bit of a nuisance. Perhaps understandably HSE found our questions difficult and time consuming to answer when they were understaffed.

Gas Consumers Council (now Energywatch), allowed CO-Gas Safety to hold meetings at GCC premises but were unwilling to take up any of CO-Gas Safety's concerns or lobby for the changes CO-Gas Safety considered were important. GCC seemed horrified when CO-Gas Safety suggested that GCC attend inquests into accidental deaths from Carbon Monoxide to find out where the problems were because GCC stated this had "resource implications". CO-Gas Safety suggested that GCC lobby for increased resources but GCC seemed unable or unwilling to do this. CORGI was perhaps understandably more interested in dealing with its own problems, which were huge because their subsidy from British Gas was being withdrawn.

When talking to victims it became obvious very quickly that there were three main problems: —

(a) Lack of awareness of the dangers of Carbon Monoxide poisoning and what to do to prevent it.

Even quite affluent people were being injured or killed. The public simply did not realise that failing to have an appliance serviced could be the difference between life and death.

(b) The need for a British Standard for carbon monoxide alarms so that people could have an extra safeguard.

CO-Gas Safety pushed for this very quickly and it was achieved. CO-Gas Safety believes that the British Standard has made more difference than anything else to the numbers of deaths and injuries from CO.

(c) The need for the gas emergency service (Transco) to carry and use equipment to test for carbon monoxide so that the right appliance could be disconnected.

CO-Gas Safety came across the Mills case through being contacted by the family after Trotter was interviewed on TV's London Today.

Gerald Mills died in April 1999, one month after a visit from Transco.

The central heating boiler was later found to be emitting large quantities of CO (26,900 parts per million). The Transco operative had no equipment to test for carbon monoxide despite the fact that CO is odourless and invisible. CO-Gas Safety kept hearing and still hears of cases where Transco has disconnected an appliance, which is safe, but left one on which is emitting CO. Or indeed, where Transco has cut off the gas altogether in a flat (with the fear of vulnerable people dying from hypothermia) when the CO was being emitted from another flat.

(d) The need for CORGI installers to check their work with the use of equipment to test for CO.

(e) The need for investigators to have equipment to test for CO in order that a finding of CO could be made, where there was CO poisoning. This is necessary so that doctors do not waste time and resources treating people for other conditions when in fact they were suffering from CO. Having their condition recognized also helps victims. Without definite proof, victims often suffer the additional stress of being told they have imagined their damage.

(f) Where a person had been poisoned, a measurement of CO and evidence of where it was coming from, enables victims, who are badly damaged, to recover damages from a person who has caused that poisoning. This proof also frees the state from supporting such victims. Proof further drives up standards so that others are less likely to be poisoned.

Please will the Select Committee take note that you cannot be sure that someone is safe from an odourless, colourless poisonous gas unless equipment is used to test for CO. In many cases, there will be visual signs, such as sooting etc. but in some there will be no signs. Gas expert, Harry Rogers of T & T Engineering is very willing to give evidence about this. He is preparing a submission with evidence for you.

CO-Gas Safety is convinced that should these recommendations become compulsory and sufficient funding from the fuel industry raised to implement them properly, deaths and injuries from CO could be dramatically reduced. This should also greatly reduce wrong diagnosis and wasteful use of NHS funds.

So why have these vital recommendation not been implemented?

27. Some possible reasons

The safety levy must either be raised by a compulsory change in the law to compel gas supply companies to provide funds or it must be provided voluntarily

(a) Compulsory

In CO-Gas Safety's opinion, compulsion would be better and fairer. However, there is a lack of political will and Parliamentary time. Perhaps this Select Committee could help to spur political will and so provide Parliamentary time. It is disgraceful that Parliament can, for example, pass a bill in relation to insurance for terrorism in a matter of hours, yet a measure, which is for the benefit of our citizens, is endlessly delayed.

(a) Voluntary

As it is a company's duty to make as much profit for its shareholders as possible and as there is no tort of wrongful death in this country, there seems to be no financial incentive, (indeed there are many disincentives), to provide funds to help warn about Carbon Monoxide poisoning and other gas dangers.

Yet the HSE persists in maintaining that the gas supply companies will provide this levy. CO-Gas Safety finds this rather a nave attitude from a Government department. However, what else can HSC & HSE do? The HSE and HSC should be able to engage the media to publicly call for this levy and demand that Government change the law to provide the compulsory levy. Can the HSC/E do this? If it can, why is the HSC/E not doing this?

However, perhaps the HSC/E cannot even demand more funding for itself. During the last Select Committee inquiry into the work of the HSC/E, Gwyneth Dunwoody MP asked Jenny Bacon, (then DG of the HSE), "do you need more resources to undertake the work of the HSE?" Bacon replied, "it is not how much you have but what you do with it that counts". Please note these words are from Trotter's memory. Trotter was bitterly disappointed at this missed opportunity. No civil servant seems to be allowed to say publicly that their department is underfunded, even if that department is unable to undertake the necessary work. If the HSC/E is adequately funded, why is it that it has taken four years so far before its recommendations have been implemented? If it is lack of political will, then the HSC/E ought to be able to at least lobby more effectively.

D. CO-Gas Safety's Problems With HSC/E

28. Some of the civil servants have been very helpful. However there have been many problems.

(a) CO-Gas Safety felt from the start that it was patronized and treated as if we were wasting valuable time. This is perhaps understandable but in the end, more time has been wasted and not just CO-Gas Safety's time.

(b) There was no Commissioner for Victims whom CO-Gas Safety could appeal to. Things have improved since Dr. Bob Maynard of the Department of Health very kindly wrote to HSC/E on CO-Gas Safety's behalf. However, CO-Gas Safety considers that DoH's time is very valuable and we should not have needed to take it up. Please note that CO-Gas Safety has tried to appeal to the Commissioner for Consumers but found that this did not produce any real understanding or help.

(c) Angela Eagle MP, then Minister responsible for HSC, was briefed by HSE and Hansard reports that she stated "The Co-Gas figures may include, for example suicides, and are not as reliable as our statistics", Hansard, (21.01.98 Pt. 15 enclosed—(enclosed—"CO-Gas Safety 9")). (Please note that HSE seems to have omitted to brief Angela Eagle MP on our correct name.) CO-Gas Safety in fact made and makes, huge efforts to exclude suicides and this is not as difficult as first thought. CO-Gas Safety writes to all the Coroners on a regular basis and most respond. Trotter telephoned the House of Commons to explain the problem but was told that Hansard could not be changed. Trotter contacted HSE, gave HSE the name and date of every one of the deaths from CO that we had recorded and asked them to let CO-Gas Safety know which ones were suicides. After a year, Trotter had heard nothing. Trotter chased and HSE admitted they had no evidence that what we had stated, (ie that all the deaths we quote are accidental and not suicides) was not true. In this case, it was not so much the fact of the inaccuracy that disturbed us but the way this criticism was given and the lack of any acknowledgment or apology.

Furthermore, we consider that records of deaths without names of the deceased could be inaccurate.

(d) CO-Gas Safety has never been able to compare the deaths we record with HSE's satisfactorily (or in fact at all) because HSE does not name the dead people. Yet the names are in the public domain. CO-Gas Safety had a meeting with the HSE to discuss this but nothing came of it except to demonstrate the fact that CO-Gas Safety could not compare its statistics with HSE's due to the lack of names. Why does HSE continue not to name the people who have died? Please note all CO and gas deaths are quoted in public at an inquest. In any case deaths in general are not secret.

(e) CO-Gas Safety gave a presentation with some victims about their experiences of either accidental CO poisoning or having had a loved one die of accidental CO. The civil servants who attended this appreciated the efforts made and the presentations made a huge difference to their attitudes. Various suggestions were made that this be given again to the HSC Commissioners. However, this has never happened. No doubt the

Commissioners are very busy but do they ever hear from victims and the families of victims because if not, CO-Gas Safety's opinion is that victims should be asked to address Commissioners regularly? Could the Select Committee please ask the Commissioners about this?

(f) When the HSE undertook its Fundamental Review into Gas Safety, it produced two documents, a small (two page or so) leaflet for consumers and a thick legal looking "tomb" for stakeholders. HSE held some events for consumers but CO-Gas Safety was not informed beforehand or invited. Trotter was invited to the stakeholders" meeting (mainly gas supply companies who had been sent the large document) but CO-Gas Safety was told by an HSC/E civil servant that she was not allowed to bring any victims because, there would not be enough capacity in the room allocated. However, when Trotter attended the event, the room was very large and only about half full. Luckily, one of our victims had requested the full document so was also invited to the stakeholders' meeting. However, CO-Gas Safety could have brought many more victims along to contribute or, if this had been considered too many, at least several others. Trotter considers that this division between stakeholders was and is wrong. Surely victims are stakeholders and should not be put in such a different, (and we submit, lower) category so that fuel supply companies never have to see them or hear what they say?

Could the Select Committee please ask HSC if the Commissioners have regular events to which victims are asked to talk about their experiences and fuel supply companies and other industries, such as construction, are also asked to attend? If not, please could such events be arranged in the future.

(g) It took CO-Gas Safety about an inch of correspondence, hours on the telephone and the mercy of one brave civil servant to allow CO-Gas Safety to become members of the two HSE Work Groups (Publicity and Transmission), which were most relevant to us. Why is the HSE so reluctant to invite organizations such as CO-Gas Safety on to its Work Groups and committees etc? HSE persisted in stating that it was up to Energywatch to be on the Work Groups and later to allocate places for CO-Gas Safety on the Work Groups. CO-Gas Safety was eventually allocated by Energywatch to Work Groups which were inappropriate and where we would have been unable to make a useful contribution. Energywatch denied CO-Gas Safety membership of the groups which CO-Gas Safety asked to join and where the charity could make a useful contribution namely "Publicity" and "Transmission". Energywatch rarely attends Work Groups etc. and when it does, it makes almost no contribution. There is now some doubt about whether Energywatch has a consumer safety remit, (since the Utilities Act 2000), and Trotter has received a recent letter from Alan Usher CE of Energywatch in which he states that Energywatch does not want to extend their remit, yet Energywatch's presence seems to have made it much more difficult for us to be part of these committees etc. for years. Why did HSE continue to allow this? Molly Maher, vice president of CO-Gas Safety has had problems with gas suppliers' contracts and sought Energywatch's help. Maher found from this that this well funded body appeared to have no lawyers and no trained gas safety consultants. The issue of Energywatch's remit needs clearing up and Trotter has suggested that Energywatch seeks legal advice about its remit so everyone knows where they stand.

(h) It took CO-Gas Safety three years of asking and two presentations at open meetings to be invited on to the Gas Safety Sub-Committee. Why? (See enclosed—"CO-Gas Safety 10")

(i) CO-Gas Safety has never been put on the HSE press release list. Why not?

(j) CO-Gas Safety has never been allowed a meeting with Bill Callaghan—why? CO-Gas Safety appreciates that Bill Callaghan must be very busy but does he often meet with business stakeholders? In nine years we have never been allowed a single meeting.

Please note Trotter did accompany Anne Jones (mother of Simon Jones) to a meeting with Bill Callaghan but that the meeting was to discuss safety issues relating to the death of Simon Jones, not CO-Gas Safety.

Nick Starling was kind enough to see CO-Gas Safety—the charity was trying to persuade him that CO-Gas Safety should be allowed on to the Gas Safety Sub-Committee and the meeting was mainly about this. CO-Gas Safety failed at that time although it has since been successful.

(k) The 12 hour rule.

Basically, Transco has to prevent gas leaks (including CO) within 12 hours of notification. Transco also has to attend leaks "as soon as is reasonably practicable". HSE does not prosecute Transco for failure to prevent gas leaks within 12 hours if the leak is, for example, in the middle of a field. HSE wanted to change the 12 hour rule to "as soon as is reasonably practicable". There was a joint meeting of work groups on 26 July 2002 where the 12 hour rule was discussed but not minuted. (Letter to Patrick Maple dated 1 April 2003 and minutes of meeting on 26 July 2002 and meeting on *3 December 2002 enclosed (enclosed—"CO-Gas Safety 11")). Then at a subsequent meeting of the Transmission Work Group only, on *3 December 2002, the 12 hour rule was brought up again as if it had never been discussed before. It was the last or virtually last, item on the agenda. Trotter was the only person to object to the change on the basis that "as soon as reasonably practicable" could be a far less onerous duty (depending, for example upon the number of operatives whom Transco employed) and the only reasons for change was to reduce safety and that any person injured by a gas leak not prevented after 12 hours would then have a much more difficult burden in any subsequent legal case. The original minutes again did not mention Trotter's objection. This was later changed, (see enclosed letter to Patrick Maple 01.04.03 in "CO-Gas Safety 11"). David Heyes MP and his research assistant Bruce Wylie were very helpful and a further meeting was sought and had with HSE on this matter and also on research which we consider should be being undertaken on the use of equipment to

measure CO on an emergency call out (see briefing document for meeting with Barry Watkinson 10.07.03 (enclosed—"CO-Gas Safety 12")). CO-Gas Safety is still concerned about this issue and is concerned that this 12 hour rule may be changed. CO-Gas Safety is concerned that bureaucratic "tidiness" seems to have been treated as more important than safety.

(l) Lack of proper research into the use of equipment to sense Carbon Monoxide (CO) on an emergency visit by Transco.

CO-Gas Safety has sought meetings to deal with this issue. Only our gas experts have been allowed to attend meetings at Advantica. HSE seems to be unwilling to recognise that without research being undertaken now in the field, (not just in the laboratory on appliances) on the use of equipment to sense CO, Transco will simply state that it cannot use such equipment even if legislation (as recommended by HSE) is brought into force requiring this. CO-Gas Safety cannot understand the reluctance of HSE to insist upon proper research in the field on this vital safety issue.

Advantica does have good laboratory facilities. However, unlike the Building Research Establishment, Advantica has no houses in which to undertake research. We submit that the correct research should be carried out in houses or mock houses. CO-Gas Safety considers that this problem has arisen because of the lack of CO and gas experts in HSE and within the steering group running this research. Also, it should be noted that Advantica is owned by National Grid Transco. CO-Gas Safety considers there is a clear conflict of interest. Why does HSE refuse to undertake the correct research as suggested by our gas expert, Harry Rogers? CO-Gas Safety is very concerned that this research will not be undertaken, or at least not undertaken soon enough to enable the recommendations. Please see enclosed document written by Harry Rogers (enclosed—"CO-Gas Safety 13").

Submissions from Andrew Wall and the Hopkins family

29. CO-Gas Safety has received two submissions which will be sent to you directly but which we also include (enclosed—"CO-Gas Safety 17 and 18").

Document 17 is from Andrew Wall (who states he has been poisoned by CO). Wall has set up a support group for CO victims in the South West. Wall undertook a survey of HSE officers employed at district level and found that "the level to assist in such cases was poor". He states that therefore there would not be an investigation and that these cases would not be suspected of causing chronic CO poisoning. This echoes CO-Gas Safety's experience. We find that it is a Catch 22 situation. In order to prove that you have suffered poisoning from CO you need to show that there is some CO.

In document 18, the victim was (very unusually) able to show CO due to the fact that a friend advised her to obtain a CO detector and that a blood test was taken and a positive finding of CO was made. However, if the CORGI installer who had originally installed the cooker or the CORGI installer who had given the safety certificate or the Transco operative had had and used equipment to test for CO, CO would have been found and this university student would either not have been poisoned at all or would not have continued to have been exposed to this deadly poison. Please note that written permission is being sought from the student's solicitor as to whether this document can be made public, as the case may be sub judice.

E. The Need to Change the Law in Order to Improve Health and Safety and Make the Work of the HSC/E or a New Body More Effective

The Health and Safety at Work Act 1974

30. This Act places the duty on the employer. Where this is a company, this means the company, an abstract legal entity, not physical persons. This can cause difficulty, especially with large companies, as often it seems to victims that nobody is responsible.

The primary duty of directors is to act in the best interests of the company and that usually means making the most profit for its shareholders.

31. The existing law and practice around safety means that the risk of a prosecution is remote. Even if there is a conviction, a fine on a company is not much of a deterrent to an unscrupulous company and its directors. In contrast, even a remote risk of a prosecution, fine on the company and the subsequent media attention, can be a real deterrent to a respectable company and its directors. Obviously, anyone concerned about safety should be more concerned about the unscrupulous companies and their directors.

32. It is possible to change the law and practice to encourage better health and safety standards. Please see enclosed articles, "Corporate manslaughter" New Law Journal March 2000 pages 454, 455 (enclosed—"CO-Gas Safety 3") and "The Paddington Rail Crash" NLJ October 1999 page 1505, (enclosed—"CO-Gas Safety 4") by Trotter. Even the much heralded proposals on corporate killing by the Law Commission will not, in the opinion of many, improve health and safety.

33. Please read in particular, "Corporate manslaughter" NLJ March 2000 pages 454, 455 (enclosed—"CO-Gas Safety 3") for a number of "pick & mix" ideas to improve health and safety. However, Trotter has tried to summarise the most important issues and solutions below.

In brief, to improve health and safety there needs to be: —

1. Improved resources.

The funding for HSC/E is that of the West Midlands Police Force, (Centre for Corporate Accountability), yet HSE is put forward by Government as an independent body which looks after everybody's safety. Can the HSC/E fulfill this expectation on these resources?

2. Clear responsbility for people running companies including directors, plus an easy to follow guide of what directors must do to avoid the totally unnecessary tragedies that occur daily.

3. Either a different HSC/C or a new body that is independent and can lobby publicly for legal changes that would improve health and safety.

Solutions in more detail

(a) If increased resources were found to be necessary, resources for HSC/E could be dramatically improved in many ways.
CO-Gas Safety suggests that the most straightforward method would be to license companies and other bodies for safety-licence fees could vary according to size, turnover, type of operation and safety record.

Spot checks should be undertaken regularly to keep companies up to safety standards. There should be enough resources and political will to enforce existing legislation. Companies and other bodies with the worst records could be made to pay higher licence fees. Please note that dog kennels have been licensed for over thirty years, (but of course, dogs have fur!).

(b) The law could be changed to impose safety duties on all directors, with one appointed director responsible for safety and registered at Companies House.

The Safety Director should follow an agreed formula of consultation about safety.

If anyone were concerned about a safety issue, s/he could write to the Safety Director by contacting Companies House to find the name and address. Companies House should encourage all such letters to be sent registered post and for copies to be kept by the sender and/or sent to the licensing authority.

Safety issues should then be brought up at board meetings. To ensure that board members do discuss safety, the Safety Director would be able to escape responsibility, (eg after any death or injury), by showing that s/he brought up the relevant matter at board meetings. Minutes would need to be made and kept. Minutes are often the vital evidence that is missing when a corporate manslaughter charge is considered or brought. The Safety Director would have a personal interest in making sure board meetings discussed safety concerns and that minutes were made and kept.

This would act to improve safety generally. We know that some directors tell managers and others, not to inform them of safety concerns.

If the law was changed in the way advocated above, we now need to consider what might happen after the Safety Director had brought a safety concern to the attention of the board but even so, a death or injury occurred that was relevant to the safety issue brought to the board's attention by the Safety Director. In such a case, the other directors would be primarily liable unless they could show that:-

(i) either appropriate measures were taken, (eg a proper risk assessment showing that the cost was disproportionate to the risk provided that the judge could make sure this was true), or

(ii) that some measures were taken, (but sadly these were not sufficient and it was not obvious at the time these measures were taken that they would be insufficient) or

(iii) that it was not practicable to reduce or remove the risk that caused the death or injury. The fact that directors would be primarily responsible and could face a criminal trial, would improve safety. Please note that although the HSC/E have written guidelines based on the above, sadly these is merely good advice and there are no mandatory requirements. Therefore, the most unscrupulous companies and directors will ignore the guidelines while responsible directors will obey this good advice: ironically this compliance may have the result of making it easier to bring a prosecution against an individual director under S. 37 of the Health and Safety at Work Act 1974. So, the bad boys may get away with it at the expense of the good guys. This cannot be right. (See "Money is much more important than life and death" NLJ. March 16, 2001—(enclosed—"CO-Gas Safety 5")

Other specific ideas to improve safety

(a) All companies (not just airlines) could be under a legal duty to undertake their own investigation into a death or serious incident. This would encourage a more safety conscious and efficient culture.

(b) Make it easier to ensure that the police are called in after a death or injury and the evidence is preserved.

At the moment, our understanding is that the police are called after a death but as far as we know, not necessarily after an injury. However, in both cases we have heard that evidence is suppressed or changed.

David Potter (see paragraph 12 above) also said, "if an injury occurs on site the HSE takes around 3 hours to visit so the company tidies up first. Things were better in the 1970s when companies were worried about the HSE because it was new and unknown—now managers know how HSE works and they know they can get away with it."

It is high time the HSC/E showed its teeth and made sure this complacent attitude has radically changed.

Perhaps union representatives and employees could be encouraged to call the police after a death or serious incident.

Making sure evidence is not changed or tampered with is a complicated area. We suggest that an inquiry, taking the views of interested parties, including employees (not merely unions) and victims, should be undertaken about how to improve this.

(c) Directors, or at least the Safety Director, should have to attend criminal trials for health and safety offences, even if the charge is made only against the company. It is appalling for the families of victims to find that there are no directors at all in court. Requiring the presence of directors or at least one director would keep directors better informed of safety issues and would mean that at least one director would understand the impact of deaths and injuries. This would improve safety in the future.

(d) After a prosecution with regard to safety, it ought to be possible for the court to order a safety audit of the whole system at the company's expense.

(e) The court should also be able to order "Company Probation". This would assist the company to change its future conduct and make sure the company is monitored and so continues to improve.

(f) Courts should always first hear about the state of the company's finances when considering fining a company. A fine of even £100,000 is merely petty cash to companies who make billions.

(g) Fines on the company should not merely go to the government but, where the company cannot afford both the fine and the safety improvement, should primarily be used to improve the safety of the company, pay for bodies such as HSC/E and perhaps also go to the victims without reduction of their civil damages.

(h) The consequences of the breach of a duty under Health and Safety at Work Act 1974 should always be mentioned in the charge. Why should a charge of lack of care centering round the lack of a guard around a machine, fail to mention that the employee lost an arm?

(i) Greater use should be made of s. 37 (1) of the Health and Safety At Work Act 1974 to charge directors as individuals for breaches of health and safety legislation. (This would be easier if safety duties were imposed on directors.)

(j) Make imprisonment a possible sentence for all breaches of health and safety legislation. This would be imposed extremely rarely but would perhaps, concentrate the minds of those in control. Financial offences are normally imprisonable. Why should personal injuries and death be treated as less important than money? This attitude adds to the misery and bitterness that victims suffer. Surely most people, given a choice of two evils, would rather be robbed, than badly injured or killed? So why is it that it seems that health and safety offences are treated so lightly? The reason is probably because it is difficult to prove that a real person actually knew there was a safety issue, had the power to do something and then did not do anything to improve safety. This is why it is so important to impose safety duties on directors with a Safety Director primarily responsible.

(k) Make the publication of health and safety performance in annual reports, compulsory.

(l) Make the declaration of insurers compulsory including the company's safety record.

(m) There should be higher awards of civil damages for personal injuries and for death.

(n) There should be a tort of wrongful death.

It is surely, totally wrong that parents can lose an 18 year old, beloved child and recover only funeral expenses, despite, for example, a landlord's admission that s/he caused the death by gross negligence. It is insulting, unjust, brings the law into disrepute and is tantamount to leading to a breach of the peace that such wrongdoers "get away with murder". CO-Gas Safety knows of one case where the landlord admitted manslaughter by gross negligence of 19 year old Tracy Murphy. While the landlord was serving his sentence of imprisonment, he was receiving rent for his properties (as landlord), including the property which caused Tracy's death.

The parents only obtained a conviction for manslaughter because a solicitor acted free for Tracy's parents at the inquest. The Murphys could not afford solicitor's fees.

CO-Gas Safety appreciates that things have improved in relation to inquests and legal aid but it would be helpful if parents etc. had the real hope of receiving a reasonable lump sum after a death so, where necessary, they could pay lawyers to represent them at an inquest or other inquiry.

The proposition that money cannot compensate for the loss of a life is often given by judges as justification for the fact that there is no tort of wrongful death. However, the same logic also applies to the loss of a limb, yet the loss of a limb is compensated by money.

CO-Gas Safety asks the Select Committee to ask people they meet, how much do you think parents would receive for the death of a child who is studying and who was 18 or over, where someone, reasonably well off, has admitted to killing them?

Please see enclosed (enclosed NLJ October 2000 "Double jeopardy and the cost of death"—"CO-Gas Safety 6')

CO-Gas Safety

February 2004

Memorandum submitted by Alan Osborne

BACKGROUND AND EXPERIENCE OF WITNESS

1. I have been creating frameworks and systems to improve health and safety for over 20 years. I graduated with a degree in Health and Safety Engineering in 1982, and spent my early years working in health and safety management roles in the chemical industry (Bayer, Burmah Oil and BOC).

2. 15 years of my career have been at director level and I am a fellow of the Institution of Occupational Safety and Health and a fellow of the Institute of Quality Assurance.

3. I was Safety and Quality Director for London Underground Ltd (seven years) and Director of Safety and Risk Management for the British Airports Authority (eight years).

4. Following Lord Cullen's criticisms of the Health and Safety Executive (HSE) in his report into the Ladbroke Grove train accident, he recommended that the HSE should create a new post and appoint "a person of outstanding managerial ability" with the objective of injecting "new imagination and energy".

5. I joined the HSE in this role (as a board member with responsibility for rail safety) in November 2002. It had been my life long ambition to work for the HSE. My degree was a foundation course to be a HSE inspector (unfortunately HSE had a recruitment freeze on when I graduated so I pursued a career in industry).

6. Having tried everything I could to effect change, I reluctantly resigned the following October after 11 and a half difficult months in the job. I concluded that the HSC/E was not committed to change and the job turned out to be largely about defending HSE's current approach rather than changing it (as Lord Cullen required). I found HSC/E to be dysfunctional across its policy and inspectorate functions, not listening to its stakeholders, lacking in modern corporate governance processes and grossly inefficient.

7. Whilst I influenced these issues I could not gain board acceptance of the need for change and I was not prepared to live with such fundamental problems. My only motivation now is to try to improve the situation by relaying my experiences and challenging the *status quo*. This is why I am making this written submission to the Works and Pensions Select Committee inquiry.

8. I have not included reams of facts and figures nor many specific examples in this submission. This is deliberate because they tend to distract from the big issues but I would be happy to provide further information to the Select Committee should they wish. My aim is to explore a few core principles as an input to the Select Committee's considerations.

THE CASE FOR CHANGE

9. A great deal has been achieved over the last 30 years using the principles developed by Lord Robens and his committee. The resulting Health and Safety at Work Act 1974 has served the UK well but there does now seem to be a growing body of opinion that direction and momentum has been lost over the last few years. A stubborn plateau (indeed a slight worsening) in health and safety performance seems to have been reached despite considerable effort and resource being expended.

10. Extrapolating available data suggests that the Revitalising Health and Safety targets set in 1999 will not be met (and I have some concerns that HSE are looking at redefining the measures agreed in 1999 as this will make it very difficult to assess real progress). A series of serious accidents in the railway industry (plus a very sour relationship with the railway industry stakeholders) and a number of perverse regulatory actions (one important one being the prosecution last year of the Metropolitan Police Commissioner) have damaged the HSC/E's reputation and credibility. HSC/E is seen by many to be part of a "nanny culture" and not focusing on the right things.

11. Perhaps more fundamental than this is whether the current Health and Safety System still meets societal and UK Plc needs. Supplementary questions include: whether the bureaucracy associated with the health and safety system is harming the UK's competitiveness and wealth (and job) creation; whether the UK is now too risk averse and whether this is stifling innovation and business development in the UK;

whether the HSC/E is causing such risk aversion through its policy formulation and enforcement activity; whether HSC/E are tackling the right issues (and how such issues are decided upon); whether the barriers to good health and safety performance are still the same as those defined by Robens in 1972?

12. Could a new approach be created which facilitates a re-invigoration of health and safety performance in an even more efficient way? In other words have we really defined today's problems before we move into solution mode? This is more fundamental than simply considering what developing hazards might need to be tackled. It is more important to consider how flexibly the existing framework might cater for new hazards. Can the framework be simply expanded to include complex issues like stress? Care also needs to be taken to avoid a "one size fits all approach" which can result in inappropriate solutions (for example the HSE guidance on stress management is not even followed by the HSE because it is so complex and requires so much time and effort to follow it). The central control within HSE which forces a "one size fits all" approach also distorts the local priorities of the HSE major hazard inspectorates (of which rail is one).

13. The way HSE is structurally organised into a separate operational (the inspectorates) and policy functions causes the organisation to pursue separate objectives and give out different messages to stakeholders (this is well documented in the rail area). HSE is also poor at taking its own medicine and does not really know how to improve its own health and safety without creating an expensive and time-consuming bureaucracy. All in all it has many challenges and needs major surgery.

14. Can these questions and challenges be answered and addressed by the HSC/E? My experience is that they are not capable of doing so. It needs a fresh start and the existing leadership are not capable of thinking "outside the box" to create a radical and modern agenda (as can be seen from the early outputs of the HSC's new strategy it is largely more of the same). This is deep-seated cultural issue. HSE has a very poor record when it comes to change management and there have been a number of failed initiatives over the last few years. This was because the leadership failed to take the staff along with them.

15. 30 years on we need a new Robens type inquiry to carefully consider what is required for the next 30 years. An eminent health and safety practitioner or informed industry leader (not a regulator) should be tasked with leading an independent inquiry. Such an inquiry needs to start at the grass roots level (just like the Robens Committee did) to consider how health and safety management fits together with the way industry is managed today. It then also needs to consider the framework for improvement and regulation. The review must also be highly involving of HSC/E and its wider stakeholders.

16. Also of vital importance is a consideration of other branches of management that have emerged over the last 30 years (for example risk management, corporate governance, quality assurance, total quality management, corporate and social responsibility reporting, sustainability etc). HSE has not been particularly quick to embrace these opportunities for revitalising health and safety. Integration is the answer rather than bolting on.

17. Industry is having real difficulties in fitting together all the initiatives resulting from these new approaches to management and it is critical that as far as possible they are integrated. This incremental approach can place enormous burdens (and costs) on managers and there is a need to simplify the arrangements for all. Health and Safety is an important risk, however it is but one of a number of risks that any organisation must manage to be successful. My personal preference is to use risk management as the umbrella approach, identifying, prioritising and managing the myriad of risks facing an organisation. It must be for a Robens type inquiry to consider how all these approaches can be more joined up with a modern and integrated health and safety framework.

18. The techniques used in the world of finance to manage financial risks read across well to the management of health and safety. For example the production of published annual report and accounts that are externally verified (by qualified and registered professionals), internal auditing that is risk based (and provides a level of assurance about the effectiveness of internal controls), external auditing, a clearly responsible director, clear responsibilities for all directors under the law (the Companies Act) etc. Many of these approaches are used in safety but in a rather *ad hoc* and incoherent way and the Health and Safety at Work Act is aimed at employers and employees rather than a more targeted approach (though the directors) as is found in the Companies Act. Much can be done to create a parallel system of regulation that uses the same tools and techniques and language between the finance and safety worlds, all underpinned by risk management. This would be very helpful to industry and regulators alike. HSC/E planning and thinking should be at the leading edge on such thinking but it is too busy defending the old approach and its patch.

Inside the HSC/E Today

19. The HSC/E has been, through the 1970s, 80s and 90s, a useful unifying mechanism and it has facilitated an integrated approach to health and safety management across industry. There are still many talented people in the HSE but the focus and direction of the organisation has been lost. As one senior person said to me whilst I was at the HSE, "I don't think there is anyone on the bridge". The judgment call is whether it is capable of leading a step change in performance or whether it has "had its day".

20. There is no doubt that the two-tier structure of the HSC/E is extremely cumbersome and old fashioned. In the current leadership's defence, this structural arrangement was prescribed by the Health and Safety at Work Act in 1974. The Commission is made up of part-time Commissioners appointed to represent

their particular areas of interest (employers, trade unions, trade associations, local authorities etc). This tends to result in a group of people coming together to defend their patches rather that being a cohesive group developing and sharing a common vision.

21. The HSE has a board but it is not a board in the legal sense. There is very little interface between the Commission and HSE Board. The HSE board also has two tiers (some members of the board are members of the so-called "executive" and others are not). The HSE board does not have non-executive directors sitting on it and therefore the normal checks and balances in decision-making are absent. This results in a board that is divisive with operational board members being compelled to agree the things that the three strong "executive" have brought to it. A fellow board member summed the situation up at a board awayday late last year when he said he felt like "a second-class member of the board".

22. The HSC and HSE board do not conduct their "business" in the way that is now required by shareholders in the business world. Companies falling short of shareholder expectations on effective corporate governance are increasingly suffering tarnished reputations. It is interesting for example that institutional investors in Royal Dutch Shell are currently raising concerns about the ineffectiveness of the supervisory board system (which HSC/E have) complaining that it is not facilitating effective performance and is causing poor decision making. This I believe is a root cause issue for the HSE.

23. There are real question marks about the accountability for HSC/E and how its priorities are decided and its performance monitored. Whilst HSE tries to be an "open" organisation it does not engage well with its stakeholders (and there are many). The board's openness standards were challenged in an audit by The Constitution Unit in December 2002 but very little has been done to implement the recommendations to date ("we noted the reduction in board papers made available from early 2001. We understand this reflects a change in policy, under which fewer decisions supported by such papers, are taken by the board . . . has HSE become less open? Some stakeholders were sceptical about HSE's claim to be an open organisation, and sometimes this scepticism was combined with a degree of mistrust"). This report makes interesting reading and was the subject of a somewhat rose-tinted HSE press release on 12 December 2002.

24. The most worrying areas relate to the decision-making process and governance arrangements. The minutes of HSE board meetings do not record differing points of view and important issues bypass the board completely and go straight to the Health and Safety Commission. It is not uncommon for decisions that have been approved by the board to be later changed by the Commission. This causes significant tensions and confusion.

25. The HSE Board adopted, in September last year, the "balanced scorecard" to begin to measure the performance of the HSE. This system uses a traffic light approach (green, amber and red) and the team who presented the first report rated "leadership" as a red meaning that urgent attention was required. The board rejected this assessment (on the basis that there was not yet hard evidence of poor leadership!) and changed it to amber and it remains at this rating despite further concerns being expressed by the reporting team. This same measurement system shows difficulties with HSE's stakeholder engagement mechanisms (but again the board changed the reporting teams assessment from a red to amber). HSE are also having difficulty reducing accidents to their own staff and I still find it astonishing that HSE do not report on its sickness absence record as this is an important measure of "staff happiness". Many of these measures (including staff happiness) will be able to be put into context through the 2004 Staff Survey. This survey should be available in February 2004 and will be invaluable as an input to the Select Committee's deliberations.

26. Board members do not get to see important work carried out by (so called) board sub-committees (which tend to be run by the Executive members of the board) on things like the effectiveness of HSE's risk controls, financial statements, the work of the audit committee etc. HSE's new vision, mission and strategy have been developed with very little involvement of the board. I certainly strongly objected to the emphasis on "workplace" in the mission and vision because it was too narrow for the work of the Railway Inspectorate, which naturally, devotes most of its resource to regulating passenger safety. This was however not accepted. This emphasizes HSC/E's difficulties with combining a role on worker safety and public safety (section 2 v Section 3 of the Health and Safety at Work Act). I gave evidence to the Transport Select Committee earlier this year to the effect that HSE should not regulate rail passenger safety—it should hand over this role to the newly constituted Office of Rail Regulation. Whilst this will help the regulation of railway safety it will not resolve the remaining difficulties within HSC/E.

27. There is a lack of clarity and effective corporate governance of the kind recommended by the Cabinet Office's Better Regulation Task Force. There is also an issue about the experience and backgrounds of the people appointed to the Commission and HSE board—there is a distinct lack of up to date health and safety management knowledge and experience. I therefore do have a concern that the HSC/E leadership may not be capable of another step change (but many of its staff are).

28. In summary, the entire process of governance of the HSC/E requires a fundamental review before it can begin to function as an effective and modern regulator. It has been some time since the National Audit Office reviewed the HSC/E (10 years in fact). A topic audit is in progress at the moment on construction safety and this will be useful in informing the select committee's inquiry. It was due to be completed by the end of December 2003 but I gather has been delayed and will now be completed in the Spring 2004.

ADEQUACY OF RESOURCES

29. The Select Committee will also be considering HSC/E's resources. I think this is very difficult to consider in the context of the need to do things differently in the future. A smarter kind of intervention from the regulator in the future may require significantly less resource. Having seen the scale of the inefficiencies within HSC and HSE great care should be taken before any agreement to increase HSC/E's budget or resources as this may not represent value for money to the taxpayer. Reform is necessary before increasing funding.

30. Systematic benchmarking against other regulators may well reveal that HSE does things that it should not, that it is not driven by risk (the Financial Services Authority carries out an annual risk assessment to prioritise its work which I believe is very helpful and provides a real focus for the organisation) and its interventions are inefficient and ineffective.

31. The brand new head office premises in Bootle (in addition to the London HQ) and brand new premises in Buxton seem at odds with an organisation wanting to focus its efforts on front line health and safety activities. There is no doubt that the contracting out of its information systems has also not yet delivered the defined benefits first thought available. These developments do not seem to fit with HSC/E's new strategic direction and yet considerable cost (many millions of pounds in fact) is involved with these developments.

32. Decision seem to be taken in isolation from each other but most important of all is the cost burden on industry if ever increasing health and safety standards do not produce improved performance (set out in the regulatory impact assessments). HSC/E are not finding it easy to make the business case for health and safety under the current system.

RECOMMENDATION

33. I therefore believe that there is compelling evidence for a review. The HSC/E celebrates its 30th anniversary this year and this is an excellent time to take stock. I recommend that the select committee consider the case for setting up a committee (like the Robens Committee) to decide whether the Health and Safety at Work Act and the associated regulatory bodies are still appropriate.

Alan Osborne

10 February 2004

Memorandum submitted by AIRSAY

The Committee have been asked to consider how well the HSE achieves the right balance between prevention and enforcement and whether it is adequately resourced for the task, in respect of both existing hazards and anticipated hazards of the future.

AIRSAY are a registered Charity whose interests lie in the dangers posed to public health by the use of fossil fuels indoors. Perhaps the best known of these dangers is that of accidental Carbon Monoxide poisoning.

At this time the HSE are concerned primarily with the "workplace" and routinely refuse to attend accidental poisonings in a domestic setting. This is irrespective of whether or not the accommodation is rented—with landlords who are failing to comply with the relevant public safety legislation—or whether the incidents are caused by the malpractice or substandard work of engineers.

As a result prosecutions are few and far between and whilst these are not exclusively the responsibility of HSE it is felt that they should be taking a much more proactive lead in this area.

It is appreciated that the activities of the HSE/C are largely intended to be confined to the workplace. However, more and more people are now working from home. Health and Safety considerations should not be the exclusive prerogative of factories and offices. People also need to be safe at home. The HSE service needs to be expanded to include all accidental poisonings resulting in personal injury or death.

Our experience is that the HSE investigators are often grossly under-qualified. Where Gas Safety is concerned they are largely dependent on CORGI and Advantica for the provision of technical expertise in investigation. Both these organisations are industry dependent—and industry has a vested interest in the public perception of a clean and safe product. This is even more poignant in relation to the use of CORGI engineers at scenes—where a failure on behalf of a CORGI engineer may be a relevant factor. This is in our opinion a conflict of interest that casts doubt over the integrity of the HSE as an independent investigator and scrutineer.

The HSE currently produce "statistics" relating to accidental death resulting from CO poisoning. These are deemed to be more accurate than alternative sources such as ROSPA because the ROSPA figures also take into account smoke inhalation and deaths at fires. Yet how accurate are these figures?

If an elderly person dies at home in front of a gas fire and the cause of death is certified at scene as Myocardial Infarction 1 nor further investigation takes place to determine the cause of this MI. Yet in a proportion of these deaths, the Heart Attack may have been triggered by CO. It is therefore impossible to say how many premature deaths are caused annually by CO.

Even where death is not certified at scene there is no guarantee that post mortem examination will include a screening for accidental poisoning by CO. Unless someone like a Police officer who has had no training in gas safety picks up on the fact that something may be wrong with an appliance at a Sudden Death—and this is extremely unlikely—no measurements will be taken of exhaust gases.

If the HSE are to produce statistics of this nature—then they need to be taking steps to validate them.

There is a need to make all accidental poisonings (including non-fatalities) "notifiable" and to provide statistics on these so that what we believe to be a major public health issue can be properly assessed. Problems that are not properly addressed. There is need for legislative change with proactive enforcement in this area. Ideally all incidents of spillage in occupied premises should be reported by the CORGI engineer detecting them. It should be the role of the HSE to actively promote this.

Most government funded Departments and bodies are now required to work in an interagency setting. For example—through the National Service Framework—the DOH are required to work with other health care providers including the voluntary sector. Hospitals have to work with patients and patient groups—the police have to work with victims and community groups. Why are the HSE different?

As buildings become more and more "energy efficient" basically through insulation against the elements—so too do the risks of accidental poisoning increase. There is a desperate need now for a coherent long-term strategy to minimise the risks this poses to public health and widespread consultation with interested parties including the voluntary sector and others who do not have a commercial interest in the use of fossil fuels indoors.

A final point for consideration is the composition of Natural Gas. The HSE currently rely on TRANSCO and CORGI to tell them what is in this product. We are in possession of the TRANSCO analysis of Natural Gas which purportedly contains about 30 elements 1 most of these minor constituents. We are in possession of a list provided by the METron gas company in the US which suggests there are in excess of 200 elements—some of which (although trace) are highly toxic. Natural Gas is a product piped into millions of homes and businesses across the UK—it needs to be "labelled" or at least accurately analysed and public health measures adopted accordingly. This is not something commercial concerns can be relied upon to do for us. The HSE needs to be taking a more proactive role in this area.

AIRSAY

6 February 2004

Memorandum submitted by Graphical Paper and Media Union (GPMU)

GPMU has recently responded to the Health and Safety Commission consultation on its "Strategy for Workplace Health and Safety in Great Britain to 2010 and beyond".

Much of this is also relevant to the points being addressed by the Work and Pensions Select Committee. Therefore, these responses have been adapted to the questions asked by the Select Committee.

We also support the submission to the Select Committee from the TUC.

The Graphical Paper and Media Union (GPMU) represents 100,000 workers in the papermaking, packaging, printing and publishing industries. GPMU members work in a wide range of organisations, from large companies, through to small and medium enterprises. A significant number of GPMU members work in small print companies, often employing less than 10 people.

The GPMU therefore has wide experience of companies of all sizes, and is directly involved in the work of two IACs; the Paper and Board Industry Advisory Committee (PABIAC) and the Printing Industry Advisory Committee (PIAC). We also represent the TUC on the HSC Advisory Committee on Toxic Substances (ACTS).

The GPMU also has a wide variety of joint arrangements with employers on health and safety.

The legislative framework: to what extent has the Health and Safety at Work Act 1974 and subsequent legislation at national and European levels been successful in improving standards of health and safety?

We believe that the 1974 Act, and the subsequent "6-pack" based on European Directives, and especially the Management of Health and Safety at Work Regulations, were major milestones in developing health and safety legislation in the UK. They account for many of the successes in the UK in health and safety over the last 30 years. Unfortunately, experience has shown that there are two specific areas that need further work from the HSE.

These are:

— Risk assessment
— Involvement of, and support for, trade unions and trade union appointed safety reps.

Risk Assessment

If the HSC wants to understand the failings of much current activity on health and safety it should look more critically at "goal setting legislation" and the process of risk assessment.

Current health and safety legislation is based almost entirely on the concept of employers conducting adequate risk assessments, yet the vast majority of employers simply fail to do this. This is why most goal setting legislation fails, except when it is applied by the largest and most well informed and supported of enterprises.

The HSE has said that they do not want to issue prescriptive advice, yet this is what the vast majority of employers want. In fact the HSE had made very important steps forward in recent years in issuing some more prescriptive advice and being willing to say to employers "If you do these things you can expect to meet the law". The development of COSHH Essentials is a successful and well-received example of this approach, which should be extended to other health and safety areas.

The HSC often talks about self-regulation, a concept introduced by Robens before the 1974 HSW Act, but much misused ever since. The suggestion is that good performers on health and safety can effectively be removed from regulation—a very dangerous concept.

The fact is that so-called self-regulation can only operate effectively within a regulatory structure, where failure to "self regulate" leads to clear sanctions. The danger of removing some organisations from regulation is that their standards of health and safety deteriorate.

Safety Representatives and Tripartite Arrangements

We must state, in the strongest possible terms, our concern and amazement, that not one of the main points of the HSC's draft strategy refers to the value and influence of trade union safety representatives. The HSC strategy needs to make this clear, and set out the means by which the HSC will support, enhance and extend the role of safety representatives.

An important statistic for the HSC to recognise is that just under 50% of employees work in companies where trade unions are recognised.

It is obvious we would like the figures to be higher, but the decline has stopped and there is a small increase in trade union membership.

Overall however it shows that TU safety reps are well worth supporting and that TUs have direct links into consultation arrangements for half the working population. This makes trade unions and TU safety reps a clear part of the success story, and not the problem. What HSE needs to do is clearly support these TU structures, trade union involvement at all levels, and the rights (and enhanced rights) of safety reps. More demonstrable support for safety reps will bring in more safety reps—addressing another one of the HSE's claimed failings.

One of the best ways to maintain and develop this trade union input is to support tripartism and tripartite structures, to recognise the role of trade unions and their reps, which goes beyond basic membership figures (eg safety reps do represent non-union members on H&S issues). Attacking IACs and ACs goes directly against this and will have a negative effect on safety.

In particular, the HSC needs to make the support and involvement of safety representatives a key feature of their strategy in improving health and safety in the UK.

IACs in particular are the best way for the HSE to engage these target groups. The Print IAC is likely to be the most effective way of engaging small printers, for example, in fact PIAC has plans to do exactly that. It is IACs that have the best chance to identify (which many have done) and achieve, the revitalising targets. Many unions have encouraged this process, and the GPMU, for example, has worked with the paper industry and the corrugating industry to persuade them to set targets for their members. Target setting has extended into the print sector as well.

The problem is not with unions but with employers who are non-union and not consulting and involving their workers in health and safety. The fact is that most of them do not want to involve their workers. The HSC and the HSE should be targeting these non-conformers and devoting their energies to the ones that employ the most people, and probably in the 20 plus or maybe 50 plus category. The problem category should be all about failing employers. If employers do not consult, HSE inspectors should be enforcing the law, ie the Safety Rep Regs, Representatives of employee safety Regs and the Offshore Regs.

Separately, HSC should be exploring methods of applying IAC principles to those areas where representational structures for employers and workers are weak, and seeking to build and support appropriate structures. The biggest problem of these areas is that they are populated by employers that are less than willing to meet H&S laws, consult and involve their workforces, and set targets for improving health and safety.

Achieving outcomes: is Britain on course to meet the targets set out in the Revitalising Health and Safety Strategy? Does the HSE get the balance right between prevention and enforcement? Is it sufficiently proactive to address developing hazards at work such as stress and passive smoking? Are penalties for health and safety offences set at an appropriate level? To what extent is health and safety legislation properly understood? Does more need to be done to encourage good practice? Is there sufficient emphasis on "health" in health and safety?

The HSC underestimates the value of its "badge" and that of the HSE. It overestimates the criticism of HSE and its inspectors, and places far too much value on the negative criticisms of groups whose main aim is to avoid regulation, compulsion, inspection or involvement of HSE in their affairs.

Change, Where Necessary

The GPMU supports the need for review, and change, where necessary, and welcomes the commitment of the HSC to rehabilitation of workers who have been damaged by the work they do. However, in changing, the HSC/HSE must not abandon those activities that have proved successful so far, or hold the highest potential for success.

HSE Reputation

While there is always a need to pay attention to reputation, the GPMU feels that the HSC has overestimated the problems in this area, and therefore should not devote such a significant part of its strategy to this area. The HSC/HSE continues to command huge respect from the working community of employers and workforce. HSE is seen as an authoritative body that gives accurate and impartial advice. Crucially, that advice could form the basis of any enforcement action, something that employers are very keen to be clear about.

HSE/LA Enforcement

The HSC has hinted that it wants to change the balance of enforcement activities between HSE and Local Authorities. The GPMU is opposed to any moves that put more enforcement in the hands of LAs.

There is no question in our view that if we were setting up a new enforcement system there would be no such separation, and we would have a national agency for health and safety, with national enforcement duties. In an ideal world, the GPMU would want to see an HSE based model.

We have already commented on this in previous consultation, and have indicated our preference to see the enforcement of warehousing safety transferred from LA inspectors to HSE inspectors. We accept the logic of LA inspectors dealing with retail and food hygiene related premises, and also see the value of food hygiene and health and safety inspections in such premises being carried out at the same time.

However, we believe that some LA inspection/enforcement activity on health and safety is so inadequate that it is almost non-existent. This has been highlighted by recent research. Health and safety enforcement in LA sectors has been described elsewhere as a "postcode lottery". We have also found inconsistencies in approach amongst LA sectors, and believe that many LA inspectors do not have sufficient knowledge or expertise to carry out their functions as effectively as the HSE. If there is a problem of "reputation management" we suspect that any problems that exist probably lie in the LA area.

We are absolutely opposed to the suggestion that there should be a significant move to more areas being assigned to LA inspectors. The idea that all SMEs should be inspected by LAs is ludicrous. We want all employers in our sectors to be inspected by one authority—the HSE—on a consistent national basis, to standards that apply through the whole of the UK.

The GPMU is opposed to, and rejects, any model that would appear to place all print companies, for example, under LA enforcement. The reference by the HSC to local, joint decision making suggests the setting of local standards and the move away from national standards. We cannot see any logic in different standards for printing health and safety based on location. Any such moves could seriously undermine the health and safety of print workers. Our experience of LA inspection also suggests that this could lead to lower standards of enforcement and inconsistency from local authority to local authority. It would also make much more difficult the process of national co-ordination of health and safety, and undermine the role of national based IACs.

Advice and Enforcement Should Co-exist

Enforcement officers, HSE or LA, develop their experience of workplace health and safety through the joint activities of enforcement and advice. It is very important that they are not solely seen as agents of enforcement—which would be the natural consequence of HSCs proposed strategy. This could have the disastrous result of damaging HSE's reputation and making some employers even more reluctant to engage with HSE. This in turn would damage individual inspectors ability to develop a broad based experience of the working world.

It is a serious mistake to believe that there is a real problem for the HSE in both giving advice and enforcing that advice. Unfortunately this idea is based on a myth pursued by those organisations that are against health and safety regulations, and which attack regulation and advice without having first hand knowledge of it.

One of the best vehicles for HSE to use to give advice and separately enforce already exists—it is the IAC structure which HSC and HSE senior managers continue to attack.

There are many examples of HSE inspectors working within the tripartite AC and IAC structure, and engaging effectively with employers and workers. Those IACs understand the role of HSE and are perfectly capable of appreciating, and embracing, the relationship between advice and enforcement. The HSC should be actively supporting IACs and tripartite arrangements in general.

If IACs are not as effective as they should be, HSC should be actively pursuing a policy of development of IACs.

The involvement of HSE in tripartite structures, the setting of agreed targets and standards, and joint expectation of where enforcement is needed, actually helps HSE inspectors in the field. It also helps to fulfill the "bargain" that where better companies achieve improvements by agreement, the poorer performers are subject to greater scrutiny by the HSE.

Telephone/Web-based Advice Line

HSC says that there appears to be a low awareness of existing confidential health and safety advice services such as HSE's Infoline. This is a highly significant conclusion that the HSC strategy fails to address. If there is a serious problem of communication, then further work on the HSE Advice line is essential. Many organisations now run highly successful Helplines on a variety of issues. The health and safety advice line should be one of the best of these, yet currently it appears to be a failure. This also provides a significant opportunity to offer advice that is independent from enforcement, at least in terms of the way the advice line is perceived. This might address some of the points expressed earlier.

The advice line could be given another name, and extended to provide email and web-based advice, that directs organisations, safety reps and employees to the HSE advice they need. The GPMU believes that a key feature of the HSC strategy should be to put into place and promote a health and safety advice line that is second to none. This in itself would address many of the issues that the HSC say are crucial to the health and safety process. This advice would be equally available to employers and safety reps, and would serve a vital function. Should such a resource be made available the GPMU would be very willing to promote it in any way possible.

We are not against the concept of health and safety advice that is perceived as separate, but we believe that the strength of HSE advice is that it is developed through experience and involvement and through consultation with representatives of those for whom the guidance is intended.

Changing Worlds—Continuing Hazards

The HSC says that since 1974, the workplace and the world around it have changed significantly. Undoubtedly this is true. There are fewer large firms and far more small ones—over 90% of the 3.5 million or so businesses employ less than 10 people. But HSC fail to point out that 2.6 million of these workplaces have no employees, being sole proprietors, partnerships, self-employed owner managers etc. In total this group represents less than 11% of the working population, and is excessively hard to get to. In fact it has never been directly accessed by HSC/HSE.

August 2003 published figures (from: SME Statistics 2002 Number of enterprises, employment and turnover by number of employees, UK, start 2002 Source: Small Business Service) do confirm that the total workforce is 27.6 million. This represents over 3.8 million workplaces.

- However, 2.6 million of these workplaces have no employees
- Nearly 48% of workers are still employed by companies of over 500 people
- 8.4% are employed in companies with less than five employees
- 14% in companies with less than nine employees.

Targeting

In our view there must be doubts about the costs/benefits of skewing the whole HSC strategy towards targeting companies with less than five employees, especially on issues of consultation and appointment of safety reps or worker reps.

It may even be questionable whether it is worth targeting companies with less than 10. However, in almost all circumstances we believe that the best way to get to these groups is first of all through existing structures. Therefore, getting the health and safety message to small print companies is, as we repeat below, best

achieved through the Printing Industry Advisory Committee, and through guidance to all printers. We support the use of intermediaries to help his process, and this is a longstanding proposal from the PIAC, which has been frustrated recently by the various reorganisations and reviews taking place within the HSE.

The most important point here, however, is that the material used to target these groups has been produced with the HSE and carries the authority of the HSE. Small employers want to be told what to do to meet health and safety requirements, and they want authoritative guidance. They want to be assured that this guidance has the clear support of the HSE.

Our concern is that a small number of people or organisations (HSC has termed them "hard to get to") who are actually anti-regulation, anti-inspector, anti-guidance and anti-advice, may be dictating a major part of the HSC strategy. If this is the case, it is like asking a group of burglars what they think about putting policemen on the beat!

Manufacturing Still Kills People

The HSC say that the manufacturing sector has been exposed to intense international competition. The service sector has become more important. Information technology has become part of our daily lives at work and at home. They say public attitudes to risk and redress, blame and compensation, have changed. They say new challenges in health and safety are almost all health rather than safety related and much of the pressure for change in our legislation comes from Europe rather than from home. And crucially, they say the rate of improvement in safety has now slowed.

While this may be true to a degree, there is still a strong manufacturing sector in the UK that contains many safety hazards as well as health hazards. We should not deal with one at the expense of the other, and we must not abandon manufacturing because the service sector needs attention.

Many deaths and serious injuries still occur in the manufacturing sector, target health hazards like musculoskeletal disorders and stress are common, yet HSE is devoting fewer resources to this area. HSE have admitted that their expertise in particular industries is also diminishing as a result.

Resources: is the HSE sufficiently well-resourced to meet its objectives? To what extent is there good co-ordination between HSE and those other parts of central and local government with a role to play in promoting health and safety?

All of the GPMU's comments need to be accompanied by our deep concern that the current considerations of the HSC are confusing health and safety strategy with health and safety cuts.

We are alarmed that the influx of civil service managers to the senior positions of the HSE has been accompanied by a severe cut in resources. It is a failing on their part, and on the part of the Government, that a better financial settlement has not been reached.

We understand that the overall reduction in the HSE budget is, at least, of the order of 5%. The cuts that the GPMU is seeing in the HSE's support for manufacturing industry is at least 10%.

Though we have no doubt that the HSC strategy needs to develop and adapt to changing circumstances, we cannot accept that these changes should increase the risks to the health and safety of our members. Unfortunately we believe that this is the case, and that some parts of the proposed HSC strategy are based more on enforced cost savings than on steps to improve health and safety.

The HSE needs more resources to fulfill its responsibilities on health and safety.

GPMU

11 February 2004

Memorandum submitted by the Trades Union Congress (TUC)

The Trades Union Congress represents around 7 million employed people in 71 trade unions. It campaigns for fairness and decent standards at work and promotes partnership with the employers and government to secure stable industrial relations, growth and prosperity.

The TUC welcomes the opportunity to make a written submission to the inquiry of the Select Committee. Our submission will focus on the operation of the Health & Safety at Work Act 1974, (HSWA) the performance of the Health and Safety Executive and Commission, and the resourcing of health and safety.

The TUC is strongly of the view that the key to a good safety management system is to have it underpinned by the twin pillars of proper risk assessment and active worker involvement and many of our comments will reflect that.

1. The Legislative Framework

1.1 The introduction of the HSWA was followed by a steady decline in the rates of serious and fatal injury within British industry. This decline plateaued in the mid 1990s. This has corresponded to a similar decline in the numbers employed in heavy industry although the decline in fatality rates in every industry makes it clear that the reduction in deaths at work is not merely an artefact of the changing composition of the economy. At the same time there has been a large increase in the number of cases of self-reported occupational illness, with 2.3 million people reporting a work-related illness in 2001–02 and 1,800 people dying every year from mesothelioma (and probably twice as many again from other asbestos-related diseases).

1.2 Overall, the TUC believes that the HSWA has stood the test of time. Its basic premise, that employers have a duty of care and must protect the health safety and welfare of their workers and others, and should assess all work activities in order to reduce risk is uncontroversial and accepted by most unions, businesses and professionals. However the legislation is primarily enabling, and much of the application of the HSWA has been through regulation. Since 1992 that has focused much more on risk assessment rather than the setting of specific absolute standards. In principle the TUC supports that approach so long as employers carry out proper risk assessments and implement the findings. However there is evidence that this is not happening. It is also the case that the HSC appears to be relying much more on goal-setting as opposed to actual prescriptions, which makes both compliance and enforcement more difficult, particularly in small and medium sized enterprises.

1.3 The HSWA also had the principle of consultation with workers, through their unions, at its core. This principle was designed to create flexibility in the legislation, and was the basis for the self-regulatory regime which was envisaged as developing. Unfortunately this message was effectively abandoned during the 1980s when the then Government was generally hostile to unions, and has not subsequently been given sufficient profile, or enforcement activity. In addition, since the 1970s, the proportion of the workforce with union representation has almost halved from about 75% to 30–40%, meaning that the potential for proper self-regulation has also declined.

1.4 At the time of it's introduction the HSWA probably created one of the most clear and practical frameworks on health and safety anywhere in the world—the only other countries with comparably low work fatality and injury rates are the Scandinavian countries which have a very similar legislative structure. However since 1989 more and more of the regulations made under it have been based on European Directives, which, despite some anti-European rhetoric, are in fact based largely on the same Anglo-Scandinavian principles as the HSWA. The HSC have now indicated that they do not envisage any further major regulation unless it is instigated by Europe. This has had the effect of transforming the UK from a world leader, to a follower.

1.5 The TUC believes that the HSWA, in itself, requires only limited review to ensure that it reflects the reality of working life in the 21st century. The main issue is its enforcement, which is dealt with later in this submission.

2. Health & Safety Executive and Health & Safety Commission

2.1 The TUC believes that the HSE/C provide an excellent service. Its research and guidance is second to none, and its staff are of an extremely high standard. The TUC sees most of the difficulties of the organisation as stemming from restrictions in the resources available rather than organic failures.

2.2 The TUC pressed for the decision to place the HSC/E under the overall control of the Department of Work and Pensions, to ensure that HSC/E was able to play its part in reducing the economic burden of poor health and safety, and to stimulate action on rehabilitation.

2.3 The current structure of the commission has the broad support of the TUC. Its ability to give a strong strategic leadership has been illustrated by recent initiatives such as "Revitalising Health and Safety", developed in partnership with the ODPM, and their "Priority programme" which was a bold attempt to ensure that the HSC/E addressed the actual issues facing those in the workplace in the 21st century. Both these initiatives have had the enthusiastic support of the TUC. Sadly the application of the work that flows from these two programmes has been hampered by a lack of resources.

2.4 The TUC welcomes the fact that the Commission and Executive has now taken a more active role in rehabilitation, however it believes that this lead from the HSE/C must be taken up with more vigour by the Government if it is to have any real success in reducing the very high levels of long term sickness absence.

2.5 In recent years there appears to have been a campaign within certain parts of the press and by some employers to undermine the HSE and the safety culture that they try to develop and enforce. The TUC sees this as a sign of the success of the HSE. In the following paragraphs the TUC will be raising a number of issues where we believe that problems have arisen or things can be improved but these should be seen in the context of our broad support for an organisation that has tried to provide a first class service with third class funding.

3. Resources

3.1 The budget of the HSE has been frozen for 2003–06. This amounts to a 10% cut in real terms. The £260 million allocated to the HSE in the current year corresponds to under 20p a week to protect each worker. The TUC believes that this does not represent the investment that society would like to see placed on protecting the UK's 27 million workers. The levels of death, injury and ill-health that we see today are a result of the lack on investment on proper and robust safety systems and the enforcement of the HSWA and regulations made under it.

3.2 The TUC would like to see a considerable investment made in safety with increased resources being made available to both the HSC/E and local authority enforcement departments. The benefits of such an investment would far outweigh the costs. The Select Committee should be aware that more than eight times as much is spent on compensating injured workers through Industrial Injuries Disability Benefit that is spent funding the HSE. In addition a further £1.4 billion is spent on Employers Liability Insurance.

4. Enforcement

4.1 The level of enforcement of health and safety is both low and inconsistent. Excluding the specialist divisions, there are around 590 frontline inspectors. This figure is expected to fall even lower in 2004. They are responsible for enforcing health and safety in almost three quarters of a million premises. On average a registered premise that is not seen as high risk will receive an inspection every 20 years. The number of contacts with employers has been falling steadily since 1995.

4.2 Most inspections are supportive, however some are investigative. Unfortunately, of the major injuries reported in 2000–01 only 19% were investigated, and only 4.5% of "over three day injuries" were investigated. Injuries in traditional industries are far more likely to be investigated than injuries in the service sector. There are also considerable regional differences.

4.3 There has been concern expressed by a number of unions over the lack of contact with safety representatives during inspections or visits, and often a lack of willingness to share information with safety representatives.

4.4 The TUC also has concern over the levels of prosecutions instigated by the HSE. While we recognise that the priority for the HSE must be to prevent injury and ill-health, we recognise that prosecutions are unfortunately a necessary part of ensuring that the culture within workplaces is changed. While the HSE cannot be blamed for the appallingly low levels of fines, we do believe that they should be prosecuting in more cases where an employer is breaching health and safety law, even is cases where no injury has been sustained. This is particularly the case where bad practices can lead to an occupational illness in the future.

4.5 It is clear that the HSE rarely prosecute for offences that can lead to disease as opposed to immediate injury. If you look at the conviction figures for 2002–02 the three regulations which were used most frequently for securing a conviction were the construction, work equipment and gas safety regulations. Which each led to over 85 convictions. Only one person was successfully prosecuted under the noise regulations and another one under the manual handling regulations. None was convicted under the working time or VDU regulations in that year. Yet it is breaches of these regulations that have led to the epidemic of back pain, stress, hearing loss and RSI that we have seen in recent years. In addition only 81 people were convicted under the management regulations, which includes the requirement for risk assessment, despite evidence of widespread non-compliance.

4.6 It is also of concern to the TUC that no employer has ever been convicted for not fulfilling their duties to consult with their workforce since the regulations were introduced in 1977.

4.7 The TUC is aware that there is some confusion relating to the enforcement of work-related safety on the highways. Over a thousand deaths on the road—over a quarter of all road traffic deaths—involve people driving for their work (excluding deaths caused by those commuting to work)—four times as many as die in all other work-related accidents combined. While the investigation of road traffic accidents is a matter for the police, many accidents are a result of management failings and need to be considered in that light. HSE should be given the resources and the task of ensuring that employers manage the risks of occupational road use in line with HSWA principles. We believe that HSE involvement in this area would make a major contribution to the Government's targets for reducing road traffic injuries and fatalities.

5. Division of Enforcement Between HSE and Local Authorities

5.1 The TUC does not support any major changes to the current regime however we do believe that the HSC should exert greater control over the level of enforcement undertaken by local authorities to ensure consistency and quality. We welcome the audit/benchmarking systems now being promulgated, and the effective use of s18 guidance by HSC

5.2 Overall local authorities enforce very well, however the TUC has concerns over the variability of enforcement across the local authority sector, and the lack of resources and support given by local authorities to this function.

6. Tripartitism

6.1 The HSC is founded on the belief that health and safety is best promoted through employees, trade unions and government working together. The tripartite approach has been one of the strengths of the HSC. In addition research has shown that in those workplaces where trade unions and employers have a joint approach to health and safety there is a better safety culture than in those without trade unions. The TUC would wish the select committee to be aware that in those workplaces where there is consultation and trade union recognition, the level of work-related injuries is half that of workplaces with no union recognition and consultation.

6.2 Unfortunately the joint approach is not seen to be at the core of the HSE's work. Instead of using safety representatives to help ensure a safe working environment the focus of their prevention work has been focussed almost exclusively at employers and managers.

6.3 The TUC would wish to see changes to the Safety Representatives regulations to make them more effective and relevant to the present day. These include giving safety representatives the right to inspect all premises where they have members, and those of contractors. We would also wish to see a duty on employers to respond to issues raised by safety representatives, and greater clarity and enforcement of the rights to training and information.

6.4 The TUC would wish to see the HSE use trade union safety representatives as a positive force in improving the safety culture within workplaces and, as part of their inspection regime, automatically seek to ensure that employers are complying with the HSWA and Regulations on consultation. We would also wish to see more materials specifically aimed at Safety Representatives. There are currently no such publications available from the HSC, although there are many hundreds aimed at employers and managers.

6.5 Tripartitism has also underpinned the various Industry Advisory Committees which have been established by the HSC. Some of these have been extremely effective in promoting safety within the industries or sectors they cover. Unfortunately, in recent years the commitment from the HSE to these bodies seems to have waned with some Advisory Committees being wound down, and others finding it harder to gain access to the support they need. There has also been a trend towards diluting the employee/employer interests on advisory committees, thereby undermining the principle of tripartitism.

7. Sectors

7.1 The view has been expressed in the past that the HSE is not necessarily the best organisation to enforce safety in high profile sectors such as electricity and gas generation, offshore extraction, railways and major hazards sites. The TUC does not share that view.

7.2 It is important that the same standards of safety and risk management principles are consistently applied and enforced across all industries. A separate regulatory regime for any specific industry would not be consistent with that. These sectors all involve many different companies and an even larger number of contractors, many of whom work across sectors. To have separate bodies enforcing safety in different industries will mean these companies will have to operate to different regimes and potentially different standards depending on the industry in which they are working.

7.3 We would point out that the cause of the vast majority of injuries within these industries are no different from in any other industry and are not specific to the processes being undertaken. For instance, in the railways, two thirds of reported accidents can be attributed to slips trips and falls.

7.4 The TUC would be concerned if any attempt were to be made to move responsibility for any sector currently enforced by the HSE to any other body which was primarily responsible for economic regulation or political control of that industry as that could lead to decisions on safety being made on economic or political grounds.

8. Profile

8.1 The TUC believes that the HSE and HSC must develop their profile. They are not aggressive enough in pushing the moral justice of the importance of preventing people getting killed, injured or made ill through their work. At times they come across as viewing new regulations aimed at preventing injury as a burden. They should be our leading ambassadors on health and safety and need to portray a sense of pride in their work.

9. Communications

9.1 There is no doubt that the quality of materials published by the HSE is of a very high standard. Their guidance is both extensive and very practical. Unfortunately much of it is not available to those that need it. Most guidance and regulations are priced. This means that they are inaccessible to one half of industry, the workers. Safety representatives are volunteers who do not have the resources to purchase the materials they need. The TUC would like the Select Committee to consider the communications strategy of the HSE, which effectively denies safety representatives access to the tools they need.

9.2 The TUC is particularly concerned with the arrangement that the HSE has with Butterworth Tolley to provide a subscription service on-line, which gives access to all publications. This arrangement means that the HSE cannot publish any of its priced guidance or regulations on the web. This is counter to the trend in other organisations where the practice is to make as much information freely available as possible. We hope that the committee will consider this issue.

10. Summary

— The HSWA is generally robust, but is undermined by a lack of enforcement
— The TUC wishes to place on record its support for the HSC and the work it does
— The work of the HSE/C has been considerably curtailed by a lack of funding
— The levels of inspection are unacceptably low and inconsistent
— The HSE/C should exercise greater control over the quality and quantity of enforcement activity by local authorities
— The HSE/C needs to put worker involvement and trade unions at the heart of its work
— There is no support for changes to the enforcement role of the HSE in specialist industries.
— The TUC would welcome an increased profile from the HSE/C
— There should be greater access to regulations, guidance and advice than at present.

Trade Union Congress

12 February 2004

Memorandum submitted by Federation of Small Businesses (FSB)

Introduction

1.1 The Federation of Small Businesses (FSB) is the UK's leading non-party political lobbying group for UK small businesses existing to promote and protect the interests of all who own and/or manage their own businesses. With over 185,000 members, the FSB is also the largest organisation representing small and medium sized businesses in the UK.

1.2 The FSB broadly supports the changing strategy of the HSC/E. We agree it is in the interests of business for a focused, streamlined and well-resourced HSC/E structure to successfully develop to 2010 and beyond.

1.3 Our evidence highlights the small business view on the balance between prevention and enforcement, the success of the HSC/E in engaging with the small business community and encourages a review of the *Revitalising* targets. We also discuss general small business awareness of the complexities of health and safety regulations, the new emphasis on health in the workplace and the ability of the HSC/E to deliver on its strategy with existing resources.

1.4 The majority of small businesses want to comply with health and safety legislation and consult with their employees on best practice in the workplace for a productive workforce and business. However, SMEs are not always well resourced to deal with the complexities of health and safety and do not necessarily see the HSE as the first point of contact. Small businesses are most concerned about enforcement and the inconsistency of inspections and inspectors at a localised level.

The Balance Between Prevention and Enforcement

2.1 Small businesses primarily see HSE and local authorities (LAs) as enforcement, rather than guidance bodies. The majority of small businesses are inspected by LAs, with the exception of those in high risk sectors.

2.2 While it is important to maintain a healthy and safe work environment, we would like to see a formal agreement within the HSC/E and LA partnership as to the level of responsibility public authorities have for the protection of workers and the level of responsibility employers must assume. Small business would not support increased levels of enforcement, through additional bodies filling the gap left by the HSE and local authorities.

2.3 Local inspectors and inspection rates remain a concern for small businesses. Anecdotal evidence suggests that small businesses perceive inspectors to be removed from the realities of the workplace. Business finds the inspection process inconsistent and believes inspectors are too quick to enforce, rather than offer advice and check at a later stage if this has been completed.

2.4 As one FSB member suggested, "with each inspection comes a different inspector, looking for different things than the last one. They rarely check our progress from the previous inspection and the worst of it is that they don't understand the industry. My experienced workforce have to explain good health and safety practice to them!"

Engaging With the Small Business Community

3.1 According to DTI figures, there are 3.7 million small businesses in the UK today. It is a huge task to reach all of them and the HSE is to be commended for its recent consultation with stakeholders such as ourselves on how best to target this "hard-to-reach" market.

3.2 However, the FSB 2002 "Lifting the Barriers to Growth" survey suggested that only 13% of small businesses access advice on health and safety.

3.3 Recent statements from the HSC/E suggest the need for a separation of its guidance and enforcement functions. The FSB supports this exercise in theory, however we would advise the HSE to choose its disseminating bodies carefully. "Lifting the Barriers" also noted that only 14% of our members access central Government business support, which included the HSE. More importantly, only 10% of our members recorded a level of satisfaction with the service they received from these bodies.

Revitalising Targets

4.1 The FSB agree there should be a formal review of the "*Revitalising*" targets and determine if these are still relevant in today's changing world. The current targets are broad and we see a need for developing more robust and extensive future targets, which are business, rather than enforcer focused.

Small Business Awareness of Health and Safety Legislation

5.1 Evidence suggests the majority of small businesses are aware of the major pieces of legislation under which they are expected to operate. However, the consistent increase of regulations from both the EU and UK is a growing concern for small businesses. Small businesses continue to suffer under the burden of regulation and enforcement of their health and safety policies.

5.2 It is unlikely that the majority of smaller businesses will actively seek out the HSE to check if there is new legislation they need to be aware of. Generally, this information is disseminated through the HSE and bodies such as local authorities and ourselves. However, as we have previously suggested, such dissemination does not reach all 3.7 million businesses in the UK.

5.3 In many situations, an enforcement notice is the first time an employer is made aware of new responsibilities. Therefore, rather than the traditional "stick" approach, the average small employer would respond more positively to official recognition that while they are following the "spirit" of the law, they are not following the letter. If this were followed by an opportunity to improve the workplace voluntarily, employers would be more likely to undertake change in a positive manner. Further, it highlights the importance of health and safety as a business benefit, rather than a regulatory burden.

A Wider Health Agenda

6.1 A major issue for small businesses will be how the HSC/E tackles new and complex health issues. It is in the interests of business that there is a focus on issues such as occupational health.

6.2 However, the lack of robust statistics may misinform future policy developments, conflict with business priorities and lead to further, and burdensome regulations. Therefore, the FSB would encourage further statistics be gained before any targets to tackle additional areas such as, managing rehabilitation in the workplace are set.

6.3 Occupational health expertise will presumably remain with the DoH and NHS. However, with the European model encouraging in-depth research and an emphasis on psychosocial harms, there are likely to be further Directives and the costs are likely to effect business.

6.4 If is to be HSE involvement, we would caution it not to burden small business unnecessarily in terms of cost and to influence the NHS and DoH into adopting the same policy. Employers must buy into the issue on a voluntary basis, trusting in its credibility.

6.5 The HSE must also ensure the message on occupational health is simple and accessible, although we are aware that the link between ill health and the workplace is becoming less defined. The HSE itself suggests that ill-health may results from a combination of occupational and non-work causes. Therefore, the limit of employer responsibility for health in the workplace should be defined as clearly as possible.

6.6 The HSE, NHS and DoH may decide to pool resources, expertise and policies in order to deliver a streamlined and simple service. However, would such a package detract from current provision of public health services, or strengthen them? If it is to be the latter, the cost to small businesses should be minimal.

Delivering on Current Resources

7.1 The HSC/E must judge the likelihood of risk within both the public and private sector and reallocate resources appropriately. However, SMEs would be reluctant to support public service best practice management at the expense of resources being devoted to making the private sector compliant and viable.

Additional Concerns

8.1 The proposed move towards an HSC/E that is a focused, guidance led body constantly reacting to a changing world is a positive one. However, the effectiveness of the new strategy could be undermined if other equally important issues are not addressed:

— The existing role of employers and the resources they are voluntarily committing to develop safe and productive workplaces;

— The continuing influence of the EU in UK health and safety practices and the HSE's ability to influence this;

— The disproportionate effect new policies will have on small businesses. We encourage the HSE to complete a regulatory impact assessment on any proposed changes that will affect small businesses, concentrating on potential costs and effect on productivity.

— Other stakeholder interests. Refocusing and entering new areas of health and safety will require new partnerships. Business continues to question whether the HSE is always the best body to deliver change and opening up to partnership could deliver effective use of resources and expertise. For instance, tackling new and complex health issues would be more effective if, like the Scottish and Northern Ireland models, HSE were a partner in developing policy, rather than the main enforcement body.

Federation of Small Businesses

12 February 2004

Memorandum submitted by The Royal Society for the Promotion of Health

1. *To What Extent Have The Health and Safety at Work Act 1974 and Subsequent Legislation at National and European Levels Been Successful in Improving Standards of Health and Safety?*

Comparing health and safety on the working environment in 1974 and 2004 is difficult because although accident rates have certainly dropped, there have also been dramatic changes in the nature of work, with sectors of industry such as engineering and mining largely replaced with new sectors such as IT. These changes may have had a more substantial effect upon accident figures than any legislation, regulation or enforcement.

However, although these long-term social changes may make the precise effects of the legislation difficult to quantify, there is no doubt that the Act has been a powerful pull in the right direction, not least because it covers all sectors and all employees, and embodies the common law duty of care in an employment situation.

An important feature of the Act which has served us well over thirty years is that it is a piece of enabling piece of legislation. It has thus created a development framework within which a culture of improving health and safety has been able to grow, responsive to needs which are changing constantly over time. Although this has been a positive strength, it has also perhaps meant that because it focused on big-picture aspirations for a safe and healthy workplace rather than on detailed specifics and individual measures, it has led peoples' aspirations for health and safety to outpace delivery. There is however plenty of incentive within this context for further improvements before we could argue that the Act has outlived its usefulness.

Where the Act has been most successful, it has succeeded in generating a pro-active attitude, at all levels of the organisation, towards health and safety issues. This attitude, when it prevails, can readily be detected in all levels of management, frontline workers, safety reps and Trades Unions. They regard the Act as providing support when a high level of risk control is required, by enabling a common sense, "reasonably practicable" approach.

These kinds of attitude, which the Act was intended to foster, are however by no means universal. One problematic aspect is that it is based on the philosophy of self-regulation. However, to be effective, self-regulation relies upon three underlying principles:

1. a sound risk assessment methodology;

2. consultation between employers and employees as to the hazards and risks to be combatted and the appropriate controls to be utilised; and

3. the inculcation of a positive health and safety culture;

In Britain, risk assessment is in its infancy and very few organisations apply it effectively. At the same time, consultation is non-existent in many workplaces (especially SMEs). It could therefore be argued that self-regulation has imposed a burden on industry which, after thirty years, many sectors are still not entirely ready to assume.

Given the prevailing "minimum compliance" approach perhaps we ought to consider a return to more prescriptive legislation, at least in the shorter-term. Reverting to prescriptive legislation would also allow for more precise "goal setting" and therefore even if companies only work to satisfy threshold requirements and nothing more, there is a greater chance of a specified standard being met (subject to the usual caveats about how organisations often find ways of appearing to satisfy requirements which are not in the spirit of the original intention). Achieving threshold levels is much more difficult to achieve in a system based on risk assessment as the control measures are always necessarily subjective. As things stand, two health and safety professionals undertaking the same assessment will often come up with quite different approaches to the problem, so it is easy to see how hard-pressed SMEs can find compliance problematic. One of our members drew a useful illustrative comparison between two major areas of compliance on construction sites—the building regulations (prescriptive, easy to abide by, easy to police) and health and safety (risk-based, therefore always open to interpretation and dispute).

Most organisations would probably prefer the reassurance of certain knowledge that they had complied with a specified threshold standard than the uncertainties which surround the current risk-assessment model. Many organisations feel that the risk-assessment approach is a fairly easy way for the HSE to obtain convictions since it is all too often possible to review a risk assessment and find some shortcomings in it. Given that the legal basis for health and safety practice is a duty of care, organisations feel that they are effectively guilty until proven innocent (ie until they can demonstrate having properly discharged their responsibilities); in this context the risk assessment can be seen as a hostage to fortune rather than as a constructive management tool.

Prescriptive legislation would ensure a minimum level of compliance that would not be open to individual interpretation in the same way as the current risk assessment approach. The prescriptive approach would provide an effective benchmark against which both the HSE and insurers could assess compliance. This approach would also prove easier for SMEs to achieve with little H&S knowledge and without the cost of retaining H&S consultants for prolonged periods.

2. *Is Britain on Course to Meet the Targets Set Out in the Revitalising Health and Safety Strategy?*

The whole question of targets is problematic. Even thirty years ago, when health and safety was more concerned with easily quantifiable workplace accidents, it was possible to meet targets by evasion rather than by prevention—as is now generally understood, targets can almost always be met by means other than those intended. At the same time they almost always produce systemic distortions and perverse incentives.

Now that we are more concerned with health issues such as stress, which are much harder to quantify, the possibilities of evasion are ever greater. The targets in the strategy are fairly ambitious, not least because they focus on issues which have not really been effectively addressed in the past and which may not even be fully understood at the moment.

Management by objectives has the advantage of providing a sense of direction, but the disadvantage of often becoming meaningless in practice. Worse still, targets can encourage cultures of blame or concealment. Some of the targets set out in the strategy lack transparency and can not really be described as SMART objectives. Some were plainly misjudged from the outset, as was made plain with the change of emphasis on statistics in the construction industry.

However, even if the targets set out in the strategy are not reached, this does not mean that nothing worthwhile has been achieved. For example, recent Department of Health requirements for improved reporting under its Controls Assurance initiative have led to an increase in reporting. However most people in the health and safety field believe that it is not only reporting which has increased; associated standards of health and safety have correspondingly risen and awareness has been focused on these matters. Thus, even if the targets may be missed, a significant improvement in health and safety has nevertheless taken place.

Sadly, one effect of the current funding arrangements for the HSE is to enshrine a particularly perverse incentive. The mechanism relates future funding to achievement of previous target. This ensures that, allowing for the risk of prosecution, it is broadly speaking in the best interests of non-compliant organisations to remain steadfast in their negligence. The more failure there is, the further the HSE will fall short of its targets. The greater the shortfall, the more funding it loses, thus leaving it still less able to pursue and prosecute the companies which pose the greatest risk to their own workforce. The Royal Society for the Promotion of Health is strongly of the view that if the targets in *Revitalising Health and Safety* are not met, there should be a strategic review to determine whether the delivery mechanisms in place are adequate, and that any proposed solution should involve additional funding rather than cuts.

3. *Does the HSE get the Balance Right Between Prevention and Enforcement?*

The HSE is in a difficult position. In many respects there needs to be a reasonably sound body of science before the HSE offers guidance or influences legislation. In addition to the science, account also needs to be taken of society's view on risk. It is particularly difficult when society has formed a "view" before scientific evidence is available. In 2002 the HSE published "Taking Account of Societal Concerns About Risk" (Research Report 035). This is an excellent piece of work and demonstrates a good understanding of virtual risk; risk perceived through science; and directly perceived risk. (This report was carried out by the University of Bergen and UCL, London.)

On the positive side, many health and safety professionals find the HSE to be a very professional organisation which gives them vital support in their jobs, providing useful and helpful information—especially when discussing issues with inspectors. Indeed the major successes of the HSE are probably due to education, support and influencing trade bodies, rather than to prosecutions.

However there is a feeling that the shortage of inspectors makes it very difficult for them to play, as they should, a more proactive and advisory role. The position with regard to local authority environmental health officers is very far from satisfactory. They are forced to place food hygiene enforcement before health and safety enforcement and often lack adequate health and safety training in order to play a more proactive role. Essentially a result of lack of resources is leading to "firefighting" on the high risk issues, with little time for guidance and advice other than the publications.

If the HSE wants to tilt the balance—as most people feel it should—more towards prevention, then there is a widespread feeling that its inspectors should be more prepared to actually offer advice. It is frustrating for businesses to ask for guidance and receive what they often feel are non-committal replies. As one of our members commented "When you ask an officer in the field, they do not want to proffer suggestions. However if someone loses an arm you will certainly get an opinion". Being "wise after the event" is not much help to businesses and does not encourage them to see the HSE as an "honest broker". Here again the HSE is in a difficult position because of the risk-based model to which it works.

In general, organisations tend to do the minimum required to meet compliance requirements but are more likely to take action on health and safety issues if their insurance company puts up their premiums. A recent survey by British insurers has concluded that there was an average rise in Employers Liability premiums of 67% in 2002 and this, as much as any work by inspectors, may drive better compliance—at least among those who have a reasonable risk of being caught. We suspect that insurers, and indeed the HSE itself, would be likely to find threshold standards set out in prescriptive legislation easier to assess and evaluate than the current risk-based approach. As an example of this—the old construction regulations in the 1960s stated that for excavations deeper than 1,200 mm, suitable protection for the excavation sides was required. Current legislation now leaves this open to assessment, making it less straightforward for employer, workforce, insurer and HSE alike to know whether adequate precautions have been taken.

It is generally held that the risk of detection and prosecution for negligent firms is very far from evenly spread. Again and again our members speak of the shortage of inspectors and the diminishing likelihood of any individual employer being inspected. As resources become more stretched, it is believed, the HSE is concentrating on "easy wins"—taking action to enforce "exquisite" levels of compliance from certain larger organisations which are already discharging their duties responsibly, while over 80% of the workforce are based in SMEs which are left largely untouched. One member attests to having heard an HSE principal inspector openly admit that the current strategy is to bear down hard on the larger companies so that they will, in turn, impose higher standards on smaller companies which supply and service them.

This instance highlights how the debate about prevention versus enforcement is being rapidly overtaken by changes in working practice. In the past there was a more straightforward distinction between firms with a good health and safety culture, and those without; those who complied willingly and to the best of their ability, and those who always tried to cut corners. This began to change around a decade ago when it became more commonplace for larger organisations to shed their own workforce and contract out an ever greater range of services on the basis of competitive tendering.

A particular example is the construction industry. There are about 120 Construction Inspectors who are meant to police over 4,500 major sites and an incalculable number of many smaller construction sites or jobs which are simply are not notified. The result is that the big sites with the major companies are treated as "sitting ducks". The small contractors are rarely, if ever, subject to inspection and can effectively do what they like. There seems little point in exhortations to the construction industry to put its own house in order when, for so many small contractors, there is simply no good reason why they should assume a significant additional cost burden when there is little realistic chance of their ever paying any penalty for not doing so.

There is plenty of evidence to suggest that these problems are growing ever more serious. In recent years it is generally accepted that there has been a burgeoning black economy, with more and more work particularly in cleaning, catering and agriculture undertaken by illegal migrants. As the recent tragedy in Morecambe Bay highlights, there are now complex, opaque but close relationships between concerns with a minimal interest in the health and safety of their employees and more "legitimate" traders. The old distinction between firms with a good record and firms with a bad record is now breaking down, since today it is entirely possible for an employer with a good record, sound policies and effective practice to find themselves at the apex of a supply pyramid whose base stands in the world of gangmasters, sweatshops,

people traffickers and organised crime. It is becoming increasingly clear that the people working in the most hazardous and riskiest environments are almost always those whom it is incredibly difficult for current health and safety enforcement to have a positive impact on.

The Government has recently adopted an approach to health policies which focuses resources on tackling the most intractable health inequalities. This was based on a recognition that while average health outcomes are improving, there are pockets of deep inequality such that, for example, life expectancies have not improved for half a century in certain localities. It was also based on an understanding that while average health outcomes continue to improve, the rising average can easily conceal the fact that certain groups are being left further and further behind. This kind of perspective might be useful in an evaluation of the HSE's work. Clearly overall health and safety outcomes are improving, but at the same time there are certain types of enterprise which are contributing nothing to the rising average, and these should be more closely targetted.

4. *Is it Sufficiently Proactive to Address Developing Hazards at Work Such as Stress and Passive Smoking?*

Broadly speaking we do not feel that there is sufficient emphasis on these areas. In addition, it is not really appropriate to characterise the growing emphasis on these hazards as "proactive" when it is in fact largely reactive. Both passive smoking and stress measures, for example, are being driven by civil claims. The increasing volume of claims amounts, in effect, to a privatised and individualised form of welfare; as more and more individuals seek redress in the courts because they were exposed to hazards which could have been avoided as a matter of general entitlement. If a more proactive and preventative approach was adopted then these claims would not arise in the first place and a great deal of pain and suffering would be avoided. This would of course require a very substantial increase both in promoting health and safety campaigns and in resourcing enforcement action.

Linda Varney's team at the HSE, which leads on health, is very small and under-resourced. Emphasis needs to be placed on the HSE working in partnership with GPs to develop an effective way forward with benchmarking for diagnosis. Presently employers receive very little support in this area and as a result, are subjected to ever increasing claims and long-term sickness. It is likely that many of these claims for stress may not be well-founded. However GPs are not really "fully-engaged stakeholders" in this process and are generally inclined to accept the purported self-diagnosis of their patients, prescribe time off work, and delve no further.

Our members did not feel that the HSE was giving a great deal of attention to passive smoking. The HSE website has a search menu with a list of topics—passive smoking is not one of them. The topic list menus for "confined spaces" and "asthma" do not offer any leaflets or other information on passive smoking either. While information on passive smoking is available from the HSE we do not see much evidence of its being a high priority. The high profile of the recent debates about whether employers could potentially be at risk of legal action from their staff under Health and Safety legislation was led by anti-smoking groups such as ASH, and not by the HSE.

5. *Are Penalties for Health and Safety Offences set at an Appropriate Level?*

On the whole Society members responding to this question felt that penalties are currently set at appropriate levels. However they indicated the following reservations:

1. the continuing lack of effective measures to bear down on corporate manslaughter is a major loophole in the penalty structure. Members were clear that they expect the new legislation to include appropriate custodial sentences as well as financial sanctions when it comes into force;

2. most courts are not using the penalties already available to them effectively;

3. there is an increasing discrepancy between penalties for breaches of health and safety legislation on the one hand and breaches in environmental legislation on the other 1 and a strong feeling that one can often be more severely punished for polluting the environment than for exposing one's employees to significant and immediate risks;

4. likewise, a growing disparity between the penalties enforced by the criminal courts and the settlements awarded by the civil courts; and

5. the anachronistic anomaly of Crown immunity needs to be changed so that employers such as the Royal Mail can be prosecuted if there is a need.

6. *To What Extent is Health and Safety Legislation Properly Understood?*

There is a very mixed picture of understanding. Some organisations have recruited good health and safety professionals at he appropriate level and correspondingly have a good grasp of what is required.

In other cases there is a reasonable understanding of what is required but a countervailing lack of detailed knowledge of how best to manage compliance. This is largely because neither the HSE nor local authorities has the resources to provide the kind of high-value support and consultancy which are beyond the resource of most SMEs.

There is so much health and safety legislation, which is forever changing or being updated, that it takes a conscious effort even for experienced professionals in the field to keep up-to-date—and even then only usually in the areas which most specifically concern them. Indeed safety personnel are often at variance even among themselves over interpretations. Approved Codes of Practice have been of tremendous benefit in this respect.

Given the difficulties faced by dedicated professionals in larger organisations, it is not too difficult to see why health and safety continues to pose problems for many smaller businesses with no full-time or highly qualified staff. The HSE are making some goodattempts to target SMEs and many of their free leaflets for this group are very useful. However, it is first necessary to get many small businesses, including contractors on site, to take safety sufficiently seriously before something goes wrong.

It is disappointing that government will fund courses for new business startups on topics such as marketing and developing a business plan, but offers no training on health and safety on a similar basis. This could be a simple half day course covering: registration, safety policies, risk assessment (general and specific), competent assistance, accident investigation, recording and reporting and emergency procedures. If simple concepts such as these were introduced at the start, they might be seen as a core element of the success of the business, not as an irritating set of external rules which it is a distracting burden to comply with.

Recently the HSE undertook a joint survey with Personnel Today, in which 87% of respondents expressed the view that HSE information & publications should be free (a copy of this survey was available at £25). The internet makes free online publishing a possibility as never before, and given that the work of the HSE is already paid for by taxpayers, it is not easy to see why small business in particular should be expected to paid for its advice. In the USA, OSHA provides a great deal of free support to business in the form of training and outreach programmes. Here in the UK the HSE is often wary of giving direct advice (on the basis that it is up to the questioner to conduct a risk assessment and answer the question themselves as best they can).

Although the HSE does now make some material available online and free, we feel there needs to be a much greater emphasis on practical information, with photos, case studies and examples that relate to the people the legislation is trying to reach. The HSE has partly done this with some of their Approved Codes of Practice but this work needs to be built on for the future. By working in partnership with trade bodies, professional bodies such as ourselves and through POOSH, the HSE could probably ensure earlier and readier adoption of its guidance.

Work should also be done to ensure that the HSE has a properly consistent approach to enforcement as presently inspectors' opinions vary from region to region and in some regions from inspector to inspector due to a lack of co-ordinated guidance. This undermines respect for the HSE and is frequently seen as a stumbling block to achieving compliance.

7. *Does More Need to be Done to Encourage Good Practice?*

All responding members wanted to move away from a reactive enforcement culture towards a proactive climate of good practice, leading to lower risks and fewer hazards. The HSE does carry out work in this area, but it needs to be given more publicity and more resources. It is an area of great potential opportunity, particularly working with trade associations and professional bodies. It is also an opportunity to share expertise and to find what works.

One good way of promoting good practice would be for the HSE to host local and regional forums to bring health and safety professionals together to discuss issues and most importantly to network. The HSE would be seen to be presenting a "friendly face".

If there were more and better-resourced inspectors they would be able to play an important role. More reasonably priced (or free!) HSE videos and DVDs aimed at advising new and small organisations would also be useful. The recent free "Work at Height" packs are an example of the kind of thing we would like to see more of.

One positive development noted by some members is the increasing tendency of HSE inspectors to visit senior management rather than simply conducting policing visits accompanied by the site manager or safety advisor. This kind of visit underlines the importance of a more strategic approach and can encourage a firm to really put health and safety at the heart of its business rather than regarding it as a low-grade compliance issue to be dealt with at foreman level.

8. *Is There Sufficient Emphasis on "Health" in Health and Safety?*

That health is now a major issue is due, partly, to previous successes in safety. When the majority of working people died at relatively young ages in industrial towns, long-term health problems either did not have time to arise or were rarely identified and poorly understood. Greater longevity has made long term health effects of work more evident. As a result, workplace health is no longer the poor relation of workplace safety.

We have argued the case, above, for considering a move away from a risk assessment model and towards more prescriptive legislation on health and safety. Although we feel this might bring many benefits where "safety" issues are concerned, such an approach would plainly pose problems for much of the occupational health agenda. Wellness and illness are highly dependent on the individual's physical condition and on determinants which belong outside the workplace. In general, we suggest, workplace health therefore lends itself more readily to a risk-based approach.

Often positive initiatives on health may be difficult to measure if they focus on long-term preventive action. For example, if an employee fitness programme stops someone having a heart attack, how do you measure that? One forward-looking workplace recently began a staff Positive Lifestyle Initiative following on from the results of a stress audit. Two months into the programme there was clear anecdotal evidence that people were starting to pay attention to these matters. However, pressure from the Quality Manager to provide hard statistical evidence of measurable success so early on was seen by the people trying run the programme as negative and stifling.

An example of the kind of project which brings together safety professionals and health professionals in a productive relationship is the North Tees Workplace Health Promotion Partnership. This allows organisations making a submission for the Partners in Health Promotion Award run by the North Tees PCT. The award is auditable and there is therefore every incentive to keep up the momentum. This local scheme is a very positive way forward in looking after employees' health and exemplifies the benefits of closer integration of those involved in safety and those involved in health.

As the emphasis on occupational health continues to grow, we believe that it is likely that the role of health and safety professionals will change. It is likely that over time they will become the equivalent of GPs in the NHS; having a general grounding in all major areas and referring particularly problematic cases to specialists (such as ergonomists, physiotherapists etc.) as required. The Institution of Occupational Safety and Health has provided the appropriate foundations for this approach over many years, with the NEBOSH diploma giving a general grounding which can be topped up with specialist courses as required. A Registered Safety Practitioner grading is awarded on the basis of sufficient knowledge and experience, both theoretical and practical.

Looking to the future, we believe that just as immediate safety concerns eventually led us towards a broader workplace health perspective, it is reasonable to expect that the emphasis on conditions such as stress will lead, in due course, to a new focus on workplace welfare. This will be a long way from where health and safety started and it will pose questions about the appropriateness of current professional structures and training of health and safety specialists. Will it be reasonable to expect one person to know detail of regulation on forklift trucks as well as techniques of psychodynamic counselling? Are these properly two quite separate areas which should be headed up by different professionals? Will there be new legislation on workplace welfare? If workplaces continue to become safer and there is an ever greater emphasis on health and welfare, what is the future of the health and safety professional?

9. *Is the HSE Sufficiently Well-Resourced to Meet its Objectives?*

None of members answered in the affirmative to this question. As previously indicated, there is a strong consensus that there are not nearly enough inspectors, and that those inspectors are not adequately resourced to play a supporting and advisory role.

10. *To What Extent is There Good Coordination Between HSE and Those Other Parts of Central and Local Government With a Role to Play in Promoting Health and Safety?*

Major problems have been encountered in the relationship between the HSE and local government. On the one had there has been a perception of "HSE arrogance" in dealing with local authorities. There are moves to redress this but they are regarded with some suspicion by local authorities who perceive the HSE as trying "dump" difficult issues onto them.

On the other hand there is a recognition that local environmental health is so overstretched that it simply cannot deliver much more on the health and safety front. To make the present system work, central government needs to properly resource local authorities' health and safety activities and monitor their effectiveness. Failing this the role needs to be taken away from local authorities altogether, and given to HSE to administer directly—provided the resources of HSE are increased in order for them to effectively carry out both their existing and new duties. Either way a lot more funding is required.

The Royal Society for the Promotion of Health

12 February 2004

Memorandum submitted by CORGI

1. Executive Summary

1.1 CORGI, the national gas safety watchdog, is the body charged by the Health and Safety Executive (HSE) to maintain a register of competent gas installers in Great Britain. We therefore work closely with both the Health and Safety Commission (HSC) and the HSE. We welcome the Committee's Inquiry as an opportunity to advance the policy debate on health and safety, recognising areas where the HSC and HSE have brought about improvements in health and safety, and identifying areas where further improvements can be made.

1.2 In our written evidence we have suggested a number of recommendations which the Committee may wish to consider making as part of its Report:

- CORGI would welcome a recognition by the Committee that a shortage of resources can delay the effective implementation of policy and therefore potentially compromise health and safety and a subsequent recommendation that resources for the HSE should be increased (3.1.4).
- CORGI believes that the preventative model established for gas safety in partnership with the HSE has been successful and could be applied to other areas of health and safety. We would welcome the Committee's views on how this could be achieved (4.2).
- CORGI would welcome the recognition by the Committee about the importance of proactive and sustained awareness raising as a means of prevention, and would further welcome a recommendation that the HSE should work with energy suppliers and CORGI to ensure the early introduction of a joint campaign (4.5.7).
- CORGI regrets that the HSE no longer provides systematic feedback on the outcomes of all referrals for enforcement and would welcome a recommendation from the Committee that the HSE reinstates this as soon as possible (5.4).
- CORGI would welcome a recommendation from the Committee that the HSE needs greater resources to effectively enforce gas safety legislation. We would urge the Department for Work and Pensions and Her Majesty's Treasury to give this issue the utmost consideration during the Spending Review 2004 process (5.5).
- CORGI would welcome a recommendation by the Committee that the HSE conduct a review of the relative effectiveness of an independent solicitor co-ordinating enforcement cases as opposed to an HSE Principal Inspector (5.6.2).
- CORGI would welcome the Committee's recommendation that the possibility fixed penalty fines should be further explored (5.6.3).
- CORGI would welcome a recommendation by the Committee that the HSE conduct a review of local authority policies in this area and publish best practice guidance for local authorities (5.6.5).
- CORGI would welcome a recommendation by the Committee that the definition of competence contained in the Gas Safety (Installation and Use) Regulations be tightened so as to avoid misinterpretation by the public (6.4).

1.3 We hope that the Committee will see fit to recommend that gas safety should form an important part of and future health and safety strategy, incorporating the suggestions for improvement made in this response. We would welcome the opportunity to expand further on these ideas by giving oral evidence to the Inquiry if the Committee would find this helpful.

2. Introduction

2.1 CORGI is the national watchdog for gas safety. It is the body charged by the Health and Safety Executive (HSE) to maintain a register of competent gas installers in Great Britain. CORGI was established as a voluntary registration scheme in 1970 following the Ronan Point tower block disaster. In 1991 new legislation was introduced requiring any business or self-employed person undertaking work on gas fittings or appliances to be a member of a mandatory registration scheme. The HSE then approved CORGI to run the registration scheme.

2.2 The mandatory registration scheme is established under Gas Safety (Installation and Use) Regulations, which cover all gas work on the customer's side of the meter.

2.3 We currently hold a database of more than 44,000 registered gas installation businesses employing some 95,000 gas-fitting operatives. As well as helping consumers locate a local registered installer, CORGI will investigate complaints about the safety of gas work undertaken by both registered installers and non-registered installers free of charge to the consumer. We also work to raise consumer awareness about gas safety.

2.4 Our mission is to lead standards in safety and our expertise lies in managing complex registers of competence, advising on proactive regulation to promote safety and in promoting consumer awareness. Safety drives everything we do—from administration and registration through to training and inspection,

we have developed over the years an expertise in gas safety that is also applicable to other health and safety issues. We welcome the commitment by the Health and Safety Commission to effect a reduction of at least 10% in gas-related fatal accident levels over a 10 year average. However we believe that every gas-related death is preventable and operate a zero tolerance policy on defective gas work.

2.5 CORGI works very closely with the HSE, both in maintaining and running the register of competent gas installers, and in developing wider gas safety policy. We welcome the Committee's Inquiry into the work of the Health and Safety Commission and Health and Safety Executive and we look forward to contributing our thoughts on the effectiveness of the current arrangements to promote health and safety, particularly in the area of gas, as well as identifying possible measures which could be introduced to improve standards further.

3. Observations on the HSE Structure

3.1 *The Role of the HSE in Making Gas Safety Policy*

3.1.1 CORGI reports to the Flammables and Gas Policy Division of the Safety Policy Directorate of the HSE. The HSE attends CORGI Council meetings and the CORGI Annual General Meeting. The performance of the registration scheme is assessed against Criteria set by the HSE. The current criteria were set in August 1998. As part of its duties in running the mandatory registration scheme, CORGI has regular contact with the HSE at all levels:

- Local operational contact includes regular liaison between HSE and CORGI field inspectors on operational issues.
- National operational contact includes regular meetings of senior management at CORGI and the HSE.
- Strategic contact includes HSE observer status at CORGI board meetings and senior review meetings.

3.1.2 The HSE sets gas safety policy through the Fundamental Review of Gas Safety. The most recent Review took place in 1998. CORGI believes that the HSE consults effectively with the main stakeholders, including CORGI, both at the time of the Review and on a day to day operational basis. We hope this continues.

3.1.3 Although some progress has been made in taking forward the 1998 Review, progress in implementing the 47 recommendations has been slower than anticipated. CORGI is concerned that the diversity of focus of the HSE, with many competing priorities including transport and health and safety at work, has meant that resource is spread too thinly. Staff shortages have resulted in preventable slippages to the timetable for implementation of the recommendations made in the Review.

3.1.4 We would welcome a recognition by the Committee that a shortage of resources can delay the effective implementation of policy and therefore potentially compromise health and safety and a subsequent recommendation that resources for the HSE should be increased.

3.1.5 CORGI also works closely with the HSE on the enforcement of gas safety legislation. We discuss this in more detail in Section 5.

3.2 *The role of the HSE in promoting gas safety policy across Government*

3.2.1 A number of Government Departments are responsible for the implementation of policies which will impact upon gas safety. These include:

- The Department for Trade and Industry (consumer safety, energy).
- The Office of the Deputy Prime Minister (housing safety and building regulations).
- The Department for the Environment, Food and Rural Affairs (Warm Front, fuel poverty, energy efficiency).
- The Department of Health (carbon monoxide poisoning).
- The Department for Work and Pensions (HSC and HSE).

3.2.2 In order for the policies set on gas safety to be reflected across Government, it is important that the above Departments work closely with the HSE. Although co-operation on issues such as fuel poverty has improved with the establishment of the Ministerial Advisory Group on Fuel Poverty, there are still areas where policies are developed without effective co-operation.

3.2.3 However CORGI actively works across Government to focus officials' and ministers' attention on gas safety and we have found an increasing willingness to engage with issues that will affect gas safety and revise policy accordingly. A recent best practice example of this is that the Office of the Deputy Prime Minister reacted positively to our advice on the gas safety implications of the draft wording of the Home Condition Report which is included in the current Housing Bill. Officials are now working with CORGI to improve the wording so as to reflect current gas safety best practice.

4. The Importance of Prevention in Health and Safety

4.1 In the area of gas safety, the HSE mainly acts as a catalyst in terms of prevention, with CORGI taking the lead on implementation. The HSE also works with other industry stakeholders to encourage best practice in gas safety.

4.2 CORGI believes that the preventative model established for gas safety in partnership with the HSE, which is outlined below, has been successful and could be applied to other areas of health and safety. We would welcome the Committee's views on how this could be achieved.

4.3 CORGI believes that there are two major areas in preventing gas safety incidents:

- Ensuring that all gas installers have the necessary expertise and skills to operate safely, through running an effective mandatory registration scheme.
- Raising awareness and understanding of key gas safety messages.

4.4 *Ensuring That all Gas Installers Have the Necessary Expertise to Operate Safely*

4.4.1 CORGI's primary responsibility is to maintain a register of competent gas installers. In 1995, following a review undertaken by Touche Ross consultants, CORGI was give a responsibility by the HSE to develop the Nationally Accredited Certification Scheme for Individual Gas Fitting Operatives (ACS), according to a prescribed blueprint. This updated and replaced the Approved Code of Practice (Standards of Training in Safe Gas Installation) (ACOP). The ACS is the primary method of measuring competence of experienced gas operatives. New entrants generally enter the industry through the National Vocational Qualification (NVQ) route, which is aligned to the ACS. All gas installers and their operatives must go through the ACS process every five years to maintain their CORGI registration.

4.4.2 CORGI believes that the Government's decision to introduce a mandatory registration scheme was an important step forward for gas safety and has led to a marked improvement in standards. We believe the HSE's policy oversight and guidance has made a valuable contribution to this improvement.

4.4.3 In particular, the HSE in partnership with CORGI, has overseen the development and implementation of the ACS, which for the first time has introduced a clear national standard of competency. As well as providing additional quality assurance for consumers, CORGI believes that the introduction of the ACS has raised standards and has driven from the industry individuals who are unable to demonstrate their ability to undertake safe gas work. We are currently conducting a review of data, which will help us to understand changes in levels of competence that have taken place in the industry since the introduction of the ACS.

4.4.4 Where a gas safety complaint is made about a registered installer, CORGI will investigate free of charge. Registered installers are required by CORGI to rectify defects identified during a complaint inspection. Action will also be taken to address any gap in skills which may become apparent. In serious cases, or where an installer has failed to make adequate redress, s/he may be removed from the CORGI register and referred to the HSE for enforcement.

4.5 *Raising Awareness and Understanding*

4.5.1 The HSE has limited financial resource for raising awareness and understanding. Although it initiated a major gas safety advertising campaign in the mid-90s which was supported by a number of stakeholders including CORGI, most awareness work falls to other stakeholders and industry bodies. However such work is generally undertaken in consultation with the HSE. The HSE has also made welcome attempts to introduce greater co-ordination in activity and messages across the sector. For example, the HSE chaired a publicity working group comprising of a number of key stakeholders, including CORGI.

4.5.2 As the national gas safety watchdog, CORGI takes the need to raise awareness very seriously, running two major campaigns every year which receive significant national and local media coverage. We are also grateful for the political support these campaigns receive, including from Ministers and the All Party Parliamentary Gas Safety Group.

4.5.3 CORGI also constantly works to raise awareness amongst groups it feels to be particularly at risk. An example of this is the Colin the Skunk campaign aimed at students living in the private rented sector, which was run with the support of the National Union of Students.

4.5.4 In addition to this proactive awareness raising amongst consumers, CORGI regularly co-operates with consumer-interested media and organisations who campaign in this area. Recent examples include the BBC's Rogue Traders, which exposed the illegal and unscrupulous activities of a number of non-registered installers, and *Woman's Own Magazine*, which launched a campaign to identify non-registered installers.

4.5.5 As well as informing consumers of their rights, CORGI works with private and public sector landlords to ensure that they are aware of their legal responsibilities, which include ensuring that every gas appliance they own in a property for which they are responsible is checked for safety every 12 months by a CORGI-registered installer.

4.5.6 Proposals have been brought forward by representatives of energy suppliers to collectively and voluntarily fund awareness raising activities on gas safety. CORGI believes that this would be a welcome advance and looks forward to contributing our expertise to this campaign and working with suppliers to ensure early implementation.

4.5.7 CORGI would welcome the recognition by the Committee about the importance of proactive and sustained awareness raising as a means of prevention, and would further welcome a recommendation that the HSE should work with energy suppliers and CORGI to ensure the early introduction of a joint campaign.

5. The HSE's Record on Enforcement

5.1 In the unfortunate event that prevention fails, CORGI believes that it is essential to have effective enforcement of gas safety legislation. As well as removing a potentially dangerous operative from the industry, effective enforcement acts as a deterrent to others.

5.2 The HSE's lack of resources has hindered effective enforcement of gas safety legislation.

5.3 In our capacity as the national gas safety watchdog, CORGI works closely with the HSE on enforcement. In 2002–03 CORGI received 1,311 complaints against non-registered installers. Following investigation, 1,003 cases were reported to the HSE for enforcement.

5.4 CORGI regrets that the HSE no longer provides systematic feedback on the outcomes of all referrals for enforcement. As part of our review meetings with the HSE we have been advised that they treat every notification as a complaint, that action is undertaken on each complaint, ranging from a letter to an improvement or prohibition notice and a successful prosecution. We understand that the HSE is awaiting a new computer system which will ensure feedback is provided on each complaint. CORGI would welcome a recommendation from the Committee that the HSE reinstates systematic feedback as soon as possible.

5.5 CORGI does have concerns that effective enforcement is hindered in some cases because the HSE lacks adequate numbers of personnel. CORGI would therefore also welcome a recommendation from the Committee that the HSE needs greater resources to effectively enforce gas safety legislation. We would urge the Department for Work and Pensions and Her Majesty's Treasury to give this issue the utmost consideration during the Spending Review 2004 process.

5.6 *Enforcement Penalties are Frequently Inadequate*

5.6.1 CORGI regularly receives anecdotal evidence from registered installers about what they see as inadequate penalties for non-registered operatives who have been carrying out gas work. These penalties can be as small as a few hundred pounds and we believe that this is not an adequate deterrent to practising without a valid CORGI registration. CORGI's figures show that there is a significant chance that work undertaken by a non-registered installer will have a serious gas safety defect.

5.6.2 CORGI is also concerned that there may be a differentiation in the level of fines imposed on non-registered installers when an independent solicitor is retained by the HSE to co-ordinate the enforcement as opposed to a case being led by an HSE Principal Inspector. We would welcome a recommendation by the Committee that the HSE conducts a review of the relative effectiveness of an independent solicitor co-ordinating cases as opposed to an HSE Principal Inspector.

5.6.3 Following the last Fundamental Review of Gas Safety, the HSC stated that the possibility of giving the HSE the power to impose fixed penalty fines to non-registered installers should be explored. CORGI would welcome the Committee's recommendation that the possibility of fixed penalty fines should be further explored.

5.6.4 We welcome the role of the HSE in securing recent high profile large penalties imposed on local authorities and housing associations for failing to adequately maintain gas appliances in properties for which they are responsible.

5.6.5 CORGI believes that standards of gas safety amongst local authorities have improved since the introduction of the requirement for annual landlord safety checks in 1994. However we are concerned that tragedies such as that in Hammersmith indicate that a variation in standards still exists. We would welcome a recommendation by the Committee that the HSE conduct a review of local authority policies in this area and publish best practice guidance for local authorities.

6. Current Health and Safety Legislation

6.1 Health and Safety legislation is only as strong as the enforcement which backs it up. In Section 5.5 we have set out our concerns that the full range of penalties available to the courts are not used.

6.2 In addition, the current Gas Safety (Installation and Use) Regulations, which stem from Health and Safety at Work Act 1974, leave what we believe to be an unnecessary area of interpretation, which can undermine public understanding of gas safety messages.

6.3 Part B Regulation 3 (1) states that "no person shall carry out any work in relation to a gas fitting or gas storage vessel unless he is competent to do so"—CORGI believes that a clearer guidance as to the definition of competence would assist in conveying the message that gas work is better left to experienced, qualified professionals who are registered with CORGI.

6.4 CORGI understands that a revised version of the Gas Safety (Installation and Use) Regulations is currently being developed and will be published in due course. We would welcome a recommendation by the Committee that the definition of competence be tightened as outlined above to avoid misinterpretation by the public.

7. The Next Steps for Gas Safety

7.1 CORGI welcomes the Government's commitment to improving standards of health and safety. We look forward to continuing to work with the HSC and HSE, on improving standards of gas safety, as well as assisting in other areas in which our expertise may be of use. Given the current focus on housing and building safety, we also believe that the Office of the Deputy Prime Minister should be involved in developing policy in this area alongside the HSC and HSE.

7.2 We hope that the Committee will see fit to recommend that gas safety should form an important part of any future health and safety strategy, incorporating the suggestions for improvement made in this response. We would welcome the opportunity to expand further on these ideas by giving oral evidence to the Inquiry if the Committee would find this helpful.

CORGI

12 February 2004

Memorandum submitted by the British Safety Council

Founded in 1957, the British Safety Council is Britain's largest independent organisation devoted to health and safety in the workplace. Its 10,000 member companies employ approximately one in six of the UK's workforce. The BSC has an annual turnover of £10 million and employs 140 full-time and 40 part-time staff. It achieves its mission by training (30,000 delegate days per year), company audits, advisories, a helpline, on-line assistance, its monthly magazine SAFETY MANAGEMENT, and monthly pocket guides and workplace posters. Award schemes, including the highly prestigious Sword of Honour, encourage companies to raise awareness of health and safety issues among their staff.

1. *The legislative framework: to what extent has the Health and Safety at Work Act 1974 and subsequent legislation at national and European levels been successful in improving standards of health and safety?*

2. The statistics speak for themselves. The 1974 Act and subsequent legislation has been extremely successful in bringing down the rates of death and serious injury at work. But the figures also tell another story; the rate of progress is slowing down. We are now in a position where a reverse is highly possible. New people joining the workforce mean that old battles must be continuously re-fought. To ensure the figures continue downwards, new thinking is required.

3. *Achieving outcomes: is Britain on course to meet the targets set out in the Revitalising Health and Safety Strategy?*

4. No. Although some sectors are on course, it seems likely at this point that there could be a considerable undershoot of the overall targets unless changes are made quickly.

5. *Does the HSE get the balance right between prevention and enforcement?*

6. It has probably done so in the past, but a change is now needed. We believe the only way left to improve the statistics is for individual companies to make more effort to achieve best practice. Modern technology should be used by the HSE to enable inspectors to target their enforcement activities more specifically, and to communicate with companies. Companies should also know what they need to do to reduce the likelihood of a visit from an inspector. This is the major amendment that is needed to the present system. We propose the following:

a) No change to the regimes for the major hazard areas such as nuclear, chemical, and railways:

b) For each company in mainstream industry, commerce and the professions there should be a database held by HSE giving information about the company which the inspectors can use to decide whether to make a visit. Companies should have the right, and be encouraged, to add to the database any information that shows they are managing their risks adequately. Factors that inspectors should take into account would include:

- Does the company have an Employers Liability policy
- Is there an active safety policy in place
- Is there a "competent person" on the staff or regularly visiting
- Does the company have regular audits of its health and safety system

— Is full and relevant training carried out on a regular basis

— How does the company and relevant information on risks and preventative and protective measures

In addition to the above, the methodology being worked on by Greenstreet Berman for the HSE for a health and safety management index could be incorporated for larger companies. The HSE should regularly contact each company on the database by email to remind them of the information held on them, and it should be a legal requirement for companies to confirm, possibly at six month intervals, the accuracy of the information. This system would allow greater use of less-skilled personnel, saving the highly trained inspectors for enforcement work. When companies realise that taking positive action to improve their performance is more economical than facing an inspection, we believe that progress will be made.

7. *Is it sufficiently proactive to address developing hazards at work such as stress and passive smoking?*

8. No, but the HSE could make it clear that having active policies on these matters is a factor that companies should add to the database in their favour.

9. *Are penalties for health and safety offences set at an appropriate level?*

10. No. Last year the level of fines fell by more than 20% compared with the previous year, and in any event fines are not high enough to command the attention of many employers.

11. *To what extent is health and safety legislation properly understood?*

12. Very little. Health and safety practitioners can now aspire to be part of a recognised profession where they will have a good understanding of the law. However, there are probably only about 10,000 properly qualified professionals among 3,500,000 companies. Most companies do not have a real understanding or access to the legislation or the Approved Codes of Practice. The British Safety Council trains workers at all levels, from shop floor to the Board: some of them do not know the legislation, and some of them are not aware of it all. They are still entitled to be healthy and safe at work. The HSE clearly recognises that it has difficulty in reaching many companies, and that sending out reams of paper is not an effective way of getting to them. Some people can only be influenced in a face-to-face situation, including a training session. More needs to be done to help organisations other than the HSE to get to those companies to help fill in the gaps that exist.

13. *Does more need to be done to encourage good practice?*

14. Yes. The proposal outlined in 6(b) above is one simple way to do that.

15. *Is there sufficient emphasis on "health" in health and safety?*

16. The emphasis on "safety" must be maintained, but the statistics show that much more needs to be done on the "health" side. Thirty-three million working days lost each year through ill-health is an unacceptable cost to the nation and must be addressed. Employers need much more assistance in formulating policies on stress, rehabilitation, etc, and putting those policies into effect. Many employers, however, are frightened to approach the HSE for help, and so this can be better done by others.

17. *Resources: is the HSE sufficiently well-resourced to meet its objectives?*

18. If the HSE concentrates its current resources on those things that only it can do, and leaves other matters to the many providers capable of doing everything else, there should not be a need for an immediate, large increase in funding for HSE. We believe that too much of the available money is currently spent on advice, including helplines, without getting to those companies who fear any contact with the HSE.

19. *To what extent is there good co-ordination between HSE and those other parts of central and local government with a role to play in promoting health and safety?*

20. There is definitely a perception that local authorities concentrate mainly on food safety, to the detriment of other aspects of health and safety, and that the HSE is a much more competent body overall. Unfortunately, in the past year or so the HSE has been the target for much criticism from government and quasi-government bodies, and has also been subjected to vicious attacks in the press. It would be better if it were seen to be concentrating more on its enforcement role, where it has an admirable success rate, while encouraging role, where it has an admirable success rate, while encouraging other bodies to carry out the training, education, dissemination of information and other activities where it has not achieved as much.

British Safety Council

February 2004

Memorandum submitted by Public and Commercial Union (PCS)

Introduction

1. The Public and Commercial Services Union (PCS) is by far the largest civil service trade union with a total membership of almost 300,000 working in the civil service and related areas.

2. PCS represents 1,381 members working directly within the Health and Safety Executive (HSE), engaged in the delivery of the HSE mission to "protect people's health and safety by ensuring risks in the changing workplace are properly controlled".

3. PCS member's duties include the delivery of basic advice and guidance about health and safety (H&S) legislation in a range of industries, providing support for H&S operational activity, the formulation and development of policy on fundamental and strategic health and safety issues that span HSE, and assuring coherence in HSE's approaches to Europe, the environment, and quality regulation.

4. PCS welcomes the opportunity to provide this inquiry with our views and we would be happy to support this submission with oral evidence.

Background

5. There has been considerable improvement in health and safety at work arrangements since the passing of the Health and Safety at Work Act in 1974. The number of incidents has decreased, and risk is now managed more effectively. However old problems have not gone away despite a change in the type and nature of work carried out by UK workers in response to advances in technology. Health issues impact on many and are often practically more difficult to manage than traditional safety issues and consequently they have been relatively neglected.

6. As Europe continues to exert considerable influence on health and safety legislation, PCS recognises that there is no room for complacency and our members accept that change is needed, but we want to see evidence based change that is well managed and enhances the delivery of government priorities.

Legislative Framework

7. The 1974 Health and Safety at Work Act was one of the major pieces of progressive legislation from the Labour Government of 1974–79. The basis of the legislation remains valid today but we need to build on the success of the Health and Safety Commission and Executive. We want legislation that is not generally prescriptive; rather it should be goal setting, and flexible enough to deal with any employment or societal views or changes.

8. Corporate killing legislation, the use of penalties, removal of Crown immunity and an enhanced role for trade union health and safety representatives must enhance the general H&S regime, not cut across it.

Achieving Outcomes

9. PCS recognises the key roles played by both local authority environmental health officers and trained HSE inspectors, although we believe that there are not enough of either of these groups to be fully effective. We also want the work of our members in the Health and Safety Executive (both those involved in back office and operational activity) to be recognised as important if HSE is to work effectively and efficiently in delivering its legal and policy strategies.

10. In the 1990s, despite opposition from PCS's predecessor unions, HSE cut back on the number of our members' jobs who worked alongside inspectors in HSE's main Field Operations Directorate. We know that members of other trade unions and HSE senior management now recognise that this was a mistake. It has resulted in inspectors having to do more work in the office and that has prevented them from getting out and about doing what they are best qualified to do: inspect, advise and enforce the law.

11. PCS agrees that we need more inspections of workplaces and that the best way to do this is to increase the number of inspectors; but inspectors alone will not deliver the necessary and essential services we must have if we are to improve the UK's health and safety record.

12. Recent research has shown a low level of understanding about the role and services that HSE provides. This has an impact on the effectiveness of the inspector's role. PCS represents workplace contact officers, regulatory compliance officers, gas officers, working time officers, complaints officers and railway inspectorate contact officers. All of these front line staff have a part to play in increasing awareness of how HSE operates, in supplying guidance on health and safety compliance, and, if necessary, providing a route into inspection and investigation, as part of a broad range of intervention strategies alongside traditional and necessary inspection.

13. PCS feels it is important to ensuring sufficient resources and the right mix of skills are made available, so that HSE and local government can ensure that all workplaces are safe and healthy environments for workers. PCS believes that this should be seen as the first priority.

RESOURCES

14. The funding of HSE has been reduced as part of the last government spending round. PCS opposed this reduction as it will mean that enforcement of new legislation will prove difficult and that HSE must rebalance its operational activities to have a continued impact on H&S in the workplace.

15. HSE is now faced with some no-win choices. Cuts in its funding mean that some of HSE's planned work and, crucially, the number of incidents it is able to investigate will be sacrificed due to lack of money.

16. Prioritisation to deliver on public service agreement targets is a reality for public servants across the civil service; but when deciding on the relative importance of Health and Safety priorities this can mean, quite literally, making a choice about life and death. PCS believes that adequate funding should be made available to ensure duty-holders protect their workers by complying with the law.

17. The economic costs to UK of injury and ill health run into the billions. It is common sense that in order to reduce this waste, we need to invest in improvements to H&S arrangements.

REVIEW OF RAILWAY REGULATION

18. We note that a fundamental review of the way the railways are regulated has recently been announced. PCS believes that there is a synergy between railway safety and rest of HSE's work, and would consider that HSE should retain its rail safety role.

19. PCS agrees with the statement made by Bill Callaghan, Chair of the HSC, when he said that "health and safety should be truly independentable to hold the industry to account". To echo Mr Callaghan's words, the Cullen Report recommended HSE retain responsibility, and PCS believes it would be a mistake to unravel the work carried out by HSE in taking the report's recommendations forward.

RECOMMENDATIONS

20. It will be hard work to make further in-roads into the toll of accidents and ill health at work. HSE needs a mix of traditional principles in a modern setting. PCS members' roles must continue to change to complement the inspector's, but crucially, not to replace it. We all have a role to play to ensure Health and Safety remains a priority.

21. Quite simply, PCS members have complementary competences, and PCS is determined that we will continue to play our part in delivering Health and Safety targets. Our recommendations are therefore to:

- Resource HSE to enable the recruitment freeze to be reversed and sufficient staff recruited and trained.
- Leave the basic legal framework alone, but implement corporate killing legislation with a significant role for HSE.
- Increase penalties for those who break H&S legislation.
- Remove crown immunity.
- Increase the powers of H&S reps.
- Enhance HSE's ability to enforce.
- Retain railway safety within a unified H&S regulatory regime.
- Urge the Government to strongly affirm and promote the place of H&S in our society.

Public and Commercial Union

12 February 2004

Memorandum submitted by the Institute of Directors (IoD)

INTRODUCTION: THE IOD AND HEALTH AND SAFETY

1. This is the IoD's response to the public invitation to comment, for its inquiry into the work of the HSC and HSE, that was issued in Works and Pensions Committee Press Notice, PN03, Session 2002–03.

2. The IoD is an individual membership organisation made up of some 53,000 directors of business and other important organisations worldwide, but mainly in the United Kingdom.

3. Members of the IoD are drawn from all sectors and functions within organisations. These include people who are health and safety professionals, or who are involved in the health and safety sector, or both.

4. The IoD is also involved in scrutinising Government and European Union (EU) policies for their effect on business. The IoD regularly comments on health and safety consultative documents, whether issued by the HSC or HSE or other government bodies. The IoD also has an interest in health at work. The IoD issues

its own policy documents that cover health and safety matters and their relevance to business. Several have appeared in the last few years. Underpinning the IoD's comments are various postal and telephone surveys of the membership, as well as direct contact with members and the geographically-based regions and branches of the IoD. The IoD also advises its members on new developments and on examples of good practice. For example, the HSE arranged to have circulated to IoD members the HSC's guidance on directors' responsibilities[1]—which the IoD had been involved in drafting, in discussion with the HSE. The IoD has also been invited on several occasions to address training events for HSE inspectors, on directors and health and safety.

Summary of the IoD's Comments

5. *The main points:*

(a) It is not possible to state categorically that the Health and Safety at Work Act 1974 and subsequent United Kingdom and EU legislation has led to improved health and safety performance, but we note that the UK's performance on health and safety as such is good by comparison with many other countries. See paragraph 6.

(b) The amount and complexity of health and safety legislation and regulations can cause problems for organisations having to implement it. This also has implications for whether or not the law is actually understood. Some of the HSC/HSE documents need to be made easier to read and understand. On the positive side it can be productive to positively engage with organisations and their principals (such as directors) in terms that make business as well as health and health and safety sense. See paragraphs 7–9.

(c) It is almost certainly the case that health issues in general constitute a bigger problem than "health and safety". Some of the problems are rather more intractable, including that of occupational rehabilitation. See paragraph 10.

(d) There is a host of public sector bodies (including local government) that have some responsibility for health, and health and safety issues. There seems to be a need for better "joined-up government", to make it easier for outside bodies or "users" to seek advice and guidance on health and safety matters. This is especially the case now that the HSC and HSE have been getting involved in "health" issues, which are also the province of bodies such as the National Health Service (NHS) and ministries such as the Department for Work and Pensions (DWP). Again on the positive front, there could be benefits from genuine joint working (and including employers and insurers) in tackling the issue of occupational rehabilitation. See paragraphs 11 and 12.

(e) Consideration should be given to changes of name, to at least avoid the confusing references to the HSC and HSE as separate entities. See paragraph 13.

The UK's Health and Safety Performance

6. The HSC itself has cited evidence that shows the UK's health and safety record to stand good comparison with many other countries, and even by comparison with other existing EU member states.[2] Even noting that there may be differences in statistical classifications between different parts of the world, some of that success will have been due to the work of bodies such as the HSE. It would be hard to state unequivocally that it is the sole cause of the relatively good performance, however. It is also important for the HSC and HSE to continue working with practitioners in business and other sectors to maximise the beneficial effects.

Legislation and Regulation

7. The IoD supports the need for legislation, and for enforcement of health and safety rules. However, as with all regulations, there is a balance to be struck. A survey of IoD members, carried out in late 2003 (the results of which are due for publication on 18 February 2004) revealed that health and safety regulations constituted the second biggest area of concern (after employment law). This was mainly in terms of the cost of implementation and of distraction of management effort.[3] The HSE, while not being the only body responsible for health and safety law, does of course have continued obligations to reduce the bureaucratic implications of proposals in this regard.

8. Some of the practices and language used by the HSC have been outmoded. An example is the debate around what were originally referred to as roving workplace health and safety representatives. What eventually became a fairly pragmatic set of proposals for a Workers' Safety Adviser Challenge Fund

[1] Directors' responsibilities for health and safety, INDG343, HSC, published by HSE, 2001.

[2] For example, in Revitalising Health and Safety Consultation Document, Department of the Environment, Transport and the Regions (DETR) and HSC, DETR, London, July 1999, Annex B, pp 34–35.

[3] The real impact of red tape an IoD survey, Regulation Comment, James Walsh, IoD, February 2004. See also www.iod.com/policy/papers after 17 February 2004.

originally started out as an immensely bureaucratic set of ideas.[4] The Commission itself changed these, seemingly realising that mechanics used in trade union-employer liaison procedures in 1974 were not necessarily appropriate a quarter of a century later. This "modernisation" approach needs to continue, not only to reduce red tape but also to help improve the image and perception of the HSC and HSE.

9. Some HSC and HSE documents still need to be made easier to read and understand. The HSE has appointed a senior communications professional, and we hope that this will help enhance that particular function. On the positive side it could be productive to positively engage with organisations and their principals (such as directors) in terms that make business as well as health and health and safety sense.

Health

10. It is almost certainly the case that health issues in general constitute a bigger problem than "health and safety". Some of the problems are rather more intractable, including that of occupational rehabilitation. This is an area that the HSC and HSE have an interest in (along with bodies such as the IoD). This is an area ripe for improved "joined up government"—see paragraph 12.

Joint Working

11. The fact that different public bodies have responsibility for health and safety can cause problems. For example, the HSE and local government have responsibilities for separate aspects of health and safety advice and enforcement. Interestingly, a survey of IoD members in July and August 2002 indicated that 67% of those directors who had had contact with the HSE for advice thought that the standard of service was good or very good, 24% that it was neither good nor bad, and 9% poor or very poor (381 respondents to a self-completion questionnaire).[5] (The same asked about local government advice on health and safety—albeit covering different aspects of health and safety, potentially—were 38%, 34% and 28%, respectively.) Greater clarity and guidance on this is needed from government as a whole, not just the HSC and HSE.

12. On the health front there is an excellent opportunity to improve cross-departmental working. On the matter of occupational health and rehabilitation, where the HSC/HSE has a known interest, there is also the need to try to co-ordinate better with the DWP, the Department of Health, the NHS, and the devolved administrations. The HSC has already stated that it cannot achieve its aims in isolation,[6] and that many partners are needed, from business, government and trade bodies. The huge problem for the country of occupational rehabilitation is one where the principles of such working need to be really put into practice.

Terminology

13. A corporate governance point: it can be very confusing to refer to both the Health and Safety Commission and the Health and Safety Executive. This distinction harks back to somewhat outmoded corporate governance terminology. It is not usual practice to make a distinction between a supervisory body (here, the Commission) and the executive, so it might be better to come up with one term that can be used both internally and—more importantly—by the outside world. We made this same point to the House of Commons Environment Sub-committee in a memorandum of September 1999.[7]

Institute of Directors

12 February 2004

Memorandum submitted by the Scottish Trades Union Congress

The Scottish Trades Union Congress is Scotland's Trade Union Centre. Our purpose is to co-ordinate, develop and articulate the views and policies of the trade union movement in Scotland.

The STUC represents some 630,000 trade union members in Scotland, the members of over 40 affiliated organisations. We speak for trade union members in and out of work, in the workplace and in the community, as workers and as citizens. Our affiliated trade unions have members in every sector of the economy and across a broad range of occupations.

We welcome the opportunity to provide this written evidence and the following comments reflect our existing policy.

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[4] "Securing effective employee involvement: Draft consultative proposals for harmonised regulations and other measures to promote greater employee involvement to ensure health and safety at work", HSC paper HSC/03/83, 2003.

[5] "Health and safety", IoD News, October 2002, p 12.

[6] A Strategy for Workplace Health and Safety in Great Britain to 2010 and Beyond, HSC, undated [2003].

[7] "Memorandum by the Institute of Directors (HSE13)", The Work of the Health and Safety Executive Memoranda relating to the inquiry submitted to the Environment Sub-committee, House of Commons Session 1998–99, HC828, The Stationery Office, London, 26 October 1999, pp 26–28.

SUMMARY

The HSC have stated that changes in legislation will be focused on implementation of EU Directives. The STUC are concerned that the Government has been slow to implement changes in other areas designed to provide protection for workers, most noticeably the Working Hours Directive, in order to meet the demands of employers.

Increased commitment is needed from the HSC and Government to introduce changes to ensure we comply with the European Health and Safety Framework Directive, specifically in relation to removing the economic test of reasonable practicability that we feel is in contravention of the directive.

The Government has failed to introduce legislative changes proposed in the "Revitalising Strategy" action points that are key to the success of the strategy.

The "Revitalising Strategy" has proved resource intensive at the expense of enforcement activity in other non-priority areas. Increased resources are required to redress this balance and ensure enforcement is the core activity in identifying and addressing workplace hazards.

Current structures within the HSC fail to recognise the opportunities created by the devolved Parliament in Scotland and action is required to address this concern and would welcome further discussion regarding this.

We also believe that individual Field Operations Directorates should be given more resources and more autonomy to achieve results and identify geographical trends and priorities.

The HSC/HSE has to review current working arrangement with trade unions and health and safety representatives to utilise the skills and expertise the trade union structures can bring to health and safety improvement

Many of the areas to be considered by the enquiry have been included in the recent HSC consultation on the strategy for 2010 and beyond. We have concerns that in common with revitalising and noticeable low levels of enforcement there will be little hope of success without substantial increased resources.

1. *The Legislative Framework*

1.1 The STUC believes that Britain has robust health and safety legislation and statistical evidence suggests that the Health and Safety at Work Act 1974 (HSWA), subsequent amendments and new regulations have contributed to the reduction in the number of fatalities and major injuries to workers since it's introduction. However, we are concerned that HSE statistics for Scotland show that for the last four reporting years the amount of fatal injuries to employed and self-employed workers has actually increased. Although we would accept that the numbers for fatalities are low and subject to fluctuation, the statistics for major injuries show a 6% increase over the last four years while the same figure for Wales shows a reduction of 15%, and nationally a reduction of less than one 1%.

1.2 The STUC acknowledges that the principle of risk assessment, if properly implemented and updated can have significant impact in improving workplace safety. Therefore, we were concerned the existence of civil liability exclusion undermined the preventative effectiveness of risk assessment by denying the right to seek civil remedy to enforce employers to carry out their legal obligations to measure the risks of tasks undertaken and work systems in their organisations. While we welcome recent changes to legislation we continue to be concerned that the inclusion of reasonable practicability is an economic measure of health and safety and remains within our legislation. We view this as a contravention of the European Health and Safety Framework Directive.

1.3 The STUC believes that if the Health and Safety Commission wishes to achieve its commendable objective to be a world leader in protecting workers health and safety then it is inevitable that changes will be required in existing legislation. Such changes will allow the Government to comply with the European Health and Safety Framework Directive and should be targeted at not only protecting workers safety, but also the rights of trade union health and safety representatives who actively seek to improve workplace safety in workplaces. We are concerned that the attempts to impose implicit duties on company directors have been dropped, again because the Health and Safety Commission could not reach consensus. Attempts to consolidate and update the Safety Representatives and Safety Committees Regulations and Health and Safety (Consultation with Employees) Regulations 1996 met the same fate. The STUC is concerned that the decision-making by consensus is resulting in proposed legislative changes, aimed at protecting workers being dropped because employers do not wish to accept more responsibility and invest financially in the health and safety of their workers.

2. *Achieving Outcomes*

2.1 As outlined in the last section the STUC is concerned as we approach the point at which 50% of the targets set under the revitalising strategy it is clear that it is unlikely Scotland will meet these outcomes particularly in reduction of fatalities and major injuries. This could indicate an unwillingness of Scottish employers to endorse the strategy. It may also mean that employers willing to take the risk of not fulfilling their legal obligation in the absence of adequate deterrents or the reduced likelihood of being prosecuted as

a result of ineffective proactive enforcement. It would also appear to question a national strategy, setting priorities for the whole of Britain when it is clear that on numbers of fatalities and major accidents alone Scotland appears to be moving in the opposite direction to England and Wales.

2.2 The STUC does not believe that the balance is right and we would support and increase in enforcement activity, but not at the expense of reducing preventative measures by provision of advice and assistance. We view enforcement activity as the most effective preventative method of reducing accidents in the workplace, instilling higher standards of health and safety management in workplaces and more awareness of health and safety issues in workers.

2.3 We do not believe that the HSE strategy is correct when addressing new and developing hazards, taking stress as an example this was an emerging concern of trade unions in the early 1990's. However the HSE only launched its stress pilot and management standards in 2003. We view development of guidance as a waste of resource as there is no legal duty placed on employers to follow this advice. Similarly with passive smoking the guidance has had little or no effect in high-risk workplaces, specifically in the hospitality industry. The reluctance to address these issues more effectively has an adverse impact on the HSE and its public profile.

2.4 The sentencing options available are inadequate to act as a deterrent and this is compounded in Scotland by a failure of our Judiciary to impose penalties at the upper end of the scales available. We are also disappointed that the promised Safety Bill never materialised and we continually see efforts of individual Members of Parliament to bring forward Bills frustrated in the House of Commons. We support extending the amount of offences that cover a period of imprisonment for those found guilty of breaches of health and safety offences as well as more severe penalties for employers who fail to purchase compulsory Employers Liability Insurance.

2.5 It is hard to measure the extent of understanding of health and safety legislation on the basis outlined. Understanding is undoubtedly higher in unionised workplaces where safety representatives are visible; equally this can be said of organisations where good partnership working agreements exist. However there are many workplaces where employers may have understanding of their obligations but chose not to communicate these to their workforce. And then there are irresponsible employers who are not aware of their responsibilities and make no effort to do so. We feel that inadequate enforcement activity allows employers to ignore their responsibilities on the premise it is highly unlikely they will be subject to normal regulatory inspections. Therefore, we feel that it is not only a question of spreading good practice but providing employers with training, especially those in the small and medium sector whilst also ensuring that employers are made aware of the consequences failing to continually improve their health and safety management systems.

2.6 The HSE have worked with the STUC and other stakeholders in various Scottish Executive initiatives that focus on improving access to occupational health services to workers and employers throughout Scotland. The focus of limited HSE activity has focused on preventing accidents in the workplace and we feel that there has been little attention placed on addressing health issues and this is evident from the revitalising strategy. The STUC supports the view that occupational health services would be most effectively delivered through the National Health Service and we remain disappointed that both the Westminster Government and the Scottish Executive failed to recognise this when they implemented proposals to recover costs incurred in treating personal injuries from defendant's insurers. We are firmly of the opinion that such costs, and those incurred in treating those suffering from occupational diseases, should have been utilised to provide better care for those made ill or injured by their work and improve research into occupational ill-health and disease. We are also concerned that the HSE appears to be powerless to instruct employers to carry out research into occupational disease retrospectively. We therefore feel that more attention has to be paid to occupational health issues including identifying new hazards and the Government and Scottish Executive should ensure those who suffer from chronic and often fatal occupational disease are supported through improved medical research facilities to ensure they enjoy the highest quality of life as their illness progresses.

3. *HSE Resources*

3.1 The STUC is firmly of the view that substantial investment is required by the Government to ensure the HSE is resourced to meet its objectives as outlined in the revitalising strategy and provide adequate protection to workers who do not work in the priority sectors. We believe that the current levels of funding effectively prevent the HSE from enforcing in areas other than the priorities outlined in the strategy documents and the very real dangers faced by many workers go unchecked. Enforcement activity in Scotland is woefully inadequate although this should not be seen as a criticism of the organisation or individuals employed in HSE Field Operations or in Scottish local authorities.

3.2 In Scotland we feel that the current lack of resources is likely to have an adverse impact on prosecution levels with inspectors more likely to issue improvement notices for offences that might normally deserve more serious sanctions. In Scotland it is necessary for evidence to be corroborated in order for prosecutions to succeed and we feel that the most effective way to ensure this would be to have inspections in priority areas, known high risk workplaces or in cases involving frequent offenders carried out by two HSE or Local Authority Inspectors.

3.3 The issue of effective levels and use of resource extend beyond HSE and Local Authority personnel who enforce legislation. Increased enforcement activity will undoubtedly lead to a greater administration burden being placed on an already stretched HSE. Currently front line field inspectors spend increasing amounts of time carrying out administration functions and this is clearly a waste of specialised inspectors and consideration has to be given to providing adequate resources at all levels within enforcement agencies to allow inspectors to focus on inspection, accident investigation and preparation of cases.

3.4 While we would welcome more consistency in enforcement activity between HSE and Local Authorities the STUC are not of the view that a unitary enforcement body would provide better results. Any convergence of the two functions would be problematical and we feel that the HSE and Local Authorities can provide more efficient enforcement by closer working arrangements with each other and other Government departments including the DWP and DTI. This would ensure priority is given to keeping people in work and not having the increasing burden, through payment of incapacity and disability benefit, of supporting individuals unable to work.

3.5 The HSC/HSE should also consider the working arrangements with trade union health and safety representatives and how the provision of increased powers and protection to representatives could impact on the effectiveness of health and safety enforcement. The responsibility of health and safety enforcement is clearly the responsibility of the enforcement agencies although we would support the extension of the safety representatives regulations to include the right to issue provisional improvement notices. If these rights were to be extended there would be opportunities for earlier intervention in workplaces to reduce risks and prevent accidents by eliminating hazards at the source. This would not only produce tangible benefits in the workplace but also develop relationships between health and safety representatives and enforcement agencies.

4. *Other Issues*

4.1 We believe that the Health and Safety Executive is at risk of being perceived as business friendly and we feel that this undermines the tripartite health and safety structure that has contributed to improvements in our health and safety record over the last 30 years. The closer involvement of trade union health and safety representatives in workplace inspection and investigation, as required by law, and determined effort by the HSE and Local Authorities to raise their profile is vital if workers are to be encouraged to approach enforcement bodies and raise concerns in relation to their workplace. This should include instilling confidence in workers that enforcers will treat complaints genuinely and confidentially.

4.2 In common with the TUC we are of the view that HSE publications, while being of high quality are outwith the budgets of many trade union health and safety representatives and would especially echo their comments regarding the arrangements with Butterworth Tolley to publish priced documents on the web. We have had an occasion only recently when we were refused a complimentary copy on a resource produced for work placements specifically in Scotland, despite our standing as Scotland's Trade Union Centre on the basis we were not a learning establishment. We believe that the HSE should consider pricing and distribution when reviewing its communication strategy.

Scottish Trades Union Congress

13 February 2004

Memorandum submitted by the Royal College of Nursing

TERMS OF REFERENCE OF THE INQUIRY

The Committee will examine the work of the Health and Safety Commission and the Health and Safety Executive and the effectiveness of current arrangements to promote high standards of health and safety. In particular the Committee will focus on:

— The legislative framework

— Achieving outcomes

— Resources

1. INTRODUCTION

1.1 With a membership of over 360,000 registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets, the Royal College of Nursing (RCN) is the voice of nursing across the UK and the largest professional union of nursing staff in the world. RCN members work in a variety of hospital and community settings in the NHS and the independent sector, including the workplace. The RCN

promotes patient and nursing interests on a wide range of issues by working closely with the Government, the UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations.

1.2 Occupational health nurses are the largest single group of health professionals involved in delivering health services in the workplace, and as such have an important role to play in the management of workplace health and safety. Throughout the European Union there are 45,000 nurses working in the field of occupational health and in the UK alone the RCN has approximately 6,000 members who identify occupational health as an area of their work. In practice occupational health services are predominantly nurse led.

1.3 The RCN provides training and support for more than 1,500 health and safety representatives, and is committed to developing their role. We are currently running a campaign to recruit and train more.

2. The Legislative Framework

2.1 The Health and Safety Commission is comprised of nine members and a chair. Membership includes employer and employee representatives, local authority representatives and a number of public appointments. Employer representatives are nominated by the CBI, and employee representatives by the TUC. Under the current board arrangement the RCN has achieved representation only once, a situation which we feel is disproportionate to the level of nursing involvement in occupational health. This is particularly true given that the RCN is a predominantly female based trade union and that there is a need to ensure a gender balance on workplace safety issues.

2.2 Currently the Commission operates independently from Government and we would like to see this independence retained in order to maintain public confidence in the impartiality of HSC decisions. Furthermore, whilst we welcome the motivation behind introducing specific reporting systems such as CHAI, NPSA and the NHS Fraud Department, it is felt that in practice they are actually diluting best practice safety management. It is vital that the HSC retain control over these non-statutory agencies if it is to ensure its independence.

2.3 The RCN believes that the current composition of the Commission with 10 members should be maintained in order to ensure efficiency. However we suggest that a more innovative approach is adopted to identify the employer and employee representatives. For example, a representative from the Confederation of Small Business could replace one of the CBI places, and whilst we believe strongly that trade union representation is necessary, we feel that replacing a TUC place with a representative from a non-TUC affiliated trade union would allow much wider representation.

2.4 We would like to see an expert advisory group established, which would inform the work of the Commission but operate as a separate entity. Its membership would be comprised of representatives from the key disciplines involved in the delivery of health and safety strategies in the UK. The membership would each consult their respective representative bodies on the Commission's approach to health and safety policy. We would envisage the group operating on a similar basis to the Advisory Committee on Dangerous Pathogens. The RCN strongly believes an expert advisory group would allow a greater breadth of experience and expertise and create much stronger links between the HSC and those on the ground implementing health and safety policy.

2.5 The HSC and HSE are well respected in Europe and work well within the European framework. However, to date the HSC's work has focused primarily on the safety remit, and it would be beneficial to emphasise the health aspect in the future.

2.6 The HSC has been very successful in improving health and safety standards on the major issues, and there is a danger that if changed too much, or too often the progress made to date could be lost. However this is not to say that the HSC could not benefit from incremental improvements. Currently, membership of the Commission changes every two years, a timescale which we consider too short to ensure continuity. The RCN operates a system whereby elected representatives are chosen for two consecutive periods of four years and this is a model which we believe the Commission could benefit from adopting.

3. Achieving Outcomes

3.1 Despite the successes achieved by the HSC, improvements need to be made with small to medium enterprises (SMEs). Some of our members have noted that there is a lack of leadership on occupational health issues in GP surgeries, and any improvements which have been made can be attributed to the "Improving Working Lives" initiative rather than health and safety executive interventions. Therefore encouraging good practice in health and safety among SMEs should be a priority.

3.2 The targets outlined in "Revitalising Health and Safety" and "Securing Health Together" were important indicators in occupational health and safety. These targets have not been met in relation to funding, the level of skills available, or commitment to the health and safety agenda. The targets set were too crude to be of any real value and will most probably never be achieved. Effective intervention required to meet the targets will depend on the resources available and the access employers have to occupational health and safety expertise.

4. Balance Between Enforcement and Prevention in the HSE

4.1 In "A Strategy for Workplace Health and Safety in Great Britain to 2010 and Beyond" the HSC proposed separating the roles of enforcement and prevention. The principle behind this is to be welcomed as at present there is a reluctance among employers, particular SMEs to seek advice from the HSE as they fear enforcement measures will be imposed as a result. In England this is understood to be a problem, but in Scotland we understand there is anecdotal evidence showing that the same problem does not exist. The HSE should learn and build on the experiences of Scotland in this respect.

4.2 Whilst there is merit in separating the roles of enforcement and prevention we feel that the HSE internal auditing of enforcement targets should be replaced with the measurement of "compliance targets". Doing so would go some way to ease concerns about the implications of seeking advice on prevention and would secure more active participation of all stakeholders.

4.3 Although separating the HSE's functions is to be welcomed, it is important to recognise that the two roles must continue to be linked in order to ensure that the guidance is consistent and complied with. The RCN envisages enforcement and prevention being the responsibility of different departments, but remaining under the umbrella of the HSE. This would go some way to altering the perception that enforcement is the inevitable result of seeking advice. Furthermore, thought should be given as to how advice on prevention is made available. Information should be as accessible as possible, with a greater emphasis on internet based advice.

4.4 The HSE has made clear its intention to dispose of the role of Standing Committees such as the Occupational Health Advisory Committee and Health and Safety Advisory Committee as they are no longer considered useful. In the experience of the RCN the Committees have been an excellent source of specialist knowledge and advice to the HSE and there is no clear evidence of the need to discard them. Whilst we would wish to retain their function, we do recognise that the Committees have their shortcomings and accept that the way they work and select appointees could be modernised. The proposal to replace them with a number of short life working groups is equally concerning. Such an arrangement would cause confusion as they would be liable to a constantly changing remit and membership. There is also a concern that the groups would lack the transparency and accountability of the Standing Committees, thereby undermining confidence in occupational health and safety strategy as a whole. The RCN is opposed to dissembling the Standing Committees as we are unconvinced that the working groups are a viable alternative. Instead, we feel efforts should be concentrated on improving their effectiveness. However we do recognise the need for such short life groups in the appropriate circumstances, programme action groups being a good example.

5. Strategy Streamlining

5.1 Occupational health and safety strategy must be streamlined in order to ensure effective implementation. The HSE has revised its strategies twice since publication in 2000, and although the RCN accepts the need for modernisation we feel that this should not be at the expense of the trust invested in the HSE and HSC by the general public. The emphasis must now be on putting these strategies into practice, monitoring, managing and evaluating them.

5.2 Devolution has led to questions over the best method of implementing health and safety strategies consistently across England, Scotland, Wales and Northern Ireland. The majority of health and safety regulations originate in Europe. The RCN feels that because of the European dimension to health and safety policy, there is no need to devolve the legislative framework to the various UK institutions. However, having said this there is a role for devolution when it comes to delivering strategies at the local level. Devolving responsibility for delivery would enable services to respond to local needs more effectively. An example of successful devolution at the local level occurs in Scotland, where the HSE appears to be much more effective than its devolved counterparts in securing funding from the health budget.

6. Resources

6.1 There can be no doubt that at the present time, the HSE is both under-funded and under-resourced. Lack of funding is a perennial problem for health and safety and does need to be addressed. However in terms of implementing health and safety strategy, the lack of resources and manpower is a much more pressing concern. HSE inspections can occur as infrequently as once every five years due to lack of capacity. There is also an imbalance in the number of health specialists as opposed to safety specialists within HSE. The RCN would welcome a review of funding in order to establish what resources are required.

6.2 Health and safety representatives are integral to the implementation of health and safety policy in the workplace. The HSC and HSE must continue to provide the statutory framework to give safety representatives the rights to carry out their functions. Their role could be strengthened in the workplace and improved methods for communication and exchange of information would enhance their influence in the workplace.

6.3 The HSC has proposed a new focus on rehabilitation rather than prevention. Whilst the need for rehabilitation is recognised, the RCN feels that it would be more beneficial in the long term, to dedicate equivalent resources towards research into prevention. Not only would this assist the promotion of health, it would contribute to a reduction in the costs associated with rehabilitation.

7. Conclusions

- The independence of the HSC should be retained in order to maintain public confidence
- The organisational structure of the Health and Safety Commission should be maintained but the selection of employer and employee representatives should be altered
- An expert advisory group, separate to the HSC should be established
- The HSC has achieved success on the major issues, but it must now concentrate its efforts on SMEs
- Health targets have not been achieved. Future success will depend on the resources available and the level of access to expertise
- Although separating enforcement and advice in the HSE is to be welcomed the two functions should remain under the direction of the HSE
- The Standing Committees should not be discarded in favour of short life working groups
- Modernisation of occupational health and safety is necessary, but the trust and respect of the general public should not be squandered
- Delivery of health and safety strategies should be devolved to local level
- The HSE should be better funded and better resourced, and resources for prevention should be equal to those for rehabilitation
- The role of health and safety representatives could be strengthened and communication improved

Royal College of Nursing

13 February 2004

Supplementary memorandum submitted by the Royal College of Nursing

With a membership of over 360,000 registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets, the Royal College of Nursing (RCN) is the voice of nursing across the UK and the largest professional union of nursing staff in the world. RCN members work in a variety of hospital and community settings in the NHS and the independent sector. The RCN promotes patient and nursing interests on a wide range of issues by working closely with Government, the UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations.

As outlined in our initial submission to the Committee, we are broadly supportive of the work of the Health and Safety Executive and Health and Safety Commission and we acknowledge that progress has been made in certain areas. However we feel that particularly in the health sector there are improvements which could be made in the delivery of occupational health and safety policy.

1. Challenges Faced by the Health Sector

1.1 One of the greatest challenges facing the health sector is the fragmented structure of occupational health and safety services which has developed as a result of the modernisation agenda. Currently there is no clearly identified structure for health and safety either within the NHS or the independent sector. Modernisation has led to a multi-agency approach with numerous bodies, such as the National Patient Safety Agency and the Counter Fraud and Security Management Service being created with responsibility for particular aspects of health and safety. Additionally the recently re-constituted Health Services Advisory Committee has not been active for over a year. This has led to confusion about the role of the Health and Safety Executive, and uncertainty about which body has responsibility for which aspect of health and safety policy. This lack of coherence, and leadership and accountability to the public was compounded further by the disbandment of the Occupational Health Advisory Committee (OHAC). As yet OHAC has not been replaced and and it remains unclear who will carry out the advisory role in its absence and how the HSE plans to obtain expert skills and advice that it lacks "in house". It is fundamental that this lack of coherence is addressed with the Health and Safety Executive demonstrating a greater level of leadership and accountability. Although the Chief Executive of the NHS maintains that he is accountable overall for the standard of occupational health and safety in the NHS, there are now no supporting structures within the Department of Health to deliver new strategies as it is unclear how the Employer's Association within the NHS Confederation will function.

1.2 The multi-agency approach to health and safety has also in part been a result of the shortcomings of the HSE in its response to health and safety concerns. Primarily the HSE adopts a reactive, rather than proactive stance on many issues. For example the HSE issued guidance for employers on dealing with the problem of violence towards staff. Whilst this was welcomed, it was not followed up with any practical measures to tackle what was an increasing concern for staff. More recently, as the problem persisted this proved to be an inadequate approach and led to the creation of the Counter Fraud and Security Management Service. On the more contentious issue of low level electromagnetic radiation from mobile phone masts, little action has been taken despite the potential health risk. which exists. A more proactive approach from the HSE would allow many health and safety issues to be dealt with more effectively before they become critical.

1.3 The multi-agency approach to health and safety has also led to an increase in the number of audits that are carried out by each individual body. Whilst the process of auditing is generally regarded as a beneficial one, staff are finding they are becoming more frequently tied up with the process of auditing thereby accentuating the problem of staff shortages. A more structured, coherent auditing system would go some way to help ease the pressure on staff.

1.4 Resourcing problems remain a concern for the health sector. In terms of training, the lack of involvement in preparing people in health and safety for work by schools, of academic and vocational institutions is a problem which needs to be addressed. It is essential that workers in all employment sectors receive training before they enter the workplace. Including a health and safety element on all healthcare courses should be a priority.

1.5 Research is a vital resource in tackling health and safety problems. Although the HSE has commissioned some high quality research in the past it rarely gets translated into practice guidance. If health and safety policy is to move forward it is essential that research is made more accessible and where appropriate, translated into practice. Furthermore, the majority of research into occupational health and safety is primarily scientifically based with little emphasis on day to day issues. As a result the research tends to be overly technical and has limited relevance for those implementing health and safety policy in the workplace. Finally we would like to see the publication of a coherent national occupational health and safety research strategy as happens in other countries such as the USA and many of our European Union partner countries.

2. How are These Challenges Being Addressed?

2.1 The reality is that the challenges facing the health sector are not being adequately addressed. There is a lack of action by the HSE on health issues that are perceived as being too difficult to tackle. In contrast safety issues are considered to be more straightforward and are often focused on at the expense of health related issues. Stress has long been identified as a major cause of ill health at work, yet the HSE has been slow to respond to the problem. Research was carried out on the management of stress in the healthcare sector, with the intention of compiling guidance for employers. This was an excellent piece of research which has not been made accessible to managers in the sector. Instead the HSE has become sidetracked by the arguments of employers who are questioning the existence of workplace stress related ill health. Similarly, smoking does not appear to be a priority for action by the HSE, whereas other EU countries have taken the passive smoking risk to workers very seriously eg Ireland.

2.2 It should be stressed that there have been examples of good practice which the RCN has wholeheartedly supported. The action taken to develop a website on latex and the proposed website on prevention of needlestick injuries are both examples of good practice. However the reality is that such action is invariably too little, too late. Studies by the National Audit Office on health and safety in the workplace in 1996 and 2003 have shown the same recurring issues. Problems such as stress, needlestick injuries and musculo-skeletal disorders persist because they are not being dealt with quickly or effectively enough. In some instances trade unions have led the way on health issues, developing their own guidance which has preceded official guidance. For example the RCN's guidance on manual handling of patients and latex allergy preceded the HSC's guidance by many years.(examples?). This situation is unacceptable and action must be taken to ensure the HSE is leading the pressure for change.

3. Provision of Occupational Health Services Outside the Health Sector

3.1 The lack of skilled staff and resources is a major obstacle to the provision of occupational health services and will prevent the HSC from achieving its strategy targets for occupational health. At the moment employers outside the health sector have difficulties accessing occupational health services because of a shortage of skilled and qualified staff unavailable to provide the necessary support. The HSE will not achieve its objective of a national health and safety strategy if it does not take action to increase access to appropriately qualified specialists. Added to this is the more general shortage of nursing staff which further accentuates the problem. Many nurses are leaving the UK to work abroad or are reaching retirement age, meaning that there is a general shortage of staff across all disciplines. If the situation is to change the reasons behind this general shortage, such as increasing the funding available for nurses to undertake specialist occupational health educationimplementing more flexible working practices, must be addressed. In addition

the HSE must provide encouragement to the employer by as well as allocating more resources to alleviate the skills shortage and enhance competence for those specialists already in employment. This issue is fundamental to improving both the quality and quantity of occupational health support. A good example of the impact of specialist staffing and skill shortages on policy implementation is the Government plan to enable occupational health staff to issue sickness certificates, which is currently being piloted. With fewer than 3% of the working population with access to an occupational health service, it is difficult to see how this policy will have much impact on either reducing general practitioner workload or improving occupational rehabilitation practice, yet these are the primary aims of the policy.

Royal College of Nursing

28 April 2004

Memorandum submitted by the Royal Society for the Prevention of Accidents

BACKGROUND

1. The attached paper sets out a draft submission from RoSPA to the forthcoming inquiry by the House of Commons Work and Pensions Committee (see Annexe one) into the work of the Health and Safety Commission (HSC) and Health and Safety Executive (HSE) and "... the effectiveness of current arrangements to promote high standards of health and safety".

2. RoSPA understands that issues which are expected to be included in the Committee's inquiry are:

— The legislative framework: to what extent has the Health and Safety at Work Act 1974 and subsequent legislation at national and European levels been successful in improving standards of health and safety?

— Achieving outcomes: is Britain on course to meet the targets set out in the Revitalising Health and Safety Strategy? Does the HSE get the balance right between prevention and enforcement? Is it sufficiently proactive to address developing hazards at work such as stress and passive smoking? Are penalties for health and safety offences set at an appropriate level? To what extent is health and safety legislation properly understood? Does more need to be done to encourage good practice? Is there sufficient emphasis on "health" in health and safety?

— Resources: is the HSE sufficiently well-resourced to meet its objectives? To what extent is there good coordination between HSE and those other parts of central and local government with a role to play in promoting health and safety?

3. It is understood that the W&P Committee expects the inquiry particularly to focus on how well the HSE achieves the right balance between prevention and enforcement and whether it is adequately resourced for the task, in respect of both existing hazards and the anticipated hazards of the future.

4. The Committee hopes to hold oral evidence sessions in the spring and welcomes written submissions in accordance with its guidelines by 13 February 2004.

5. The draft builds on RoSPA's previous submissions to the HSC on their "Revitalising Health and Safety" (RHS) programme, "Securing Health Together" (SH2) and, latterly the HSC's consultation on their strategy up to 2010 and beyond.

EXECUTIVE SUMMARY

RoSPA welcomes the decision by the House of Commons Work and Pensions Committee to undertake an inquiry into the work of the Health and Safety Commission (HSC) and Executive (HSE). This submission builds on RoSPA's input to the HSC's recent consultation on their future strategy up to 2010 and beyond. Although, overall, Britain has a good occupational safety (but not occupational health) record, there is still an unacceptable gulf in levels of health and safety (H&S) performance between larger, higher performing organisations and many small and medium sized enterprises (SMEs). In RoSPA's view the Committee should enquire into progress towards and problems encountered in meeting the 10 key themes and 44 Action Points in "Revitalising Health and Safety". Government must give a lead by supporting the role of the HSC/E as a "development agency" for the whole H&S "system", providing adequate resources and leading by its own example as an employer committed to high H&S standards. The HSC/E's wish to work in closer partnership with other players in the "system" is welcome but a consultative mapping exercise is urgently needed to secure consensus about the "system", to provide a basis for "partnership agreements" and to help enlarge the composition of the Commission, for example by creating a new advisory group on corporate H&S management issues. Working with others in the "system" however should not be viewed as a deregulatory agenda and will only be successful with the provision of additional resources. HSC/E needs an additional £35 million per annum but this increase needs to be seen as "spending to save". The new HSC/E "vision" has been too heavily influenced by negative media caricatures of H&S requirements and needs to be refocused onto empowering duty holders to manage H&S risks effectively through having access to

professional advice and training. (This needs to be integrated with business advice to SMEs and made part of the agenda of Learning and Skills Councils, Business links, Investors in People etc). HSC/E has a major role to play in providing intellectual leadership in the H&S "system", in co-ordinating research and in leading safety and risk education. It must avoid retreating from its current approach to regulation based on goal setting law, proportionality of control and good guidance. It must champion new themes across Government including "learning from accidents and incidents" and "safe design". It must also seek to influence H&S globally. A number of innovations are needed in enforcement, including: "putting higher performers" "on trust" to manage without HSE intervention; providing technical mediation on ALARP decisions; enforcing management systems, advice and competence requirements; requiring employers to investigate accidents and incidents properly; and introducing new arrangements for remedial sentencing with professionals from outside HSE appointed by the court to supervise and report on compliance. The rehabilitation agenda is important but must not detract from the primacy of prevention. Notwithstanding the need for HSC/E and others to focus on chronic health issues such as stress and musculo-skeletal disorders, there is still a need to address acute safety issues, particularly occupational road risk (twice as many people killed here at work as in all notifiable accidents) and to continue to address the protection of the public from work related risks. "Upstream" H&S targets (training, auditing etc) need to be set as well as "outcome" targets (reducing injuries and days lost). There needs to be a co-ordinated National Health and Safety Services Strategy and much more emphasis on the need for effective workforce involvement. A strong development programme is required for all HSE staff and new promotional fora are needed in Wales, in Scotland and the English Regions to bring together a range of bodies at local level to help to promote H&S.

Introduction

1. RoSPA strongly welcomes the decision by the House of Commons Work and Pensions Committee to conduct an inquiry into the work of the Health and Safety Commission (HSC) and the Health and Safety Executive (HSE). The inquiry is timely, coming as it does as the Commission and the Government are about to publish their plans for future strategy for health and safety at work up to 2010 and beyond.

General

2. Britain has a good occupational safety record but there is clearly scope for reducing casualties, particularly those occurring in work related road accidents. Its occupational health performance however is weak and, despite considerable progress in dealing with gross health damage associated with exposure to traditional physical, chemical and biological agents at work, much remains to be done. At present:

- around 250 workers and up to 100 members of the public are killed by work activities;
- 27,000 workers in the UK sustain a major injury (eg injuries hospitalising someone for more than 24 hours);
- 130,000 suffer injuries keeping them off work for more than three days (these are reported accidents—studies show that reporting levels can be as low as a third, so the real toll is likely to be much higher);
- 2.3 million suffer from illnesses caused by or made worse by work.

3. Britain has yet to develop an effective strategy for tackling major causes of work related sickness absence including, musculo-skeletal disorders and work related stress and much remains to be done to ensure that workers who whose health currently prevents them from working are helped to return to and remain in work. Accidents and ill health caused or made worse through work represent a massive toll of largely unrecognised suffering which blights the lives of victims and families. They also impose a massive burden on the economy. There is still an unacceptable gulf between the levels of health and safety performance achieved by higher performing organisations and those commonly found in many small and medium size enterprises which lack either the motivation, the expertise or the resources (or all three) to manage health and safety systematically. If standards achieved by the "higher performers" were achieved across the board, work related casualties and days lost in Britain could be cut by more than half. Action to manage work related risks and to adapt work to people's health needs is essential to Britain's future. Better health and safety at work performance can not only deliver a better environment for people at work; it can also deliver massive savings as well as numerous incidental benefits which can help promote efficiency, effectiveness and productivity. From this point of view the Government must support the HSC/E by providing further resources to enable them to lead and energise the whole "health and safety system". Also, ministers and Departments in particular must provide a lead by proclaiming the social and business case for high standards of health and safety at work, building health and safety into all appropriate policies and demanding that the Government, as an employer, exemplifies this approach in the way safety and health are managed in the Government service and the public sector generally.

The HSC/E Strategy to 2010 and Beyond

4. RoSPA firmly welcomed the HSC's decision to consult on their future strategy in the recent consultation document "A Strategy for Workplace Health and Safety in Great Britain to 2010 and beyond". This has been discussed by RoSPA's National Occupational Safety and Health Committee (NOSHC) and, in many respects, echoes RoSPA's own vision for the future of health and safety (H&S) at work (see annexe one). RoSPA believes that HSC/E need to be helped to build on their considerable strengths so that they can continue to move forward in a changing and challenging world.

5. While RoSPA appreciates that HSC have sought to focus on broad themes in developing their strategy, it has been concerned that they have not attempted any kind of evaluation of successes and failures in carrying through the 10 key themes and 44 Action Points that were contained in RHS launched by the Deputy Prime Minister in June 2000. Some form of assessment by the Commission and the HSE of what has gone well and what has proved more difficult would certainly have helped to put many of the ideas in their recent consultation document into perspective for potential respondents. RoSPA hopes that, as part of their inquiry, the Committee will review progress achieved by HSC/E in pursuing key themes and initiatives within RHS and the associated strategy for health, "Securing Health Together" (SH2). Many of these will of course carry over into the new strategy and thus it behoves HSC/E in their evidence to report to the Committee on what has been achieved as well as on continuing challenges.

Developing the "Health and Safety System"

6. What RoSPA welcomes particularly are signs that HSC/E has begun to develop a much broader vision of its role as a regulator in contemporary Society, not just addressing "changing world of work" issues (the shift from manufacturing to services, contracting, stress etc.) but thinking much more creatively about what needs to be done to make high standards of health and safety at work a reality for every worker and in every workplace. What is particularly welcome is HSC/E's apparent enthusiasm to exercise a broader leadership, facilitative and development role in the UK "health and safety "system"; something which RoSPA been arguing for for some time. The whole idea of the "health and safety system" however needs thinking through in much more depth and with more rigour. Indeed, RoSPA believes that much more time is needed to engage more people and key organisations in radical thinking here, revisiting all the processes through which people at work are actually protected from harm (ie not just by periodic inspection but as a result of all the internal and external factors which together promote and support effective health and safety management and culture). Without this work RoSPA believes there is a danger that the term, "health and safety system" will become used superficially, without HSE and other key players developing a sufficiently broad and rich understanding of the system's complex anatomy and their place within it. In RoSPA's view it is particularly important that HSE abandons its previous view that, as the "prime mover", it somehow sat naturally at the centre of the "system". The "world of work" must be seen as centre of the "system" in which there are many other bodies and forces which determine if and how risks at the workface are managed. (In this sense HSE is a planet rather than a star but, of course, it has a major gravitational effect!)

Consultative Mapping Exercise

7. The list of "system" players in the consultation document on HSC's future strategy was quite restricted and needs expansion and major development to explain the roles, contributions and interactions of the wide range of institutions and bodies involved. For example, the whole health and safety "supply side" (including training, consultancy, provision of personal protective equipment etc) was not mentioned at all, although clearly it plays a vital role. RoSPA has suggested that HSC/E should undertake a major mapping exercise in consultation with key players (including key non H&S bodies) to get their views about where they think they fit into this wider and more complex picture. (A priority area for 'system' mapping is the H&S training sector.) There is a need particularly to mobilise key promoters such as: the insurers (who need to be encouraged to address insureds' H&S management standards, rather than just their claims history); consulting accountants (who can promote H&S as part of the Corporate Social Responsibility agenda); the banks (who potentially can influence H&S plans as part of business plans in SMEs); and the Government's business support infrastructure (where there are many advisers who need help to understand the "business case" for good H&S performance). Beyond these there are many other important players such as the key professional bodies as well as the very many separate trade associations, professional bodies, trades unions and local health and safety groups. HSC/E need to see their role as helping all these players to work together more effectively and in partnership. This will not happen however unless they are able and willing to share in a wider vision of where their contributions fit with those of others, hence the need for a consultative mapping exercise. This needs to both national as well as sectoral in scope.

Policy Governance and Development

8. Recognising the complexity of the "system" also means that the HSC's composition (if not its constitution—including its advisory committees) needs to be opened up to reflect the diversity of "key players". RoSPA questions whether an essentially bipartite (employer/employee) Commission as a present can still be justified. HSC also needs to establish more specialist advisory groups to give it access to expertise

outside HSE as it has done by establishing Programme Action Groups as part of SH2. In RoSPA's view there is a particular need for a strategic group on corporate health and safety management issues to advise among other things on indicative standards of compliance with the "arrangements" duty in the Management of Health and Safety at Work Regulations (MHSWR). There is also a need to develop a broadly based, standing advisory group to help stimulate much more innovative approaches to workforce involvement.

Vision and Values

9. While the suggested HSC "vision", "To secure recognition of health and safety as a cornerstone of a civilised society." is a worthy sentiment, it could be said that it lacks focus and does not address the main issue. In RoSPA's view the Commission have been unduly influenced by negative caricatures in parts of the media and elsewhere which depict health and safety as the province of risk averse zealots whose advice is invariably grossly disproportionate to real safety and health needs. This is not a new problem and merely underlines the need for continuing education to explain the case for adopting a balanced approach to managing safety and health risks. In this context the main problem to be confronted is not the relatively small number of "don't know, don't care" employers (nor indeed the even smaller number of "do know, don't care" employers). (They must be dealt with through effective enforcement.) The greatest problem is how to assist the much greater number of "do care, don't knows"; those who accept that workers and the public should be protected but who are unsure of either their problems or how to go about managing them. In RoSPA's view the overriding "vision" needs to be one not so much of securing commitment in principle to H&S as a "civilised value" as one of instilling expertise; or alternatively not so much enhancing motivation as delivering empowerment which can turn general commitments into practical action. In this respect the Commission's commitment in the "strategy" to making competent health and safety services and advice available to every workplace is much nearer the mark.

Intellectual Leadership

10. Above all HSC/E's role in developing the wider "system" has to be one of providing strong "intellectual leadership". For example, over the last two decades HSE has played a key role in establishing a risk/evidence based approach to health and safety which it has been able to champion with others right across Government. This now needs to be developed further and made much more accessible to everyone. Indeed, in RoSPA's view, the suggestion in the document that HSE should now move back to a prescriptive approach—for example, because ALARP ("as low as is reasonably practicable") is not for small firms—may seem superficially attractive but it masks the danger of an even greater proliferation of quasi-prescription. This in turn risks eroding the underlying philosophy of regulation based on goal setting, proportionality and good guidance and give rise to inappropriate applications of control further reinforcing negative stereotypes of H&S.

11. A risk-based approach however will only ever succeed if there is a strong focus on ensuring safety and risk literacy at all levels in society. HSE have a massively important role to play (with others) in ensuring, for example, that safety and risk concepts are effectively embedded in the National Curriculum and in further, higher, professional and business education. Indeed, in RoSPA's view, HSE's role in enhancing standards of "safety and risk literacy, particularly among opinion formers and shakers" is the key to tackling the reputational threats referred to in the HSC's consultation document that arise from misrepresentation of H&S objectives in contemporary Society. (Media correspondents and MPs should be seen as two clear target groups in this respect.) HSE need to move on from "risk assessment" to create a new strategic focus on further cross cutting themes such as "safe design" and on "learning from prevention failure" (promoting effective approaches to H&S investigations)—powerful themes on which they can take a clear lead right across Government and business.

Research

12. Similarly HSE have a key role to play in strengthening an evidence based approach to policy making, although of course it is vital that this is tempered by the precautionary principle in which the benefit of any scientific doubt always goes to those exposed to risk. The HSE's research agenda needs to be far more strategic, looking not just at their own research needs but encouraging co-operation between key players.

HSC/E as a "Development Agency"

13. As RoSPA has stressed repeatedly, HSC/E needs to see their role as not just a regulator/enforcer and provider of information and guidance but the "development agency" for the whole "system". HSC/E's "mission" therefore should be to ensure that there are effective risk management systems and culture in all work organisations and that all parts of the "system" work effectively together to deliver this. HSC/E's challenge therefore is not just how best to mobilise its own resources but how to mobilise all the health and safety resources of UK PLC taken as a whole. (For example, there are now many more health and safety professionals outside the HSE than within it and they need to be drawn into closer partnership with HSC/E as the lead H&S agency.)

14. While HSC/E are right to focus on what it is they can do well within the "system" and to look to how to enhance the contribution of other players, it is very important that this is not approached as a deregulatory agenda in which HSE reduces its input in the hope that resulting gaps will be covered by others. It will only be successful if it is backed by more Government resources not less (see below).

15. One mechanism which could go a long way to promoting this kind of closer involvement would be the establishment of medium term (say three year) formal "Partnership Agreements" between key players and HSC/E in which each agreed what they were going to "bring to the party" in pursuit of shared priorities and objectives and with a commitment to review progress periodically and feed back lessons learned. RoSPA agrees that HSC/E, for example, should not necessarily be the source of all guidance. Indeed as far back as 1972 the Robens report envisaged much authoritative H&S guidance being produced on the basis of consultation by bodies outside HSC/E but with clear recognition and signposting by the regulator as to its status.

International Development

16. HSC/E also need to look beyond the UK to see how they can play a much more powerful role in embedding health and safety management in Britain's international development effort. Gaining recognition of health and safety as a "cornerstone of a civilised Society" has arguably very much greater relevance in developing countries, particularly since at a global level more people die annually from work related accidents and diseases than are killed in wars! HSE should be asked to take a lead, for example, to ensure that health and safety risk management is a prominent feature of all UK sponsored overseas development projects. Indeed, developing an approach to health and safety "...which leads the world." (HSC/E's vision) has two inter-related meanings here!

Enforcement

17. While partnership and co-operation are fundamentally important in securing more effective promotion of H&S it would be a mistake if this led poor performers to believe that HSC/E had "gone soft" on enforcement. HSE and the Government need to signal their determination to bear down even harder on blatant and serious non-compliance—with a new offence of corporate killing, tougher and more demanding use of enforcement procedures and more effective penalties, including compulsory retraining and remedial programmes.

18. RoSPA is planning to feed in views as part of the current review of the HSE's "Enforcement Policy Statement". Enforcement plays a vital role in the H&S "system", indicating Government's (and ultimately Parliament's) determination that employers should meet their obligations to comply with legal requirements and deliver effective protection of people at work and others from work related harms. The quality of enforcement however is as (if not more) important than the quantity of action taken and the overall direction of enforcement action needs to support and inform the direction of UK H&S strategy taken as whole. The principles under-pinning HSE's approach to enforcement (proportionality, targeting, consistency, transparency and accountability) are essentially sound but their application needs to be revisited. On the application of "reasonably practicable" standards, for example, HSE need to avoid giving the impression that that standards set out in guidance have mandatory status. Where there are differences of view, instead of an HSE inspector issuing a notice and leaving it open for the duty holder to appeal, there should be agreed procedures for independent technical mediation.

19. HSE and Local Authorities (LAs) need to target their scarce enforcement resources so that they address really serious issues, focusing on employers whose performance is poorest. To free up more resources to this end, RoSPA would favour a system whereby acknowledged "higher performers" could be put on trust to manage their health and safety risks without HSE or LA intervention—unless there was an accident, health damage or a serious complaint and provided that the organisation made use of independent, professional external audit. Such an approach however would need very careful piloting to ensure that effective safeguards were built in, including, for example, consulting workforce representatives before putting such arrangements in place. The Society plans to encourage wider debate among stakeholders around this idea. It believes that many "higher performers" would be keen to earn (and preserve) the enhanced reputation that such "on trust" status would imply.

20. While the priority topics set out in "Revitalising Health and Safety .." are clearly important, targeting of HSE enforcement effort within any organisation needs to be prioritised in the light of the risk profile of the organisation in question. Also more proactive inspection effort needs to be directed towards assessing employers' approaches to managing work related road risk (see below). Very importantly, HSE need to prioritise their enforcement effort towards the rectification of underlying health and safety management weaknesses such as the absence of professional advice, absence of appropriate management and skills H&S training, absence of risk assessment, absence of active and reactive monitoring, absence of consultation and performance review etc. To help tackle alleged inconsistencies in enforcement RoSPA would favour the idea of employers' associations providing secure web-based facilities for their members (accessible also to HSE) to flag up issues, spot problems and help facilitate the rectification of any alleged problems in enforcement performance before these can become a wider issue of concern in the sector concerned. Transparency in the

use of enforcement powers is also vital if duty holders and other key stakeholders are to have confidence in the overall enforcement regime. Some typical (but anonymised) case studies of reasoning underpinning enforcement decisions which were easily accessible via the HSE website or sector sites could do much to help in this area. To improve accountability HSE should be prepared to put their internal ratings (for the purposes of prioritising proactive enforcement) of organisations in the public domain. HSE inspectors must also ensure that they meet with workforce representatives during their visits to premises and explain to them the approach they are taking.

21. There is clearly much public pressure for HSE to investigate more accidents, incidents and cases of work-related health damage. However desirable an increase in such investigation might appear to be, if they were to move too far in this direction at the expense of proactive inspection and the provision of information and advice, H&S standards might actually fall. It is vital that HSE are far more insistent that employers, as the primary duty holders, carry out adequate and suitable investigations. Except in circumstances where it is clearly merited, HSE should not move to investigate themselves but call for a copy of the employer's investigation report within a specified timescale. HSE must also make it clear (a) that they cannot prosecute for every infraction and (b) that they will explain their reasons for bringing prosecutions some cases rather than others. Also HSE should not seek to secure the prosecution of an individual where it cannot secure the conviction of the organisation for which they work but where the faults of an organisation are the responsibility of controlling individuals, they too should be prosecuted.

22. On this latter point, RoSPA has made radical proposals for remedial sentencing (as developed, for example, to deal with other areas such as motoring offences and youth offending) to bring the expertise of health and safety professionals outside HSE into play to act as supervisors appointed by the courts to help promote and sustain improvement among failing employers. This approach could be used to require persistently non-compliant employers to undergo training and to implement improvement programmes or face having to pay large suspended fines. Developed in the right way it could bring another important layer of professional health and safety expertise into the enforcement process.

23. It is important that a digest of views received as part of the review and HSC/E's response are put in the public domain before any decisions are made about amending the statement.

Linking Compensation, Prevention and Rehabilitation

24. The Government and the HSC/E have quite correctly identified the need for a better system of compensation for workplace injury which also incentivises and supports prevention and helps rebuild damaged lives. Whether or not the recent and continuing work of Department of Work and Pensions will secure the more effective engagement of the ELCI (Employers Liability Compulsory Insurance) sector remains to be seen, although the insurance industry has already taken a number of interesting steps to link ELCI premia to H&S management performance. The rehabilitation (or person/work optimisation) agenda is clearly vitally important for both individuals, the future labour market and public expenditure but it is also important to ensure that ministerial pre-occupations with getting more of the long term sick off benefits and into work do not lead to any diversion of HSC/E from their prime focus which must always be prevention.

Meeting the Needs of SMEs

25. One area however where better "joined up government" is clearly vital is in creating a co-ordinated system which integrates health and safety development in small and medium size enterprises (SMEs) into existing frameworks for delivering business development advice and training to small firms. H&S still needs to be much more effectively embedded in the work of the Learning and Skills Councils, the Small Business Service and schemes like Investors in People etc., so that all these bodies and schemes are capable of playing a much stronger part in delivering health and safety services, including health and safety training and are capable of addressing health needs at work. There are many training advisers, for example, who visit workplaces and they need help to enable them to engage employers in discussion on the latter's H&S training needs, particularly H&S training for managers and supervisors and specific H&S skills training.

Paying for HSC/E

26. While RoSPA supports HSC/E's intention to focus in their long-term strategy on the provision of an advice and information, it also believes that there is an urgent need to increase resources to enable HSE inspectors to carry out their key function of enforcing the law. It would be wrong, in RoSPA's view, to see the new emphasis on "services" as an alternative to driving improvements by regulation and enforcement where necessary. HSE needs to work in partnership with other players in the "system" but it also needs additional resources to enable it to carry out its basic functions and develop closer links with other "system players".

27. Spending on HSC/E needs to be viewed as "spending to save". Just as DWP and other Ministers have urged employers to invest in H&S in order to reduce the costs and accidents and ill health, so the Treasury needs to be urged to examine the "business case" for expanding investment in HSC/E.

28. The £260 million allocated to HSE in 2003 amounted to less than 20p per week to protect each of the UK's 27 million workers, while the budget allocation for the next three years equates to a 10% reduction in real terms (HSE's gross budget remains static to 2005–06). Prospect, the trades union which represents inspectors in HSE, estimates that the minimum necessary to put HSC/E back on track would amount to £35 million extra each year. This is a small sum compared with the cost to the Nation of H&S prevention failure. [For example, some £2 billion a year is paid out in compensation and industrial injuries benefit alone]. Holding HSC/E's budget static represents a real terms cut of over 10%. HSE has instigated a range of cost-cutting measures across departments resulting in cut backs on staff with a freeze on recruitment and cutting of posts or jobs remaining unfilled. RoSPA has been told that Field Operations Division (FOD), which is to lose 50 of its 590 front line inspectors, is reducing the number of investigations and inspections carried out by the division by 10,000 per year.

29. HSC/E and the Treasury need to be urged to consult H&S system stakeholders on macro economic "spend to save" projections, comparing additional HSC/E inputs with the savings that might be achieved as a result of meeting agreed targets.

Allocating Resources

30. Even if they were to receive a substantial increase in funding, HSC/E would still face dilemmas when deciding the best allocation of resources between, for example, proactive inspection versus responding to incidents or programmes to address high prevalence, chronic problems such as stress and musculo-skeletal disorders on one hand as opposed to more acute problems such as asbestos linked disease, cancer, and occupational asthma on the other. While widespread chronic problems such as MSDs are clearly important (particularly from the point of view of protecting workers' quality of life and reducing working days lost), this has to be balanced with the need to place adequate emphasis on tackling safety and health problems with potentially fatal and serious outcomes, particularly where risks are high and interventions stand a good chance of securing a significant casualty reduction. In this context it is vital that work related road safety (WRRS) must be made a clear priority in the new programme. Not only are more workers killed and injured when on the road while at work than in all other RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences) events put together, but there is major scope for enhancing prevention and reducing costs to employers and economy as a whole. (Injury in work related road accidents is a major cause of lost work time.) Also, WRRS is very much a "changing world of work" issue, associated as it is with increasing workforce mobility, stress and even with higher rates of low back pain. RoSPA has developed a detailed brief setting out 18 robust arguments in support of making WRRS a priority in the HSC/E's programme to 2010 and beyond (see annexe three).

Maintaining a Balance Between H&S

31. RoSPA agrees a major emphasis on health in future HSC/E strategy is absolutely vital. More than twice as many people suffer ill health as a result of their work as are injured in accidents. Health is still the "poor cousin" in the H&S relationship but this will not be overcome by establishing "OH" (Occupational Health) as something separate from "H&S" and indeed there are signs that internally at the level of policy HSE may be attempting to close the artificial rift between these two stereotypical domains.

32. At the same time it is also vital that the "safety baby" must not be thrown out with the "Revitalising" bath water. In RoSPA's view, it is a mistake to think that safety problems at work have been solved. Similarly it is naive to think that health problems are complex and that accidents are simple. Indeed, as anyone who has investigated an accident in any depth will know, the aetiology of safety failure is in many ways as complex and as intellectually challenging as the aetiology of work related disease.

33. RoSPA also believes that there is still much scope for enhancing prevention of fatal and serious injuries to members of the public from work activity and thus any wholesale abandonment of enforcement of Section 3 of the HSW Act (as hinted at by HSC/E on a number of occasions) would, in RoSPA's view, be a major strategic error.

Targets and Performance

34. RoSPA agrees strongly with the idea that H&S must be presented as a business performance issue and not just a matter of minimal regulatory compliance. It believes that HSC/E need to continue to maintain a focus on health and safety as a top-level, strategic, board focused issue with challenging targets set at every level to help secure progressive reduction in work related injury and health damage from all causes, (including from work related road accidents). At the same time the wider strategy must have "upstream" targets as well as "downstream" or "outcome" targets such as reductions in accidents and days lost etc. One such target the might be to ensure that all managers in UK PLC must have had some health and safety training by 2010.

35. For the majority of businesses in the UK however, "outcome" targets have little statistical significance and thus greater emphasis needs to be given to setting targets such as revision of risk assessments, improvements in risk control measures, improvements in training, consultation, monitoring and so on. RoSPA would like to see every business being challenged by HSC/E to have an appropriate H&S action plan and targets (covering inputs, outputs and outcomes).

36. The engagement of key intermediaries is also vital here, for example, working with the major consulting accountants to link health and safety in much more effectively with the burgeoning Corporate Social Responsibility movement. But in turn this means developing much better advice about what is meant by health and safety performance in different contexts. The wider vision needs to be one of every business having an effective health and safety management system in place, led by senior and line managers, supported by safety representatives and health and safety professionals and reporting on targets and performance to its stakeholders. In the context of its work on DASH ("Director Action on Safety and Health"), RoSPA has welcomed HSC's guidance on the H&S responsibilities of directors and also work to develop a Corporate H&S Performance Index.

Working with the "Higher Performers"

37. Besides exploring the idea of putting the "higher performers" on trust, HSC needs to continue to think about how to utilise the commitment and momentum of such organisations in both private, voluntary and public sectors, encouraging them to seek recognition of their performance, for example through external auditing (in RoSPA's view, every major employer should be challenged to adopt effective, independent audit) and awards and pressing them to demand high health and safety standards of their business partners (such as contractors and suppliers). They should also be encouraged to share their H&S training resources, for example, with their immediate neighbours and sector peers. They should also be encouraged to put summary reports on their policies targets, performance and plans on their websites. RoSPA has developed a web-portal, "GoPOP" ("Going Public On Performance") to give quick access to such data. It is hoped to extend this to employers in the public sector.

Government as Leader and Exemplar

38. On the other hand, HSC/E cannot promote health and safety as a top-level issue within business unless it is similarly a top-level issue within Government, with clear leadership of all prevention issues (not just related to work) by a Cabinet level Minister. Government too needs to be seen to be acting as an exemplary employer committed to health and safety "best practices", promoting high standards via procurement, building health and safety requirements into all its policies and plans and abandoning crown and parliamentary immunity. (RoSPA would suggest that the Cabinet Office urges all Government employers and agencies to test their level of health and safety management achievement by using appropriate, independent auditing tools and entering H&S award schemes.)

Access to Services

39. RoSPA strongly welcomes the HSC/E's statement that it wants "to see the development of occupational H&S advice and support outside HSE with national coverage that is active in preventing ill health, promoting rehabilitation and getting people back to work more quickly". In its submission in the consultation phase of RHS RoSPA made suggestions for a co-ordinated National Health and Safety Services Strategy. This needs a number of elements. Firstly, stronger guidance on (and, where necessary, enforcement of) the requirements in the MHSWR on "Arrangements. . .", "Competent persons" and "Training"; secondly, registration of competent H&S service providers; thirdly, codes of conduct on the delivery of services; fourthly, integration of such services into the UK's business support infrastructure; and fifthly, close liaison with and promotion of such services by HSE and other key players. The approach must also be comprehensive with no artificial separation between H&S and OH. HSE must also have a lead role in reviewing and developing the strategy. There must be a strong emphasis throughout on making organisations as self sufficient as possible in basic H&S skills and on finding cost effective solutions to securing first line advice such as membership of local H&S groups. Where accidents and ill-health have occurred because employers have failed to make use of appropriate expertise or have not invested in H&S training, HSE need to use their notice powers if necessary to get employers to address these underlying issues. Indeed it could be argued that HSE should stop providing extensive guidance and support to employers who have failed to engage or employ appropriate professional health and safety. Similarly they should stop issuing enforcement notices which only address immediate risk issues when it is clear that relevant failures in control are only symptomatic of deeper systemic weaknesses in H&S management and the real need is to issue notices which require employers concerned to engage professional advice.

Mobilising Workforce Commitment and Expertise

40. RoSPA believes that, in addition to securing strong management commitment to H&S throughout all organisations, it is absolutely vital that HSE recognises the importance of employers mobilising workforce involvement and tapping workers' expertise. This is a vital ingredient in any corporate strategy designed to raise and sustain standards of health and safety at work. Safety representatives in particular play a vital role in representing workers' concerns, bringing workers' understandings and insights into analysis and decision-making and communicating H&S messages within their organisations. RoSPA would wish to see changes to the various regulations on safety representatives and safety committees to make them more effective and relevant to the present day. These would include ensuring that safety representatives were able to support workers in smaller or dispersed workplaces as well as, for example, employees of contractors. The regulations should be amended to create a common regime on consultation and involvement across all kinds of employment with a clearer requirement for employers to seek, consider and respond to safety representatives' views and to involve them in decision making and in investigations and to ensure that they are able to get the training and support which they feel they need to carry out their role. RoSPA would wish to see more encouragement given by HSC/E to employers to use safety representatives as a positive force in improving the safety culture within workplaces, for example in areas such as induction training, inspections, behavioural safety programmes, H&S management systems auditing etc. In this context much greater emphasis should be given in case studies illustrating corporate H&S excellence to the role played by safety representatives so that more examples of positive forms of involvement are made available for those organisations wishing to enhance the role which their workforce plays in improving their overall H&S performance.

Developing HSE

41. Developing a broader develop role for HSC/E as implied in many of the suggestions made here might be seen as asking a very great deal of the people who make up HSC/E and suggest possibly that, at a senior level at least, they might be required to have an almost encyclopaedic grasp of all aspects of the "system" if not the subject of H&S—which in its detail is as complex and diverse as work itself. To be fully effective every HSE policy and enforcement officer needs some first hand familiarity with the sector, business or risk issues they are being asked to address. There are strong arguments to suggest that every policy officer in HSE must have had some experience (if only indirectly) of managing health and safety in an organisation. HSE and LA field staff need to be thoroughly immersed in H&S management systems thinking. HSE and LA career structures need to be made more flexible to allow staff to move between employers in the public, private and voluntary sectors and back into HSE or their Authority with career prospects and pension rights protected. There also need to be more creative approaches to career breaks and secondments to allow senior HSE people "to get back to the floor". Every Commission member should also have a mentored CPD (Continuing Professional Development) plan.

Promotion and the Way Ahead

42. The key to taking forward the new Strategy will lie in ensuring even greater participation and partnership. This is particularly true in relation to the role of LAs where RoSPA has already made proposals for "Partnership Agreements". RoSPA favours the idea of setting up new Welsh, Scottish and English Regional fora to bring together key H&S promoters at this level. A model for such an approach already exists in the "Scottish H&S Revitalisers' Forum", although experience here suggests that the success of this approach depends heavily of strong leadership, involvement of HSE staff and adequate resourcing.

Conclusion

43. Now is an exciting time for the future of health and safety at work. HSC/E need to be helped to expand both its agenda and its focus and work even more closely with all other key players in the H&S "system". HSC/E needs to act as the key development agency for the whole "system". This will only be successful however if it is backed by additional "spend-to-save" resources. HSC/E need to be able to exercise a strong and challenging intellectual lead. Many of these elements are signposted in the HSC/E's draft strategy. It remains to be seen whether the Government and HSC/E have the vision and determination to drive through the necessary programme of change and development.

Roger Bibbings
Occupational Safety Adviser

11 February 2004

Annex 1

HOUSE OF COMMONS WORK AND PENSIONS COMMITTEE

The membership of the Committee is as follows:

Sir Archy Kirkwood (Chairman)	Liberal Democrat	Roxburgh and Berwickshire
Ms Vera Baird QC	Labour	Redcar
Miss Anne Begg	Labour	Aberdeen South
Ms Karen Buck	Labour	Regent's Park and Kensington North
Mr Andrew Dismore	Labour	Hendon
Mr Paul Goodman	Conservative	Wycombe
Mr David Hamilton	Labour	Midlothian
Mrs Joan Humble	Labour	Blackpool North and Fleetwood
Rob Marris	Labour	Wolverhampton South West
Andrew Selous	Conservative	South West Bedfordshire
Mr Nigel Waterson	Conservative	Eastbourne

Committee press notices can now be distributed by e-mail which allows receipt on day of issue by contacting Emily Lumb (Telephone 020 7219 5833 E-mail: workpencom@parliament.uk House of Commons, Work and Pensions Committee, 7 Millbank, London SW1P 3JA.)

The Committee Office is now providing an additional service for those interested in committee activities. A dedicated telephone line provides recorded information about forthcoming meetings including venues, subjects under discussion and contact numbers for further details. The recording (020 7219 2033), which is updated daily, covers select and standing committee meetings occurring within the next two sitting days. The general inquiry lines for committee activity remain 020 7219 3267/4300.

Annex 2

OCCUPATIONAL HEALTH AND SAFETY: RoSPA's "VISION"

"Our Safety Vision"

The world of occupational safety which RoSPA wants to see includes:

- an inclusive system of H&S policy governance which involves employers, employees, professionals and all other major H&S system stakeholders;
- a co-ordinated national research strategy to advance understanding of the prevalence, causation and prevention of work related harms;
- challenging targets set at every level to help secure progressive reduction in work related injury and health damage from all causes, including work on the road and stress related accidents;
- every business having an effective H&S management system, lead by senior and line managers, supported by safety representatives and H&S professionals and reporting on targets and performance to its stakeholders;
- new emphases on safe design and on learning from accidents and incidents;
- continuing development of health and safety law based on goal setting and risk assessment backed by clear guidance;
- a major increase in resources for HSC/E and local authorities together with a new offence of corporate killing, stronger enforcement and more effective penalties, including compulsory retraining and remedial programmes;
- a better system of compensation for workplace injury which also incentivises and supports prevention and helps rebuild damaged lives;
- a co-ordinated system, linked to business development advice for small firms, for delivering health and safety services, including health and safety training and capable of meeting health needs at work;
- ensuring that all organisations demand high health and safety standards of their business partners (such as contractors and suppliers);
- top level leadership of H&S by a Cabinet level Minister with the Government acting as an exemplary employer committed to H&S "best practice" and promoting high standards via procurement and building H&S requirements into all its policies and plans and abandoning crown and parliamentary immunity;
- embedding of safety and risk concepts in the National Curriculum and in further, higher and professional education; and

— better international co-operation to share H&S knowledge and expertise and raise standards throughout the world.

Roger Bibbings
Occupational Safety Adviser

29 October 2002

Annex 3

Royal Society for the Prevention of Accidents

PRIORITISING WORK RELATED ROAD SAFETY "EIGHTEEN ARGUMENTS FOR ACTION BY THE HEALTH AND SAFETY COMMISSION AND EXECUTIVE"

A. Background

Working together with some 66 other organisations in the Occupational Road Safety Alliance (ORSA) (visit www.orsa.org.uk), RoSPA is continuing to work to ensure that occupational road risk is addressed by employers and regulators as a mainstream health and safety at work issue. In light of the report of the Government's independent Work Related Road Safety (WRRS) Task Group (Dykes Report) the Health and Safety Executive (HSE) and the Department for Transport (DfT) have recently published guidance for employers entitled, "Driving at Work" (http://www.hse.gov.uk/pubns/indg382.pdf). The Health and Safety Commission (HSC) are now following up their "Revitalising Health and Safety" (RHS) programme launched in 2000 by seeking views on the development of their strategy up to 2010 (http://www.hse.gov.uk/consult/condocs/strategycd.pdf). RoSPA has welcomed many aspects of the strategy but is concerned that the HSC document contains no reference to WRRS and in particular is very concerned that the new HSE/DfT guidance contains a statement as follows:

". . .HSC's enforcement policy statement recognises the need to prioritise investigation and enforcement action. Current priorities, as set out in HSC's Strategic plan, do not include work-related road safety. . ."

RoSPA believes that, notwithstanding their need to work in partnership with other agencies and "key players", HSC/E should:

— accept that MORR is mainstream health and safety and should be addressed by employers within their health and safety management systems;
— increase staff resources devoted to MORR;
— facilitate greater benchmarking and sharing of information on MORR, for example via the HSE's MORR web pages;
— focus on on-road as well as site transport safety (for example, during inspectors visits to workplaces);
— in this context, issue enforcement notices where necessary;
— deal with complaints by workers on MORR issues;
— in partnership with the Police, investigate work-related road crashes and, where appropriate, take high profile prosecutions;
— lead the MORR research agenda; and
— take a lead within Government as an exemplar employer in relation to MORR issues.

The rest of this paper sets out a series of arguments which, taken together, underpin the case for prioritising action on these lines by the HSC/E.

B. Arguments for Action by HSC/E

1. *Work related road accidents are the biggest cause of work related accidental death*

Between 800 and 1,000 people are being killed annually in work related road traffic accidents as opposed to some 450 fatalities which are currently being notified annually under the Reporting of Injuries Diseases and Dangerous Occurences Regulations (RIDDOR).

2. *Levels of occupational risk to workers who drive as part of their job are relatively high*

Levels of risk of fatality faced by those covering significant distances annually by car or van in the course of their work are the same risk of accidental death as workers in acknowledged high-risk sectors such as construction, agriculture or quarrying. Those covering 25,000 miles per annum for their work by car are close to tolerable levels of risk described in HSE's seminal risk document, "Reducing risks, protecting people" (R2P2).

3. *A preventative approach is clearly justified*

Although there are clear needs for more research on the prevalence, severity, causation, costs and "preventability" of work related road accidents, it is already clear that the problem is so serious as to warrant early action. Employers can clearly do much to exacerbate risk (eg poor scheduling, excessive working/driving hours, incentives to speed etc) and conversely they can do much to reduce risk (for example, by ensuring safer vehicles, safer journey planning, improving driver competence where necessary and developing a better road safety culture).

4. *There is major scope for safety gain and cost savings to business, the NHS and Local and Central Government*

Similarly, while further research is needed, it is clear that besides helping to meet the national road casualty reduction targets (40% reduction in numbers killed and seriously injured by 2010), action by employers to manage risk on the road can result in early net cost savings to businesses, public agencies and the HM Treasury. (RoSPA estimates that several million working days are likely to be lost annually as a result of employees being injured in "at work" road crashes.)

5. *There is clear public support for the idea of making work related road safety part of health and safety at work*

The overwhelming majority of respondents to the WRRSTG's discussion exercise agreed with this idea, many occupational and road safety professionals pointing to the advantages which this approach could have for both road and occupational safety. (Many see it as a useful way of helping to build effective "health and safety culture" in their organisations.)

6. *The suggestion that the prevention of road accidents while at work is not really part of occupational health and safety is ill founded*

When a person is killed in an accident while at work, whether or not they were engaged in activities that were taking place on an employer's premises or were on the public road is largely irrelevant. The more exposure employees have to the road environment, the more likely they are to be involved in an accident. The accident has occurred while the employee was engaged on their employer's business and could possibly have been prevented or its effects mitigated by appropriate employer action.

7. *Health and Safety Law applies*

The WRRSTG report confirmed that the general duties in the Health and Safety at Work (HSW) Act and the Management of Health and Safety at Work (MHSW) Regulations apply while employees are at work on the highway whether as drivers/riders, passengers or pedestrians.

8. *There is a clear case for an HSE enforcement role*

The argument that persons at work on the road (and others who may be affected by them) are adequately protected from harm by the enforcement of road safety law (and other measures) applying to all road users (the "Foot letter"—see below) is short sighted in that it fails to appreciate: a) the extent to which the actions of employers can affect levels of risk both faced and created by their employees while at work on the road; and b) that, in the main, road safety law is silent on the duties of employers to ensure safe systems of work for employees when they are on the highway.

9. *There are clear parallels with violence at work*

Although at one time it was argued that the general duties of the HSW Act were never intended to protect persons at work from the risk of assaults (and that they were protected by the law relating to offences against the person), later it was it accepted that employers did indeed have HSW Act duties to assess risks and take reasonably practicable measures to protect staff from violence. Since then action on violence has become part of the occupational health and safety mainstream, usefully complementing the objectives of criminal law in this area.

10. *There is a need to revisit the "Foot Letter"*

There is now a strong case for revisiting the terms of the "Foot letter" of the early seventies. (This established the principle that, in circumstances where there is more specific safety legislation—eg covering road, air, marine, consumer safety etc—it is this law that will be enforced rather than the general duties of the HSW Act.) Since it was agreed nearly 30 years ago, much has changed and in many ways the "Letter"

is now out-of-date. (It predated, the MHSW Regulations and their health and safety management requirements—including the requirement for risk assessment and it pre-dated the widening health and safety agenda and the need for "joined up Government".)

11. *The anticipated additional burdens placed on HSE's investigation resources are not likely to be as great as is being suggested*

While HSE staff are understandably concerned about the possible impact on their existing programmes and priorities of having to investigate work related road crashes, the precise number of cases in which HSE will need to become involved is probably quite small. The Police will continue to take the lead in investigation and the guidance contained, for example, in the ACPO "Manual for Investigating Road Deaths" will mean that, initially at least, only a very small fraction of the 800–1,000 estimated fatalities identified in the WRRSTG report will require HSE to become involved. Some additional training and guidance will be needed but, in general, HSE inspectors already have the expertise required to promote a risk management approach in this area and they can usefully link this with their existing guidance on site transport safety (HSG136).

12. *Work related road safety was not part of the "Revitalising Health and Safety" consultation exercise*

When the RHS discussion exercise was launched in 1999, the WRRSTG had not yet been established so that, although important priorities such as workplace transport accidents (see DDE18) were clearly considered, the much bigger issue of work related road safety was still not "on the HSC/E radar screen".

13. *WRRS is clearly part of the "Changing World of Work"*

The whole issue links very closely with other key priorities in the HSC/E agenda that are connected with "the changing world of work", particularly the increasingly peripatetic workforce and the links between "at work" driving and stress and musculo-skeletal disorders. (75% of male employees and 49% of female employees are required to use a vehicle—usually their own—in the course of their work—excluding commuting. Excessive driving can cause stress and stress in turn can increase the risk of crashes occurring. Long spells behind the wheel are a major cause of lower back pain.)

14. *There could be legal challenges*

Were HSC to fail to commit to following up the WRRSTG's recommendations, it is likely that this could result in further public pressure, Parliamentary Questions etc and it could also possibly give rise to judicial review of cases in which HSE had decided not to investigate particular work related road accidents.

15. *The issue is one that clearly demands "Joined-Up Government"*

Until the WRRSTG report was published, the contribution which greater employer action could make to help achieve national road casualty reduction targets had been severely underestimated. (The targets in the Government's strategy for road safety—"Tomorrow's Roads: safer for everyone"—and in the HSC's RHS need to be viewed in parallel.)

16. *The UK needs to be abreast of international developments*

The UK, including HSC/E, will need to learn from the wide range of activities being taken in other countries to promote occupational road safety this. The UK should have a clearly developed policy line to advance in any future discussions on WRRS within the European Union.

17. *The immediate need is to focus on raising awareness*

The priority task recommended by WRRSTG was the need to raise awareness, suggesting that, while the HSC/E may need time to take action on research and enforcement liaison, it needs to work closely with others (such as members of ORSA) to get the message across to employers and "key intermediaries".

18. *HSC/E can develop its role through partnership working*

In the light of the HSE DfT guidance, HSC/E will be able to develop their involvement by working in partnership with other organisations (such as members of ORSA) to develop a more co-ordinated approach to awareness raising and identification of good practice.

C. Conclusion

Responding to the WRRS agenda poses clear challenges for HSC/E (and in the longer run will not be possible without additional resources). In the short term however the above arguments suggest that neither the Commission nor the Executive can continue to maintain their previous policy position on this issue based on the "Foot letter"—which, in any case, with the passage of time needs revisiting. HSC and E need to accept that WRRS must be made a priority in the 2010 strategy while at the same time working with others to focus on raising awareness and using the coming period to get to grips with some of the more challenging aspects of this very important issue.

RoSPA hopes that others will refer to the ideas set out in this paper when developing their comments on the HSC's 2010 strategy consultation document. (Comments must be sent in by 1st December 2003 to "Strategy", HSE Strategy and Intelligence Division, 8NW, Rose Court, 2, Southwark Bridge, London SE1 9HS.) Further information can be obtained by calling me on 0121 248 2095 or Emailing me at rbibbings@rospa.com.

Roger Bibbings
Occupational Safety Adviser

11 November 2003

Memorandum submitted by Association of Personal Injury Lawyers (APIL)

Introduction

1. APIL welcomes the opportunity to submit evidence to the Department of Work and Pensions Select Committee on the role of the Health and Safety Executive and the Health and Safety Commission. The comments in this submission are restricted to issues which fall within the area of expertise of APIL members.

2. In summary:

— APIL believes that resourcing for the HSC/E is inadequate

— APIL believes that the penalties available for breaches of health and safety law are insufficient

— APIL maintains that the level of enforcement by the HSC/E is not sufficient to prevent health and safety breaches

— APIL would welcome an increased emphasis on rehabilitation and mediation

Achieving Outcomes

The Changing World of Work

3. Tackling the changing world of work is imperative if the HSC is to achieve its ultimate goal of making health and safety the cornerstone of modern society. With technology and telecommunications becoming more advanced and prevalent in today's world, the working environment has changed and will continue to do so. More and more people are now "mobile workers", not using an office, but conducting their business either from home or on the move. This change brings with it new health and safety challenges. Some have already been tackled, such as using a mobile phone whilst driving, but the speed of change means that HSC will need to be more pro-active in its focus.

4. In addition, the occupational needs of the workplace are growing. For example new types of working environments, like the call-centre, are producing new problems, such as work place stress and repetitive strain injury (RSI). APIL believes that in this changing environment, personal injury litigation can be a useful tool in the prevention of accidents. This is because claims resulting from accidents can affect the overall cost to the organisation's insurance provider and this can lead to increased pressure from the insurance industry for improvements to health and safety provision. For example, if there was a sharp increase in the number of nurses in a particular hospital suffering back injury, an insurance company could force the hospital authorities to invest in better training or equipment for nursing staff who routinely lift heavy patients.

5. Examining external influences and predicting how workplaces will change in the future will help both the HSC and policymakers to prevent, rather than have to respond to, new health and safety issues.

Enforcement

6. APIL believes that improvements to health and safety could most effectively be achieved with regular and thorough site inspections and appropriate enforcement of breaches of health and safety legislation.

7. APIL agrees that there is a need for two-way dialogue between the HSC and business, and that such dialogue needs to be pro-active in nature. We feel that a good way of allowing this flow of information would be to establish a dedicated confidential HSC phone line. This phone line would offer advice and suggestions

to both employers and employees. It would also be a mechanism by which potential criticism of the health and safety regime could be fed back to the HSC. This feedback would hopefully enable the identification of growing health and safety concerns, the further definition of the HSC's enforcement remit in relation to problematic areas and would make the HSC seem more approachable.

8. APIL believes that the system is not working as well as it could be in relation to at-work risk. For this reason, in May 2002, APIL called for the HSE to develop an Approved Code of Practice (ACoP) in order to clarify employers' obligations in respect of managing at-work road risk and to provide guidance on how employers can comply.

9. Our members have made the general point that they believe it is inappropriate for inspectors to be responsible for both providing advice and for prosecuting companies. It is felt that resources are often insufficient for them to perform both functions successfully and that it is difficult for an inspector to simultaneously provide a "carrot" and wield a "stick". It has also been pointed out that breaching health and safety law is not perceived as a proper crime and that health and safety should attract the same resources as the criminal system.

Health and Safety Duties of Directors

10. Health and safety responsibilities are currently placed upon legal entities, ie companies. Companies will only achieve health and safety improvements to the extent that its directors encourage it although there are currently no legal duties upon them to do this. It is, therefore, no surprise that many directors do not properly address their minds to health and safety, nor that this results in poor health and safety practises within many organisations.

11. The most desirable means of creating such legal duties would be by way of a regulation under section 15 of the Health and Safety at Work Act 1974. This would prevent delay due to problems of parliamentary time. It may then be appropriate to develop an Approved Code of Practice to guide directors on how to comply with the legal duties.

12. Organisations representing directors may allege that the imposition of legal duties will create an expensive and unnecessarily burdensome regulatory framework on directors and organisations. APIL believes that this, however, is untrue. Companies already have legal responsibility for health and safety even though individual directors do not, and those in charge of companies should already be ensuring that the organisation complies with its legal obligations. Imposing legal duties upon directors will merely place duties on directors to effectively ensure an organisation fulfils its health and safety responsibilities.

Penalties

13. APIL believes that the full force of the law should be brought to bear on negligent employers and the sanctions for health and safety breaches should be more in tune with the harm and damage they cause. For example, if someone seriously injured another person outside of the workplace he would be charged with a criminal offence and serve an appropriate prison sentence. If, by a company's negligent act or omission, a worker is similarly seriously injured, it is unlikely that any person will be charged with a criminal offence or indeed serve a prison sentence, yet the effect of the damage caused is the same. APIL has continually supported the introduction of legislation in order to criminalise health and safety breaches, as well as pushing for a new corporate killing law which will more effectively punish the negligent acts of company directors.

14. In addition to increased resources, APIL also endorses the strict enforcement of health and safety sanctions. In order for any type of enforcement regime to work effectively the use of sanctions must be a true deterrent to possible offenders. Sanctions must be applied stringently and consistently for all offences.

"Appropriate Action"

15. APIL is concerned that in the HSC consultation "A Strategy for workplace health and safety in Great Britain to 2010 and beyond" issued in late 2003 it was proposed that the HSE's involvement in health and safety enforcement should be reserved to taking "appropriate action". Whilst we feel that the HSC's move to adapt to the changing world of work should be supported, this strategy should not in any way influence the use of sanctions as an effective deterrent. We have, on several occasions, expressed our concern about the current HSC enforcement policy, which is based on the Department for Trade and Industry's (DTI) enforcement concordat. This concordat seeks to promote "proportionate" enforcement. It states that action should be proportionate to the seriousness and persistence of the breach and should be the minimum necessary to secure future compliance.

16. Health and safety law exists to protect both workers and members of the public from death and injury. Every breach of it should be taken seriously. Applying "minimum" standards equates, in our view, to tolerating breaches. This is unacceptable.

17. If health and safety in the workplace is to be improved, employers must be aware that the full force of the law will follow a failure to comply with the relevant legislation. Proportionate enforcement fails to secure this message.

Mediation

18. The remit of our members falls almost entirely within the field of civil law we have been looking at the issue of mediation between negligent employers and injured workers. We believe that mediation can be particularly valuable following workplace accidents involving an ELI claim, because it can be used to help restore a damaged working relationship between an employer and an employee who has been negligently injured. Mediation is just one aspect of the more "holistic" approach to personal injury law, which has been promoted by APIL over recent years.

Rehabilitation

19. APIL has long supported rehabilitation, which seeks to restore an injured person to as productive and as independent a lifestyle as possible through the use of medical, functional and vocational interventions. APIL was involved in drafting the Code of Best Practice on Rehabilitation for personal injury claims which seeks to encourage claimant and defendant lawyers to liaise with each other to secure rehabilitation for injured claimants.

20. Rehabilitation, however, should not only be considered within the context of litigation. APIL believes that employers should be under a legal duty to at least consider the use of rehabilitation after an injury has occurred. In short, rehabilitation should be an integral part of an employer's health and safety strategy and, more specifically, it should be mandatory for employers to have a rehabilitation policy.

Resourcing

21. APIL has consistently raised its concerns about the under-resourcing of the Health and Safety Commission and Executive. The safety of all members of society should be a priority of Government policy. In view of current limited resourcing, however, we agree the work of the HSC/E should be prioritised on the basis of clear and objective criteria. This would assure the public that the HSC/E is addressing the most important safety issues.

22. APIL would like to see the HSC's budget increased to allow for the adequate enforcement of health and safety legislation. We recognise that even if the HSC's budget were increased, it would still be finite. Due to the nature of our members' expertise, however, it is difficult for us to comment on the areas in which the HSC/E and local authorities should reduce their involvement.

Conclusion

23. APIL believes that:

- HSE's budget is woefully inadequate.
- breaches of health and safety regulations are not perceived as a proper crime. Extraordinary resources are put into the criminal system and APIL believes similar investment to be made in health and safety.
- there should be a greater use of stricter sanctions for all types of health and safety breaches as a pro-active deterrent.
- there is a need for more effective enforcement of health and safety regulations in the workplace.
- there should be specific health and safety duties introduced for directors of companies.
- proportionate enforcement as interpreted by the HSE is inappropriate for health and safety breaches.
- the HSC should establish a dedicated phone line for use by employers and employees to allow criticism of a firm's health and safety regime to be fed back to the HSC.
- there should be an approved code of conduct in order to clarify employers obligations in terms of at work risk.
- increased use of mediation and rehabilitation when injuries have occurred should be encouraged and promoted.

Association of Personal Injury Lawyers

13 February 2004

Memorandum submitted by UK Petroleum Industry Association (UKPIA)

1. UK Petroleum Industry Association (UKPIA) is the trade association representing the oil refining and marketing industry in the UK. Our members operate all nine of the major crude oil refineries in the UK, supply 90% of the inland oil product market plus substantial net exports to EU and USA, and own around 4000 of the UK's 11,000 petrol stations. Some 4 million people per day visit a petrol station. The industry is closely regulated to ensure the health and safety risks associated with products and operations are properly controlled at each stage, and both UKPIA and its members have a range of regular contacts with HSE officials.

2. UKPIA supports the work of HSC and HSE in promoting high standards of health and safety and in enforcing legislation. In our experience the HSE is an effective and respected regulator. Our comments are intended to help work in these areas to develop in an effective and efficient manner, and the comments below broadly follow the structure outlined in the Committee's Press Notice.

The Legislative Framework

To what extent has the Health and Safety at Work Act 1974 and subsequent legislation at national and European levels been successful in improving standards of health and safety?

3. We understand that international comparisons support the view that the UK has a successful legislative framework and regulatory regime. Outcomes are more easily measured for safety than for health. The more modern legislation is almost all of EU rather than UK origin, and has tended to focus on safety rather than on reducing absence from work through all forms of ill-health.

4. The HSE is unusual in having responsibilities for the development of policy and legislation and also for its enforcement. HSC is also unusual in giving special status to CBI (as part of a tri-partite approach) on its advisory committees, such that industry committee members sit as CBI representatives rather than as representatives of their industry. Until recently UKPIA has actively supported the work of the Advisory Committee on Dangerous Substances, however when we ceased membership of CBI we reluctantly had to resign our representation on ACDS. We believe the HSC should find more effective ways of involving relevant industry expertise and avoid reliance on CBI membership. Government departments such as DEFRA frequently set up consultation groups to enable stakeholders to comment on specific areas of policy and legislative developments, and we believe this model would be more appropriate for HSC/E.

5. We have the impression that the HSE is sometimes reluctant to allocate resources to support the work of the subcommittees working for HSC. For example, during 2003 there were concerns over the provision of adequate HSE resources to the working group on pipeline safety.

6. We believe that the strategy outlined in the recent HSC consultation "A Strategy for Workplace Health and Safety in GB to 2010 and beyond" is directionally right. However, the problems of absence from work vary greatly from sector to sector, and we believe that sectoral responses will be required.

Achieving Outcomes

Is HSE sufficiently pro-active to address developing hazards at work?

7. There is a natural tendency to focus effort on occupational safety, where accidents are relatively easy to identify, report, and measure. However, some of the more difficult policy areas may contribute far more to fatalities and absence from work, eg at-work road accidents. We are pleased that efforts are being made to promote good practice in more difficult areas such as this, and believe they should be encouraged and adequately resourced.

To what extent is health and safety legislation properly understood?

8. Good, timely and concise guidance is very important to enable operators to comply efficiently with new legislative requirements. However, there has been tendency for HSE to carry on developing detailed requirements long after the publication of the relevant general guidance and the deadlines for operator compliance, and to allow a confusing proliferation of guidance. For the oil refining industry the main example of this occurred with the introduction of the COMAH (Control of Major Accident Hazards) regime of 1999, with the effect that operators of oil refineries were required to undertake very substantial and expensive re-working of their Safety Reports (the document which demonstrates that all measures necessary to control risks have been taken).

9. There were over 20 separate guidance documents issued for COMAH, of which several were very bulky, and there appeared to be an excessive preference for producing new documents rather than revising the existing core guidance. There is a need for much tighter managerial control on what guidance is issued, its status, and the relation of each document to the others. Both operators and regulators would benefit from a more disciplined and structured approach.

10. There are also cases of guidance whose status is confusing. In December 2001 the HSE published "Reducing Risks—Protection People" (commonly known as R2P2) which sets out thinking on the control of risks, and is "aimed at explaining the decision-making process in HSE". We understand that this document has not been endorsed by a Minister—yet it is much quoted and referred to by HSE (and even by the Environment Agency) as if it were endorsed by Government as a cornerstone of policy.

Does more need to be done to encourage good practice?

11. Yes. Subjects such as at-work road accident prevention, and stress are often difficult to address by traditional regulation, because the boundaries between employer responsibilities and the individual's private life are unclear and difficult to separate. We welcome the move towards production of guidance on good practice in these areas.

Is there sufficient emphasis on "health" in health and safety?

12. This is also an area where much can be gained by the promotion of good practice and development of employee awareness, and by employer attention to absence records and analysis of reasons. A more expensive option may be the wider application of occupational health screening—however this is resource intensive and needs to be well-targeted, and raises questions of cost-effectiveness and who should bear the cost.

RESOURCES

Is the HSE sufficiently well-resourced to meet its objectives?

13. Industries regulated under COMAH (eg refineries) and other high-hazard regimes (eg offshore oil) are charged the full cost of HSE regulation, and these costs are considerable. We have supported HSE's efforts to benchmark the cost of its activities and to improve its efficiency and productivity, and we welcome the efforts being made. In our experience the HSE is not under-resourced in enforcement.

14. However, we have observed some lack of resources for the development and revision of policy, for example there have been delays to the implementation of the Dangerous Substances and Explosive Atmospheres Regulations 2002 (DSEAR) and the associated modernisation of the legislation controlling petrol stations.

To what extent is there good coordination between HSE and those other parts of central and local government with a role to play in promoting health and safety?

15. HSE and the Environment Agency are joint competent authorities for the COMAH regime, for which DEFRA is the lead department. We are concerned that there has been a proliferation of confusing guidance on this subject (see paragraphs 8 to 10 above), and that this reflects a lack of unified management control.

16. Enforcement of petrol station regulation is devolved to local authorities. There are some concerns on consistency of enforcement, although the Petroleum Enforcement Liaison Group (PELG) has helped.

GENERAL

The Committee expects the inquiry particularly to focus on how well the HSE achieves the right balance between prevention and enforcement and whether it is adequately resourced for the task, in respect of both existing hazards and the anticipated hazards of the future.

17. There is more to be done in prevention, and especially in the areas of promoting awareness of healthy and safe working practices where traditional legislative control is more difficult to apply, such as in cases of stress and at-work road accidents. If there is a case for more resources for HSE we believe that they should be deployed in prevention and in ensuring policy development is timely. Preventive work is often most effective when undertaken jointly with the industries concerned, eg good practice guidance, safety passport schemes, computer-based tools to help small businesses (such as petrol station managers) comply with the range of relevant health, safety and environmental legislation which they face.

UK Petroleum Industry Association Limited (UKPIA)

13 February 2004

Memorandum submitted by the Scottish Hazards Campaign Group

The Scottish Hazards Campaign Group (SHCG) is a network of individuals and organisations interested and involved in workplace health, including trade union health and safety representatives, trade union officials, safety officers, occupational health professionals, campaign groups, community groups. It is part of the UK Hazards Campaign and the European Work Hazards Network.

We appreciate the opportunity to have an input into this Select Committee inquiry. Much of what is included here is based on our response to the consultation document: A Strategy for Workplace Health in Great Britain to 2010 and Beyond.

1. The Legislative Framework

The SHCG is concerned by reluctance to legislate in some areas including workplace stress and passive smoking. It is felt that guidance on its own will not be a strong enough tool to bring about improved practice in these areas. We are disappointed that, despite strong evidence that active trade union health and safety representatives are a major factor in reducing accidents at work, there appears to be little commitment to strengthening their role. We would hope that consolidation and updating of the Safety Representatives and Safety Committee Regulations will go ahead and that recognition will be given to the positive results of the worker safety advisor pilots.

We would also hope to see UK law more accurately reflecting European law. We believe the concept of reasonable practicability should be removed from UK law and that, for example, the opt out within UK working time regulations should be removed. We also believe there should be a requirement for the provision of occupational health services.

2. Achieving Outcomes

SHCG believes that the enforcement role of the HSE should be strengthened. There is clear evidence, recognised by both the HSC and HSE, that fear of enforcement is a prime motivator for action on health and safety. Concerns have been expressed about public views of the HSE. We believe strongly that the best way for the HSE to secure respect is by doing the job of enforcement better; by taking stronger action against those negligent in health and safety matters.

We are, however, also aware of the need for proactive work in education and support for prevention. As we said in our response to the consultation document, we do not fundamentally disagree with the proposal that occupational health and safety advice and support be provided from outside the HSE, but feel strongly that this must be done with additional funding and not be in competition with vital enforcement activity.

There will undoubtedly be issues regarding the understanding of health and safety legislation, but we would be more concerned about the inability or unwillingness of many enterprises to put what is known into practice. Again, we would stress the important role that union health and safety representatives can and do play in education, training and pressing for action on workplace health issues. They should be supported and strengthened in carrying out these functions.

Another change which would contribute to an improvement in knowledge and understanding of health and safety legislation would be to make HSE publications more widely available. With increasing access to the internet, we would argue that all HSE guidance and information aimed at employers/employees should be freely available on the world wide web. We have also had reports that the quality of information being given by the HSE information line has deteriorated and would ask if this is due to it being contracted out to independent providers.

The SHCG has long argued for provision of an independent and free occupational health service. We welcome the fact that the need for this has begun to be recognised within Scotland with the establishment of the Safe and Healthy Working pilot. However, this provides only a limited advice service, whereas what is needed is far more comprehensive. This could be provided and funded in different ways, but the potential role of the NHS should be explored.

As is argued by many others, we believe that the sentencing options and levels of penalties imposed are totally inadequate.

3. HSE Resources

The SHCG has been extremely concerned by cutbacks in HSE funding. It is angered by statistics which indicate the inability of the HSE to carry out its inspection and investigation role to anything approaching an acceptable level. We are equally concerned by under resourcing of environmental health services. This is not a criticism of the individual inspectors who, we believe, often share our frustration. We are aware, from reports from members, that local access to the HSE is limited to working hours. It is important that members of the public/workers have access to some form of emergency service outwith these times (eg discovery of unsafe removal of asbestos).

4. In addition to the above, we would conclude by saying that the SHCG wishes to see a larger role for the Scottish Parliament in occupational health and safety matters, particularly given its full responsibility for health.

Kathy Jenkins
Scottish Hazards Campaign Group

13 February 2004

Memorandum submitted by SCA Packaging

1. Enforcement—There is no doubt that the enforcement powers of the HSE have influenced compliance with regulations in medium to large businesses. It is my view that the impact on smaller businesses has been less. I can understand the difficulty of tracking and managing small concerns from a health and safety viewpoint—but it seems that larger and medium sized businesses are sometimes over scrutinised as they are easy to see, with greater impact immediately on a larger number of people. All of this is true, but in a land of many small business health and safety practice seems to be a less well-regulated area.

2. There has clearly been a lot of concentration on getting the paperwork right. This has an impact—but we do seem to be sadly lacking in how to positively drive safe behaviour—having good quality documentation does not necessarily deliver good results.

3. There is no doubt that Health and Safety legislation needs to be enforced, but I am not sure whether this can be linked with a support role. Good practice and benchmarking are highly attractive from the point of view of businesses. Seeing how somebody does it well gives operational context to what can be an area where it is difficult to summon positive enthusiasm.

4. It may be worth considering how to either positively link advice to enforcement or to sever the link completely between enforcement and advice.

5. As with a number of areas it is sometimes difficult to recruit people into these roles with operational experience who can look at things in a business context—another argument may be for dividing the enforcement and advisory tasks.

6. The charter the HSE operate by also seems to need some consideration. In most other areas bound by potential legal concerns it is normal for those being questioned as a result of an incident are fully aware of the options that are available to them. This does not always seem to be the case currently.

7. We should also consider whether the whole context of health and safety should be considered in the broader context of occupational health. We tend to use very blunt instruments to look at safety performance, little if anything is utilised concerning occupational health. Today's occupational health issues may be tomorrow's safety issues. Why we make the distinction between an accident—ie something which is in relation to a specific immediate incident and a health issue which is an accident, which may be the result of a long re-germination period I am not sure.

8. This links to the whole area of behaviour—we identify the accident and its immediate surroundings well, we are less good at identifying long term endemic problems that provide long term safety issues, after all, all accidents—long term or otherwise are accidents.

9. Finally—the HSE have probably done a better job than some other countries of driving compliance with legislation. As manufacturers we are faced continually with the issue of losing work abroad to cheap labour rates, if we are to compete then the playing field needs to be far flatter than it is today, or I am afraid the subject of health and safety will be of merely academic interest in the context of the UK Manufacturing industry.

10. I know work is proceeding in these areas, but to be honest it seems like too little too late to help us.

SCA Packaging

13 February 2004

Memorandum submitted by Retail Motor Industry Federation

SUMMARY

The Retail Motor Industry Federation (RMI) has a long history of collaboration with the Health and Safety Executive with HSE staff sitting, at times, on the Federation's Environment, Health and Safety Committee. The RMI plays a significant role in the National Engineering Group's Motor Vehicle Repair Forum which has its own HSE website displaying advice written by the Forum for the motor trade.

The RMI recognises the sound foundations which HSC/HSE have established in the past but, increasingly, sees the dichotomy between the hierarchy dealing Europe, strategy, government departments and legislation and field operations with the task of making pragmatic decisions on increasingly specialised legislation. The recent strategy document produced by HSE leaves the Federation with no confidence as to HSC/HSE's ability to change to address the consequences of the real transition taking place in Britain. That is, from an industrial economy to a post-industrial service economy based, increasingly, on small and micro-businesses without the benefit of the support of health and safety professionals.

The UK is awash with health and safety legislation, for the most part unimplemented. Before HSC/HSE embarks on producing yet more legislation market surveys should be initiated to determine the extent to which current legislation is being implemented, and effort devoted to correcting the balance. Prosecutions are wasteful of HSE resources and fail to have a significant deterrent effect so the penalties become irrelevant except to the business paying them. HSC/HSE must certainly change to address post-industrial Britain, but until it can be demonstrated that the organisation can develop appropriate strategies, structures and programme plans to provide better support to the small and micro-businesses then, in the RMI's view, it should not be given increased resources.

1. *Introduction*

1.1 The Retail Motor Industry Federation (RMI) represents the interests of retail businesses within the automotive industry, one of the largest industrial sectors in the UK, employing 600,000 individuals. With 10,500 member companies spanning petrol retailers, bodyshops, small garages, medium-sized businesses and large motor dealership groups, the RMI is one of the UK's biggest trade bodies. Despite having the major motor dealership PLCs within membership the great majority of RMI members are small or micro-businesses.

1.2 Prior to joining the RMI as Environment, Health and Safety Adviser in 1993 the writer worked for the Shell Group for 32 years in positions requiring a technical background. For his last three years with Shell he co-ordinated health, safety and environment activities within Shell UK Oil. He has worked for the RMI for over 10 years, firstly as full time employee and latterly as a consultant.

1.3 In support of its garage membership, the RMI has for many years maintained strong contacts with the HSE, primarily through the staff of the HSE's Engineering National Interest Group and latterly though the HSE's National Engineering Group and the Motor Vehicle Repair Forum. The MVR Forum was established to address the specific health and safety issues of the garage and motor dealership trade and has proved a fruitful collaboration with the trade associations involved in producing advice and leaflets specifically targeted at MVR activities.

1.4 In addition to its activities through the Forum and its associated working groups, the RMI responds to the various consultation documents where outcomes are likely to affect its members. It is largely the contrast between these two elements of the RMI's dealings with the HSC/HSE which the RMI would like to address in this submission.

2. *The Dichotomy Within HSE*

2.1 From the RMI's perspective, there are two parts of the HSE. The one which at a higher level deals with EU and UK legislation and produces Advisory Codes of Practice and other publications in support of that legislation; the other the field inspectors who have the unenviable and possibly disheartening task of visiting businesses, of predominantly micro and small size, to assess and advise on the implementation of that legislation and where appropriate, enforce it. The gap between these two activities could not be wider. Because if the people who are proposing, negotiating and writing the legislation had any understanding of how little of it is actually implemented, or even cared whether it would or could, realistically, be implemented by the majority of small businesses then the HSC/HSE and parliament would spend less time producing ever more complex legislation requiring specialist interpretation and ensure that more effort was applied at the coal face to get over the very basics of health and safety to the micro- and small businesses which provide the majority of the employment in the UK.

2.2 It is very evident that HSE is very comfortable talking to the health and safety professionals of large companies when framing legislation but has no idea as to how to communicate with small and micro businesses over the same issues. Preaching to the converted is a serious waste of resource.

2.3 Take, for example, the Control of Substances Hazardous to Health Regulations (COSHH). Here is a fundamental part of H & S legislation conceived with very good intentions. In the RMI's experience, it would be exceptional to find any business which had implemented it fully. A sizeable proportion of businesses have only a fraction of the material safety data sheets for substances used on their premises, but these are kept in a file and the handling requirements and safety precautions have not been communicated to the workforce. Most motor dealerships do not have key data sheets like petrol or battery acid. 25% implementation of COSHH over large, medium, small and micro-businesses is probably an over estimate. Electronic COSHH Essentials may be a useful tool for health and safety professionals but it is very doubtful whether small or micro-businesses will use it. Yet the latter is the market HSC/HSE should be addressing.

2.4 What effort has HSC/HSE made to determine which elements of health and safety legislation have been implemented by businesses of different sizes, and to what extent, and which have not? This is a fundamental question to which we very much doubt that the HSC/HSE hierarchy know the answer. But market surveys such as this should provide the basis for any review of HSC/HSE strategy, structure and work programme. We expect that the seasoned professionals within the ranks of the field inspectors of the HSE know many of the answers, but herein lies the dichotomy within HSC/HSE.

2.5 In the absence of any knowledge as to the answer to this question, it would, in our view, be wise to assume that the EU, the UK Parliament as well as the HSC/HSE are engaged in a pretty useless exercise of piling unimplemented legislation upon unimplemented legislation. The whole of HSC/HSE activity appears to be project oriented without any idea as to whether project results will be implemented and be fruitful in encouraging a safety culture within businesses or just provide another straw which blows in the wind. We are already past the stage where the straw would break the camel's back as there is so much health and safety legislation that a small business could not hope to implement all of it.

2.6 Attached as Annex I to this submission is a copy of the RMI's Response to the Health and Safety Commission's Report—A Strategy for Workplace Health and Safety in Great Britain to 2010 and Beyond. Annex I gives a background to the RMI's views on HSC/HSE and from this you may gather that we are more impressed with the field operations activities of HSE and rather less with the hierarchy.

3. *The Legislative Framework*

3.1 We believe that the Health and Safety at Work Act 1974 was well conceived and appropriate for its era. However, the industrial landscape and working environment within the UK has now changed and the manner in which health and safety is addressed must change with it. Large industries and major companies are disappearing from the UK and no longer form the key recipients of legislation. The smaller CBI is a reflection of this. Companies that remain are slimmed down and many no longer have health and safety professionals on the payroll but rely on external consultancies or an ad hoc DIY approach. So HSC/HSE's ability to consult and get feedback from the larger companies is both more difficult and increasingly less appropriate. With medium, small and micro-businesses it is even more difficult to get feedback but more important to do so. This situation has great dangers because with a less critical audience any well meaning but misguided legislation HSC/HSE proposes can be pushed through with less control and overview. The same concerns apply for European directives where the HSE staff tell UK stakeholders that they put forward UK industry's arguments but get outvoted in committee. Presumably by other Member States who also have no concern as to whether legislation is implemented or not.

3.2 HSC/HSE's innate tendency to gold plate legislation, either home grown or that stemming from European legislation is, we believe, misplaced and particularly so against the background of low levels of implementation by businesses in the UK, and, reputedly, against even lower levels of implementation in many other European countries. For comparison take a look at how many pages the Irish Republic uses to implement a European health and safety directive relative to the UK. Other UK government departments were renowned for gold plating, the old DoE for example. With Defra there are signs of change, and we hope that this will extend to HSC/HSE also.

3.3 Gold plating legislation makes it less likely that it will be implemented by businesses and is, therefore, counterproductive.

4. *Outcomes*

4.1 The Revitalising Health and Safety Strategy was introduced because improvements were no longer being seen in accident statistics. That HSC is seeking a new strategy suggests that the Revitalising Health and Safety Strategy itself is not working. If it was working, why change it?

4.2 The RMI's view is that the HSC/HSE should spend considerably more time on prevention and far less on the drafting on new legislation which is not going to be implemented by businesses. As argued in Annex I, the most effective way of improving health and safety awareness is by a visit from a seasoned health and safety inspector with the power to apply enforcement procedures if improvements are not made. Contrary to the statements that HSC/HSE has to tackle new trendy, and possibly politically correct areas, like stress and passive smoking, the same accidents are occurring for the same reasons in the same industries and have been doing so for decades. These are still the issues HSC/HSE has to address, but are they too boring for the hierarchy? In our view the HSC/HSE is taking its eye off the ball, moving to more peripheral issues which are societal and not amenable to its attentions. At the same time they are failing to address not new issues but old issues, and for the increasingly important small and micro-businesses that can only be done by a site visit. The need is very much for a "back to basics" emphasis. Slips trips and falls, manual handling, moving goods and vehicles around premises, etc. The old causes of accidents are still there. The accident statistics tell us that the emphasis should not change.

5. *Prosecutions and Penalties*

5.1 We cannot understand HSC/HSE's obsession with penalties and prosecutions. It came up at the last strategy presentations when Bill Callahan promised more enforcement and greater penalties on businesses which transgress. It should be patently obvious by now that, as an option, this does not work. Yes, an accident is a failure of management, and one for which the company will pay over a long time in increased employers liability insurance, but it is also a failure of HSC/HSE. Prosecutions are very expensive in terms of HSE resources and do not have the deterrent impact on other businesses which HSC/HSE may like to believe, "because it is not going to happen to me, I've not had a accident for 20 years." Furthermore, prosecutions deflect resources from site inspections which have a more lasting effect on business management and on the staff working there. We know this because invariably the employer is on the phone to the trade association asking for advice after the visit. HSE has not succeeded with its prosecutions policy so far. Isn't it time for a rethink?

5.2 The issue of penalties is, in our view, also of low importance for the reasons given above. Penalties have little bearing as a deterrent because prosecutions and fines cannot be communicated by HSC/HSE to the hundreds of thousands of businesses who would need to hear the news. Most would not call up the pages on the internet to read about it, they are too busy ensuring that they stay in business.

5.3 The vast majority of businesses in the UK will never read a piece of legislation. They have to be told what to do to meet the requirements of regulations. Trade associations assist in this respect but very many businesses are not members of trade associations, hence the need for site visits from HSE inspectors. Although it may be important to communicate specific legislative requirements we are sure that the Select Committee understands that the key requirement as far as health and safety is concerned is to develop a safety culture within businesses, targeting the employees through schools and colleges as well as the employers. Once the safety culture is established employers and employees will seek out the good practice.

6. *Health*

6.1 There are certain activities at work where exposures to harmful agents are associated with short or long term health effects, for example, the exposure to isocyanate curing agents when paint spraying in bodyshops. Short and long term health effects also occur as a result of poor posture when at a display screens or when manually handling loads. These are legitimate areas for HSC/HSE involvement. When it comes to such contentious issues as stress and passive smoking, we do not believe that HSC/HSE should get involved. If HSC/HSE cannot manage the basics effectively by ensuring the much wider implementation of the more fundamental pieces of legislation, which at present they cannot, there is little point in attempting to move into more marginal areas for which, it may be argued, they have no mandate.

7. *Resources*

7.1 It is the Federation's view that as a means of improving health and reducing accidents in the UK both HSC and HSE should concentrate far more on existing legislation rather than trying to develop new legislation, and that that message should be communicated to Europe also. The UK needs new health and safety legislation as much as it needs a hole in the head. At present the HSE is not using its resources effectively. For example, two or three years ago HSE produced a publication on diesel exhaust. At the time, when in draft form, RMI questioned the need for such a document which was longer than HS(G)67—Health and Safety in Motor Vehicle Repair, covering the whole of motor vehicle repair . There are only two basic issues to note about diesel engine exhaust. If you can smell it, service the engine and if indoors, improve the ventilation. End of story. The booklet itself will have taken at least 100 man days to produce, print and publish. Think, of the number of premises a field inspector could have visited in that time and made a real contribution to the health and safety of small businesses.

7.2 Until the HSC/HSE develops more appropriate organisational structures, strategies and programme plans to deal with massive existing deficits, and demonstrates that it can use effectively the resources already allocated, there is nothing to be gained by increasing its resources.

7.3 Resources are not only an issue for the HSC/HSE they are also an issue for every business in the land and it is equally if not more important that HSC/HSE do not waste the resources of UK businesses. On the issue of chrysotile asbestos there is an outstanding issue which HSC/HSE has failed to resolve despite being asked to do so. How can the UK and Europe hold a view as to the cancer-forming potential of white asbestos which is totally at odds with that of the USA? On 9/11 some 40 tons of white asbestos entered the New York air. Was the Administration concerned? No! Because years before a court case had resolved on the basis of the evidence that white asbestos was harmless. Has such judicial scrutiny been given to the evidence in Europe? We suspect not. When the RMI asked the HSE to present evidence of the harm it was not provided. Yet every time a building containing asbestos cement sheet is modified or demolished specialist contractors must be used at exorbitant cost.

8. *Local Authorities*

8.1 Because, for some motor dealerships the local authority is the enforcing authority while for others it is the HSE, the RMI has dealing with both. Consistency of interpretation of legislation and lack of pragmatism are issues with local authorities where there seems to be a higher turnover of staff who are consequently less experienced. For this reason the Federation has always expressed a strong preference for any business which undertakes motor vehicle repair to have the HSE as the enforcing agency. Motor vehicle repair is after all light engineering which automatically comes under the HSE.

9. *Conclusions*

9.1 It has often been said that politics is the art of the possible, this may be so, but for health and safety this is even more the case. However, if we look at existing and emerging health and safety legislation it is becoming increasingly more detailed requiring specialist interpretation and so impossible for small businesses to implement without significant expenditure. Consequently, it is often ignored. The Dangerous Substances and Explosive Atmospheres Regulations provide one such example where specialist input is required. UK legislation to implement the Physical Agents Directives will provide others. It is, quite frankly, astonishing that anyone involved in producing such legislation can do so with the expectation that it will be substantially implemented. And if it is not, what purpose does the legislation serve other than occupying the time of HSC/HSE and Parliament?

9.2 If legislation is to be effective for small businesses, it must be prescriptive rather than generic; and if it is to be prescriptive then it requires an understanding of what is happening at the coal face and how a small business can implement its requirements without having to employ consultants. That understanding must be there before the legislation is framed and will require, in the Retail Motor Industry Federation's view, a marked change in the way HSC/HSE works.

9.3 Prevention through site visits to small and micro-businesses by experienced inspectors with the power of enforcement is in the Federation's experience the way to instil a safety culture. Taking enforcement action is most often like closing the stable door after the horse has bolted. Until the HSC/HSE has reorganised to use its existing resources more appropriately to achieve these ends it is pointless to increase its resources.

Retail Motor Industry Federation

13 February 2004

Annex I

Retail Motor Industry Federation

RESPONSE TO THE HEALTH AND SAFETY COMMISSION'S REPORT—A STRATEGY FOR WORKPLACE HEALTH AND SAFETY IN GREAT BRITAIN TO 2010 AND BEYOND

INTRODUCTION

The Retail Motor Industry Federation (RMI) represents the interests of retail businesses within the automotive industry, one of the largest industrial sectors in the UK, employing 600,000 individuals. With 10,500 member companies spanning petrol retailers, bodyshops, small garages, medium-sized businesses and large motor dealership groups, the RMI is one of the UK's biggest trade bodies. Despite having the major motor dealership PLCs within membership the great majority of RMI members are small or micro-businesses.

Despite the RMI's size as a trade association, it recognises that as many as two-thirds of the businesses in the sector do not belong to a trade association. A recent joint HSE London/ HSL exercise relating to compliance with health and safety legislation by bodyshops, in the context of controls to limit workforce exposure to isocyanates, has served to underline this point. It demonstrated that those businesses within the sector which are not members of trade associations tend to operate to lower standards of health and safety. Indeed, some businesses are not accepted into membership of the RMI because they fail membership screening appraisals.

Against this background, the points we would wish to make which are of relevance to any HSC strategy are these:

1. The over-riding and all-consuming task of small and micro-businesses is staying in business and attending to the cash flow so that they can pay the workforce at the end of the week/month.

2. Against this all other issues are of lesser importance and that includes considerations of health and safety.

3. The mind-boggling mass of detail of health and safety legislation is not something that small and micro-businesses are likely to absorb even if it was thrust in front of them. It has been reported that some of the employers in small businesses have a reading age of 14. So they are going to read neither an Advisory Code of Practice nor the raw legislation itself.

4. The most common response that the RMI gets from hassled small business managers is, "Don't tell me what the law is! Tell me what I have to do!". If the HSC/E wishes to improve compliance then that is exactly what it has to do.

5. However, worthy HSC/E's objectives may be, any solution which involves bringing in outside expertise or consultants, as for asbestos surveys, or for the implementation of DSEAR or Physical Agents legislation will be, for most small and micro-businesses, an non-starter. So anything HSC/E proposes must be realistically achievable by the business itself. What is more, HSC/E should consider this an over-riding criteria when framing UK legislation and contributing to EU Directives

6. In a recent presentation to the CBI's Health and Safety Panel on the outline strategy, Justin McCracken, HSE's Deputy Director referred to HSE as now seeking 80% solutions. Our initial reaction was to applaud the fact that perhaps a sense of reality was now beginning to emerge within HSC/E, though, with compliance for many major requirements like COSHH at nearer 25%, in the majority of businesses, a 40% or 50% solution may be more realistic as a target.

7. Likewise, within the same presentation there was the recognition that HSC/E had to do more to target small businesses. A past attempt by HSE to reach out to small businesses through "working breakfasts" was laughable, given that they ended up preaching to the converted because the audience they really needed to attract would not attend because they cannot afford to be away from the business first thing in the morning (see point 1 above).

8. The difficulties of communicating with small and micro-businesses who are outside trade associations cannot be over-emphasised. Mail shots are not particularly helpful for the reasons given in points 1, 2 & 3. Even the more motivated trade association members do not necessarily absorb the important information being given to them in the trade journals, so to expect businesses outside the trade bodies to take note of what is in trade journals or local papers is not particularly realistic. Further, the idea that enforcement through heavy fines will send messages to businesses in a particular sector and permanently change the situation in that sector is not borne out in practice. It will change the behaviour of the business concerned but will not have other than a very local impact

9. As most HSE inspectors in Field Operations Divisions will tell you, the only way to get through to these small businesses is to find out where they operate and to pay them a visit. Or to mis-quote "inspection, inspection, inspection". This is a view with which the RMI entirely concurs.

THE STRATEGY ITSELF

General

We read the Strategy Document with a considerable measure of dismay and a large measure of cynicism. Even taking into account the false optimism of the Chairman's introductory letter, the reality of HSC/E's lack of achievement, and lack of direction (admitted on page 3 of the strategy document) cannot be disguised and forces itself through the inconsistencies in generic strategy verbiage.

The 7 Point Strategy

(Page 3 of the strategy document refers to five big strategic issues. It is by no means clear which of the seven points are the five big ones and which two are less important)

1. The strategy is about the health and safety system in Great Britain as a whole, not just HSC, HSE and LAs. HSE's role is to stimulate, orchestrate, audit, assure, and take appropriate action when things go wrong—reserving its involvement for that which only it can do.

Fine words but utterly meaningless in the context in defining the role of HSC/E.

2. HSE recognises that it must change. More of the same, even with increased efficiency, will not deal with health issues or the changing world of work. We need to strengthen our links to keeping people in, or getting them back to, work.

It is not surprising that HSE recognises that it must change. Since there is no longer an improvement in accident statistics and, in fact, an increase in fatalities in some areas, HSC/E's earlier strategy clearly did not work. It is pointless trying to hide behind high sounding phrases like "the changing world of work" as a reason for change of strategy. Since the last strategy very little has changed in the nature of work which is of major significance. The same accidents still happen in the same industries for the same reasons. The profile of accidents is still the broadly the same. Slips, trips and falls, moving goods and vehicles about workshops,

manual handling etc, etc. Likewise, the health effects associated with specific industries or occupations have not changed. The percentages only change significantly when HSE changes the classifications, some cynics may say, to make comparisons more difficult.

What is meant by "We need to strengthen our links to keeping people in or getting them back to work." Surely, the way to keep people in work is to reduce accidents and ill health. So what has changed? Why is it that the reader gets the impression that someone in the Department for Work and Pensions has had the bright idea that HSC/E should be diverted from its established tasks to try and reduce pay-outs.

3. Communications and reputation management will be major interventions in their own right and crucial in making the case that health and safety is an enabler, not a hindrance.

It is by no means clear what "reputation management" means and the text does not enlighten us! HSE can only protect and enhance its reputation if it is successful in reducing work-related accidents and ill health still further. If improvement has ceased then the key question is "Why"? What was HSC/E not doing that it ought to have been doing. We believe that communication ought to be the major intervention from the HSC/E with the ever present threat of enforcement if properly targeted and realistically framed communication falls on stony ground. HSC/E may well have created one of the biggest information-providing machines in Government, but it has only been effective in communicating with the converted. As considered earlier, it has failed to find ways of communicating with the majority of small to micro-businesses.

4. We need new methods to help firms, large and small. HSE will move away from the automatic presumption of producing general written guidance towards specific, targeted support and advice directed to the areas of greatest need. Because stakeholders tell us we need to separate enforcement from support and advice to be effective, much of this will beproduced or distributed by others rather than by HSE.

The major gap in HSC/E's proficiencies is the ability to contact small to micro-businesses. It is in this area that specific targeted support should be aimed. Increasingly, Advisory Codes of Practice are suitable only for health and safety professionals and in some cases are stretching even these people. They will do nothing for small businesses and have a negative impact on micro-businesses where the greatest need exists. A good example of this incoherence is the DSEAR general ACoP which in turn referred to two British Standards at £113 each. For such reasons, we welcome the recognition that targeted and sector specific advice is needed. In our own sector such documents are produced with the co-operation of the Motor Vehicle Repair Forum.

After producing such advice it has to be communicated across the sectors. The internet should play a major role here, and we make the plea that all HSC/E publications be downloadable from the internet, without exception.

It is not our view that support and enforcement should be separated. When HSE inspectors deal with individual businesses through site visits, it is the threat of enforcement which gains the attention and the time of management. The latter is the over-riding objective. So clearly, the Federation does not accept the stated hypothesis and would suspect that there are not many seasoned HSE inspectors who would agree either.

5. This is a strategy about hard choices and priorities. We have finite resources. HSE, working with LAs, will develop a new interventions strategy. We will give priority to those activities that only the enforcing authorities can carry out and will ensure that appropriate action is taken when things go wrong. Where the proper management of risks can be assured, we will not intervene.

Quite apart from sounding like the Prime Minister, (which will alienate some readers from the start) and stating the glaringly obvious, this element of the strategy tell us nothing about how HSC/E is going to capture the undivided attention of small and micro-businesses. Might we expect to see a two tier HSE with fewer trouble-shooting inspectors for enforcement, but many more HSE "communicators" that move from business to business handing out sector targeted pamphlets and giving advice, or alternatively will LAs provide the communication and HSE staff the enforcement? The key question is "Who is going to do the groundwork?"

Whatever the outcome there is the sneaking suspicion from the strategy document that HSC/E is seeking to distance itself from the more difficult tasks of finding and communicating with small businesses, because its resources are being mopped up by the plethora of EU Directives adding ever more detail to the already excessive existing regulations. Since HSC/E has spectacularly failed to ensure implementation of the existing regulations there seems to be little point in producing new ones. As an exercise to illustrate this point HSC may care to extract in simple terms, not H&S jargon, from every current piece of UK health and safety legislation the prescriptive requirements that would be appropriate for a six-man business. Examine how many pages of documents are involved and then discuss whether one can expect a micro-business to understand and implement the requirements while still staying in business.

The reality is that most HSE inspectors and even more local authority officers only touch on the basics relevant to ten or fewer pieces of legislation during a site visit to a small business

Prescriptive advice stated in the simplest of terms is essential for small and micro-businesses with no access to health and safety professionals.

6. We wish to see the development of occupational health and safety advice and support outside HSE with national coverage that is active in preventing ill-health, promoting rehabilitation, and getting people back to work more quickly.

How is this statement consistent and supportive of HSC/E's stated mission "For HSC/E, working with LAs, to protect people's health and safety by ensuring that risks in the changing workplace are properly controlled"?

This strategy element is after the event whereas the mission's thrust is before the event. Where does it fit within the five big strategic issues? How is such advice to be given national coverage and who is going to pay for it?

7. We will not back away, where necessary, from redesigning health and safety institutions and their respective roles to achieve any of the above.

Clearly, HSC/E must change its internal structure and the key question in our minds is whether the separation of Commission and Executive is worthwhile. Does it waste internally two much of the resources of HSC/E, resources which could be better used to achieve the common objectives? However, before any change of structure is contemplated the must be clarity as to how the new structure would achieve improved performance regarding both accident prevention and occupational health of the workforce.

Feedback Questions

Q1 *This strategy covers a number of years. For the issues we have identified, what do you think should be the priorities for action and why?*

(a) Develop better systems for communicating with small and micro-businesses. This is where HSC/E is not performing and it is the major area in which accidents and occupational ill health will occur.

(b) Until current legislation is effectively communicated and enforced resist the temptation to propose any new legislation either within the UK or EU. If there is legislation on the statute books which HSE and LAs are not prepared to enforce scrap it. It is a complete waste of tax payers' money, and Government time to develop, draft and support legislation which is not being effectively communicated and enforced.

(c) Ensure that there is consistency between vision (not pipe dreams), aims and strategy and that all three are realistic.

d) Get HSE staff out into the field where the accidents and ill health are occurring not stuck in front of computer screens writing reports.

Q2 *We have assembled available evidence on health and safety interventions (eg inspection, enforcement, advice and campaigns) and will be looking for more. Please use the space below to tell us about any evidence you have about the effectiveness of health and safety interventions—positive or negative.*

It has been the consistent experience of the Federation over many years in dealing with specific health and safety enquiries from its members that a critical visit from an HSE inspector motivates and encourages business management to take steps to raise the status of health and safety within their organisation. That motivation stems from the field inspector's specific knowledge about what should be done (and most are pragmatic in this respect) and the associated powers of the inspector to take enforcement action if necessary. Separating the roles of educator/communicator/adviser from that of enforcer would, in our view, be counterproductive. Campaigns do have some impact, but this is limited and can never be as effective as site visits by inspectors.

There is, however, a limit to the number of specific pieces of legislation which the inspector can cover in a visit. Further, there is a limit to the number of necessary actions a small business will register and implement. That is why prioritisation of legislation and of accident and ill health messages must be practised.

Most businesses are not adverse to accepting responsibility for the health and safety of their employees and for promoting safe working practices. But this is not a one-sided activity. It requires responsibility on the part of legislators and enforcers also not to seek what it is unreasonable to expect in the context of the business and the sector. If the State makes demands which it cannot reasonably justify on the basis of cost to the business then it should not be surprised if those demands are ignored. Too often, and with the Physical Agents Directives in mind, gold plating and 100 % solutions are sought but practically cannot be enforced.

Q3 *To do more of some things we need to do less of others. What three things do you think HSE should stop doing and why?*

(i) Stop running an incestuous organisation which is out of touch with the major employers in the country ı small and micro businesses. Unless specifically targeted like rail and off-shore exploration/production etc., H & S legislation and HSC/E should be geared to the understanding and capabilities of small businesses not to major PLCs. Costed prescription of proved effectiveness is far more likely to be adopted by small and micro-businesses. Major PLCs can afford the specialist advice, micro-business cannot.

(ii) Stop writing generic Advisory Codes of Practice which require specialist interpretation and start writing, with the key sectors concerned involved from the outset, simple leaflets telling small and micro-businesses what they need to do in specific terms and why.

(iii) Stop. . .and think! Carry out detailed surveys on actual implementation of the action points on specific pieces of legislation current and future talking not to trade associations as much as to the representative businesses affected. That is, market surveys before legislation is framed, not just the CDs approach where your minds are mostly made up anyway and little if anything is changed by the consultation process.

FINALLY

The strategy document admits that there is no coherent direction to the overall health and safety system, yet the Chairman suggests in his first sentence that "This strategy builds on success." Such inconsistencies are present throughout the strategy document and this does not inspire confidence in either the validity of the five or seven strategies themselves or the outcome of any developments from such strategic thinking. HSC/E is not going to improve its performance by wasting its energies internally or continuing to preach to the converted. The latter is too easy an option, a waste of resources and should be resisted. That HSE is recognising the need for change is a huge step forward which we hope will continue.

Peter L Barlow BSc(Hons), CChem, FRSC, FEI
Retail Motor Industry Federation

13 February 2004

Memorandum submitted by the Construction Confederation (HS 31)

INTRODUCTION

1. The Construction Confederation represents some 5,000 companies who comprise approximately 75% of the contracting industry and provide 8% of the UK's Gross Domestic Product. We represent a range of employers from major contractors, some of which are international companies, to small and medium sized employers.

Members of the Construction Confederation are:

The Major Contractors Group (MCG)

National Contractors Federation (NCF)

Civil Engineering Contractors Association (CECA)

National Federation of Builders (NFB)

Scottish Building

British Woodworking Federation (BWF).

2. Construction is a major industry in the United Kingdom. We support around 1.5 million jobs. Our record on health and safety is not as good as we would wish. Over the past three years members of the Construction Confederation have embarked upon a major programme of culture change within the industry to improve performance. Our targets are:

- To reduce the incidence rate of fatal and major injuries by 10% year on year;
- To aim to reduce the incidence rate of work-related ill health by 10% year on year; and
- To aim to reduce the number of days absent from work due to work-related injury and ill health by 10% year on year.

Investment in Health and Safety by the Construction Industry

3. The main plank of the industry's drive towards a safer and healthier work environment is an initiative to ensure that all workers are properly qualified to carry out the work they are assigned. By 2010 all workers in the industry will need to carry a CSCS (Construction Skills Certification Scheme) card showing that they are adequately qualified and have passed an appropriate health and safety test.

4. Leadership for this initiative has come from the MCG. Its (15) members will not use sub-contractors on their sites unless they have a fully qualified workforce or are taking clear steps to qualify their workforce. It is MCG's aim to have 100% qualified workers on its sites as soon as possible—the current figure is 66%. The National Contractors Federation has adopted an identical strategy and CECA has adopted a similar strategy and is on target to achieve a fully qualified workforce by 2007, with the remaining Confederation members achieving this by 2010.

5. These steps have already seen a major culture change—over 600,000 CSCS cards have now been issued 1 this covers over a third of the industry's workforce.

6. In addition to this initiative members are following a number of other programmes aimed at reducing health and safety risks. On safety these include:

- Induction procedures to ensure that workers do not go onto a site until they are familiar with its hazards;
- Consultation with the workforce to identify and eliminate hazards;
- Circulation of best practice advice and toolkits;
- An accredited membership scheme—for small and medium sized builders—requiring members to meet CHAS (the Contractor Health and Safety Assessment Scheme) standards; and
- Production of model health and safety policies.

7. On health, the MCG is pioneering an occupational health strategy. It will help reduce the incidence of known occupation diseases (eg Hand-arm Vibration Syndrome, and dermatitis) and measure days off work through sickness. As the scheme develops, there will also be an emphasis on improving rehabilitation of sick or injured employees. The Confederation is also working with the HSE to develop an occupational scheme for small and medium sized construction companies. This is likely to be piloted later this year.

HSE's Performance

8. The Construction Confederation enjoys a constructive and much valued relationship with the HSE. The establishment of a dedicated construction directorate in April 2002 has increased its ability to focus on construction issues. For example, HSE has been able to turn its attention to raising the profile of health issues, engaging designers in health and safety issues and tackling back problems especially caused by manual handling of kerbs. It should also help improve the consistency of HSE's enforcement of legislation. We have worked closely with both officials and Ministers in developing our work programmes to improve construction health and safety and are particularly grateful for their efforts in trying to get the occupational health scheme off the ground. HSE's Construction Division have been willing and constructive supporters of Confederation initiatives, particularly on health issues. HSE staff have been regular attendees at MCG Occupational Health Working Group meetings, and have thrown their weight behind projects on hand-arm vibration and manual handling. The Confederation has participated in a range of projects with HSE, and it is clear that the Construction Division is committed to greater partnership on a policy level. Even so, there are a number of areas where we believe that HSE's performance, and that of wider government, could be improved. These are set out below.

The Legislative Framework

9. Health and safety in construction is largely governed by the Construction (Design and Management) Regulations (CDM). Amongst contractors, there is widespread disenchantment on the effectiveness of these regulations because:

- Clients can easily avoid their responsibilities by appointing a Planning Supervisor and Planning Supervisors are seen to be ineffective in driving better health and safety conditions;
- There is a lack of understanding of CDM amongst the design community. This was starkly illustrated in HSE's own research in 2003 which showed that only 37% of designers were able to identify more than three hazards found on construction sites and only 24% could show an actual example of risk removal at source in design work they had done/were doing;
- Competency requirements that have led to a profusion of bureaucratic pre-qualification schemes. All of these have added to cost without driving up health and safety standards. The Department of Trade and Industry's (DTI's) attempts to establish a one-stop shop pre-qualification system known as "Constructionline" have not been as successful as hoped;

— The prosecution record over the past 10 years has been overwhelmingly biased against contractors, with virtually no clients or designers being brought to court. In addition, HSE rarely follows an audit trail beyond the contractor to the designer for enforcement, despite the fact that HSE's own research shows that up to 47% of accidents could be prevented by designers; and

— Increasingly driven in part by a lack of resource to draft industry guidance, HSE has been unable to provide sufficient prescription in regulations and guidance. HSE have failed to deliver on a commitment made in 1998 to produce sector specific guidance on the Lifting Equipment and Lifting Operations Regulations. Also of concern has been the failure to replace HSE Guidance on demolition (GS28), which has been "under draft" since 1997. All those working in construction, particularly SMEs, believe there is a need for prescriptive standards in particular areas of work 1 eg work at height, mobile plant, excavations and demolition. HSE has recently suggested ("A Strategy for Workplace Health and Safety in Great Britain to 2010 and beyond") that some of this work might be contracted out to third parties. We think this would be misguided. We are worried that this will divorce the regulators from a genuine understanding of those with whom they are dealing. It also raises the possibility that the link between the advice given and enforcement practice will be broken. We cannot be certain that the third party advice and information agencies will necessarily provide all the information needed to reflect enforcement practice.

10. HSE accept some of these shortcomings and is currently working with the industry to address concerns. The outcome of this exercise needs to be revised regulations that have a practical emphasis, are enforceable for all duty holders, and extend ownership of health and safety beyond the contractor community.

Achieving Outcomes

11. The construction industry's health and safety record speaks for itself. In 2002–03, 71 workers were killed on UK construction sites, and it is estimated that the annual cost of occupational ill health to construction is in the region of £760 million. Clearly more needs to be done but we do not think the answer is necessarily increased regulation.

12. We believe that a shift in priorities and resources would achieve a better outcome. For example, we believe that a good deal of time and energy has been wasted on trying to meet the public desire for corporate manslaughter convictions when it is clear that sufficient evidence rarely exists to secure convictions. It has also been counterproductive because company directors are increasingly reluctant to take on health and safety duties. In a similar vein, HSE has spent far too much time seeking to promote trade union-backed roving health and safety representatives rather than accept that in an industry which is largely non-unionised (with less than 20% members of unions) there are other means of consulting and involving the workforce.

13. Instead, we would like to see the following issues addressed:

— *Increased resources*: Whilst the establishment of the dedicated directorate has been helpful, HSE still only has sufficient resource to be largely reactive after the event rather than proactive in stopping accidents happening. If HSE had another 50 construction inspectors they would be able to devote more time to visit construction sites where there is most risk of accidents happening and help put measures into place to prevent them and to visit more designers and suppliers. Where pro-active visits are taking place, HSE tends to target the sites of major contractors, which are easily identifiable and less resource-intensive to visit. However, their site safety records are well above the industry norms. The spotlight needs to be at the other end of the spectrum—often the one-man band self-employed builder. We have recently made this point to the Chief Secretary to the Treasury in the context of the current spending round. As you will see from the correspondence at Appendix 1 this has fallen on deaf ears. At the time of writing we have still been unable to meet with Treasury officials to pursue the matter further;

— *Data gathering and intelligence*: HSE collects a significant amount of information on accidents through the 1995 Reporting of injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR). Even so, the amount of data published on the causes of accidents is comparatively sparse. Moreover, there is almost a complete lack of any meaningful data relating to the incidence of occupational ill health in construction. We have pressed successive Ministers on the issue. All have been sympathetic but no real progress has been made in improving the data available;

— *HSE guidance*: HSE's role is not just about enforcement. It is also about enabling committed companies to tackle health and safety issues, encouraging those companies who are concerned about them but struggling to tackle the issue and enlightening those that are confused. HSE needs to make its published guidance notes as freely available as possible. We have recently been threatened with legal action because HSE allege that, through repeating some text from one of their guidance notices, we have breached their copyright. This is particularly galling given that we were involved in the drafting of the original guidance note. We believe there should be unrestricted access to HSE guidance. It should review its policy on charging for information. We believe all web-based information should be free—including HSE Direct; and

— *Working with industry practitioners*: We are concerned that HSE is reducing the scale of its consultation activities with the industry. Following very limited consultation last year, HSE decided to reduce the size of the Construction Industry Advisory Committee (CONIAC) the official forum through which HSE consults the industry. However, we do not believe that the newly constituted body has enough construction representatives on it to provide the in depth advice that HSE needs. Construction covers a very wide spectrum of different and complex disciplines and it is important that they are all taken into account. The previous arrangements worked well and we would like to see them maintained. Similarly, woodworking and joinery previously had its own national interest group within HSE (WOODNIG), which encouraged liaison between the industry and the inspectors. This was abolished last year and absorbed into the general manufacturing directorate. We have been concerned that the long-term effect of this is that HSE will lose the specific expertise and understanding of the sector.

THE GOVERNMENT'S WIDER ROLE

14. There are two areas where the Government could be doing more to improve health and safety in construction:

— There is a huge black economy in construction. Its value is thought to be around £4.5 billion (around 6% of construction output). Firms working in this sector do not pay tax, flout health and safety regulations and produce sub-standard work. They also drive out *bona fide* traders, especially from the home improvement market, because they cannot compete. We have campaigned, to no avail, for some years for the Treasury to take a serious interest in this problem and introduce measures to reduce it. We have suggested that VAT is reduced on domestic repair and maintenance to 5% so that illegal traders lose their competitive advantage. We have also suggested that a better resourced HSE would be more able to take action against those firms ignoring health and safety regulations; and

— The public sector is a huge consumer of construction. The current massive spending on schools, hospitals and general infrastructure means that over 40% of construction is in the public sector. As clients, government departments and local authorities could play a powerful role in changing attitudes to health and safety. Yet it has taken over two years to get the Office of Government Commerce to issue guidance (which is not mandatory) to Government departments advising that they take into account a company's health and safety record before awarding contracts. Despite pressure on the Office of the Deputy Prime Minister no such guidance currently exists for local authorities.

CONCLUSION

15. Whilst the Confederation has found a real commitment to partnership in HSE's Construction Division, we retain some real reservations about deployment of resource on the frontline. We believe that HSE will struggle to deliver on the Health and Safety Commission's current strategy given budgetary and structural constraints. HSE has an invaluable role to play in improving health and safety in our industry, both as an authoritative broker in the formulation of best practice, and in the effective enforcement of regulation. Health and safety law, and the guidance that goes with it, must be easily understood by those for whom it is intended, and enforced vigorously for all those who flout it, not just those that are easiest to catch.

The Construction Confederation

13 February 2004

Memorandum submitted by the Rail Safety and Standards Board

The Rail Safety and Standards Board (RSSB) was established in April 2003, implementing one of the core sets of recommendations from the second part of Lord Cullen's public inquiry into the Ladbroke Grove accident. The Company's primary objective is to lead and facilitate the railway industry's work to achieve continuous improvement in the health and safety performance of the railways in Great Britain, and thus to facilitate the reduction of risk to passengers, employees and the affected public. The company therefore works closely with the HSE, the industry's safety regulator.

1. We see this inquiry as being particularly timely in view of the Government's current review of railway organisation and the speculation that Her Majesty's Railway Inspectorate (HMRI) may be moved away from the jurisdiction of the HSE. In addition, the HSE is currently undertaking a fundamental review of railway safety regulations. We have submitted a comprehensive response to the HSE's discussion document, issued as the first part of the review process, and the views we express here have already been submitted to

the HSE as part of that response. However, in making our views known, we were aware that some of the issues lie beyond the HSE's remit. This is why we see it as appropriate to bring these views to the attention of your committee.

2. We have questioned whether the Health and Safety at Work etc Act 1974 (HASAW) is appropriate to the particular circumstances of the railway industry. HASAW assumes a simple organisational model, but the 1993 Railways Act fragmented the industry in a way that could not have been foreseen at the time when HASAW was drafted, creating a situation where interface responsibility is shared between duty holders. We believe the industry needs a legislative framework that sets out explicitly where health and safety responsibilities lie; alternative approaches should be considered and evaluated independently of the HSE. If HASAW were found to be an inappropriate model for the industry, then it follows naturally that railway system safety should not be regulated by the HSE, whose primary task is to enforce HASAW.

3. For the railways, in common with a number of other industries it classifies as "high hazard", the HSE operates a "permissioning regime". This means that operators must prepare a safety case which has to be accepted by the HSE before they can commence their business. However, the stance of the HSE has always been that they take no responsibility for the risk associated with the licensed activity. We see this as an untenable position; in fact, it is questionable what purpose a permissioning regime serves if the regulator takes no responsibility for its decisions. The current court case involving Thames Trains and the HSE in connection with the Ladbroke Grove accident may shed some light on this issue.

4. An even greater anomaly, which we firmly believe should be addressed, is the joint HSE role of regulator and prosecutor. This potentially leads to a conflict of interest particularly where the HSE operates a permissioning regime, and could be held accountable for safety failures in areas which it has licensed. We believe that a model where the HSE is not the prosecuting authority should be considered.

5. We also have concerns, in relation to the regulation of the railways, about the undue weight the HSE seems to have given to societal concerns. The HSE has stated on many occasions that it believes that there is widespread public concern about safety on the railways, although, notwithstanding the tragedy of death and injury arising from train accidents, research undertaken by RSSB indicates that this is not the case. In fact, the HSE all too often appears to equate societal concern with media concern, particularly in the aftermath of major accidents. This is not only potentially commercially damaging to the railway industry, *vis-à-vis* other, less safe, modes, but can also affect safety decision-making, to the overall detriment of safety on the railways. We accept that societal concern is a factor that needs to be taken into consideration, but it should always be in the context of an objective assessment of risk. The current approach means that limited resources may be diverted into areas where they will be less effective.

13 February 2004

Memorandum submitted by Police Federation of England and Wales

The Police Federation of England and Wales is a staff association set up by statute charged with the representing of the welfare and efficiency of police officers up to and including the rank of chief inspector. We currently represent over 130,000 police officers.

SUMMARY

— Police Service Revitalising Strategy not followed.

— Diverted from full role. Enforcement low and inconsistent.

— Need more pro-activity with easier and free access to publications on the internet.

— Police Federation support in general the role and functions of HSC/HSE having regard to their limited resources.

— Penalties not fully used.

— Deliberate misunderstanding of the legislation.

— Enhanced role / use of safety representatives.

— Health not to the detriment of safety.

— Extra resources needed.

— HSC to exert greater control.

1. *Revitalising Strategy*

1.1 Shortly after the publication of the Revitalising Strategy our organisation and members of the Health and Safety Executive (HSE) attempted to get the police service to set targets. The employers represented by the Association of Chief Police Officers (ACPO) were unable if not unwilling to set such targets. The Home Office have also failed to pursue the issue of setting targets despite frequent attempts to raise the issue by ourselves and HSE. Therefore the police service has made no attempt to meet the targets set in the strategy, or indeed any part of it.

2. *Balance between Prevention and Enforcement*

2.1 Health and safety legislation has only applied to police officers since 1998. In the initial years of application the HSE achieved a satisfactory balance with emphasis on prevention. However, in general since 2001, and particularly since the prosecution involving the Metropolitan Police this has regrettably not been the case. The HSE are now reluctant to become involved with the police service having received unjust public criticism of their actions in bringing the prosecution. As a result they are described as an organisation without any knowledge of the police service and therefore unable to fulfil their role. This is not the case, even with their limited resources they have a vital role in delivering a safer and healthier police, service, achieving reduced sickness absence and increasing the number of officers available to deliver the frontline service to the public. The HSE must not be permitted to be diverted from their tasks by senior police management and return to the requirements placed upon by the HSC/HSE enforcement policy.

2.2 The current emphasis on prevention needs to be supplemented by enforcement in appropriate cases in order to indicate that compliance with the requirements of the legislation is not voluntary. When this is achieved the balance can again be reviewed. In fact if the police service attempt to comply with basic health and safety legislation, enforcement may not even be necessary. This situation, for different reasons is undoubtedly replicated throughout all sectors of employment.

3. *Pro-activity*

3.1 The Police Federation of England and Wales believe that the HSC and HSE perform their roles efficiently and professionally considering the limited resources they have available to carry out their functions. The lack of resources makes pro-activity very difficult despite it being the best form of prevention and cure.

3.2 We support the HSC priority programme but would suggest that it is reviewed frequently to ensure that it is addressing the correct areas and sectors of concern and that the priority areas are not based on perceived level of hazards and risk.

3.3 One area where the pro-activity of the HSC and HSE has been evident is in the publication of advice and guidance literature and educational products. It is important that this work continues. All sides have a high regard for the publications issued by these organisations whose guidance is immediately accepted as authoritative.

3.4 Communication can be seen as a part of a proactive strategy, and as such we are concerned that the guidance issued by HSC and HSE often has a substantial cost implication, which has a disproportionate financial impact on employees. There is a need for this review to consider making much of this information available on the internet.

4. *Penalties*

4.1 The levels of penalties currently allowed by legislation are sufficient; their use by Courts is not.

5. *Understanding*

5.1 The health and safety legislation is fairly simple to understand and comply with. The understanding is assisted by Approved Codes of Practice and other authoritative guidance. Understanding of the principles is only a problem for those employers who do not wish to follow them or believe themselves to be above the law.

5.2 In our specific role there is critisism to be levelled at the HSE for the lack of vigour with which they attempt to address the reluctance of chief police officers to attempt to understand the basic principles of health and safety legislation.

5.3 We have concerns about the apparent enthusiasm of the HSE in assisting the employer to achieve their aim of avoiding prosecution, if necessary at the expense of good health and safety management. The HSE should ensure that clear understanding of their independence is evident to all parts of the tripartite structure which has until now proved effective in progressing health safety and welfare standards in this country.

6. *Encourage Good Practice*

6.1 Good practice will only be achieved if there is an effective and well resourced enforcement regime proactively supporting circulation of good practice.

6.2 The Police Federation would like to see the HSC/HSE make far greater use of safety representatives when going about their functions. There is a continual need to remind employers about the benefits to be achieved from utilising the skills of trained safety representatives.

6.3 There is also a need for the HSE to enforce the Safety Representatives and Safety Committee regulations more proactively, with particular emphasis on the requirements on employers to consult.

6.4 There is a need for the HSC to review and enhance the legislation relating to staff association and trade union appointed safety representatives. This review to include the issue of specific detailed approved codes of practice for these individuals to operate under.

7. *Emphasis on Health*

7.1 At the time of the enactment of the Health and Safety at Work Act in 1974 the main cause of work related sickness and injury was as a result of safety breaches. Over the years the effect of work related health problems have become more readily identifiable. Scientific evidence now supports the adverse affect on health of such issues as long hours and exposure to psychological hazards. We would support an increase in activity relating to health issues but it is important that this is not done at the expense of dealing with safety related matters.

7.2 Whilst we fully support the rehabilitation process it must always be remembered that when dealing with work related matters rehabilitation must by its nature always follow the failure of the safety and health regime of an organisation. The cost effective approach is to deal with health and safety matters prior to the cause of rehabilitation.

8. *Resources*

8.1 The freezing of the HSE budget for the period 2003–06 is a major concern; it shows a lack of understanding about the economic, moral and social benefits to be gained from investment in good health and safety practice. It is an accepted fact that good health and safety culture starts at the top, It is therefore incumbent on the government to set the standard of this culture by investing in the resources of the HSE and HSC. This investment will be recouped several times over in reductions in compensation and benefits to people made sick or injured as a result of their work.

9. *Coordination*

9.1 We do not consider any major changes are necessary in this area but do believe that the coordination and cooperation could be enhanced and better directed if the HSC were to take greater control in directing the work activities of the other agencies.

Clint Elliott
Police Federation of England and Wales

13 February 2004

Memorandum submitted by The Heating And Ventilating Contractors' Association

0.1 The Heating and Ventilating Contractors' Association (HVCA) is a trade Association which represents businesses which operate in the building engineering services sector of the construction industry.

0.2 The HVCA represents the interests of businesses active in the design, installation, commissioning and maintenance of heating, ventilating, air conditioning and refrigeration(hvacr) products and equipment. HVCA membership comprises some 1,400 companies with 2,000 offices located throughout the UK, having a combined turnover of £3 billion and a 50,000-plus workforce.

0.3 It is estimated that HVCA members are responsible for the installation and maintenance of some 80% of the country's industrial and commercial hvacr systems.
The Association is pleased to be able to have the opportunity to make a submission to the Select Committee on this subject and would be happy to appear in person should the Committee feel this would be beneficial.

1. *The HSE "Fundamental Review of Gas Safety"*

1.1 In 1999, the HSC published a discussion document asking for views on the regulatory regime as it applied to gas.

It is understood that there was a good response to the document, and from the feedback the HSC published a "proposals for change" document making 47 recommendations for change.

The recommendations were accepted by the then Minister (DTLR) and HSE were asked to implement.

To date, very few of the recommendations have been implemented. The timescale for the introduction of new legislation has been put back on several occasions.

At the current rate of progress the next fundamental review will be initiated before the recommendations of the existing review have been implemented.

It has been suggested that the reasons for the HSE's difficulties relate to a lack of management resources. However, the Association is not convinced that this is the case and believes that the HSE has simply "lost interest" in implementing the review recommendations

2. *HSE and its Role in Regulating CORGI*

2.1 In 1990, the HSE oversaw the formation of a statutory registration scheme for gas installation businesses. It was also instrumental, with the support of industry, in the formation of The Council for Registered Gas Installers (CORGI).

CORGI was initially managed by the CORGI Council, a body made up of interested organisations. However, following a review of its operation, the management of CORGI was taken away from the CORGI Council by the HSE and given to a board of management appointed by the HSE.

Since this change, the HVCA has seen CORGI become uncommunicative, unresponsive and dictatorial in its operations. It no longer has the Association's support or that of a number of other gas industry bodies.

The way that it has recently introduced new entry requirements for trainees wishing to take competency testing , in such a way that Plumbing trainees can no longer gain their NVQs is a case in point.

The HSE, who created the body and oversee its operations, seem unwilling or unable to bring about the change it recognises is needed to re-introduce the transparency and accountability that much of the industry believes is essential.

It has been suggested that the reasons for the HSE's difficulties with CORGI relate to a lack of management resources. However, the Association is not convinced that this is the case and believe the HSE simply does not have the desire to make the necessary changes.

With regard to the specific issues identified in your Press Notice, we would comment as follows:

3. *The Legislative Framework: To What Extent has the Health and Safety at Work Act 1974 and Subsequent Legislation at National and European Levels Been Successful in Improving Standards of Health and Safety?*

3.1 The Health and Safety at Work Act 1974 and the other national and European legislation which are in place provide an effective framework for regulating health and safety in the UK. From our contacts with other similar trade bodies in the EU and worldwide it is clear that the British framework is held in very high esteem.

3.2 However, in terms of the factors that affect the hvacr sector, the lack of HSE monitoring and enforcement activity allows less responsible firms to operate with poor safety management processes in place in an environment where there is very little likelihood of getting caught.

The responsible businesses in the sector who are complying fully with the legislation, for example those who are members of our Association, find that this lack of a level playing field regarding health and safety compliance extremely worrying. They are concerned that it is damaging the general perception of the industry and but also affecting their ability to compete in the marketplace.

3.3 We do recognise that the HSE's strategies and programmes are the best that could be achieved with the very limited resources it has available.

However, a properly resourced HSE would be able to carry out the greater degree of monitoring and enforcement which would we believe is necessary in order to accelerate the rate of change.

3.4 We believe that in addition to trying to convince industry of the business case for good health and safety management, a significant part of the HSE's role is to enforce the legislation which it has put in place.

ACHIEVING OUTCOMES:

4.0 *Is Britain on Course to Meet the Targets set out in the Revitalising Health And Safety Strategy?*

4.1 We believe that the UK is on course to meet most, if not all of the very challenging targets put in place by the Government and HSE in the Revitalising Health and Safety policy document.

The hard work and endeavour by the hvacr sector of the construction industry to improve it's health and safety performance has been impressive.

However, it is disappointing to note that while there has been a step change in terms of health and safety within the responsible side of the sector, is hard to quantify how much work has been carried out by those who do not belong to a trade association or who operate on the fringes.

Members still report of contractors whose working procedures are extremely slipshod and leave much to be desired.

5. *Does the HSE get the Balance Right Between Prevention and Enforcement?*

5.1 We do not believe that the HSE has established the right priorities to bring about improvements in the sector. We believe that in addition to trying to convince industry of the business case for good health and safety management, a significant part of the HSE's role is to monitor work activities and enforce the legislation which is in place. There are many businesses who are not impressed by the rhetoric and still do not see the commercial value of adopting good sound health and safety practices. Such businesses seem only prepared to respond to routine monitoring and enforcement action.

6. *Is it Sufficiently Proactive to Address Developing Hazards at Work Such as Stress and Passive Smoking?*

The HSE has been very successful in identifying the developing emerging hazards at work such as stress, passive smoking and driving at work. However, dealing with the proactive aspects of health and safety is merely one facet of the Executive's activity and should not be further developed at the expense of what the Association sees as being one of its core activities ie monitoring and enforcement.

7.0 Are Penalties for Health and Safety Offences set at an Appropriate Level?

7.1 The penalties for health and safety breaches for medium and larger size businesses seem appropriate. However, the fines meted out in magistrates courts to smaller companies do not seem to be very severe. This may be due to the Government's tariff structure but the message it sends to industry is that the little companies "get off" relatively lightly.

It also seems that the HSE have a policy of taking enforcement action against larger companies. This seems to be based on the view that the publicity gained from one large company prosecution is more beneficial than prosecuting a number of small companies.

Many medium and large businesses have reached a point where they feel they are being "picked on".

8. *To What Extent is Health and Safety Legislation Properly Understood?*

8.1 The very nature of health and safety legislation in this country, which is formulated on the basis of the "goal setting" approach does present difficulties for business and industry.

The goal setting approach means that a further tier of statutory guidance and advice is contained in Approved Codes of Practice (ACOP) and even these often do not prescribe what must be achieved.

When asked to clarify, the HSE usually refuse to give further guidance and say that it would be for a court to decide how the laws, ACOP and guidance should be interpreted.

8.2 Terms such as "adequate" "reasonable" and "suitable and sufficient" leave business in the unenviable position of trying to set in place a standard which they hope will satisfy a court should the subject be tested.

In order to ensure compliance, the business takes the "belt and braces view" and puts in place procedures and paperwork systems which are overly complex and restrictive, widening the gulf still further between those companies who want to be good, safe employers, and those who do just enough.

From a trade association viewpoint, because of the goalsetting nature of the legislation, and the lack of prescriptive guidance, any advice given by the trade association will inevitably not be based upon what is reasonable, but what will ensure compliance in the worst case.

9. *Does More Need to be Done to Encourage Good Practice?*

9.1 We believe that whilst the HSE have a role in helping industry to develop good practice, this is not one of their primary roles. Guidance and what can be deemed good practice will develop much more effectively if there is clear and unambiguous law and sound support from the HSE when an industry guidance document is being promulgated.

10. *Is There Sufficient Emphasis on "Health" in Health and Safety?*

10.1 There is certainly less emphasis currently being placed on chronic ill health issues caused by work. The hvacr sector is likely to be one of those hit hard by the effects of Asbestos related illness as most workers will have come into contact with the substance at some point during their working lives and focussed support from the HSE on how employers should deal with the issue would be most welcome.

RESOURCES:

11. *Is the HSE Sufficiently Well-Resourced to Meet its Objectives?*

11.1 The Association believes that this is the primary issue. The HSE has suffered from a year on year decrease in funding in real terms and have clearly reviewed their activities on the basis of the finances available. The main casualty of this approach appears to have been a reduction in monitoring and enforcement with HSE taking backseat role.

Whilst the case for good, sound health and safety practices in business are clear to the converted, there are many businesses whose health and safety practices leave much to be desired.

Such businesses are able to work to lower standards and can tender at prices that good responsible companies cannot match.

We believe that the most effective way to affect the culture in such businesses is to have an effective enforcement regime.

12. *To What Extent is There Good Coordination Between HSE and Those Other Parts of Central and Local Government With a Role to Play in Promoting Health and Safety?*

12.1 We are not aware of any coordination between local authorities and the HSE.

The Heating and Ventilating Contractors' Association

13 February 2004

Memorandum submitted by the Parliamentary Advisory Council for Transport Safety

INTRODUCTION

1. The Parliamentary Advisory Council for Transport Safety welcomes this opportunity to contribute to the Work and Pensions Committee Inquiry into the work of the Health and Safety Commission and Health and Safety Executive. PACTS is a registered charity and associate Parliamentary group advising and informing MPs and Peers on air, rail and road safety issues. It brings together transport safety specialists from a range of backgrounds to promote research-based solutions to transport safety issues having regard to cost, effectiveness and achievability. Its charitable objective is: "To promote transport safety legislation to protect human life".

Is there sufficient emphasis on "health" in health and safety?

2. The Committee is correct to enquire whether the balance between health and safety is being met. PACTS shares with HSC its vision "to gain recognition of health and safety as a cornerstone of civilised society". PACTS is concerned, however, that any new emphasis on health should not be at the expense of safety. While it is true that "HSC, HSE and LAs have done a great job on safety"[i] in many areas, the focus on safety needs to be ongoing to continue this record in areas where it has succeeded and to improve areas where risk can be further reduced. Work-related road safety is one of these areas. While there were 226 fatalities to workers in 2002–3 (rightly labelled by HSC Chair Bill Callaghan "a failure of a basic human right—to have our health and safety protected"[ii]), there were also over 1,000 deaths in road collisions involving someone at work.[iii] These casualties have a catastrophic impact on those involved and for their families and workplaces. They also have a considerable economic cost: DfT estimate the value of preventing a fatal accident to be more than £1.4 million.[iv]

3. Within the emphasis on safety, it is of utmost importance that safety of driving at work should not be marginalised because it occurs on the road rather than in the workplace. For increasing numbers of workers, the road is the workplace. Modes of working have changed dramatically since the Health and Safety at Work Act was passed in 1974 and HSC is correct to identify "a changing economy in a changing world" as a key issue in its recent review of strategy. One aspect of this trend (labelled by sociologists as a "post-industrial society") is a move away from heavy industry and towards new forms of working (often based on services or information rather than manufacture) that require workers to be mobile. Driving at work is a key characteristic of this changing economy: 10.5 million people drive a licensed road vehicle for business

purposes,[v] and RoSPA estimated that 75% of male employees and 49% of female employees use a vehicle in the course of their work (excluding commuting).[vi] Journeys are also becoming longer: between 1985–86 and 1999–01 the length of business trips went up from 17.3 to 20.3 miles on average, and took 40 rather than 32 minutes.[vii] As trends continue, these figures may increase.

4. While driving at work is widespread, it is also a major area of risk. HSE research indicates 25% and 33% of all serious and fatal traffic incidents may involve someone who was at work at the time—this represents between 9,850 and 13,150 deaths and serious injuries every year.[viii] The levels of risk involved for higher-mileage drivers are comparable to some of the more dangerous industries, including construction, quarrying and coal mining,[ix] and in practice may approach the "intolerable" level identified in HSE"s publication *Reducing Risk, Protecting People*.[x] Drivers at work also present significantly more danger than other drivers: repeated TRL reports found that company car drivers and drivers with high proportions of work-related mileage have about 50% more injury accidents than "ordinary" drivers, when differences in demographic and exposure variables have been allowed for.[xi/xii]

Is Britain on course to meet the targets set out in the Revitalising Health and Safety Strategy?

5. The Revitalising Health and Safety Strategy specifically excludes transport safety (in part because it was set out while the Ladbroke Grove Inquiry was preparing to report). PACTS would urge the committee to remember that "Revitalising Health and Safety Strategy" is not the only set of targets that HSE's work covers. Specifically, *Tomorrow's Roads—Safer for Everyone, published in 2000 by DETR, sets targets to reduce the number of people killed and seriously injured in road collisions by 40% by 2010 and reduce the number of children killed or seriously injured by 50% by 2010, compared to the 1994–98 baseline.*[xiii] The document clearly envisages HSE and HSC playing an important role in the process of casualty reduction through workrelated road safety. Among other roles, the documents suggests that HSC "help dovetail road traffic law and its enforcement with health and safety at work law and its enforcement", in conjunction with other government agencies.

6. In this context, it is extremely worrying that work-related road safety appears to have been downgraded within HSE and HSC. The projected dovetailing of traffic enforcement and health and safety enforcement does not appear to have occurred. The recent HSC document on "A strategy for workplace health and safety to 2010 and beyond"[xiv] neglected to mention work-related road safety despite road casualties forming the greatest source of at-work fatalities. Most bizarrely, HSE"s recent 12-page leaflet on "Health and Safety in Road Haulage"[xv] contained no references to work-related road safety (focusing entirely on areas such as loading and unloading) and omitted to include HSE"s own guidance on work-related road safety in the "further reading" section.

To what extent is health and safety legislation properly understood? Does more need to be done to promote good practice? Does the HSE get the right balance between prevention and enforcement?

7. There is strong evidence to suggest that improved fleet safety depends on integrating work-related road safety with a strong workplace health and safety culture. A TRL review of fleet driver safety concluded "fleet safety is most likely to be improved by the introduction of an integrated set of measures based on a strong safety culture within the organisation". Considerably more could be done to promote this as a form of best practice and to promote understanding and compliance with legislation.

8. HSE guidance to employers and publications such as *Driving at Work: Managing Work-related Road Safety*[xvi] have proven to be useful in promoting integrated workplace safety cultures. They need to be supported, however, by enforcement activity. While the police clearly play a major role in enforcing road safety, their remit tends to be limited to an individual level. HSE should take responsibility for enforcing work-related road safety at an organisational level, integrating this where appropriate with enforcement of requirements for other areas of transport safety. In particular HSE should monitor and enforce guidelines regarding work-related pressure to speed, drive while fatigued, use mobile phones while driving, or drive while distracted. In this context, the "balance between prevention and enforcement" does not appear to have been met. While enforcement by HSE has become an integral part of ensuring safety on the railways, for example, enforcement does not occur at an organisational level in relationship to work-related road safety.

To what extent is there good coordination between HSE and those other parts of central and local government with a role to play in promoting health and safety?

9. To rectify the problems identified above, better co-ordination between HSC/HSE and other agencies will be necessary. In particular, co-ordination with road safety officials at DfT will be necessary to further research and monitor the scope and causes of work-related road casualties and to develop innovative ways of enabling integrated workplace safety cultures that understand the importance of safe driving at work. Co-ordination with the Home Office, ACPO and the police will also be necessary to ensure guidelines on driving at work are effectively and appropriately enforced.

10. Finally, in the longer term PACTS would like to see more effective coordination and consistency within the HSE. There seems to be a disparity between the attitude to risk displayed in the field of rail safety, which operates a framework on making risk "As Low As Reasonably Practicable" (ALARP), and that of work-related road safety—even though casualties related to driving at work are considerably higher than casualties on the railway. PACTS believes that for the work of HSE and HSC to be most effective, attitudes toward risk and enforcement should be comparable across all modes of transport.

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Memorandum submitted by Institution of Occupational Safety and Health (IOSH)

IOSH recognises the benefits to society that a respected, independent, effective and efficient regulator can bring to OSH; has recently responded to the HSC's draft strategy documents (see annexes A and B); and welcomes this opportunity to make a succinct written submission to your inquiry.

1. IOSH: founded in 1945, IOSH has over 27,000 members, is Europe's largest occupational safety and health (OSH) professional body and has strong OSH links worldwide. A chartered body and registered charity, we are the guardian of OSH standards of competence in the UK and provider of professional development and awareness training courses. The Institution regulates and steers the profession, maintaining standards and providing impartial, authoritative, free guidance on OSH issues. Our members work at a variety of strategic and operational levels across all employment sectors. Our vision is: "A world of work which is safe, healthy and sustainable"

2. Cornerstone of a civilised society: public safety issues are often highlighted by tragedies—rail accidents, ferry capsize, sports ground fatalities and others. In each case, as with wholly occupationally-related matters such as oil rig incidents, the development of rigorous systems for the protection of people lies within the professional remit of the OSH practitioner. IOSH believes that over-regulation of UK organisations is undesirable, but that an appropriate level of risk management is essential to ensure efficiency, the care of the workforce and others and the provision of world-class products and services. An understanding of the continuum of public and occupational safety, and of high standards of health and safety with success in a globalised economy, is the foundation of our submission. IOSH supports the development of a "risk literate" society which equips all levels of the working community with the relevant OSH competencies (see annex C: IOSH response to "21st Century Skills" White Paper).

3. The legislative framework: IOSH does not advocate rafts of new legislation, but rather the improved communication and more effective enforcement of existing legislation, including more appropriate penalties from the courts. IOSH believes the following would strengthen the UK framework: RIDDOR to include work-related road traffic accidents; MHSWR to include an explicit duty to investigate work-related accidents and ill health; the introduction of a new offence of "corporate killing"; directors' responsibilities guidance to be re-issued as an ACoP; a "passive smoking at work" ACoP to be issued; and equal rights provision for non-union appointed safety representatives.

4. Achieving Outcomes

4.1 Revitalising health and safety and securing health together: the statistics for workplace deaths and injuries (2002–03) show the incidence rates of major injuries have increased in construction, agriculture, manufacturing and service sectors. It is also the case that GB statistics understate the true situation as, unlike other European countries, they do not include work-related road traffic injuries and deaths. Furthermore, according to Health and Safety Statistics 2002–03 "evidence suggests that the overall incidence of work-related ill health is likely to have risen since 1999–2000, the base year of Revitalising information suggests work-related stress is rising, while musculoskeletal disorders—the other major cause of ill health—shows no change."

4.2 Role of regulator: it is our view that HSC/E are not sufficiently proactive in either educating/advising employers and workers or in enforcement activity, and will be unable to become more proactive unless their funding is restored to levels commensurate with the government's ambitions for Revitalising. We see HSC/E's education/advisory role as being one of: helping to ensure national, vocational and professional curricula adequately cover health and safety; funding OSH research; providing free authoritative, evidence-based guidance and standards; "licensing" competent service providers; and auditing and coordinating the OSH system of GB (see diagram in annex A, p 5). We think there should be research to establish the most effective forms of intervention and the optimum levels of enforcer presence required in those workplaces that cannot demonstrate effective OSH management. The current division of enforcement between HSE and LAs is outdated and needs attention due to the changing nature of the UK economy and the practicalities of devolution. Should a unified enforcement authority not be an option, we would support closer working between HSE and LAs with more joint enforcement initiatives to achieve greater consistency and impact. The constitution of HSC is also outdated—there are now more than three major stakeholder groups, and effective linkages with the devolved administrations are via HSE rather than HSC directly.

4.3 Role of OSH professionals: unfortunately, we feel HSC/E consistently fail to understand, recognise or research the role of competent OSH practitioners in educating and advising employers, insurers and the workforce and thus helping to raise OSH standards in the workplace. This is evidenced in their publication the Health and Safety System in Great Britain which makes no explicit reference to OSH practitioners; and the HSC's strategy document, which inadequately describes the OSH practitioner role and states that HSC/E cannot and should not do it all, seeming to overlook the fact that it never has. We have suggested a redefinition of the OSH system for GB which places duty holders centre-stage and includes a scheme for enforcement agency "licensing" of competent, proactive service providers (see diagram in annex A, p 5).

4.4 Emphasis on health: in its draft strategy document, HSC/E has not identified how it will address the problem of inadequate OH provision in GB. IOSH has described a proposed, regionally delivered system based on joint-stakeholder funding in our suggested redefined OSH system for GB (annex A, pp 2 and 5).

5. Resources: we strongly support an increase in resource and continuing ministerial support for HSC/E, in order to allow it to adequately discharge its statutory duties and to establish and implement evidence-based interventions, ensuring competent stewardship of an effective OSH system for GB. We also strongly advocate that, should a unified enforcement authority not be an option, government funding for LA enforcement activity is ring-fenced.

6. Conclusion: IOSH is keen to be an active participant in both the debate and the solutions and firmly re-iterate our ongoing commitment to helping improve the effectiveness of the OSH system for GB. We have deliberately kept our submission brief, but would welcome the opportunity to make an oral representation to the committee.

13 February 2004

Memorandum submitted by the GMB—Britain's General Union

Introduction

1. The GMB is a major (general) trades union representing around 650,000 members, employed in a wide variety of occupations in virtually every sector of the economy including (in particular) public services, private services and manufacturing.

2. The GMB has a well-deserved and enduring reputation as the leading trade union on health and safety at work issues. It has campaigned consistently for improvements in health and safety standards at work. It trains thousands of safety representatives every year, and supports their efforts to reduce risks at work with high quality advice, guidance and publications. It has vigorously promoted a partnership approach with enlightened employers to reduce injury and ill-health rates in workplaces. It has been successfully involved in a diverse range of tripartite arrangements with the Health and Safety Executive and employers, and has made a major contribution to the UK health and safety system since the 1970s.

Summary

3. The GMB welcomes the establishment of a Select Committee inquiry into the work of the Health & Safety Commission and Health & Safety Executive. Motions to the Union's Congress in 2003 expressed a view, firmly held by many GMB health and safety representatives, that the HSE is under-resourced and does not enforce the law vigorously enough. Some would argue that the HSE is a failing organisation.

4. This submission will therefore identify a range of serious concerns about the performance of the Health and Safety Commission and Executive and the resourcing of health and safety. It will also identify the need for the HSC/E to ensure that the involvement of trade unions, and in particular our workplace safety representatives, is central to any future strategy to improve the management of health and safety at work. Central to the viewpoints outlined below are: the establishment of a Work Environment Fund (WEF) to generate extra and much needed resources; and the granting of new and improved rights for trade union safety representatives, to create new opportunities for enhancing and expanding the most successful model for improving health and safety standards at work.

The Legislative Framework

5. The steady decline in the rates of serious and fatal injury within British industry that followed the introduction of the 1974 Health and Safety at Work Act (HSWA) is a testament to the principles and approach enshrined in the Act. The HSWA had the principle of consultation with workers, through their unions, at its heart, and this led to the engagement and involvement of many thousands of trade union safety representatives. These safety representatives effectively contributed towards the "policing" of the self-regulatory regime which Lord Robens (whose report led to the enactment of HSWA) envisaged as developing.

6. The HSWA is based upon the notion of employers adhering to a duty of care towards their employees, with both the regulators (the Health and Safety Executive) and the unions (as the collective instrument of the workforce) contributing towards the creation of conditions that encourage employers to comply with their obligations. HSWA legitimised the role of trade union safety representatives within the regulatory framework through the enactment of the 1977 Safety Representatives and Safety Committee (SRSC) Regulations under HSWA.

7. The basic premise of the Act, and the role it afforded trade unions (through the SRSC Regulations) in participating in joint endeavours to reduce work-related injuries and ill health remains sound. As enabling legislation, HSWA also created an effective legislative framework for the making of specific regulations to address prevailing risks in the workplace. This remains the case.

8. The GMB's view is that the problem is not with the legislative framework. It is that the effectiveness of the self-regulatory approach has been diluted by a number of developments: the predominance of "goal-setting" regulations; the performance of and resources available to the HSC/E; the lack of enforcement of health and safety regulations; the predominance of small to medium enterprises (SMEs); the emergence of new hazards and an increase in occupational ill-health (eg stress) resulting from changes in the nature and structure of employment and; the marginalisation or declining influence of safety representatives, without the existence or emergence of any credible alternative means of involving or consulting employees. These points are expanded on below.

"Goal-setting" vs "Prescriptive" Regulation

9. Whilst employers must legally protect the health, safety and welfare of their workers and others, and should assess all work activities in order to reduce risk, far too many do not. Goal-setting regulations, in contrast to prescriptive ones that place specific and absolute duties on employers, rely heavily on the use of risk assessments to inform decision-making on the preventive and protective measures that need to be implemented. Many employers do not understand the risk assessment concept or process, and many more

do not carry out assessments. For "goal-setting" regulations to be effective, HSE must put considerable more effort into assisting employers to understand the purpose of risk assessment, and must enforce the law when risk assessments have not been conducted.

10. There must also be less dependence upon the mono-culture of only enacting goal-setting regulations. The GMB believes that the judicious use of some prescriptive regulations (for example, a specific duty to prevent falls from a height above 1 metre, as opposed to a duty to prevent falls from a height "that is likely to cause injury") would be welcomed by employers and employees alike. SMEs, in particular, are often anxious to know that they have done enough to comply with the law. Prescription offers certainty, therefore, it is apparent and obvious whether or not the regulations have been adhered to. This has benefits to employers, employees and their safety representatives and enforcing authorities alike. The balance between the use of goal-setting regulations and prescriptive regulations needs to be redressed to incorporate more use of the latter.

The Health and Safety Commission and Executive

11. The GMB believes that the HSC/E should fulfil a vital role in ensuring the health, safety and welfare of the workforce. HSE is regarded as an extremely important authority by our members, safety representatives and their employers. For example, the importance of the HSE "badge", on research, guidance and publications cannot be over-stated. The endorsement of an approach or preventive measure by the HSE gives it a credibility that is essential to employers and employees alike. Many HSE staff are of an extremely high standard, and are undoubtedly committed to the tripartite approach towards improving health and safety at work. The GMB sees many of the difficulties of the HSE as rooted in the constraints imposed by a lack of resources, but nevertheless we do have concerns about an apparent lack of commitment to the principle of recognising and embracing the contribution made by trade unions to the UK's health and safety performance.

12. The GMB welcomed the decision to place the HSC/E under the overall control of the Department of Work and Pensions. It was hoped that the outcome of this would be to ensure that HSC/E played a more proactive role in promoting a greater awareness of the need to recognise and reduce the economic and social burden of poor health and safety management. The current structure of the HSC also has the broad support of the GMB, but its inability to give a strong strategic leadership has been illustrated by recent initiatives such as the failure of the HSC to secure support and resources for "Revitalising Health and Safety".

13. The HSC recognised in 2000, with the development of the "Revitalising Health and Safety" strategy that the initial progress achieved as a result of HSWA had stalled. The principle of setting targets for the reduction of injuries and ill-health and the development of priority programmes to achieve measured outcomes was strongly supported by the GMB and other unions. However, the "Revitalising" strategy has not properly involved, and was never properly established to sufficiently involve, trade union safety representatives. Whilst it may be argued that a lack of resources has hampered the progress of the strategy, the failure to involve safety representatives represents a missed opportunity to ensure the engagement of a greater number and diversity of key stakeholders in order to achieve the desired outcomes at workplace level.

14. The GMB recognises that in recent years there have been concerted efforts within certain elements of the press, and by some employers, to undermine the safety culture that the HSE seeks to develop and enforce. The GMB sees this attack on the HSE as a regulatory body as one element of a wider attempt to portray health and safety regulations themselves as "burdens" on business. The GMB believes that there is no case to answer that health and safety is a burden on business—on the contrary, poor health and safety management costs the UK economy between £14 and £18 billion per year. The HSE should mount a forceful defence to this charge by making the business case for preventive measures to reduce accidental loss much more vigorously. The HSE's partners in this endeavour could be the trade unions, who have access to evidence, in the form of case studies, of our work with employers that has resulted in reduced accident rates. This partnership approach has been developed in some sectors, but the culture of indifference towards unions that seems to exist at a senior level within the HSE has perhaps precluded the possibility of a more widespread effort to challenge the hostility expressed by the "burdens on business" brigade.

15. The HSE has consistently failed to pick up trends and changes in demographics which can impact on health and safety. For example, the GMB has continued to raise concerns about the aging workforce, the increased number of women in employment and the rise in migrant labour. To date, there is no evidence that the HSE has made any progress with these issues.

Resources

16. We have serious concerns that the freezing of the HSE's budget for 2003–06 will have a negative impact on health and safety and will result in a failure to meet the Revitalising Targets. In the recent HSC Document "A Strategy for Workplace Health and Safety in Great Britain" there appears to be a general acceptance of the limited resources and a thrust towards self regulation to reduce the burden on the HSE. Inevitably, the resource intensive but highly effective inspection and enforcement activity is the first casualty.

As there appears little will within the HSE to support worker involvement through increasing the rights of safety representatives and by actively supporting the work of trade unions, self regulation will not be the answer to reducing the burden on the HSE and subsequently reducing workplace injuries and ill health.

17. We believe that the Treasury needs to fully understand the economic benefits of preventing work related injuries and ill health. The cost of work related injuries and illnesses to the UK economy are well documented, but may only be the tip of the iceberg, especially when it comes to the costs on the NHS. In addition to the human cost, chronic injuries and long term ill health caused by work, place a drain on our health services. Investing in the prevention of these injuries and illnesses as well as early rehabilitation will reap long term benefits for the UK economy. Investment in prevention comes through adequate resourcing of the HSE and through the HSE spending their budget on effective preventative measures including inspection and enforcement activity.

18. Equally, we appreciate that financial resources are not infinite. We believe that it is time to use the "polluter pays" approach to health and safety through the establishment of a Work Environment Fund. Raised through a small payroll levy, this fund could provide an equitable means of ensuring that practical advice and assistance is available to employers. The funds could also be used to finance research into emerging health and safety problems, best practice and evaluation of projects. Just twenty pence per week per employee would double the HSE's current budget.

19. We also believe that there has been inappropriate use of resources by the HSE, particularly in relation to publications. The priced publication "Health and safety in golf course management and maintenance" and the free leaflet "Health and safety in ski-slope operations" are just two examples of publications which we believe were not priorities at the time of printing. Yet a free publication, helping employers understand how to comply with the Safety Representatives and Safety Committee Regulations and the benefits of worker involvement has never been published despite claims by the HSE that worker involvement is central to their strategy.

20. In relation to publications, we are very concerned about the current moratorium on new HSE publications. Generally, HSE publications are seen as authoritative and highly regarded by safety representatives and employers alike. Publications which offer practical solutions to common problems such as ergonomics, violence and noise are particularly welcome as are industry specific publications. Increased reliance on the website as a source of information is helpful to some groups but should not be a substitute for the production of hard copies of publications. The assumption that every employer and every safety representative has access to a website is erroneous. We believe that a Work Environment Fund and a strategic publishing budget, where key stakeholders, including advisory committee members, are consulted on future publications is the way forward.

Enforcement

21. The GMB is alarmed by the low level of enforcement of health and safety. On average a registered premise that is not seen as high risk will receive an inspection every 20 years. The number of contacts with employers has been falling steadily since 1995.

22. HSE's own research has found inspection and enforcement activity as an effective means of securing employer compliance. Research into the impact of the HSC/E found that, if targeted at key groups, inspection can bring about significant improvements in health and safety performance. The same study implies that HSE awareness raising campaigns are already preaching to the converted. Studies have found a high level of compliance with improvement notices and that the effects of such notices endure. We are aware of several companies, who as a result of an improvement notice, significantly changed their safety culture to one that is more proactive.

23. In the HSE's analysis of the responses to "A Strategy for workplace health and safety in Great Britain to 2010 and beyond" they found little appetite for reduced inspection/enforcement and a good number of calls for increased activity in this area. This view is not only expressed by unions but by employers and their representative groups. Hard to reach groups, as defined by the HSE, also indicated that there should be far more regular inspections.

24. We believe that in 2003 the media attention around the HSE enforcement notice on stress at the West Dorset NHS Trust had more impact on duty holders than a costly advertising campaign on stress at work.

25. The GMB has been highly critical of the failure by many HSE field inspectors to communicate with safety representatives during a visit to their workplace. Whilst we have seen some improvements, it is by no means consistent throughout the country. We believe that these improvements have been driven by the individual attitudes of Regional Directors but that progress has been hindered by the HSE's institutionalised inertia and failure to recognise the benefits of consultation at policy level.

26. Consistent failure to enforce the 1977 Safety Representatives and Safety Committee Regulations has also been a major concern to the GMB. As of January 2000 HSE Inspectors had served just one improvement notice under the 1977 Regulations (in 1984) 1 that's one in 22 years. We have numerous examples of employers failing to comply with these Regulations and know of cases where the assistance of the local HSE has been sought but has not been supportive. In our opinion, there remains a perception

within the HSE that the 1977 Regulations are about industrial relations, rather than regulations implemented under the Health and Safety at Work Act to promote partnerships and joint working on health and safety.

27. We also believe that inspection and enforcement activity should be separated from information and advice giving and propose the separating of the two functions and the formation on one body responsible for health and safety enforcement in all workplaces.

Reforming the HSE's Enforcement Responsibility

28. The steady decline in local authority inspections is a grave concern, particularly as the workload of local authority inspectors is increasing as the industrial profile of the UK changes. Competing pressures, including food safety and environmental controls, mean that health and safety frequently takes a back seat.

29. The GMB believes that it is fundamentally inequitable that the geographical location of a worker is the sole determinant as to whether he or she is better protected. In the 2003 report "Safety Lottery: How the Level of Enforcement of Health and Safety Depends on Where you Work" it is quite evident that (for example) workers in Rossendale District Council are less protected than those working in Kennet District Council.

30. The GMB believes that it is time to draw a line behind these inconsistencies and give the HSE the budget and sole responsibility for enforcement of health and safety in all sectors. We do not believe that the proposed audit/benchmarking systems and the effective use of s18 guidance by HSC will make enough of a difference. HSC/E does not, and is unlikely to ever have, a say in how individual local authority budgets are spent, which is the overriding factor when it comes to resourcing health and safety enforcement activity in the local authority environment.

The Tripartite System

31. The HSWA is founded on the belief that health and safety is best promoted through employers, trade unions and government working together. The GMB believes that this tripartite approach has been one of the strengths of the current system, and is alarmed that a lack of resources could end in the potential disbandment of a number of key tripartite committees. We have already expressed concern, at paragraph 13 above, that the HSE does not wholly recognise the need to keep the trade unions at the heart of its strategy. This concern would be exacerbated by any developments which were to result in a further erosion or fragmentation of the tripartite approach.

32. Since the HSWA, the principle of tripartitism has successfully underpinned the various Industry Advisory Committees which have been established by the HSC. Some of these have been extremely effective in promoting better health and safety within the industries or sectors they cover. Unfortunately, in recent years, the commitment from the HSE to these bodies seems to have waned with some Advisory Committees being wound down, and others finding it harder to gain access to the support they need to deliver outcomes, such as the production (with input from both employer and union representatives on the Advisory Committee) of sector-specific guidance. There has also been an unwelcome trend towards diluting both the employee and employer interests on Advisory Committees, thereby undermining the principle of tripartitism.

Improved Rights and Better Support for Safety Representatives

33. The most enduring and successful model for improving health and safety standards at work is the "trade union" model. Independent research, including studies that were recently cited in a paper discussed by the HSC, demonstrates that in those workplaces where there is consultation and trade union recognition, the level of work-related injuries is half that of workplaces with no union recognition and consultation. The GMB has produced and circulated a wealth of case studies that describe the benefits, in terms of measurable reductions in accident and injury rates, of joint union/employer initiatives in workplaces where the union is recognised.

34. The GMB's approach towards achieving health and safety improvements for our members at work is founded on the belief that health and safety is best promoted through employers and trade union safety representatives working together. In addition to our own case studies, research has shown that in those workplaces where trade unions and employers have a joint approach to health and safety there is a better safety culture than in those without trade unions. The GMB has an excellent track record of delivering joint training courses that assist managers, supervisors and safety representatives to develop a joint approach towards risk assessment, and help companies to examine and improve their safety culture.

35. Despite the success of the joint approach pursued by the GMB and other trade unions, this contribution does not seem to be fully recognised and placed at the core of the HSE's work. There are notable exceptions, such as the "Recipe for Safety" initiative developed in the Food Industry, but the HSE's policy approach and the thrust of its prevention work has been focussed predominantly on employers and

managers. Over 25 years after the publication of the SRSC Regulations, and regardless of the enormous contribution that unions have made, the HSE still often does no more than include a token sentence in its guidance informing employers of their legal duty to consult our safety representatives.

36. The GMB believes that to achieve tangible improvements in health and safety at work, the HSE must recognise, value and include trade union safety representatives as a positive force for improving the safety culture within workplaces. Inspectors should, as part of their inspection regime, automatically ensure that employers are complying with their duties to consult. We would also wish to see more HSC/E materials specifically aimed at Safety Representatives—there are currently no such publications available, although there are many hundreds aimed at employers and managers. The GMB has also, for many years, advocated a publication that describes to employers, in positive terms, the benefits to be gained from meaningful consultation with Safety Representatives.

37. Of utmost necessity, and the GMB's top priority, are the changes required to the Safety Representatives and Safety Committee Regulations to make them more effective and relevant to the present day. These include changes to Regulation 8 to introduce "Roving Safety Representatives", giving safety representatives the right to inspect all premises where they have members, and those of contractors. It is of fundamental importance that the Regulations are amended to reflect the changes in the way that many people work nowadays, by comparison to when the SRSC Regulations were introduced. Examples include the numbers of people working in SMEs, the proliferation of contractors, people working part-time for a "portfolio" of employers etc. As union membership is less concentrated in large, fixed workplaces, like the factories of the 1970s, many GMB members no longer have a safety representative permanently present in their place of work. An amendment to Regulation 8 is necessary to ensure that their health and safety representation is assured, and to bring the benefits of the successful model of union-initiated improvements to a wider audience of employers and employees.

38. Another important reform, which would help to bring a new impetus to the system of self-regulation referred to in previous paragraphs, would be to grant safety representatives the right to issue their employer with a Provisional Improvement Notice (PIN). Issuing a PIN would be a last resort when there was a failure to act upon a recognised health and safety risk which could endanger life and limb. This system works well elsewhere, and would take advantage of the existence of the vast number of trained safety representatives present in workplaces throughout the UK. Even with a massive increase in resources, HSE Inspectors cannot match the numbers of safety representatives operating on a daily basis within workplaces, and the proposal to allow the serving of a PIN offers a sensible and practicable "enforcement" option that would be, in our view, a giant step towards reducing accident and injury rates.

39. Other reforms to the SRSC Regulations that the GMB would like to see include an explicit duty on employers to respond to issues raised by safety representatives, and greater clarity and enforcement of the rights to training and information.

40. The GMB (in common with other trade unions) has campaigned for and advocated the reforms to the SRSC Regulations described above for many, many years. We do not believe that these proposals have been given the serious consideration that they deserve. In our view, this is indicative of the inability or unwillingness of the HSC/E to promote and progress imaginative and sensible measures that we are convinced would make a significant contribution towards improving health and safety standards at work. In view of the remarkably persistent levels of injury and ill-health that occur in our workplaces, and the manner in which the progress achieved since the 1974 HSWA has been stalled by economic, social and industrial developments, it is an indictment of the HSE that it has failed to respond imaginatively to the ideas advanced by key stakeholders in the health and safety system.

Summary of Conclusions

1. The basic legislative framework of the HSWA remains valid, but the UK health and safety system is under strain due to developments since its inception in 1974.

2. Poor health and safety management, and a lack of understanding of the regulatory requirements amongst employers, coupled with inadequate enforcement of the law, costs the UK economy £14–18 billion per year, and results in hundreds of deaths and thousands of workers injured or suffering from ill-health.

3. The balance between the use of goal-setting and prescriptive regulations is weighted too heavily towards the former.

4. The HSE does not enforce the law effectively. This leads to unfounded claims of over-zealousness on the one hand, whilst trades union safety representatives representing the victims of occupational injury and disease regard the HSE's enforcement activities as weak and ineffectual.

5. The HSE cannot be "all things to all people". It should be an effective and recognisable enforcement agency with sole responsibility for enforcing health and safety regulations in all sectors. Advice, guidance and information on health and safety should be provided through a separate agency. This could be resourced by the establishment of a Work Environment Fund.

6. The HSC/E lack the strategic vision to recognise, embrace and promote the success of the trade unions in reducing accidents and ill health. This has meant that opportunities to improve health and safety at work by reforming and improving the SRSC regulations have not been grasped.

7. The HSE's future strategy to 2010 and beyond is predicated upon an assumption that stakeholders must accept that the organisation needs to withdraw from a range of activities. Predominant on this list appears to be the abandonment of the commitment to maintaining a range of tripartite arrangements, which are the most successful means of ensuring the involvement of key stakeholders and ensuring that "revitalising health and safety" targets are met.

8. The HSE is under-resourced. The lack of funds necessary to invest in the future health and safety of the nation's workforce represents a major constraint. The GMB's view is that the establishment of a Work Environment Fund to generate dedicated resources is central to the promotion and development of an effective preventive strategy to reduce injures and ill-health at work.

Kevin Curran
GMB

13 February 2004

Memorandum submitted by ABPI

Introduction

The Association of the British Pharmaceutical Industry brings together companies in Britain producing prescription medicines both through manufacture and supply as well as research and development (R&D). The membership of the Association includes all the significant manufacturers of such medicines in the UK and accounts for the vast majority of manufacturing activity in this field in this country.

The Association has worked with the Health & Safety Commission (USC) and the Health & Safety Executive (HSE) over many years and we are pleased to offer our comments to the current Inquiry.

It is a common misconception that industry always objects to regulation and to regulatory bodies. However and while we do object to poor regulation and to over regulation, we support regulation the burden of which is proportionate to its aims; and which is applied reasonably. In the case of HSE, it has, since its formation in the 1970s, earned a deserved reputation in industry for quality advice and fairness of enforcement. In particular HSE should be commended for:

- Sound policymaking based on tripartite (USC/Industry/Unions) advisory committees and cutting edge research.
- Having a proactive approach to prevention, that is founded on well-written guidance, developed in conjunction with the social partners and expert professions.
- Striking a good balance between enforcement and advice based on the sound judgment of inspectors in the field.
- Actively promoting health and safety in a variety of innovative ways.
- Taking a leadership role in Europe, for example in the introduction of risk-based legislation and in systems for managing exposure to chemicals.

In short, HSE has been an example of good regulation. Over the last few years, however, this premier position has been eroded by the cumulative effect of resource cuts. This, we believe, has led to a diminution in the quality of HSE's policy-making and implementation, as detailed below.

- Disengagement from taking a leading role in Europe, concentrating instead on the implementation of EU-made regulation. For example, the UK will no longer initiate the setting of occupational exposure limits for chemicals, even though the established UK system has been widely recognised as more robust than the EU system. This may save USE resources in the short term but leaves industry to meet the costs of less-well-validated standards.

EU legislation is also more prescriptive than the goal-setting approach adopted in the UK, reflecting custom and practice in other member states. This can exacerbate bureaucracy without any real benefit to health and safety. Recent examples can be seen in the voluminous COSHH Regulations 2002 which implement the European Directive on Chemical Agents, and in the excessive documentation required by revisions to the major hazards regulations.

We strongly believe that USE should regain its previously eminent position in formulating EU legislation. It is a false economy to cut back on involvement in Europe if the price of that saving is over-prescriptive legislation that results in increased downstream regulatory costs and burdens that undermine competitiveness of industry (both in the UK and Europe) without achieving the regulatory objectives.

— Loss of advisory committees such as the Occupational Health Advisory Committee (QUAC) and (nearly) the Working Group on the Assessment of Toxic Chemicals (WATCH). While change is necessary to maintain progress, it ought to be undertaken in open discussion with the social partners and with clear commitment to maintaining the tripartite approach. Instead, advisory committees are being cut to save quite nominal sums of money and against the advice of stakeholders. These are false economies. Regulation works most effectively when there is a degree of consent and buy-in from the regulated. Retreating from the use of advisory committees risks losing that.

— Cutbacks in research inhibiting development of novel approaches (such as Chemical Essentials) and innovative research into emerging issues. USE now struggles to raise commercial funding for approaches which in the long term could lead to substantial improvements in health and safety for the benefit of all.

— Loss of experienced staff both in the field and from policy. Part of our industry's support for the work of USE stemmed from the fact that we could in general respect the professionalism and expertise of its staff, even on the occasions where we did not agree with them. Now however, more often than not inspectors being recruited are relatively inexperienced. In turn this has led to an increase in poor enforcement decisions, which not only place unnecessary burdens on industry, but do not advance the cause of health and safety. In many cases, where an experienced inspector would be able to use his experience to apply regulation with common sense to a particular set of circumstances, more junior staff are often unwilling or unable to vary from a rigid "check list" approach. There is growing industry dissatisfaction over the implementation of new regulations such as COMAH, in terms of both policymaking and enforcement practice.

It is perhaps understandable that political support for health and safety may be lacking when there does not appear to be a crisis and, indeed, there is a strong record of success. The extent to which the continuation of that success relies on a properly resourced USE should not be underestimated. The problems referred to above appear to be the result of USE not being properly resourced, and making false economies as a result.

The Association of British Pharmaceutical Industry

13 February 2004

Memorandum submitted by Simon Jones Memorial Campaign

INTRODUCTION

Simon Jones was killed at Euromin Ltd in Shoreham harbour on 24 April 1998. Simon was taking a year out from Sussex University before sitting his final exams. His death was horrific and entirely preventable. It happened because his employers made no attempt to comply with Health and Safety Law—a situation made possible because that law is not rigorously enforced. The Simon Jones Memorial Campaign was set up by Simon's friends and family to obtain justice for Simon, to campaign against vulnerable, poorly paid people being used to replace a properly trained and experienced workforce and to raise public awareness of the under enforcement of Health and Safety Law. True justice would ensure that people like Simon would not be killed at work. In the absence of this we need to ensure that all work place deaths are properly investigated and that all undertakings comply with Health and Safety Law. To quote from the campaign literature, "People like Simon Jones get killed at work all the time and nothing gets done about it—not this time!" The Simon Jones Memorial Campaign is manned entirely by volunteers and receives no funding. We rely entirely on donations and fund raising events to cover our expenses. We are not affiliated to any political party or any other organisation.

1. THE CHANGING WORLD OF WORK

The DWP press notice of 16 January states, "In June 2000 the Revitalising Health and Safety strategy was launched with the aim of injecting impetus into the Health and Safety agenda and ensuring the approach remains relevant to the changing world of work over the next 25 years."

When HSWA was first introduced most workers were directly employed by a company, which trained them. There was a permanent work force that knew one another and worked together as a team. Nowadays many companies and other undertakings are subcontracting out labour to employment agencies. This is particularly notable in such high hazard industries as construction, dock work, factory work and agriculture but is also prevalent in office work, teaching and nursing. The lack of a permanent group, the members of which know and understand one another, makes communication more difficult and increases the hazards of the job.

This large "flexible" workforce is not only denied any form of employment protection but it is also less protected by Health and Safety Law than directly employed workers.

One reason for this reduced protection is that the agencies themselves are unaware of their Health and Safety responsibilities. In September 2000 HSE published its research into recruitment agencies. They found that 80% of agencies considered the responsibility for an agency worker's health and safety lay with the host employer. In fact as the agency is the employer, the responsibility is theirs. There is also the fact that HSE itself may fail to recognise that an agency's employees are not solely represented by those employed directly in the company's offices, leaving the inspection of the agency to the local authority and ignoring the fact that the vast majority of the agency's workers are not office based. Many agencies attempt to avoid their responsibility to employees by saying that the worker is self employed, but this assertion is belied by the fact that the agency pays wages, makes deductions for tax and insurance and dictates the place and hours of work.

Regardless of the fact that these employees are often being sent to dangerous workplaces, the agency does no risk assessment of the work to be undertaken.

Although MHSWR 1999 requires all employers to conduct a risk assessment, this requirement is commonly flouted by employment agencies. At best they make a simple check of working conditions during a phone call but in many cases no sort of check or assessment is made at all. HSC/HSE refuse to insist that a site visit is made to the host employer to assess the risks before the agency allocates an employee to a job.

This means that people like Simon are sent to a place of work not knowing what they will be required to do and with no prior knowledge of whether the place is well organised and supervised, or whether like Euromin it is seriously undermanned by untrained, casual workers with no supervisor on site and no attention paid to the requirements of HSWA 1974.

Sadly Simon's case is not isolated, in October 2000, one month after the publication of HSE's research into employment agencies, Michael Mungovan, a student at Brunel University, was sent by McGinley's employment agency to work for Balfour Beatty doing railtrack maintenance. The agency had done no risk assessment for the job to which Michael was sent and therefore did not know that he had no experience of the work he was to do that night, that he was inadequately trained for the job and that he would be working unsupervised. Michael was killed at work.

These are only two examples of our unprotected workforce. The policy of subcontracting labour leads to many layers of responsibility but no accountability from those who employ these workers. The recent high publicity given to the plight of migrant workers, following the death of the cockle pickers at Morecambe Bay, illustrates again how inadequately our law protects workers who are not directly employed. It is not only agriculture and fisheries where these people are exploited but also in factories eg many are employed in the plastics factories in Hartlepool, working excessively long hours, which are injurious to health. HSE does not seem to be aware of the problem.

Despite the findings of its research in September 2000, HSE has made no suggestions as to how the situation can be remedied.

2. The Legislative Framework

From the introduction of HSWA in 1974 until 1994 statistics show an improvement in Health and Safety at work. Deaths and injuries at work, though still unacceptably high, appeared to be on the decline. Since 1994 the figures have fluctuated a little but there has been little sign of improvement. It is true that we appear in a favourable light compared with our European neighbours. However just because we look good compared with countries that are bad should not give us cause for complacency. Each of the 400 work related deaths and 30,000 major injuries in this country represents pain and suffering for the bereaved family, loss of income and increased expenditure by the bereaved, increased costs to the emergency services, the health service and the benefits agency. The negligent companies and their decision makers meanwhile experience little inconvenience.

As long as the law simply places responsibility on the "company" and not the decision makers within the "company" we are unlikely to see further improvement.

In June 2000, action point 11 of revitalising Health and Safety stated:

> "The Health and Safety Commission will develop a code of practice on Directors' responsibilities for health and safety . . . "The HSC will advise ministers on how the law would need to be changed to make these responsibilities statutory . . . It is the intention of ministers, when Parliamentary time allows, to introduce legislation on these responsibilities."

There is no requirement in law for a director to inform himself of the safety/lack of safety in the working environment of his employees. This makes it virtually impossible to secure a conviction against a director or senior manager no matter how negligent or reckless their behaviour has been. They can simply say that they didn't know what was going on and no matter how unlikely this assertion it is very hard to disprove it. In Simon's case, James Martell had deliberately discarded the safe lifting hook, which the excavator firm had supplied, and in its place had hooks welded directly onto the clam-shell grab forcing workers to operate within its jaws. Even though he insisted that this dangerous modified system must be used unless he directed

otherwise and even though he failed to employ sufficient workers or a supervisor and frequently absented himself from site, the defence successfully argued that he couldn't be expected to know exactly how the system was being used that morning and he was therefore acquitted of manslaughter.

With such a defence possible, there is no incentive for a director to adopt the voluntary guidance introduced by HSC. It means that the most careless of directors/senior mangers escape accountability when they place employees at risk.

It is true that some companies have attempted to follow the voluntary guidance but HSE only surveyed very large companies and organisations and of these 15% had no arrangements in place to facilitate board level involvement in safety issues and had no plans to do so.

If the speed limit signs at the road side were for guidance only, few motorists would drive below 30 mph in a built up area. Even if all but 15% did so, this would still leave a dangerously high number of motorists driving at excessive speed. Only legislation backed up by effective enforcement has been shown to be effective. The same has been true for alcohol related road deaths. Government advertising campaigns had little impact but the introduction of legislation backed up by the breathalyser and consistent prosecution had a dramatic effect. We need similar legislation and enforcement to reduce work place deaths and injuries.

Sadly HSC has decided not to advise the government that legislation on directors' duties should be made statutory. This despite the fact that in 2002, a poll by the British Safety Council of some of the top FTSE 500 companies showed that many company bosses believed profits are more important than the safety of their workers despite the prospect of strengthened legislation and unlimited fines for Corporate Killing. Shareholder profits and customer satisfaction were consistently rated above worker safety.

This should come as no surprise because company law effectively excludes the consideration of worker safety in its single minded policy to pursue profit. Directors are required to "act in good faith in the best interests of the company as a whole". This duty has been generally interpreted by the courts to mean acting in the interests of shareholders by maximising profits. If introducing safer systems of work means extra expenditure on training, staffing levels, safer use of machinery etc this would reduce profits and effectively be contrary to company law. Prosecution rates and fines are so low that this has little impact on company profits.

To offset the pernicious prioritisation of profit over safety, directors must be made legally responsible for the safety of the work force.

At present only a few premises eg nuclear installations are required to apply for a licence to operate. For all other premises the only requirement at present is that machinery must be checked for safety. The method of its use however remains unchecked unless an inspector happens to observe dangerous usage or until incorrect usage results in death. Simon's case and evidence given to me by other bereaved relatives shows that this problem is widespread and just about anyone can set up in business using heavy plant or machinery. I feel that these undertakings should have to submit their modus operandi in advance to the HSE for approval. Only when they can satisfy HSE that they have designed a safe system of work should they be given a licence to operate.

One piece of legislative reform, which would inform the public of possible workplace hazards and could allow companies to learn from the past mistakes of others would be to require Health and Safety reports to be published, once it has been established that no further legal action is to be taken or three years after the investigation ı whichever is the sooner. At present unless a public inquiry is ordered, the findings of the Health and Safety Inspector languish in a filing cabinet and no-one benefits save the negligent company.

3. Enforcement

More needs to be done to enforce Health and Safety legislation, particularly with regard to agencies that supply labour to construction, docks, factories, warehouses etc. An onsite visit should be obligatory to qualify for a risk assessment in these circumstances. It is difficult to see how anyone can assess risk if they have never seen the premises and have no idea of how well the site is managed. It is accepted that in very low risk undertakings eg offices and retail premises a site visit may not be necessary but the requirement to conduct a risk assessment should still be enforced. Although a written assessment of risks is a good start point it is not sufficient simply to have the paper work in place. As Alistair Darling, Transport secretary, said in July 2002, "It isn't enough to put in place processes ı ticking boxes to show that the process has been followed. Checks are needed to see that they've actually done what they are supposed to do." He was speaking of monitoring maintenance subcontractors but his statement is equally true of ensuring safe systems of work.

An audit of the work of the HSE undertaken by the CCA has shown that between 1996 and 2001 there was a 41% decline in the number of "contacts" with premises involving inspections. In the same period there was a 43.5% increase in investigations into reported injury and death. Investigations of adverse incidents are absolutely essential but the inference here must be that with insufficient resources one activity can only increase at the expense of another. Preventative inspections are also essential; we need to be proactive as well as reactive.

The recent report of the Transport Select Committee also emphasises this point. It noted that harbours have become the most dangerous workplaces in Britain with a death and injury rate overshadowing that in construction, coal-mining and quarrying. MPs have argued for tougher safety measures and enforcement and that more expert staff need to be employed. For all of Britain's docks there are currently only 25 inspectors and none of them is dedicated to dock work.

Even when enforcement action results in prosecution, the penalties imposed by the courts are insufficient to act as a deterrent. In November 2003 the HSE announced that the average fine for a conviction on a health and safety offence had dropped by 21% from £11,141 in 2001–02 to £8,828 in 2002–03.

This shows that employers can kill, injure and disable workers in the knowledge that the worst they will incur is a comparatively small fine. Many cases involving the death of a worker are still being heard in the Magistrates Courts, which does not reflect the serious nature of the offence and where the maximum penalty is a £20,000 fine.

4. Funding/Resources

HSE lacks the funding to properly inspect, investigate and prosecute offending companies. Few companies are visited more often than once in five years and many never receive a visit from HSE at all until a fatality occurs.

HSE employs 847 inspectors in its Field Operations Division; 243 of these are trainees leaving only 604 fully qualified inspectors. There are a further 500 inspectors responsible for hazardous industries such as oil and chemical refining, offshore gas and oil exploration and production and the nuclear industry. These 1300 inspectors cover the 740,000 premises currently known to the HSE. Many thousands of premises are not on the HSE's database. The result of these very low staffing levels means that on average a workplace is visited about once every ten years and that of the nearly 30,000 major injuries reported annually, HSE investigates at best 15%. In the construction industry one inspector is responsible for three London boroughs and the 4,000 new building projects in Scotland are policed by one inspector.

The lack of support staff means many inspectors spend more days in the office doing admin work than inspecting premises. As there are few regional offices, inspectors have to spend a long time travelling from base to reach premises to be inspected/investigated. Prosecutions are time consuming and HSE inspectors have to deal with these in addition to their usual workload.

This situation could and should be remedied by increasing both the numbers of inspectors and the numbers of support staff. Prosecutions should be handed over to the CPS or handled by a separate department so freeing the inspectors to do the specialised work for which they are trained.

5. Summary

The changing world of work presents new challenges for the enforcement of Health and Safety law. Although HSE has conducted some research into this problem it has not implemented any strategy to deal with it. With fewer permanent contracts available and increasing numbers of migrant workers entering the country the problem of vulnerable, exploited, poorly protected workers is likely to increase.

The present legislation is insufficient to adequately address the problem of reducing death and injury at work because it allows the decision makers responsible for the systems of work which kill, to distance themselves from the incident and so escape responsibility. The imposition of legally binding health and safety obligations on company directors would redress the problem that company law requires them to maximise profits but does not require any consideration of the safety of the work force.

The secrecy surrounding health and safety reports means that the tax payers who pay for the report can never read it and benefit from its findings.

Enforcement action should be increased and no organisations should be allowed to avoid conducting a proper on site risk assessment before sending workers to a job. Employment agencies must be brought in line with other organisations. Prosecution should be more consistent and breaches of regulations, which result in death, should be prosecuted in Crown Courts. Fines should be related to the damage done. Ideally they should be a percentage—say 10% of the company's annual turnover in order to have a better deterrent effect. Negligence resulting in death should attract a prison sentence.

More funds need to be made available to HSE to enable them to carry out their role effectively.

The present levels of inspection and enforcement mean that Britain is in contravention of its obligations under the Human Rights Act.

Article two states that it is the duty of a state to take action to prevent avoidable deaths and should it fail, it must inquire into that failure.

Most workplace deaths are preventable and this country is failing in both its legislation and its enforcement of that legislation to prevent avoidable deaths.

Keith Burrell
(Prospect)

17 February 2004

Memorandum submitted by the Ergonomics Society

The Ergonomics Society is the professional organisation for ergonomics in the United Kingdom It has a total of around 1,300 members and it is currently going through the process of becoming a chartered organisation.

Aims and Objectives

We think it is important to go back one of the main principles of the 1974 Health and Safety Act/safety by design. There are three levels:

Getting the culture right.

Getting the organisation right.

Getting individual jobs right.

This means taking an ergonomic approach right through the organisation. Whilst there are large parts of the HSE which believe in this we have great doubts as to whether it has spread far amongst senior managers outside.

There is a need to look very carefully at the balance between guidance and punishment/prosecution. There are obvious points of role conflict in the present situation. It might be that the HSE looks more at guidance and local authorities take on a wider punishment role.

Linked with this is the need to engage senior managers more from outside the HSE. It is important that they see that health and safety are a part of the wider picture of getting an effective and reliable organisation. They are not just costs but a lead into wider benefits.

Research

We also think there is a problem with the present set up regarding the procurement of research connected with Health and Safety. Concerns are:

— The research councils will not fund research that is very obviously H&S as they regard this as the responsibility of HSE. HSE have a relatively modest research budget and want to use this strategically. HSE procures the research it is interested in at any particular time and is unreceptive to unsolicited proposals (it does accept these but chances of getting funding are small). The problem with this is that it leaves a significant gap re "blue sky" research ideas in the field. Given H&S is a key part of ergonomics, the implications for the discipline are significant. We think the solution is for agreement to be reached with the research councils over who should fund research of a more speculative nature.

There are weaknesses with the co-ordination of the research that HSE does procure. The absence of any process of peer review means that poor quality research is commissioned, with significant overlaps sometimes occurring between projects.

— There is narrow dissemination of research findings. HSE's Research Reports are not peer reviewed. Very little of the research HSE commissions makes it into wider scientific literature. This is a loss to the wider advancement of knowledge.

Measurement of Performance

We are also concerned about setting targets. It is always difficult to measure the absence of anything ie complete safety is the absence of accidents. Health and safety measures are usually in relation to consequences such as days off because of injuries, but what we should be interested in are causes and these are very difficult to recognise and to measure. Also these are much more difficult for regulatory staff to cope with. They are much more uncertain and it is difficult to apply numbers to them.

The Ergonomics Society

April 2004

Memorandum submitted by Prospect

Executive Summary

We welcome the opportunity to make a written submission to the inquiry of the Select Committee. Our submission will focus on the resourcing of health and safety, the legislative framework, and future health and safety priorities.

Resources

Prospect believes there needs to be a balance between HSE preventive work, the provision of advice and information, and reactive work. We also believe such work needs to be adequately resourced. The real terms cut of 10% to the HSE budget over the next three years needs to be reversed.

Legislative Framework

Prospect accepts the need to change the legislative framework, although we believe the Health and Safety at Work Act remains highly effective. Specifically, we are convinced of the case for a new law on corporate killing. We also believe Crown Immunity must be removed, and new powers should be given to trade union safety representatives so they may take on a more developed role enforcing workplace health and safety.

Health and Safety Priorities

Prospect believes future priorities should *inter alia* include the management of occupational road safety, the expansion of the "Prosecution Pilot" model, a greater focus on rehabilitation, and the removal of the moratorium on work on HSE publications.

Introduction

1. Prospect is the trade union formed by the merger of IPMS (Institution of Professional Managers and Specialists) and EMA (Engineering Managers Association) and we represent 104,000 scientific, technical, management and specialist staff in the civil service, related bodies and major companies. Our membership includes professionals in a number of enforcing authorities including HSE. As we represent a range of specialist grades within HSE (1800 members) we are fortunate in being able to draw on this broad range of knowledge and expertise to inform our views. However we also have a broader interest in the protection of the health and safety of all employees. To this end we continually review the training and guidance that we give to Prospect safety representatives to support the valuable work they do with employers to prevent accidents in the workplace and ensure that the minimum legislative standards are met.

Background

2. Each year around 250 workers and up to 100 members of the public are killed by work activities. 27,000 workers in the UK sustain a major injury (eg injuries hospitalising someone for more than 24 hours), and 130,000 suffer injuries keeping them off work for more than three days (these are reported accidents—studies show that reporting levels can be as low as a third, so the real toll is likely to be much higher). 2.3 million suffer from illnesses caused by or made worse by work.

3. This toll of injuries and ill health in Great Britain is totally unacceptable and costs the economy billions as well as wrecking lives. 3,000 people a year are dying of asbestos-related diseases. This death toll will rise to 10,000 a year by 2010. This rise is largely due to historic exposure but exposure is still occurring from the tons of asbestos found in up to 500,000 commercial, industrial and public buildings in the UK. Britain's workforce is being maimed, made ill and is suffering an epidemic of stress. About 1,000 people a year are killed in road accidents whilst at work: and yet nothing is done to require employers to tackle this.

Resources

4. The Minister, in replies to letters prompted by our recent HSE resources campaign, cites that the "UK has one of the best workplace health and safety records in the world". We hope that this fact will not be taken in any way as a comfort by the Government, that further improvements need not necessarily be required through proper funding of HSE's activities.

5. Investing in HSE is investing to save. £2 billion a year is paid out in compensation and industrial injuries benefit alone. Take into account lost production, increased labour costs, costs to the NHS and the estimates soar to £18 billion. None of this takes into account the personal cost in pain and suffering of the employees who are damaged in the workplace and the lives of families wrecked by preventable accidents and disease.

6. HSE costs the Government a mere £208 million or so a year. It is trusted by employers, employees, trade unions and the public and is respected around the world—and yet Prospect considers it is now under threat.

7. Firstly it is being starved of cash. The 2002 spending review settlement for HSE was little short of disastrous—the gross budget remaining static over the three years of the settlement, which with inflation and other rising costs means a real terms cut of over 10% (see annex A). The immediate consequence of this includes a freeze on recruitment. The impact on the biggest part of HSE's frontline, the Field Operations Directorate (FOD) illustrates the seriousness of this. By April the number of frontline (B3/4) inspectors left will be around 540 as numbers fall due to natural wastage with no backfill recruitment. The numbers will then dip below 500 fairly soon after that. These inspectors cover all of the following: all manufacturing (except chemicals manufacturing), the health services, education, all LA activities, Government departments and agencies, fire and police services, the defence industry and MOD, construction, agriculture, fairgrounds, domestic gas safety, utilities, and others. These 500 or so inspectors will be expected to do all the preventive (spot-check) inspections, all the accident and complaint investigations, and prosecutions.

8. The numbers of specialist inspectors are also dwindling, and there is a risk that the way it deals with serious incidents will be compromised by not having specialist engineering backup immediately available.

9. To cope with the lack of resources HSE is looking to pull out of work. For example, there is no prospect that HSE will be able to enforce new legislation aimed at removing the risk from asbestos. New regulations come into force in May 2004 requiring employers to manage asbestos in buildings: carpenters, electricians and others are those most at risk from asbestos as they go about their work installing, drilling etc oblivious to the presence of this deadly fibre. However, employers can rest assured that they don't have to do anything about complying if they don't feel like it: because there will be no inspectors to check up on them. There are no plans for inspectors to raise this at their visits, which continue to be restricted to the "Revitalising" priority programmes or matters of evident concern, instead there is a publicity campaign to try to persuade employers to comply.

10. HSE has produced guidance on driving at work, but it is guidance in a vacuum, because no one will be getting employers to comply, or to do anything to stop the 1,000 or so deaths caused by this. The guidance itself states: "HSC's enforcement policy statement recognises the need to prioritise investigation and enforcement action. Current priorities, as set out in HSC's strategic plan, do not include work-related road safety". So employers who choose to do so will be able to carry on making employees spend excessive hours behind the wheel of badly maintained vehicles and working to unreasonable deadlines and there will be no comeback.

11. HSE is also looking to rein back from accident investigations. It is currently piloting new accident selection criteria in the North West as part of a pilot to see how it can run with fewer inspectors. Under these new criteria serious accidents such as some lacerations, serious fractures, burns to less than 10% of the body, and amputations of fingers are not being investigated even when there is evidence that there has been a serious breach of the law. It is akin to the police withdrawing from stabbings because of lack of manpower. These new accident selection criteria effectively ditch carefully worked out criteria set up in response to criticism of a the Select Committee on Environment, Transport and Regional Affairs Fourth Report on the Work of the Health and Safety Executive (Session 1999–2000) (paragraph 35).

12. Clearly there needs to be a balance between preventive work such as inspections and provision of advice and information and reactive work such as investigation of accidents, occupational illness and complaints. However, with so few inspectors, HSE cycles between responding to demands to investigate serious accidents and equally strong arguments to do more preventive work to stop the causes of injury and ill health.

13. Prospect sees the starting point in determining inspector numbers as being a sufficient number to investigate all serious accidents where there has been a serious breach of health and safety law. This is a moral issue—if someone is seriously injured by their employer they deserve the causes to be found and they deserve justice where that employer has been negligent. At present unscrupulous employers are getting away with committing crimes and are going unpunished. This is unacceptable.

14. We need a sufficient number of inspectors to provide a credible presence "on the beat", providing advice to those open to persuasion and forcing compliance on the unscrupulous.

15. There is a duty on HSE under Section 18 of the HSWA to make adequate arrangements to enforce health and safety law. Prospect considers compliance with this Section to be in serious doubt given the numbers of serious accidents not investigated and the dwindling numbers of inspectors "on the beat".

16. Another area looked at critically by the previous Select Committee report on the work of the Health and Safety Executive was that of the policy on prosecutions (paragraph 40). HSE set up a Prosecutions Review in December 2000 to bring its procedures into line with best practice and guidance from the Attorney General, including making the roles of investigator and prosecutor more distinct. It has been the practice in HSE for inspectors to investigate and for their managers to confirm the decision to prosecute. This is no longer acceptable and there is a need to establish independent legal oversight by someone legally qualified who is not identified with the investigative process. A Pilot Prosecution Branch was set up to trial new ways of dealing with prosecutions to provide independent legal oversight and improve competence, efficiency and consistency. The pilot branch was staffed by four lawyers, three law clerks, an inspector and an

administrator and ran from September 2001 for one year. This pilot was very successful and showed great benefits in having a team of legally qualified staff providing independent legal oversight for prosecutions and assisting inspectors by provision of legally trained secretarial support to free inspectors from the administrative work involved in prosecution. As a model it also showed scope for improving the quality of evidence by providing inspectors with legal advice during investigations and in improving consistency between different parts of the country by similar evidence tests being applied to cases. However, this pilot will not be rolled out in anything other than a piecemeal and partial fashion because of a lack of money. HSE hopes to identify those cases, which pose the most serious risk to HSE and provide independent legal oversight for a few cases only, based on affordability. This sticking plaster approach is unacceptable.

17. Prospect believes improvements are needed to the way HSE handles prosecutions, particularly if the stakes are raised by health and safety law being treated more seriously by the courts. Prospect has long argued for penalties to include imprisonment as well as higher fines, and for introduction of a new law on deaths at work. We see enforcing the law on Health and Safety as being the core purpose of HSE and so it is vital that it remains an effective prosecution body working to 21st-century principles. Prospect is concerned at the message that HSE and the Government are sending out by this failure to resource prosecution work: that HSE is not a serious prosecution body and it doesn't matter if negligent employers get away with it.

18. Another response of HSE to the financial crisis is its new "Strategy for workplace health and safety in Great Britain to 2010 and beyond." There is much in the strategy that is sensible—such as looking for new ways to exert influence. Prospect members are fully behind finding the best way of getting results. However, we are concerned that the strategy may signal a shift of resource away from regulatory work carried out by inspectors into advisory and promotional work. All the evidence shows that HSE needs to take a "multi-layered approach" to be most effective—that is it needs to use a range of targeted interventions using seminars; working with others to ensure better training for managers and employees; working with trade associations, insurers and so on to get them to play a part; and research into causes and prevention of injury and ill-health. Research shows that the prime motivator for businesses to improve standards is their desire to comply with the law so that they can avoid getting caught out (Annex B). The reason that a range of approaches works is because they are accompanied by a programme of inspection to check compliance: people are motivated to attend seminars or provide training because they want to make sure they don't get caught. HSE, however, has stated that there will be a reduction in resource for inspection and enforcement. In a paper by Justin McCracken, Deputy Director General/Director of Operations produced last year he said:

19. "In terms of the balance of our efforts we want to put more emphasis on the 'educate and influence' aspects of our work, and working in partnership with others (at all levels) who can help to achieve the improvements in health and safety performance for which we strive. Encouraging our staff to use their authority and experience more on these activities means using a smaller proportion of our total front line resource for the inspection and enforcement aspects of our work."

20. HSE is looking to increase productivity of the remaining inspectors in the Field Operations Directorate by removing bureaucracy. Prospect has long argued for this. Other moves are more worrying. In an attempt to maintain the semblance of inspection activity while real numbers of staff are being reduced, HSE intends to increase the use of staff other than fully trained inspectors on inspection-type work. Part of the "North West pilot" is to look at using administrative grades to visit workplaces in lieu of inspectors. Prospect values the role-played by all HSE staff in improving health and safety, and supports initiatives which look at how best to use staff to improve efficiency. But what is now proposed is led by cuts and the union opposes the use of untrained and unqualified staff having a quasi-inspection role when what is needed is a trained and qualified person to exercise their judgement. Experience shows that even the seemingly most straightforward visit can turn into a complex situation when, for example, asbestos contamination is discovered, or there is a serious fire risk. These types of situations require training so that problems can be identified and dealt with. We owe it to working people, and to HSE staff for their own safety, to ensure visiting officers can spot and deal effectively with any hazardous situations they come across. Employers quite rightly expect the full expertise of HSE when they are inspected and to be shown a HSE warrant card.

21. The strategy also looks to set up a new occupational health service outside HSE. Again on face value this sounds like motherhood and apple pie: we need to do much more in this country on ill-health prevention and rehabilitation. We lag behind our European partners on OH provision. But at the same time the Employment Medical Advice Service (EMAS) within HSE has been run down to such an extent that it is barely functional. HSE employs just 15 doctors and 27 nurses to cover all of Great Britain. EMAS was set up to provide information and advice on occupational health to employees, the HSC, and others. There is a duty in the HSWA that it be maintained—in its current state of dilapidation, it is hard to detect any maintenance at all. And yet now rather than look at re-invigorating EMAS there is talk of other structures. It is all rather contradictory.

22. Morale amongst the staff in HSE is low. Our members are motivated by a sense of vocation and the passionate belief in what HSE does. They want to see a strong and vibrant HSE having an impact on the toll of suffering and they feel that the squeeze on funding is severely restricting what they can achieve. They

also feel undervalued and are in dispute over a pay offer, which awarded 35% a less than inflation. HSE's response seems to be to take advantage of their commitment to the organisation and say that if they are not voting with their feet and leaving HSE then they must be rewarding them satisfactorily.

23. There is also pressure on accommodation. HSE's estates policy tends to be overly driven by resource considerations rather than offices being located where visiting staff can most easily reach the sites they visit. This leads to a lot of time spent travelling rather than working with employers. We are not aware that benefits of sharing office space with the parent department have been explored since moving into the DWP.

Legislative Framework

24. We believe that the Health and Safety at Work etc Act 1974 has stood the test of time and is such a well-drafted piece of legislation that it remains very effective. It is a "goal-setting" rather than a prescriptive piece of legislation and is sufficiently flexible to allow changes in the workplace or changes in society to be brought under its umbrella. It has remained relevant, as EU legislation has emerged.

25. Considerable improvements have been made since 1974, but we do not believe that HSE can rest on its laurels: there are challenges in responding to occupational health issues such as stress, for example. HSE needs to change and staff accept that need but they want to see change led by evidence of what works and to see that change process well managed. HSE has proved to be a responsive organisation and has evolved as its environment has changed. As a model for a regulator, which unifies occupational health and safety within one organisation, it has much to commend it. It is trusted by employers, employees, trade unions and the public and it is respected around the world. It is important to retain this unified structure. In addition, the sharing of experience across the organisation greatly improves understanding and different parts of HSE learn from each other.

26. There has been talk from HSE senior managers of HSE needing to radically change the ways it works because there is a plateauing out of the historic reduction in accidents and ill health. We accept the need to change but consider evolutionary change to have worked best in HSE over the years. We should look for new ways to exert influence but such initiatives must be based on evidence for what works and we must retain a credible presence of inspectors "on the beat." In our view a key reason for the "plateauing out" is that HSE is now coming up against a 'culture of acceptance' where further reductions will prove difficult until cultural and political perceptions of health and safety at work can be changed. It is telling that the words "occupational hazard" mean something which is accepted as part of the job, something which cannot be influenced. We now need to challenge this culture in order to get breaches of health and safety law seen as proper crime, something which is not acceptable to society. It should be no more acceptable for someone to be injured by an unscrupulous or ineffectual employer than it would be if the injury occurred in an assault. Gordon Brown said in his speech to the TUC, "We will ensure greater protection for people working in workplaces from factories to hospitals and shops, remembering that safety at work is, as it should be, the mark of a civilised society." We agree and to achieve this we would like to see the following:

Increasing Fines and Other Penalties

27. There must be increases in fines; and custodial and community sentences, rather than the derisory £5,000 maximum currently available to magistrates for regulation breaches. The level of fines has remained static since 1992.

Corporate Killing

28. We need a new law on corporate killing to elevate causing death at work to the same level as causing death outside work: at the moment the best way to kill someone and get away with it is to employ them. Implementing proposals for corporate killing with HSE able to be a lead agency would raise the profile of health and safety crime. However this would require increased resources. At the moment in a work related death incident, it is not unusual for only one HSE inspector to turn up to deal with everything from the incident, witnesses, bereaved relatives, investigation etc whereas the Police notwithstanding their own funding problems would have a whole team of specialists to back up their investigative work. We hope that a bill on this issue will be published in the near future.

29. A further related worry is that under new arrangements HSE inspectors have been told that the prosecution of directors, managers and other individuals should in general take place in limited circumstances. This direction comes in detailed HSE guidance provided to its inspectors concerned with the investigation and prosecution of health and safety offences by individuals and this came into effect from 1 July 2003.

Crown Immunity

30. Crown immunity must be lifted and the Government must lead by example. We welcome proposals for the "Government setting an example Priority Programme". With over five million public sector workers in total across Great Britain—about 18% of the workforce, it is widely accepted that health and safety performance across the public sector is generally poor and falls well behind much of the private sector. This is unacceptable and a programme to address these issues is well over due.

Powers for Safety Representatives

31. We need greater recognition and powers for safety representatives—research has shown that workplaces with safety representatives are safer workplaces. Safety representatives need powers to serve improvement notices on employers who do not comply with the law. Such notices need a legal status and the provisional improvement notice system instigated in Victoria, Australia is an obvious model to follow.

Company Annual Reports

32. Health and safety must be made a requirement of company annual reports. It is not enough just to encourage this.

Other Recommendations

Increase the Number of Inspectors

33. There are more MPs in the House of Commons than inspectors looking after the working population.

34. We need to double the number of inspectors so that each workplace can be inspected at least every 5 years and so that each new workplace is inspected in its first year of operation. Doubling the number of inspectors isn't as onerous as it sounds because as explained there are currently so few inspectors—we're building from a very low base.

35. Construction is rightly a priority area, yet there are only about 120 inspectors covering over 500,000 construction sites with about 2 million workers. The House of Commons Transport Select committee has called for more dedicated ports inspectors to deal with what is recognised to be as one of the most dangerous land based industries.

Work Related Road Safety

36. Managing occupational road safety must be publicised and enforced by HSE as a mainstream health and safety issue and should be addressed by employers within their health and safety management systems. This will mean a focus on on-road as well as site transport safety (for example, during inspectors visits to workplaces). In partnership with the Police, investigate work-related road crashes and, where appropriate, take high profile prosecutions. We would envisage that the Police will continue to take the lead in investigation and the guidance contained, for example, in the ACPO "Manual for Investigating Road Deaths" will mean that, initially at least, only a very small fraction of estimated fatalities will require HSE to become involved. Some additional training and guidance will be needed but, in general, HSE inspectors already have the expertise required to promote a risk management approach in this area and they can usefully link this with their existing guidance on site transport safety.

Rehabilitation

37. There needs to be a greater focus on rehabilitation as a means by which employers can retain the expertise and skills of staff who become ill or injured during their working life. This would dovetail with the focus of work and initiatives being developed by the Department of Work & Pensions to encourage people off benefits and into work. It would also complement the legislative requirements on employers in relation to the Disability Discrimination Act 1995.

Safety Case Regimes

38. Policy and regulatory developments should be focused on the issues that give rise to both the largest number and the most serious accidents, including enhancing HSE's ability to run "safety-case" regimes for high-hazard industries. The latter may require a strengthening of HSE's technical and scientific base.

Strengthen HSE's Investigation and Prosecution Arrangements

39. HSE needs to become more professional in handling prosecutions and investigations. The "Prosecution Pilot" model should be rolled out across England and Wales. There should be much better resourcing of the professional forensic support by scientific and specialist inspector staff to back up HSE investigations into deaths and injuries at work. HSE should seek registration of its forensic support staff with the Council for the Registration of Forensic Examiners, to bring them into line with other forensic professionals.

Research

40. There should be greater investment in scientific expertise to research and develop procedures and devices of benefit to health and safety at work.

Publications

41. There is currently a review being undertaken of HSE's publications policy. Since the autumn there has been a moratorium on work on publications and important work to provide information to businesses has stopped, largely for resource reasons. We are concerned that there is talk of HSE's reigning back from publishing as much information as it does. HSE's in-house publications unit is a vital part of what HSE does. The publications staff can help with targeting the guidance and making it appropriate because they know and understand HSE's business. HSE guidance is authoritative because it gives the legally enforceable line, it tells businesses what they must do to avoid getting into trouble. All the evidence suggests that HSE guidance is well targeted and appreciated by businesses. The main complaint is that more of it is not free. It is right for HSE to continue to produce high quality practical advice to employers from the perspective of the enforcing authority, which is well placed to advise employers on the steps they need to take. Our safety representatives inform us that the use of HSE publications is a vital lever in achieving health and safety improvements in the workplace. Their employers see the HSE publications and it tells them they must address the particular issue to achieve compliance.

Prospect

February 2004

Annex A

HSE's budget was £258 million in 2002–03 but in the 2002 Spending Review HSE was only allocated £262 million for 2003–04, £262 million for 2004–05 and £260 million 2005–06. These small increases do not keep pace with rising costs and amount in real terms to a cut in expenditure of 10% over the 3 years. To keep pace with inflation alone, an increase of £5 million would have been needed for 2003–04. The reality is that some costs are rising faster than that, for example, HSE's London office costs are increasing several fold. From 2004 the budget is static in actual terms and falls the year after. The £4 million funding for work to implement the recommendations of the Cullen report is also removed in 2005 so some work on railway safety may have to be cut or cuts made elsewhere. The ministerial view on these figures is that since 2001–02 HSE's resource allocation has risen from £244 million to its current budget for 2003–04 of £262 and that HSE has been provided with an additional £4 million for 2003–04 and 2004–05 to fund the Cullen recommendations. So technically the budget has increased from 2001–02 to 2003–04 but this is only through a comparison of 2003–04 to 2001–02 and not the immediately preceding year, and in real terms we see this as a cut.

Annex B

Contract Research Report 385 2001, "The impact of HSE—a review" (http://www.hse.gov.uk/research/crr_pdf/2001/crr01385.pdf) is instructive. This literature review cites a number of other studies done on effectiveness. It says:

> *"A number of studies shed light on issues surrounding how the HSE achieves maximum impact. Although this was not directly part of our remit it seems sensible to report the main findings, if only in passing. In so doing we look at issues related to the role of regulation and enforcement as a factor motivating employers to take action on health and safety.*
>
> *The evaluations of specific legislation generally concluded that compliance with the law was the most important reason that employers took actions to improve their health and safety practices and procedures (eg Honey et al, 1996b, Lancaster et al 2001). Hillage et al (1997) found that among SMEs the threat of prosecution can raise awareness and understanding of workplace risks and can lead to the adoption of better health and safety practices. The two most influential factors identified by Lancaster et al in their examination of the factors motivating practice health and safety management were the fear of loss of credibility and the belief that it is morally necessary and correct to comply with health and safety regulations. Ashby and Diacon (1996) found that the most influential factors motivating companies to take action to limit the risk of occupational harm were compliance with government health and safety regulations and limiting possible legal liabilities. These*

were found to be far more influential than business factors such as reducing wage costs or improving productivity. The evidence therefore seems to suggest that there are at least two related factors at work here:

the fear of being taken to court and/or receiving claims for compensation if found to be in breach of the law;

the acceptance that the law is an expression of what should be done and that there is a moral duty to meet it.

If this (very simple) analysis is broadly correct then it suggests that different actions need to be taken by the HSE in different circumstances. Wright (1998) concluded that no single regulatory strategy is ideally suited to all sectors or sizes or organisation.

However their report also argues that the motivation of firms varied in a reasonably predictable way and that HSE intervention strategies should be based on an understanding of these variations. A qualitative study by Hazel Genn (1993) reached a similar conclusion that self-regulation only worked under a specific set of circumstances and that a greater understanding of the way companies worked could lead to a more differentiated response by the HSE."

Research Report 44, "The role of managerial leadership in determining workplace safety outcomes "(http://www.hse.gov.uk/research/rrpdf/rr044.pdf)" also supports the view that regulation is effective in motivating senior managers and that more of it is therefore likely to be even more effective. The evidence does not support the view that the "safety pays" message is all that effective, and that it is the strategic importance of Corporate Social Responsibility that is a better message. It contradicts the view that we should be shifting focus away from regulating compliance with the law: *"These results have important implications for government safety policy. They reject the notion that current regulatory mechanisms are ineffective in motivating corporate governance of safety, and confirm the notion that the motivation to achieve good health and safety standards are linked primarily with regulatory requirements and that government regulations are necessary in order to protect employees against excessive levels of workplace risk.*

Supplementary Memorandum submitted by Prospect

OCCUPATIONAL HEALTH

1. We lag behind our European partners on OH provision. There are many factors behind this, but an important one is that the Employment Medical Advisory Service (EMAS) within HSE has been cut drastically. It is no longer able to provide comprehensive cover on occupational health advice and prevention, nor provide the leadership role it once did to the occupational health community in Great Britain. HSE now employs just 15 doctors/occupational physicians (referred to in HSE as medical inspectors) and 27 nurses (referred to in HSE as Occupational Health Inspectors) to cover all of Great Britain. Perhaps because EMAS has been decimated, it no longer even seems to feature in HSE's strategic thinking on occupational health and safety. Just 12 years ago EMAS had around 120 staff split roughly 50:50 between doctors and nurses.

2. EMAS was set up to provide information and advice on occupational health to employers, the HSC, and others. There is a duty in the HSWA that it be maintained—in its current state of dilapidation, it is hard to detect any maintenance at all. If this was maintenance of a car it would not pass its MOT.

3. Instead of pressing for a reinvigoration of EMAS, the new focus within HSE is on setting up alternative structures for occupational health. The "Strategy for workplace health and safety in Great Britain to 2010 and beyond" says that leverage on health issues will require new methods and goes on to talk about developing "innovative partnerships in the public and private sectors to develop the provision of occupational health and safety support." On the face of it this sounds like a good idea. A European survey reported that the UK had the lowest level of occupational health provision in the developed EU at 34% of workers. Anecdotal evidence suggests that this is an overestimate when considering substantive and effective occupational health services such as access to a company doctor or nurse.

4. There is undoubtedly a pressing need for better provision of occupational health services. The question is how best to stimulate that provision and how best to use public resources to effect that change. The proposal is that a new organisation would be set up using "partners" to provide free telephone information and advice centres, and where verbal advice was not sufficient to provide a free visit by an "assessor". Only where further specialist advice was required would charging come in. The aim is to advertise the services of this new organisation and stimulate demand through marketing. It seems clear that this will not be self-financing and considerable public funding will be sucked into the new organisation. (In a new pilot for the Construction Industry, "Constructing Better Health", HSE has pledged £200,000 and has suggested that the DWP also provide funding. The costs for the pilot are estimated at £1 million for a relatively small geographical area—half of the funding from public money.)

5. Prospect recognises the need to better integrate existing provision, improve access to specialist services, and to support community based occupational health projects. However we are concerned that what is proposed starts from the wrong position which should be proper resourcing of EMAS to drive forward occupational health in Great Britain and provide leadership to the system. Setting up alternatives to a properly funded EMAS will not be cost effective in terms of the benefits secured for the resources spent. As with other concerns over the future direction of HSE, there appears to be no evidence that this new voluntarist approach will actually work in tackling the epidemic of occupational ill-health in Great Britain. A vibrant EMAS would be effective in providing incentive to employers to make effective occuptional health provision and would be able to provide the necessary advice to employers, as Parliament originally intended.

6. Prospect supports the call for a greater focus on rehabilitation as a means by which employers can retain the expertise and skills of staff who become ill or injured during their working life, but advises caution about its application. Whilst it is only right that employers should provide whatever help they can to employees to get them back to work, it is important that the focus on rehabilitation does not detract from prevention. Also the evidence for the effectiveness of resources spent on rehabilitation is sketchy. The evidence seems limited to examples where getting employees earlier treatment for injury than they would otherwise get on the NHS, reduces the length of absence, rather than that the rehabilitation interventions in themselves improve treatment outcomes. The anecdotal evidence from Prospect members working in occupational health is that the strongest factor in determining length of absence is personal motivation to return to work.

18 March 2004

Memorandum submitted by EEF

About Us

EEF, the manufacturers' organisation, has a membership of 6,000 manufacturing, engineering and technology-based businesses and represents the interests of manufacturing at all levels of government.

Comprising 12 regional Associations, the Engineering Construction Industries Association (ECIA) and UK Steel, EEF is one of the UK's leading providers of business services in employment relations and employment law, health, safety and environment, manufacturing performance, and education and skills.

Executive Summary

1. We welcome the opportunity to submit this written evidence to the House of Commons Work and Pensions Select Committee. The Health and Safety Commission and Executive are organisations we work closely with at both regional and national level. The levels of competence and commitment amongst the staff of these organisations are of the highest level. Whilst we offer criticism as well as praise for both of these bodies this is done in the spirit of seeking further advances from a "quality" team.

2. Our evidence follows loosely the format described in the Department of Work and Pensions Press Release which announced the committee's review.

3. The headline issues which we wish to raise are:

The real challenge for HSC/E to address is how to get health and safety across to small firms to ensure it is an integral part of even the smallest business HSC/E as a driving force in British health and safety The policy work and campaign initiatives across HSE lack horizontal co-ordination. This can lead to unrealistic demands being placed on stakeholders for policy responses and initiative overload with campaigns HSE should become an outcome rather than output focused organisation HSE needs to encourage companies by supporting the business case for health and safety excellence.

4. We are happy to provide further information and should the Committee wish it give oral evidence.

Legislative Framework

5. The legislative framework for Britain's health and safety system has been built on the visionary introduction of the Health and Safety at Work etc Act 1974. A significant proportion of EU legislation which has subsequently built on the general principles of the Act have shared its fundamental philosophy and therefore worked well in conjunction with the primary legislation. However, recently we have been moving into areas of new legislation which are poorly thought through. These add cost to business sometimes with few or no attendant benefits. This also undermines the status of health and safety amongst employers.

6. If the status of health and safety amongst employers is undermined it will erode the broad consensus between regulator and regulated. This must be there if the regulatory system is to have any chance of working in practice. We detect that some are starting to ponder the case for increasingly demanding good/best practice, if it does not give them any advantage over those who aim for minimum legal compliance instead

7. Some areas of EU legislation are notoriously difficult for business to understand and it is at times difficult to obtain clear direction from HSE on the steps to be taken. In particular legislation connected with the distribution and use of chemical and requirements which cover machinery/plant safety. Areas for specific concern include:

(a) The Pressure Systems Safety Regulations 2000.

(b) The Supply of Machinery Regulations.

(c) The "CHIP"1 requirements.

(d) The Carriage of Dangerous Goods suite of requirements.

8. Modern health and safety legislation is based on the concept of risk assessment. However, the duties to comply with this requirement are scattered across many differing codes of Regulations. The HSE should focus on providing in effect a one-stop shop approach enabling duty holders to determine all the risk assessment responsibilities from one source.

9. It is not clear what contribution legislation has had in improving standards of health and safety in the British economy. This is due in part to the nature of the legislation and the changing dynamics of the economy. We believe that there are three broad factors which have influenced the dramatic improvements in national health and safety performance in the last three decades. These are:

(a) The decline of traditional "heavy" primary production and manufacturing businesses.

(b) A growth in business quality which has lead to improving health and safety performance being driven internally by business.

(c) A regulatory framework which largely sets objectives rather than prescribes outcomes.

10. The decline of traditional "heavy" primary production and manufacturing businesses we believe has contributed significantly to the decline in ill-health and accidents from these sectors. Those businesses which still operate in this part of the economy are radically different enterprises to those of 30 years ago. Health and safety is now actively managed and the influence on both quality of life and economics is more fully appreciated.

11. A central plank of the "Robens" philosophy which gave rise to the 1974 Act is the concept of self-regulation. We are of the view that despite one very short-lived pilot some years ago there has been very little appetite to date within HSC/E to see self-regulation truly flourish. To thrive HSC/E should establish a framework which sets business free to operate without routine regulatory scrutiny. This would then free-up significant resources and enable them to apply their expertise to those areas of business which will benefit significantly from their input.

12. Larger employers, or sub-contractors working for them feel that they are more prone to HSE intervention, merely because they are easier to identify compared with the more elusive smaller firms where standards are often lower. Whether real or not that is certainly the perception of business and serves to further erode faith in the regulatory system.

13. We have concerns about the way in which HSE executes some of its responsibility to negotiate EU health and safety proposals on behalf of the UK. The organisation is generally excellent at the process of involving stakeholders in the developing issue. It is an exemplar to other EU States in its early development and subsequent revision as amendments are made, of Regulatory Impact Assessments. This being a lesson which the European Commission should learn. However, we are not convinced that the HSE and UKREP have a high-level strategy for influencing new EU regulatory initiatives at the design stage. Consequently HSE are often negotiating poorly constructed or justified proposals.

14. There are fundamental concerns voiced by British industry on the way in which HSE has handled the negotiations of the Physical Agents suite of proposals. The original dossiers date back to 1993. The text successfully passed its first reading and in 1994 the single text was split into four to facilitate subsequent negotiation and delivery. Two of the proposals (Vibration and Noise) have been adopted. One concerning the control of workers' exposure to electromagnetic fields is likely to be adopted before European Parliament elections and the fourth and final dossier—optical radiation, is likely to begin its Council stage in the second part of the year. Our concerns are that whilst HSE/UKREP will present a strong UK view they do not challenge the general principle of the need for legislation. For example the Physical Agents (Electromagnetic Fields) dossier will not improve the health and safety of EU workers. This is not simply the EEF view it is also the stated opinion of the HSE. However, they have resigned themselves to the fate of adopting this directive due to the Qualified Majority Voting process which this policy will follow.

15. In our view representations at the most senior level and at the earliest stage, should have been made to the effect that there was absolutely no justification for adopting this legislation. A criticism of the process adopted by HSE, again using this dossier as an example is that the Executive concluded the investigation whilst lacking knowledge or information about how the dossier would impact on manufacturing industry. It is questionable how an effective position by the UK can be maintained with this gap in their knowledge.

16. A similar story exists for the Physical Agents (Vibration) directive. This is concerned to limiting workers' exposure to two forms of mechanical vibration, hand-arm, (HAV) and whole-body (WBV). Whilst HAV is a known occupational health issue WBV is not. However, EU industry will find itself complying with expensive measures which add cost and do not improve health and safety.

17. It is our view that the HSE shelter behind QMV rather than meet the issues of principle which these examples illustrate. In a different but related field we have seen how the British Government working in concert with the French and German leadership are able to significantly change the direction of proposed EU environmental policy. We refer to the letter sent by the Prime Minister, the French President and German Chancellor regarding the "REACH" proposals. Whilst in diplomatic terms this is something of a "nuclear" option we find it hard to envisage circumstances where HSC/Ewould be prepared to advise Ministers to take such a stand?

18. While legislation provides the foundation for the British health and safety system, what it cannot do effectively in its current form is to manage expectations of various stake-holders. Ironically one of the strengths of our system—objective setting—is also a weakness because duty holders can never be sure when they have done enough. In the course of routine inspections HSE staff are, for example, unwilling to agree whether the conclusions of a risk assessment are adequate. Employers' are often circumspect about this, observing that it is after an accident or other event when HSE are likely, with the benefit of 20:20 hindsight to reach the conclusion that a company had failed to satisfy its responsibilities.

19. In the absence of clear decisions from the inspector, the employer (faced with increasingly generic goal setting legislation) is uncertain what he actually has to do. Good performers over-react because they are anxious to guarantee compliance. Poor performers do little one way or the other. The net result is that the gap between good and poor performers grows rather than reduces.

Achieving Outcomes

20. We would very much welcome a significant shift in the way in which HSC/E do business. That change would be their becoming more outcome orientated. A starting point for this analysis is to consider whether Britain is on course to meet the targets set out in the Revitalising Health and Safety Strategy. There is perhaps a pre-cursor to this question: are the revitalising targets and Action Points the correct ones? HSC/E and DTLR carried out an extensive consultation exercise with stakeholders to formulate the Revitalising Strategy. This level of inclusion is typical of the way in which HSC/E operate and is something which we applaud. However, as there is a paucity of baseline data and a lack of clarity regarding what is the objective or the deliverable of the specific action we cannot be sure that we have the right agenda.

21. Revitalising is one of many initiatives launched by HSC/E. This is an example of an important role carried out by the regulator responsible for enhancing the performance of the British system however; it also suffers from a common HSC/E problem—that of initiative over-load. At any one time HSC/E regionally and nationally are active in a number of separate campaigns or initiatives. These rarely appear to be part of a cohesive whole and a fundamental weakness of the organisations is the lack of management and co-ordination of these projects. The sheer number of initiatives also has the effect of diluting their quality and impact. It is rare for any assessment of an initiatives efficacy to be measured

22. We take the view that in order to deliver on Revitalising and other initiatives the Executive should firstly redefine part of its remit to be clearly a campaigning organisation. Secondly it should identify a narrow area of target themes or issues. Thirdly it should decide how they will know when the aim of the campaign has been reached. We believe that the long overdue appointment of a Communications Director for HSE is an important initial step in improving HSE's performance in this area.

23. A perennial question concerning HSC/E is whether the HSE get the balance right between prevention and enforcement. Clearly when a House of Commons Select Committee last reviewed the work of this organisation it decided that the balance was wrong and more emphasis needed to be placed on enforcement. We should expect that such a change was intended to improve the health and safety performance of the nation. It is still to our best knowledge, most unclear whether any correlation exists between the two. We would also reiterate the concerns of the previous committee concerning the appropriate targeting of resources.

24. The general subjective view of manufacturing industry is that there has in recent years been a greater willingness by the regulator to take some form of enforcement action. Comments regularly received from member companies suggest that the individual discretion of Health and Safety inspectors has been greatly eroded. This coupled with a relatively inexperienced field force and a greater systematisation of the processes to be followed, leads we believe, to a more rigid and therefore on occasion inappropriate use of formal enforcement action.

25. Customers are increasingly sensitive to employing contractors who have some HSE enforcement on their record, however minor. This is in essence a problem created by clients who fail to consider how the business has subsequently improved. However, this problem is underpinned by the Executive's publicity of enforcement and not achievements or improvements.

26. HSE are generally quick to publicise failure (eg the enforcement database on their website) but there is it seems no mechanism to celebrate excellence. The latter could become a real and substantial business benefit. There should be more focus on demonstrating that "good health and safety is good business".

27. An area of specific concern voiced by our members is the way in which Improvement Notices (INs) are checked-off by Health and Safety Inspectors. The IN is issued by the inspector identifying a failure to comply with the HASAWA or regulations made under it. The notice details the breach and often suggests remedies which may be applied. Our concern is that companies will often invest significant time and other resources in compliance with such a notice. The subsequent check by inspectors is often described as "cursory." This is often a significant de-motivator for the business concerned. If an issue is of such a serious nature to warrant the service of an IN, in our view it should deserve a detailed consideration by the HSE to ensure that it has been adequately discharged.

28. It is vital that the HSC/E has as part of its remit researching and investigating new occupational health and safety issues. However, we believe that its response should always be proportionate to the need. There is still much which needs to be done with work and processes which are far from novel. Sadly work at height is still one of the most significant hazards in diverse working environments. The HSC/E resources should flow to where the problems are known to exist rather than seeking out new areas of interest.

29. One of the concerns which we have voiced about the way in which HSC/E deals with new/emerging issues is. In their haste to gain authority over a policy area, they have carelessly defined stress as occupational stress. The use of this phrase has in our view, lead to the popular misconception that work and stress are synonymous. This is simply not the case. Such carelessness in the message sends a negative impression of the world of work and fails to engage some of those who may be best placed to deal with mental health problems when and indeed before they arise in the workforce. The workplace provides the ideal arena for addressing adult and particularly male, health issues.

30. Stress may or may not be rooted in the way in which an individual perceives their working environment. It is their perception which is at the heart of this. The perception of stress is no less likely to change than that of happiness. When as employers we address this issue we do so from the perspective that the feeling of stress is very much part, albeit an unpleasant part, of the human condition. However, in its attempt to raise awareness and encourage employers' to address the issue of stress when it manifests itself in the workplace the HSC/E have been guilty of a gross oversimplification.

31. Work related stress is also potentially a fertile area for civil litigation. At the same time it provokes all manner of complex interactions with employment law and possibly disability discrimination. We have to recognise this in our advice to members. In this respect there should be much more practical joined-up thinking between government departments. This applies to both the employment initiatives which are proliferating as well as H&S ones.

32. The message which HSC/E should be voicing is their wish to engage with business to address stress related problems through the workplace. In a similar way that other lifestyle initiatives have been followed in other public policy areas such as healthy diet and the importance of exercise.

33. Another area which we understand that the select Committee is interested in as an "emerging" issue in the workplace is "passive smoking". The lack of progress of the Approved Code of Practice on this subject has been a matter for concern in many quarters. It is vital that any policy change in this area is one which is co-ordinated across public policy. The workplace must not be in the vanguard of changing social policy. It should play its part but in a way which means the same restrictions on smoking are being placed on the general public at the same time. This will both deliver the health based policy objective and not lead to conflict in the workplace. Many employers have very positive polices towards smokers and the effects they may have on others. Companies will often offer practical support to employees who wish to give-up smoking.

34. Penalties for health and safety offences are often a subject of public debate and have recently been the subject of public comment by HSE's Director General, Timothy Walker. However, there doesn't seem to be any evidence of which we are aware that indicates a correlation between fines and behaviour. In other parts of the criminal code it is relatively easy to demonstrate such a relationship, many motor offences would in our view, fall into this category. We are aware that HSE have recently commissioned Greenstreet Burman to do some research in this area, this is yet to report. We believe this study is based only on the subjective opinions of stakeholders. This issue returns us to an earlier comment that concerns the HSE following strategies which are intended to deliver some sort of change. The argument for higher fines would be won if a correlation between them and workplace health and safety could be demonstrated. Our suspicion is that such a relationship is unlikely to become apparent because circumstances which give rise to health and safety offences being committed are fortunately very rare and in many cases are not directly transposable to another workplace. As a consequence an individual business is unlikely to modify its behaviour. If the sole justification for higher fines is to exact greater retribution or as a covert way of raising revenue then we believe that these aims should be made clear.

35. At present the HSC/E receives no resource benefit from prosecuting offences. We would support a policy change which lead to HM Treasury hypothecating fines so that the fines from employers and employees are re-invested in the HSC/E to facilitate their driving greater improvement.

36. An area of prosecution which is still rare, although this appears to be changing slowly, are the prosecution of individuals. Whereas the prosecution of for example one engineering company is not likely to influence the others in the geographic area the prosecution of one of the company's employees at what ever level within the business, is likely we believe, to have both an immediate and long lasting effect on the behaviour of those within the enterprise.

37. The understanding of health and safety legislation is subject, as might be expected, to greatly differing levels of comprehension. Whilst many would claim to have a proper understanding of the legislation there are traps waiting for the uninitiated. Fundamental to our system are the particular definitions to concepts such as hazard and risk. Whilst lawyers, HSC/E staff, and health and safety practitioners will understand the distinct and importantly, separate meanings assigned to these terms the uninitiated may use them interchangeably which is done in everyday language. Another difficulty exists for all in interpreting much health and safety legislation and particularly what is meant by "competent"? For example when a "competent person" is referred to in legislation there is usually generic supporting guidance on what this means. In practice the practical definition of the term usually only arises through litigation in defining by exception what a competent person is not. This is another example of where business only finds out when it has failed to meet rather than achieve the required standard.

38. We hold the view that an important part of HSC/E's work is to inform and guide duty holders to assist in their understanding of specific responsibilities. To support this process they have a reputation as a prodigious publisher. However, all but the briefest of leaflets (and even those in multiple copies) are charged for. Whilst we understand the need to charge for hard-copies we equally believe that all the material should be freely available to view on their web-site. We believe that recent on-line initiatives like "COSHH Essentials" and the forthcoming "Chemical Essentials", (in partnership with EA/SEPA) are excellent. There is also the excellent example of the free DTI/Envirowise environmental guides which HSE would do well to aspire to.

39. Better adherence to health and safety good practice will be a function of a better educated community, not a culture of "fear" where the threat of punishment is seen as the first and only approach. Therefore issues such as:

- relating to senior managers (see comments below, para 42);
- educational rather than confrontational site visits; and
- aligning the LA Enforcers to act as the "infantry" in everyday work.

40. H&S specialists understand the difference between regulations, codes, guidance, leaflets etc. generally employers do not. If it is published by HSE it's frequently taken as "what you have to do". Formulaic wording in the foreword does not overcome this.

41. The impact of guidance is amplified by the threat of civil cases. Rightly or wrongly most perceive that if you have not complied with the HSE guidance in full, you will automatically be prone to compensation claims. By and large it is the better H&S performers who recognise these concerns and react to them. Poorer performers may not have even read the guidance. Thus the gap between good and poor performer is increased rather than reduced.

42. Guidance has to deal with goal setting legislation. There is always some uncertainty. We detect a tendency in HSE guidance to default to the more onerous/cautious option. A good example is the proposed guidance on hand arm vibration (see para 16 above). The draft guidance with regard to measurement reads to the effect "unless you can be sure you don't need to, measure it" rather than what it should be: "don't measure it if you don't need to". This is likely to lead to responsible employers carrying out excessive, expensive and unnecessary measuring when they could simply have carried out more generic risk assessments to decide on appropriate effective preventative actions. The guidance needs to be more practically and realistically based.

43. HSC/E needs to consider carefully how it can communicate the health and safety message more effectively to small firms. Despite research into this area2 we have seen little evidence of marked improvements in targeting those businesses which most need help. Written guidance is often too long and lacks the "plain English" approach.

44. Encouraging good practice is in our view a fundamental part of HSC/Es responsibilities. Britain's contribution to European Health and Safety Week is held up as an exemplar to other Member States. We believe that on a regional basis that there is much more that can be done both to encourage the development of good practice and also to celebrate success. This is something that at operational level, the organisation appears to have shied away from. We would encourage this policy to be reversed. In one or two HSE regions there are the early signs that attitudes are changing with the development of greater trust in working with partners to deliver health and safety in the workplace. Much more needs to be done on this front.

45. It is vital that HSE's field inspectors have access to the right support so they can do their job properly. We are of the view that this support for those officers dealing with the manufacturing sector has deteriorated significantly over the past 6 years. Inspectors working inspecting engineering premises used to be supported

by a well resourced National Engineering Group based in Birmingham. One of this national team's functions was to support field inspectors when difficult or complex issues arise. This unit is no longer effectively resourced which is detrimental to the consistency of inspection and prevents a strategic approach being adopted by HSE in this sector. It is essential that the HSE field force have similar support to that enjoyed by their colleagues working for the Environment Agency.

46. Is there sufficient emphasis on "health" in health and safety? The initial gut response is probably not. However, the reality is we simply do not know. The HSC/E is fond of stating that our safety performance is world class in contrast to our rather tardy occupational health performance. When pressed on this, references are often made to availability of access to occupational health services in other countries as a surrogate for demonstrating better occupational health performance. This is simply not evidence enough. The problem is compounded by an organisation that whilst espousing the importance of placing renewed emphasis on occupational health has cut its own specialists in this area to a fraction of that which they once were. Whilst not wishing to appear as though we believe that the only positive work which can be done in the occupational health sphere is done by physicians and nurses—this is not the case—however, it does send something of a mixed message if the body calling for refocusing on these issues will not itself invest in the skilled staff. What are we stakeholders to make of this? We agree with HSC/Es that occupational health is important and have appointed a senior Occupational Physician to deliver our occupational health business plan on our members' behalf; the only business organisation in the UK to our knowledge to have done this.

Resources

47. There is a lack of clarity concerning HSC/E's current objectives which makes it difficult to comment on whether adequate resources are provided. We simply do not know whether the appointment of say 50 more health and safety inspectors would lead to improvement x in health and safety performance and therefore secure saving y for all concerned. This is why we have emphasised in our comments the need for the organisation to become outcome rather than output orientated.

48. As previously mentioned we believe that the occupational health specialism within HSC/E—EMAS—is significantly under-resourced particularly as a major part of the future strategy concerns itself with health related issues. To be credible in this agenda they will need to have access to high quality occupational health advice.

49. In considering resources it is also necessary to return to the proposal which we made earlier when considering fines. That is the concept of hypothecation so that there is a direct relationship between fines and the resources which HSE receives.

50. There is a vital role for HSC/E to play in facilitating good coordination between themselves and those other parts of central and local government with a role to play in promoting health and safety. We believe that with regard to Local Authorities, (LAs) HSC/E has always been hamstrung in not being given any influence other than that of persuasion over these separate enforcing authorities. To businesses inspected by the LAs that means priorities are set locally or not at all and that there is inconsistency of approach adding cost to multi-site operators.

51. The Revitalising strategy makes much of the public sector becoming an exemplar of good health and safety performance. There appears to be little evidence of this happening or indeed of HC/E's leadership role in this. HSE needs to demonstrate this leadership across other government departments as well as local authorities. It also must gain more influence to ensure that government as a major client, uses its influence through procurement, to influence their suppliers, health and safety performance.

Research Funding

52. It appears to us that the HSC/E have a growing reliance on research companies such as Greenstreet Burman who are tasked to produce reports such as the recent enquiry into compliance levels with the Employers' Liability Compulsory Insurance act 19693. These reports will typically be based on the subjective views of a variety of stakeholders, which are often drawn from the same pool. These opinions are then presented as a statement of fact and used as the basis upon which to take policy forward. We believe that if such work is necessary it should be as a precursor to verifiable results.

Small Firms, Competing Demands and New Areas of Work—HSC'S Future Strategy

53. The HSC draft 10 year strategy4 for the first time recognises that the health and safety system has not served small firms well. The real challenge for the system and the regulator at the heart of that system is to improve health and safety practice in these companies. They are in our view the hardest to reach however, the majority of people who work in the private sector work in such businesses. We believe that HSC/E should be given more directional authority over LA health and safety operations and re-focus their own and LA activity to put the emphasis into small firms. An example of HSC/Es willingness to change is that contrary to the self-regulation philosophy espoused by "Robens" most small firms simply want to be told what to do. We understand that ways are now being investigated of meeting this need. At the other end of the spectrum many larger businesses would welcome a lighter touch from the regulator. These are businesses

which have moved beyond minimum compliance and set their own continual improvement agenda. HSC/E should be encouraged in having the confidence to work with business to facilitate this approach. This should not be seen as de-regulation but simply enabling the regulator to direct its resources to where they are needed and where they can most make a difference.

54. Our support for the lighter-touch described above is also logically consistent with our concerns that HSC/E is starting to see a role for itself in the Corporate Social Responsibility, (CSR) agenda. This by definition only involves companies performing well beyond the compliance zone. Typically they are also pan-national or global enterprises. It is highly questionable why HSC/E should use its resources to try and influence this movement which has grown from without national state institutions. HSC/E resources are much better directed to the below compliance enterprises, arguably this is also where its legal responsibilities lie.

55. We believe that as society has become increasingly risk-averse so has the pressure increased on the health and safety regulator to respond to an ever wider spectrum of demands. We have strongly urged HSC/E to define in straightforward terms its "footprint" of operations, the draft strategy failed to do this. By doing so they will be assisted in managing the expectations of their many stakeholders and reduce the pressure on them to be "the enforcer of last resort" ie If there is no other specific criminal legislation then the Health and Safety at Work Etc Act will be used.

56. A proposal which the draft strategy offered which we believe has merit is the separation of information and enforcement functions. This could have great merit and is a model followed in the US and other EU countries.

57. An important area where we feel HSC/E still has work to do is in being a credible voice to those people running enterprises. HSC/E has a very full communication with the health and safety community. However, they still struggle to be a convincing voice in the boardroom. We believe that this is because HSC/E still has to find effective ways of communicating to business at the most senior level that business sustainability is inextricably linked with good health and safety management.

Business Awareness

58. The HSC/E have for a number of years voiced the view that good health and safety management is good for business. We agree with this assertion and yet what we wait to see are programmes from the HSE working in concert with DTi demonstrating how enhancing health and safety performance supports business sustainability and so is a vital component of developing world-class enterprises.

59. In the environmental arena "Envirowise" have for a number of years published guidance which both enhances profitability and environmental performance for the businesses that follow this. This is a model which we have encouraged HSE to follow.

60. Another aspect of the business awareness agenda is that HSC/E does not assess the civil consequences of changes to the criminal code which it is proposing. Understandably they will argue that their sphere of operation is solely the criminal. However, their customers have to have regard to both. We would like to see a greater awareness particularly amongst policy staff of the way in which proposed health and safety legislation fits into the broader landscape of managing a business.

61. There is a feeling that HSE inspectors would benefit greatly from spending periods of time in industry to appreciate the real and practical difficulties of complying with legislation and how criminal requirements fir into a broad range of management responsibilities.

62. HSC/E is excellent at following Cabinet Office guidelines on consultation; however, this is marred by the apparent inability to co-ordinate activity across different policy areas. Consequently business will often find itself being asked to respond to a number of detailed consultations at the same time. This is symptomatic of a serious deficiency that being the apparent inability to co-ordinate various work-streams. The problems of delivery co-ordination problems are also well illustrated by the failure of HSE to deliver the guidance which industry needs to comply with new regulatory requirements at the same time as these requirements come into force. A recent example off this is the suite of guidance produced to support the Dangerous Substances and Explosive Atmospheres, (DSEAR) requirements. The full supporting documentation was only available to business a year after the Regulations commenced.

Conclusion

63. An area which does not appear to be part of the Committees deliberations or for that matter our detailed comments are the management arrangements of HSC and HSE. Although most other tripartite organisations have been and gone, some may consider this model out-moded, we hold the opinion that the separation of Commission and Executive and the broad composition of the Commission have served us well over the last 25 years and should continue to do so.

EEF

April 2004

Memorandum submitted by Business Services Association

The Business Services Association is a policy group for major companies providing outsourced services to companies, public bodies, local authorities and government departments and agencies. The combined annual turnover of its 20 members is around £15 billion. Member companies employ directly and indirectly more than 500,000 people. BSA members provide services to at least 98 FTSE 100 listed companies and 194 FTSE 250 listed companies.

BSA welcomes the opportunity to respond to this inquiry, which touches on issues of great concern to the private sector. BSA member companies are very conscious of their corporate responsibility and recognise the important role which Health and Safety (H&S) plays in this. For this reason representatives from member companies with Health and Safety responsibility are keen to be involved both at this stage of the inquiry and with any subsequent evidence sessions or inquiry.

The Legislative Framework

The guidance in the Health and Safety at Work Act 1974 is still relevant and useful as a general guidance document, but problems can occur in specific situations where the Act is simply too broad. It is unsatisfactory that the interpretation of the Act often has to be dependent on legal rulings which may not take full account of the practical realities. This is a situation that could be avoided with better sector specific guidance or better national education of those responsible for ensuring H&S standards are maintained within companies.

The current guidance is complex to understand and implement. As a result, while big businesses which are already aware of H&S issues generally work hard to maintain good H&S standards, there is a tendency for smaller organisations to either tolerate guidance or ignore it until a crisis occurs. SMEs often do not know which laws apply to them, and do not always have access to competent advice.

In these circumstances H&S may only be perceived as important to ensure and maintain a good reputation or through fear of the penalties involved. The extra costs involved in maintaining a "safe" working environment may not be spent in order to keep profit levels high enough for a company to stay afloat.

Achieving Outcomes

We believe that further regulation is unlikely to improve health and safety levels. This will come about only through stakeholder pressure and the further development of initiatives such as corporate social responsibility.

Prosecution is a result of failure, and should be avoidable in the majority of cases if proper education and training is provided. A major culture change is needed to shift the main focus to prevention rather than prosecution as the best way to address H&S issues. In order to achieve this, HSE needs to be visible in the workplace, but it appears that much of the advisory material produced at present is not appropriately targeted and that adequate resources to carry out wider preventative work are not currently available.

A number of major companies employ their own internal H&S inspectors to perform regular audits. These representatives promote awareness of the rules and can be approached internally without fear of punishment. We believe that HSE should look at developing closer links with these inspectors, who could provide a valuable resource to promote and support HSE's role in safety management within their own businesses. Increased free information and advice and the provision of properly administered training sessions for company H&S representatives would set the ball rolling to improve standards throughout the supply chain.

Both employers and employees need to be more aware of their responsibilities in the area of Health and Safety, both in prevention and enforcement. While it may often be the case that an individual's failing are a consequence of failings on the part of the employer, situations do arise where an employer has provided appropriate information and equipment and the employee has chosen to ignore these provisions. In these situations, clearly the employer is not entirely to blame. Overall Health and Safety will not be improved until it is fully acknowledged that Health and Safety is the joint responsibility of the whole workforce. In practical terms, the achievement of such a shift in perception is likely to require an amount of enforcement.

Prevention and enforcement need to be the main focus of HSE's activity, but it is important that this should be achieved without stifling innovation. New ways of encouraging H&S good practice need to be devised and greater attention should focus on HSE guidance in respect of the balance between prevention and enforcement.

Further guidance is needed to assist in the recognition and objective assessment of developing hazards (especially stress) and a code of conduct for dealing with these matters would be welcomed. However some issues which were a matter of concern in the past, such as passive smoking, have now been addressed adequately.

The issue of health hazards is a complex one, since the assessment of such hazards and the diagnosis of their symptoms or associated causes is inevitably subjective. In general, we believe that there is already sufficient emphasis on "Health" in H&S, and that attempts to increase this aspect of HSE's role are likely to prove unworkable. It is essential that HSE should provide specific advice and documentation on any health hazards, such as stress, that it does opt to focus on.

Local authority enforcement of H&S standards can be problematic due to varying standards and priorities across different authorities. There has been evidence of officers wishing to make a name for themselves in the public eye, with priorities differing from proper enforcement practices. Although this can result in local benefits it is sometimes disadvantageous nationally. It may be preferable for enforcement to be dealt with solely by the HSE rather than through the local authority, particularly as this is an area that is often under resourced at local government level, although clearly this would have major resource implications for HSE itself.

In general, legislation is properly understood and applied in large organisations but problems can still occur when staff transfer from public to private sector employment. In dealing with the public sector BSA members have observed a tendency towards a more lax approach to H&S with unsafe acts and conditions allowed to persist. Reported examples include a lack of statutory training when staff are transferred, and a failure to undertake asbestos surveys in buildings prior to transfer. Much of the public sector is seriously under resourced in these areas, both in staff levels and funding, and H&S training is often inadequate. Serious issues may be left unreported and subcontractors are a problem. These are matters which government needs to address urgently if the necessary improvements to overall health and safety in the workplace are to be achieved.

Resources

It is clear that HSE will require more funding and resource if it is to be enabled to work effectively in partnership with industry and business to improve their ability to deliver health and safety advice. In order to ensure that this is of the highest quality and at appropriate levels HSE will need to invest in the areas of research and development. This alone will take a sizeable resource financially.

One possible way of increasing the resources available to HSE could be through the penalties imposed on companies. Penalties for H&S offences could be increased and the additional revenue used to fund inspectors. This could create a self-sufficient cycle. However it is worth noting that large, reputable companies have more to lose in reported cases in terms of image and loss of future opportunities than financial damage.

In summary, the BSA welcomes the increased recognition of the role which business has to play in the improvement of standards of health and safety. Much has been achieved in terms of raising awareness of these important issues, but still more resource need to be invested to enable HSE to promote its objectives and to be equipped to tackle the anticipated hazards of the future.
The association would welcome the opportunity for further involvement in this important area and is happy to provide further evidence, whether written or oral, to supplement this initial statement if required.

Business Services Association

20 February 2004

Memorandum submitted by UCATT

The Legislative Framework

We are supportive of the underlying principles of the Health and Safety at Work Act 1974 in that employers have a duty of care and must protect the health, safety and welfare of their workers and others. However, much of the detail is contained in regulations, which rely in the main on risk assessments being carried out, rather than setting absolute standards.

Our experience tells us that many employers do not carry out risk assessments or they use generic ones, which do not take into consideration the actual risks involved. Where risk assessments are undertaken, employers do not always implement their findings or make those assessments known to the workers undertaking the task.

The HSC appears to have adopted an increasing reliance on goal-setting rather than the more robust actual prescription. We believe that this approach makes the task of compliance and enforcement more difficult for both employers and workers, especially in SMEs.

The principle of consultation with workers through their trade unions was enshrined in the HSWA. The legislation was drafted at a time when the industrial relations landscape was very different. Since that time many of the workers rights which existed in 1974 have been removed by consecutive governments. In particular the HSWA relied strongly on there being a recognised trade union which could appoint safety

representatives and with whom employers could consult. However, construction workers today are faced with employers who are anti-union and many workers are forced into adopting pseudo self-employed status to carry out labour-only subcontracting. Indeed one of our members was employed by an agency but when he became a safety representative his services were suddenly no longer required. As the agency for whom he worked did not recognise trade unions, he was left with no form of redress. There is very limited potential for self-regulation within the construction industry without there being an open culture of consultation and the attitude of these employers means that the vast majority of workers are denied participation.

HSE and HSC

The advice, guidance and research provided by HSE and HSC are excellent, and reflect the qualified and committed staff they employ. However, this cannot compensate for the lack of resources which prevent the inspectors carrying out enough workplace inspections where no prior warning has been given to the employer or being able to fully investigate all the circumstances which have led to serious accidents or injuries.

We support the structure of the Commission and recognise the strong strategic leadership provided by the Commissioners especially in regard to issues such as the priority programmes. These, we believe, reflect accurately the issues faced by our members on construction sites up and down the country. While we support the concept of carrying out blitzes of construction sites in a specified area and over a defined period of time we would be happier if HSE had the resources to inspect more sites, investigate more accidents, instigate prosecutions where offences have been committed and generally become more visible so that employers have an expectation that they will have their site inspected without receiving prior warning.

We are pleased to see that more attention is being paid to occupational health and that rehabilitation is now firmly on the agenda. However, it will require significantly more resources if these issues are to deliver the benefits to society that they are clearly capable of doing. Although government is right to lay down the framework, it cannot be left to government alone. The industry must face up to its responsibilities right the way through the supply chain.

Resources

We have deep-seated concerns about the lack of resources available to HSE and are surprised that the government seems to attach so little importance to protecting the health and safety of Britain's workers. Every time the number of people who are in employment rises, HSE are effectively having their resources cut again and again. The fact that their budget has been frozen until 2006 is serious enough and it is small wonder that they are finding it increasingly difficult to retain skilled inspectors.

The benefits to be gained from increased resources to HSE and Local Authority enforcement departments would far outweigh the additional cost. There is already a shortage of skilled workers in construction and yet as a society we are prepared to continually lose them to occupational ill health and accidents and fatalities. The money spent compensating workers for injury and ill health would be better spent by HSE being able to invest in protecting workers for the future.

However, we consider that more resources should be linked to better enforcement of consultation between employers, safety representatives and workers. It is time that safety representatives were seen as a solution and not a problem by employers.

Enforcement

We have concerns about the extent to which the current number of inspectors can realistically be expected to enforce Regulations on an ever increasing number of building sites. The evidence also suggests that there is little likelihood of anything other than a very serious accident being investigated and therefore no incentive for employers to improve conditions to prevent a similar occurrence in the future.

There is also some evidence to suggest that there is a lack of contact with safety representatives during inspections or visits although there are also reports from safety representatives of inspectors demonstrating that they consider them to be a vital resource as an indication of the true level of management commitment to safety.

We recognise that the primary role for HSE is prevent injury and ill-health but unless there are sufficient deterrents in terms of prosecutions then there will be no incentive for employers to make any changes. We consider the current number of prosecutions is too low. While we also consider that the level of fines are also too low we accept that this is outside the control of HSE. We are particularly concerned that prosecutions are not brought even where employers have received prior notice of a visit for instance where a blitz in a particular area has been widely publicised. It is demoralising for our members as they report that even where serious breaches have taken place, their employer is only subjected to a letter asking for the situation to be remedied and no follow up inspection takes place. We believe that if more resources were made available to HSE, there could be a greater number of inspectors allowing them more time in which to address these issues.

Within the construction industry we consider that an employer's failure to carry out a risk assessment and to then take action on that risk assessment is widespread and responsible for a large proportion of the injuries and fatalities. This view has also been put forward by HSC/E. It would therefore follow that if HSE had more resources they would be able address these issues and make a real difference to the revitalising agenda.

One area that is of particular concern to workers in the construction industry is the lack of consultation by employers and yet not one employer has been convicted for a failure to consult. We have been told that inspectors are frequently advised that there is no safety representative when they arrive to inspect a site and we would question why they do not then challenge employers about whether they have arrangements in place to consult with their workers. At present there is a climate of fear in relation to taking on a safety representative role. This fear is well-founded as many safety representatives have subsequently found that their services are no longer required and while there is statutory protection, there is no likely prospect of reinstatement.

Division of Enforcement Between HSE and Local Authorities

We do not support any major changes to the current arrangements but believe it would be useful for HSC to be able exert greater influence over local authority enforcement. The major issue we would want to see addressed by this change would be the variability of enforcement and the lack of resources across the local authority sector.

Tripartite Approach

We believe that the tripartite approach is one of the strengths of the HSC. Research has consistently shown that where trade unions and employers develop a joint approach to health and safety there is a better safety culture than in those without trade unions. The major benefit of this approach is that in workplaces where there is consultation and trade union recognition with trade union trained safety/ representatives in place the accident rate is 50% lower than in workplaces without these arrangements.

However, much of the guidance issued by HSE is aimed exclusively at employers and managers and does not give sufficient prominence to the role of safety representatives and the impact they can have on safety.

We would like to see changes to the Safety Representatives Regulations which would remove the restriction on inspections and representation being limited to one employer. Construction is a many layered operation with a network of sub-contractors. We would prefer a system where a safety representative can inspect all premises where they have members, including those of contractors.

Publications

We have concerns about the availability of guidance published by HSE. It is of high quality and anyone using it will find it easy to understand. However, much of it is available only as priced publications which creates unnecessary barriers to employees and safety representatives as they do not have the resources to purchase the materials they need. We would like to see all their guidance freely available on the web in accordance with an open government strategy.

George Brumwel
UCATT

20 February 2004

Memorandum submitted by Health and Safety Commission and Health and Safety Executive

Summary

This memorandum sets out the context of our work, describing achievements to date, and the way we are adapting to a changing economy. The introduction of the Health and Safety at Work etc Act in 1974 established both the Health and Safety Commission and Health and Safety Executive, providing a framework of accountability to the Secretary of State and effective corporate governance for the Executive. The Act signalled a new era; the "goal setting" approach to health and safety reflected in the Act was seen by Government as an enabler of innovation, and that approach continues to stand the test of time.

Since introduction of the Act, our work has made a substantial impact, contributing to a reduction in workplace fatalities of more than two thirds. In response to a slowing rate of improvement in the 1990s, Revitalising Health and Safety was launched, setting bold targets and recognising occupational health as a crucial issue. By 2003 it was clear that more had to be done, and our new strategy for workplace health and

safety to 2010 is the result. This defines a more proactive approach, with four high level themes of partnership, support, targeting our resources, and communicating effectively. These are aimed at encouraging good practice and increasing understanding of health and safety requirements.

This memorandum explains our approach to regulation (including in the major hazard industries), following the better regulation principles. We do not see new regulation as the automatic response to new issues or changing circumstances, but will continue to press for higher fines, a new law on corporate killing and the removal of Crown Immunity. We also explore in an annex to this memorandum the difficult issue of finding the correct balance between prevention and enforcement.

The memorandum describes the current resource position of Health and Safety Commission and Executive and the pressures upon it. A programme of efficiency savings and cost reductions aimed at freeing up resources for increased operational output has been implemented in response to these pressures.

Introduction

1. This Memorandum sets out briefly the constitutional, regulatory, strategic and operational context of the work the Health and Safety Commission (HSC) and the Health and Safety Executive (HSE). Our mission, working with local authorities (LAs), is to protect people's health and safety by ensuring that risks in the changing workplace are properly controlled.

2. We welcome this inquiry, which comes at a time of development and change. In 2002, as a result of Machinery of Government changes, the Department for Work and Pensions (DWP) became our parent Department. We view this as a positive move with important synergies between our preventative mission and DWP's responsibilities to support an active workforce and to help people into or back into work. We are pleased with the constructive way our relationship has been developing.

3. We are proud of our achievements since being established in 1974 and this memorandum offers some highlights. We view as a vote of confidence the recommendations from successive public inquiries to pass regulatory responsibility to us for an increasing number of major industries. The most recent Cullen Inquiry into the Ladbroke Grove rail accident confirmed the view that we remain the right home for the independent health and safety regulation of the rail industry.

4. The Health and Safety at Work etc Act 1974 (the Act) was welcomed by both sides of industry and continues to enjoy their support. We work closely with businesses and with unions as representatives of workpeople. Our consultation processes cover a wide range of stakeholders appropriate to the issue in hand, and special efforts are made to engage groups that are harder to reach, such as small businesses. We also attach the highest importance to engaging the whole workforce for they are the ones who are exposed to the risks and best placed to identify them. As testimony to this commitment, HSC will shortly be launching a Statement that promotes worker involvement and consultation.

5. That said, we are not resting on past glories. The working environment has been changing rapidly and in 2003 we undertook a major evaluation of our approach. As a result, HSC recently agreed a new forward looking strategy which was formally launched on 23 February 2004. This has important implications for us and for the rest of the health and safety system. It shows health and safety as an enabler, not a hindrance. It is good for employment and productivity, it contributes to the government's agenda on health, rehabilitation and health inequalities, and it can enhance public sector delivery.

6. The strategy also makes clear that we are not seeking a risk free society but one where risks are properly understood and managed. We will achieve this through a sensible and proportionate approach. We will also use this to counter the myths and stories about our alleged "risk averse" approach.

Constitutional Framework

7. The independent enforcement of health and safety has been a feature of the regulatory system in Great Britain for more than 150 years. The modern system owes its origins to the Robens Committee of Inquiry and the subsequent passing of the Act. This established HSC and HSE as two separate non-Departmental Public Bodies accountable to the Secretary of State. It also confirmed a role for LAs in health and safety enforcement.

8. HSC has overall responsibility for policy on health and safety, and, uniquely among other government regulators, advises Ministers on relevant standards and regulations. It also conducts research and provides information and advice. The Chair and members of the Commission are appointed by the Secretary of State for Work and Pensions following consultation, advertisement and open competition.

9. Although legislative responsibility for occupational health and safety is reserved to Westminster, health more generally has been devolved to the Scottish Parliament and Welsh Assembly. HSE has evolved its structure to enable the development of close working relationships with the devolved administrations.

Corporate Governance of HSE

10. HSE advises and assists HSC and has a statutory responsibility to make adequate arrangements for the enforcement of the Act and other relevant statutory provisions in Great Britain. The Act sets out the corporate governance regime for the HSE. Broadly speaking, HSC provides non-executive oversight of HSE. HSE implements its share of the HSC work plan, itself approved by Ministers, and exercises a number of functions delegated to it by HSC. HSE's responsibility for enforcing the Act is carried out in accordance with the Enforcement Policy Statement (www.hse.gov.uk/pubns/hsc15.pdf), set by HSC after full consultation with stakeholders. Individual Commissioners are increasingly engaged in monitoring HSE's performance in particular areas and a Commissioner has recently taken on the role of chairing HSE's Audit committee.

Legal Framework

11. The Act sets out the general duties that employers have towards employees and members of the public, those that employees have to themselves and to each other, and the duties of the self-employed. A fundamental principle of the legal framework is that responsibility for health and safety lies with those who own and manage workplaces, or who work there, including the self-employed. They must assess the risks attached to their activity and take appropriate action. This "goal setting" rather than "prescriptive" approach takes account of what is reasonably practicable and encourages innovation. Regulations made under the Act can be supported with Approved Codes of Practice that detail how employers can comply with the law.

12. In its strategic review of health and safety in 2000 (Revitalising Health and Safety; see paragraph 22), the Government considered that the basic framework of the Act had stood the test of time and remained relevant for the future. In the "Innovation Challenge" report (December 2003) the DTI called for more "outcome" based Regulations to encourage innovative compliance, and undertook "to work more closely with HSE in promoting health and safety as an enabler of innovation".

13. HSC does not see new regulation as the automatic response to new issues or changing circumstances, but does believe that imposed fines are too low (the conclusion of the Court of Appeal in R v Howe 1998); large company health and safety fines being up to ten times lower than the general level of financial services fines for larger companies. HSC will continue to press for higher fines, a new law on corporate killing and the removal of Crown Immunity.

14. Further background on the health and safety system, and the roles of HSC, HSE and LAs within it, can be found in the document Health and safety system in Great Britain (www.hse.gov.uk/pubns/ohsingb.pdf)

Influence of the European Union

15. The development of health and safety legislation in Great Britain has been significantly influenced by the European Union (EU). A key element was the Framework Directive (EEC/89/391), which established broadly based obligations for employers to evaluate, avoid and reduce workplace risks.

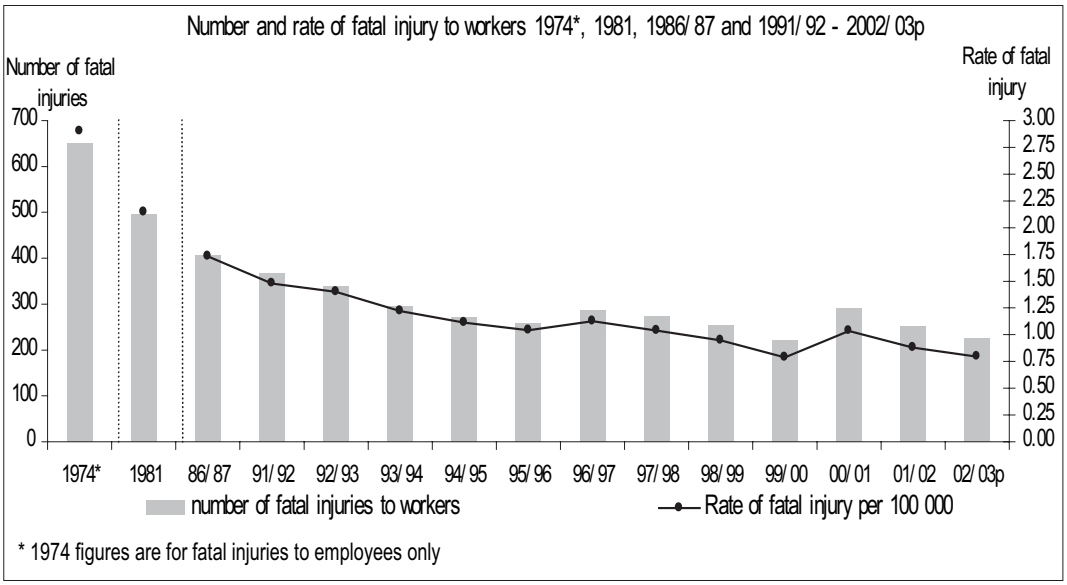
16. Following approval of a Ministerial mandate, HSE negotiates in European discussions to ensure consistency and proportionality in legislation, to achieve improvements where justified by risk, and to promote better standards across Europe. When European legislation has been agreed, HSE's approach is to implement Directives without the addition of unnecessary extra requirements.

17. In July 2003 the Government received a Reasoned Opinion from the European Commission, alleging under-implementation of the Framework Directive relating to the use of 'so far as is reasonably practicable' in our legislation. A reply has been sent to the Commission and their reaction is currently awaited.

Achievements Since 1974

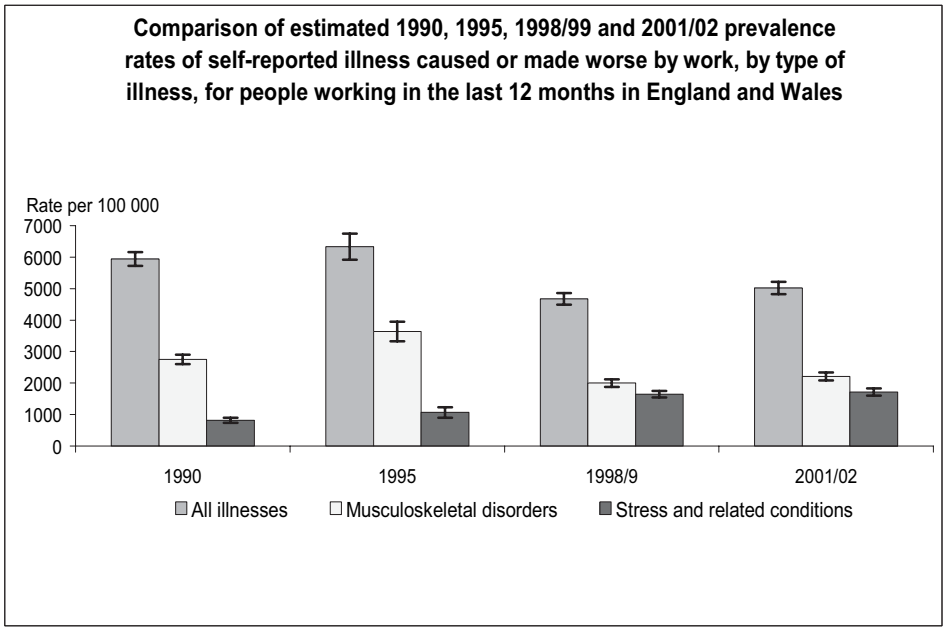
18. The achievements of HSC and HSE, working with LAs, since the introduction of the Act have been very substantial. The accident levels highlighted in Robens' report make stark reading. For instance, in 1974 there were 651 fatal injuries to employees in production and some service industries. The comparable figure for the year 2002–03 is 182, a reduction of over two thirds. Figure 1 presents the number and rate of fatal injuries to workers, ie employees and self employed, since 1974 and clearly illustrates this continuing improvement. That said, Figure 1 also illustrates the point that the rate of improvement has been gradually slowing to a plateau during the 1990s.

Figure 1. Number and rate of fatal injuries to workers 1974 to 2002–03



19. On ill health trends, very few sources provide a consistent basis back to 1974. Since 1990, information on work-related illness based on self-reports has been available from a series of surveys linked to the Labour Force Survey. Overall data for England and Wales are shown in Figure 2.

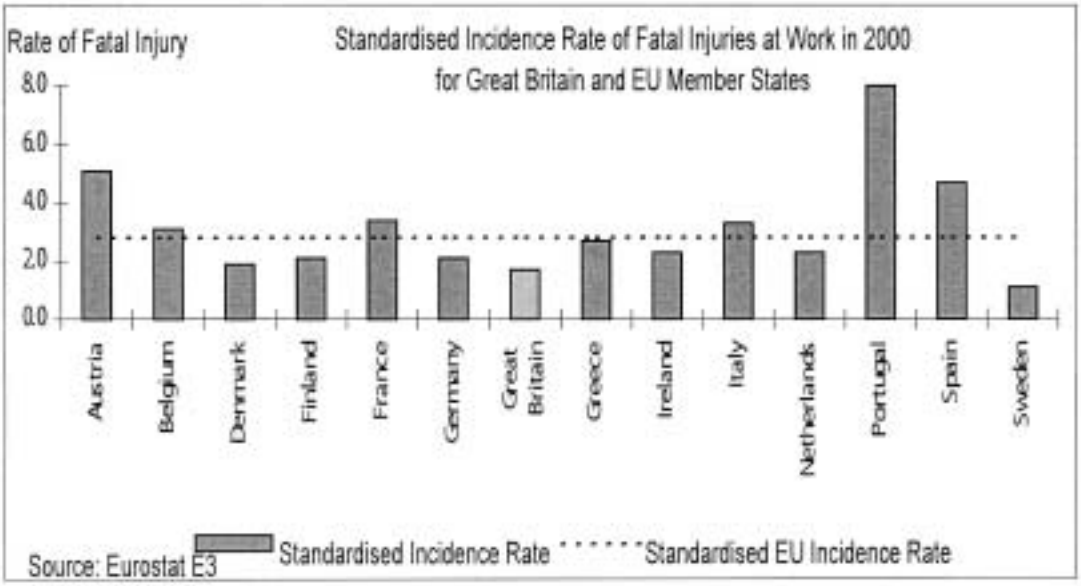
Figure 2. Health data for England and Wales since 1990



20. Comparisons suggest that, over the past decade, the overall rate of self-reported work-related illness prevalence has fallen. The estimated prevalence rate of stress and related (mainly heart) conditions has increased over time and is now around double the level it was in 1990.

21. Great Britain's achievements in health and safety performance are also commendable on an international basis. Though some care is needed when making comparisons between countries, the EU has published the chart, reproduced in Figure 3 below, showing the annual rate of workplace fatalities in 14 Member States (2000 figures). On this basis Great Britain has the second lowest rate of 1.7 per 100,000 workers compared with the EU average of 2.8.

Figure 3. EU comparisons for rate of fatal injuries



Revitalising Health and Safety

22. In 1999, with the Act operational for 25 years and the rate of improvement in national performance clearly slowing, the Government and HSC instigated a major review. The Revitalising Health and Safety strategy statement, launched by the Deputy Prime Minister and the HSC Chair in June 2000, signalled a need to "re-energise" the system and set national targets for improving health and safety performance (www.hse.gov.uk/revitalising/index.htm). These were by 2010 to reduce:

- the incidence rate of fatalities and major injuries by 10%;
- the incidence rate of cases of work-related ill health by 20%;
- the number of working days lost per 100,000 workers from work-related injury and ill health by 30%;

and to achieve half the improvement under each target by 2004.

23. We responded to Revitalising by identifying eight areas for priority action, chosen on the basis of maximum likely impact on the targets. Two of these priority areas were the emergent health issues of stress and musculo-skeletal disorders which now comprise a large proportion of all self-reported illness, as shown by Figure 2.

Progress with Targets

24. There is no conclusive evidence as yet of the extent of progress towards the first target. A programme of research into underreporting of major and over-three-day injuries is underway, and is designed to tell us more about recent changes in the reporting of major injuries.

25. On the overall incidence of work-related ill health, the balance of evidence suggests that it is likely to have risen since 1999–2000, although this may be due to an increasing awareness of work related ill health problems such as stress that previously may not have been attributed to work. On the last target—days lost due to workplace injury and ill health—it is not yet possible to make a judgement on progress, as figures are available for one year only. Further charts relating to progress with targets are at Annex 1.

26. The conclusion at present must be of limited progress towards targets, based on currently available hard evidence. However, because there is inertia in the system, ie a time lag between actions taken and response in terms of progress towards targets, some proxy indicators have been developed for the purpose of quarterly reporting to Ministers. Measured against these indicators, we are starting to show some early gains.

Strategy for Workplace Health and Safety

27. The Revitalising targets stimulated a new approach in HSC and HSE to tackle the "performance plateau", but it became clear that more had to be done to mobilise the whole health and safety system if targets were to be achieved. A key challenge was to make appropriate risk management relevant to the modern world of work. Since 1974, the workplace, employment trends and public attitudes to risk and redress have changed significantly.

28. As a first step, HSC adopted a new vision in early 2003. That vision is to gain recognition of health and safety as a cornerstone of a civilised society and, with that, to achieve a record of workplace health and safety that leads the world.

29. The development of a new strategy followed. It supported Revitalising and recognised the following key drivers for change:

- a perception that there is no coherent direction to the overall health and safety system. HSC, HSE and LAs cannot or should not do it all;
- HSE and LA resources are limited, spread too thinly and need to be targeted to where they can have the most impact;
- HSC, HSE and LAs have done a great job on safety but there is still a huge job to do on health;
- many organisations are motivated to make improvement but do not turn to HSE and LAs for advice;
- long-term gains need hearts and minds not grudging acceptance.

30. HSC's new strategy followed extensive consultation, has been endorsed by Ministers and was formally launched on 23 February 2004. Copies of the published document, *A strategy for workplace health and safety in Great Britain to 2010 and beyond*, are provided for Committee members. It can also be accessed on the HSE website at (www.hse.gov.uk/aboutus/hsc/strategy.htm).

31. This strategy signals a new approach. First, we cannot do this alone. We need to understand and value more the contribution of others and work with them in robust new partnerships. This includes using our links with DWP to best effect in emphasising rehabilitation and getting people back to work.

32. Second, we need to work better and smarter to support the whole health and safety system and create a greater understanding of its concepts. Trade union workplace representatives operating in partnership with management are an important part of realising health and safety benefits. We also need to:

- promote the business case;
- make risk assessment more useable as a concept;
- develop nationally available occupational health support;
- simplify our advice and guidance wherever we can;
- do more to encourage others to develop and promulgate good practice.

33. Third, we need to be clear about our priorities and focus our activities on our core business and the right interventions. This means concentrating more on the areas and interventions where we can make the greatest impact, and developing new ways to exert influence. The draft work-in-progress document at Annex 2 offers some illustrative examples. The focus on priorities also means determinedly moving away from intervening in those areas of public safety that are better regulated by others or by other means—including civil law.

34. Last, we need to be more effective in communicating our vision and making clear that we are not seeking a risk free society but one where risks are properly understood and managed. We recognise that we must be more mature, open and inclusive in our communications. We must deliver our advice and guidance in ways that small businesses, for instance, find easy to assimilate, and make best use of intermediaries.

Our Approach to Regulation

35. Our approach is informed by the principles of better regulation: transparency, accountability, targeting, consistency and proportionality. This approach is set out in the Commission's Enforcement Policy Statement (see paragraph 10). HSE has established memoranda of understanding with other regulators to ensure that potential boundary issues, overlaps and omissions are properly addressed.

36. The National Audit Office is due to report in the near future on an audit of HSE's construction strategy and programme, and have been considering whether:

- it is appropriate and based on sound evidence;
- it is making an impact on the control and management of health and safety risks; and
- the barriers to improvement in the health and safety record of the industry are being tackled effectively.

While this audit is confined to a specific, albeit major industrial sector, it may provide an insight into HSE's wider regulatory approach and achievements.

The Balance of Preventative and Reactive Intervention Techniques

37. There is strong evidence to support the continuation of a balanced mix of advice (persuasion), enforcement and business incentives. Enforcement is an effective means of securing compliance. It creates an incentive for self-compliance and a fear of adverse business impacts, such as reputation damage, in all sectors and sizes of organisations. There is also evidence that enforcement and HSE leadership is an important element in prompting major hazard firms to manage health and safety, including major accident prevention. There is some evidence that advice and information are less effective in the absence of the possibility of enforcement.

38. The question raised by the Committee, of the balance between prevention and enforcement, is a critically important one for HSE and for LAs. However, the three areas of activity encompassed by those terms—proactive work, reactive work and enforcement—share a common preventive purpose. The essential question therefore is about how to apply them to best achieve this purpose while satisfying public expectations of and demands upon HSE. In recent years the trend has been towards spending more time on investigation, to the detriment of proactive work, and to a degree which HSE now believes is not the best use of the available resources. Given that our primary purpose is to prevent harm through improved standards, the organisation is now acting to redress that balance towards proactive work. These issues are elaborated at Annex 3.

Regulating Major Hazard Industries

39. Regulating major hazard industries forms a significant part of our responsibilities. These industries have the potential to cause catastrophic events or major accidents involving fatal or serious injury to significant numbers of people. We aim, working with business, to prevent these catastrophic failures and major incidents. We work largely through a system of prior approvals and permissioning based on the submission by operators of safety cases. This gives us the opportunity to ensure that arrangements exist which, if adhered to, will provide for adequate management of risk.

40. HSC and HSE were created in the immediate post-Flixborough era and, since then, our strategies and operational procedures for regulating major chemical sites have proved successful. Our approach has also been highly influential in Europe. Responsibility for safety at nuclear installations also transferred on our formation. This too is a success story of close scrutiny and no major events. The same can be said of the offshore oil and gas industry, responsibility for which transferred to us in 1990 in the wake of the Piper Alpha tragedy.

41. Full responsibility for safety on the railways was also transferred to us in 1990. This has been a more complex story and the regime for rail has been the subject of much recent scrutiny. At the turn of the year, HSE submitted evidence to the Transport Select Committee's inquiry into the future of the railways. On 19 January, the Secretary of State for Transport announced a major review of the structure of Britain's railways. Our input to the review will spell out the strengths of HSE's approach and will emphasise key principles such as the importance of an independent safety regulator, and of a satisfactory interface between worker and public safety. One piece of evidence we have submitted to this review is a chart which plots the annual number of significant train incidents per million train miles from 1975 to the present time. This standardised index has fallen from 0.53 in 1990–91 to 0.20 in 2002–03.

The Future

42. We intend to take a proactive approach to the future of health and safety regulation by examining our role as a regulator and how we are responding to the changing economy around us. We are approaching other regulators, such as the Food Standards Agency and the Environment Agencies, to see if we can achieve a common view about the best way forward.

43. We are also evaluating the current enforcement approach and consulting stakeholders on what they see as the key enforcement issues. As the fear of enforcement is a significant motivator for organisations, there is value in exploring whether alternative approaches or sanctions could help improve impact. This will include the extent to which restorative justice may prompt offending organisations to change their behaviour.

Delivery Through Programme Working

44. HSE is developing its planning and governance arrangements to ensure that the business and the deployment of resources are oriented to delivering strategic priorities. This puts in place structured delivery management based on best-practice programme working. This is overseen by a new HSE Delivery Board, chaired at Executive level.

RESOURCES

45. We are funded mainly by grant from DWP. We also receive money from charging for aspects of our work—mainly in relation to regulating major hazard industries and through sale of publications. We have some freedom to increase activity levels where work is funded by charging, but our net budget is set by DWP through the Spending Review process. The table below shows the overall budgetary position up to 2007–08

	2001–02 £m	*2002–03* £m	*2003–04* £m	*2004–05* £m	*2005–06* £m	*2006–07* £m	*2007–08* £m
Gross Budget	254	262	278	279	271	271	271
Income	51	52	58 forecast	Income level subject to further work on charging			
Gross Spend	255 (outturn)	256 (outturn)	260 forecast				

Notes

1. SR2004 projected budget (06/07 and 07/08) assumes roll forward of 2005–06 baseline.

2. The ring-fenced Cullen funding of £4 million is included in figures for each of years 2003–04 and 2004–05.

46. Following a period of modest increase in resources, Spending Review 2002 set a baseline which rises slightly in 2003–04, and 2004–05 and drops back in 2005–06. When rising costs are taken into account this represents a significant reduction in spending power.

47. To meet this we have adopted a financial strategy of efficiencies and cost reductions. The objective has been to reduce spend below budget now, and build up funds to help bridge the gap in 2005–06 and beyond. For this reason the table above shows gross spend as less than gross budget for the years 2002–02 and 2003–04. The efficiency programme has been aimed at freeing up resources for operational activity, while increasing operational productivity.

48. The table below details HSE's staff numbers for 1999–2004

Staff In Post Data 1999–2004

	April 1999	April 2000	April 2001	April 2002	April 2003	January2004
Total Staff HSE/HSL	3,880	3,937	4,081	4,282	4,162	3,995
Agency Staff constituent	N/A	N/A	187	232	94	85
No of Inspectors	1,497	1,507	1,534	1,625	1,651	1,619

49. The Trade Union, Prospect, have campaigned for increases in HSE inspectors, particularly in the Field Operations Directorate (FOD). Inspector numbers fluctuate, particularly as staff are recruited into FOD but, when experienced, may move into more specialised work elsewhere. FOD are piloting new approaches where visiting administrative staff work alongside inspectors in frontline roles, delivering key health and safety messages. There are now some 60–70 such administrative staff, and their work enables inspectors to spend more time targeting the dutyholders most in need of HSE's attention. This more efficient approach to deployment of frontline staff will be extended across the whole of FOD, as resources allow.

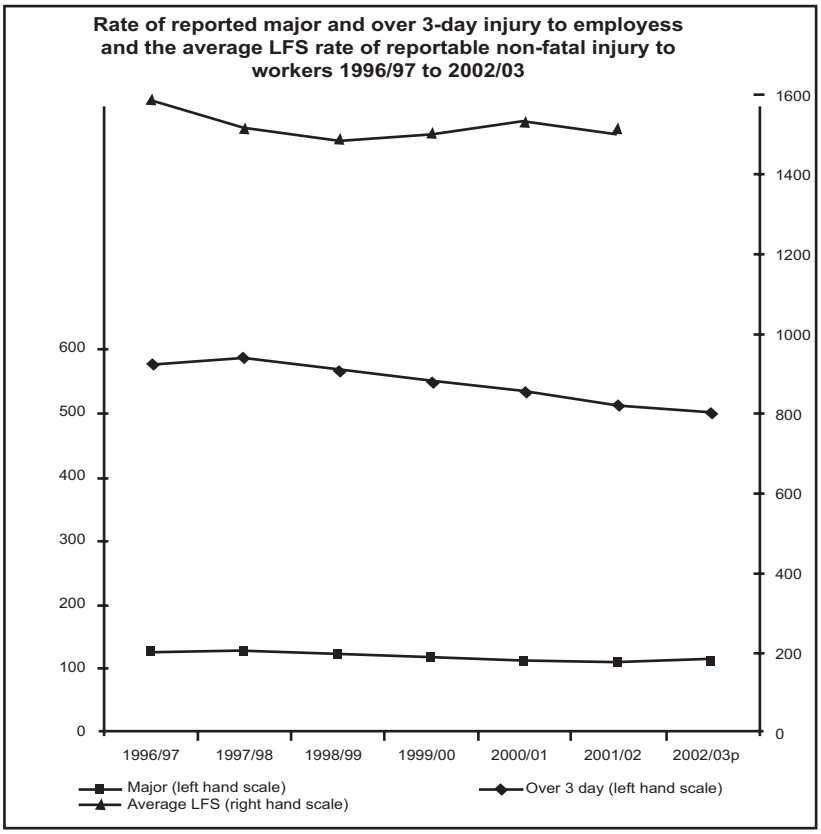
Phil Kemball
Health and Safety Executive

20 February 2004

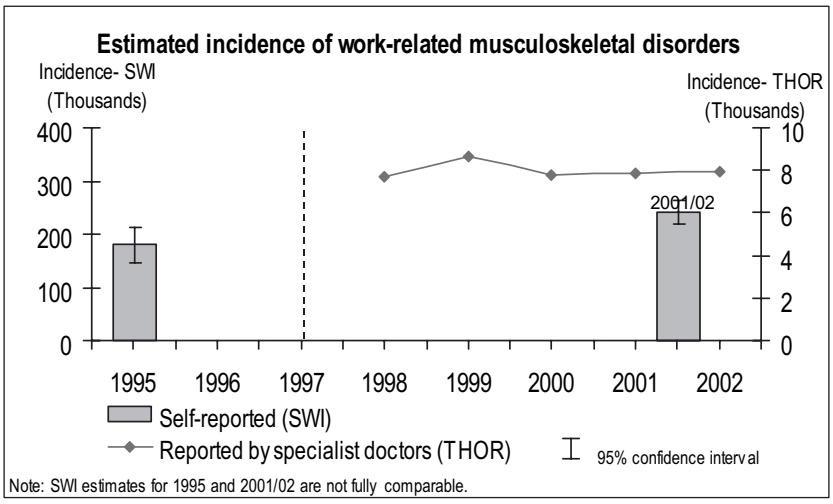
Annex 1

PROGRESS AGAINST REVITALISING TARGETS

Injury Target



Ill Health Target



Annex 2

BUILDING ON SUCCESS: A BROAD RANGE OF INTERVENTION STRATEGIES A WORKING DRAFT FOR DEVELOPMENT BETWEEN LOCAL AUTHORITIES AND HSE

Editorial Note

As the subtitle above indicates, this is a draft document that will be developed jointly with LAs, to support the closer working in partnership envisaged by the new Strategy. It does not at this juncture contain detail about the intervention strategies that it outlines. It was drafted with non-major hazard activities in mind.

This statement sets out key principles for using to best effect all the available tools and techniques for continuing to drive improvements in standards of health and safety and lists the main intervention strategies.

The first principle is a fresh emphasis on encouraging duty holders to do more to improve health and safety by updating and improving the financial and other arguments to persuade duty holders that good standards will help their business.

The second principle is to be vigorous and consistent in going beyond compliance assessment and enforcement to make full use of other intervention strategies; but to be very clear in dealings with duty holders to distinguish between what the law can compel them to do, and what regulators and others in the health and safety system can encourage them to do.

The following strategies, often applied in combination, may be used to combat risk at three points of opportunity.

1. Before, and at the Point of Creation, of Risk

Partnerships

— Strategic relationships between organisations or groups who are convinced that improving health and safety will help them achieve their own objectives. This may involve duty holders or trade unions, regulators, other Government departments, trade bodies, investors, insurers, or educational or media organisations.

Motivating senior managers

— Engaging with the most senior managers to enlist their commitment to achieving continuous improvement in health and safety performance as part of good corporate governance, and to ensure that lessons learnt in one part of the organisation are applied throughout it (and beyond).

Supply Chain

— Encouraging those at the top of the supply chain (who are usually large organisations, often with relatively high standards) to use their influence to raise standards further down the chain, eg by inclusion of suitable conditions in purchasing contracts.

Design and supply

— Working with those who can improve health and safety by improving the design of processes or products.

Sector and industry-wide initiatives

— "Gearing" achieved by stimulating a whole sector or an industry to sign up to an initiative to combat key risks, preferably taking ownership of improvement targets.

Working with those at risk

— Working with safety representatives, trade unions and other organisations who represent people put at risk by work activities to support them in their roles.

Education and Awareness

— Seeking further ways of getting messages and advice across early to key target groups, particularly those who are difficult to reach, using channels such as small business groups, chambers of commerce, etc. Promoting risk education as a curriculum item at all levels of the education system.

2. At and During Exposure to Risk

Inspection and Enforcement

— The regulators within the system will continue to use all the tools available to them. Inspection and enforcement will remain vital intervention strategies, and will often be the means by which other strategies are brought to bear. They are important means to achieve the objective of improved standards, and they represent what many stakeholders expect to happen.

Intermediaries

— Enhancing the work done with people and organisations that can influence duty holders. These may be their trade bodies, their insurance companies, their investors, or other parts of government who perhaps are providing money or training to duty holders.

Best practice

— Encouraging the development of best practice examples with those organisations which are committed to leading edge performance, and then using these examples to show to others the practicality and value of improving their own standards.

3. When the Consequences of Exposure to Risk Arise

Incident and ill health investigation

— Making sure that the immediate and underlying causes are identified, taking the necessary enforcement action, learning and applying the lessons.

Dealing with issues of concern that are raised, and complaints

— Encouraging duty holders to be very active, and making sure that concerns and complaints from stakeholders are dealt with appropriately.

Draft: 17 November 2003.

Annex 3

THE BALANCE BETWEEN PREVENTION AND ENFORCEMENT

1. The Committee has indicated that it expects the inquiry to particularly focus on how well HSE achieves the right balance between prevention and enforcement and whether it is adequately resourced for the task. This Annex addresses the question about balance, concentrating on the approach in HSE's Field Operations Directorate (FOD), which is responsible for the majority of dutyholders that fall to HSE. Somewhat different considerations apply in the major hazard sectors.

2. To plan, carry out and monitor operational work, HSE addresses the Committee's question by considering three categories of activity, rather than two:

(1) Proactive work—mainly in the form of planned inspection (and, increasingly over the next few years, other intervention techniques applied by a wider range of frontline staff, as described in Annex 2);

(2) Reactive work—the investigation of accidents, dangerous occurrences, diseases and complaints; and

(3) Enforcement—a term encompassing all those activities directly associated with ensuring dutyholders discharge their duties, from giving advice through to the use of formal enforcement tools (principally, enforcement notices and prosecution). The term implies the possibility of escalation if the dutyholder does not respond appropriately.

3. The distinction between these three categories becomes a false/unhelpful one if it is too sharply delineated. All three have preventive objectives and the essential judgements for HSE are:

— about which to use, when, and to what degree/extent;

— how to secure the maximum preventive effect for the given resource, bearing in mind that the potential demands on HSE's attention always greatly exceed the supply of available resources; and

— that HSE must satisfy public expectations which do not always match HSE's judgements about where it is best to direct preventive effort.

4. HSE is alert to a range of indicators about how well risks are being managed. These range from intelligence about unregistered businesses, records of the opinions formed at previous inspections and of the time that has since elapsed, through to complaints and reports of incidents where the failure to control a risk has had harmful results. These indicators inform policy decisions about the best balance of activities.

5. It matters greatly that HSE secures the best preventive impact from that balance as it takes, on average, five times as long to investigate an accident as to carry out a preventive inspection. For example, if FOD were to do nothing but investigate accidents (ie no preventive inspections at all), they would still only have the capacity to investigate about 30% of all reported accidents. But in so doing they would be investigating accidents that would be relatively trivial in terms of their causes and/or consequences, and thus would contribute far less to prevention than if that time were to be spent proactively.

6. Our policy has remained that prevention is our primary aim. This was endorsed in 2000 by the Select Committee on Environment, Transport and Regional Affairs which enquired into the matter and concluded that "HSE's focus should remain largely preventative". However the Committee went on to urge HSE to increase the rates of investigation and prosecution.

7. In response, HSE undertook to increase the number of investigations by 50%, from 6.8% in 1999–2000 to 10% in 2001–02. Achieving that change has created conflict with the intention to maintain a largely preventive focus. The ratio of time on proactive and reactive work, which had been 70:30 in 1997–98, fell to 50:50 in 2002–03, and this was felt not to be the best balance (taking the time devoted to each activity as an approximation for the best mix of the two activities in terms of preventive impact). Accordingly steps were taken in 2003 to streamline and improve investigation procedures, and a set of revised selection criteria are being piloted with the aim of re-establishing a 60:40 time ratio of proactive to reactive work.

8. The managed reduction in reactive work, towards what HSE considers to be a better balance, is designed to enable frontline staff to increase time on activities that more directly impact on Revitalising targets. It is combined with a set of initiatives to broaden the range of staff in frontline roles and to increase productivity. These activities include:

- Preventive inspection targeted at organisations where the priority topics are significant causes of injury and ill-health;
- In-depth interventions with poorly performing large organisations which have disproportionately high incidence rates;
- Enforcement-led initiatives based on analysis of reported incidents, local knowledge or other intelligence, such as targeted "blitzes" with a high enforcement content.

9. The purposes of reactive investigations are essentially, but not exclusively, preventive. They include identifying the causes and any necessary improvements—which may include immediate actions by the dutyholders, or deeper attention to the underlying management systems, or indeed actions by other dutyholders facing the same risks—but they also encompass the expression of public concern or condemnation through formal legal proceedings. The majority of prosecutions taken by FOD arise from investigations. This puts pressure on the balance between proactive and reactive work because formal enforcement affects the scale and complexity of investigations from an early stage (eg requiring the pursuit of all reasonable lines of enquiry).

10. HSE and LAs use their formal enforcement powers (principally in FOD, the use of enforcement notices and prosecution) to:

- ensure that duty holders take action to deal immediately with serious risks;
- promote and achieve sustained compliance with the law;
- ensure that duty holders who breach health and safety requirements, and directors or managers who fail in their responsibilities, may be held to account.

In 2002–03 12,720 notices were issued by FOD and 1,513 informations (criminal charges) were laid.

11. Prosecution is one form of response by HSE to a failure to control risk. A range of tools is used to secure compliance and to ensure a proportionate response to criminal offences. Inspectors may offer duty holders information, and advice, both face to face and in writing. This may include warning a duty holder that in the opinion of the inspector, they are failing to comply with the law. Where appropriate, inspectors may also serve improvement and prohibition notices, withdraw approvals, vary licence conditions or exemptions and they may prosecute (or report to the Procurator Fiscal with a view to prosecution in Scotland). Enforcement notices are an extremely effective and widely-used method to secure control of risk and thus prevent harm. Levels of compliance with notices are extremely high and appeal against them very low. In summary, much of HSE's enforcement work (by the definition at paragraph 2 above) is preventive rather than punitive in its main purpose, whether it arises from proactive or reactive work.

12. HSC/E believe that a ratio balanced towards proactive work is appropriate, but inevitably this is a judgement rather than a "right answer" which is affected by a number of other factors. These include:

- Increasing evidence (leading to a new strategy to 2010 and beyond) in favour of a broader range of largely preventive intervention strategies.
- Rising numbers of complaints and an increasingly litigious culture.

— More safeguards built into formal enforcement procedures, making prosecution a lengthier and more complex process.

— Divergent views on the question, among the range of interested parties and lobbying organisations to whom our work is a matter of serious, legitimate concern (a divergence noted by the Select Committee in 2000).

13. We will be pleased to develop our evidence to the Select Committee on the above points and on any other matters that the Committee wishes to scrutinise during its examination of this essential, but very difficult, question.

Supplementary memorandum submitted by Health and Safety Executive

THE ROLE OF THE HEALTH AND SAFETY EXECUTIVE IN SCOTLAND

Introduction

1. This Memorandum provides information on the role of the Health and Safety Executive (HSE) in Scotland following devolution and summarises new ways of working with Scottish stakeholders and intermediaries including links with Scottish Executive Departments to take forward the new Health and Safety Commission (HSC) Strategy in a Scottish context.

2. HSE has a current workforce of some 300 staff in Scotland across all Directorates. They are housed in offices at Edinburgh, Glasgow, Aberdeen and a small one in Inverness. In addition to Field Operations Directorate (FOD) staff in all of them, Edinburgh covers the onshore work of the Hazardous Installations Directorate (HID), and the Specialist Support Group. Aberdeen is the main centre for the Offshore Division of HID. There are also two operational policy groups based in Scotland who lead on their topic areas for HSE across Great Britain, as described in paragraphs 19 and 20.

Constitutional Framework

3. Legislative responsibility for occupational health and safety is reserved to Westminster. However, many related areas of government, such as health, transport and justice, are devolved. In addition, MSPs can, and do, debate health and safety issues in the Scottish Parliament. It was therefore necessary to formalise the relationship between HSC & HSE with the newly formed Scottish Executive by way of a Concordat devised in consultation between the bodies. This remains the basis of our ongoing working relationship, and it is monitored to ensure it remains current and relevant.

HSE's Response to Devolution

4. In response to devolution HSE appointed a Scotland Director, based in Edinburgh, to be the "public face" of HSE in Scotland. The Director has operational responsibility for FOD in Scotland and more generally represents HSE activities in Scotland, advising the Director General on relations with the Scottish Parliament and Executive. This has been particularly useful in providing a focal point for consultations with the Scottish Executive, has helped clarify government priorities in Scotland, and offered HSE opportunities to play a part in shaping these priorities.

5. HSE's response to devolution has enabled it to work with the Scottish Executive on a number of very positive initiatives and influence a much broader range of interests in the administration than was possible before. The Enterprise and Life Long Learning Department of the Scottish Executive holds the portfolio for health and safety but HSE also has close contact with all the other departments to discuss issues which cut across HSE and Scottish Executive responsibilities.

6. The health of the nation is one of the Scottish Parliament's main priorities, and HSE is working with the Health Department in its role of raising the standards of health of the Scottish population as a whole.

7. Over the last few years HSE has also been well supported by the Scotland Office and the Ministers of State who have spoken at a number of high profile conferences and seminars about health and safety. This has helped to raise HSE's profile and emphasised the importance of our message.

HSE's Operations in Scotland

8. This section details some of the key operational work carried out in Scotland across HSE's Directorates.

Construction

9. Site Safe Scotland is an industry group led by HSE over many years to involve all duty-holders in the construction industry in Scotland, including clients, professional bodies, contractors, etc to agree improvements in the way construction work is carried out.

10. Additionally, the Construction Innovation and Excellence Forum has been established in response to recommendations in the strategy paper "Achieving Construction Innovation and Excellence in Scotland", published by the Modernising Construction Strategic Group. The strategy includes plans to improve health and safety, procurement, industry image and training. The Forum will provide strategic advice for the construction sector, the Scottish Executive and the Scottish Parliament.

11. The Scottish Parliament Cross Party Group for Construction has been formed and held its inaugural meeting in October 2003. The convenor is a Member of the Scottish Parliament. HSE will not be a voting member of the Group but will act as an observer. The first main issues to be taken forward are skills and training, and procurement and workload.

12. Construction fatalities in Scotland are likely to fall significantly in 2003–04 from the figure of 11 last year. Despite this, HSE recognises that construction fatal injury figures in particular are high when compared with England and Wales, although there is no common understanding of why this should be. As a result, HSE has funded a research project looking at factors affecting the rates of fatal and major injuries in Scotland. The aim is to identify relevant factors where positive influence can be used to bring about an improvement.

Agriculture

13. HSE in Scotland has the national lead on health and safety in the fish-farming industry, a sector which has a variety of issues due to the location of workplaces, adverse weather conditions, etc.

14. There has also been liaison with the Scottish Executive under the Land Reform (Scotland) Act over access onto farms and the potential risks from animals, farm machinery, spraying, etc. HSE has also worked with the Cairngorm Partnership in setting up the new National Park, giving advice on agricultural practices and public interface with animals and other agricultural activities.

Railways

15. Transport was one of the issues devolved to the Scottish Executive with consequent differences to the work of the Railway Inspectorate in Scotland. This has resulted in close contact on policy issues with the Scottish Executive, and a need to take account of where these may be different to the position in England and Wales.

Hazardous Installations Onshore

16. A key onshore responsibility for HID is the administration and enforcement of the Control of Major Accident Hazard Regulations (COMAH). COMAH implements a European Directive which has environmental aspects as well. As a result HSE is a joint "competent authority". In Scotland this means working with the Scottish Environmental Protection Agency (under a separate Memorandum of Understanding), as opposed to the Environment Agency in England and Wales. There are also different arrangements for controlling land use planning in Scotland.

Hazardous Installations Offshore (OSD)

17. OSD have close working ties with UKTI (DTI/FCO) in Glasgow to promote UK upstream interests overseas (eg to encourage new companies to come to Britain) and with the Scottish Council Development and Industry to promote Scotland's oil industry. They report occasionally to the oil and gas group of MSPs on oil industry matters.

18. OSD also administer all UK diving activities from Aberdeen, including training and medical records, as well as being the centre of expertise for the industry.

HSE National work led from Scotland

19. HSE has two operational policy groups based in Scotland which lead on their topic areas for HSE across Great Britain. The first is the Commercial and Consumer Services, Transportation and Utilities Sector (CACTUS), based in Glasgow. CACTUS's responsibilities cover a very large number of workers (13.5 million employees—over half the total in Great Britain) and a wide range of health and safety issues across a variety of industries. In addition, CACTUS has significant interests in public safety, such as fairgrounds and gas.

20. The Health Unit, based in Edinburgh, is the other Group. It is at the forefront of the development of standards to assist inspectors in their work to improve occupational health. Health Unit staff are involved in important areas such as stress and musculoskeletal disorders, and also manage the British asbestos contractor licensing system.

Legal Framework

21. Health and safety legislation applies across Great Britain, but there are differences in HSE's approach in Scotland because of the different legal system.

Scottish Legal System—Key Points

- Virtually all criminal proceedings in Scotland, including those proposed by HSE and local authorities, are by means of public prosecution, conducted by Procurators Fiscal.
- Crown Office is the departmental headquarters of the Procurator Fiscal service.
- All HSE cases in Scotland begin in the Sheriff Court before a Sheriff who is legally qualified either as a solicitor or an advocate.
- Since devolution the administration of justice in Scotland has been the responsibility of the Minister for Justice. The Justice Department is responsible for the police and fire services, aspects of criminal justice and civil law, for courts administration, legal aid and liaison with the legal profession.
- HSE inspectors have regular contact with Procurators Fiscal over possible and pending cases and annual meetings are held with Crown Office to discuss current issues. For the first time, a joint meeting was held earlier this year between Crown Office, HSE and the STUC to discuss STUC concerns.
- At present, there is no formal protocol in Scotland for work related deaths. The England & Wales model states that the Police have the lead in such deaths (with HSE support) until it becomes clear that it is a matter for HSE, whereupon the investigation is handed over to HSE. It is felt that this model could be used as the basis for an expanded Scottish version which would recognise the legal differences, and it is an issue currently being discussed with stakeholders.
- A number of factors affect the pattern of HSE prosecutions in Scotland—for example, the number of cases and charges taken, the types of charges taken, and the outcome, both in terms of result and penalty. Some of these factors are only relevant in Scotland; some are also relevant to prosecutions in England and Wales, but vary in their effect. Comparisons between Scottish and English enforcement statistics need to be treated with caution. HSE is working with Crown Office to agree clearer and more consistent statistics, and intends to discuss enforcement statistics more broadly with interested parties later in the year.

ACHIEVEMENTS—POST DEVOLUTION

22. Scotland, because of its large size and small population, its employment patterns, its legal, educational and local government systems, and its representational networks, is different. HSE has always aimed to work with the important players in Scotland, both to seek support for our own strategy and to support that of others.

Joined-up Working—Initiatives

- Working Backs Scotland—HSE worked closely with NHS Scotland (formerly HEBS) and other stakeholders on the development of this initiative. This was an innovative package aimed at employees, employers and health professionals, and its central message "keep active" has made big in-roads into the national consciousness.
- HSE previously funded the development of a pilot telephone advice line in North Lanarkshire and the experience of that has helped develop a new support system for SMEs—"Safe and Healthy Working". This initiative is funded by the Scottish Executive and has been developed by a working group led by NHS Health Scotland, strongly supported by HSE and LAs. The aim of the service is to give SMEs and their workers access to free occupational health and safety advice and

guidance. The service operates through a telephone advice line and website, and a regional network of advisers who carry out workplace assessments for businesses. HSE is conscious of the wider interest in what is a possible model for a national health and safety service. HSE is funding evaluation of the scheme.

— Scotland has also had a workplace awards scheme "Scotland's Health at Work" (SHAW) for almost 10 years, again funded by the Scottish Executive, which concentrated initially on health promotion through the workplace, but has since, in consultation with HSE, developed to include occupational safety and health. HSE in Scotland also supports the DWP "Healthy Return" rehabilitation initiative in the Glasgow area.

— These, and other initiatives are now being considered as part of the Scottish Executive's "Health Improvement Challenge", launched by the Minister for Health in March 2003. "The workplace" is one of the four main themes of the challenge under the title of "Healthy Working Lives" which is being led by the Health department with support from HSE, LAs and a wide range of stakeholders including employers' organisations, individual employers, the STUC and the voluntary sector. *This is an initiative of particular interest to DWP in its quest to help people remain in and return to work*. A final paper on how this should be taken forward has been produced by a short life working group and is to be considered by Ministers.

— HSE has also worked closely with the STUC over the past 10 years and recently part-funded the development of an initiative on support for safety representatives. HSE has also supported work on violence in the retail sector which has important economic and social equality elements as well as health and safety implications.

— HSE is also involved in, and provides support to the Scottish Health and Safety Revitalisers Forum. The Forum was formed in 2001 and its main objective was to help deliver the Revitalising and Securing Health Together targets in Scotland mainly by sharing and promoting best practices. Membership consists of central and local government, employer organisations, professional bodies, medium/large/multi-site companies, regulators and worker organisations.

— HSE's health services priority programme has included an awareness day for care homes, run jointly with the Scottish Care Commission, where nearly 50% of Scottish care homes were represented.

— HSE has worked with Her Majesty's Inspectorate of Constabulary Scotland to ensure more robust monitoring of health and safety in their inspection of police forces.

Comparative Injury and Ill Health Statistics

23. Annex 1 contains tables comparing fatal and non-fatal injuries in Scotland (from 1994–95 to 2002–03), with England and Wales (from 1999–2000 to 2002–03). It also contains snapshot (2001–02) comparison figures for self-reported illness, musculoskeletal disorders (MSD) and stress/depression/anxiety caused or made worse by work. These figures show certain anomalies which HSE in Scotland is exploring and feels that it is important to resolve. For instance, fatal injuries, when expressed as a rate per 100,000 employees, are higher than for the rest of GB. So far no definitive reasons have been found for this (See also paragraph 12). On the other hand, rates of self-reported illness are lower than for the rest of GB. Once it becomes clear why these anomalies exist, it will be possible to more closely target efforts to tackle them.

The Future

24. It is clearly understood by both HSE and the Scottish Executive that there is no intention to change the current reserved status of health and safety legislation, and that HSE will still be responsible for taking legislative steps as required. At the same time opportunities are offered by synergies which permit the raising of standards on certain aspects of health in particular. It is therefore proposed to establish a health and safety forum to increase stakeholder involvement in Scotland, examine areas where Scotland appears to differ with the rest of GB, and bring forward solutions where appropriate. This remains in the discussion stage at present, but in principle it would be beneficial in formalising the respective roles of HSE and the Scottish Executive, and tackling issues such as the injury and ill-health statistics in Scotland.

25. The Scottish Executive will continue to legislate and have an impact on areas of interest to HSE. One example is proposed legislation on work-related violence to emergency workers (possibly extended to other public service workers). This has clear overlap with HSE policy on this topic, where steps have already been taken with hospitals in particular. HSE in Scotland has been involved with this in order to inform discussions and ensure our influence is brought to bear, but HSE generally welcomes the opportunity to raise standards in this way, possibly prior to implementation on a national basis.

Phil Kemball
Health and Safety Executive

20 February 2004

Annex 1

INJURIES TO EMPLOYEES AND SELF EMPLOYED PEOPLE, FATAL AND NON-FATAL INJURIES TO MEMBERS OF THE PUBLIC AS REPORTED TO HSE—1999–2003p

SCOTLAND

Severity of injury	*Employment Status*	*1994–95*	*1995–96*	*1996–97*	*199798*	*1998–99*	*1999–2000*	*2000–01*	*2001–02*	*2002–03*
Fatal	Employees	16	25	28	28	26	23	25	24	26
	Self Employed	10	12	14	9	7	8	12	4	10
	Member of Public	5	6	10	6	8	9	8	7	10
Major	Employees	1,389	1,323	2,010	2,337	2,400	2,695	2,758	2,783	2,796
	Self Employed	103	94	95	32	49	26	40	77	86
	Member of Public	660	606	1,988	1,373	1,270				
Over 3 Day	Employees	11,546	10,314	9,889	10,676	10,623	11,661	11,135	10,713	10,192
	Self Employed	176	193	231	39	48	29	30	70	66
Non Fatal	Member of public						1,549	1,236	931	767

WALES

Severity of Injury	*Employment Status*	*1999–2000*	*2000–01*	*2001–02*	*2002–03p*
Fatal	Employee	8	5	13	7
	Self Employed	4	6	4	5
	Member of Public	7	12	8	8
Major	Employee	1,848	1,534	1,626	1,528
	Self Employed	43	38	35	74
Over 3 Day	Employee	7,330	7,460	6,984	6,826
	Self Employed	29	31	37	46
Non Fatal	Member of Public	840	693	581	484

ENGLAND

Severity of Injury	*Employment Status*	*1999–2000*	*2000–01*	*2001–02*	*2002–03p*
Fatal	Employee	124	172	157	140
	Self Employed	46	61	37	29
	Member of Public	86	94	73	71
Major	Employee	23,623	22,780	23,102	23,626
	Self Employed	564	552	817	905
Over 3 Day	Employee	113,408	112,408	109,028	106,256
	Self Employed	568	654	810	816
Non Fatal	Member of Public	19,696	15,842	10,637	8,777

ESTIMATED PREVALENCE AND RATES (%) OF SELF-REPORTED ILLNESS CAUSED OR MADE WORSE BY WORK, BY COUNTRY, FOR PEOPLE EVER EMPLOYED 2001 − 02

Country	*Estimated prevalence (thousands) 95% C.I.(a)*			*Rate per100 ever employed 95% C.I.(a)*		
	Central	*Lower*	*Upper*	*Central*	*Lower*	*Upper*
England	2,019	1,957	2,082	5.4	5.2	5.5
Scotland	174	156	191	4.5	4.0	4.9
Wales	135	118	151	6.2	5.5	6.9

ESTIMATED PREVALENCE AND RATES (%) OF SELF-REPORTED MUSCULOSKELETAL DISORDERS CAUSED OR MADE WORSE BY WORK, BY COUNTRY, 2001–02

Country	*Estimated prevalence (thousands) 95% C.I.(a)*			*Rate per100 ever employed 95% C.I.(a)*		
	Central	*Lower*	*Upper*	*Central*	*Lower*	*Upper*
England	980	937	1,023	2.6	2.5	2.7
Scotland	85	73	98	2.2	1.9	2.5
Wales	61	50	71	2.8	2.3	3.3

ESTIMATED PREVALENCE AND RATES (%) OF SELF-REPORTED STRESS, DEPRESSION OR ANXIETY CAUSED OR MADE WORSE BY WORK, BY COUNTRY, 2001–02

Country	*Estimated prevalence (thousands) 95% C.I.(a)*			*Rate per100 ever employed 95% C.I.(a)*		
	Central	*Lower*	*Upper*	*Central*	*Lower*	*Upper*
England	494	462	525	1.3	1.2	1.4
Scotland	39	31	47	1.0	0.08	1.2
Wales	31	23	38	1.4	1.1	1.8

(a) = 95% Confidence Limits.

Memorandum submitted by the Chemical Industries Association (CIA)

1. Introduction

The Chemical Industries Association (CIA) comprises 180 operating companies, based at over 300 manufacturing sites nationwide. It is the predominant trade association and employers' federation for the UK chemical industry and embraces companies of all sizes from UK divisions of multinational companies to small privately owned enterprises. Many of our members operate sites at which major hazards are present and which are regulated under the Control of Major Accident Hazards (COMAH) regime.

CIA member companies have a sound record in managing risks, and their sites are subject to close scrutiny by HSE; this is entirely reasonable given the presence of the hazards referred to above. CIA's interest in the Committee's inquiry is based on a recognition that the maintenance of high health and safety standards is essential in protecting both a company's licence to operate and its ability to continue running its businesses profitably. CIA members have enjoyed a good working relationship with the HSE for many years and believe that the nature of this partnership between regulator and companies has been fundamental to achieving these high standards of performance.

The following submission to the Work and Pensions Select Committee Inquiry into the work of the Health and Safety Commission and Executive is structured according to the specific questions posed by the Committee.

2. Success of the Health and Safety at Work Act and Subsequent Legislation

The UK chemical industry is a leading industry sector in safety performance, having shown a continuous, sustained improvement in accident rates over a very long period. This has been achieved through a balance of regulation and other activities, such as the production of guidance publications and the provision of sound advice at a local level, as well as voluntary programmes like Responsible Care, which has been adopted by the CIA and its members. The Association believes that, overall, the HSE also recognises the need to employ a variety of means to achieve success in improving health and safety standards in the UK. It is clear, from the performance of some other sectors, where performance is not at a high standard, but where the same UK regulation applies, that regulation alone does not succeed in raising standards.

The implementation of the Health and Safety at Work Act 1974 marked a major milestone in Health and Safety in the UK, but the CIA believes that the Act is as important for some of the working mechanisms it put in place as it is for the details of the regulations themselves. A prime example of this would be the provision of safety committees and safety representation. Engagement of the workforce and debate about how management and workforce can work together to address safety issues has been an integral part of the sustained improvement in the UK chemical industry.

A further fundamental feature of the UK's health and safety regulatory regime and culture is the principle of reasonable practicability. This principle is well understood by regulators and duty holders alike and enables sound decision making on appropriate measures to put in place for the management of risk.

There is increasing concern among the membership of the CIA that translation of European directives into UK law is constraining the HSE in its ability to continue to maintain the ALARP/SFAIRP (As Low As Reasonably Practicable/So Far As is Reasonably Practicable) approach by calling for a much more prescriptive approach. The Association believes that this would be a serious retrograde step and would lead to more "box-ticking" approaches to compliance, rather than real in-depth assessment and management of risk.

There have also been instances where the Association has been concerned that the need to meet deadlines driven by EU timetables and commitments has led to HSE being seriously constrained in its ability to produce vital guidance documentation on implementation of regulations. The lack of clear/timely guidance in turn impacts on industry's ability to fully understand the implications of the legislation and implement its requirements.

Two major tranches of regulation have been introduced in relation to major hazard sites—Control of Industrial Major Accident Hazards (CIMAH) in 1984 and Control of Major Accident Hazards (COMAH) in 1992. For the most part, the Association believes that HSE have responded appropriately to dealing with this specialist permissioning regulatory regime with the dedicated Hazardous Installations Directorate (HID). This aligns with earlier comments about the good working relationship between CIA and HSE.

The chemical industry was particularly disappointed when the HSE was obliged to introduce charging for inspections and services in 1999. The level of charging is not the issue here, but the fact that previous long-established partnership arrangements, where members felt able to contact the HSE for advice and guidance, to resolve matters as part of a prevention regime, was suddenly placed in a very different "charging for consultancy" framework. There is no doubt that regulation and the way in which it has been implemented to date in the UK by the HSE has played a very important part in improving standards of health and safety. However, continuation of progress requires:

- Avoidance of an over prescriptive approach to wording and implementation of regulation
- A range of measures to support regulation, including support for voluntary initiatives, encouragement of worker involvement and ability for industry to continue to see HSE personnel as sources of advice and guidance as well as the enforcer of regulation
- Adaptation of tried and tested mechanisms to take account of the major changes taking place in workplace demographics

3. UK Progress on the Revitalising Health and Safety Strategy Targets

The CIA has set targets for its members that are tougher than those set by HSE in Revitalising health and safety. For example, Revitalising set a target for reducing the incidence rate of fatal and major injury accidents by 10 per cent by 2010, and the CIA's response was to set a target of 50 per cent reduction in lost time injuries by the same date. The Association is confident that it can work with its members to help them achieve these targets and make a significant contribution to the UK's overall Revitalising Health and Safety targets.

4. HSE Prevention and Enforcement Balance

The CIA believes that the HSE does get the balance right most of the time and places a very high value on the Executive's willingness to engage in debate and dialogue when occasions arise where the balance is not right. The CIA values the opportunity to work constructively with HSE and has recently done so in the production of guidance for the location and design of occupied buildings on chemical manufacturing sites, as well as on a current initiative to identify cases of inconsistent or disproportionate enforcement of legislation and to seek resolution of these matters. The Association welcomes the HSE's strong support for this initiative.

It should be noted that, within its overarching sustainable development activity, the CIA is now broadening its agenda to address other health and safety matters, including stress and work-life balance, as part of every individual's right to enjoy a safe and healthy working environment. The Association applauds the Health and Safety Commission's recent consultation on a new strategy, which seeks to focus on current priority areas, some of which will require new approaches from the HSE and from industry. The CIA looks forward to working together with the HSE in delivering on all of the elements of the new strategy, which apply to the UK chemical industry. The CIA also welcomes the intent to focus on areas of poor performance and greatest cost/concern

5. HSE Ability to Proactively Address Developing Hazards at Work

The Association regards the Health and Safety Commission's recent strategy consultation as marking a major shift in approach, towards becoming more proactive in addressing emerging workplace risks. Delivery of the agenda will be a major challenge for industry and the HSE, as it requires:

— The need to recognise the importance of new skills and approaches on both sides

— Tough decisions to stop doing some of the traditional tried and tested activities in order to release resource for new initiatives

— Continued diligence in getting the balance right to remain a regulator which takes a proportionate approach to risk management rather than being seen to over prescribe and encourage widespread risk aversion

6. Penalty Levels for Health and Safety Offences

Financial penalties resulting from health and safety offences do have a significant impact on companies, but the Association believes that it is the prosecution/penalty process itself, which acts as the real deterrent, rather than the level of the financial penalty. By far the greatest damage suffered by a company following prosecution is the impaired reputation of both the company and the industry sector resulting from the adverse publicity.

7. Level of Understanding of Health and Safety Legislation

Within the chemical industry, the level of understanding is high, mainly for historical reasons (major accidents such as those at Flixborough and Bhopal) and because of the longstanding working level contacts between duty holders and field inspectors. Not every sector of the UK economy has the same level of risk awareness or understanding of its regulatory obligation for health and safety.

It is clear that the boundary between the health and safety of the workforce and the interaction with public safety is not well understood. The public perception of the role of the HSE and the Commission is much more about prevention of disasters with major public impact than dealing with general workplace health and safety.

8. Encouraging Good Practice

The Association believes that there are many opportunities for good practice to be transferred amongst different sectors of industry. This is an area that is not exploited at present, but the chemical industry would be a very willing participant in such a process.

9. "Health" Emphasis Within Health and Safety

Historically, the CIA believes that there has not been sufficient emphasis on health from either the regulator or duty holders. However, the Association applauds the HSE's recent initiative to rectify this balance and will certainly respond to this (see item 3 above). It is important, however, to re-emphasise the need for new skills and approaches on all sides to address this matter.

10. Resourcing of the HSE

The level of resource required largely depends upon a very clear appraisal of the tasks to be done and the most effective methodologies to achieve them.

For example, because of the time sometimes taken for HSE to respond to a company communication, it can appear to the company concerned that there is a lack of resource. This may not be the case but it does indicate the need to review the efficiency and effectiveness of the work process within the HSE in order to deliver the response.

If there is to be a policy to shift the Executive's resources towards other industries with relatively poor safety records, this must be properly explained in order to counter the perception that there exists a problem of under-resourcing.

Many industry sectors regulated by the HSE (including the chemical sector) have made enormous changes to working practices in recent years through productivity gains and work process redesign. The challenge currently faced by the HSE is much more about the need to adapt and change the culture of a highly respected and technically competent organisation to meet the changing needs and expectations of the world of work it is required to regulate in the 21st century.

11. Co-Ordination Between HSE and Other Central and Local Government Bodies Involved in H&S

Because of the nature and size of their operations, CIA members are regulated by the HSE, not local government. The Association is therefore unable to comment on this aspect. However, the Association is aware that the HSE works closely with the Environment Agency and SEPA as the joint Competent Authority for the COMAH (Control of Major Accident Hazards) Regulations. To date, the evidence collected from CIA members indicates that these arrangements seem to work well overall from our industry's viewpoint.

12. Strategy for Workplace Health and Safety in the UK to 2010 and Beyond

The CIA very much supports the key messages in this document, namely: working in partnership, supporting people, focusing effort where the impact is greatest and sharing the vision. The Association looks forward to working with the HSE in putting this strategy into practice and welcome this initiative to re-position the role of HSE/C to effectively address the current workplace health and safety priorities.

Gillian Buzzard
Chemical Industries Association

24 February 2004

Memorandum submitted by DWP

Introduction

1. This memorandum provides a written contribution by the Department for Work and Pensions to the Work and Pensions Select Committee's inquiry into the work of the Health and Safety Commission and the Health and Safety Executive.

2. The Health and Safety Commission (HSC) and the Health and Safety Executive (HSE) were created in 1974 by the Health and Safety at Work, etc Act 1974 (HSWA). HSC, comprising a Chair and up to nine Commissioners, is appointed by the Secretary of State for Work and Pensions.

3. HSC is responsible for making arrangements to secure the health, safety and welfare of people at work and the public from work activities. It advises Ministers on health and safety issues including proposals for new legislation and standards. The HSC appoints the senior members of the Executive with the consent of the Secretary of State.

4. The Executive assists and advises the Commission in discharging its responsibilities. It employs approximately 4,000 staff including inspectors, policy advisors, technologists, and scientific and medical experts. The HSE and in some cases Local Authorities enforces the HSWA. The Act regulates most health and safety at work activities including, nuclear installations, railways, offshore gas and oil installations, chemical, gas safety, movement of dangerous goods and substances, mining, as well as offices, shops, schools and general factories. Consumer and food safety, marine, aviation safety and environmental protection are dealt with by other bodies.

Track Record

5. The approach to health and safety in Great Britain has been a success. The HSWA modernised the approach to health and safety regulation from prescription to goal setting. Importantly the act puts responsibilities to reduce risks on those that create them. The onus is on the duty holder to demonstrate that the risks have been reduced so far as is reasonably practicable. But the duty holder is also able to take decisions about what they believe is the appropriate way to manage these risks in their particular circumstances. The HSE exists to assist and guide them in this, and to enforce minimum standards.

6. Thirty years on, this remains a "modern" approach, which has brought about significant improvements in health and safety in Great Britain. Great Britain has one of the best records in Europe on health and safety. And the HSE has an international reputation for excellence.

SPONSORSHIP OF HSC/E

7. The sponsorship of HSC/E has rested with a number of Government Departments since 1974. Most recently, it was with Department for Transport, Local Government and the Regions before moving in 2002 to Department for Work and Pensions.

8. HSC and HSEs work on health and safety fits well with the Department for Work and Pensions agenda of keeping people in work and rehabilitation in getting people back to work. Preventing accidents and ill health at work plays a major role in this agenda, particularly in relation to health issues such as stress and musculoskeletal disorders.

9. Department for Work and Pensions Ministers are responsible for:

- Appointing the Commission and approving the appointments of the most senior members of the Executive.
- Approving the Commission's Plan of Work, and agreeing the strategic direction.
- Accountability to Parliament for legislation/regulation on health and safety issues (principally considering and approving proposals brought by the Commission)
- Payment of grant-in-aid to HSC/E, assessing its delivery and so securing Value for Money.
- Conveying to HSC/E the context and priorities of the Government's wider policy agenda and providing for HSC/E support and access within and across government

10. In addition, a number of other Ministers retain an interest in specific activities of the HSC/E. These include:

- Department for Transport: Railway passenger safety and carriage of dangerous goods.
- Department for Trade and Industry: Safety of public from nuclear processes; negotiation and implementation of "single market" Directives on safety of products used at work; testing of flameproof apparatus; offshore oil and gas wells consents regime.
- Home Office: Security of explosives.
- Department for Environment, Food, and Rural Affairs: Pesticides and veterinary medicines in use.
- Department for Education and Skills: Enforcement of and advice on licensing of activity centres for young people. Regulation of curricular low level ionising radiation in schools.
- Scotland and Wales: Territorial equivalents of the above.

11. Several government departments have an interest in HSE activities on its work on civil contingencies. This includes ensuring that response to civil contingencies takes proper account of health and safety risks to the rescuers, but at the same time for health and safety law not to get in the way of an effective emergency and contingency response.

12. HSC and the HSE are non-departmental public bodies. They generally act independently of government. They are not accountable for their day-to-day operations to the Department for Work and Pensions. HSWA specifically limits the role of Ministers in respect of individual enforcement cases.

SHARED ANALYSIS OF CURRENT POSITION

13. Since the establishment of the current health and safety regime in 1974, there have been significant gains. The number of fatal injuries to employees since 1974 is down by over two thirds.

14. The main role of HSC/E over this period was:

- Defining standards through legislation and guidance
- Working with local authorities in enforcement activities (through inspection, investigation, prosecution etc).
- Promoting research and guidance.

The main focus of HSE activities was on safety (as opposed to health) as this was seen to be the major problem and significant gains have been achieved in this area.

15. By the mid 1990s there was a gradual levelling off in the rate of reduction in injuries. HSC/E also recognised the challenge of better addressing health issues. In response to this, government and HSC/E launched its "Revitalising Health and Safety" strategy in June 2000. Specific targets were set which included:

- Reduce the number of working days lost per 100,000 workers from work related injury and ill health by 30% by 2010.
- Reduce the incidence rate of fatal and major injury accidents by 10% by 2010; and
- Reduce the incidence rate of cases of work related ill health by 20% by 2010.
- Achieve half of each of the above targets by 2004.

In making the next step to meet the health targets "Securing Health Together" was launched. Further details can be found on the HSE website www.hse.gov.uk/revitalising/index.htm

However, the evidence suggests that the relatively "flat" trend in performance has continued. For this reason HSC/E and Department for Work and Pensions Ministers took advantage of HSC/E transfer to a new sponsoring department to review the strategic position.

16. The nature of the economy in Great Britain has evolved significantly since 1974. There has been a move from manufacturing industries to the services sector. This has led to a shift of emphasis from the traditional type of hazards to other hazards principally causing health problems such as stress and musculoskeletal disorders (MSD). Of late this trend has accelerated.

17. A fundamental conclusion of this strategic review was that whilst the "revitalising" objectives remained right, HSE had to evolve its approach. More of the same, even more of the same done better, would not deliver these ambitious targets.

18. A further conclusion was that HSE, and its sponsors, needed to broaden the context for their work. At its heart remains a moral prerogative: that people should not be harmed by their work, but we also recognised a need to broaden the context, to make better linkages between effective and proportionate health and safety regulation and the wider agendas of competitiveness, productivity, insurance costs, and labour market policies. In all of these areas good health and safety practices can make a positive contribution.

19. Having reached a shared strategic analysis the HSC has responded by developing an important new strategy-its response to that analysis.

20. The Department for Work and Pensions has been engaged with HSC and HSE in ensuring that the new strategy is based on available evidence, innovative, widely consulted on and that the views of the stakeholders are incorporated into the final document.

Strategy for Health and Safety in Great Britain to 2010 and Beyond.

21. The new strategy is based on the available evidence on the effectiveness of health and safety interventions and a process of consultation. It is driven by the need to deliver the challenging targets. It is strongly supported by the Department for Work and Pensions. Further information on the strategy can be found in the HSC document "A Strategy for Workplace Health and Safety in Great Britain to 2010 and beyond".

22. The main themes in the new strategy are: (a) developing and working in closer partnerships, (b) focusing on those interventions that have the greatest impact, (c) rising to the challenge of occupational health, (d) communicating effectively, and (e) promoting the benefits of health and safety. Some of the key points arising from these themes are:

- Intervention Strategies. HSE has finite resources. The Department for Work and Pensions wants to ensure that these are effectively used on those activities that have the greatest impact. This means more resources aimed at industries that have a poor record and less on those where the risks are well managed. It also means drawing the right balance between providing information and advice, and enforcement, based on evidence.
- Legislation and regulation. The current system has served us well and is suitable for the foreseeable future. The HSC believe that the regulatory framework for safety is largely complete and that the occupational health agenda will place less emphasis on prescription regulation. The Department for Work and Pensions is supporting HSC in promoting the case for higher fines, and is working with other Departments to progress the Government's commitments to reform the law on corporate killing and remove crown immunity for health and safety offences. But more generally, the new strategy envisages a "downplaying" in the role of further regulatory solutions.
- Partnerships. The national improvement targets for health and safety are for the whole of Great Britain's health and safety system. For Great Britain to meet these, it will require HSC/E to forge greater strategic partnerships with other key players in the system, especially those, who through their activities can stimulate action by others to reduce accidents and ill health arising from work as well as those whose actions can have more direct and immediate effect.
- Persuasion. Simply "forcing" stakeholders to comply with the law is neither feasible nor desirable, as a strategic approach it is too prescriptive. This is a question of winning "hearts and minds" of duty holders to make significant improvement. It will require both effective communication, and demonstration of the business benefits as well as the moral case. The Department for Work and Pensions has been supporting HSC/E in a number of initiatives to demonstrate the business benefits of proper management of health and safety.
- Local authorities. These have a wide range of local and regional knowledge. They also have an existing enforcement role and are a large employer. The new strategy recognises local authorities as one of the key strategic partners that HSE needs to work with so that they can contribute to meeting the targets.

— Enforcement. Inspection works for many risks. And the threat of prosecution remains an important influence on employer's behaviour. In developing new approaches we must not lose sight of the key tools, which have underpinned our success so far.

23. The Minister for Work has been actively involved in the development of the strategy and will be playing his part in its launch and promotion.

Achieving Outcomes

24. We believe that the ambitious targets set in "Revitalising" were the right ones. We reaffirm our commitment to them. However, we do not think that they told the whole story. A large and vital part of HSE's work involves dealing with "major hazards". Targets for "major hazards" have now been developed.

25. The Department for Work and Pensions, HSC and HSE recognised a need to place delivery of these high level objectives at the heart of HSE's business. In response HSE has set about transforming its programme delivery and performance monitoring arrangements.

Delivery and Performance Monitoring

26. The Department for Work and Pensions has supported and encouraged the introduction of changes by HSE to improve both the effectiveness of the organisation and its management information and performance monitoring.

27. Following the introduction of the targets in 2000, HSE introduced eight priority programmes identified in the HSC's strategic plan 2001–04. These were intended to address key areas where HSE activity would have the greatest impact.

28. Current available information indicates that while the interim safety targets for 2004 may be met, it is unlikely that health targets will be met. The health issues are far more complex and challenging to address than safety issues. This is reflected in the new strategy with much more emphasis on health. Further statistical details can be found on HSE website www.hse.gov.uk/revitalising.

29. The Department for Work and Pensions has worked with HSE on strengthening HSE's delivery of its targets, and to improve the interface between and reporting to the Department for Work and Pensions. HSE has been seeking to allocate resources more effectively, concentrating on those areas where it can have the greatest impact on achieving the targets. A Delivery Board has been set up, comprising senior managers from both HSE and DWP which reviews progress. HSE formally reports on a quarterly basis on its performance to DWP. The Minister for Work meets quarterly with HSC/E to discuss performance and progress towards the targets.

Engaging Ministers

30. The Minister for Work engages routinely and regularly on Health and Safety issues, including:

— Regular meetings with the HSC Chair and HSE's Director General on current key issues;

— Approval of strategy, plans and other proposals from HSC, including regulatory proposals.

— Approval of plans and bids for the Spending Review

— Managing HSE's relations with Parliament and government. This can take a number of forms from answering PQs, involvement in debates etc.

— Meetings with trade unions, employer organisations and other stakeholders.

Making Commission Appointments

36. Since 1974 the central role of the Commission has been to provide independent advice to Ministers, propose new Regulations, and approve codes of practice.

37. More recently The Commission has taken on an enhanced and leading role in shaping future strategy. It is developing a closer more integrated relationship with HSE much in the way that other NDPB's work with a non-executive board superintending the activities of its executive arm. Department for Work and Pensions Ministers believe that this will improve corporate governance.

38. New job descriptions for Commissioners reflect their greater role, key parts of which include:

— Providing greater focus on strategic issues and performance management of HSE programmes.

— Provide individual leadership and champion the priority programmes.

— Provide a greater focus on external representation, communicating and engaging at a senior level with external stakeholders.

APPROACH TO LEGISLATION/REGULATION

34. HSWA states that legislation passed before 1974 should be progressively replaced by a system of regulations and approved codes of practice. As a result there has been a significant reform of the legislation leading to a much simpler and more effective system of largely goal-setting regulations.

35 Most recent legislation originates from requirements to meet European Directives. These are aimed at promoting minimum standards of health and safety, maintain a single market and to protect the environment. HSE has played its part in influencing the way in which these directives are developed to reflect the UK approach to health and safety and the principles of proportionate risk based approach.

36. The development of European harmonised standards also forms an important part of HSE's work. These standards support the "new approach" directives made under Article 95 of the Treaty of Rome. These standards allow manufacturers to design and build products to the harmonised standards, and thus deemed to satisfy the essential health and safety requirements in the relevant directives.

37. The Department for Work and Pensions Ministers and HSC are in agreement that this legislative framework is broadly complete. The framework is proportionate and flexible. It has led to simplification of the law helping to better cope with innovation and technological change, and changes in work practices. The focus now will be on seeking better ways of ensuring compliance with the legislation. Department for Work and Pensions Ministers wish to see better compliance with existing law and to see this delivered through enforcement activities, better support for employers and employees, better communication and raised awareness generally. Health and safety should not be an add-on; it should be part and parcel of everyday business.

CONCLUSIONS

38. Since the establishment of HSC/E in 1974 there has been a significant decrease in the number of accidents and major injuries. The number of fatal injuries to employees since 1974 is down by over two thirds.

39. HSE is internationally renowned and respected for its expertise and effectiveness. Great Britain has one of the lowest records of workplace ill health and injuries in Europe, and the HSC and HSE play a leading role in technical and policy development abroad.

40. HSC, HSE and DWP have reached a shared analysis of challenges facing the health and safety system. We have jointly:

- Clarified our delivery priorities (the "Revitalising" and "Major Hazards" targets).
- Recognised the need to make a step change in regulatory approach in order to deliver these priorities.
- Transformed the approach to delivery and performance reporting within HSE in a way, which integrates with DWP's own systems.
- Evolved the role of the Commission to further develop its strategic leadership and capacity to scrutinise the Executive.
- Encapsulated our analysis, targets, organisational changes and new approach in a new strategy.
- Linked this work to the wider agendas of competitiveness, productivity, insurance costs, and labour market policies.

Department for Work and Pensions

25 February 2004

Memorandum submitted by the Centre for Corporate Accountability

INTRODUCTION

1.1 The Centre for Corporate Accountability is an advice and research organisation concerned with the promotion of worker and public safety. It focuses on the role of state bodies in the enforcement of health and safety law and the role of the criminal justice system in holding organisations and individuals to account. Its core charitable activities are funded by the Joseph Rowntree Charitable Trust.

1.2 The CCA has particular knowledge of the work of the Health and Safety Commission/ Executive as a result of:

- its "Work-Related Death Advice Service", which is the only national service to provide advice to bereaved families on investigation and prosecution issues. Providing advice to families requires the CCA to have constant contact with the HSE inspectors and to have a detailed understanding of HSE"s policies and procedures;

— research undertaken in the last few years by the CCA on the levels of inspection, investigation, and prosecution by HSE and Local Authorities.

1.3 The CCA very much welcomes the opportunity to provide evidence to the Select Committee. The scope of the select committee's inquiry is wide; the CCA evidence's however is focusing on those areas about which the CCA has particular experience or expertise. We apologise for the length of the evidence—however we hope that the Select Committee will recognise that the complexity of the issues do require the provision of detailed information and argument rather than a superficial point of view[8].

1.4 We would like the Select Committee to be aware that since its last report a number of significant improvements have been made by the HSE in improving its policies and procedures in the enforcement arena—which were in part response to the final Select Committee report[9]. We have set these out in Annexure One.

Summary

2.1 The CCA's evidence concerns: (a) resources; (b) prevention/enforcement; (c) directors duties and jurisdiction; (d) HSE and public safety (e) HSE and Local Authorities.

Resources

2.2 The CCA's evidence on resources can be summarised in the following manner:

— the Government's current financial settlement will mean that the HSE has less money to spend on the "administration" budget—which pays for inspector costs—in 2005–06 than 2003–04.

— The average yearly increase in HSE's administration budget between 2000–01 and 2005–06 will have been around 2.5% the rate of inflation—though two-thirds of that increase came in one year. Since that one year—where there was an increase of 9%—the level of increase has risen on average by less than 1.25%.

— the number of inspectors is crucial to the core work of the HSE—inspection, investigation and enforcement activities—and the absence of adequate resources for their employment severely impacts upon HSE"s ability to carry out these activities which is to the detriment of health and safety;

— apart from its direct impact upon inspection/investigation/prosecution issues, lack of resources has resulted in HSE (a) adopting a new highly restrictive policy concerning HSE's future engagement on public safety issues; (b) considering new enforcement strategies that seem to directly contradict the findings of international and HSE's own research; (c) failing to supervise appropriately local authority enforcement (d) deciding against setting up legal independent oversight of HSE's prosecution decisions;

— the HSC has failed to campaign publicly about the problem of resources: the result, it appears, is a resource driven enforcement strategy.

Prevention and Enforcement

2.3 The CCA's evidence can be summarised in the following manner:

— the CCA understands the issue here as the relative priority that the HSE should give to (a) inspections on the one hand and investigations on the other and (b) informal advice on the one hand and formal enforcement on the other;

— investigations should not be seen as only about "accountability". Investigations serve important preventative functions—with some advantages over inspections;

— whilst prosecutions serves to bring about criminal accountability, the evidence indicates that they serve an important preventative function as the fear of legal action and reputational damage has important deterrent impact;

— the prosecution criteria in HSE's Enforcement Policy Statement should be changed so that breaches of safety law that result in major injuries are treated in the same way as breaches that result in deaths;

— HSE's new evolving policy on enforcement—to move away from inspection, investigation and formal enforcement—as proposed by HSE's Deputy Director in October 2003, contradicts overwhelming international and HSE evidence that it is inspection, investigation and formal enforcement that works best;

— HSE's continuing focus on the "business case for safety" has been shown to have little impact in motivating employers.

[8] Please note that apart from paras 4.8–4.19, this material has been prepared specifically for the Select Committee.

[9] The CCA gave written and oral evidence to the Committee on a number of these issues.

Legal Framework: Directors Duties and Jurisdictional Matters

2.4 The CCA's evidence can be summarised in the following manner:

— there is a gap in the law so that company directors have no legal obligation to take any positive steps to ensure that their company is complying with safety law. This has serious implications for both prevention and accountability;

— the HSC/E acknowledges that the conduct of company directors can be crucial to the safe management of a company;

— the findings of international and HSE research indicates that legal regulation is the principle mechanism to motivate senior company officers in relation to safety;

— the government and the HSE have not kept their commitments relating to legislating in this area;

— the HSC has decided to go down a voluntarist approach without any evidence of its effectiveness and in contradiction to its own and international research.

HSE and Public Safety

2.5 The CCA's evidence can be summarised in the following manner:

— As a cost-cutting measure, the HSE has recently established a new restrictive policy on public safety issues which will, for example, mean that many deaths and injuries suffered by members of the public will no longer be investigated.

2.6 HSE and Local Authorities

— CCA analysis of Local Authority inspection and investigation rates indicates the need for the HSE to be carrying out its supervisory functions more assiduously and not just employing one person to audit 410 local authorities.

Resources

3.1 The Select Committee has specifically asked for evidence on whether the HSE is "sufficiently well resourced to meet its objectives?" The CCA views the question of "resources" as a crucial issue which goes to the heart of many arguments relating to the way in which the HSC/E does or should function.

3.2 In this section the points that the CCA would like to make are as follows:

— the Government's current financial settlement will mean that the HSE has less money to spend on the "administration" budget—which pays for inspector costs—in 2005–06 than 2003–04.

— The average yearly increase in HSE"s administration budget between 2000–01 and 2005–06 will have been around 2.5%—the rate of inflation—though two-thirds of that increase came in one year. Since that one year—where there was an increase of 9%—the level of increase has risen on average by less than 1.25%.

— the number of inspectors is crucial to the core work of the HSE—inspection, investigation and enforcement activities—and the absence of adequate resources for their employment severely impacts upon HSE's ability to carry out these activities which is to the detriment of health and safety;

— apart from its direct impact upon inspection/investigation/prosecution issues, lack of resources has resulted in HSE (a) adopting a new highly restrictive policy concerning HSE's future engagement on public safety issues; (b) considering new enforcement strategies that seem to directly contradict the findings of international and HSE's own research; (c) failing to supervise appropriately local authority enforcement (d) deciding against setting up legal independent oversight of HSE"s prosecution decisions;

— the HSC has failed to campaign publicly about the problem of resources: the result, it appears, is a resource driven enforcement strategy.

Understanding HSE's Financial "Settlements"

3.3 The HSE obtains money from two main sources: the Government in the form of a "grant-in-aid" and from its own income generating activities.

3.4 The Government not only determines the level of "grant-in-aid" but also the level of income that the HSE can generate and use in any particular year. It also decides in what way this money should be used—whether for "administration" costs, "projects" or on "capital" costs.

3.5 In the CCAs view it is "administration costs" that is the crucial budget heading that needs to be given particular scrutiny. Whilst project and capital costs are important, it is the level of "administration costs" that determines the numbers of inspectors that the HSE employ, and as discussed below (paras 3.17–3.39),

it is the number of inspectors that is crucial to the HSE being able to carry out its core activities. Out of this budget also comes resources for support staff and lawyers who are crucial to the efficient working of HSE's inspectors.

3.6 Since May 1997, there have been two financial settlements between the HSC and the Government—one in 2000 and the other in 2002. The CCA has not found it easy to understand HSE's funding but—based on HSE figures—we have set out below our best analysis.

Analysis of First Settlement

3.7 In 2000, it was announced that the Government was providing the HSE "£45 million" of new money over a three year period. However the following needs to be noted about this figure (see annexure 2, table 1):

- only £24 million of that was actually allocated for "Administration costs" ;
- of that £24 million, 20 million was money that the Government was actually giving the HSE; the remaining £4 million had to be earned by the HSE through increased income generating activities.
- the figure of an additional "£24 million" for administration costs is in itself rather misleading. The real increase in the proposed "administration" budget between 2000–01 and 2003–04 directly as a result of this settlement was £9 million.[10]
- However, it should be noted that the administration budget in 2000–01 was £179.5 million and the budget in 2001–02 was 195 million—a £15 million increase—most of which was in place prior to the 2000 settlement. The £15 million comprised £5 million of Government money from the settlement; a further £5 million of (pre-settlement) HSE income and £6 million from reclassification of capital and revised treatment of VAT.
- As a result between 2000–01 and 2001–02, there was a 9% increase in the administration budget; between 2001–02—2002–3 there was a 2% increase; and then between 2002–03—2003–04 there was a 0.5% increase.

Analysis of the Second HSE Settlement

3.8 In December 2002, the Government announced that it would provide the HSE with an extra £10 million over a three year period. This was all to go into HSE"s "administration" budget.

3.9 However, this figure is again somewhat misleading. At the end of the three year period, this increase equates to an increase of only £2 million on the administration budget when compared with 2002–03—the year prior to the Settlement. (see annexure 2, table 2):

3.10 In fact, the current arrangement would mean the amount of money that can be spent on "administration" by the HSE in 2005–06 is less than the amount that can be spent in 2003–04. This is therefore a real cut in HSE funding of HSE "administration"

Analysis of the Settlements Combined

3.11 Table 3 of annexure 2 puts together the five years covered by the Settlements. It should be noted that this table is different from both tables 1 and 2 since the second settlement changed the 2002–03 figures made in the first Settlement

3.12 This table shows that in 2005–06, the Government is allowing the HSE to spend £22 million more than the level it allowed the HSE to spend in 2000–01. That is to say the administration budget will have risen from £179 million to £201 million.

3.13 This increase represents a year-on-year average increase of about 2.5%—which about matches the level of inflation. However, two thirds (£15 million) of the total increase (£22 million) came in the one year 2000–01—2001–02 and of this £15 million the Government actually only contributed £5 million in direct grant in aid. Subsequent to that year, the level of funding was on average less than 1.25% increase year on year.

Impact of Financial Settlements on Numbers of Inspectors

3.14 The increase of money in the "administration" budget between 2000–01 and 2001–02 resulted in the HSE undertaking a significant increase in the recruitment of inspectors. According to figures provided by the HSE to the CCA, in 2001 there were 575 Grade 3 Field Inspectors. This is the grade that undertakes the core inspection and investigation work. This number increased by 122 in two years with a total of 698 inspectors in 2003—an increase of over 25%.

[10] The sum of 24 million comes about by "double" counting the previous years increase in the subsequent years. So 2001–02 is 5 million of funding: 2002–03 is 5 million + 4 million: 2003–04 = 5 million + 4 million + 1 million.

3.15 In November 2002, however, HSE told its staff that "the financial climate has now changed" and that "we will not fill any vacancies for the time being" and that "we also have no plans at the moment for further recruitment".[11] Due to staff retiring and leaving, this will mean a significant drop in inspector numbers and—according to the trade union PROSPECT—will result in levels of inspector numbers below the level prior to the recent recruitment.

3.16 A comparison with other law enforcement agencies should be noted. There are now more police officers than ever before, and police resources have more than doubled in real terms since the mid 1970s. HSE resource allocation does not compare favourably with even the more peripheral divisions of the police. So, for example there are more police-employed traffic wardens than HSE inspectors, and there are more British Transport Police officers than HSE inspectors currently employed in the UK.

How the Level of Resources Impacts Upon HSE

3.17 As stated above, changes in the administration budget impact directly upon inspector numbers. Any below-inflation increase in the "administration" budget risks their decline—either through redundancies or with posts not being filled up. Any increase can result in more inspectors being employed.

The work of Inspectors

3.18 Inspectors are responsible for the enforcement of safety law in almost one million premises (throughout England, Scotland and Wales) involved in construction, agriculture, manufacturing, quarries, chemicals production, railways, health services, the police and much more. Their two core activities are preventative inspections and investigations into reported incidents (deaths, injuries, dangerous occurrences, ill health incidents). Both an inspection and investigation requires an inspector to access a workplace, undertake detailed inquiries, determine whether or not there has been compliance with health and safety law and whether enforcement action is or is not required. Unlike most inspections, most investigations will require an inspector to take witness statements—which can require many days and weeks. Every reported work-related death is investigated (currently around 250), but only a small proportion of reported incidents (19% of over 22,000 reported major injuries; 5% of 105,000 over-3-day injuries, and 33% of 3,800 dangerous occurrences[12]). If it is decided after an inspection or investigation that a prosecution is appropriate, the HSE inspector is responsible for the preparation and prosecution of the case. Any imposition of enforcement notices will require further inspection to determine whether or not they have been complied with.

Resources and the Levels of Investigations:

3.19 Any change in inspector numbers will directly impact upon the level of inspections and investigations that the HSE can undertake. When resources rise, and more inspectors can be employed, the number of inspections and investigations that the HSE can undertake will be able to rise, and vice-versa.

3.20 And when inspector numbers are relatively stable, any increase in the number of investigations will almost certainly result in a decrease in the number of inspections (and the other way around). This is clearly indicated by the CCA/UNISON research that showed that, as the level of major injuries investigated rose from 10% in 1996–97 to 19% in 2000–01, there was at the same time a 41% decrease in the level of preventative inspections.[13] (report is annexed)

3.21 A decline in resources not only results in a decrease in inspector action—but also sets up a misleading debate about "inspections" versus "investigations". So when, for example, it became clear within the HSE that the shift towards investigations resulted in a sizeable decline in inspections, the only way the HSE could respond was to suggest that the "balance had gone too far the other way". This is despite the fact that the CCA/UNISON analysis showed that:

- — although 20% of reported major injuries in 2000–01 were investigated, 80% of major injuries to workers were not—including for example, 16 out of the 62 amputations to either hands, arms, feet or legs, and 69 out of the 178 major injuries involving electricity
- — although the number of investigations into reported dangerous occurrences increased from 26% to 31%, 73 out of 128 building collapses, 146 out of 223 plant fires and explosions and 88 out of 126 incidents involving the release of a biological agent were not investigated.
- — 90% of reported major injuries to members of the public were not investigated
- — 55% of reported industrial disease incidents were not investigated

3.22 It is difficult to see how the "balance has gone too far" towards investigations when, despite the shift, so many serious incidents were still not being investigated.

[11] "FOD Briefing: To All FOD Staff" November 2002, pages 1 and 2.
[12] These figures are based on 2000–01 figures reported to Field Operational Directorate of HSE.
[13] CCA/UNISON (2002).

3.23 As a result the HSE is now reducing both the level of investigations and the time spent on each one. A recent instruction to HSE inspectors states:

> "Time spent on investigation work by [Field Operations Directorate (FOD)] has risen substantially since the revised criteria were introduced in April 2001. With finite resources, this work has been completed at the expense of preventive work. To get a better balance FOD has looked at both its management of investigations and the incident selection criteria. FOD envisages an increase in proactive activity to halfway between the current position and that in 1995–96. This should still meet the pressure to investigate a higher proportion of reported injuries (than HSE did in the late nineties) while restoring a largely preventive focus."[14]

3.24 The instruction to reduce time spent on investigations is in force now throughout Britain. The plan to reduce the number of investigations is being piloted in the North West of England though the intention is for this to go nationwide.

3.25 Numbers of investigations will be brought down by changing the new investigation criteria. The following indicates some of the effects of these new criteria and the types of injuries that will no longer be investigated if they come into force:

- currently, "all amputations of digit(s) past the first joint" need to be investigated. The new criteria require only those amputations of digits past the first joint "where the incident involved potential for more than one finger or for hand/arm amputation" to be investigated;
- currently all "serious multiple fractures (more than one bone, not including wrist or ankle)" from whatever cause need to be investigated. The new criteria require only those injuries if they resulted from a "crush injury" or they are associated with "workplace transport" or "falls from height" to be investigated;
- currently all "scalpings" need to be investigated. The new criteria do not require them to be investigated.

3.26 Crucially, the new criteria do not give inspectors any discretion in deciding whether or not to investigate an incident. The new criteria make it clear that if reported incidents are not required to be investigated, they should not be investigated.

3.27 It is not clear how many fewer investigations this will mean the HSE has to investigate. If the level was halfway between 1996–97 and 2000–01 levels, it is likely to mean that the percentage of major injuries investigated would decrease by around 5%, from 20% of the total to 15%. This will mean about 1,000 fewer major injuries being investigated, a fall from about 4,300 (figures in 2000–01) to 3,300.

3.28 It should be noted that the new criteria is simply a mechanism to ensure that inspectors spend less time on investigations and thereby maintain (already low) rates of investigations, not because the HSE argues that investigating these incidents are unimportant.

3.29 Any decline in investigations in the CCA's view is very problematic. The reasons for this are discussed elsewhere (paras 4.5–4.19). In summary however the reasons are as follows: (a) investigations are crucial to both prevention and accountability; (b) one of the primary factors motivating companies to improve their health and safety performance is fear of enforcement and investigations are a primary mechanism to detect offences that should result in prosecution.

Resources and Inspections

3.30 The CCA/UNISON analysis showed that in 2000–01, only 1 in 20 premises received at least one inspection during the course of the year, though this ranged from 1 in 10 in the construction sector to 1 in 36 in the Service sector.

3.31 There are clear problems with such low levels of inspection. However, it appears that, at the most, the proposed increase in inspection numbers will it appears at the most only increase this level of inspection to 1 in 15 premises.

3.32 Again, it is important that the level of inspections is kept as high as possible since as discussed elsewhere, they are crucial to ensuring compliance with health and safety law (see 4.5–4.19).

[14] HSE (2003).

Resources and the Levels of Prosecutions

3.33 There are two issues here. The extent to which funding constraints impact upon (a) the level of prosecutions in a general sense and (b) particular decisions by inspectors about whether or not to prosecute. It is worthwhile noting that there was a 14% reduction last year in the number of prosecutions.

3.34 Most prosecutions are the result of investigations. Therefore any decrease in the numbers of investigations will almost inevitably result in a decrease in the number of prosecutions.[15] HSE's decision to reduce investigations will therefore reduce the number of prosecutions which as discussed elsewhere are important to any preventative strategy of the HSE (see paras 4.26-4.31).

3.35 In addition, although any enforcement action taken following a decision to investigate or inspect should theoretically be unaffected by resource constraints[16], research indicates that it is simply not possible to sustain the division. A major, recent Oxford University study on how HSE inspectors decided whether or not to prosecute breaches, a study which was based on unrivalled access to HSE and indeed was part-funded by them, demonstrated unequivocally that resources are a key constraint on decisions to prosecute.[17] This is supported by anecdotal information that the CCA has heard from HSE inspectors themselves, This is for the following reasons:

— the new public interest tests still allow HSE inspectors significant discretion on whether or not to prosecute in a particular case;[18]

— decisions by inspectors—unless they relate to an investigation into a death—are rarely subject to challenge. Most decisions can therefore be made in the knowledge that they will not be scrutinised too closely or at all

— HSE inspectors, who already may be tasked with undertaking a particular number of inspections and investigating a particular number of incidents, and perhaps already involved in a number of prosecutions may well be forced to decide that it is simply not possible for them to prosecute any more cases at a particular point in time. This will mean that they will not investigate a particular incident with the usual level of rigor or will use their discretion to use some other form of enforcement action than prosecution.

3.36 Resource constraints are also likely to have a particular impact upon prosecution decisions relating to directors or senior managers. This is because:

— these require far more investigation than prosecutions against companies, particularly when dealing with larger companies;

— these are more likely to result in a not-guilty plea and have to go to trial, which require more work and resources.

3.37 It is important to note that resource constraints are more likely to act to the benefit of large companies and their directors. This is because (a) it is much more difficult to investigate and prosecute the conduct of directors of large companies (again requiring more resources if this is to be done) and (b) large companies tend to have a far more aggressive approach to defending HSE prosecutions (resulting in the need for more HSE resources to be put into them).

3.38 If the HSC and the Government want the current enforcement policy to be properly and equitably applied, it is essential that there are enough inspectors to undertake appropriately comprehensive investigations and prosecution preparation.

Resources and Principal Inspectors

3.39 It is Principal inspectors who are responsible for managing inspectors—determining whether they should be conducting inspections, investigations or whether in response to these, they should be pursuing legal action. Anecdotal information provided by HSE inspectors to the CCA indicate that lack of resources places these inspectors in untenable positions—where, with only a small band of inspectors, they have to juggle inspections, investigations and prosecutions. Decisions have to be made to cut short investigations

[15] This is common sense but also acknowledged by the HSE. In relation to the London and SE area and the level of prosecutions, the HSE have commented "A large proportion of prosecution traditionally stem from incident investigation . . . The number of incidents investigated has declined in the London Area, addecteing the number of cases put forward." HSE Paper "Pilot Prosecution Branch" (London and South East) 10/9/01-6/09/2002.

[16] This is because the new Enforcement Policy Statement does not discuss resources in the context of prosecution.

[17] Hawkins K (2002) See in particular pages 318–325.

[18] Para 39, HSC's Enforcement Policy Statement (2002).

(which would ideally not be cut short) or decide not to pursue prosecution action (when ideally it is appropriate that action should be taken).Thus, a senior HSE official is quoted in Hawkins' 2002 study as saying:

> "We found in the efficiency scrutiny that the very simplest case where there was to all intents and purposes an open and shut case, where we had a guilty plea in a magistrates' court, then the resource input from HSE to that case was at least five times greater than if one had simply written a notice. And that's the simplest circumstances. In other circumstances, the factor rises to 20-plus times. So there is a very big resource constraint on people doing prosecutions"[19]

Resources and HSE's new Paradigms of Enforcement

3.40 The HSE's Board is currently trying to change the whole emphasis of HSE's work from an enforcement minded body to an advisory one. This is made clear in a report to HSE's Board in September 2003 by HSE's Deputy Director Justin McCracken which has also recently been circulated to the HSC. As is dealt with elsewhere in our evidence (paras 4.23–4.31), HSE's new view on enforcement contradicts (a) HSE's own evidence relating to what enforcement strategies work and (b) the consensus of international research.

3.41 Although the new policy is carefully articulated, it appears to be the case that the catalyst for this new policy is the context of limited/declining resources for the HSE.

Resources and Public Safety

3.42 The HSC has recently published new guidance that severely limits the role of the HSE in the realm of public safety. This is discussed elsewhere in our evidence (section 6) but this new policy—which the Centre believes may well be unlawful—has had to be implemented in order to cut the work that the HSE undertakes.

Resources and Local Authority Enforcement

3.43 We discuss elsewhere (section 7) the relationship between the HSE and Local Authorities—but in the context of resources, it is important to note that the HSE (through the HSC) has a responsibility to monitor the role of Local Authorities in their responsibilities of enforcing health and safety law. Section 18(4) of the HSW Act, requires that local authorities perform their duties in accordance with guidance issued by the HSC which has the power to report defaulting local authorities to the Government.[20]

3.44 It is the CCA's view that these "supervisory" responsibilities are very important. Research that the CCA/UNISON undertook comparing inspection, investigation, and enforcement levels between over 340 Local Authorities indicated huge divergence in practice—with some local Authorities, for example, investigating all reported injuries whilst others investigated none[21].

3.45 Despite this, however, the HSE's Local Authority unit employs only one person to audit all 410 local authorities. This compares for example to the Food Standards Agency (FSA) which, although it is structured around a different model of regulation, is comparable to HSE in relation to its role of co-ordinating local authority enforcement. The FSA has over 40 people involved in auditing local authorities in their enforcement of food safety standards. Sufficient resources need to be provided to the HSE to carry out this function.

Resources and HSE's Prosecution Pilot

3.46 The CCA understands that, due to lack of resources, the HSE has decided against "rolling out" to the rest of the HSE regions, a London and South East prosecution pilot project that had ensured that there was independent legal oversight over prosecution decisions.

3.47 The background to this is as follows. In December 2000, a review by the HSE had recommended that a new prosecution model should be put in place involving independent legal oversight of the decision to prosecute, separating out the functions of prosecution from investigation. This recommendation was in line with recommendations set out in the 1981 Royal Commission on Criminal Justice (The Philips Report) and the 2001 Gover-Hammond Report. These reports had recommended such a separation of function to secure the necessary fairness, efficiency and accountability required of independent prosecuting authorities.

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[19] Hawkins K (2002) page 319.

[20] Paras 10 and 11 of HSC's 'Section 18 Guidance" state: "If an LA fails to meet its legal obligations under section 18 of the HSW Act, the Secretary of State may, after considering a report submitted to him by HSC, cause a local inquiry to be held. If the Secretary of State is satisfied by such an inquiry that an LA has failed to perform any of its enforcement functions, he may make an order declaring the authority to be in default. The order may direct the authority to perform their enforcement functions in a specified manner within a specified period of time. If the defaulting authority fails to comply with such an order under section 45 of the HSW Act, the Secretary of State may enforce the order, or make an order transferring the enforcement functions of the defaulting authority to the Health and Safety Executive (HSE). In such a case, HSE's expenses are paid by the defaulting authority.

[21] CCA (2003).

3.48 A recent paper by the HSE stated that "In order to assess the resources necessary to put in place [this new system] it was agreed that this approach should be piloted in London, Kent, Surrey and Sussex for a period of one year. David Eves, Deputy Director General, who set up the review envisaged that roll out would fold on in 2003–04".

3.49 An assessment of the pilot project indicated some very important benefits—not just those foreseen—with very limited drawbacks (see annexure 3).[22] Yet although the full economic cost of the London project was only £777,672 and the cost of rolling it out to the rest of the country would likely be less than £10 million, this was not possible "within current resources".[23] In fact the London pilot has now been disbanded and all the benefits that it provided have been lost. The CCA is of the view that the HSE needs to be provided with sufficient resources so that all prosecution decisions have independent legal oversight.[24]

HSC's Position on Resources

3.50 The CCA is concerned about the way the HSC fails to highlight to the public the financial situation of the HSE and how this affects its activities. As far as the CCA is aware the HSC has never publicly raised any questions or concerns about its lack of resources. The most it has ever said is that any increased resources "would be welcome".

3.51 It may well be the case that behind closed doors, the HSC demands more resources from the Government with cogent arguments—but there is no public evidence that this is the case or that they are particularly successful.

3.52 Assuming that the HSC does consider that it is under-resourced, why is it not a champion for more resources, publicly indicating how lack of resources limits the activities of the HSE? The answer to this is not clear. Health and Safety Commissioners are independent and do not have the limitations of civil servants (unlike HSE employees).

3.53 There is certainly nothing prohibiting the HSC from being more of a champion for HSE resources. Indeed, it could be argued that it has some form of obligation to do so. Section 11 of the 1974 Act states that "it shall be the general duty of the Commission to do such things . . . as it considers appropriate for the general purposes of this Part". Section 1(1) of the Act states that:

The provisions of this Part shall have effect with a preliminary. view to

(a) securing the health, safety and welfare of persons at work;

(b) protecting persons other than persons at work against risks to health or safety arising out of or in connection with the activities of persons at work; ..."

3.54 One could easily expect the HSC to be more forthright and public about the issues of resources which directly impact upon the health and safety of workers and those affected by work activities. The HSC needs to explain why it feels unable to do this[25].

3.55 In addition, if it is correct that HSE officials can not argue publicly for more resources—due to their position as civil servants, for example—then in the CCA's view it is important that they do not conversely argue that the HSE is adequately funded, as HSE's Deputy Director, Justin McCracken did on BBC Radio 4[26] when he said "we have enough money to do the job adequately."

"The Right Balance?": Inspection, Investigation and Enforcement

4.1 The Select Committee has asked for evidence specifically relating to "how well the HSE achieves the right balance between prevention and enforcement." This section of our evidence looks at this question and can be summarised in the following manner:

— the CCA understands the issue here as the relative priority that the HSE should give to (a) inspections on the one hand and investigations on the other and (b) informal advice on the one hand and formal enforcement on the other;

— investigations should not be seen as only about "accountability". Investigations serve important preventative functions—with some advantages over inspections;

[22] It should be noted that there is no reason to suggest that this new model would result in more prosecutions. The CCA supports the initiative since it is good prosecution practice, should result in better prosecution decisions and greater efficiency.

[23] HSE (2002) Para 6.1. It should also be noted that the report also concluded that "The view of the Branch Manager is that the experience of the initial 12 months of the pilot has demonstrated that independent legal oversight is not necessary for all HSE prosecution cases". However there was nothing in the report itself that appeared to support that conclusion, nor was it explained which cases required oversight and which did not.

[24] The HSE is in the process of setting up a system where only the most important/major prosecution decisions are dealt with by lawyers.

[25] The CCA has other general concerns about the way the HSC functions. For example, some Commissioners refuse to meet up with outside bodies (like the CCA) to discuss health and safety matters and issues to be discussed at Commission meetings. There is a "Commissioner" who is supposed to represent the "Public Interest" but has not attempted to define public interest and.

[26] 16 June 2003.

— whilst prosecutions serves to bring about criminal accountability, the evidence indicates that they serve an important preventative function as the fear of legal action and reputational damage has important deterrent impact;

— the prosecution criteria in HSE's Enforcement Policy Statement should be changed so that breaches of safety law that result in major injuries are treated in the same way as breaches that result in deaths;

— HSE's new evolving policy on enforcement—to move away from inspection, investigation and formal enforcement—as proposed by HSE's Deputy Director in October 2003, contradicts overwhelming international and HSE evidence that it is inspection, investigation and formal enforcement that works best;

— HSE's continuing focus on the "business case for safety" has been shown to have little impact in motivating employers.

4.2 In the CCA's view there is a problem in the nature of the question—since there is no necessary tension between prevention and enforcement. Indeed, they are complementary activities within the HSE's attempt to achieve its mission.

4.3 The HSE has recently defined enforcement as:

> "activities directly associated with ensuring dutyholders discharge their legal duties. Techniques may include giving advice (written or oral), withdrawing approvals, varying licences, serving notices, issuing cautions, prosecuting. The term implies the possibility of escalation if the dutyholder does not act appropriately (eg move from advice to notice if the advice is not followed)"[27]

The CCA endorses this definition and in our view all of these activities listed are concerned with prevention since they are trying to change a duty holders conduct in order to ensure compliance with health and safety law. By so doing, the risk of death and injury will be reduced. It should be noted that prosecution is also an enforcement technique relating to prevention since, as is discussed below[28], overwhelming evidence suggests that compliance with health and safety law depends upon the perceived likelihood of detection and enforcement action—including prosecution. That is to say, the weight of evidence indicates that deterrence should underpin enforcement strategy in this arena.

4.4 Our interpretation of the Select Committee posing the question on "prevention" versus "enforcement" is whether there is a right balance in two different respects: first the balance between "inspection" versus "investigation" (which is a question of how inspectors should access workplaces); and, second, the balance between "informal enforcement" (ie advice) v formal enforcement particularly prosecution (which is a question of what enforcement techniques HSE inspectors should use when faced with a breach of the law).

Inspection v Investigation

4.5 The HSE has recently defined inspection as "the proactive mechanism used to assess the extent to which dutyholders have discharged their duties and to motivate them to do so. It is usually done at the workplace, and includes looking at the workplace, the work activities, the management of health and safety, talking to employees and their representatives, and the offering of guidance or advice."[29]

4.6 We have problems with this definition since inspections are not just about "motivating dutyholders" or the "offering of guidance or advice". They are—and should be—about enforcing the law using all the different techniques available. Indeed as the HSE knows, a significant number of enforcement notices and prosecutions arise from inspections.

4.7 HSE's recent definition of Investigation is defined as "the inquiry into a set of circumstances, most usually those surrounding either an incident or a complaint. The aim of investigation is to identify the immediate and underlying causes of the circumstances in question and to take necessary enforcement action to ensure risks associated with the circumstances are controlled."[30] The CCA has no problems with this definition.

4.8 The HSE has historically prioritised inspections. The reason for this appears to be linked to its perception of itself as an organisation concerned principally with "preventing death and injury" rather than one concerned with "accountability". It is better to prevent a death or injury rather than simply responding to these incidents when they happen. This has resulted in an emphasis on inspections rather than investigations as the latter—in contrast to the former—are seen as principally concerned with "accountability", not "prevention".

[27] HSE (2003b).
[28] Paras 4.23—4.31.
[29] HSE (2003b).
[30] HSE 2003 (b).

4.9 In the CCA's view, it is certainly correct to say that an important element of investigations is "criminal accountability"—something which is generally absent in relation to inspections. Whilst inspections can reveal circumstances that justify a prosecution, the absence of harm usually make it less appropriate for prosecutions to take place unless the risk of endangerment or the detected failure is very high[31]. This is because the criminal justice system generally deals with offences involving harm, and experience has shown that courts take prosecutions less seriously where no harm has been caused. As a result inspections have a primarily preventative function. In contrast, since most investigations concern "harm", or circumstances where a high risk of harm is reported to have existed, an important purpose of investigations—over and above their preventative function (see below)—is to ensure that consideration is given to criminal accountability issues. Unless investigations take place, organisations and individuals escape the possibility of prosecution.

4.10 However, it is wrong to suggest that investigations do not have a strong preventative purpose. An important part of any investigation must be to rectify the circumstances that resulted in the harm (or, in the case of a dangerous occurrence, that resulted in the risk of harm) occurring in the first place. At the very least an investigation should ensure that any future risk of a similar incident taking place is very low. The absence of an investigation will mean that a risk of a repeat incident will continue to exist. Indeed HSC's enforcement policy statement says as much when it says:

Investigations are undertaken in order to determine:

- causes;
- whether action has been taken or needs to be taken to prevent a recurrence and to secure compliance with the law;
- lessons to be learnt and to influence the law and guidance;
- what response is appropriate to a breach of the law.[32]

4.11 In addition, it should also be noted that investigations can fulfill a preventative role in a more targeted fashion than inspections. The identity of the premises that will be inspected is determined by a "hazard rating" that is given to it at a previous inspection/investigation. This prior contact may have taken place quite some time earlier and may not be an accurate reflection of the company's level of safety at the time of the subsequent visit. Time spent on some inspections may as a result not be that useful.

4.12 In contrast, investigations take place in relation to a particular incident that has just occurred. A report of such an injury or dangerous occurrence is very good grounds for believing that unsafe or illegal practices may exist in relation to a particular workplace. Of course, a death or injury may have occurred where the premises were faultless and conversely a dangerous workplace may never have a reportable incident or injury. Yet since it must be the case that deaths or injuries are more likely to occur in unsafe workplaces (for if this wasn't so, there would be no point in trying to improve workplace safety conditions) the very fact of a reported incident is important up-to-date intelligence that there are issues of safety that need to be considered.

4.13 This point is even stronger in relation to reported "dangerous occurrences". Unlike a report of an injury (which may well not, as suggested above, be the result of unsafe or illegal conditions) a report of a "dangerous occurrence"—like the collapse of a scaffold or contact with overhead power lines—indicates that a situation has in fact arisen which is unsafe and dangerous and most probably a breach of health and safety law. The situation needs immediate rectification, and the only way this can be done is through an investigation.

4.14 Both inspections and investigations reduce future risks of death and injury. However, what investigations can do in addition is to ensure that those organisations and individuals that have committed criminal offences that deserve prosecution be held accountable.

4.15 In this debate, it is very important to note that the principal motivator of companies/directors is regulation, backed by credible enforcement and inspections and investigations are the mechanisms by which breaches of health and safety law are detected. (See previous section on "Resources")

4.16 The purpose of the above discussion is not intended to argue that the number of inspections should be reduced even more to allow for more investigations or indeed that the HSE have got the balance right. The CCA is in no position to suggest what—in the context of HSE's current financial circumstances—should be the appropriate balance between inspections and investigations. It is our contention that the HSE should simply not be in a position of having to choose between one of its two core activities in the way that it has been forced to do. (See discussion on resources, section 3)

4.17 It is important, however, that the HSE recognises the value of investigations over and above that of ensuring "accountability" and that any decision about redrawing the balance should not be based on an inaccurate view that an increase in investigations will only result in increased accountability and not prevention.

[31] Indeed this is accepted in para 39 of HSE's Enforcement Policy Statement that sets out the circumstances when prosecution should be expected.

[32] Para 31.

4.18 Also, for the sake of transparency, the HSE should spell out more clearly to the public:

— its rationale for any decision to increase/decrease the level of investigations/inspections;

— the effect that a decision like this will have on its other activities;

— the role played by the lack of resources in making the decision.

4.19 A particular problem faced by the HSE in making choices about priorities is that it has not commissioned any research—or at least published it—into the compararive effectiveness of its inspection and investigation regimes. It is therefore difficult for the HSE to know what are the positive benefits of an increase in investigations, on the one hand, or an increase in inspections, on the other, and what will be the effects of reducing one at the expense of the other.

Mode of Enforcement

4.20 The key question here tends to be around whether HSE prosecutes too much or too little. It should be noted that since the publication of a new Enforcement Policy statement that sets out relatively clear criteria on when prosecution should be "expected" and when it should be "considered", the context of this discussion has significantly changed. As a result, therefore, the question of whether prosecution should or should not take place has been put on a far more "objective" basis than before.

4.21 Since this is the case, the question about whether there should be more or less prosecutions revolves around whether the HSE should amend the criteria set out in the EPS. In the CCA's view there can be no justification for limiting any further the circumstances when prosecution would be expected. It is already narrowly drawn so either (a) only the most serious breaches of health and safety law or (b) only the most serious results of a breach (ie a death), can expect to result in a prosecution. This can mean that there could be some serious breaches of health and safety law resulting in serious injuries that will not currently result in a prosecution.

4.22 In the CCA's view, it would be appropriate to amend the EPS criteria, so that "major injuries" are treated in the same way as "deaths". It is important to extend the possibility of prosecution, rather than limit it, because of the evidence, that credible enforcement is a key motivating factor to ensure compliance.

HSE's New Policy? Retreat From Both Inspections/Investigations and Formal Enforcement

4.23 In this context, we would like to bring to the attention of the Select Committee, HSE's current new thinking on inspection/investigation in particular, and its enforcement strategy more generally. In the CCA's view, HSE's new thinking is wholly inconsistent with its own and other research and is fundamentally a strategy designed to accommodate reductions in resources, not one aimed at making the HSE more effective.

4.24 A recent discussion paper entitled "Regulation, Enforcement, Inspection and What we will Do", was presented by Justin McCracken to an HSE Board meeting on 3 September 2003, and has been circulated to the Commission. The paper indicates that the HSE is considering whether it should "put more emphasis on the 'educate and influence' aspects of our work". It is also recognised that this will necessitate "using a smaller proportion of [the HSE's] total front line resource for the inspection and enforcement aspects of [HSE's] work".[33] This "significant shift of emphasis" is justified on the basis of:

> "a belief (and we agree that at present our evaluation of the effectiveness of different approaches and techniques is not sufficiently well developed to allow it to be more than this) that by altering the balance in this way will help us to climb off the current plateau in safety performance and to tackle increases in ill health".

4.25 Whilst McCracken is right to acknowledge that there is no evidence indicating that such a shift would have a positive effect on occupational health and safety outcomes, he is mistaken in suggesting that there is insufficient evidence to consider the relative effectiveness of different regulatory strategies. On the contrary, there is a substantial international and UK literature on what motivates employers to improve their occupational health and safety performance. Four major reviews of this literature have recently been undertaken—all commissioned by national regulatory authorities.[34] In addition there are a number of smaller UK-based studies. In the following section we present the main findings of this research as they relate to a range of regulatory options, and consider whether they provide support for a shift of resources away from enforcement and inspection activity and towards the provision of education and advice.

4.26 The main findings of international and UK research on the relative efficacy of various regulatory tools are as follows:

[33] http://www.hse.gov.uk/aboutus/hse/meetings/2003/030903/item7.pdf Accessed 22/02/04.

[34] Wright (1998); Gunningham (1999); O'Dea and Flin (2003); wright *et al* (2004).

— All the major reviews of the international literature conclude that one of the most important drivers of improved occupational health and safety performance is legislation, backed by credible enforcement. This finding is mirrored in the UK studies, where the need to comply with the law was the most commonly cited reason for health and safety initiatives amongst all sizes of organisations.[35]

— Respondents to many survey studies indicate that "the prospect of enforcement is a key reason for making health and safety improvements, and that higher levels of enforcement would prompt organisations to make further improvements".[36]

— A wide-ranging review of the international literature on a range of inspection regimes found that "almost all studies concluded that inspection works". "Inspection activity" was broadly defined by the authors to include: planned inspections, reactive investigations and enforcement action (formal and informal).[37] Some studies demonstrate significant reductions in individual plant injury rates following inspections coupled with some form of enforcement action.[38] Brief inspections that did not result in penalties had no injury reducing effects.[39]

— All of the studies identified fear of reputational damage as either one of the most important drivers, or as the next most important driver after regulation.

— Whilst awareness of legislation was found to be a key initiator of action,[40] there is some evidence that advisory, awareness raising and educational activities are less effective in the absence of the possibility of enforcement. More generally, there is significant evidence of the limits of voluntarism.[41]

— All of the major reviews identified serious limitations with the "safety pays" and cost avoidance arguments that are commonly relied on by regulatory agencies in this and other countries.

4.27 Whilst many of the studies reviewed are self-report studies, thereby raising concerns about subjectivity and possible bias, three factors suggest we can be fairly confident in the validity of the main findings outlined above. First, there is remarkable consistency with regard to the findings reported in the international literature, giving rise to confidence in the conclusions reached by the individual studies.[42] Second, four separate reviews of the international research have reached identical conclusions with regard to what the majority of the studies tell us about the drivers of management commitment to occupational health and safety, indicating that not only are the findings of the various studies consistent, but also that they are unambiguous.[43] And third, these findings are replicated in relation to research on environmental management, where compliance with regulation was the most commonly cited spur to greater management action.[44]

4.28 Whilst other factors (such as the wish to avoid paying compensation) can influence health and safety management in the UK, the only factors commonly identified by the UK research to prompt health and safety improvement were the fear of loss of corporate credibility and the need to comply with health and safety regulations.[45] Moreover, fear of loss of corporate credibility is itself partly created by a fear of adverse regulatory enforcement action, and therefore, the enforcement of regulations is virtually a precondition in creating reputational risk.[46]

4.29 In relation to SMEs, the main motive for occupational health and safety improvements seems to be fear that their operations might be curtailed by a regulator and/or loss of business subsequent to a high profile incident.[47]

4.30 Thus regulation backed by the threat of credible enforcement is the most effective lever that regulators possess for motivating management to improve the occupational health and safety performance of their undertakings. And this is true for both large, and small- and medium-sized (SMEs) organisations. However, as Wright points out, it is likely that optimum results will only be achieved: "if there is a real possibility of detection and subsequent enforcement in the event that standards are not maintained, implying that the actual or perceived level of direct contact with the regulator should be high."

[35] Ashby and Diacon (1996); Honey *et al* (1996); Hillage *et al* (1997); Wright (1998); Gunningham (1999); Wright *et al* (2000); Hillage *et al* (2001); Lancaster *et al* (2001); Baldwin and Anderson (2002); O'Dea and Flin (2003); Wright *et al* (2004);
[36] Wright (2004: 13).
[37] Hussain and Willday (2000).
[38] OECD (2000); Wright *et al* (2004:12).
[39] See for instance, Gray and Scholz (1993: 192) and Hopkins (1995: 90).
[40] Hillage *et al* (2001: 33–34).
[41] Wright et al. (2004: vii; 14).
[42] Gunningham N. (1999: 10), and Wright M. (1998: 8).
[43] Wright (1998); Gunningham (1999; O'Dea and Flin (2003); Wright *et al* (2004).
[44] Wright (1998); Gunningham (1999).
[45] Wright (1998).
[46] Wright *et al* (2004: 32).
[47] Wright (1998: 44).

4.31 Insufficient resources for the HSE (see previous section on "resources") already severely restrict the amount of inspection and enforcement activity it can undertake. It is likely to be HSE's inability to properly fulfil its enforcement and inspection functions that has brought about the current plateau in safety performance and increases in ill health referred to by Justin McCracken.[48] HSE should therefore not be contemplating shifting resources away from front line inspection and enforcement activities.

Other Enforcement Strategies

4.32 It is worth while considering what evidence there is for the utility of other enforcement strategies:

4.33 Corporate Credibility, Enforcement and "Naming and Shaming": In the case of larger and reputationally sensitive firms or firms operating in high risk sectors, fear of adverse publicity and loss of corporate credibility may be significant motivating factors. As stated, regulatory enforcement action is a key factor in creating reputational risk. In addition, the evidence suggests that additional regulatory and legal strategies which capitalise on these concerns—for instance, mandatory occupational health and safety performance reporting, formal court ordered sanctions of adverse publicity, the regular and widespread naming and shaming of noncompliant organisations and their directors—are also likely to be effective.

4.34 Recent HSC/E initiatives are failing to fully motivate companies through capitalising on the latter's concerns to preserve credibility and reputation. For instance, although the HSC/E are now encouraging companies to publicise health and safety performance in their annual reports, this is entirely voluntary and as such does not provide a sufficient incentive to companies to improve their performance. In relation to the publication of HSE's prosecutions and notices database, the HSE contemplated and then rejected the option of ranking offending companies, thereby missing the opportunity of shaming the most recalcitrant occupational health and safety offenders.

4.35 Penalties: Wright *et al* observe that since "the fear of enforcement is a significant motivator for organisations, there may be value in exploring new types of penalties . . . to maximise the deterrent effect of enforcement, such as court ordered publicity".[49] However, the HSC/E have not undertaken any work in considering more imaginative penalties such as: on-the-spot-fines, equity fines, adverse publicity orders, corporate probation orders, corporate community service orders, or the disqualification of culpable directors. This is despite the fact that Action Point 9 of Revitalising Health and Safety required the Health and Safety Commission "to advise Ministers on the feasibility of consultees' proposals for more innovative penalties.".

4.36 "The Business Case": The HSC/E continue to put great emphasis on information-based strategies promoting the economic and business case for health and safety,[50] despite the fact that study after study has demonstrated that UK management are not motivated by the economic arguments for health and safety, and that in many circumstances safety does not "pay".[51] This is largely because, even if they can be calculated adequately, the real costs of occupational injury, death and ill-health in the UK are borne by victims, their families and the state, and not by employers.[52] Whilst it may be useful, in some contexts, to demonstrate that health and safety improvements are cost neutral or may offer positive financial benefits, the evidence suggests that the more general usefulness of such strategies are limited and certainly should not be pursued as an alternative to, or at the expense of, enforcement and inspection activities.

4.37 Trade Unions: The only other factor shown to have a measurable and significant impact upon workplace health and safety is employee and trade union representative involvement.[53] The evidence that increased workforce consultation and participation has a positive impact on health and safety outcomes is extremely robust and really now beyond dispute, and yet no mention is made in the HSE discussion paper of regulatory strategies to increase worker participation.

4.38 HSE's further Strategies: Alternative strategies which are mentioned in the HSE discussion paper (partnerships; motivating senior managers; intermediaries; supply chain; best practice; education and awareness; provision of information) may be useful and sometimes necessary adjuncts to HSE's core inspection and enforcement activities but, again, cannot be pursued as alternatives to, or at the expense of, regulation and enforcement. This is because the evidence does not demonstrate that these are key drivers of behavioural change for employers.

[48] See for instance Brabazon et al. (2000) who found that lack of effective enforcement of the Construction (Design and Management) Regulations was a significant factor impeding implementation of the regulations by construction companies..

[49] Wright *et al* (2004: 73).

[50] For example, the discussion paper by Justin McCracken states: "We need to update and improved the financial and other arguments to persuade duty-holders that good standards will help their business." See also the HSE's business benefits homepage at: http://www.hse.gov.uk/businessbenefits/index.htm.

[51] Wright (1998); Gunningham (1999); Wright *et al* (2000); O'Dea and Flin (2003); Wright (2004).

[52] Gunningham (1999: 18–22).

[53] Reilly et al. (1995); Alder *et al* (2000); Litwin (2000); Walters (2001); Stone and Holder (2003).

Conclusion

4.39 There is a striking disjuncture between the approach advocated by McCracken in the paper referred to above, and the factors identified by independently conducted international and domestic research on the relative effectiveness of different regulatory strategies.

4.40 McCracken states that: "Inspection and Enforcement will be a vital part of our work". However, he also acknowledges that resources will need to be shifted from the HSE's inspection and enforcement activity. The bulk of the evidence suggests that such a reallocation of resources is likely to result in a deterioration in workplace health and safety.

The Legislative Framework

5.1 The Select Committee has asked for evidence on the extent to which existing health and safety legislation has "been successful in improving standards of health and safety". The CCA would like to raise two issues with the Select Committee on this subject:

- our primary concern—one relating to the absence of legal obligations on company directors;
- a secondary concern, relating to the territorial limits of the application of health and safety law.

Directors Duties

Summary

5.2 The key points that we would like to make are

- there is a gap in the law so that company directors have no legal obligation to take any positive steps to ensure that their company is complying with safety law. This has serious implications for both prevention and accountability;
- the HSC/E acknowledges that the conduct of company directors can be crucial to the safe management of a company;
- the findings of international and HSE research indicates that legal regulation is the principle mechanism to motivate senior company officers in relation to safety;
- the government and the HSE have not kept their commitments relating to legislating in this area;
- the HSC has decided to go down a voluntarist approach without any evidence of its effectiveness and in contradiction to its own and international research.

The Problem

5.3 Health and Safety law imposes obligations upon employers, manufacturers, suppliers etc. Where a business has been incorporated, the employer, or manufacturer is "the company"—the fictional legal entity created by incorporation. The company as legal entity is entirely separate in law from the individual "directors" appointed to manage it. It is the legal entity of the company which has the legal contract with the employees and upon which falls the principal obligations relating to safety. Although a layperson may think that the company and the directors are synonymous, in law they are entirely separate: legal obligations upon a company are not legal obligations upon directors.

5.4 The company can of course only operate through the conduct of individuals. The individuals who have most control over "the company"—both in fact and in law—are the company directors. In relation to safety, company directors are the individuals who have the most control over how a company operates and whether or not it will conform to legal safety standards. They are the individuals who have the power, for example, to determine its policies and where the company's resources will be spent. It is entirely uncontentious to say that the conduct of company directors will very often determine the extent to which companies are or are not complying with health and safety law. The HSC/E and British Standards Institute acknowledge this in many of their reports.

5.5 However despite (a) company directors having the most control over the way a company operates and (b) the safety of a company depending to a great extent on their conduct, company directors have no positive legal obligations to take measures to ensure that their company is complying with health and safety law. The only obligation they have in law is to take steps to rectify a situation if they are aware that their company is not complying with health and safety law.[54]

5.6 What this means is as follows. In the absence of clear legal obligations there are often no other incentives on company directors to proactively manage health and safety. For instance, an HSE-commissioned review of the relevant research reports that, ". . . there is no evidence to support the

[54] It is commonly thought that section 37 imposes positive duties upon directors. This is not the case. It only creates an offence which directors can commit. It does however impose an "implicit" duty that if a director is aware that his/her company is committing an offence, s/he must act to rectify it. This is because a director can be prosecuted for conniving with the company to commit an offence (ie turning a blind eye).

proposition that health and safety performance has any impact upon top managers' remuneration" and that "... top managers are often shielded from any untoward financial consequences of accidents or catastrophes."[55]

5.7 In fact, since the lack of legal duties upon company directors makes it easier for directors to escape prosecution for either health and safety offences or for manslaughter[56], there may actually be an incentive on directors to insulate themselves from safety problems in their company by delegating responsibilities to others lower down the management chain, thereby insulating themselves from accountability for safety management. The lack of legal duties imposed upon company directors thus discourages individual directors from taking the initiative in safety management.

5.8 The lack of any real incentives on directors to take responsibility for health and safety may explain the findings of recent research in the UK that reveals low levels of knowledge about, and lack of enthusiasm for, health and safety matters amongst the directors and senior officers of some of the UK's largest companies. For example, one study has identified a "leadership vacuum at executive level in respect of health and safety" and found "no evidence of real enthusiasm for H & S management coming from and through executive and senior management" amongst many of the companies surveyed in their study[57].

5.9 It is important to note that the lack of obligations tends to work in favour of medium to large sized companies. In very small companies, directors will very often have a hands on role in the company and will be working on 'the shop floor". It is much more difficult for such a person to insulate himself or herself from having knowledge of safety problems that the company is facing. Company directors of large companies however can protect themselves through delegation of responsibilities to others in the management chain and can effectively insulate themselves from having knowledge of safety issues if they so wish.

5.10 In light of these findings, the important question for Government and for the HSC/E is how best to motivate individual directors to assume responsibility for the safe and healthy operation of their companies. The Health and Safety Commission and the Government have two basic options: (1) they can rely on a wholly voluntary approach, whereby they attempt to persuade board directors to voluntarily assume certain responsibilities for health and safety, or (2) they can introduce legislation that imposes safety obligations on directors, backed up by guidance and other forms of advice.

The Government's Commitments

5.11 In Action Point 11 of their Revitalising Health and Safety Strategy Statement, the Government committed itself to introducing legislation on directors' responsibilities when Parliamentary time allowed. The Health and Safety Commission undertook to (1) develop a code of practice on Directors' responsibilities and (2) advise Ministers on how the law would need to be changed to make these responsibilities statutory (see annexure 4 for full text)[58].

5.12 Subsequent to this, in July 2001, the Commission published voluntary guidance, Directors' responsibility for health and safety[59]. The guidance was principally aimed only at large companies and organisations and imposed no legal requirements. It is in effect a wish list of what the HSC would like directors to do. The HSC also asked the HSE to commission research to evaluate the effectiveness of the guidance. This research was carried out by Greenstreet Berman and published in July 2003.

5.13 On 14 October 2003, the HSC met to discuss how to proceed on this issue. The HSE suggested three different options. These were:

(i) continue with the existing "voluntary" approach; or

(ii) enhance the present voluntary approach by, for example, re-invigorating the current HSC guidance and seek through publicity, case studies and conferences to influence those directors and organisations currently not providing direction and leadership on health and safety; or

(iii) undertake work to develop legislative options bearing in mind the lack of consensus in support of legislation and challenge of differing points of view and no indication that legislative time could be found.

5.14 The CCA were surprised by the way the third option was articulated. First it did not take into account that "Revitalising" had required the HSE to advise ministers on "how"—not "whether"—the law should be changed. Second, the only time there has been consultation on the issue of directors—through the "Revitalising" process—there was widespread support for legal duties on directors, which is why Action Point 11 arose. Third, the fact that the CBI (or the IoD) may not support legal duties cannot indicate a "lack of consensus" when the HSC has failed to set out the arguments in relation to the issue, and the CBI's views on directors duties is based around a misunderstanding about whether the duties need to be imposed upon one individual director (see para 5.21, section (a)) below). Fourth, it is difficult to see why the Commission

[55] O'Dea and Flin, 2003: 10–11.

[56] This is because the offence of manslaughter needs proof of a "breach" of a "duty of care", and one of the limbs of Section 37 of the HASAW Act 1974 is "neglect".

[57] Osborne and Zairi, 1997: 54. See also: British Safety Council, undated, 3; and Health and Safety Commission, 2000: 26.

[58] DETR/ HSC 2000: 26.

[59] INDG 343.

should take into account whether or not legislative time is, or is not, available. It is simply not part of their remit to give consideration to such an issue. It is the merits of the case for or against legislation that need to be assessed. This is particularly the case, for example, when directors duties could be dealt with through "regulations" rather than "statute"—where legislative time in not an issue.

5.15 At the meeting the HSC resolved that it should continue with its existing voluntary approach to promoting greater director accountability and responsibility. The CCA is concerned that, in making this decision, the HSC has not acted on the basis of the best available evidence on the most effective means of motivating senior company officers to take responsibility for health and safety—including evidence that the HSE has itself commissioned on this issue. Nor do the HSC appear to have considered how their decision will impact on the issue of accountability and justice.

Justification of HSC's Approach

5.16 It is not altogether clear why the HSC have decided to pursue a voluntary approach in preference to the imposition of legally binding duties on directors. The Minutes of the meeting recording this decision state the following:

> Although legal obligations did make people take their responsibilities more seriously, further legislation should be seen as an option only once all other avenues, including voluntary approached (sic), had been fully explored. An approach based on voluntarism might be the most appropriate way of bringing about cultural and behavioural change . . . At this time the case for new law on directors' responsibilities had not been made. Corporate social responsibility, reputation and other factors would contribute to further improvements.[60]

Taking each of these assertions in turn, we will consider whether there is either an evidential or a principled basis for the HSC's promotion of a voluntary approach to the issue of director's accountability and responsibility.

5.17 "Further legislation should be seen as an option only once all other avenues, including voluntary approaches, had been fully explored".

It is not clear where such a policy originated. However, it appears that the HSC are following advice contained in a progress report prepared by Neal Stone of the HSE, which was considered by the Commission at their meeting on 14 October. Stone states:

> In considering the way forward, the Commission may wish to take note of the Better Regulation Task Force's guidance on policy development which indicates that a voluntary approach should always be pursued rigorously in the first instance. It is only when this is shown to be inadequate that regulatory routes should be followed.[61]

5.18 To support this contention, Stone refers a report by the Better Regulation Task Force (BRTF) entitled "Imaginative Thinking for Better Regulation". However, none of the recommendations included within the BRTF report contain such guidance. In fact, the Task Force recognises that "regulatory intervention can be necessary" and that "classic regulation can be the best way to regulate".

5.19 What the Task Force does recommend is that departments and regulators should first consider whether alternatives to classic regulation might be more effective than new legislation. This is reflected in the Prime Minister's statement that: "new regulations should only be introduced when other alternatives have first been considered and rejected, and where benefits justify costs".[62]

5.20 Neither the Task Force nor the Government, therefore, have advised that a voluntary approach must be "pursued rigorously" until it is shown to be ineffective. Such an approach would potentially be a great waste of time and resources. The guidance only requires that departments consider alternative approaches to classic regulation, presumably in the light of the best available evidence about "what works".

5.21 "An approach based on voluntarism might be the most appropriate way of bringing about cultural and behavioural change . . ."
What evidence do the HSC have for suggesting this? The HSC appear to have come to this conclusion after considering:

- arguments made by the CBI contained in a note, which was circulated at the Commission meeting on 14 October;[63] and
- the results of a survey of large private and public sector organisations by Greenstreet Berman.

[60] Health and Safety Commission (2003a: para 5.2).
[61] Health and Safety Commission (2003b: para 10).
[62] Cabinet Office (2003).
[63] Minutes of the meeting state at paragraph 5.1: "A note from the CBI giving its views of this subject was circulated at the meeting." The Centre for Corporate Accountability has obtained a copy of this note.

(a) The position of the CBI

In a note considered by the Health and Safety Commission at their 14 October meeting, the CBI states that it is opposed to legislation specifying directors' responsibilities for health and safety for the following reasons. The CBI is of the opinion that:

— The appointment, allocation of functions, responsibilities and structures for directors should be the prerogative of the organisation and its board so that it can be tailored to the needs of the organisation.

— Health and safety is a shared responsibility inappropriate to allocation to an individual director. It should not be used as a focus for blame for management failures of the organisation.

— If legislation and enforcement action is to be strengthened, guidance should be directed at all those individuals and groups who can have an impact and responsibilities for health and safety at the workplace. In addition to employers, and directors, this should include employees, the self-employed, suppliers of goods for use at work, owners/occupiers of premises, members of the public etc.

In relation to these arguments we would like to point out:

— That the need for organisational flexibility and control in allocating individual directors' functions and responsibilities need not be compromised by the imposition of specific safety duties, any more than the imposition of specific fiduciary duties restricts organisations' abilities to determine the specific roles of individual directors. The concept of management control should not be used as a cloak behind which directors can delegate responsibilities that properly belong to them.

— The argument about "directors duties" is not about one individual director having responsibility for safety. The CCA has, for example, proposed that a general duty should be imposed upon all company directors to "take all reasonable steps" to ensure that the company complies with its duties under health and safety law. In addition the CCA has proposed that all companies not defined as small or medium should have to nominate one director as the "Health and Safety Director". The responsibility of this director would be to provide particular categories of information on safety issues to the Board so that the directors are in a position to carry out their general duty. The duty of this nominated director is not to carry out the responsibilities placed upon the other directors. This provision should avoid the problem of scapegoating mentioned by the CBI.[64]

— Third, current law already imposes duties on employees through section 7 of the Health and Safety at Work Act [HSWA] 1974; the self-employed (section 3(2)-(3), HSWA 1974); designers, manufacturers, importers and suppliers of goods and substances for use at work (section 6, HSWA 1974); controllers of premises (section 4, HSWA 1974); and even members of the public through section 8 of HSWA 1974. The only group presently exempt under current law are directors.

— Finally, the CBI argues that a recent survey undertaken by Greenstreet Berman on behalf of the HSE demonstrates that: "to date, the success of measures to secure [corporate responsibility and accountability for occupational health and safety] . . . has been based on a voluntary approach."[65] It appears that the HSC accept the CBI"s argument, and have interpreted Greenstreet Berman"s research findings as evidence that the current voluntary approach is proving effective. Indeed, one of the aims of the report was to determine whether the level of voluntary uptake of corporate responsibility amongst the large firms surveyed negates the need for further HSC action.[66] Whilst the authors themselves are equivocal on this point, there are a number of methodological and substantive reasons why this research should not determine whether a voluntary approach to directors" responsibilities is pursued as an alternative to the imposition of statutory duties.

(b) Concerns over the Greenstreet Berman survey

The CCA has the following concerns with the way the HSC seems to have relied on this survey:

— First, Greenstreet Berman's research was not designed to assess the relative merits of a voluntary as opposed to a mandatory approach to directors' duties. In other words, it was not designed to answer the question: what works best? So whilst the survey found that 66% of the responding organisations reported that health and safety is directed at board level, the survey cannot tell us whether the imposition of statutory duties would push this figure up, perhaps closer to 100%.

— Second, the survey does not establish that it is solely (or even mainly) voluntary factors that have prompted 66% of the organisations surveyed to arrange for board level direction of health and safety. This is for the following reasons:

[64] Draft Bill is available at:.

[65] CBI (2003).

[66] See discussion by Wright *et al* (2003: 104-105).

— When asked why their boards had assumed some responsibilities for health and safety, a significant number of respondents reported that "new legislation and/or health and safety laws" had prompted this.[67]

— Whilst the HSC/E's voluntary guidance on directors' responsibilities ranked amongst the top five factors influencing board level direction of health and safety, it was only rated as "somewhat" of an influence, and in fact amongst the top 350 companies surveyed the "fear of the company being prosecuted" was a stronger motivating factor than the HSC/E guidance in both 2001 and 2003.

— Respondents' sense of a "general increase in the importance of health and safety" ranked amongst the top five factors influencing organisations" arrangement for board level direction of health and safety. However, this sense of "a general increase in the importance of health and safety" could be the effect of a number of regulatory and legal factors—the expansion and implementation/ application of European Community law on health and safety, for instance.

— And finally, the research does not control for the fact that companies—particularly large and well-resourced companies—often attempt to pre-empt and/or prepare for new legislation by voluntarily putting in place the required arrangements before the legislation itself is introduced. So for instance, Gunningham cites one study reporting that it is not just actual legislation but also "planned or threatened . . . legislation . . . [which] was the most frequently cited driver of company action."[68] In view of the fact that Ministers were stating their intention in 2000 to introduce new law on directors' duties, it is probable that organisations' anticipation of government action explains and underlies some portion of the reported levels of board direction of health and safety in both the baseline (2001-2002) and the follow-up (2003) surveys.

— Third, self-report surveys raise the possibility of bias, and although the authors claim that "self-selection was minimised", the possibility that those organisations most confident about their health and safety arrangements were the ones most likely to take part cannot be discounted. In addition there was no, or very little, attempt to validate respondents' claims. It is therefore possible that the findings overestimate the extent to which large organisations direct health and safety at board level, and overestimate the depth of directors' involvement with health and safety matters.

— Fourth, the survey was restricted to large private and public sector organisations with over 250 employees.[69] Even if we could be certain that the survey results are reliable, and therefore representative of practice amongst large organisations, the findings cannot necessarily be extrapolated to small- and medium-sized enterprises (SMEs). Research findings that smaller organisations are more likely to have "low levels of motivation" to proactively manage health and safety;[70] are less likely to be aware of specific pieces of legislation (and therefore less likely to be complying with them),[71] and that smaller undertakings may have higher major and fatal injury rates,[72] provide support for the proposition that, in general, SMEs are less likely to be motivated to improve health and safety performance in the absence of regulatory compulsion. Thus we cannot assume that the findings of Greenstreet Berman's survey will be representative of current practice amongst SMEs. Since over 40 % of the working population are employed in businesses possessing fewer than 250 staff,[73] it would be foolish to base future regulatory strategy (such as the pursuit of a voluntary approach to directors duties) on the results of a self-report survey that cannot be extrapolated to SMEs.

In addition to the methodological limitations of the survey, the CCA would argue that the survey results themselves do not provide evidence that voluntarism is "working" and do not justify the HSC's advocacy of a wholly voluntary approach to directors responsibilities.

— First, one third of the large firms surveyed revealed that their board of directors had not assumed any responsibility for ensuring that their companies operated safety. Furthermore, around 15% of the organisations surveyed indicated that they had no plans to change this arrangement.[74] In relation to this, the authors of the report observe: "Remembering that the vast majority of respondents are aware of INDG343, this suggests that there is a minority of organisations that may not introduce board level direction of health and safety despite awareness of the HSC guidance . . . If the objective is for all organisations to have board level health and safety direction, this could be interpreted as implying the need for further HSC action."[75]

— Second, whilst at first glance the figures for the number of firms reporting that they have an individual at board level responsible for health and safety seem better (with 82% of respondents reporting a board level person responsible for heath and safety) the survey also reveals that 38%

[67] Wright *et al* (2003: 29).
[68] Gunningham (1999: 12), Emphasis added.
[69] Wright *et al (2003:ii)*.
[70] Wright (1998: iii).
[71] Hanson *et al* (1998).
[72] Wright (1998); Health and Safety Executive (1998).
[73] Department of the Environment, Transport and the Region/ Health and Safety Commission (2000).
[74] Health and Safety Commission (2003b: 10).
[75] Wright *et al (2003: 105)*. *Emphasis added.*

delegate that responsibility. This means that, in reality, only 62% of the organisations surveyed have an individual at board level with genuine responsibility for health and safety. Third, only a third of organisations have specifically appointed a director of health and safety. This is significant because the survey results also indicate that, "there is a higher level of activity amongst directors with responsibility for health and safety than for the board itself" in terms of the extent to which various tasks noted in INDG 343 are carried out.[76]

— Finally, and crucially, the HSE itself has acknowledged that, "It is clear from the research that the level of real Board involvement in some cases is fairly superficial—while health and safety may be on board agendas direction and leadership is lacking."[77] (Emphasis added). This can be seen in relation to the regularity with which boards were reported to discuss health and safety, the scope of performance measures received, boards' response to performance reports, and levels of consultation with the workforce.[78] For instance,

— Only around half of the respondents' boards discussed health and safety either monthly, or had it as a standing item in 2001. This figure dropped to 40% in 2003.

— Whilst around 74% of organisations surveyed report that their boards received health and safety performance reports, only 50% of these boards (37% of all organisations) discussed all serious cases of accident and ill health, and only 65% (48% of the total) were notified of enforcement notices—that is, only 48% were notified of serious incidents of non-compliance within their companies.

— Of those boards receiving performance reports, one in five do nothing in response. Moreover, the percentage of boards doing nothing in response to performance reports has increased from 17% in the baseline survey to 20% in the follow-up survey, making this the third most frequent response in 2003.

Thus, whilst the HSC has been keen to point out that the number of organisations reporting board level direction of health and safety has increased by 8 % between surveys, the nature of that involvement for some boards is clearly superficial and in relation to some of the tasks listed the level of board involvement has actually decreased—by 10% in some cases—between the baseline and follow-up surveys.

In conclusion, the Greenstreet Berman survey does not contradict, and in some senses provides additional evidence for the contention that in the absence of legally binding duties company directors may adopt a superficial and supine approach to the management of health and safety in their companies, even where there is some level of formal board involvement. This survey does not provide any concrete evidence that a voluntary approach would be the most effective means of bringing about behavioural and cultural change. There is, however, ample evidence from both international and domestic studies—including studies that were commissioned by the HSE—to suggest that legislation, backed by credible enforcement, is the single most powerful driver of behavioural change.

(c) The results of international and domestic research

All the major reviews of international and domestic research on the drivers of corporate commitment to occupational health and safety identify regulation and the fear of reputational damage as the most important factors motivating behavioural change.[79] Moreover, fear of reputational damage is itself partly created by a fear of adverse regulatory enforcement action:

> "Corporations and other organisations do not wish to be seen or perceived to be in breach of regulations. Thus, the existence and enforcement of regulations is a key aspect of creating reputational risk".[80]

In addition to the international research, a number of smaller studies dealing specifically with UK businesses provide additional confirmatory evidence that legislation, backed by credible enforcement, is the primary driver of corporate commitment to occupational health and safety. For example:

— A survey of 127 corporate risk and finance managers selected from 350 of the largest UK companies found that the respondents placed most emphasis on ensuring statutory compliance with health and safety legislation and on avoidance of legal liabilities.[81]

[76] Wright *et al* (2003: 81).

[77] Health and Safety Commission (2003b: 12).

[78] Wright *et al* (2003: 104).

[79] See for instance, Australian Industry Commission (1995); Wright (1998); Gunningham (1999); Hillage *et al* (2001); O'Dea and Flin (2003); Wright *et al* (2004).

[80] Wright *et al* (2004: 32).

[81] Ashby SG and Diacon SR (1996) Motives for occupational risk management in large UK companies, Safety Science, 22:229–243.

— Hillage *et al* observe in relation to the findings of evaluations of specific pieces of health and safety legislation in the UK that the most important reason that employers took action to improve practices and procedures were the need to comply with the law, and fear of being taken to court and/or receiving claims for compensation if found to be in breach of the law.[82]

— And finally, recent research undertaken by researchers from the London School of Economics, which involved structured interviews with senior staff from 50 large UK companies, found that concerns for corporate reputation, followed by fear of corporate criminal liability/ penalties and fear of competitive or market effects of criminal convictions, were the main drivers of companies' efforts to manage regulatory risks.[83]

Much of the international research seeks to identify what motivates company (or sometimes management) commitment to health and safety rather than what motivates individual directors. Nevertheless the findings have direct implications for the latter question. In addition, one of the major reviews does address the issue of personal commitment, and its findings are consistent with the findings of other major studies. In his report to the National Occupational Health and Safety Commission of Australia, Gunningham directly addresses the question of how chief executive officers (CEOs) and/ or business owners can be motivated to place a much higher premium on, and commitment to, improved occupational health and safety outcomes. Following a review of the international literature, Gunningham observes that the large majority of studies identify "the threat of personal criminal liability (in particular of prosecutions brought against them as individuals) as the most powerful motivator of CEOs to improve [occupational health and safety.]"[84] Gunningham therefore concludes that the key to motivating CEOs and senior management to improve safety is to make them liable to personal prosecution (and in particular by the imposition of "due diligence" provisions) and to actually enforce such provisions. "Such prosecution" states Gunningham "is not only a powerful motivator to the CEO concerned, but also has a flow-on effect to senior management in other organisations."[85]

5.22 "At this time the case for new law on directors' responsibilities had not been made."
In making this statement it is clear that the HSC have not considered:

— how the current gap in the law impacts upon the safety of companies;

— the issue of accountability and how the current law fails to ensure that culpable directors are properly held to account;

— how the current gap in the law creates inequalities between employees and directors with respect to the imposition of legal responsibilities on the former, but not on the latter;

— the domestic (including HSE-commissioned studies) and the wider international research, which overwhelmingly demonstrates that imposing legal obligations, and enforcing those obligations, would be the most effective mechanism for bringing about the desired behavioural and cultural change.

Instead, the HSC appear to have relied solely on an ill-informed evaluation of the voluntary guidance and have perhaps been unduly influenced by the representations of the CBI. As we have already argued, there are a number of problems with the HSC's reliance on the Greenstreet Berman report as the basis of future regulatory action (or inaction). And in light of this, and the fact that the vast majority of independently conducted research points to the inadequacy of pursuing a wholly voluntary course, the survey should not be allowed to determine the HSC's approach to such an important issue.

Conclusion

5.23 The weight of the evidence suggests that the imposition of legally binding duties on directors would:

— increase the likelihood of directors taking ownership of health and safety problems since failure to ensure that their companies are complying with health and safety law could result in directors being held personally liable for any resulting harm;

— positively impact on the current levels of preventable work place death and injury.

5.24 In addition, the introduction of new legislation would:

— bring about an equality between directors, employees, the self-employed and the public since all of these groups of individuals, with the exception of directors, have legal obligations in relation to workplace health and safety;

— enable the HSE to take action in the case of those directors refusing to act responsibly in the absence of regulatory compulsion, thereby creating a more level playing field between negligent directors and directors who take their health and safety obligations seriously;

[82] Hillage J, Tyers C, Davis S, and Guppy A (2001) The Impact of the HSC/E: A Review, Contract Research Report 385 for the Health and Safety Executive, HSE Books;
[83] Baldwin and Anderson (2002: 25).
[84] Gunningham (1999: 39).
[85] Gunningham (1999: 13-14; 39–40).

— allow the law to hold culpable directors to account, thereby ensuring justice for the victims of work place death and injury.

Jurisdiction

5.25 Health and safety law only applies to duty holders operating in Britain—if a British or non-British national is killed or seriously injured as a result of the operations of a British company operating abroad, the HSE has no jurisdiction over the case—however inadequate local laws are or however inadequate the investigation into the death may have been.

5.26 The CCA is particularly aware of this issue since the CCA's Work-Related Death Advice Service is currently advising the British based families of two British nationals who died abroad when working for a British company. The HSE have no role in this matter.

5.27 There is no record of how many other workers—British or not—have died whilst working for British companies abroad. In the CCA's view this is a gap in the current legislation.

5.28 In the CCA's view, as a first step, consideration should be given to expanding the jurisdiction of the health and safety at work act when a death has take place abroad as a result of the activities of British companies. This would require an obligation upon such companies to report such incidents to the HSE.

HSE and Public Safety

6.1 The CCA is very concerned that the HSE has implemented a significant policy shift in relation to its role in the enforcement of public safety[86]. As a result of this change, the HSE will inspect and investigate only a very limited number of public safety issues. Many deaths and injuries to members of the public—which HSE's previous policy required it to investigate—will no longer be subject to HSE scrutiny.

6.2 The HSE has undertaken no external consultation in relation to this change nor made any formal announcement of the change in policy. The CCA only came to know about the new policy when the CCA's "Work-Related Death Advice Service", on behalf of a bereaved relative, asked the HSE the reasons for why it was refusing to investigate the death of a member of the public.

6.3 The HSE has made it clear that the policy shift is the result of resource constraints.

6.4 In the CCA's view this new policy will result in many "undertakings" whose activities result in deaths and injuries to members of the public being exempt from any formal safety enforcement regime. The CCA is currently seeking advice on whether the new policy is "lawful".

The Law

6.5 Health and safety law:

— imposes a broad duty upon employers, the self-employed, and occupiers of non-domestic premises, to take reasonable and practicable measures to ensure the safety of members of the public who may be affected by their activities. These duties are set out in section 3 and 4 of the Health and Safety at Work Act 1974; and

— requires the HSE to make adequate arrangements for the enforcement of these duties (unless Local Authorities or other bodies have, by Regulations, been made responsible for their enforcement). This is set out in section 18 of the Health and Safety at Work Act 1974.

The old and new Policy

6.6 It should be noted that this new policy will not effect situations when public safety issues are indivisible from worker safety issues (ie in relation to construction, the railways and the nuclear industry). Making construction sites and railways safer for workers will make them safer for the public, and vice-versa. In such industries, the HSE does accept that it continues to have responsibilities to enforce the legislation concerned with public safety.

6.7 However the HSE does not now accept that it necessarily has any role in the enforcement of health and safety law in relation to members of the public when the public safety issue arising from a work-activity is entirely separate from anything that will make the work-place safer for workers.

6.8 It used to be HSE's policy to intervene when either of the three scenarios below existed:

— there was no other agency involved in regulating the safety of this particular work activity, or;

— the legislation this agency was enforcing was not adequate to regulate health or safety issues; or

— the agency did not have the necessary enforcement powers.

[86] Operational Circular 130/9—used by HSE inspectors—which is dated 17 November 2003.

In line with its legislative responsibilities, this policy continued to give HSE considerable role in the enforcement of public safety issues.

6.9 However, the new policy states that the HSE will only investigate deaths and injuries to members of the public that arise out of certain activities when ALL of the following conditions applies:

— the HSE is provided with a sufficient indication that a breach of section 3 of the Health and Safety at Work Act was the probable cause of, or a significant contributory factor, to the injury or risk complained of; and

— there is a high level of risk or HSE needs to act/investigate in the interests of justice; and

— there is no other, more appropriate, regulatory body to deal with it.

6.10 There are a number of concerns about these criteria:

— Even when there is no other appropriate regulatory body, the HSE will not investigate unless it is given evidence that provides a sufficient indication that (a) there has been a breach of section 3 and (b) that the breach was a "probable cause of, or a significant contributory factor", to the injury or death.

However, it is usually the very purpose of an HSE investigation, to find out both of these things—and it is difficult to see how this evidence can be obtained unless an HSE investigation itself takes place.

— in relation to some public safety activities there are agencies other than the HSE that have some supervisory responsibilities. For example, the Police Complaints Authority or the Commission for Health Improvement. However, in many of these cases, the non-HSE body has no power to enforce their own regulations or indeed health and safety law. They cannot impose enforcement notices like the HSE nor can they prosecute.

6.10 However, HSE's new policy says in deciding whether or not there is a an alternative agency, it should not take into account the fact that the other agency has no enforcement powers—unable either to impose enforcement notices or criminal sanctions.

6.11 This means that even when there is a death/injury where (a) there is sufficient indication of a breach in health and safety law and the breach caused the death/injury and (b) its would be in the interests of justice to investigate, the HSE will not investigate the incident even though another agency which is investigating the incident has no enforcement powers of any kind in relation to safety issues.

6.12 There is also an overriding concern about whether HSE's new policy is compliant with its own legal obligations concerning making "adequate arrangements for the enforcement" of section 3 of the Health and Safety at Work Act 1974 as required by section 18 of the Act. The HSE is of the view that the new policy is in compliance with its obligations under section 18.

6.13 It is the CCA's view that the decision by the HSE to remove itself from most public safety issues — where there is no alternative enforcement body with similar powers as itself—is likely to have significant adverse health and safety impacts.

HSE and Local Authority Enforcement

7.1 This section concerns HSC/E's responsibilities for supervising the enforcement regimes of the 410 local Authorities which have responsibility for safety enforcement in what is commonly called the "Service Sector", These include offices, retail and wholesale shops, warehouses, fuel storage depots, residential care homes and premises involved in providing catering, leisure, cultural or consumer and other services.

7.2 In fact local authorities are responsible for enforcing the law in more premises than the HSE—though many of these premises tend to be less hazardous and result in fewer deaths and injuries.

7.3 Last year, the CCA/UNISON published a report which for the first time undertook a comparative analysis of individual local authorities on a number of different enforcement criteria. (annexed) It related to the year 1999–2000—which was the only year available at the time. The CCA is currently in the process of undertaking analysis of more recent data.

7.4 We summarised the highlights of the report in the following manner:

— There was huge variation between different local authorities in levels of inspection, investigations, in enforcement notices and numbers of health and safety inspectors.

— Whilst Rossendale District Council reported no visits of any kind to its 1,540 registered premises, Kennet district Council, with its 1,226 premises, undertook 1,515 visits.

— Whilst Lambeth undertook no inspections of it 7,680 premises, Mansfield District Council, with 1,640 premises, undertook 1,109 inspections.

— Whilst, 90 local authorities investigated every single reported injury to a worker 17 local authorities investigated less than 10 per cent of reported injuries.

— Whilst Milton Keynes investigated all of its 351 injuries (62 of which were major) Wigan MBC only investigated 3% of its 315 injuries (39 of which were major)

— Whilst Solihull MBC imposed 65 notices from its 422 visits—one enforcement notice for every 8 visits—Ashford only imposed one notice in relation to its 1,116 visits.

— Whilst East Dunbartonshire had 4 inspectors for its 1,105 premises, the London Borough of Islington reported it had one part-time inspector for its 3,418 premises.

Relationship Between HSC and Local Authorities

7.5 Section 18 (4) of the Health and Safety at Work Act 1974 requires that local authorities "make adequate arrangements" for the enforcement within their area of the relevant statutory provisions and that they perform their duties in accordance with guidance from the Health and Safety Commission (HSC) The guidance states, for example, that "LAs need to ensure that they devote sufficient resources to the health and safety enforcement function to comply with their duties under section 18(4) of the HSW Act".

7.6 The guidance gives powers to the Secretary of State under section 45 of the HSW Act 1974 to direct a Local Authority to perform their enforcement functions in a particular manner. In the long run the Secretary of State may enforce the order or make an order transferring the enforcement functions of the defaulting authority to the HSE.

7.7 The HSE has a Local Authority Unit one of whose responsibilities is the auditing of the performance of local authorities. As stated earlier in the evidence, one person is used to audit all 410 local authorities, compared to over 40 employed by the Food Standards Agency to audit the way local authorities enforce food safety standards.

7.8 In the CCA's view the HSC needs to have a much stronger level of supervision of local authority enforcement. It is important for example that the HSC undertakes its own comparative analysis of Local Authority annual returns and act upon it. The comparative analysis should be made public so that the people can see how their local authority ranks in comparison to other authorities.

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Annexure One

KEY DEVELOPMENTS IN HSE'S ENFORCEMENT POLICIES SINCE THE LAST SELECT COMMITTEE'S REPORT

1. *New Enforcement Policy Statement:*

This is a significantly improved version in that it:

- clarifies the purpose of an "investigation";
- contains clearer criteria on when prosecutions are "expected" and "considered";
- includes statement about HSE's intention is to identify and prosecute individuals where appropriate;
- directs inspectors to send copies of enforcement notices to directors;
- removes "resources" as something to inform prosecution decisions.

2. *Enforcement Management Model*

This is a model that should assist inspectors in testing out whether their enforcement decisions are the appropriate ones. It should result in greater consistency.

3. *New Investigation Criteria*

This makes clear the criteria upon which the HSE is making decisions about whether or not to investigate reported incidents or not.

4. *New Investigation Manual*

This is a detailed manual setting out the steps that HSE inspectors should take when investigation incidents.

5. *Instructions to inspectors on the investigation and prosecution of Individuals*

This is first time that the HSE has given its inspectors guidance on how to investigate the conduct of individuals—and in particular senior company officers—and issues relating to their prosecution.

6. *Enforcement Guidelines*

The Enforcement Handbook that contains guidance to inspectors on enforcement issues in general and prosecution in particular is now available on HSE's website.

In the CCA's view these are all important new policies that should—if implemented—improve the quality, rigour and consistency of HSE's enforcement decisions.

Annexure Two

FINANCIAL TABLES

Table One

First HSE Settlement

		Years involved in 2000 settlement		
	2000–01 Baseline	*2001–02*	*2002–03*	*2003–04*
Total to be spent on Administration	£179.5	£195	£198	£199
Resulting Year on year increase		£15.5 million	£4 million	£1 million

Table Two

Second HSE Settlement

	Years involved in 2002 settlement			
	2002–03 Baseline	*2003–04*	*2004–05*	*2005–06*
Total to be spent on Administration	£199	£203	£203	£201
Resulting Year on year increase/ decrease	–	£4 million	£0 million	–£2 million
Year on year increase if funding had been pegged to 2.5% inflation	–	£4.9 million	£5.1 million	£5.3 million
		(£203.9)	£209	£214.3

Table Three

Settlements combined

	2000–01	*2001–02*	*2002–03*	*2003–04*	*2004–05*	*2005–06*
Total allowed to be spent on Administration	£179	£195	£199	£203	£203	£201
Year on year increase/ decrease	-	+£15 mil	+£4 mil	+£4 mil	+£0 mil	Minus £2 mil

EXCERPT FROM HSE'S OWN EVALUATION OF PROSECUTION PILOT

Benefits/Achievements

1. The formation of the Prosecution Branch has created a separation between the investigation and prosecution processes to provide independent legal oversight as recommended in the Philips and Gower Hammond reports.

2. All prosecutions completed so far have been successful, with 5.4% of cases (2 of 37) being defended.

3. Tighter controls of costs monitoring and recovery have been introduced, with 90% of cases having full costs as claimed awarded by the courts, totalling over £96,000.

4. An agreement was reached with the Greater London Magistrates' Court Authority whereby it was possible to have all Greater London area prosecutions listed at City of London Magistrates' Court in the first instance. This has resulted in savings in time and resources, and has enabled a very good working relationship to be developed between the Branch and the Court. HSE cases are committed to the Old Bailey for sentence, thus raising their profile in the eyes of defendants, the public, and the criminal justice system.

5. The Branch was closely involved in the planning of the London construction blitz and new cost-effective ways of gathering evidence and submitting abbreviated files for prosecution were trialled with good results. Ten defendants were prosecuted within only two months of the completion of the blitz, with 9 guilty pleas resulting in total fines of £28,050 for non-accident offences.

6. The Branch has utilised skilled law clerks for a broad range of tasks, the first time this has been done in HSE, ensuring work is carried out at the right level.

7. The Branch has been able to run training courses for Inspectors and its own staff on legal issues without the need to employ external providers.

AREAS OF CONCERN/ONGOING ISSUES

1. The Branch was introduced to provide independent legal oversight of cases, Fully Closed (Exemption 2—internal discussion).

2. No evidence has been gathered to demonstrate that the Branch has improved internal consistency in the decision making process and there are no objective measures currently available to demonstrate such an improvement. However, there are no reported negative indications.

3. The Branch's caseload fell to around half of what had been initially anticipated, although this has been offset by the Branch undertaking work in areas which were originally outside its remit, such as legal policy work on railway related issues and the reviews of work-related death investigations.

4. The contribution of the Band 2 Inspector to the Branch could not be fully explored.

5. There is limited evidence of the impact of the Branch on Inspector time, with indication that there is an additional burden on Inspectors in having to copy papers to the branch and, in some cases, gather further evidence when requested by the reviewing lawyer. However, there is a time saving in that there is no longer a need to prepare and serve summonses, advance information and Friskies schedules, and, in the majority of cases, an opening court speech.

6. The lower than expected level of casework has meant that there has been little opportunity to explore the benefits of using solicitor agents, particularly in geographically remote areas. Those that have been instructed have performed successfully in accordance with clear instructions and the full cost has been recovered from the defendant on conviction. The Branch is currently in the process of formulating model instructions to be used when instructing solicitor agents as there is currently no formalised, enforceable method of controlling the extent or value of work done by agents.

7. Some Inspectors have commented on the delay caused by the processing of cases by the Branch and, it has been claimed, this adds in the region of 4–6 weeks to the process. The Branch manager accepts that some cases could be processed more swiftly than at present, but some of the delays are inherent in having a system of independent legal oversight. There is also a wider issue in the overall delay involving the investigative process.

Annexure 4

Action Point 11 of the Revitalising Strategy Statement stated that:

> The Health and Safety Commission will develop a code of practice on Directors' responsibilities for health and safety, in conjunction with stakeholders. It is intended that the code of practice will, in particular, stipulate that organisations should appoint an individual Director for health and safety, or responsible person of similar status (for example in organisations where there is no board of Directors).
>
> The Health and Safety Commission will also advise Ministers on how the law would need to be changed to make these responsibilities statutory so that Directors and responsible persons of similar status are clear about what is expected of them in their management of health and safety. It is the intention of Ministers, when Parliamentary time allows, to introduce legislation on these responsibilities." (emphasis added)

Centre for Corporate Accountability

26 February 2004

Memorandum submitted by Confederation of British Industry (CBI)

1. The Confederation of British Industry (CBI)—with a direct corporate membership employing over four million and a trade association membership representing over six million of the workforce—is the premier organisation speaking for business in the UK. The CBI welcomes the opportunity to submit evidence to the Work and Pensions Select Committee Inquiry into the work of the Health and Safety Commission and Health and Safety Executive and the effectiveness of current arrangements to promote high standards of health and safety. This response reflects the wider views on a more strategic level of issues affecting CBI member organisations representing business of all sectors and sizes.

2. The CBI is actively involved in the work of the Health and Safety Commission and Executive, providing briefing to the employer Commissioners, nominations for the advisory committees, and respond to consultations. It is also effectively engaged directly and via UNICE as a social partner in Europe.

OVERVIEW

These comments are made in the light of the recently published HSC publication—A strategy for workplace health and safety in Great Britain to 2010 and beyond—which we see as an evolving position from the Revitalising Health and Safety Strategy published in 2000. There are many encouraging signs recognising the best application of limited resources both in HSE and business and the recognition that the case for further legislation as a motivator for higher standards of health and safety standards has not been, nor is it likely to be made. The CBI will play its part as a strategic partner to improve health and safety performance at the workplace, involving others and assisting in communicating the benefits of good health and safety standards to business and others. We look forward to working with the HSC/E in the development of the strategy to a plan

3. The CBI believes that the existence of an independent and well funded HSE and HSC is the most effective way of setting the benchmark for high health and safety standards and regulating to achieve them. They have also played a key role in the success achieved so far of setting the reputation and performance of the UK in Europe as a key player in the field of health and safety. In Europe, the tripartite model, involving Governments, employer and employee representatives still dominates the social agenda as the main partners in delivering health and safety improvements at the workplace

4. The separation between the HSE and the DWP is important because it ensures that the HSE is, and is perceived to be, independent of direct government influence, it strengthens the tripartite partnership of the HSC/E, and provides stability and consistency in the development of health and safety legislation. In addition, the existence of an independent body raises the profile of health and safety and "carries the flag" for health and safety.

5. However, there is scope for greater co-ordination between HSE and other government departments, particularly where there are overlapping responsibilities. The CBI believes that the HSE approach to risk based regulation could usefully be applied to other regulatory regimes. Our members also welcomes the moves towards adoption of risk based approaches to fire safety and some environmental regulation which assists in creating consistent approaches with health and safety. Health and safety regulations, environment regulations and others are ultimately applied by business to one process and under a coherent set of management standards, therefore require one solution. This needs to be recognised by regulators if they are to avoid conflicting and duplicating requirements.

6. Furthermore, improved communication and consistency across regulatory areas would enable government to move towards a "first stop shop approach" to regulation which would ease the burden of regulation on business, particularly on small firms. Business is not able to look at health and safety in isolation, rather it manages health and safety within the wider business management process, together with other facets of management eg environment. Business needs to have regulatory contacts who can provide specialist advice but they also need to have a simple way of accessing government. The CBI therefore favours a "first stop shop" approach which brings together the expertise of a wide range of officials, through a single contact point. As an interim measure the HSE Info Line has proven to be a valuable resource especially for SMEs.

7. The CBI also believes that the separation between policy and enforcement, represented by the HSC and HSE, combined with the close links between the two organisations has resulted in effective and independent policy. The independence, effectiveness and integrity of the HSE is essential for business to demonstrate publicly its credibility in the health and safety area. The separation of the HSC and HSE ensures this integrity and independence while enabling business to participate in consultation which ensures that regulations are reasonable and practical. Furthermore, the close links between the HSC and HSE inform the debate by providing practical advice and experience to policy makers, identifying key hazards and operational issues. This structure has worked effectively for nearly 30 years, and has adapted and must continue to be able to adapt to changing social and economic conditions.

LEGISLATIVE FRAMEWORK

8. The CBI believes that the legal requirement to consult on health and safety has been the trigger for a culture of openness and consultation within the HSE which has benefited all stakeholders. This has had the effect of including a wide range of opinions such as employees, employers, scientists, academics etc. into the policy formulation and development process. However the involvement of employers and employees representatives ensures that those who have to deliver health and safety performance are engaged in the process of developing policy to achieve it. They can provide information about the realities in practice, the costs likely to be incurred and the benefits achieved. Furthermore the process of consultation enables government to make the argument for new regulation which can influence behaviour before regulations are introduced.

9. The UK legislative structure covering employers, employees, the self employed and others is more inclusive than the model driven from Europe so already provides solutions to challenges that Europe has yet to address. The CBI believes that the current legislative structure provides comprehensive protection for employees and others working in a variety of circumstances. Changing patterns of employment have thrown

up some challenges such as contractorisation and the recognition of the growth of small firms but the CBI believes that the current regulatory system can be applied more effectively to these circumstances by targeting guidance and by directing the HSE"s promotional activities to these areas.

10. Regulatory Impact Assessments and other commentaries have currently been important in questioning the need for further UK regulations that place more burdens on business where the economic costs may outweigh the benefits. However they have not been influential in the European arena where legislation has been brought forward for political considerations even though a clear cost-benefit case has not been made (eg introduction of physical agents directives). For policy initiatives to be embraced by business and stand any chance of delivering measurable health and safety outcomes they must be justified by realistic commercial language and understanding of business.

11. Although in the UK improvements in health and safety standards, measured by accident and illhealth rates, have been achieved, they have lately begun to plateau. Even though initiatives have been taken at European level to harmonise statistics, they are not sufficiently robust to make any clear judgement about health and safety performance and trends let alone to attribute them to any particular set of factors. There is no clear indication that legislation has been the sole or even major motivator for improving standards in health and safety if they are measured in terms of accident and illhealth reporting. Structural changes in businesses and economies, voluntary initiatives by business, improved education, training and information systems and the aspirations of society have all played a part.

12. "Revitalising Health and Safety" recognised that accident and incident rates have plateaued in recent years. The implementation of the framework directive and supplementary directives, as well as the development of UK legislative initiatives provides an extensive body of health and safety regulation. There is now a great deal of detail requiring expert interpretation of law into practice, there is repetition, duplication and additional burdens as each set of regulations has been brought forward. Constant changes and amendments are being driven largely from Europe and well developed legal principles such as "so far as is reasonably practicable" are under threat. These changes require monitoring and understanding and the effort required by business to do this is rarely reflected in changes that will provide real health and safety improvements. HSE should now shift its focus from policy to greater promotion and enforcement activities in order to improve standards. New legislation is not what is needed to tackle the plateau, but rather effective support for and enforcement of the principles of the existing legislation.

13. Many safety standards have been adequately addressed over the years by legislation and good practice and the focus has now shifted to an interest in occupational health provisions where the link between cause and effect is not so direct as that for safety standards. The CBI welcomes the opportunity to work with the HSE particularly on its occupational health agenda but it is essential that any regulatory proposals which are brought forward are based on sound science. It is also important that HSE restricts its activities to those relating to workplace health and safety, rather than being diverted into lifestyle issues or public education. The CBI agrees that HSE should support government initiatives to raise risk awareness, but the CBI would not wish the HSE's limited resources to be diluted by activities which are not part of its core responsibilities.

14. The HSE should not be used as a focus for actions more legitimately dealt with by others simply because there is a legislative framework that however obtuse can be used. Society, business and enforcers get distorted messages about risks when the employer/employee relationship is used to address wider public health or lifestyle issues. In identifying the new and complex health issues HSE is seeking to play up issues that have been around a considerable time but have never been perceived by most stakeholders as tackled effectively. This is because issues such as musculoskeletal injuries, passive smoking or stress are not viewed by business as, and often in reality they are not, wholly work-related.

Achieving Outcomes

15. Setting target: Business is not complacent about accidents and ill health in Britain. Any incident is one too many and the costs on business and society too high, but benchmarks show that Britain is world class in the area of health and safety standards and performance. Yet the HSC/E in their agenda in Revitalising Health and Safety has set even more demanding targets for businesses and the public sector to achieve. These targets lack a cost and benefit rationale. Whilst targets are an important motivator for improvement and may encourage improvements in measurements, unless they are based on robust statistics and baselines we can"t really determine what they are telling us. Apparent performance against targets in the short term could set policy measures that drive us in the wrong direction in the long term. We are concerned that the unquestioning acceptance in the February 2004 Strategy on achieving these targets has not grasped an important opportunity for review of whether they are, or ever were appropriate. An honest assessment that we have nothing better, might serve us well at the day of reckoning in 2010

16. The function of the HSE is principally to monitor compliance with the law, primarily offering advice and assistance to businesses and taking enforcement action when necessary in a way which is proportionate, objective and consistent.

17. Practice reflecting principles: HSE interventions in inspection and enforcement need to reinforce the message that those who invest in good health and safety standards and practices will be recognised and rewarded for success. HSE needs to work with others, particularly the insurance industry, procurement and the supply chain, to convince business managers that good standards will be rewarded as much as failures will be penalised. Co-operation between regulator and regulated is essential for effective operation of the UK health and safety "system" and partnership and achievement recognition programmes can influence businesses of all sizes. Self regulation involving a "light touch" rather than "no touch" should apply to those business that merit it, reinforcing and encouraging business investment in best practice. This could be addressed by a research contract to define, then role-out key businesses and health and safety risks. Initiatives such as industry accreditation, passporting schemes for major industry groups and competency frameworks for high risk activities would serve as potential indicators to the public of high health and safety standards within industry. Successful performance must be measured not only in "lagging" indicators such as accidents and prosecutions but in "leading" indicators such as access to training. It will provide the stimulation and example for businesses and release HSE resources for where improvements may be needed. The planned European risk observatory may also provide further insight and enable directions to be set for the future.

18. Investment in good health and safety standards by employers must receive recognition: British business does not need convincing that "good health is good business". Over the years many companies have responded by instigating sophisticated health and safety management systems that have consistently delivered high standards, saving lives, protecting people and making efficient businesses. They are convinced by the reality of the benefits, not just the rhetoric, of good health and safety. However this message needs to be reinforced at all levels and particularly endorsed by the actions of HSE and others.

19. Enforcement action and penalties for offences must be set in the context of the general discussion about levels of penalties, the motivation behind penalties and the use of innovative penalties. Penalties for health and safety offences should be set alongside those for other comparable offences to achieve the main objective of compliance with the law and deterring offenders. The recent Home Office consultation about adding surcharges to penalties for criminal offences (some of which will be health and safety offences) in order to shift funding for victims from the current scheme to a new income stream is an example where there is a lack of Government coordination in providing the right motivation and messages to business.

20. Charging: The CBI believes that the effective working relationship between HSE and business at all levels from policy to enforcement is critical to the successful management of the UK's health and safety standards and should be guarded. The CBI has expressed on several occasions its concern regarding the effect that the introduction of charges will have on the relationship between operators and inspectors in these high hazard industries. The CBI is concerned that the submission of invoices, on a full cost recovery basis, will result in conflicts about over-enforcement and inaccurate billing which will lead to relationships between operators and inspectors deteriorating and have a detrimental effect on the quality of enforcement.

21. In particular we would be concerned if the introduction of charges for the provision of advice would dissuade businesses from seeking advice and reduce the budget available to businesses, particularly small businesses to make real health and safety improvements. The CBI has been working closely with HSE officials to try and mitigate the negative effects of the charges through industry/government review groups and will be monitoring the effects closely over the next few years.

22. Insurance: Both criminal and civil law pose risks to businesses and are both part of health and safety management. Guarding against the increasing frequency and size of claims against them is dominating the corporate health and safety agenda and is not necessarily related to protecting people. The recent rise in insurance premiums because they are dominated by market conditions and the consequences of failure unduly influenced by the compensation culture has meant that insurance activity in businesses has been more prominent than that of HSE. There needs to be a closer relationship between good standards of health and safety management and the expectations of both regulators and insurers. Businesses and the insurance industry are working to link premia more closely to risk management to provide commercial incentives for investment in cost-effective risk management measures.

Resources

23. It is clear that the demands on HSE to be the regulator of last resort on all issues of work-related health and safety affecting all people are unsustainable for the future. Clear decisions about the use of HSE and Local Authorities (LA) resources are needed. Whatever the allocation, business needs to have a clear understanding of the resources available and that they are able to deliver consistent and effective enforcement within a clearly identified programme of priorities. They need to be accountable and we do not believe that a memorandum of understanding between HSE and Local Authorities will delivers the business needs. There needs to be a more open debate about available resources, competence, who pays and how. Currently CBI members report that insurance companies experts are more visible than inspectors in the workplace and are setting the agenda for companies performance and priorities.

24. Defining the boundaries: HSE needs to look at both the probability and severity factors of risk considering particularly the number of people, whether employees or public, that could be harmed by work activities. As HSE resources are finite then their scope should be as well. HSE needs to set the proposition

and seek a formal understanding of the extent to which they could and should be the protectors of society and/or workers. Having come to some agreement on what risks are not tolerable HSC/E should decide which are the most appropriate levers to promote change—education, economic penalties, enforcement and whether HSE is the most appropriate actor.

25. Setting the priorities: The need to focus on occupational health performance signals a predictable shift in emphasis from the focus of traditional safety risks, which should not be overlooked but must be put in context with occupational health and the general health performance in Britain.

26. Allocating enforcement resources: Who will inspect the business activity? An evaluation of the effectiveness of current enforcement arrangements of LAs should be made before decisions can be taken about transferring enforcement / inspection responsibility between HSE and LAs. Then consideration can be given to the most effective arrangements for delivering a consistent service for the priority programmes identified. Business would reject any further hidden taxation by direct and indirect charging either by business rates, charging for inspection or indirect taxation if there is a shift in allocation. The principal concern of business in its relationship with any enforcer is that there must be an understanding of business arrangements and a known approach to enforcement processes including grounds, policy approval and risk which delivers consistency across sectors and regions.

27. Goals are being set by the public agenda: The demands on HSE are being set by the public agenda and HSE needs to test how much the public is prepared to pay for standards of health and safety and the control of risks. This is not just a question of taxation from the business and public purse to fund an enforcing authority and provide advice and information. HSE and others will need to provide education and information to underpin a rational debate about health and safety standards, delivery of services and issues surrounding the balance of responsibilities between government, employers and individuals

28. There are some issues that the CBI considers are not been adequately addressed by HSC and which could undermine the effectiveness of the developing strategy for 2010 and beyond and these points should be further explored in the inquiry:

- — the involvement of the private sector in the public sector service economy;
- — risk and liability management by business contracting services out to competent specialists;
- — the continuing influence of the EU in health and safety via the social agenda and the shift to psychosocial issues, wellbeing and quality of work in the health agenda and HSE's ability to influence this.

Business Role in Securing Improvement in Health and Safety Performance

Business sees opportunities to work in partnership with HSE and others to secure improvements in the UK health and safety performance

29. Reducing days off work is clearly in business' interests but the lack of robust HSE baseline statistics may misinform future policy developments and conflict with business priorities. There are already many sources of statistics and those that are validated rather than based on attitudes or opinions should be used. Business will work with HSE to identify and build on these sources rather than add new reporting burdens on employers.

30. HSE expertise in the provision of occupational health expertise for employers and employees is limited and other multidisciplinary service providers could be engaged, on a voluntary basis, when there is an identifiable business need. Compulsion would not be compatible with a risk-based approach.

31. Employers support the contribution that effective rehabilitation programmes can make to returning employees to productive work and the potential they may have in making effective use of balancing compensation and insurance costs.

32. Business can help identify and publicise programmes that deliver the best rewards and focus on those areas where the need is greatest. There is an opportunity for electronic linkages and greater use of the HSE website to identify and share examples of good practice in health and safety management.

33. The workplace is also an important learning resource and informal classroom that can help HSE to provide information to inform debates.

CHI Study on Business View of HSE/C Performance

1. In 2002 the CBI conducted a study to ascertain business views of HSE/C performance, the results of which are outlined below and should add value to the inquiry.

Key Findings

HSE Functions

2. Business regards fair enforcement as the principal focus of the HSE and is generally satisfied with the quality of service provided by the HSE, rating enforcement highest and administration lowest.

3. Most businesses believe the quality of service has remained stable. While nearly one in four CBI members questioned felt it had improved in the last five years, there was felt to be some room for improvement in all areas of service delivery, with most emphasis put on practical advice and technical expertise.

4. Only 22 % of respondents use their enforcement authority as their first port of call for technical or health and safety advice. Of the remainder, trade or industry bodies were the most favoured source of advice, followed by in-house company consultants/specialists. "There is a reluctance to approach HSE too often as there is a misconception that this might be construed as indicative of an incompetent regime and attract unwelcome attention from the agency".

Visits and Enforcement

5. Routine accident prevention remained the main reason for HSE visits. Only 12% of the respondents who had received visits, had them for enforcement actions, while 16% of them had received visits because they had requested them.

6. Businesses reported little change in the nature of visit activity, though encouragingly 11% reported an increase in the level of preventative visits.

7. While most businesses noted no significant change in enforcement activity, 22% reported that enforcement had become more rigorous and a further 10% reported an increase in enforcement activity.

8. Four fifths of respondents affected by enforcement were in favour of more preventative inspections.

Inspectors

9. Businesses were generally satisfied with the competence of inspectors. Most had noticed no change over the last five years, with 16% noting improvement and 7% a deterioration.

10. While businesses generally rated inspectors" understanding of business as satisfactory, this emerged as their weakest competence (technical competence being rated strongest).

Charging

11. There was very little support for an increase in the level of charges for current HSE activities or for extending charges to a wider range of activities, though respondents were more willing to consider increased charges that led to better trained staff.

12. Three quarters of respondents believe that charging had not affected their relationship with inspectors, but nearly one quarter felt that the relationship had been adversely affected.

Health & Safety Commission

13. Nearly half of the respondents had some understanding of the work or role of the HSC but no engagement with it. For the rest, responding to consultations was the main form of engagement, with only 7% participating in working groups and 13% claiming no awareness of the work or role of the Commission.

14. Businesses felt that the most important priorities for the HSC were to improve consultation with them, and establish a clear strategy for health and safety policy and enforcement. Promotion of health and safety was also identified as the next area needing improvement.

Regional Dimension

15. While there were no marked regional differences in respondent experience with their enforcing authority and the quality of service they received, those in the North and Wales were generally more satisfied with the quality of service enjoyed than their counterparts in London and East Anglia.

16. While only 3% of business in Wales felt the competency of inspectors had deteriorated, 11% in East Midlands and Yorkshire supported this view.

17. In all regions except London, the HSE was the main enforcer of health and safety, with the highest involvement in Wales and the North.

18. For respondents in all regions, their enforcement authority was not the first point of call for technical advice and this was more so in London than in Wales.

19. All regions were happy to see a programme of increased preventative inspections.

Size/sector Dimension

20. The HSE was the main enforcing authority for all sectors and sizes of business except those involved in catering and hotels, leisure and hospitality, business services/offices, distribution and public services. Fair enforcement of the law and the provision of practical advice were seen by all sectors and sizes of business as the most important functions of their enforcing authority.

21. Although all sectors and sizes of business felt the area their enforcing authority needed to improve most was in the provision of practical advice, this view was strongest among the construction, quarrying, and chemical sectors, and sites with over 5,000 or fewer than 20 employees.

22. More respondents from the education, public services, construction and offshore sectors believed the overall quality of service by the enforcement authority had improved over the last five years.

Janet L.Asherson

27 February 2004

Memorandum submitted by the Local Government Association (LGA) and the Local Authorities Coordinators of Regulatory Services (LACORS)

1. Introduction

1.1. The Local Government Association (LGA) is the national voice for local communities, speaking for nearly 500 local authorities (LAs) in England and Wales, representing over 50 million people and spending £65 billion a year on local services.

1.2. The Local Authorities Coordinators of Regulatory Services (LACORS) is a local government central body, working with and on behalf of the UK local government Associations—the LGA, the Welsh Local Government Association (WLGA), the Convention of Scottish Local Authorities (COSLA) and the Northern Ireland Local Government Association (NILGA). LACORS was set up in 1978 and coordinates the enforcement activities of a wide range of regulatory services. Since April 2003 this has included health and safety at work (H&S) in England and Wales.

1.3. The Employers' Organisation for local government (EO) was established by the LGA and the WLGA in 1999. Their main role is to support local authorities, in their role as employers, to deliver quality services. The EO provides advice and information on people management and development, and lead in the formulation of policy on some employer issues, including health, safety and welfare at work.

1.4. Both the LGA and LACORS—in their role to support and coordinate LA H&S enforcement services—welcome this opportunity to submit written evidence to the Committee. Any requests for information relating to LAs as employers and duty holders under the legislation should be addressed to the EO.

2. Local Government's Role Within the British Health and Safety System

2.1. The Health and Safety at Work etc Act 1974 (the Act) and related legislation places the same duties on LAs and the Health and Safety Executive (HSE) to enforce H&S law. The Health and Safety (Enforcing Authority) Regulations 1998 (EA Regulations) divides enforcement between LAs and the HSE according to the main activity carried out at individual work premises. Currently for LAs, these premises are mainly in the distribution, retail, office, leisure and catering sectors.

2.2. Some councils act as a "lead authority" for multi-outlet businesses in the LA enforced sector. This involves acting as a focal point for liaison on H&S issues between the business and the LAs in whose areas they trade. The aim is to promote consistency in enforcement and improve health and safety management systems across the business organisation. The LGA and LACORS see this as a crucial role for local enforcers working together to share intelligence and good practice.

2.3. The HSE issues guidance to LAs under the Act and formal liaison takes place through the national Health and Safety Executive/Local Authorities Enforcement Liaison Committee (HELA) which is jointly chaired by an LGA nominee and the HSE. An Enforcement Liaison Officer network exists in HSE regional offices to provide advice and support for LAs.

2.4. The LGA, in partnership with LACORS, facilitate central:local government liaison through a variety of communication channels, including e-mail bulletins to LAs and joint steering groups to take forward H&S initiatives.

3. Local Government as Community Leaders

3.1. The Local Government Act 2000 (the 2000 Act) enshrined in law for the first time the community leadership role, giving local councils a new power to promote the economic, social and environmental wellbeing of their area. The 2000 Act requires councils to develop a strategy for their community with local people and partner organisations.

3.2. Many of the issues facing local communities today—crime and anti-social behaviour, the environment, unemployment, health inequalities and regeneration—can only really be tackled effectively if the public, private and voluntary sectors work collectively. LGA/LACORS sees the new strategic relationship being developed with the Health and Safety Commission (HSC) and the operational partnership under discussion with HSE as key to moving H&S forward to the mainstream.

3.3. Community strategies promote the economic, social and environmental well-being of local communities, focussing on priorities for action and provide a means of joining up services and tackling cross-cutting issues in a coherent and integrated way. Health inequalities often affect the most vulnerable in society who are employed in workplaces where the standards of H&S are low.

3.4. Local Strategic Partnerships provide a single, overarching local coordination framework within which other, more specific, partnerships can operate. For example:

- The role of H&S in achieving improved working conditions will have a direct impact on the health of those living and working in the area;
- Better H&S advice will help businesses comply with their legal responsibilities and reduce the number of days lost due to ill health which is good for business and the community;
- For those off work due to work related ill-health, the support needed to return to full time employment can be provided jointly between H&S, social services and Primary Care Trusts.

3.5. Community safety—The Crime and Disorder Act 1998 puts a duty on LAs to put crime prevention at the heart of all its work. Community safety strategies promote action to tackle criminal and anti-social behaviour and to secure sustainable reductions in crime and the fear of crime in local communities.

3.6. An innovative project in the London Borough of Camden sees council H&S officers working with police crime prevention officers to use H&S powers to "design out crime" at retail premises where staff had been violently assaulted during the course of a robbery. Modest improvements that can act as a deterrent, such as modifying the counter, adjusting CCTV and repositioning door signs, have been secured thereby improving the safety of the workplace and reducing crime.

3.7. Regeneration—Promoting enterprise in rural and deprived communities as well as towns and cities is a key policy area for both central and local government. The recent Haskins report on rural delivery recognises the need for integrated regulation to reduce bureaucracy and duplication and suggests an enhanced role for LAs in on-farm regulation and compliance. The transfer of the enforcement of H&S on farms is one area which could be considered.

3.8. All of the above plans are developed in consultation with the community and councils are finding ways to engage with employees as well as businesses. The private sector is a significant user and supplier of local services as well as a key provider of local employment and must be fully involved in the process.

4. A Joined-Up Approach to Regulation

4.1. It has been reported that local resources put into H&S enforcement by LAs are, in general terms, declining. It is not disputed by the LGA or LACORS, taking into account the latest available data, that the number of full-time equivalent LA officers responsible for H&S has declined year-on-year. Less well documented are the underlying reasons for that trend; we would like to take this opportunity to explore those reasons further.

4.2. Evidence from recent LGA/LACORS research (copy attached at Appendix 1), with key people in LAs about their perceptions of the role of regulatory services, shows that:

- regulatory services were perceived to have a low profile with stakeholders—local and central government, as well as the public—by the majority of respondents;
- regulatory services generally appear to have the political support they need within authorities—97% said they get all or most of the support they need;
- budgets have been maintained (63%) or increased in the majority of local authorities (24%);
- the three elements of regulatory services which were perceived to have the highest impact on the quality of life are food hygiene (76%), environmental protection (64%) and health and safety (57%);

— the majority said that being excluded from the Comprehensive Performance Assessment (CPA) had not had an impact on funding (65%);

— the majority (89%) reported that they had a problem recruiting suitably qualified staff; and nearly as many (77%) reported a problem with staff retention.

4.3. It can be concluded from the research that while general LA regulatory services, such as environmental health, building control and trading standards, have a low profile with stakeholders and compete for resources against high profile services like education, social services and transport, budgets are being maintained. However, the demands on those budgets increase all the time as a plethora of central government departments and agencies squeeze the same limited resource, with no obvious reference to each other resulting in conflicting and competing demands.

4.4. Regulatory services in a typical unitary authority are subject to simultaneous direction and scrutiny from the following:

— Office of the Deputy Prime Minister (building control, private sector housing);

— Department for Trade and Industry (trading standards, consumer protection, fireworks);

— Department for the Environment, Food and Rural Affairs/Environment Agency (air quality, noise, contaminated land, pests, animal health and welfare, private water supplies);

— Food Standards Agency (food standards and safety);

— Cabinet Office (enforcement standards);

— Department for Culture, Media and Sport (alcohol and entertainment licensing);

— Home Office (motor vehicle salvage, sex establishments);

— Department for Work and Pensions/Health and Safety Commission (health and safety at work);

— Department for Health (infectious diseases, health protection);

— Department for Transport (taxi licensing).

4.5. LGA believes that this scale of involvement is unprecedented in any area of the public sector and would like to see a more joined-up approach from central government to the delivery of local regulatory services, to enable LAs to focus regulatory resources where they can be most effective in line with local priorities. To this end, the LGA has written to the Minister for Work to ask for support in setting up constructive cross-Whitehall dialogue with all the departments and agencies who audit LA regulatory performance.

4.6. The research shows that even within regulatory services some areas, such as food hygiene, are seen as having a greater impact on quality of life than others, and consequently are more likely to be better resourced. The "ranking" accorded to the different elements of regulation in regard to community wellbeing is difficult to assess without access to local factors.

4.7. Additionally, anecdotal evidence from senior officers suggests that the Food Standards Agency's (FSA) success in keeping food safety high up the public and political agenda and their robust approach to LA performance has skewed resources towards food hygiene enforcement at the expense of other activities, such as H&S.

4.8. The LGA and LACORS are concerned that there is a growing assumption in certain government departments that threats of intervention in authorities that are poor regulatory performers are a sustainable way of gaining improvements. This is not always borne out by experience; improvement must be for the right reasons.

4.9. Firstly, LAs must see a particular regulatory activity, such as H&S, as an intrinsic part of their role in promoting the economic, social and environmental wellbeing of their communities. Our survey shows that regulatory services do not have a high enough profile among key decision makers and users of the services. In fact, H&S enforcement is often called the "Cinderella" of "Cinderella services". Officers who manage regulatory services are well placed to promote H&S, and other regulatory activities, within their authority and should use the service planning process to show how links have been made to the broader community agenda outlined above. There is no reason for H&S to exist in a professional silo any more.

4.10. Secondly, the targets imposed on regulatory services must be seen to bear some relation to delivering improvements in community wellbeing. Member authorities increasingly express concern that targets focusing on narrow numerical inspection targets do not always produce outcomes that stand up to scrutiny, thereby exacerbating existing tensions around resource allocation.

5. The New Health and Safety Partnership—Working for the Future

5.1. The LGA and LACORS commend both the HSC and HSE for recognising the importance of LAs in enforcing H&S by creating a Strategic Programme to ensure that there is equity—as well as maximum synergy—in the partnership between LAs and the HSE at both strategic and operational levels. We recognise that the creation of this programme represents a cultural shift in DWP's attitude toward LAs in the enforcement of H&S. We wish to reaffirm our commitment to engage fully with the Programme to ensure its success.

5.2. Having acknowledged the importance of the start that has been made with the initiation of the Programme, there is much to do to ensure that the good intentions are transferred into practical reality. It is crucial that LAs involved in service delivery experience a shift towards a genuine partnership and that real improvement is seen in public health as a result. For example, the HSE contribution to the local wellbeing agenda is not clearly understood. In fact many Councillors are not even aware of the HSE function in relation to education and enforcement of workplaces in their area. We would like to see HSE as active members of Local Strategic Partnerships in the future, working alongside their LA colleagues to ensure the protection of all people at work.

5.3. Affirmation within the HSC's strategy document—"A Strategy for Workplace Health and Safety in Great Britain to 2010 and Beyond"—of LAs as an important, and equal, partner in H&S enforcement is extremely positive. The HSC strategy recognises the need to move to a more genuine partnership, expressed in a high-level document to be endorsed by LA political leaders, the HSC and HSE. This is a laudable aim.

5.4. However, at present the HSC relies on HSE for secretariat functions and policy direction. In our view, this is not sufficiently independent to instil confidence in the HSC's role of overseeing the H&S network. We urge the government to address this and note that in its strategy document, the HSC states that "We will examine our institutions and ways of working and change them where they mitigate against effective working". We believe that tackling this issue will facilitate the HSC's aim to become a stronger influencer—a champion and advocate for the H&S system.

5.5. In addition, the LGA and LACORS believe that an essential element of an equal partnership between the HSE and LAs is that both enforcing authorities should be scrutinised in the same way, reporting to the same independent auditor. The performance of both HSE Field Operations Directorate (FOD) inspectors and LA inspectors should then be analysed by the HSC independently of the HSE. The current system, in which the HSE audits LAs, cannot truly claim to treat both sides as equals. Failure to treat the scrutiny of enforcement activity of HSE and LAs equally sends out the wrong message to both LAs and the wider world.

5.6. With this in mind, we would like to see the reporting of the performance of FOD's inspectorate, ideally on the basis of regional FOD groups, to reflect the authority by authority analysis of LA performance. This method would identify possible areas for improvement within the HSE and allow better scrutiny of the effectiveness of the deployment of the overall inspection resource between the HSE and LAs.

5.7. LGA and LACORS believe there is scope for reviewing the EA Regulations, under the umbrella of the HSC's Strategic Programme, to determine whether the current division of responsibilities makes the best use of the joint enforcement resource given that—for example—LAs provide approximately 60% of the total number of inspectors.[87]

6. Conclusion

6.1. The LGA and LACORS have already taken steps to bolster the local government contribution to the H&S enforcement system:

- The LGA (and WLGA), through top-slice funding, has allocated to LACORS more than £100K to provide advice and guidance to LAs and promote local excellence;
- The LGA's Public Protection Executive has set up an elected member Task Group to look at H&S enforcement for the first time;
- The LGA (and WLGA) have formed the Regulatory Services Partnership with LACORS, the Employers' Organisation for Local Government, the Improvement and Development Agency (IDeA), the Chartered Institute of Environmental Health and the Trading Standards Institute to raise the profile of regulatory services and address the crisis in recruitment and retention of Environmental Health Officers and Trading Standards Officers. A brochure setting out the partnership's action plan is attached at Appendix 2.

6.2. The LGA and LACORS believe that LAs have a vital part to play in the enforcement of H&S. LAs bring a number of valuable assets to the H&S enforcement system, which include:

- Local accountability through elected Councillors;
- Well-developed existing working relationships with business;
- Partnerships with other key local and regional stakeholders (eg Primary Care Trusts);
- Flexibility and innovation;
- Extensive local knowledge;

[87] The precise proportion depends on which inspectors are included in the LA figure and which in the figure for FOD. The number of LA full-time equivalent (FTE) inspectors for the period 2001–02 (including personnel with a management role who carry out some inspections) is 1,060. The number of LA inspectors represents 63% of the total number of LA/FOD inspectors if only "generalist" FOD inspectors are included or 54% if "specialist" FOD inspectors are also included (eg inspectors specialising in explosives and other areas). The figures for FOD are accurate as of October 2003. Both the number of LA inspectors and the number of FOD inspectors used are the most up-to-date available. Data from Safety and Enforcement Statistics Department, HSE—November 2003.

— A diverse workforce from a wide range of backgrounds, reflecting the diversity of the communities on whose behalf LAs work;

— Ability to respond quickly to local circumstances;

— A sound understanding of the expectations of the public;

— Joined-up local service delivery that contributes to the wider well-being agenda.

6.3. As discussed at para 5.4 above, the LGA and LACORS believe that the current reliance of the HSC on the HSE for policy and secretariat functions does not serve the HSC well in acting as an independent body that sets the strategic direction of H&S. We believe that this issue should be tackled as a priority. We also believe that the performance of HSE inspectors and LA H&S inspectors should both be subject to independent scrutiny by the HSC.

6.4. As mentioned at para 4.5 above, the LGA and LACORS have some specific issues that we wish to discuss with central government:

— The competing, and sometimes conflicting, demands of central government departments and agencies on a very finite regulatory resource. For example, over the next two years we will see the implementation of the Licensing Act which, if insufficiently resourced, will inevitably lead to a diversion of resources from other areas to meet the strict legal deadlines in the Act. LGA continues to lobby hard to make sure that this is not the case but this is a potent illustration of the difficulties faced by LA service managers in allocating scarce resources;

— The different approaches of government departments and agencies in relation to intervention in, and naming of, poor authorities and the possibility of developing a single intervention/naming protocol across all departments and agencies;

— The potential for an agreed regulatory programme, and partnership work on performance improvement, across the regulatory spectrum.

6.5. The LGA and LACORS will continue to work with HSC and HSE to drive up H&S standards.

LGA Public Protection/LACORS

1 March 2004

Memorandum submitted by Sheffield Occupational Health Advisory Service

THE SECURING HEALTH TOGETHER TARGETS WILL NOT BE MET

The Government's occupational health strategy Securing Health Together will fail to meet the targets set for reductions in new occupational disease cases at the halfway point in 2004.

The targets set were modest, in that they accept very high levels of work-related ill-health (WRIH) will persist even if the targets are achieved. They are problematic because defining "cases" is difficult for the major kinds of occupational disease, and because the data collection systems were not fully operational at the start of the recording period.

The major problems with achieving the targets as set are that;

— the enforcement agencies lack the means to achieve them;

— employers lack the services to play their part, and

— employees suffering from WRIH do not have the employment security and the participatory mechanisms to play theirs.

THE ROLE OF ENFORCEMENT AGENCIES

For enforcement agencies to play their major role in WRIH prevention, they must be able to identify where cases are occurring. They must also have the intervention methods that they need to bring about change in the workplace, and the monitoring systems to make sure that change has occurred.

At present there are no data-collection systems by which HSE inspectors and Environmental Health inspectors can locate cases of occupational morbidity. The RIDDOR system is discredited as a method of locating cases (there is likely to be an inverse relationship between use of the system and need—only well-managed firms will use it). In a Yorkshire city of 200,000 people one of the enforcement agencies received just one case of occupational illness under RIDDOR last year. There is no system of data collection through the health care system though primary care occupational health projects could provide this in the future (the Sheffield scheme sees 1,200 patients with occupational health problems for the first time each year). Employment insecurity and confidentiality issues limit the data collected at workplace level that enforcement agencies could use (see below).

Inspection systems fall down when it comes to looking for occupational health problems and their causes. Missing guards and helmets are obvious, occupational stressors, or an assembly line speed that is too fast or a bench that is the wrong height for some members of staff are not. At the very least much more probing and time-consuming inspection techniques would be required. Mandatory or recommended audit procedures of the kind envisaged in the Stress Management Standards could be developed further. The main point is however that survey based methods that aim to find out whether indices are above or below a benchmark are necessary but not sufficient. Case-finding approaches are necessary because ill-health is most likely to affect a minority of the workforce particularly vulnerable to poor conditions at work. Risk-based approaches to defining poor health and safety performance need to be adapted to this reality.

Another problem highlighted by HSE's own research is the difficulty of defining satisfactory compliance outcomes for inspection visits. This is likely to be one reason for the small number of prosecutions reported each year for failure to comply with health related regulations.

The mismatch between enforcement agency strength and the number of workplaces to be inspected is often cited as the major obstacle to more complex or thorough inspection procedures. It is worth remembering that 56% of workers are employed in workplaces with 50 workers or more, and that most of the smallest employer units are in the construction industry where the CONDAM Regulations provide a way of integrating health and safety management across many employers.

Employers' Role

Employers are required under the EU Framework Directive (89/391) on the management of health and safety to have or to access prevention services. The UK Management of Health and Safety at Work Regulations 1992 did not transpose this duty in the way intended, and as a result, most employers lack even the most basic structures for the prevention of occupational disease.

Workers' Involvement

Worker involvement is the key to reducing the burden of WRIH. At present employees are reluctant to reveal health problems to managers because of the risk to their jobs. The results of health surveillance are rightly protected by medical confidentiality and must remain so, though this causes problems for RIDDOR—if employers know only that someone is not fit to do their job (the content of most communications between occupational health departments and managers), how can they know that their workers have health problems covered by RIDDOR ?

Resolution of these difficuties is unlikely that workers without greater employment protection than that provided by existing employment and disability legislation. Non-legal solutions might include the development of secure communication systems between workers and enforcement agencies, or the development of alternative sources of data collection not currently available. Inspectors will struggle to prevent health problems of which they are not aware.

Simon Pickvance,
Senior Occupational Health Adviser
Sheffield Occupational Health Advisory Service

2 March 2004

Memorandum submitted by the Employers Organisation for Local Government (EO)

1. Introduction

1.1 The Employers' Organisation for Local Government (EO) is the national organisation that provides advice and support to local authorities on people management and development issues. We also host DIALOG, the national team responsible for helping authorities to mainstream diversity issues into all local government activities, including service delivery, and a health and safety function responsible for supporting local authorities in meeting government health and safety at work targets. With the IDeA, 4ps and LACORS we are part of the LGA-led Performance Partnership, working to provide a co-ordinated programme of support for improvement in local government.

1.2 The Local Authority (LA) sector is the largest employment sector in the UK, with approximately 2.2 million employees. These employees work in a diverse risk environment, as LAs are responsible for a variety of activities ranging from entry into sewers to caring for older people. LAs vary in size from a few hundred employees within a small district council to many thousands for the largest city and Metropolitan authorities. Typically the LA will be the largest employer within area.

1.3 Inspectors from the Health and Safety Executive visit local authorities to determine compliance with health and safety legislation. LA environmental health officers and other officers have enforcement powers under the Health and Safety at Work etc Act 1974. They enforce on behalf of the LA in (broadly) the service sector of the economy. Evidence from the Local Government Association and LACORS has addressed the issues associated with enforcement.

1.4 The EO's Local Authority Health and Safety Practitioners Panel have been consulted in the preparation this submission.

1.5 The EO welcomes the opportunity to contribute to the debate on this very important issue.

2. Summary

2.1 LAs as both employers and exemplars have a significant contribution to make to the Revitalising Health and Safety (RHS) and Securing Health Together (SH2) targets.

2.2 The LA forum is a good example of key stakeholders working together to drive up health and safety performance in LAs by influencing from the centre.

2.3 HSE has a role in assisting LAs develop health and safety issues within the community leadership framework

2.4 The current legal framework appears to work but is difficult to say if it has delivered the improvements or whether there are other factors at work.

2.5 There are inconsistencies reported by LAs in the way that HSE inspectors enforce. More emphasis appears to be placed upon enforcement than prevention. This is based on anecdotal evidence rather than firm research.

2.6 HSEs attention to stress and the wider health agenda is welcomed. The issues of passive smoking should be dealt with outside the health and safety framework as general health issue.

2.7 Penalties are sufficient in the higher courts, therefore if a higher fine is required cases should be dealt with in Crown Court.

2.8 LAs understand the law and what they need to do, as they employ trained health and safety professionals to assist them.

2.9 HSE appears under-resourced in terms of front line inspectors and medical inspectors.

2.10 HSE is generally joined up in the way that it operates internally and with external stakeholders. HSE is being innovative in the way it deal with LAs as employers.

2.11 The EO welcomes HSC's new strategy and will continue to work with the HSE/C and other key stakeholders to drive up health and safety standards within LAs.

3. Local Authorities and Government Strategies

3.1 The twin strategies of RHS and SH2 challenge LAs in common with all employers to improve their health and safety performance. However, significantly, government (including local government) is expected to be an exemplar of health and safety management practice. This role has recently been reinforced by the launch of HSE's 9th priority programme, which relates to Government getting it's own "health and safety" house in order.

3.2 In 2001 the EO appointed a national health and safety policy adviser to assist LAs in rising to the challenges posed by RHS and SH2. The purpose being to provide the strategic focus by responding to initiatives emerging from the centre and feeding back the views of LAs into the policy making framework.

4. Joint Working Between HSE and the Central Bodies

1. It would be fair to say that prior to the launch of RHS and SH2 the LA employed sector had been neglected by the HSE in strategic terms. There was no industry advisory committee (IAC), although some LA functions eg schools had been within the scope of the education IAC.

2. In July 2001 the HSE rectified the position with the establishment of the LA Forum. The Forum draws its members from the Employers Organisations in England, Scotland and Wales, the relevant trade unions, the Institution of Safety and Health, and other government departments The LA Health and Safety Commissioner sits on the Forum, which is chaired, by the Head of HSE's Public Services Sector. The Forum has developed a three-year work plan, which is about to be reviewed.

3. A primary function of the forum is to enable the key stakeholders collectively to influence government policy, to ensure that health and safety is properly considered within the policy development process. This seeks to maximise the levers available to drive forward health and safety improvements. To this end the Forum has engaged with the Audit Commission and Office of the Deputy Prime Minister with some success.

4. The forum works well, is light on its feet, is quick to respond and is focused on delivery. It is a good example of HSE engaging with the key stakeholders of an employment sector to drive up standards.

5. Recently the central bodies (EO, LGA, and LACORS) have been working more closely with HSE to promote the joint issues of LAs as duty holders and enforcers. The two messages were successfully brought together at the HELA conference, which took place in December 2003. This is further evidence of the HSE engaging with key stakeholders to deliver a strategic approach raising awareness of health and safety issues within LAs.

5. Health and Safety Executive role with local authorities

1. LAs have a developing role. They are moving from deliverers of services in their own right to community leaders. This change in emphasis is rooted in legislation. As community leaders, LAs should be providing leadership and assistance to local business in terms of health and safety performance. Clearly, HSE have a role locally with individual LAs to assist them in improving their health and safety performance to achieve exemplar status. It is therefore essential that work undertaken nationally with HSE be translated into a positive working relationship locally.

2. It is essential that health and safety be mainstreamed into a number of initiatives focusing on community safety and health.

6. The legislative framework

1. The Health and Safety at Work etc Act 1974 has been in force now for some 30 years with only minor amendments. It has withstood scrutiny during the review of regulation in the mid 1990s and emerged unscathed from this process. The architecture therefore appears right.

2. The modern approach of goal setting legislation underpinned by risk assessment and supported by an Approved Code of Practice and/or guidance, appears to have worked well. This framework allows the duty holder flexibility in how they meet the legal minimum. But with sanctions if the mechanism chosen does not meet the appropriate standard. LAs favour this flexible approach but small employers who do not have the opportunity to refer to professional safety advisers may favour a more prescriptive approach.

3. The Commission's recent strategic consultation has floated the proposal that HSE would step back from the presumption of automatically providing guidance. The gap being filled by intermediaries such as trade associations. As an intermediary the EO is alive to possible resource implications of this change. If this proposal becomes policy then there are two reasons why HSE should still retain an input

— To give the guidance the HSE "stamp of authority"

— To set the standard for employers and inspectors

5.4 It is undeniable that accidents have fallen since the introduction of the Act. However, it is difficult to say that the Act and subsequent regulation has been entirely responsible for this decline. Other factors are clearly at work not least the move from manufacturing to a service/knowledge-based economy.

5.5 In the early 1990s there was a feeling that the UK was overwhelmed by new legislation driven by Europe. This feeling has subsided as the UK and Europe entered a period of consolidation. It would now appear that if new regulation is required, it is in the field of health and not safety. But it could be argued that the Health and safety at Work etc. Act 1974 already provides the framework and architecture within which occupational health issues can be adequately considered.

7. Achieving Outcomes

1. Within the LA employed sector (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)) reported accident numbers provided by HSE continue to fall. Clearly this is a very positive trend, however there are two caveats. First, accident numbers may be falling because LAs are contracting out many services and contractors' employers are getting hurt rather than LA employees. Second RIDDOR may not give the complete picture due to possible under reporting.

2. The picture in terms of the occupational ill health target is more difficult to interpret. Sickness absence levels for LA employees are around 4.6% with slight changes upward. It is very difficult to assess how much of this absence has an occupational component. However, 43.5% of sickness absence suffered by LA employees (EO annual sickness absence study 2002–03) is attributed to stress, other musculoskeletal injuries and back problems. Clearly, these causes of absence are likely to have an occupational component and therefore it makes sense for LAs to concentrate on these issues as a priority though local figures may indicate variation from these causes.

3. These issues for LAs to address feature in the HSE's priority programme areas. Therefore in terms of LAs, HSE are putting their resources into the issues causing them significant loss.

4. Feedback from LA practitioners suggests that on occasions HSE inspectors are felt to be too keen on enforcement and that this approach appears to have hardened over the last three years. This view has to be balanced with those LAs who are happy with their local inspector and the assistance they provide.

5. It has been suggested that this more enforcement-based approach is predominant with less experienced inspectors. Some practitioners have expressed the view that LAs are easy enforcement targets.

6. There appear to be issues of consistency of enforcement in terms of emphasis on different issues and variety of action taken. The topic based inspection approach should ensure that inspectors across the country are looking at the same issues. The additional transparency around work plans will enable LAs to understand the tack to be taken during inspections.

7. A better balance re enforcement and advice may be achieved by greater promotion of HSE's info line and separation of the functions of enforcement and advice. HSE's workplace contact officers do provide advice without the threat of enforcement, as they are not inspectors.

8. New and emerging health risks have not been given the prominence that they deserve by HSE. There has been an emphasis on safety rather than health. This is now changing largely because of the changing nature of the economy and particularly in the area of work related stress. The draft stress management standards are testament to this change, which is welcomed by the EO. Greater emphasis should be placed on occupational health issues, this is particularly important as the workforce becomes older and the proportion of women increases.

9. With respect to passive smoking, most LAs as employers are on top of the issue and have been for many years. However, It remains an issue for those who work in the entertainment and hospitality industries and it should be tackled.

10. Some time ago the Health and Safety Commission consulted on an Approved Code of Practice for passive smoking. This document sought to bring it within scope of health and safety legislation, with all the attendant problems of enforcement largely by LA employed inspectors. The argument has now moved on and it is the view of the EO that it is more easily addressed by introducing a ban on smoking in public places for comfort and general health reasons. A ban has been successful in New York and bans are proposed in other cities, this is the correct way forward on this issue.

11. There is scope within existing legislation for unlimited fines in higher courts and indeed some LAs have been subjected to very large fines as a result of HSE enforcement action. Therefore with respect to LAs as public sector organisations with limited budgets the EO feels that there is adequate sanction available to the courts for health and safety offences. If the capacity for a larger fine is required then greater effort could be put into persuading Magistrates to either not accept jurisdiction or for cases to be passed to Crown Court for sentencing.

12. LAs are large organisations whose activities create a diverse risk environment. To prevent of manage these risks effectively they are required to have access to competent health and safety advice. Most, if not all employ health and safety practitioners who are skilled and experienced in the interpretation of health and safety law and the supporting Approved Codes of Practice/Guidance. Understanding and interpreting legislation and guidance is likely to be a problem for smaller organisations that do not have ready access to this level of expertise.

13. The opportunity to learn from good practice is essential and the EO is constantly looking to capture and promote examples in the health and safety field. This is the way forward in terms of securing compliance and improving standards and HSE have used the case study approach in much of their recent guidance

8. Resources

1. Over recent years HSE has been subject to restricted budgets, though there was a period of additional funding around 1998–99. The cuts appear to have impacted greatly upon the Employment Medical Advisory Service This has had little impact upon LAs who have access to their own occupational health services but there may well be an impact on smaller companies. In a period where health issues are coming to the fore then the funding of EMAS would seem a priority.

2. Generally it is felt that HSE would benefit from increased funding particularly to bolster the front line inspectorate. Face to face contact with employers is remains crucial in giving advice and ensuring compliance and thus preventing accidents and cases of occupational ill health. Though as said already LAs are for in a fortunate position with respect to internal health and safety expertise. Whilst LAs are not hostile to HSE scrutinising their health and safety performance perhaps there are other organisations, which would derive greater benefit from their attention and interventions.

3. From our experience working with the centre and representing LAs as employers there are a number of examples of good joined-up working internally between HSE's policy, and operational sectors including field inspectors and the Employers Organisations. Initiatives, which have emerged from the LA Forum, follow this model. This is to be applauded and supported as a way forward in terms of improving standards in partnership. Work needs to continue to ensure that this is always the case.

4. HSE has recently embarked on a new initiative to engage more effectively with LAs as employers. The North West pilot seeks to secure commitment from the top of the organisation both from the Chief Executive as head of paid service and the political leadership to drive up health and safety standards through out the organisation. This approach is focused on a softer touch to securing improvements in organisational culture but with the possibility of enforcement where appropriate. Health and safety practitioners welcome this approach as they see it as being effective in raising the profile of health and safety within senior levels and ensuring continued impetus to achieve sustained improvement in performance.

9. The New HSC Strategy to 2010 and Beyond

1. The Commission's vision and aims outlined in "A strategy for workplace health and safety in Great Britain to 2010 and beyond" seeks to address the issues, which currently challenge the UK's health and safety system. The EO welcomes the bold approach being taken to focus resources on specific risks and place greater emphasis on health issues.

2. It is felt that greater separation of the Commission and the Executive in terms of support and location, would be beneficial. This would enable the Commission to take a more independent view of the challenges to the UK health and safety system and the effectiveness of the Executive in delivering the strategy on the Commission's behalf.

Steven Sumner
Employers Organisation for Local Government.

12 March 2004

Memorandum submitted by the Employers Organisation for Local Government (EO)

1. Introduction

1.1 The Employers Organisation for Local Government (EO) has prepared this evidence in consultation with health and safety practitioners working within Local Authority (LA) Social Services Departments (SSDs).

1.2 A questionnaire was circulated through electronic networks to health and safety practitioners within SSDs. However the response rate was disappointing with14 returns, but within very limited time scales available the survey has gathered rich qualitative data which provides illuminating perspectives on the situation within SSDs. As some of the evidence is based upon the survey results, some caution should be exercised, as it may not be indicative of experience across all authorities.

1.3 This evidence addresses questions posed by the Select Committee relating to health and safety issues confronted by LAs in the delivery of social care services. In particular

- Specific risks and how well they are controlled;
- Protection of agency workers;
- Contracting out and improving health and safety performance;
- Effectiveness of HSE in securing the health and safety of those employed in social care delivery;
- Interpretation of the law and perceived tensions in delivering services.

2. Summary

2.1 Of the particular hazards identified by the Committee, stress and musculo-skeletal disorders (MSDs) have been recognised by SSDs as significant issues. Considerable activity is underway to reduce the impact of these issues, with some success particularly with MSDs.

2.2 The health and safety of in-house agency workers appears to be protected by both SSDs and Health and Safety Executive (HSE) inspectors.

2.3 Contracting out and partnership working is increasingly the model for social care provision. Contractor health and safety performance is used as a selection criterion and the procurement process is used as an opportunity to improve contractor health and safety performance. Some contract monitoring for health and safety compliance is undertaken.

2.4 Relationships between SSDs and HSE inspectors are good but here is scope for improving HSE support to SSDs in securing health and safety of their employees.

2.5 The effective and sensitive application of the Risk Assessment (RA) process should enable the appropriate care to be delivered without exposing the client or carer to unreasonable risks to their health and safety.

3. Local Authority Role in Social Care Delivery

3.1 The way that social care is provided and the role of LAs in its delivery has been subject to significant and continuing change. The "traditional" role of LAs as the provider of care has changed dramatically. Greater emphasis is now placed on contracting out functions to the private and voluntary sectors and the establishment of partnerships with the NHS, private and voluntary organisations.

3.2 As an example consider care for older people. The modern approach is to support and care for people in their own home. In the past the home carer would have been employed by the LA, now they could be from a private contractor or a voluntary organisation. Those older people who are not capable of remaining in their home often in the past would have become a resident in a LA older persons home. That place may now be in a voluntary or private care home procured by the LA.

3.3 LAs are becoming procurers of services, or partners in provision rather than providers in their own right.

4. Enforcement of Health and Safety Legislation in Social Care

4.1 The application and enforcement of health and safety legislation within the social care sector is complex.

4.2 The enforcement of health and safety legislation is split between HSE inspectors and health and safety inspectors appointed by LAs. Generally all activities undertaken by the National Health Service (NHS) and LAs are inspected by the HSE. With private and voluntary provision being inspected by LA inspectors except in nursing homes where the HSE would inspect.

4.3 Generally, HSE are responsible for all employment in domestic premises.

4.4 Taking the example of residential care for older people. HSE would therefore inspect an LA owned and operated homes and LA inspectors would inspect a private or voluntary sector home.

4.5 From 1 April 2004 the Commission for Social Care Inspection (CSCI) is responsible for ensuring service user safety. A memorandum of understanding is being developed to mark out the boundaries of activities between the HSE, LAs, and CSCI.

5. Exposure to Specific Risks

5.1 The Committee expressed an interest in specific issues, in particular stress, MDSs and biohazards within the social care sector. The EO holds some national data on sickness absence within SSDs and reference was made to this data in previously submitted evidence.

5.2 Stress and MSD are significant causes of sickness absence within SSDs. The EO's study for 2001–02 indicates MSD and back problems account for 19% and stress and other mental health issues account for 22.5% of absences respectively. This broadly reflects the picture in the wider LA employed community.

5.3 All but one (13 of 14) of the questionnaire respondents indicated that stress was either very prevalent or prevalent. For MSDs five of 13 indicated they were very prevalent or prevalent.

5.4 For risks associated with biohazards the picture is not as clear only two respondents considered biohazards to be very prevalent or prevalent.

5.5 Absences due to infections accounted for 8.7% of the total. This is lower than absences attributed to infections within the general LA work force for the same year being 15.1%. Whilst it is not possible to attribute any of these absences directly to an occupational cause, if there were significant uncontrolled biohazard risks in SSDs then it is reasonable to assume that there would be a high rate of absence attributed to infections. This does not appear to be the case. Therefore biohazards may be under some measure of control.

5.6 A hazard, which will be significant within the social care sector, is latex allergy from the use of latex gloves. Exposure can result in asthma and dermatitis.

5.7 Some respondents indicated their concern about incidences of violence and aggression to their staff from service users. This also poses the threat of infection from agents such as hepatitis if carers are bitten during delivering services to disturbed or aggressive service users.

5.8 For all three issues, in terms of activity in controlling risks the responses of very active or active were as follows, stress 10 of 14, MSDs 12 of 13 and biohazards nine of 13. However the effectiveness of this activity was disappointing particularly for stress where only two of 14 suggested that their action was very effective or effective. Greater success was achieved for MSDs with eight of 13 reporting as very effective or effective and nine of 13 for biohazards.

5.9 Action taken by some SSDs have significantly reduced the incidence of MSDs. Social Services staff of a metropolitan authority, were suffering a large numbers of MSDs through lifting clients. After employing a physiotherapist to carry out risk assessments, train staff and supervise the introduction of mechanical handling techniques injuries have been cut in one year by some 24%, significantly reducing absence and the cost of civil claims.

5.10 In terms of general health and safety performance, 10 of 13 respondents reported that their organisation was very effective or effective in securing the health and safety of its social care employees. Comments included that performance was improving, and reducing accident rates.

6. Agency Workers and Health and Safety

6.1 The EO undertakes an annual Social Services Workforce Survey on behalf of the Social Care and Health Workforce Group. This survey explores significant employment issues for SSDs including the use of agency staff and partnership working.

6.2 The latest report (November 2003) is posted on The EO website at http://www.lg-employers.gov.uk/documents/recruitment_careers/workforce_surveys/ssws_report_2002.pdf

6.3 This report indicates that 82% of the 107 respondents were using long-term agency staff. They were used mainly in the areas of children's social work and home care, and London SSDs employed 66% of all agency staff.

6.4 The estimated number of long-term agency staff at September 2002 was 4,800 full time equivalents (FTEs). This equates to approximately 2% of the total SSD workforce (13% in London) at a cost (April-September 2002) of £114 million (2.3% of payroll costs).

6.5 It is interesting to note that UNISON carries on its web site links to employment agencies specialising in, amongst others, social care and social work jobs.

6.6 Respondents to the survey indicated a wide range of percentages of agency workers across a wide range of in-house services. The greatest use of agency workers in a single authority was reported in foster care (45%), and home care (30%).

6.7 In terms of health and safety protection of agency worker, respondents commented that they received the same protection as their own employees. As regards working with the agency to protect health and safety of agency staff, six of 11 reported they worked either very closely or closely with the agency.

7. Partnership Working and Health and Safety

7.1 With respect to partnership working, 48% of respondents (40 of 84) to the Social Services Workforce Survey reported that they had transferred staff either by secondment or under TUPE arrangements.

7.2 The most common partnership arrangements are with NHS primary care trusts, and NHS mental health, with partnerships with independent organisation in third place.

7.3 Where SSD staff are transferred under TUPE, their new employer will be the duty holder under health and safety legislation. Where the employee remains employed by the SSD eg when on secondment, then arrangements have to be put in place to ensure the continued protection of that person. Essentially that person should receive the same protection as those around them. Further, the partner organisation has responsibilities under Section 3 of the Health and Safety at Work etc Act 1974 to protect the health and safety of non-employees who may be affected by their work activities.

7.4 There are be examples of joint appointments; again in these circumstances policies must be in place to secure the health and safety of the individual.

8. Contracting Out and Health and Safety

8.1 As already mentioned above, LAs now contract out many services to external providers. However, even if a service is contracted out, the LA retains a responsibility to ensure that the service is delivered safely.

8.2 Safety practitioners survey respondents indicated that many services eg homes for the elderly, respite care for children and families and meals on wheels were 100% contracted out to the private or voluntary sectors. Percentages varied across a wide variety of other services.

8.3 Where services are contracted out 13 of 14 respondents indicated that contractor health and safety performance was used as a selection criterion. The remaining respondent indicated that they used the rating reports (which included health and safety) from other inspection bodies as a criterion in the procurement process.

8.4 The procurement process was used by nine of 13 respondents to improve the health and safety performance of poor contractors.

8.5 Most (four of nine) respondents indicated that contracts were monitored for compliance with health and safety provisions annually, though 3 said the contracts were never monitored.

8.6 The London Borough of Merton on behalf of the other London Boroughs has established CHAS (Contractor Health and Safety Assessment Scheme). CHAS is a web based contractor database that assists LAs in engaging only those contractors, which met minimum standards of health and safety management

and performance. Some social care providers are now on the CHAS database, CHAS reports that the assessment failure rate is high amongst this sector. In the survey four of 14 reported that they used CHAS to select contractors.

9. HSE and LA Delivered Social Care

9.1 HSE are the health and safety enforcing authority for LA SSDs.

9.2 Within the survey 5 of 13 indicated that HSE was either very effective or effective in supporting SSDs to secure the health and safety of their social care employees. However, two reported that they were ineffective. Some respondents commented that they were supportive within the time and resources they had available.

9.3 In terms of relationships, eight of 13 responded that their relationship with their HSE was either excellent or good. None reported a poor relationship, but comments were made regarding limited contact.

9.4 In terms of HSE inspectors understanding how social care is delivered, four of 10 indicated their inspector either fully understood or understood the delivery process. One comment suggested that because of frequent changes of inspector and their experience being in other fields, they were having difficulty understanding social care and partnership working.

9.5 As regards HSE's effectiveness at protecting the health and safety of agency workers, four of 8 respondents reported either very effective or effective. Some respondents commented that HSE treated them the same as SSD employees.

10. Interpretation and Tensions in Service Delivery

10.1 Recent concerns have centred on the apparent inflexible application of health and safety requirements to the extent that it is impossible to deliver some social care services to clients. These issues have been seized upon by some parts of the media and used to undermine the value of health and safety measures in controlling risks and preventing accidents and occupational ill health.

10.2 In providing any social care services, the health and safety of both the client and the carer are of paramount concern to LAs regardless of how the service is delivered. RAs are undertaken as required by the Management of Health and Safety at Work Regulations 1999. Within this process the risks to both the client and carers are assessed and balanced. The aim is to deliver the service without placing the carer at an unacceptable risk of injury. But, having regard to the dignity, independence, expectations, needs, wishes and human rights of the client and where necessary taking into account the views of the client's family.

10.3 Effective use of the RA process allows for the effective delivery of services whilst ensuring the health and safety of all those involved.

10.4 This has been at issue recently in R (*on the application A, B, X and Y) v East Sussex County Council* concerning the manual handling of clients by carers. HSE have provided advice on this issue in their publication Handling Home Care (2002), which was quoted by the court as being "up to date and relevant". This guidance was produced in consultation with the Disability Rights Commission (DRC) and Department of Health (DoH). It seeks to deal with the issues by considering the needs of the client and their family's views in policy development. Thus achieving the right balance in service delivery whilst protecting the health and safety of both the client and carers.

10.5 In addition, a moving and handling group has been established. Chaired by Beverly Dawkins of Mencap, this group draws membership from all key stakeholders including HSE, DRC, and DoH. Steve Sumner from the EO will be representing LAs at future meetings of the group.

11. Conclusion

11.1 The delivery of social care and the application and enforcement of health and safety legislation is complex.

11.2 Stress and MSDs are significant issues and considerable work is being carried out to address them within SSDs.

11.3 SSDs are using the supply chain to improve the health and safety performance of contractors in the social care sector.

11.4 Appropriate application of the RA process will enable the health and safety and human rights of both clients and carers to be effectively balanced.

11.5 HSE, EO and SSDs are and will continue to work together and with other stakeholders to secure the health and safety of clients, employees and agency workers alike.

Steven Sumner
Employers Organisation for Local Government

28 April 2004

Memorandum submitted by United Kingdom Home Care Association Ltd

Profile of UKHCA

The United Kingdom Home Care Association (UKHCA) comprises around 1500 provider offices of home care services, throughout the UK: large and small; voluntary, not for profit, private and statutory. Our members deliver in the region of 50 million hours of home care annually.

The objectives of UKHCA are to promote and develop the quality of home care provision.

UKHCA are members of several umbrella bodies concerned with home care, including the Joint Advisory Group of Domiciliary Care Associations, the Continuing Care Conference and the Independent Care Organisations Network.

This Submission Has Been Prepared by

Bill McClimont, past Chairman of the UKHCA, who currently holds positions in a number of other bodies, including:

General Social Care Council—Council Member

Topss England—Board Member/Trustee

Independent Care Organisations Network—Convenor

Profile of Home Care Services

At least 204,000 people employed in England alone—equal in size to the whole of the UK motor industry or the hotel sector—50% more than the police services. 3.5 million hours of direct care for half a million elderly and disabled people every week. Over 75% of the activity is delivered by the independent sector.

In addition to local authorities there are around 5,000 outlets for home care services, in England, mostly small local operations. More than half have only one office and 65% deliver less than 1,000 hours a week. At the other end of the scale, there is a handful of organisations with 50 or more branches. Only 14% are voluntary or not for profit but these do include some of the larger providers.

Figures do not include NHS provided community services, nor independent sector nursing services, physios etc, although 2% of the total are personal care services bought by the NHS. Home healthcare, mostly nursing or nurse led services, is one of the fastest growing areas but we have no reliable figures yet.

Home care services are not new; Although there has been dramatic growth in local authority services and local authority purchasing, since 1993, there have been independent services around for over 50 years.

We are not talking about "home helps", in the sense of cleaning, shopping and laundry. Even within the social care definition, only 15% of care hours involve practical tasks and most of that is delivered as part of a package of personal care or other specialist services. Over 60 per cent of independent providers offer skilled services for dementia, physical or sensory disabilities and hospital discharge. Half offer learning difficulties support and 45% offer specialist services for rehabilitation or mental health.

Introduction

This evidence seeks to address several inter-related areas relating to social care, with the particular viewpoint of care for people living in their own homes. It is acknowledged that practice and procedures for Health and Safety in home care have often historically been poor or at best patchy. It is arguable that strict requirements are needed to ensure that this does not continue. However, in the view of UKHCA, these requirements are often taken to extremes which are unhelpful, unnecessary and restrict vital services for care recipients.

It is public policy to enable more people to remain in their own homes, when they are in need of care services. This reflects the wishes of the vast majority of people. Unfortunately, the rules for Health and Safety are particularly difficult to interpret and implement for home care.

Patterns of work and tasks in home care are often specified by a third party purchaser with no legal health and safety responsibility for either worker or care recipient. In fact the parties involved include:

- Purchasers of care—local authorities, health authorities, individuals for themselves, their accountants, solicitors or relatives;
- Providers of care—local authorities, health authorities, self-employed individuals, employment agencies, nurses agencies, employers, organisations using volunteers;
- Recipients of care—the individuals being cared for, their relatives or other co-habitants;
- Landlords—including housing associations, councils;
- Inspectors—through requirements to register with statutory regulators and meet minimum standards.

In our experience, attempts by non-experts to codify and define working practices too often result in inappropriate "blanket" rulings. These can be inadequate or excessive for individual circumstances; in effect they may be over-expensive or not achieve what they set out to do.

Where they are inadequate, the full force of law and penalties still apply; providers can't claim they were only acting on orders. Where they are over prescriptive, the service available to care recipients is often unduly restricted and additional costs are reflected in higher charges to care recipients or to the public purse.

Such an approach can be prompted by fear of litigation and underestimation of the extent to which individual workers should be responsible for taking due care in their work. An additional issue is the difficulty or undesirability of holding care recipients or their relatives to account for the responsibilities which they nominally hold, regarding their premises.

There are genuine and important issues of Health and Safety in home care, as with any other industry. These should not be underestimated and UKHCA makes efforts to advise and educate its members in relation to health and safety practice and training. The most common difficulties encountered are those with respect to moving and handling of care recipients. These issues are similar to those encountered in hospitals or other institutional settings but are sometimes aggravated by less than ideal surroundings, over which employers have little or no control. The most common resulting injuries are back problems for care workers.

The role of insurance in influencing practice for home care is significant. As with many industries, home care has seen dramatic rises in levels of premium for Employers' liability and related cover, over recent years. Some types of care have experienced almost complete withdrawal of the insurance market from their sector. Although UKHCA has developed careful and close relationships with insurers, we are not immune from this effect so, through the good offices of DH, we have held exploratory talks with officials at DWP to discuss what can be done about it.

Recommendations

There are two key issues where we would ask the Committee to bring its influence to bear.

1. We would ask the Committee to recommend that clear responsibilities be incorporated into Health and Safety Law for third party specifiers or purchasers of services.

2. We would ask the Committee to recommend that HSE should develop specific, clear, comprehensive and appropriate guidance on Health and Safety where the workplace is a private home.

This development should be done in consultation with the whole of the home care industry, including discussions with front line care workers and with care users or their representatives.

If these discussions identify issues where current regulations are inappropriate to the effective delivery of home care services, we would ask that HSE should draw up proposals to correct those shortcomings.

1. The Over-Interpretation or "Gold Plating" of the Legal Requirements on Health and Safety

1.1 *Restrictive work procedures for many tasks performed by care workers which may be the same as they would do in their normal daily lives.*

1.1.1 Many tasks to be undertaken in home care are a reflection of what individual would do in the course of their daily personal lives. Many others will involve a common sense approach to avoiding risk or the likely risks can be the subject of simple training and preparation.

1.1.2 However, some organisations take an approach to Health and Safety which would be more suited to a hazardous industrial environment. The results include disproportionately complex procedures for risk assessment and blanket bans or undue restriction on the types of tasks which workers are permitted to do.

1.1.3 An example which gained recent notoriety is that of changing a light-bulb. This simple task could make a big difference to a care recipient living alone and unable to change it for themselves. Most people would change a worn out light-bulb at home with little thought.

1.1.4 In a working home care situation, the condition of the light fittings and the strength/stability of any steps which need to be used may be unknown to the worker. It will therefore be important for there to be a degree of assessment of the risk involved. In the majority of cases, this will be no greater than they would encounter at home.

1.1.5 In our view a worker should be perfectly capable of spotting obvious defects to light fittings or steps and there should be no reason not to change the bulb. However, the Department of Health recently screened a TV advert aimed at recruiting care workers, which showed a worker changing a light-bulb. There were complaints that this was a task which "no care worker should or would ever be permitted to do".

1.1.6 A resulting press story cited a local authority head of community care as saying that such a task would normally not be permitted. If it were to be performed, it would require four care assistants; one to change the bulb, one to hold the steps, one to switch the electricity off at the mains and another to comfort the care recipient through the event.

1.1.7 Perversely, local authorities may well run "handyperson" services where a single worker will go round fixing minor household problems and defects. It is not clear why the risk to a person called a care worker is greater than to one whose job title is handyperson.

1.1.8 Most independent sector care providers would expect care workers to undertake practical, day-to-day tasks of this nature with the exercise of reasonable caution and care. Also, as part of an initial risk assessment of the workplace, care organisations would normally identify particular risks such as old or faulty electrics and should brief their care workers accordingly.

1.1.9 Another common example is a purchaser's requirement for care workers to be issued with and always to use a "circuit breaker"/"Residual Current Device" when operating electrical equipment in the home. This blanket requirement takes no account of the age or condition of the electrics. Nor does it recognise that care workers may often need to operate a washing machine (where the plug is usually inaccessible anyway), a kettle and a vacuum cleaner simultaneously.

1.1.10 If there is a genuine risk in a particular household, then safe working methods should be adopted for that workplace alone. These are likely to be more stringent than use of a single RCD. Perhaps more importantly, genuine risks of faulty electrics are a danger to the occupier of the home and the response should be to plan proper repairs.

1.2 *Expectations of extensive health and safety assessment procedures*

1.2.1 Some organisations are thought to adopt complex assessment procedures, with lengthy forms to be completed in full, for every issue, in every house, by someone other than the worker. Some fear that they are expected to address matters which are beyond their control or would require unreasonable levels of testing to discover, like structural weaknesses or mains circuitry.

1.2.2 Most risks in home care are commonplace. Simple household safety and general risk assessment training should enable all workers to enter a private home and do the majority of tasks, without complex procedures and forms. (There are clear exceptions, such as tasks involving moving and handling care recipients, where skilled assessment will be required.)

1.2.3 It is a specific requirement of home care regulation (as well as Health and Safety regulation) that a risk assessment is performed which is "appropriate to the needs of the individual care recipient". In recent discussions with the HSE, they made it clear that it is up to the care provider to decide whether the nature of the work, the premises etc necessitates a separate "site visit" to perform a risk assessment.

1.2.4 Home care service regulators appear to be taking a view that separate site visits by service managers are always required, regardless of circumstances and even when care has already started. The is despite the fact that care regulations make specific provision requiring that care workers able to assess risks for themselves are used where response times do not permit formal risk assessment in advance.

1.3 *Re-interpretation of health and safety requirements included in other legislation or imposed by inspectors under that legislation.*

1.3.1 In addition to the issue of risk assessments cited in 1.2.4 above, inspectors of care services sometimes impose requirements for Health and Safety, which have no actual basis, either in their own regulations or in wider Health and Safety law.

An example of this is instructing organisations with 2–3 people working in a small office to obtain a fire brigade safety certificate. It is thought that such instructions derive from inspectors being used to dealing with types of service where care recipients are resident on the premises.

1.3.2 It is extremely difficult for care provider organisations to challenge requirements imposed by regulators, in this way. Not only will there be an expectation that the regulator knows more about this complex subject (which is not always true) but, especially for the very many small businesses in the sector, there is a real fear that contradicting or getting on the wrong side of the person who licenses you to be in business at all will have serious repercussions, if not direct reprisals. There is a very unequal balance of power between regulators and those regulated and serious bullying is not unknown.

1.3.2 A similar problem exists with the majority of Health and Safety consultants and advisers and indeed with some officials of the HSE itself. Having been "brought-up" on Health and Safety for industrial or commercial situations, the advice given is often impractical or out of all proportion, when applied to home care. The situation can be further exacerbated by the intervention of lawyers for the care provider organisation who take an excessively precautionary approach.

1.3.3 The example of a blanket requirement for care workers to carry a single RCD (1.1.9 above) is thought to have originated from a Health and Safety consultant to a local authority. He/she suggested that the authority should consider issuing RCDs to care workers. When the authority's lawyers examined this advice they not only made it a mandatory policy on their own operational managers but also imposed their internal policy through contracts with external providers.

1.3.4 This internal policy gained still further currency when it was stated to the external contractors that carrying RCDs was a specific requirement of Health and Safety law. It was, in fact, almost given legal status by the National Minimum Standards for domiciliary care under the Care Standards Act 2000, as a result of one member of the drafting team insisting that providers should be told about this alleged "requirement".

1.4 *Inappropriate framing of health and safety requirements for home care*

1.4.1 Home care is carried out primarily on a one-to-one basis in private homes. Most Health and Safety regulations and much of the guidance available have been created for commercial premises and processes, often on a large scale. Most of the experience of inspectors or consultants has only ever addressed similar circumstances and their advice is coloured by this.

1.4.2 Sound practice and procedures must still apply but for example, "production line" rules on food hygiene are impractical for use in preparation of single meals, using ingredients, facilities and implements which are present on site. Similarly, "dangerous substances" may be present in the form of ordinary household products, not under the control of the worker or the care provider organisation.

1.4.3 A further example would be the inappropriateness of regular testing and certification of domestic electrical appliances, in the way that such regimes are routinely expected in commercial workplaces.

2 The Apparent Failure of Health and Safety Law to Take into Account Some Complications Which Arise From Private Homes Being Workplaces.

2.1 *The employer has no control over the condition of the property where his employees will work.*

2.1.1 This is common to many working situations and H&S rules cater for this situation by expecting employers and workers to co-operate with the owner or controller of the workplace. However, in home care that co-operation may be more difficult.

- The owner of the premises often cannot afford to make them safe. Those in receipt of care services are often amongst the poorest in our society, with respect to income, even where their property assets are considerable.
- The owner of the premises does not insure their liabilities, because they cannot afford to do so, because many policies do not provide appropriate cover or because they do not appreciate the need to hold insurance at all. We understand that a high proportion of home owners hold no household insurance whatever.
- The care recipient may not themselves own or control the premises if it is run by a private landlord, council or housing association. This introduces a further party into the equation, who may not be willing to undertake adjustments or repairs to the property and has little or no interest or obligations, in relation to health and safety.
- The care recipient is a private individual with little or no understanding of Health and Safety requirements, may be confused or even hostile. It is unreasonable to expect that care recipients will understand their legal responsibilities for maintaining their premises as a safe workplace.

2.1.2 Inevitably, more will be expected of the knowledge and actions of the care provider organisation and the care worker, in these circumstances. Provider organisations can advise the care recipient and can exercise a greater degree of caution and care in developing safe methods for working. The approach which contractors working in commercial premises might take, of refusing to work in premises unless hazards are dealt with, is more difficult for care providers, as refusal to provide service will itself result in harm to the care recipient or may prompt unnecessary admission to hospital or institutional care.

2.2 *The impossibility/fruitlessness and undesirability of holding care recipients legally to account for their actions as 2.1 above.*

2.2.1 Taking extra care around assessment and development of safe working methods does not remove the underlying legal responsibility of the controller of the workplace premises. Together with the frequent absence of insurance cover held by the care recipient it does, though, mean that it would usually be pointless to pursue those care recipients through the courts. In any event, care providers would be very unwilling to do so, especially since their primary motivation is the provision of care.

2.2.2 This creates an effective void in routes for recourse by injured workers, the result of which is that care provider organisations are held disproportionately responsible, as the only insured party involved, for incidents which would not normally be considered their fault.

2.2.3 While it is acknowledged that the situation has historically been exacerbated by a lack of training in parts of the home care sector, it is felt that care providers suffer adverse decisions even more frequently, as a result of reluctance by the courts to accept that individual care workers have a significant degree of responsibility for their own safety. Again, the expectation that employers can approach Health and Safety in private homes in the same way as it would be done in commercial premises may be a contributory factor.

2.3 *The undesirability of restricting the rights of care recipients to take normal levels of risk in their daily lives*

2.3.1 The personal independence and dignity of the service recipient are fundamental goals of the home care service. Decisions on standards of cleanliness, the way the premises are arranged, temperature etc are enshrined as a right of the service recipient. The essence of empowerment for the service recipient is to encourage normal levels of "risk taking" as an integral part of self determination

2.3.2 These goals must, however, be balanced against the fear of prosecution or civil litigation brought by care workers or the service users themselves, for infringement of Health and Safety law. The approach of some organisations is to institute blanket or "barrier" precautions as has already been described (1.1 above).

Examples include: prohibitions on certain types of service (light-bulb changing): refusal to allow care recipients to run their own bath (scalding risk); taking control of "normal over the counter" medication such as headache tablets; insisting on using disposable gloves for all contact with the care recipient (cross infection).

2.3.3 These precautions all address real risks but may often be disproportionate. The approach of the National Minimum Standards for domiciliary care on risk taking by care recipients is to require agreement of the risks identified, accepted in a document signed by the care recipient (or their advocate) and incorporated into the Health and Safety risk assessment. This is intended to limit the exposure of care providers and enable relaxation of excessive precautions.

2.3.4 The difficulties with this approach include:

— that it requires, itself, a detailed and complex assessment process which is unlikely ever to be truly comprehensive and which may make more explicit as omissions, any risks which are not identified;

— that it must deal with issues which may often be difficult to agree with care recipients, such as their own challenging behaviour;

— that it does not reduce the likelihood of action being taken by care workers and may even give them explicit evidence that risks to their safety were accepted by their employer;

— that it has no validity, in relation to Health and Safety law.

3. The Additional Difficulties Arising Out of Working Under Contract to Local Authorities or Other Third Party Purchasers

3.1 This issue is closely bound up with 1 and 2 above, as is evidenced by the examples cited earlier (1.1.9, 1.3.3/4 and 2.1.3). There is no clear legal responsibility for Health and Safety on third party purchasers of services. They do not control either the premises or the workers. Yet local authorities, as purchasers of 70% of all home care services, specify the tasks to be performed, the time required, the numbers of workers to be used etc.

3.2 *Involvement of local authorities in health and safety risk assessments*

3.2.1 Local authorities (in co-operation with health bodies) perform statutory care needs assessments on care recipients, in order to decide on eligibility for services and to plan how they will be delivered. In home care, this is currently translated into detailed specification of tasks and timings for service provision, which becomes the "purchase order". (The split of these activities between purchaser and provider is likely to change, following implementation of National Minimum Standards)

3.2.2 Serious problems on Health and Safety arise in disagreements between purchaser and provider on risk assessment. The purchaser has no legal responsibility but has tight budgetary constraints. The provider has almost total legal responsibility but cannot decide basic matters such as the numbers of workers required to do the job.

3.2.3 The most common dispute is over the need for more than one worker to perform manual handling tasks, moving or assisting with mobility of care recipients who may be extremely heavy, incapable, actively resistant or aggressive. There are also some other disputes eg on dangers of lone working at unsocial hours and on the condition of the workplace.

3.2.4 All these issues ought to be an automatic part of the local authority assessment of care needs but are commonly not considered or are ignored for budgetary reasons. It should also be open to the care provider to challenge the specification for services on Health and Safety grounds but the common response is that the purchaser will simply buy from a provider who is willing to take greater risks.

3.2.5 Again providers do not have a realistic option of refusing service, where care is being purchased by a local authority, which has no clear legal responsibility for Health and Safety and which may hold a contract with the provider requiring acceptance of all service referrals. As dominant/near-monopoly purchasers in each area, the balance of power in the relationship between purchaser and provider is extremely heavily weighted in favour of the local authority.

3.2.6 An occasional problem is refusal by the local authorities to allow Health and Safety risk assessments by care provider organisations. The reason is to avoid disturbance of the care recipient by excessive numbers of visiting assessors. Of course, without explicit responsibility for the purchaser under Health and Safety law, even if the authority carries out its own assessment of risk and passes it on to the provider, this does not excuse the provider from their legal responsibility to perform their own assessment.

3.2.7 It is commonplace for local authorities not to pass on information on known risks, such as challenging behaviour or infectious diseases, due to concerns for confidentiality. This might be considered negligence but contracts almost universally require care provider organisations to indemnify purchasers for all liabilities, including for the actions or omissions of the purchaser themselves. (Whether such clauses would be enforceable in law is questionable.) These one-sided indemnities are often accompanied by unreasonable expectations of the level of insurance cover to be held by care provider organisations.

3.2.8 The issues above are an odd contrast to the imposition on care provider organisations, through contracts, of inappropriate restrictions on the types of task permitted and of blanket precautions (see 1 above).

4. Growing Issues for Health and Safety Arising Out of Increased Use of Direct Payments

4.1 *Description and scope of Direct Payments*

4.1.1 The Direct Payments referred to here are not the DWP scheme for payment of benefits into bank accounts. We are referring to the statutory right for people eligible for care services to receive regular cash payments from local authorities, as an alternative to having the services arranged for them. These payments are primarily available for people living in their own homes. UKHCA warmly welcome the introduction of Direct Payments as reinforcing the rights of individual people to self determination.

4.1.2 The take up of Direct Payments is still in its infancy, having originally been available only to younger disabled adults, who are only around 8% of the market. As the right has now been extended to virtually all the 500,000 people receiving care at home, the numbers are almost certain to rise rapidly.

4.1.3 A common (though not exclusive) use for Direct Payments is for the recipient directly to employ their own care workers. These are often referred to as Personal Assistants. In doing so, Direct Payment recipients take on all normal employment responsibilities, including full responsibility for Health and Safety.

4.1.4 Local authorities are required to establish Direct Payments support schemes to advise and assist recipients with these responsibilities. Authorities must also check periodically that products and services purchased by the recipient are meeting the assessed needs. They are not permitted, however, to place any other restrictions or requirements on how the money is spent. Specifically, authorities are not permitted to impose any requirements as to who is employed or how (if at all) they are trained etc.

4.2 *Direct payments and illegal employment*

4.2.1 There is serious concern that some local authorities are using the widening of Direct Payments as an opportunity to make budget savings. This is being achieved by paying the recipient substantially less, in cash payment, than would have been spent by the authority to acquire the care services.

4.2.2 Such short-changing denies recipients the choice (unless they reduce the amount of care received) of using formal services, where quality and safety are regulated. In some cases, payments appear insufficient to employ a personal assistant in accordance with minimum wage, PAYE, NI, statutory leave etc. Inevitably, if illegal employment does occur, Health and Safety law is likely not to be implemented.

4.2.3 Ministers at DH have said that this approach would not be permitted but we have not seen evidence of measures to detect or prevent it. There is an overarching government policy not to interfere with relationships between individual care recipients and the workers they employ. For this reason, such workers are not currently covered by any of the recently introduced quality and standards legislation.

4.3 *Health and safety problems with direct payments*

4.3.1 We have already commented on the lack of knowledge and incapacity of care recipients to take responsibility for aspects of Health and Safety to do with maintaining safety of the workplace (2.1 above). We have also commented on the impact this has on routes for recourse by care workers and the absence of enough/any insurance. of employment risks.

4.3.2 When using Direct Payments to employ a personal assistant, the recipient will also have responsibility for risk assessment, developing safe systems for working, training etc. If the new support schemes are not very effective in providing education and assistance to fill the gap, this may result in failure to meet Health and Safety requirements.

4.3.3 Even where illegal employment is not at issue (4.2 above), there is likely to be an absence of resources and knowledge to provide Health and Safety training for personal assistants directly employed by recipients. This may be exacerbated by the desire of many recipients not to suffer interference in how they organise their care. This issue of empowerment and independence can lead recipients to resist or deny normal expectations of training or other Health and Safety measures.

5. The Inflexibility of Working Time Regulations and Their Interface with National Minimum Wage, with Respect to "Live-In" Care

5.1 Live-in care is a well established model of care, where workers are temporarily resident in the care recipient's home and are expected to work, for example, up to 10 non-consecutive hours in any day, at irregular times, to be free to sleep or pursue their own activities at all other times but to be available, in case of emergency.

5.2 Current wording or interpretations of working time regulations threaten to make this model unaffordable;

— directly, by ruling that workers do not have adequate breaks because they need to remain on the premises

— indirectly by suggesting that workers are considered to be "at work" for the full 24 hours, making them eligible for the full time at Minimum Wage.

28 April 2004

Memorandum submitted by The Ambulance Service Association

About the Ambulance Service Association

The Ambulance Service Association (ASA) represents the 35 NHS Ambulance Services across the UK. In 2002–03 our members received about 6 million 999 calls and undertook about nearly 5 million emergency patient journeys. The demand for this service has been increasing by about 6 per cent per annum over the last decade. In addition the NHS non-emergency emergency ambulance service undertook about 16 million patient journeys to hospital and clinic appointments. The NHS Ambulance Service employs approximately 38,000 staff at locations throughout the country.

The ASA is pleased to have this opportunity to submit evidence to the Work and Pensions Committee and hopes that this submission will be of help to the Committee in reaching conclusions.

Summary

Ambulance Services throughout the UK are very aware of the health and safety risks facing their staff, patients and organisations. Whilst there is a great deal of effort being concentrated on addressing these risks, it remains difficult to objectively assess the real impact of control measures being taken. It is recognised however that much more work and investment on an ongoing basis is needed to reduce the risks and improve the health, safety and wellbeing of those working in our Services and those we come into contact with in the course of our duties.

The Health and Safety Executive have expressed concern regarding the accident rates for ambulance staff. As a result, they have undertaken a comprehensive round of inspections across ambulance services during the past six years, and this continues. These inspections have led to a number of enforcement actions being taken, and an even larger number of recommendations, and on the whole, ambulance services have responded positively to these.

In recognition of the need for an ongoing, proactive focus on these issues, the Ambulance Service Association established a national Health, Safety and Risk Committee, to lead a programme of improvement across all ambulance services. This committee includes representation from the Health and Safety Executive and also the Department of Health. The Department of Health has provided funding for a National Health, Safety and Risk Coordinator to take the work of this committee forward.

Working in partnership with the Health & Safety Executive in this way allows for easy and direct two way dialogue. Not only does it ensure that the work being done, particularly by the committee, is targeted correctly, but it also allows us to raise the profile and specific needs of ambulance services in this arena. This is of great benefit not only in terms of ambulance services meeting legislative and other H&S requirements but also in improving HSE's understanding of, and inspection processes for, ambulance services.

1. Introduction

1.1 The management of Health & Safety within ambulance services has seen increasing levels of input and investment since the loss of Crown Immunity in the late 80s and the introduction of various risk management standards and assessment processes, along with the whole Corporate Governance agenda across the NHS since then.

1.2 The statistics in national reports and data collected from our Services show, however, that the impact of health & safety, whether in terms of accidents, ill health retirements or sickness absence is significant and often disproportionately high when compared with other sectors of the NHS (see Appendix 1).

1.3 Our key H&S risks are those associated with:

- Moving & Handling
- Violence & Aggression against staff
- Infection Prevention & Control
- Stress in the Workplace
- Chemical, Biological, Radiation and Nuclear threats (CBRN)

1.4 It is perhaps too early to tell whether measures that have been taken over the past few years to address H&S risks are having the desired effect. Some figures appear to be rising eg violence, others appear to be falling eg accidents reported under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR 1995), but there are so many influencing factors in the basic figures and data compiled that it is difficult to explain any identified trends or assess which is the most prevalent factor creating them. Indeed, the difficulties in collecting and analysing data around H&S incidents were recognised in the recent reports by the National Audit Office*.

2. Proactive Measures by the Ambulance Service Association and Member Services

2.1 The ASA formed a central Health, Safety & Risk Committee (HSR committee) in September 2002. Membership includes an HSE Inspector (who holds a national remit for ambulance services) and also a representative from the Department of Health. The committee also has representation from two of our largest Trade Unions, UNISON and TGWU.

2.2 The main aims of this committee are to encourage Services in adopting a more corporate approach to the management of health & safety by providing national guidance, promoting best practice, reducing duplication of effort, sharing resources (eg for R&D or collection of data), influencing government bodies and others in strategy development.

2.3 The DH have funded the ASA for two years (to June 2005) for a National Coordinator for Health, Safety and Risk to take the work of this committee forward.

**"A Safer Place to Work" reports: HC527, March 2003 and HC623, April 2003*

2.4 Guidance in the form of National Frameworks for Policy and Strategy development has been produced and circulated to all Services. The first two of these address "Safer Handling" and "Violence and Aggression Against Staff". They have been developed in partnership with the HSE and widely consulted on. As frameworks they are deliberately non-prescriptive, but are designed to ensure all Services are addressing the relevant legislation as well as the variety of standards, directions and other mandatory requirements for these issues, within their own policies and strategies. These frameworks can be downloaded from our website at www.asa.uk.net (hard copies enclosed).

2.5 The HSE and the DH sponsored our national "Managing Risk Together" conference in December 2003, to launch the above documents, with Bill Callaghan, Chairman of the Health and Safety Commission as our key note speaker.

2.6 Further frameworks and guidance are currently being developed to address "Infection Prevention and Control" and "Stress in the Workplace".

2.7 Future work planned for the committee includes Occupational Health Provision and Fitness for Work issues eg fitness testing, health surveillance, criminal records checking, working time directive etc.

2.8 As the HSR committee forms part of the overall ASA committee structure, it is able to readily link with the activities of other committees to identify, explore and resolve H&S issues directly related to their activities, such as CBRN risks being coordinated by the Civil Emergencies Committee.

2.9 We also have a National Ambulance Risk & Safety Forum comprising senior managers with responsibility for risk management and/or health & safety within their Service. This has been in existence since the mid-90s and is an active network regularly attended by over 36 Services (including Wales and Scotland), where risks, untoward events, changing legislation etc are discussed and solutions and best practice shared. This Forum allows regular and ready liaison for the ASA HSR committee with member Services.

2.10 The National Health, Safety & Risk Coordinator is a member of the Health & Safety Commission's Health Services Advisory Committee (HSAC) reconstituted in 2003. This is the first time ambulance services have been represented on this group, although they have taken part in a smaller working group feeding into HSAC in the past. HSAC are in the process of developing their strategic plan of work for the coming year(s) and we are therefore able to have direct input into that.

3.0 Working in Partnership with the HSE

3.1 The Health & Safety Executive have been inspecting ambulance services in England, Scotland and Wales in a methodical programme of inspections over the past six years or so and have issued more than 44 improvement notices in that time (see Appendix 2). About a third of these have related specifically to moving & handling and a third to general arrangements for health & safety management. The main focus of their visits has so far been management of moving & handling and violence against staff. In addition they have also looked at other issues such as risk assessment, clinical waste, DSE, the working time directive, access to occupational health and reporting arrangements.

3.2 For some Services, pending inspections or the outcome of inspections has been a motivating factor in terms of taking action to comply with various requirements and this is sometimes the only way H&S priorities will be dealt with over and above day to day operational demands.

3.3 It is fair to say that relationships for individual Services and their HSE Inspectors would seem to vary in terms of the balance between enforcement and advice/prevention. Anecdotal evidence would suggest that there is some inconsistency in approach across the UK and this was one of the influencing factors in establishing the ASA Health, Safety & Risk committee with HSE and DH membership.

3.4 Sally Williams, HM Inspector, has been the HSE's lead for ambulance services for five years and has always provided pragmatic and constructive advice both to individuals within Services and more recently as the HSE representative on our committee. She leaves this role in April 2004 and we are very pleased a replacement has been found to continue working with us in this way.

3.5 Having HSE representation on our committee has helped us not only in the production of our national guidance but also in terms of having a central link to smooth over differences or gain a wider perspective. It provides a very direct route to specific advice or interpretation of requirements and also enables us to get the needs of ambulance services recognised within the whole spectre of NHS bodies covered by the HSE's Health Services Unit.

3.6 Several ambulance services are taking part in HSE funded research, for example, that being undertaken by Nottingham University into the evaluation of violence and aggression management training.

4.0 Barriers to Effective H&S Management in Ambulance Services

4.1 Whilst the HSE may provide a very direct degree of motivation for Services to comply with H&S legislation through the threat of enforcement action, the work of the ASA HSR committee seeks to motivate Trust Boards by emphasising the business case for improving and investing in management of these risks.

4.2 Difficulties arise for ambulance services through the conflict of immediate demands on resources for operational services against investment in longer term control measures where the benefits are difficult to measure and may not be seen for some time, even years. For example, introducing a comprehensive rehabilitation programme, or reducing moving & handling injuries by changing the design of ambulance vehicles or introducing a new piece of equipment, all require significant financial investment over a number of years.

4.3 The constant pressure on ambulance services to meet response targets invariably takes precedence both in the allocation of financial resources and against, for example, releasing staff for statutory and mandatory training.

4.4 Commissioning bodies in England and Wales are often reluctant to support ambulance services in funding initiatives aimed at improving health & safety as they either do not or will not see any immediate impacts on response performance—hence the need for Services to justify the need for such measures in terms of performance and good business sense. The difficulty in arguing such cases is that introducing control measures to reduce these risks usually involves tackling them from many angles eg new training programmes, new equipment, changes in working practices, introducing monitoring mechanisms etc and the results may only be noticeable in the longer term. However, it is hoped, with the continuing integration of risk management systems and use of risk registers in the development of organisational strategies and business plans, that these priorities will come to the fore.

4.5 Making clear business cases for such funding can be difficult when the objective evidence and data to support them are not readily available. Collecting data regarding H&S risks is not easy, although it is becoming more so. Whilst reporting systems have been in place in most ambulance services for a number of years now, the resources needed to support these have often not been there, leading to backlogs of reports to be processed, leading to difficulties in producing meaningful information and learning outcomes, leading to staff perhaps being reluctant to report because they think nothing is going to be done etc. Nevertheless,

spurred by the Controls Assurance initiative and the National Patient Safety Agency, reporting systems have become more robust in the past two to three years and most Services do now have more comprehensive databases to allow more accurate reporting of accidents and incidents. Monitoring trends however can only be meaningful over a matter of years as so many influencing factors will be involved.

4.6 We still have variation across UK ambulance services in terms of what data is centrally recorded within Services and what definitions are used, which makes it difficult to gain an overall picture of the effects of these risks in ambulance services. One of the aims of the ASA HSR committee is to establish national minimum data sets and agree key performance indicators for H&S to enable consistent measurement and benchmarking.

4.7 Many Services are not yet able to identify days lost in sickness absence in respect of specific work-related activities, although as new systems and technology are introduced this is becoming easier to effect.

4.8 There is little consistent or reliable information regarding the overall costs of individual H&S incidents and specific H&S risks to Services. The NHS Pensions Agency were recently able to do some manual manipulation of the data they collect, to provide us with costs relating to ill health retirements and personal injury benefits, but the information was not readily available to them and it was a lengthy exercise. Likewise, the information and data held by the HSE tends to relate to all health and social care sector organisations and it is not easy to obtain data specifically relating to ambulance services.

4.9 The ASA HSR committee are intending to develop a simple costing model so that we can begin to collect this type of information on a national basis.

4.10 Control measures that rely on equipment, for example in moving & handling patients, are often governed by what is available on the market. For example, the HSE have identified one of our highest risk activities involves use of the "carry chair" when moving patients out of their home. Their own ergonomics report into a small number of this type of equipment available was relatively inconclusive, but did state that "greater consideration should be given towards 'special' situations and dedicated equipment to assist the ambulance crews in certain high risk environments".

4.11 Ambulance services would like to be able to work more proactively with manufacturers in designing "evidence-based" equipment to meet needs specific to our working environment and tasks, designing out risks before production and purchase, however again, this requires investment and resourcing for research & development. At the moment too much time and effort is taken up with evaluating finished products and having to refine design features after accidents have happened.

4.12 Unlike some lawyers, the HSE has been on the whole suitably cautious in placing enforcement notices on Services where, for example, a new type of equipment has not been purchased simply because it would appear to address certain risk issues. Very often, Services that have perhaps too readily "converted" to different pieces of equipment, for example, a new type of stretcher, have found themselves dealing with different types of accidents and incidents than those involved with their previous equipment. The emphasis from the HSE has been to ensure that Services are assessing and reviewing their arrangements and making well judged and planned changes to working practices, rather than knee-jerk reactions, which is welcomed.

APPENDIX 1

NATIONAL AUDIT OFFICE DATA (HC 623 AND HC527)

Average sickness absence rates

	All NHS Trusts	*Ambulance Trusts*
2000	5.1%	7.1%
2001	4.9%	6.8%

Reported accidents to staff (per 1,000 staff per month)

	All NHS Trusts	*Ambulance Trusts*
1998–99	19 (est)	38 (est)
2000–01	13	21
2001–02	18	28

Incidents of violence (all types) (per 1,000 staff per month)

	All NHS Trusts	*Ambulance Trusts*
1998–99	7 (est)	7 (est)
2000–01	10	13
2002–01	14	12

DATA FROM NHS PENSIONS AGENCY

— In 2003 out of 581 Permanent Injury Benefit awards in the NHS, 58 (10%) of these were to ambulance personnel, 43 relating to musculoskeletal disorders and 14 relating to stress.
— As at Sept 2003, payments for PIB to ambulance personnel had amounted to £1,583,998 for the year.
— In 2002–03 there were 206 ill health retirements of ambulance personnel (6.09% of the total for the NHS).
— This was a 25% reduction in ill health retirements in the ambulance service from the previous year.
— Cost to ambulance Trusts for ill health retirements 2001–02 = £14,734,137 and for 2002–03 = £18,034,533

DATA COLLECTED FROM SERVICES BY ASA

2002–03 : moving & handling accidents = 9 per 1,000 staff per month*.
(*based on data from 19 Services, including Scotland and Wales).

2002–03 violent incidents (all types) = 17 per 1,000 staff per month £.

2002–03 physical assaults = 4.7 per 1,000 staff per month £.

(£ based on data from 19 Services, including Wales but not Scotland).

Average sickness absence in 2002–03 = 5.98%.

APPENDIX 2

HEALTH AND SAFETY EXECUTIVE (HSE) INSPECTIONS OF AMBULANCE TRUSTS 1998–2002

INTRODUCTION

1. Each year HSE inspectors carry out a programme of planned visits to NHS employers in England, Scotland and Wales. Between April 1998 and end of March 2002, nearly 30 ambulance trusts were inspected (some have subsequently merged to form new trusts).

2. The visits are used to inspect the effectiveness of employer's risk management systems against the risk management model laid down in HSG 65(1) Successful health and safety management and the Health Services Advisory Committee guidance(2) Management of health and safety in the health services. The guidance describes the following elements of the risk management model:

— Policy
— Organise
— Plan
— Implement
— Measure performance
— Audit/review

3. Inspectors use "key risks" as performance measures to assess the effectiveness of each element of the risk management system. For the ambulance service, the key risks have been:

— Manual handling (with emphasis on patient moving/handling);
— Workplace violence.

4. Additionally, inspectors have addressed other issues identified during the visit such as general workplace risk assessment, control of clinical waste, access to occupational health advice, and accident-reporting arrangements.

5. The management of occupational stress is now a priority for the Health and Safety Commission and will feature more prominently during future inspections.

GENERAL FINDINGS

6. Where significant risks were found during front line tasks, deficiencies higher up the line management chain were usually considered to be the primary factor. These were identified as:

— Lack of health and safety policies and arrangements for risk management, including lines of responsibility and communication. Not surprisingly, this was most evident in trusts that had recently merged.
— Lack of health and safety training for managers, particularly those with direct line manager responsibility for ensuring worker safety.

— Managers sometimes were not sure about their own particular role in managing health and safety. These were often not clear in job descriptions or monitored at periodic job appraisals.

— Inadequate supervision and monitoring of work practices.

Enforcement Notices

7. Over the period April 1998–March 2002, over 30 Improvement Notices (I/Ns) were served on ambulance services. The breakdown is shown below:

Subject of I/N	*per % of total served*
Manual handling(note 1)	33
General health and safety measures	*30*
Policy/arrangements 40%	
Risk assessment 40%	
Training 20%	
Violence	*9*
Occupational health provision	9
(includes policies for protection against	
Blood Borne Viruses)	
Assessment and control of risks from Display	*9*
Screen Equipment	
Clinical waste	*3*
Accident reporting/investigation	*3*
Asbestos	*3*

Note 1: A number of I/Ns served for general health and safety measures under the Management of Health and Safety at Work Regulations 1999, made specific reference to manual handling as a key risk to be addressed. These are counted as manual handling notices for the purpose of this paper.

8. Across the topics, 30% of Notices were aimed at improving policy and organisation, 39%for risk assessment, 22% for control measures and 8% specified training.

Manual Handling

9. Manual handling is the commonest cause of injury and sickness absence in the service. Data extracted during 2000 from the HSE RIDDOR (the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1986) database showed a three-year mean incidence rate for manual handling accidents of 38.2% 1,000 employed, with a range of 5.4 to 205.

10. Accident data from seven volunteer trusts for the three years 1997–99 for all recorded incidents involving moving/handling of loads showed a mean incidence rate of 178/1,000 employed.

11. Over the period covered by this report, there has been a reduction in injuries reported to HSE under RIDDOR.

12. Analysis of accident/injury data carried out by HSE has identified the three tasks that gave rise to the majority of injuries:

— Use of the carry chair, particularly when negotiating stairs.

— Use of the stretcher when raising or lowering and loading on/off vehicles.

— General patient handling eg back to bed lifting.

13. The general comments of para 6 are applicable to manual handling. In addition, other issues specific to the risks of musculoskeletal disorders (MSD) have been found:

— Risk assessments for "generic tasks" of patient handling are sometimes absent or inadequate in that they are out of date and do not take account of improvements in equipment design.

— Staff carrying out risk assessments may lack necessary competence. This was applicable to generic risk assessments and situation specific (dynamic) assessments carried out by crews.

— Poor identification of training needs and delivery of training patchy.

— Equipment purchasing policies centre on vehicles and stretchers with small aids such as slide sheets, banana boards, handling belts not considered.

— Communications is often poor. Staff may not always get information on new equipment available, or the lessons to be learned from investigations of incidents. This probably reflects the nature of the service as a multi site employer.

— Lack of cooperation from other healthcare bodies ie hospitals, care homes and GPs in providing advance information about a patient and their needs.

14. Of the Improvement Notices served for manual handling, the majority were for improvements to overall risk management ie the HSG 65 risk management cycle. In addition 18% specified requirements to improve training , 18% for risk assessment and 9% for production for an overarching policy.

COMMENT

15. It is evident that real improvements in the management of MSD are being achieved by some services, as reflected in RIDDOR reported injuries. This will lead to cost savings in terms of sickness absence, compensation claims and early retirements with subsequent replacement costs. Improvements in vehicle and equipment design offer further opportunities to reduce risk.

16. Other areas which are starting to show benefits in some trusts are:

— The introduction of fast-track medical intervention and rehabilitation with managed return to work for injured workers.

— Investment in training for managers and crews in risk assessment, patient handling, violence and aggression.

— The value of applying ergonomic expertise to risk assessment, equipment purchase and design of safer systems of work.

17. The challenge for the ASA is to promote the adoption of best practice across the three NHS services. Future equipment design should be customer demand led and could be coordinated through the ASA or NARSF.

Sally Williams
HM Inspector of Health & Safety
The Ambulance Service Association

28 April 2004

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Memorandum submitted by Unison

UNISON is the UK's largest trade union, with over 1.3 million members in the public services. UNISON members are employed within the public, private and voluntary sectors and are engaged in providing a wide variety of different services, including in local government, health, schools, higher education and the utilities.

UNISON welcomes the opportunity to make a written submission to the inquiry of the Select Committee. In addition to the operation of the Health and Safety at Work Act (HSWA), our submission will focus on health and safety in the health and social care sectors and the challenges they face. We will look in particular at the risks faced by workers in this sector; how these risks are addressed; the role of agency workers and the effectiveness of health and safety legislation as it applies to the sector.

1. THE HEALTH AND SAFETY AT WORK ACT

1.1 We believe that the HSWA was one of the most important pieces of legislation in recent years, and played a significant role in reducing the number of work place accidents. We also believe that the tripartite approach to health and safety contained in the HSWA should prove to be a model for other areas.

1.2 We believe that since 1974 there have been a number of important changes, not least the realisation that health and welfare are of equal importance to safety, and the growing importance of the EU in developing a pan-European health and safety strategy. In addition the employment base has moved further away from manufacturing to services, bringing with it a very different workforce with differing needs.

1.3 We are clear that the basic framework set up by the 1974 Act has stood the test of time. The duty to ensure the health, safety and welfare of workers, and others who may be affected by an employers' activities and assess all work activities in order that risks are removed or reduced is generally accepted by both employers and workers. Nevertheless we do believe that some consideration should be given to reviewing some of the principles underpinning its enforcement.

1.4 These are the current emphasis on goal setting in legislation and the level of risk deemed acceptable.

1.5 Prior to 1974, almost all health and safety legislation was absolute. With the advent of the HSWA that changed to general principles underpinned by "as far as is reasonably practical". Since the1980 European directive 80/1107/EEC and more importantly the Framework Directive 89/391/EEC, there has been a trend towards even more general goal setting regulations, often based on procedures (in particular risk assessment) rather than prescriptive legislation.

1.6 However no real investigation has been undertaken on which approach would be more effective. The decline in fatal accident rates may be impressive, but to what extent are they a result of legislation. The effectiveness of much of the European-based legislation must be in doubt given the apparent lack of awareness of such important Regulations as the six-pack. Despite the Manual Handling Regulations there are still 300,000 manual handling accidents every year of which up to 200,000 are back injuries caused by lifting.

1.7 At the same time as we have seen a reduction in accidents, we seem to have seen an increase in other occupational health illnesses or injuries such as stress and bullying.

1.8 UNISON does not, in itself, oppose the use of goal-setting legislation based on risk assessment, however it must be shown to work. That means that there should be considerable investment into research into the effectiveness of the various legislative models.

1.9 In the meanwhile, if goal setting is to be the norm, we believe that the use of the defence that an employer acted "as far as it was reasonably practical" should be removed, as it is incompatible with the principles of the European framework directive. It has also served as an excuse for many employers to either take no action at all to remove or reduce risks or do as little as possible citing this qualifier as the reason for less or non-action.

1.10 The principle of active worker involvement and consultation is also key to the HSWA. Yet it is one of the areas that is most likely to be overlooked by employers. It is therefore of major concern to UNISON that no employer has ever been convicted for not complying with their duty to consult their workforce since the regulations were introduced in 1977.

2. The Health and Social Care Sectors

2.1 UNISON represents over 460,000 workers in the health care sector and over 900,000 in the social care sector. The overwhelming majority are women, half of whom work part-time and play an essential role in improving the quality of life for thousands of people including the sick, elderly and disabled, those with learning difficulties and people suffering from mental ill-health. This work involves looking after children and adults in a wide variety of settings ranging from highly intensive residential establishments through to caring for clients in their own homes.

2.2 These workers face considerable health and safety risks. Activities such as lifting and moving those receiving care, lone working as well as exposure to infections, violence and abuse, and more general hazards such as slips and trips means that it is essential that good health and safety practices are in place.

3. Lifting and Handling

3.1 In relation to lifting and handling the social and health care sector is one of the highest risk areas for back injury with around 50% of all accidents reported in the sector attributed to helping people whose mobility is reduced by disability or long term illness. In 2001 UNISON conducted the largest ever survey in the UK of homecare workers and received replies from over 3,000 homecare workers. The results show that incidents of back pain are 10% higher for homecare workers than the rest of the adult population. The survey also revealed that younger workers aged under 34 have broadly the same level of back pain as older workers.

3.2 This is of particular concern to UNISON, as this workforce has an older age profile. Over 30% of those responding to our survey are over 55 years old. And the health care sector is no different. Data from the Department of Health suggests that up to 75 per cent of NHS staff regularly experience back pain.

3.3 In our experience the most problematic issue surrounding manual handling, relates to risk assessments. Many employers do not carry out adequate assessments and health and social care workers are experiencing back injuries as a direct result. In some cases equipment such as hoists and other lifting aids are available but not used either because adequate training is very often not provided, or because the service user is not content for this equipment to be used.

4. Work-related Violence

4.1 Work-related violence is also of major concern to health and social care workers. In 1999, the Government's Zero Tolerance Campaign was launched to tackle the rising problem of violence within the NHS. The campaign had set a national target for the reduction of violence in the NHS by 30% by 2003. The results so far show that Zero Tolerance has helped to raise awareness among staff, managers, and the public that violence to staff in the health service is unacceptable, but the 30% reduction has not been met; and only 18% of trusts had reduced accidents by 20% or more, while 55% have reported an increase.

4.2 In March 2003 the National Audit Office published its report "A Safer Place to Work—Protecting NHS Hospital and Ambulance Staff from Violence and Aggression", which looked at the extent and nature of violence and aggression towards staff working in the NHS. The report survey identified 84,214 reported incidents of violence in 2001–02—an increase of 13% over the previous year. It also estimated that up to 39% of incidents are not reported. In addition, the report shows that staff who work directly with the public and those who work in acute mental health units are at the greatest risk. For example, incidents of violence in NHS mental health and learning disability trusts are almost two and a half times the average for all trusts. This is despite the fact that staff working in mental health units are less likely to report abuse.

4.3 Within the social care setting verbal abuse, threats and actual violence is also the norm and on the increase. Results from a UNISON survey of 2,000 residential care workers carried out in March 2004 shows that in the last two years nearly half of the staff (49%) in the survey have been assaulted by residents and nearly three-quarters (74%) have been verbally abused by residents.

4.4 Across this sector workers are subject to this kind of abuse on a day-to-day level and many employers expect them to put up with it as they see it as part of the job rather than behaviour that can and should be challenged by them. In fact many employers are positively discouraging workers from reporting incidents of violence. This has not only led to massive levels of under-reporting, but suggest that employers are not willing or able to consider adequate control measures to protect staff from violence.

5. Work-related Stress

5.1 Work-related stress has become an inherent part of the job and is on the increase in both the health and social care sectors. Much of this increase stems from staff shortages, poor management, increased administration needs and workloads, insufficient time, significant changes/increases in responsibilities and the content of work. Within the social care sector this has resulted in a change from domestic or practical care to personal care. At the same time the needs of clients have increased. More dependent people are staying at home longer, with larger packages of care. The range of clients looked after has widened. UNISON's homecare workers survey showed that 75% of homecare workers now look after older people with dementia, 20% look after younger people with learning disabilities, and 14% look after younger people with mental health problems. Many look after this whole range. The range of need is wide, as is the range of skills and abilities to effectively look after them.

5.2 There has also been a significant shift towards health practices. Homecare workers are regularly helping with catheters, medication, and liasing with and preparing clients for health practitioners. This raises major questions around training, skills and responsibilities.

5.3 UNISON's survey of residential care workers reveals that this group of workers are also increasingly expected to administer medication. Many are expected to carry out invasive procedures and administer controlled drugs but are not confident to do so because they are not convinced that the level of training they have received is adequate. In some areas existing policies include the need for two members of staff to carry out these procedures, but staff shortages prevent this from happening.

5.4 In contrast some agency staff working alongside permanent staff are instructed not to administer any medication.

5.5 The additional responsibility of administering medicine has become a stressor for many staff who are concerned at the potential for something to go wrong whilst carrying out this duty. In our experience when things do go wrong, our members face disciplinary action and are frequently dismissed.

5.6 Within the health care sector research continues to show increasing levels of stress.

5.7 In 1998, a report by the Nuffield Trust drew attention to high levels of psychological distress in the main groups of NHS employees, for example:

- stress in health service staff was substantially higher than in other UK employees;
- NHS managers were twice as likely to be above the threshold for psychological distress as other British managers;
- and new stressors were occurring with the perceived risk of violence to staff and fears of contamination by HIV/Hepatitis B and C.

5.8 A literature review carried out in 2000, found that over 20 reports consistently showed that between a quarter and a half of all NHS staff were reporting significant levels of stress and that many stressors were unique to health care. In June 2001 a Policy Studies Institute report, commissioned by the Department of

Health, found senior nurses were being stressed by concerns about how to staff busy wards, competency levels among agency nurses, long hours, recruitment and retention problems and cleanliness of wards. Nurses blamed organisation and management factors beyond their control for spiralling stress levels.

5.9 The Royal College of Nursing 2001 Working Well survey, used a psychometric questionnaire to determine the psychological health of members. This showed that 11% of nurses had a similar profile to people deemed to be in need of NHS psychological therapies. But only half of these staff were receiving counselling or other treatment. These nurses also report twice the level of sickness absence as other nurses in the survey.

5.10 In February 2002 the Trades Union Congress reported a twelve-fold increase in work-related stress personal injury claims.

6. Source: National Audit Office

6.1 UNISON is concerned at the increase in levels of work-related stress and welcomed the serving of an Improvement Notice on West Dorset General Hospitals NHS Trust last year in relation to stress.

6.2 In the social care sector, staff working in childcare are often dealing with highly distressing detailed information about child sexual and physical abuse and/or neglect. Social workers are working to unacceptably high caseloads because of staff shortages, and are often given complex cases that should ideally be handled by more experienced workers or by two workers. They may also be involved in disclosure work with young people, where they are required to listen to children describing what has happened to them and take highly responsible decisions relating to child protection. Supervision and support is often inadequate, owing to shortages of staff, poor management or time and resources. This can cause stress related illness in staff. Social worker recruitment and retention is also significantly difficult in many authorities and is a major cause of the burnout rate in this area of work.

7. The Use of Agency and Contractors

7.1 The use of agency staff and contractors has increased in both sectors. Gaps in staffing, finite resources and staff absences have led to an increase in the use of such workers. In many instances confusion has arisen around the responsibility for undertaking risk assessments, the delivery of health and safety information and training, and the provision of equipment and protective clothing.

7.2 Within the social care context, agency workers are often sent to assignments without a risk assessment, or training, as the majority of recruitment agencies (mistakenly) believe that the responsibility for health and safety lies with the organisation in which the employees are placed. As a result, agency and contractors staff are potentially at greater risk.

7.3 UNISON's residential care survey found that a large majority of employers consider that the level of vacancies and the use of agency staff have a serious impact on the quality of service. For example, 11% of those replying were using agency staff for more than 30% of their hours or posts and a third (37%) had agency staff for more than 10%.

7.4 Four respondents had vacancy levels at 30% or more and 44% had vacancy levels at 10% or over.

7.5 Over 80% of the employers surveyed considered that their level of vacancies or use of agency staff had "some" significant or "serious" impact on the workloads of their regular employees. Over 95% feel that this situation has increased workloads for employees.

7.6 Within the health care setting, cleaning, security and catering are the areas most likely to be contracted out. But ad hoc replacements to meet staff shortages can mean that agency workers are also frequently used. Their lack of local knowledge of best or good practice is a potential cause of health and safety accidents and incidents. As noted in the NAO report, installation and maintenance of plant, construction and waste disposal can be particularly risky because the work has to be done on site in situations that may be unfamiliar to contractors. Accidents are therefore likely when contractors are unaware of existing risks and NHS Trust staff are unaware of the work being carried out.

8. Enforcement

8.1 UNISON is particularly concerned at the levels of health and safety enforcement, which we believe are extremely low as well as inconsistent. With less than 600 frontline inspectors it is reasonable for employers to expect to receive a visit every 20 years. With the number of contacts with employers steadily falling the situation can only get worse. Most inspections are supportive rather than investigative which means that very low levels of injuries are investigated. Given that investigations are far less likely in the service sector, work-related accidents, injuries and ill-health in the health and social care sectors will continue to increase.

8.2 We are also concerned at the lack of contact with safety representatives during inspections and a general unwillingness to share information with them. It is clear that the HSC believes in the principle of joint working between employers and employees, yet this approach is clearly missing within the core work of the HSE. Instead of using safety representatives in a positive way to help to ensure that employers provide a safe working environment their prevention work is almost exclusively centred on employers.

8.3 UNISON would like to see this focus changed. We would like safety representatives used in a more positive way that can lead to improvements in the safety culture of the service industry in general and the health and social care sectors in particular. This would involve changes to the safety representatives' regulations to include giving safety representatives the right to inspect all premises where they have members and those of contractors, a duty on employers to respond to issues raised by representatives and better enforcement on the right to consultation, training and information. This is particularly important in the social care sector where many workers are isolated and are not involved or consulted on any health and safety concerns.

8.4 In addition, we would like to see health and safety materials specifically aimed at safety representatives. There is a total lack of such guidance in circulation compared to that aimed at employers. Any such guidance should be issued free to safety representatives who do not have the resources to purchase the materials they need to carry out their functions.

9. Summary

- The Health and Safety at Work Act has stood the test of time but a review of its enforcement is needed.
- Levels of inspections are unacceptable and inconsistent.
- Better health and safety practice in the health and social care sectors is necessary.
- Better health preventative action is needed to tackle a number of concerns including manual handling; violence and stress.
- The principle of active worker involvement and consultation should be promoted.
- Increased health and safety training should be developed and delivered to agency staff and contractors.
- Changes to the safety representatives and safety committees regulations is needed.
- There should be greater access to guidance aimed at safety representatives.
- Better enforcement on the right to consultation, training and information is needed.

UNISON

28 April 2004

Memorandum submitted by NHS Confederation

1. Background Information

1.1 *The NHS Confederation*

The NHS Confederation brings together the organisations that make up the modern NHS across the UK. Working with our members, we are an independent driving force to transform health services and health, by:

- Influencing policy and wider public debate.
- Connecting health leaders through networking and information sharing.

We are the only membership body for all types of NHS organisations with over 90% in membership across the UK.

1.2 *The incidence of ill-health and injuries to NHS staff*

1.2.1 The NHS employs 1.3 million employees. The National Audit Office reported in "A Safer Place to Work" that sickness absence in NHS organisations, was in 2001–02 running at an average of 4.9% across all NHS trusts, compared with an average of 3.7% for all public administration, education and health employees.

1.2.2 During the three-year period 1999–00 to 2001–02, a total of 16,540 manual handling injuries were reported to HSE, under RIDDOR requirements, by health services employers. Incident rates of up to 2,000 accidents/100k employed have been found at NHS hospital trusts. In the ambulance service, rates in excess of 5,000/100k employed have been recorded.

1.2.3 In 2001–02, HSE received reports of 9,755 over-three-day injuries and of these, 5,089 involved handling injuries. In the same year, 122 major injuries attributable to violence to staff were reported. Physical assaults to NHS staff are the third greatest cause of accidents that result in more than three days absence. The National Audit Office, in its reports published April 2003, stated that the number of accidents/violent incidents was increasing, although this could be the result of increased reporting rates. The NAO has conservatively estimated the direct costs of work related accidents in English trusts at about £173 million in 2001–02.

1.2.4 The 2001–02 Self-Reported Work-related Illness (SWI) Survey reported that approx 240,000 people in the health and social care sector (a wider grouping than just health care) had reported a health problem caused by their work—amounting to approx 4.2 million days off work. The Survey also reported that nurses had the third highest reported rates of musculo-skeletal disorders [MSD], with an estimated 1.4 million days lost.

2. The Legislative Framework

2.1 The importance of the Health & Safety at Work Act 1974 lies not so much in the Act itself, as in the framework it provides for regulation of health and safety in the UK. Overall, the legislation has indeed been successful in improving standards of Health & Safety. A number of our members commented that the UK approach of "enabling legislation" encourages employers to own the problem and find ways to attain good practice, rather than simply making rules which must be obeyed, whether they are understood or not.

2.2 Our members view is that the legislation itself probably has less direct impact on the worker in his/her workplace than the interpretation drawn by bodies including the HSE, Government Departments and professional bodies such as the Institute of Occupational Safety and Health. The widespread view of NHS employers is that the HSE's inspectors are generally extremely helpful. Their facilitative value is reinforced by their statutory power and they play a crucial role in encouraging improvements in health and safety management.

3. Achieving Outcomes

3.1 Our members' view is that penalties for health and safety offences are generally set at the right level. An appropriate balance has to be set between punitive penalties and appropriate use of public money. NHS organisation's concern is that every pound paid in fines is a pound not spent on healthcare. We believe that within the NHS, a far more robust form of penalty is the system of performance management and Star ratings. An adverse HSE inspection and Health Commission review rating is of significance. For this reason, we would wish to see Health & Safety play a far more significant role in the design of the draft "Health Care Standards for Services under the NHS", issued for consultation by the Department of Health in February 2004. Additionally, we would endorse the Institute of Director's recommendation that Directors, including those in the public sector, who have a conviction for a health and safety offence should be banned from holding a Directorship for a specified period of time.

3.2 Health & Safety legislation is best understood by the professionals in the field. However, arguably, this understanding dilutes as one moves up through the managerial hierarchy. Regrettably, health and safety is still seen by some as a potentially expensive nuisance in balancing a range of conflicting resource demands. We would suggest that this situation is best addressed through a combination of enforcement, education and the promotion of best practice. NHS organisations face many competing demands for scarce resources. Resources for health & safety management are no exception. There is no doubt that the use of improvement notices by the HSE is a powerful method of forcing an internal review of priorities and raising health & safety up the NHS Board agenda.

3.3 The broad opinion amongst our members is that there is insufficient emphasis on "health" in health and safety. Evidence from a range of Occupational Health pilots indicates that considerable progress can be made by exploiting this opportunity. One of our members reported on his involvement in a pilot within the Rotherham area, "Workplace Health, Advice and Management" which has been very effective in developing a local employer award system and using health and safety to raise awareness amongst local employers and staff to a range of public health issues including smoking, heart disease and food safety. In this member's opinion, sustainable funding for this type of intervention allows the NHS to reach sections of the community that are normally missed by traditional public health messages. It also increases employer awareness of the support that is available to help people return to work following an accident or illness, keeping skills within the workforce and reducing the demand on primary care (especially GP workload) in supporting people who are classed as "long term sick".

3.4 Awareness programmes and initiatives specifically targeting SME's would be particularly appreciated, as these employ a large proportion of the working population and the potential to improve the health of local communities (and prevent ill health) is considerable. One Occupational Health Physician commented that "there is insufficient emphasis on 'health' in health and safety generally. This is less so in the NHS, as you would expect, but in other industry sectors people can relate to safety far more readily than to health."

4. Resources

4.1 The broad view of NHS organisations is that the HSE is not sufficiently well resourced to meet its objectives within the NHS. The NHS employs 1.3 million staff through 1,000 employers and in many thousands of workplaces including hospitals, GP surgeries, walk in centres and call centres, In 2003–04, the HSE carried out a total of 201 inspections in the NHS in England, Scotland and Wales, including 119 NHS Trusts, 65 Primary Care Trusts and 17 Ambulance Trusts.

4.2 Given our opening point regarding the important role of the HSE in advising and supporting NHS organisations in securing compliance, it is our belief that the HSE's resources are stretched thinly. We are particularly concerned regarding the need to support emerging organisations such as Primary Care Trusts, which each offer an average of 30 general practices, sometimes across huge geographical areas or within areas of significant social deprivation.

4.3 A number of our members have reported on the time taken by the HSE to produce best practice guides. For example, the HSE's policy on Latex is only just being published, and yet the more proactive NHS organisations have been addressing this issue and developing local management approaches for the past three years. On the other hand, the HSE is to be congratulated upon its proactive stance on workplace stress. The HSE needs to be consistently more proactive and timely in the provision of advice and guidance.

4.4 The 1998 HSAC guidance "Manual Handling in the Health Services" is still in print, and has been supplemented by "Handling Home Care" [2001] which deals with patient handling in the community. HSE helped DoH produce the "Back in Work" campaign material, and helped develop the Welsh NHS Manual Handling Passport Scheme. The HSE web site contains case studies on good practice in patient handling/ MSD, and more are being added. The HSE has also sponsored research into the ergonomics of carry chairs in the ambulance service, training methods for patient transfer, and evidence-based good practice.

4.5 We understand HSE guidance on biological risks in health care has been restricted to the management of legionella and clinical waste, because of the wealth of other publications on control of infection. We also understand that the HSAC guidance on the latter is about to be replaced by NHS Estates guidance, produced jointly with the Environment Agency and HSE. The Advisory Committee on Dangerous Pathogens [a joint DoH/HSE committee] is drafting guidance on biological risks in healthcare. This will focus on biological risk assessments.

4.6 Our members are particularly concerned about reducing or removing unnecessary or bureaucratic burdens on health care professionals caused by inspection, audit and accreditation. We therefore commend the work of the NHS Reviews Co-ordination Group [RCG], which developed a set of guiding principles in January 2002. This group brings together organisations that carry out reviews, audits and inspections of risk management in NHS bodies in England and Wales. It comprises the Audit Commission, the Healthcare Commission, National Assembly for Wales, Department of Health, Health & Safety Executive, NHS Litigation Authority and the Welsh Risk Pool. Its aim is to improve the efficiency and effectiveness of health bodies risk management reviews. It seeks to achieve this through improved understanding of the work of different reviewing organisations, better operational working relationships, the sharing of documentation and information and improved planning and co-ordination of reviews. Anecdotal evidence from a small number of our members would suggest that this collaborative approach is beginning to provide benefits for NHS organisations. The key relationship for NHS organisations, is that between the HSE and the Healthcare Commission. A working agreement has been drawn up between these two organisations, which we understand, will evolve into a full Memorandum of Understanding later this year. We would expect NHS organisations to be consulted on these arrangements to ensure that the bureaucratic burden upon the NHS is reduced.

4.7 Whilst the HSE is to be congratulated upon its efforts to work jointly with other reviewers, there is evidence that suggests it needs to invest further in working collaboratively with the Department of Health and the Medical Profession. The recent decision of the HSE to abolish the post of Chief Medical Officer is regarded as a retrograde step and sends an inconsistent message.

5. The Particular Challenges Faced by the Health and Social Care Sector

5.1 The Health & Safety Commission made the health services a priority sector for reducing injuries and work related ill health in its 2001–04 Strategic plan.

The thematic priorities for the NHS include manual handling, violence and aggression, stress and "slips and trips".

The organisational priorities identified by the HSE from its NHS inspection programme 2001–03 include:

- Wide variations between the best and worst performers.
- Out of date policies and poor communications, often due to reorganisations.
- Inconsistent health & safety management within trusts and little dissemination of good practice between trusts.
- Policies for patient handling and the management of violence and aggression were often ineffective, poorly communicated or not monitored.

— Induction and refresher training on health and safety was inadequate or not made mandatory.

5.2 In the Confederation's view, a further organisation priority has to be better co-ordination of health and safety policy and monitoring by different parts of the Department of Health. The NAO report flagged this issue in April 2003 and pointed to the example of the NHS wide occupational health and safety strategy in Scotland. The Confederation would intend that the NHS Employers Organisation, to be launched in October 2004, will play a crucial role in developing a consistent approach in England.

5.3 Whilst there is considerable room for improvement, the NHS has taken significant steps in putting in place effective health and safety management arrangements. Indeed, the NAO report itself highlighted a decrease by 25% of reportable accidents to NHS staff that result in more than three days of absence over the past five years. The Department of Health has made significant investment in human resource management over the past three years and introduced a range of policies including "Improving Working Lives", a "Back in Work" campaign and the rehabilitation of staff on long term sick leave. Ambulance services across the country have been identified as having particular issues in terms of accidents, violence, sickness absence and ill health retirement. A joint working group with the HSE has been formed to help address these issues and has produced policy frameworks on violence and aggression and safer handling.

5.4 The Confederation is particularly concerned about the level of resources and expertise available to Primary Care Trusts, which are relatively new NHS organisations. The HSE and Department of Health have launched a series of roadshows throughout England to raise the awareness of PCT Directors to health & safety issues and their responsibilities.

5.5 We would also identify lone workers as a particular challenge. Increasing numbers of staff work in the community, enabling patients to remain in their own homes with dignity. NHS organisations need to constantly update staff awareness and manage the risk in this area to achieve a balance between staff safety and patient choice and dignity.

6. Occupational Stress

6.1 The HSE has worked with a range of partners to develop standards of good management of occupational stress, which provides a useful tool for measuring performance against the risk factors. In addition, the HSE has published a report, "Interventions to control stress at work in hospital staff", which provides a number of examples of how sources of work stress were identified and managed in a number of hospital settings. We understand that practical guidance is planned for publication this year.

6.2 HSG 218 "Tackling Work Related Stress" was published in 2001, and "Real Solutions, Real People", a manager's guide was published last year—two of the case studies are from the NHS, and others involve public services. HSE inspectors have been encouraging trusts to assess the risk from work related stress during inspections, while recognising that this is a difficult topic for which there is little evidence based guidance or standards.

6.3 The NHS has responded by incorporating a number of health and safety [and in particular] occupational stress measures, into its CHI staff survey instrument launched in late 2003. Staff survey results were published by CHI in February 2004 for each NHS employer and these are now being analysed by each employer to inform local management action plans. The research evidence suggests that attention is most effective at the organisation level ie workload, working patterns, the level of support from line managers and clarity in terms of work expectations. A series of workshops for NHS managers has been implemented across the NHS to better understand the local strategies required. The local implementation of the "Improving Working Lives" strategy in all NHS organisations, is seen as a primary management strategy. Progress will be partly monitored through a repeat of the staff survey across the NHS later this year.

7. Agency Workers

7.1 The use of agency staff is common across the Health and Social Care sectors and in many cases essential to allow the consistent delivery of services to patients. Agencies used by the NHS are required to have appropriate arrangements for training their staff in health and safety and risk management, and to record and monitor contractors' health and safety performance. This area was identified by the National Audit Office in April 2003 as a key action for the Department of Health and NHS Trusts.

7.2 NHS Professionals came into being as a Special Health Authority in April 2004 and is responsible across the NHS in England for the employment of NHS temporary workers. Local regional offices of NHS Professionals work with local NHS employers in ensuring appropriate health and safety management arrangements for temporary workers, including nurses.

7.3 Further action is required on the part of the Department of Health and local NHS employers to ensure that contractors have appropriate arrangements for the health and safety of their staff whilst working on NHS premises.

8. The Provision of Occupational Health Services to Employers in General

8.1 The NHS has developed a comprehensive and sophisticated occupational health service provision and all NHS employees have access to occupational health support.

8.2 With the advent of NHS Plus, the Occupational Health expertise within the NHS is now being offered to an increasing number of small and medium employers. The Confederation supports this approach, particularly as it encourages the involvement of SMEs in the public health agenda.

8.3 However, we are concerned that most employees in the UK workforce still do not have access to occupational health services and believe that government should put a particular emphasis on requiring all employers to provide access to occupational health services.

9. The NHS Employers' Organisation

9.1 Finally, the NHS Employers' Organisation will come into being from 1 October 2004, hosted by the NHS Confederation. The EO will undertake a range of functions on behalf of NHS employers including pay determination and other employment issues. These functions will transfer from the Department of Health, together with the necessary resources. These functions will include health and safety, and the NHS Confederation looks forward to working with NHS employers and the HSE in developing effective management strategies to support the implementation of government policy. The Confederation is aware that the DoH is in the process of drafting a health & safety strategy and we look forward to co-ordinating employer's comments, once the strategy is published for consultation.

The NHS Confederation

28 April 2004

Memorandum submitted by National Centre for Independent Living

Our submission focuses on the particular health and safety challenges faced by disabled people and their care workers. It touches on the extent to which contracting arrangements are used effectively as means of promoting health and safety standards.

Who We Are

National Centre for Independent Living (NCIL) is an organisation of disabled people, working to promote independent living opportunities for disabled people of all ages. We are funded by the Department of Health to support the successful implementation of direct payments for care services. Direct payments allow disabled people and their families to receive cash in lieu of services. This enables them to organise services for themselves, in ways that suit them best.

Our comments focus principally on the interface between the health and safety of service users and the health and safety of front line care workers. They arise mainly from concerns over lifting and handling policies.

The Challenge about Lifting

Many disabled people use support services that involve some form of lifting and handling. Such support is often an essential requirement to enable people to go about their daily lives.

The people who provide this kind of support service—such as care workers, nurses, and personal assistants—are, rightly, protected by health and safety legislation. However, in recent times we have been aware of an increasing number of problems caused by over-restrictive interpretation of the relevant health and safety legislation.

Management of risk is an accepted part of providing services for disabled people. Risk to the individual includes not only of harm but also of loss of independence and social networks. For workers involved, emphasis has been on the risk of injury. The debate around lifting and handling (and some other aspects of health and safety) arises from a concern that the approach to these risks has become unbalanced.

A key element in the debate has been the imposition of "no lifting" policies by a range of agencies. These ban workers from any manual lifting, insisting on the use of hoists. This has developed to the point where "no lifting" has become the norm. The impetus for this development was concern among employers (particularly the NHS) about high rates of back injury in the workforce.

The negative effect of such bans on disabled people has been widespread. Disabled children have been prevented from going on short breaks or from joining in school activities. Disabled adults have been told they should wear nappies, rather than expect to be assisted to use a lavatory. Married couples have been told they must abandon their double bed and use single hospital style beds.

HSE Guidance

The relevant guidance is Handling Home care: Achieving safe, efficient and positive outcomes for care workers and clients (March 2002).

This says

> Over the past few years, some home care service providers have adopted "no lifting" policies and tried to justify this in terms of their duty to avoid manual handling activities. Where these policies operate, hoists are routinely prescribed for all moves and transfers irrespective of the wishes, and sometimes the needs, of clients. In some cases, clients unwilling to accept such care have had the service withdrawn and been left to cope as best they can. Such action is irresponsible and does not provide effective control of manual handling risk. The manual handling regulations cannot be applied arbitrarily to care plans in this way. It is also difficult to see how such action can be reconciled with responsibilities under the Disability Discrimination Act and the Human Rights Act.

The guidance goes on to stress that regulations do not prohibit all manual handling. It says there needs to be a balance in approach to ensure that:

> care workers are not required to perform tasks that put them and clients at risk unreasonably; and
>
> clients' personal wishes on mobility assistance are respected wherever possible.

HSE guidance gives several examples of how lifting can be safely managed, using appropriate equipment.

HSE advice also says

> The risk of manual handling injury can also be reduced by careful attention to the work routine. This will include considering the frequency of handling operations, the rate of working to optimise safety, flexibility of rest pauses and job rotation. (communication from Malcolm Darvill, HSE)

The Legal Position

What the law expects on manual handling was clarified in a case known as ABX&Y v East Sussex.

Key points from the judgement include:

> Blanket no lifting policies are almost certainly unlawful.
>
> Manual Handling regulations do not proscribe a "no risk" regime or a "risk elimination" regime, nor does the law require an absolute prohibition on hazardous lifting: it is a "risk reduction" or "risk minimisation" regime.
>
> Some manual handling is an inherent—and inescapable—feature of the task the personal care employee is employed to do.
>
> An employee whose job is to lift people may have to accept a greater degree of risk than one who is employed to move inanimate objects, while also recognising that an employee cannot be exposed to an "unjustifiable risk".
>
> All risk assessments must be based on consideration of individual needs and circumstances, including the physical, emotional, psychological and social impact on the disabled person of any proposed manual handling arrangements.
>
> (source: Disability Rights Commission)

Why Health and Safety Is a Disability Rights Issue

Institutionalised discrimination occurs when the values, structures and processes of an organisation result in disadvantage to or exclusion of a group of people. In the case of both the drafting and the implementation of the Manual Handling Regulations, a degree of institutionalised discrimination exists. A failure to anticipate that quite different approaches are needed to moving people as opposed to "loads" reflects a lack of awareness and concern of disabled people's situation among the drafters. A tendency to elevate the safety needs of the worker over the independence needs of the user, rather than approaching both in balance, reflects an attitudinal bias in favour of non-disabled people.

NCIL endorses the DRC view that

> Any discussion of the balance between the rights of users and workers must be set in the context of disabled people's right to social inclusion as well as their right to control their own living environment. (DRC response to HSE consultation, 2001)

Promoting Independence

All publicly funded social care services for disabled people have an explicit remit to promoting independence—particularly in respect of enabling greater flexibility, choice and control for users. (source: Modernising Social Services, Dept of Health, 1999)

Principles set out in the White Paper "Modernising Social Services" produced in 1998 include:

- Care should be provided to people in a way that supports their independence and respects their dignity.
- Services should meet each individual's specific needs, and people should have a say in what services they get and how they are delivered.
- People who receive social services should have an assurance that the staff they deal with are sufficiently trained and skilled for the work they are doing.

These principles clearly have an impact on decision making regarding moving and handling. Policies need to be compatible with independence and dignity; they should allow people a say in how services are delivered; staff should be sufficiently trained and skilled for the work.

There are other safety issues for disabled people using care services, that may or may not impact on their workers. People requiring assistance with intimate and sometimes invasive bodily procedures can be at risk if safe practice is not followed. Workers may also be at risk, for example of cross infection or needle stick injuries. It is vital that service users are involved as experts in planning and implementing risk management procedures. As noted above, usual health and safety policies do not readily allow for this. We have had reports of intrusive and inappropriate risk assessments being carried out in people's homes. Disabled people living at home do not want their homes turned into clinical institutions. The approach to health and safety in community settings needs to reflect this.

Reconciling the two aims—worker protection and user choice and control—is not unattainable.

Part of the problem in achieving balance is caused by the different philosophies informing the different laws. Health and safety law views work as the object, the worker as the subject. For social care, the user is the subject. And of course for people aiming to live independently, the impact of both policies is experienced subjectively. The challenge to campaigners and practitioners alike is to produce policies and practices that respond to individual circumstances:

The East Sussex judgement states:

> Any risk assessment needs to take into account the needs of the disabled person their Convention (and Charter) rights.

The current challenge is to bring everyday practice into line with this legal and ethical position. In particular, current training on lifting tends to focus on lift-avoidance rather than lifting as safely as possible.

Contracting Arrangements

It is important that contracting arrangements include specification for manual lifting where appropriate. At present, many agencies get round the requirement to train staff in this area by simply banning them from any lifting. This is not an acceptable position, following the East Sussex case, but we are aware that agencies continue to adopt this policy.

Paying for Health and Safety

Increasing numbers of disabled people arrange their own support via a direct payment for care services. (Note: quite different from a DWP Direct Payment.) If they use the money to employ a personal assistant (the most common use of direct payments) they take on responsibility for health and safety themselves. It is important that they have both adequate advice on managing risk and adequate funds to do this properly, whether for employing two workers for some manoeuvres or for training staff in safe techniques.

Conclusion

In conclusion, NCIL is concerned that health and safety in social care settings needs to be viewed holistically. The health, safety and wellbeing of both service users and workers needs to be taken into account. Where there is a potential conflict between the interests of the worker and the interests of the user (for example where manual handling is the best option for the user) its resolution must always focus on the aims of the service (ie independence for the user). This will require a new approach. The challenge in social care is to develop this new approach, in partnership with disabled people.

National Centre for Independent Living

28 April 2004

Memorandum submitted by the Association of Directors of Social Services

Thank you very much for the letter 30 March 2004, requesting information to assist the work of the Work and Pensions Committee inquiry into Health and Safety. As you indicated in your letter there was not a great deal of time to prepare a response on behalf of Directors' of Social Services, however I was grateful for the extension which has given me the opportunity to add some further points to this response. I am aware that there are some issues I will not have had time to collect during the last few weeks and it maybe that if the Committee wish to receive oral evidence there will be an opportunity to add further points.

There is no doubt that Health and Safety issues are of great importance in social care both in terms of protecting the vulnerable people with whom we work and also protecting staff in a very labour intensive industry.

There is evidence of vulnerable service users having died as results of accidents, eg scalding in over hot baths or being unable to move away from radiators and also as a result of the ingestion of chemicals perhaps insufficiently safe guarded in residential homes where people with dementia or learning disabilities are living. Although there are not many of such incidents clearly the relatives and carers have a right to expect that vulnerable people are protected and the balance between offering individual freedom, as far as possible, compared with the need to protect has been a dilemma for health and social care workers since the state first started to intervene in peoples lives in that way. Locking people in to prevent them putting themselves at risk will always be a significant civil liberties issue. It is not surprising therefore that having to get the right balance in these issues is also stressful for the staff with that responsibility.

Social Care staff have also been killed or seriously injured by service users perhaps sometimes because of there own mental ill health or sometimes because a service user was very angry with the worker, perhaps for not revealing where their wife and child was for instance. Social care workers visit people in their own homes in locations where other people would not choose to go at night and have to deal with unpredictable situations where police support may not be available or the luxury of having two staff may not be realistic.

Staff in residential children's homes in particular, but increasingly in residential homes for elderly people are also subject to physical and verbal assault, sexual harassment either because of the residents dementia or in the case of young people because they are not able to cope with the stress of having their actions controlled. They do not know how to deal with the emotions that brought them into care and they only know how to take that feeling of despair out on others. Staff in residential children's homes are very frequently assaulted and despite the availability of very useful training to assist staff to defuse situations the young people that we work with will continue to pose a significant challenge to staff.

Clearly in the area of moving and handling people both those who cannot move themselves or those who do not wish to move pose the risks of musculoskeletal injuries and again although there is significant training and an expectation that staff do not move heavy people without assistance from another person or a mechanical aide sometimes emergencies or accidents cause an individual to injure themselves.

An aspect to Social Services Health & Safety management that can prove to be challenging is the management of Health & Safety responsibilities with regards to externally commissioned services. Given that a great deal of Health & Social care provided by Social Services departments is commissioned from the independent sectors the duty of Social Services departments to ensure Health & Safety procedures are correctly followed in independent organisations is somewhat ambiguous. Certainly, recent conversations with the Health & Safety Executive have made it clear that a Director of Social Services cannot rely on the inspection regime to ensure that all reasonable Health & Safety procedures and practices are in place furthermore, the Health & Safety Executive raised concerns about the responsibility of Social Services departments for services provided by "the Direct Payments" arrangements where individuals purchase their own care services.

Long hours, demanding service users, frequent changes of structure, relatively high sickness levels and work that cannot be left all generate considerable areas of stress and it is known that levels of sickness are caused by stress. It is perhaps also noteworthy that where as in the past people might take a few days off when the job became overwhelming such periods of sickness are significantly longer often involving phased return to work partly because the agency needs to protect itself, once stress has been identified, from too quickly putting the person back in the same stressful situation. Inevitably when a person is away for such a reason the stress of their workload has to be carried by other members of the team either because agency staff are not available or the work cannot be left unattended.

Increased independence for vulnerable people carries more risk and if staff do not feel that their organisations or indeed legislation sufficiently protects them from reasonable decisions about risk then not surprisingly the stress of the job and indeed our ability to recruit staff may be increased. The needs of service users will not go away however, and caring for people in the community will pose as many risks and challenges as keeping them in institutions, perhaps more.

John Beer
Association of Directors of Social Services

27 April 2004

Memorandum submitted by NHS PLUS

Introduction

1. NHS Plus, launched in November 2001, was first described in a speech that Alan Milburn, the Secretary of State for Health, gave at the LSE on 4 March 2000. He linked ill health, absence, and consequent economic loss to a flexible and competitive business environment and the wider economy. He noted that some NHS Trusts were using their income generation powers to sell occupational health to non NHS employers, particularly small and medium sized businesses. He suggested that this was an excellent way of improving health, and hence economic health, while bringing additional resources into the NHS; he suggested that this service might be called "NHS Plus". There was strong support for NHS Plus from the relevant professional bodies, the HSE, the CBI, the TUC and other bodies dealing with small business (see annex 1).

2. In June 2000, a 10 year strategy for occupational health in the UK was launched. Under the title *"Securing Health Together"*, the Department of Health and other Government Departments signed up to five targets involving a reduction in work related ill health, a reduction in time lost from work through ill health and access to rehabilitation services for those temporarily or permanently absent from work.

3. Research commissioned by HSE (Contact Research Report 445/2002) demonstrated the lack of use of occupational health support by UK employers. Headline results were, unhelpfully, reported in terms of per cent of businesses, rather than the number of employees, who had access to OH support. Nevertheless, it is clear that while employees in most large companies were likely to have access to such support, in small and medium sized enterprises (SMEs-companies with less than 250 employees) only 2% of companies provided support. As 50% of the workforce are estimated to work in SMEs, it is clear that there is a large gap in provision of occupational health support.

4. As part of the NHS Plus project, improvements in access to occupational health support, particularly for small and medium sized enterprises was identified as a key action. NHS Plus was launched as a contribution to these targets. The publication of the NHS Plan endorsed the creation of NHS Plus and envisaged the creation of a national agency (see annex 2).

Current Position

5. NHS Plus is now a national network of about 50% of the NHS Occupational Health departments which:

- sells occupational health services to non NHS employers in both the public and private sectors;
- work to common standards that have been agreed with the relevant professions;
- have been accredited by their Trust's Chief Executive as continuing to provide an appropriate service to NHS staff;
- made a commitment to continuous improvement of standards.

6. NHS Plus provider units offer a full range of occupational health services including:

- Workplace risk assessment.
- Advice on the management of workplace risks.
- Pre-employment screening.
- Health surveillance.
- Immunisations.
- Medical advice on sickness absence or retirements.
- Vocational rehabilitation.
- Counselling.

plus a variety of other services such as training in manual handling or first aid and medical screening (including drug and alcohol screening), although as yet not all providers deliver all services.

7. In addition, NHS Plus publishes a website which:

- provides information to employers and employees. Many OH problems might be resolved by this means without the need for professional healthcare worker involvement;
- allows prospective customers to identify their local NHS Plus provider and their contact details.

8. NHS Plus has commissioned a number of projects to investigate new ways to provide, and increase the quality of, OH advice to the wider community:

- A study to investigate the feasibility of involving primary care is underway in Avon.
- A telephone helpline has been trialed in East Anglia.
- Two surveys of NHS plus providers have been used to design training programmes for managers of provider units.

— A programme to collate evidence based guidelines applicable to OH practice and to fund the development of additional guidelines.

9. For the first two years of operation, turnover on a like for like basis, as a surrogate of activity, has increased by 17% per annum from a base of about £12 million. It is recognised that this represents a small percentage of OH activity in England. Work over the last nine months has been directed at improving the delivery of OH in the NHS, in part to allow better and faster development of NHS Plus activity

DEVELOPMENT

10. NHS Plus depends for its success on the quality of occupational health (OH) services in the NHS but is also designed to improve those services. The National Audit Office report on occupational health and safety management in the NHS, while recognising the many excellent departments, described the overall provision of occupational health services as "patchy and variable".

11. Informal discussions with stakeholders have identified many of the difficulties with the current arrangements for the delivery of occupational health services in the NHS. A plan to improve such provision is nearing completion. In designing a more suitable structure for the delivery of OH services, and the development of NHS Plus, the following principles have been used:

— Equitable access to OH services for all parts of the NHS workforce.
— A management structure able to focus on the delivery of OH services.
— National quality standards but locally delivered services.
— Clarity of role for the different stakeholders.
— Changes to OH working practices to improve capacity.
— Allow the development of NHS Plus on a national scale to meet policy commitments.

12. NHS Plus should become one of the variety of providers of specialist occupational health support. There is no intention that NHS Plus should become the only OH provider. There is a need for a variety of OH providers, each with its own distinctive profile and expertise. In this way, those with the responsibility for ensuring that OH services are provided for their workforce can choose the model of provision that best suits their circumstances.

Dr Kit Harling MA FFOM FRCP FRPH
Director, NHS Plus

5 April 2004

Annex 1

Extract from A healthier nation and a healthier economy: the contribution of a modern NHS Alan Milburn MP, Health Secretary LSE Health Annual Lecture, 8 March 2000

THE HEALTH OF WORKERS

Indeed I think that we need to look to see what more the NHS can do here. An obvious area of potential is the sphere known as occupational health. The growth of the knowledge-based economy and the premium on retaining skilled labour means that employers—whether in the public or private sector—will face higher opportunity costs from sickness absence. They will also have to find new ways of retaining and rewarding their staff. Pay of course will be a key determinant. But people's career decisions are not simply crude financial calculations. Flexible working patterns will be important too, particularly for parents with young children. And so too will be facilities to maintain good health at work. As it is employees and their representatives are increasingly litigious about health and the workplace—so it is enlightened self-interest for employers to make sure that their own house is in order.

In the past "occupational health" has tended to have a heavy health and safety bent to it. The Health and Safety Commission will shortly publish proposals to modernise occupational health so that it is better suited to the needs of small and medium sized businesses.

The NHS has to make sure that its own house is in order on this issue. Healthcare is one of the biggest knowledge-based sectors of the economy, and we cannot afford to lose highly skilled staff. Quite the reverse. I want to expand the services that the NHS provides to make them faster and better for patients—and that relies on having more doctors, nurses and other health care professionals. Improving quality of working life in the health service is one of the factors that will help us expand staff so that we can expand services That is why I am examining how we can improve occupational health care services for our own employees whether in the primary, community or secondary care sectors.

There are some real beacons of good practice in the NHS. The Walsall Hospitals NHS Trust's Occupational Health Department for example looks after 6,000 staff at the trust as well as its neighbouring NHS organisations. Managers get pre-employment checks and staff get health checks, advice on health and

safety, health information, risk assessment, environmental health advice and stress management. But what is unusual here is that Walsall is also successfully marketing its services to both the public and private sectors, selling its occupational health services to the local university and to 12 small factories. It gets back enough money to break even. The Royal Berkshire and Battle Hospital NHS Trust generates £100,000 a year looking after employees in a number of small businesses and public sector bodies.

These two NHS organisations are making a tangible contribution to business. I am interested in exploring whether there is scope for the NHS more generally to provide similar occupational health services to employers. "NHSPlus" if you like. A service of this sort might be particularly valuable for small and medium-sized firms which lack the size to organise in-house services but where ill health amongst key employees can have devastating consequences.

Back pain and stress management services will be of particular relevance, as shown by the 19 "Back in Work" pilots that are now operating. Sandwell Healthcare NHS Trust, for example, is now working with small and medium sized businesses to provide early assessment and intervention for workplace back pain. Salisbury Healthcare NHS Trust is working with 300 local businesses in partnership with the local Chamber of Commerce.

And let's be clear about two things. First—providing these new services will potentially be good for the NHS, not a burden. Intervening to prevent and avoid injuries and sickness will have downstream benefits for the NHS in avoided GP appointments, outpatient attendances and hospital treatment. And second—these new services hold out the prospect of net savings to employers, not extra costs. What's more, as NHS waiting times come down for elective surgery, private employers will increasingly be able to free up the £1 billion-plus they currently spend on employee private health insurance, instead targeting that resource on more effective workforce health interventions of the sort that NHS Plus might provide.

There is then an intimate connection between good health, properly targeted health services and economic performance. So far my argument has focussed on three groups in the population. One—potential workers currently outside the labour market as a result of mutually reinforcing processes of social exclusion. Two—future workers, namely our children, for whom health and educational attainment are the routes to prosperity. And three, existing workers—and their employers—affected by sickness absence.

Annex 2

Extract from the NHS Plan Chapter 11

NHSPLUS

11.16 Working with the private sector is not just a one-way arrangement. The NHS also has a lot to offer industry and employers; ill health has a big effect on the economy. It has a cost in terms of lost productivity and—where the illness is severe or debilitating—can result in unemployment which in turn is a principal cause of poverty.

11.17 A total of almost a quarter of a million working years are lost through disease each year. The Confederation of British Industry estimates that temporary sickness costs business over £10 billion annually. The burden is born by employers and by the NHS too. Backpain accounts for 119 million days of certified incapacity. It also consumes 12 million GP consultations and 800,000 in-patient days of hospital care.

11.18 Individuals, business and government all have an interest then, in breaking the vicious cycle of illness, unemployment and poverty. Across the country, the NHS is already working in partnership with private sector employers to improve the health of their employees. There are managers receiving NHS pre-employment checks, other staff benefiting from NHS health checks, and a range of advice being given by the NHS on health and safety, health information, risk assessment, environmental health advice and stress management. Services of this sort are of particular benefit for small and medium-sized enterprises which lack the size to organise in-house services but where ill health amongst employees can have serious consequences. The NHS gets the benefit too, by intervening to prevent and avoid injuries and sickness before they occur.

Addenbrookes Hospital NHS Trust and Royal Berkshire and Battle Hospital NHS Trust currently make occupational health services available to small and medium sized enterprises in their areas—and cover their costs by charging employers for these services. Sandwell Healthcare NHS Trust is now working with small and medium-sized businesses to provide early assessment and intervention for workplace back pain. Salisbury Healthcare NHS Trust is working with 300 local businesses in partnership with the local Chamber of Commerce.

11.19 These partnerships will be extended. A new set of services, NHSplus, will be developed as part of this NHS Plan. A portfolio of NHS occupational health services will be identified which can then be bought, in whole or in part, by employers to improve the health of their employees.

11.20 NHSplus will be established as a national agency. The business plan for NHSplus will ensure these new services are provided at no cost to the taxpayer and will build upon local services provided by hospitals and Primary Care Trusts. Surpluses will be reinvested in the expansion and improvement of NHS services. NHSplus will be launched in 2001 and its coverage will develop as the capacity of the NHS expands.

Memorandum submitted by the Convention of Scottish Local Authorities

THE LEGISLATIVE FRAMEWORK

There is little doubt that the Health and Safety at Work, etc, Act 1974 has contributed to the significant improvement in overall health and safety performance in the UK. The "goal setting" approach taken by the Act and subsequent legislation has encouraged duty holders to take responsibility for health and safety performance. The development of health and safety strategies based on risk assessment, rather than prescriptive regulation, has undoubtedly produced innovative and effective approaches to health and safety management in those organisations that have the capacity and commitment to take such a task on.

There is, however, a growing body of evidence that indicates that this approach needs to be refined to meet the demands of the changing nature of industry and work in the UK. Enforcement officers in local authorities and HSE are very aware that the demand from small and medium organisations is for clear guidance, approaching prescription, on what to do to comply with the law. There is, in many cases, no capacity within smaller companies to provide, or buy in, the type of specialist advice and support required.

In relation to the division of enforcement responsibility defined in the Act and in the Enforcement Allocation Regulations, both HSE and Local Authorities recognise that the current divisions of responsibility are counter productive and confusing to businesses. A significant amount of work is going on at present to bring about a much closer working relationship between HSE and local authorities to address this. In the short term this should, arguably, involve the removal of barriers to joint working between the enforcement agencies.

ACHIEVING OUTCOMES

Revitalising. Whilst much good work is going on, the lack of clear baselines for the targets set by revitalising make it difficult to assess its success. It is likely that success, or otherwise, will have to be measured either against overall trends, or against industry specific initiatives (such as in the construction industry). The performance reporting framework applying to Scottish Local Authorities at present measures only input information—there is no reliable method of measuring output at present. Prevention/enforcement balance. Achieving a good prevention/enforcement balance is heavily dependant on officer resources. Prevention is much more time intensive than reactive enforcement but can have a much more sustainable effect on health and safety performance.

Local Authority Environmental Health Services have clear experience of this from their work in Food Safety enforcement, where significant improvements in compliance and performance have been achieved by proactive intervention over the last five years.

Those improvements have, however, been achieved by diverting Environmental Health Officers and other enforcement staff from other areas of work, such as health and safety, to food safety. Numbers of qualified EHOs and HSE inspectors are falling year on year with reducing numbers of students coming into the professions. If this trend is not reversed, lack of resources will force agencies to take a more reactive approach.

Penalties. The level of penalty is less an issue than the level of fine imposed on conviction. In general, the Procurator Fiscal Service and Sheriff Court system has difficulty in dealing with health and safety (and other non-police reporting agencies) legislation due to the significant demands placed on them in dealing with mainstream criminal cases, and to the complexity of both the legislation and the cases involved.

RESOURCES

Comment has been made above on the effect of resources on the balance between proactive and reactive approaches. The current HSC strategy makes a commitment to developing a meaningful partnership with local authorities that should optimise the resources available to both agencies. However, it is widely recognised that more resources, whether in enforcement officers, advice services or occupational health services, are required to achieve the further improvement in health and safety performance in the UK, particularly given the specific challenge of supporting the small and medium enterprise sector.

Communication/Co-ordination with the Scottish Executive

This has been an area of some difficulty for both HSE and local authority Environmental Health Services since the inception of the Scottish Executive. This is largely due to the fact that there is no one branch of the Executive which deals with Health and Safety or other Environmental Health issues and, therefore, discussions can involve many civil servants with competing agendas.

The situation has improved in the last two years following the Scottish Executive Health Department taking the lead on Safe and Healthy Working and, more recently, on the Healthy Working Lives proposal now before Scottish Ministers. There is now informal liaison between HSE, Scottish Executive Officials and the CoSLA Health and Safety advisor, which should provide the basis for improved liaison in future.

Performance Indicators for Local Authority Health and Safety Performance

The Accounts Commission currently has a transitional performance indicator for health and safety enforcement performance in Scotland. As mentioned above, this indicator measures input, in the form of number of target inspections achieved against a pre-planned programme, rather than output. As the targets set by the indicator are not based on a national benchmark, there is no meaningful comparison of the relative performance of the 32 local authorities in Scotland. However, some local authorities argue that, if it were not for the requirement to report on this indicator, there would be pressure to divert more resources from health and safety enforcement to other areas which are the subject of public performance reporting.

The Local Authority Unit (LAU) of HSE are in discussion with the Accounts Commission about the development of output indicators for local authority enforcement, based on the mandatory guidance issued by the HSC under section 18 of the Act.

Consistency and Effectiveness of Local Authority Enforcement

There is a strong network of enforcement liaison groups operating in Scotland, which exists to share best practice in enforcement practice. All local authorities in Scotland are participating in peer review audits of health and safety performance, in compliance with Section 18 guidance. National co-ordination of health and safety performance is managed through the Health and Safety Co-ordinating Committee (HASCOG). All four enforcement liaison groups are represented at HASCOG, as is the Society of Chief Environmental Health Officers and Scotland, HSE and the Scottish Centre for Infection and Environmental Health.

Cllr Alison Hay
COSLA

5 May 2004

APPENDICES

REVIEW OF THE RELATIONSHIP BETWEEN HEALTH AND SAFETY EXECUTIVE AND LOCAL AUTHORITIES

Draft Consultation Response

CoSLA welcomes the opportunity afforded by this consultation to comment on the future of the relationship between HSE (and HSC) and local authorities in the vital process of protecting and improving the health and safety of the working population. CoSLA is committed to developing local authorities as health improvement organisations and is keen to maintain meaningful relationships with the Scottish Executive, health boards, and other relevant organisations, to that end. Workplace health and safety is seen as an important area in meeting the aims of the health improvement agenda in Scotland, most importantly in reducing work related accident and ill health, but also for the potential opportunities afforded in improving links with employers and employees to address other health and lifestyle issues.

The Scottish Executive has prioritised workplace health and safety within the general public health agenda. In the recently published "Health Improvement Challenge"', ministers have targeted the development of a strategy to promote "healthy working lives" by October 2003. This concept includes work related ill health and accident prevention, capability and rehabilitation and the maintenance and promotion of physical, social and mental capacity such that an individual can be economically active throughout their working life.

A particular feature of the Scottish local authority context is the devolution settlement. The fact that Health & Safety enforcement is a reserved power, but that the funding of local authorities which carry out this function is determined by the Scottish Executive, introduces complications when it comes to assessing and directing resources to this issue in a devolved context.

It is CoSLA's position that the partnership working suggested in the consultation document must include working closely with the Scottish Executive (and Welsh Assembly) in order, both, to address the issues of provision and direction of funding, and the integration of Scottish Executive initiatives relating to health protection and improvement in the workplace, into the overall strategy.

In relation to the specific questions raised in the consultation, our comments are as follows.

1. *Should there be partnership in this area? What should the nature of that partnership be?*

Undoubtedly there should be partnership between local authorities and HSE and the Commission. The nature of that partnership, however, must reflect, and better utilise, the particular strengths of local authorities, ie their:

- Local accountability.
- Strong and widespread contacts with local business.
- Their ability to utilise other interventions such as licensing, planning and building control, and economic development to influence health and safety awareness and practice.

There is a clear need for correlation between the work of HSE's own inspectorate and the local authority inspectorate. There is an obvious potential for maximising that common resource, through joint resource planning against jointly agreed and fully resourced outcome targets and with equal access to the technical and scientific resources of the HSE.

Local authorities should also be full partners in the development of health and safety policy. The currently "paused" (pending the outcome of this consultation) strategic review of HELA will address this issue specifically, however it is clear that the relationship between HELA and HSE has to be improved to enable local authorities to make a full contribution towards the initiation and development of policy, rather than simply providing a reactive workforce.

With regard to the differing approaches to the operational delivery of health and safety detailed in Annexe 1 of the paper, we would strongly favour Approach three. This option allows for the flexibility that will be required to respond to local and national priorities. Joint resource planning, risk prioritisation and programme working, against jointly agreed and fully resourced outcome targets would enhance the ability of both HSE and local authorities to tackle health and safety issues. Taking such an approach in Scotland would also allow for closer integration with Scottish Executive programmes and priorities, and capitalises on the strengths of both partners. A number of legal and operational issues will have to be resolved to implement this proposal, however none of these seem insurmountable. This approach also provides the potential for improving the interface with the business community, trades unions and other stakeholders.

However, our support for Approach three is tempered by the need for further information on the suggestion that "local communities" would be involved as stakeholders within project boards and projects. There are very significant implications for governance and accountability to be addressed before this could be taken any further.

2. *How should local authorities' performance on health and safety enforcement be measured?*

Audit Scotland currently has a transitional public performance indicator for local authority health and safety performance. This records what percentage of businesses are included within the authority's risk rating programme and what percentage of businesses due for inspection in each risk category are actually inspected in any one year, against the locally determined target inspection frequency. All authorities in Scotland use the same risk-rating scheme, however there is variation in the locally determined inspection frequencies, and number of risk categories. No comparison can be made, therefore, of the relative performance of different authorities.

This type of numerical, input based performance indicator is counter productive and mitigates against special projects or changing of priorities during any year, as work done in these areas cannot be credited against the indicator.

In order to provide the operational flexibility required to meet the changing priorities in health and safety enforcement, performance indicators must be devised which measure the effectiveness of actions ahead of the number of visits to premises. The performance measures detailed in the current Section 18 guidance to local authorities on inter authority auditing (which concentrate on management arrangements, competencies of inspectors, procedures and policies for carrying out an effective enforcement service) provide a basis for such indicators. Some quantitative context to a national performance indicator is also required, however, but this can only measure comparative performance against national minimum inspection frequencies and risk categories. Outcome targets, perhaps based on the current Revitalising Targets, including the capacity to record and be credited for work on special projects or initiatives, should also form part of the performance framework.

This should be progressed by the development of an agreed National Performance Framework for Health and Safety Enforcement. It is vitally important, in the interests of a meaningful partnership between the HSE and local authorities that such a performance framework should also apply to HSE's activities.

The development of the partnership working described in Approach Three in Annexe 1 to the paper would not be possible without such a common performance standard.

Monitoring of performance against such a national framework would require third party auditing of both local authorities and HSE.

3. *What should be the consequences for poorly performing authorities?*

The Commission already has powers of intervention, which are similar to those granted to the Food Standards Agency. These powers allow the Commission to intervene where the performance of a local authority is unacceptable and make arrangements, at the authority's expense, to carry out the health and safety responsibilities of that authority.

4. *What should be the role of HSE in tErms of Capacity building?*

Our favoured partnership (Approach three) would, if operated as envisaged, give local authorities access to HSE's scientific, technical and other specialist resources. For this model to work effectively, both HSE and local authority staff would be utilising the same computer database systems, have access to the same technical advice notes, and so on. In short, the role of HSE in terms of capacity building should be to make no differentiation in the resources offered to it's own inspectorate and that of local authorities.

In terms of capacity building on policy and strategic issues; again the HELA review will address this. It is anticipated however, that HELA would enjoy the same level of support from the specialist division of HSE as the HSE Board and Commission currently enjoy.

5. *Is enough being done to iNtegrate Health and safety into local authority priorities?*

As can be seen from comments made above, the issue of workplace health and safety is an aspect of a number of key agendas, including health improvement and Community Planning. The "power to advance well being" recently conferred on Scottish local authorities is also relevant in this context.

There is, however, difficulty in raising the profile of health and safety enforcement within the competing priorities of the 32 unitary authorities in Scotland. The formation of the full partnership approach discussed above would do much to enhance that profile and allow a consistent approach to integration into local priorities such as Community Plans and Joint Health Improvement Plans. The creation of a formal National Framework Agreement in the terms discussed above would also do much to aid this process.

6. *What is successful and what is not?*

As discussed above, the current input based performance indicator used in Scotland is not conducive to innovative working, as it does not recognise the diversion of resources from inspections to other forms of intervention.

Nonetheless, there are innovative approaches to health and safety both in Scotland and in the rest of the UK. The success of the dry cleaning synergy project in Scotland is a good example of joint resource planning between HSE and local authorities and which also involved the industry sector in the project and in training provision.

An example specific to Scotland of taking a different approach to providing advice services to SMEs in particular is the "Safe and Healthy Working" project, which is funded by the Scottish Executive and provided via the NHS in Scotland. Local authority and HSE officers have been involved in the design of the project and continue to be involved in its implementation and evaluation. The full evaluation of the project may provide an insight into new ways of working successfully in this sector.

There is a need to provide a forum in which best practice, whether in the local authority sector, HSE or elsewhere, can be shared and developed—the suggested partnership model would provide such a forum and joint resource planning would enable that best practice to be promulgated more effectively.

Priorities. The issue of allowing sectors of business to self regulate can be attractive but requires further examination. Prioritising inspection intervals by risk, if done across the whole "risk continuum" (ie both HSE inspected and Local Authority inspected businesses) would naturally concentrate current resources on the areas of greater risk. Experience of self-regulation systems in other areas of legislation—for example the "deemed to specify" regime for noise insulation in the Building Regulations—indicates the pitfalls of self-assessment.

The experience of local authorities in making Lead Authority Partnership Agreements with businesses, has, on the whole been positive but is resource intensive. This could be developed into a system closer to self-assessment but which would still be under independent scrutiny. Such a system may include companies publishing an annual report on health and safety performance and subjecting themselves to a third party audit, the results of which would be available to enforcement agencies.

Other interventions do need to be explored and the evaluation of the Safe and Healthy Working project in Scotland may provide some indication about the efficacy of different approaches. However, the crucial aspect to the success of any new technique is consistent application and proper resourcing. Again, the partnership model discussed above provides an opportunity to maximise current resources to that end.

7. *How do local authorities and HSE ensure that prioritisation is effective and coordinated?*

As discussed above, by joint resource planning measured against a national framework agreement for health and safety performance, which is common to both HSE and local authorities.

8. *How could communications be improved? How can local authorities be more involved in the early stages of creating policy that affects tHem, Recognising the obviously difficulties of the numbers of local authorities involved?*

As is discussed above, the review of HELA will address these issues. Communications can be improved by the joint resource planning approach, and the enhancement of the status of HELA will assist in involving local authorities in the development of policy. The development of local authority liaison and co-ordination at regional level, the sharing of resources and clear lines of two way communication between regional groups, the HELA technical sub committee and HELA, should provide a robust communication system which is capable, both, of identifying prospective policy issues and disseminating information consistently.

Review of the Relationship Between the Health and Safety Executive and Local Authorities Additional Comments on the Final Draft

Would it be preferable for there to be a single health and safety enforcement body?

CoSLA does not support the creation of a single enforcement body. The creation of such a body would either dilute the current "economies of scale" of HSE's resources or lose the vital local accountability and responsiveness, which are the strengths of local authorities.

Working in Communities, Involving Communities

Much reference is made to issues of community involvement and accountability. It is presumed, but far from clear, from the context of the paper, particularly the section headed "Synergies", that the communities referred to are the proposed regional assembly areas in England, plus Scotland and Wales, although the term seems to be used elsewhere in the document to refer to much smaller units, particularly where linkages are made with community planning, which is carried out on a local authority area basis.

To avoid confusion, CoSLA's position is as follows.

Health and Safety can best be dealt with in Scotland by the formation of a formal partnership between local authorities and HSE Scotland on the basis of joint national resource planning, risk prioritisation and programme working, against jointly agreed and fully resourced outcome targets. This partnership should also include the Scottish Executive, to ensure that synergy is achieved with programmes (such as health working lives, safe and healthy working and with the NHS occupational health service), which address the health improvement agenda in Scotland and with the national economic development agenda.

Integration of these targets into truly "local" community plans will be enhanced by this approach whilst retaining the flexibility necessary to respond to local issues. Engaging key sectors of the community, such as employers' organisations, small businesses, trades unions etc, would be enhanced by the ability to involve them at several levels, ie national (or in England, regional) regional (ie west of Scotland, Edinburgh and Lothians) or, where appropriate, at local community level.

Neither HSE, local authorities, nor the various communities and organisations with which we jointly have to consult and involve, have the capacity to focus that interaction solely through community strategies.

Improvement in communications and involvement of local authorities in the early stages of creating policy.

CoSLA strongly supports the role of the Local Authority Unit in providing support, guidance to local authorities and in representing the local authority perspective within HSE and would anticipate an continued and enhanced role for the unit in the future. CoSLA also supports the draft proposals for the review of HELA and of its relationship with HSE and HSC as outlined in the report to HELA of 19 June 2003.

John Arthur
COSLA

15 August 2003

The view from local government—CoSLA's perspective on the future of local authority health and safety enforcement.

Cllr Allison Hay

The protection of people at work, and the development of modern working practices and workplaces to promote retention, inclusion and rehabilitation of all working age people, are amongst the core values of

local authorities in Scotland. Just as the Commission, in its Vision Statement published in March 2003, wish to "gain recognition of health and safety as a cornerstone of a civilised society", so Scottish local authorities wish to make a full contribution to establishing that cornerstone.

This is not a new challenge. The foundations of local government were laid by the great public health reforms of the 19th century, which had at their heart, the regulation of working hours, protection from adverse conditions at work and controlling the harmful effects of some industries on the local population. Then, as now, these duties were shared with a central government agency. Then, as now, new ways of working were required to meet the challenges and effect beneficial change.

In 21st century Scotland local authorities now have a "new" duty to promote well-being, and are working in partnership with our local health boards to maximise the potential of both organisations in health improvement and protection. The Community Planning process in Scotland engages all public sector agencies in directing existing resources in the most effective manner possible towards the common goal of supporting the economic and social regeneration of Scotland. All local authorities are engaged in Joint Health Improvement Planning with their health boards to support this process.

Against that background, the publication of the Commission's "Strategy for Workplace Health and Safety in Great Britain to 2010 and beyond", is timely, and CoSLA is gratified to see that, perhaps for the first time, local authorities are given "equal billing" with HSE throughout the document.

That, in itself, is an important statement of intent. The development of a true partnership between local authorities, HSE and the Commission will be the catalyst that will bring about the change required for the health and safety system in Great Britain to remain effective and relevant. It will also, in CoSLA's view, be the key to identifying and supporting hard to reach groups, such as SMEs, and in developing effective intervention strategies and support for retention, rehabilitation and inclusion programmes

Local authorities have an unparalleled knowledge of, and empathy with, their communities. In our Environmental Health Officers and Enforcement Officers we have a skilled workforce which has many points of contact with the local business community and which has a significant track record of partnership working with health boards and a range of other agencies in developing new and effective ways of delivering advice, enforcement and support.

We also have a range of other functions, including economic development, planning and building control and licensing, which have the potential to offer other avenues of influence and advice, which would contribute to the overall strategy.

The critical issue in harnessing the skills, attributes and potential of local government, however, is the development of a transparent partnership of equals which will maximise the contributions of both HSE and Local Authorities without diminishing the unique characteristics of either.

In responding to the Commission's earlier discussion document reviewing the relationship between HSE and local authorities, CoSLA promoted a regional structure, which allowed joint planning of resources against common outcomes. We also promoted a much closer partnership with HSE, including the elevation of the status of HELA from a liaison committee to a strategic body capable of initiating and developing policy.

A number of practical issues will have to be addressed to allow this partnership to reach its full potential; these include:

- Joint resource planning, risk prioritisation and programme working informed by local and national priorities and targets.
- Jointly agreed common outcome targets for both HSE and local authorities.
- Development of a national performance framework for health and safety performance, which applies to both local authority and HSE activities to provide a common measure of performance.
- Equal, and seamless, access for local authority officers to HSE's training support, research and other "back office" resources.
- Development of common information and data systems.

Taking such an approach in Scotland would also allow for closer integration with Scottish Executive programmes and priorities, and capitalises on the strengths of both partners. A number of legal and operational issues will have to be resolved to implement this proposal, however none of these seem insurmountable. This approach also provides the potential for improving the interface with the business community, trades unions and other stakeholders.

A particular feature of the Scottish local authority context is the devolution settlement. The fact that Health & Safety enforcement is a reserved power, but that the funding of local authorities which carry out this function is determined by the Scottish Executive, introduces complications when it comes to assessing and directing resources to this issue in a devolved context. It is imperative that the Scottish Executive is fully engaged in the delivery of a new strategy for Health and Safety in Great Britain.

Scotland has the unenviable reputation of having the worst health record for its working age population in Europe. The Scottish Executive has responded to this by prioritising the workplace as a major area where proper intervention can address work related injury and ill health and other lifestyle issues. In the recently

published "Health Improvement Challenge", ministers have targeted the development of a strategy to promote "healthy working lives" by the end of this year. This concept includes work related ill health and accident prevention, capability and rehabilitation and the maintenance and promotion of physical, social and mental capacity such that an individual can be economically active throughout their working life.

CoSLA is playing a full part in the development of that concept as it has in the recently launched "Safe & Healthy Working" project which provides a first stage occupational health and safety advice service to SMEs through NHS occupational health services.

These projects have a clear resonance with the Commission's strategy for the future —is it too radical to suggest, therefore, that they, and the work of organisations such as Scotland's Health at Work, and NHS Health Scotland's Workplace Health Team should be part of the regional arrangements for joint resource planning and service delivery with local authorities and HSE also?

By doing so, we would have the beginnings of a framework, which has the potential for meeting many of aspirations set out the Commission's strategy.

Finally, I would like to comment on the issue of resources. CoSLA is very aware of the many competing demands for scarce resources in local government, this is particularly acute for the 32 unitary authorities in Scotland given the large range of responsibilities they have.

We acknowledge that the overall level of resource for health and safety is unlikely to increase significantly and are hopeful that the partnership working suggested would bring some efficiencies to make that resource go further.

The Minister acknowledged the pressures on local government to shift available funding to high profile subjects which are in the public eye, and much has been made of the argument that Food Safety has drained, and continues to drain, environmental health resources away from health and safety work.

CoSLA would suggest that an important development in reversing this imbalance can be addressed at Central Government level by implementing "joined-up government" in a way that assesses the relative importance of health interventions to the improvement of public health as a whole, and directs resources, or at least prevents the distortion of existing resources, to those areas.

Local government can indeed contribute hugely to the health and safety agenda and help to achieve the commission's vision for the future. I would go further to say that the contribution of local government is crucial to that vision. CoSLA, on behalf of Scottish Local Authorities is committed to playing a full part in that partnership.

Liaison Arrangements in Scotland

Since local government reorganisation in 1996, all 32 councils in Scotland are unitary authorities, discharging all the services formerly provided by Regional and District Councils. Health and Safety enforcement continues to be carried out by Environmental Health Officers although Trading Standards Officers continue, in most Council's, to be involved in the health and safety aspects of petroleum licensing and explosives (fireworks) control. In most Councils in Scotland, Environmental Health and Trading Standards operate within the same service.

The Royal Environmental Health Institute for Scotland (REHIS) provides the secretariat for the primary liaison committee, HASCOG (health and safety co-ordinating group), which is attended by representatives of the four regional liaison groups (North of Scotland, West of Scotland, Lothian and Borders and Central, Fife and Tayside). The officers attending are all directly involved in operational issues in health and safety enforcement. In 2001, the constitution of HASCOG was changed to allow the Society of Chief Officers of Environmental Health in Scotland (SCOEHS) and HELA representatives to attend to improve the flow of information across Scotland. The Local Authority Unit of HSE also attends the quarterly HASCOG meetings.

HASCOG's primary aims are to enhance the efficiency and effectiveness of health and safety enforcement and advice across Scotland by sharing information, training and experience. An annual residential Health & Safety Update course is organised by REHIS for all local authority health and safety enforcement staff.

The Royal Environmental Health Institute of Scotland

REHIS is the body responsible for prescribing and maintaining the professional standards of Environmental Health Officers. Although REHIS maintains close ties with the Chartered Institute of Environmental Health (CIEH) it is a wholly independent organisation. REHIS sets the professional standards, examinations and CPD requirements of all EHOs qualified in Scotland and agrees competence equivalencies for EHOs qualifying elsewhere and wishing to work in Scotland.

REHIS also provides a wide range of business and community training through accredited training centres, including basic, intermediate and advanced certificates in health and safety at work.

THE SOCIETY OF CHIEF OFFICERS OF ENVIRONMENTAL HEALTH IN SCOTLAND

SCOEHS represents the strategic and policy interests of the Environmental Health Service in Scottish Local Government. Members are drawn from the most senior EHOs in all 32 Scottish Local Authorities and provide professional support to CoSLA on all Environmental Health issues. CoSLA advisors, including those to HELA (Joint HSE/LA enforcement liaison committee), are nominated by SCOEHS.

The Society's strategy document includes the following statement on health and safety:

Securing safe working conditions and promoting health and safety are core activities of the Environmental Health profession. To take these activities forward:

The Society is committed to working in partnership with all relevant agencies, and with the business community, to ensure the effective targeting of resources towards the improvement targets set out in the HSE's agenda on Revitalising Health and Safety and Securing Health Together;

- The Society will provide technical and professional support to CoSLA, the Scottish Executive, HSE and other relevant agencies to further the aims of these strategies, and of the role of local government Environmental Health Services in delivering them and in developing the agenda.
- The Society fully support both the HELA Strategic Plan 2001–04 and the HSC's Strategic Plan 2001–04 and has set its members the following priorities to that end:
  - Ensure the effective management of the health and safety enforcement function by local authorities;
  - Pursue a compliance agenda which concentrates on key risks/hazards;
  - Provide a new focus on local authorities' contribution to occupational health, and;
  - Undertake full engagement of stakeholders, particularly small firms.

HEALTH AND SAFETY INITIATIVES IN SCOTLAND

The Synergy Project (pilot transfer of enforcement responsibility from HSE to Las) on retail dry cleaning businesses has been a significant success with both the industry and EHOs, due, in no small part, to the strong leadership show by Glasgow City Council in co-ordinating the transfer, training and ongoing monitoring of the project. The response from the industry has been particularly positive. Further initiatives have included the organisation of operator training for small independent businesses in the West of Scotland. The project is a good example of Industry, HSE specialists and LA enforcement officers working together to provide a more focused advice and enforcement service.

Edinburgh City Council have pioneered research into the health and safety issues around body piercing and have successfully referred a case under the section 3 of the Health and Safety at Work etc Act 1974, the Management of Health and Safety at Work Regulations, and COSHH regulations. This resulted in the first successful criminal prosecution of a body piercer in Scotland. The Scottish Executive is now considering licensing tattoo and body piercing in Scotland, in close consultation with CoSLA and LA enforcement officers.

SUPPORTING SMALL FIRMS

The Scottish Executive, following consideration of a multi-agency report introduced a service to deliver occupational health advice to SMEs. CoSLA, through its Health and Safety Advisor, was represented on both the multi-agency working party and continue to be involved in the national steering group and the team carrying out the evaluation of the project. Safe and Healthy Advisors are employed by Health Boards (one advisor works out of a local authority Environmental Health Service), however there is a close working relationship with both LA enforcement staff and HSE officers.

Revitalising Health and Safety—partnership working. Angus Council's EHOs are currently working with Angus Community Safety Partnership to provide risk-based training on the management of violence and the promotion of security within the workplace. Advice to businesses will be targeted through statistics gathered by the Police and Health Board relating to violence in the workplace. Perth and Kinross Council have recently approved a report linking occupational health and safety and other health and social objectives both at national and local level. The report recommends the establishment of working partnerships within the Health for All framework to progress the Revitalising agenda.

Discussions are currently underway with six Local Authorities to develop a closer working relationship between HSE and Environmental Health Services. Projects under discussion range from joint working on specific topics (such as violence at work) to examining ways of improving service delivery to SMEs and other difficult to reach groups.

Convention of Scottish Local Authorities (CoSLA)

6 May 2004

Memorandum submitted by Federation of Small Businesses in Scotland

Introduction

1.1 The Federation of Small Businesses (FSB) is the UK's leading non-party political lobbying group for UK small businesses existing to promote and protect the interests of all who own and/or manage their own businesses. With over 185,000 members, the FSB is also the largest organisation representing small and medium sized businesses in the UK.

1.2 The FSB broadly supports the changing strategy of the HSC/E. We agree it is in the interests of business for a focused, streamlined and well-resourced HSC/E structure to successfully develop to 2010 and beyond.

1.3 Our evidence highlights the small business view on the balance between prevention and enforcement, the success of the HSC/E in engaging with the small business community and encourages a review of the Revitalising targets. We also discuss general small business awareness of the complexities of health and safety regulations, the new emphasis on health in the workplace and the ability of the HSC/E to deliver on its strategy with existing resources.

1.4 The majority of small businesses want to comply with health and safety legislation and consult with their employees on best practice in the workplace for a productive workforce and business. However, SMEs are not always well resourced to deal with the complexities of health and safety and do not necessarily see the HSE as the first point of contact. Small businesses are most concerned about enforcement and the inconsistency of inspections and inspectors at a localised level.

The Balance Between Prevention and Enforcement

2.1 Small businesses primarily see HSE and local authorities (LAs) as enforcement, rather than guidance bodies. The majority of small businesses are inspected by LAs, with the exception of those in high risk sectors.

2.2 While it is important to maintain a healthy and safe work environment, we would like to see a formal agreement within the HSC/E and LA partnership as to the level of responsibility public authorities have for the protection of workers and the level of responsibility employers must assume. Small business would not support increased levels of enforcement, through additional bodies filling the gap left by the HSE and local authorities.

2.3 Local inspectors and inspection rates remain a concern for small businesses. Anecdotal evidence suggests that small businesses perceive inspectors to be removed from the realities of the workplace. Business finds the inspection process inconsistent and believes inspectors are too quick to enforce, rather than offer advice and check at a later stage if this has been completed.

2.4 As one FSB member suggested, "with each inspection comes a different inspector, looking for different things than the last one. They rarely check our progress from the previous inspection and the worst of it is that they don't understand the industry. My experienced workforce have to explain good health and safety practice to them!"

Engaging with the Small Business Community

3.1 According to DTI figures, there are 3.7 million small businesses in the UK today. It is a huge task to reach all of them and the HSE is to be commended for its recent consultation with stakeholders such as ourselves on how best to target this "hard-to-reach" market.

3.2 However, the FSB 2002 "Lifting the Barriers to Growth" survey suggested that only 13% of small businesses access advice on health and safety.

3.3 Recent statements from the HSC/E suggest the need for a separation of its guidance and enforcement functions. The FSB supports this exercise in theory, however we would advise the HSE to choose its disseminating bodies carefully. "Lifting the Barriers" also noted that only 14% of our members access central Government business support, which included the HSE. More importantly, only 10% of our members recorded a level of satisfaction with the service they received from these bodies.

Revitalising Targets

4.1 The FSB agree there should be a formal review of the "Revitalising" targets and determine if these are still relevant in today's changing world. The current targets are broad and we see a need for developing more robust and extensive future targets, which are business, rather than enforcer focused.

Small Business Awareness of Health and Safety Legislation

5.1 Evidence suggests the majority of small businesses are aware of the major pieces of legislation under which they are expected to operate. However, the consistent increase of regulations from both the EU and UK is a growing concern for small businesses. Small businesses continue to suffer under the burden of regulation and enforcement of their health and safety policies.

5.2 It is unlikely that the majority of smaller businesses will actively seek out the HSE to check if there is new legislation they need to be aware of. Generally, this information is disseminated through the HSE and bodies such as local authorities and ourselves. However, as we have previously suggested, such dissemination does not reach all 3.7 million businesses in the UK.

5.3 In many situations, an enforcement notice is the first time an employer is made aware of new responsibilities. Therefore, rather than the traditional "stick" approach, the average small employer would respond more positively to official recognition that while they are following the "spirit" of the law, they are not following the letter. If this were followed by an opportunity to improve the workplace voluntarily, employers would be more likely to undertake change in a positive manner. Further, it highlights the importance of health and safety as a business benefit, rather than a regulatory burden.

A Wider Health Agenda

6.1 A major issue for small businesses will be how the HSC/E tackles new and complex health issues. It is in the interests of business that there is a focus on issues such as occupational health.

6.2 However, the lack of robust statistics may misinform future policy developments, conflict with business priorities and lead to further, and burdensome regulations. Therefore, the FSB would encourage further statistics be gained before any targets to tackle additional areas such as, managing rehabilitation in the workplace are set.

6.3 Occupational health expertise will presumably remain with the DoH and NHS. However, with the European model encouraging in-depth research and an emphasis on psychosocial harms, there are likely to be further Directives and the costs are likely to effect business.

6.4 If there is to be HSE involvement, we would caution it not to burden small business unnecessarily in terms of cost and to influence the NHS and DoH into adopting the same policy. Employers must buy into the issue on a voluntary basis, trusting in its credibility.

6.5 The HSE must also ensure the message on occupational health is simple and accessible, although we are aware that the link between ill health and the workplace is becoming less defined. The HSE itself suggests that ill-health may results from a combination of occupational and non-work causes. Therefore, the limit of employer responsibility for health in the workplace should be defined as clearly as possible.

6.6 The HSE, NHS and DoH may decide to pool resources, expertise and policies in order to deliver a streamlined and simple service. However, would such a package detract from current provision of public health services, or strengthen them? If it is to be the latter, the cost to small businesses should be minimal.

Delivering on Current Resources

7.1 The HSC/E must judge the likelihood of risk within both the public and private sector and reallocate resources appropriately. However, SMEs would be reluctant to support public service best practice management at the expense of resources being devoted to making the private sector compliant and viable.

Additional Concerns

8.1 The proposed move towards an HSC/E that is a focused, guidance led body constantly reacting to a changing world is a positive one. However, the effectiveness of the new strategy could be undermined if other equally important issues are not addressed:

- The existing role of employers and the resources they are voluntarily committing to develop safe and productive workplaces;
- The continuing influence of the EU in UK health and safety practices and the HSE's ability to influence this;
- The disproportionate effect new policies will have on small businesses. We encourage the HSE to complete a regulatory impact assessment on any proposed changes that will affect small businesses, concentrating on potential costs and effect on productivity.
- Other stakeholder interests. Refocusing and entering new areas of health and safety will require new partnerships. Business continues to question whether the HSE is always the best body to deliver change and opening up to partnership could deliver effective use of resources and expertise. For instance, tackling new and complex health issues would be more effective if, like the Scottish and Northern Ireland models, HSE were a partner in developing policy, rather than the main enforcement body.

Federation of Small Businesses of Scotland

6 May 2004

Memorandum submitted by National Care Homes Association

1. Introduction

1.1 The National Care Homes Association (NCHA) is a not for profit organisation representing providers of residential and domiciliary care to vulnerable members of our society, throughout the United Kingdom.

1.2 NCHA has a Board of 10 Directors who assume strategic responsibility for the Association, whilst the Chief Executive Officer undertakes all operational responsibilities for the Association based at the London Headquarters.

1.3 All Directors are volunteers and are either currently providers of care or have been providers.

1.4 The Association represents approximately 4,000 providers and works closely with its local Associations to ensure that both local and national agendas are addressed at all times.

1.5 NCHA has been at the forefront of many initiatives promoting good practice, with members of the Board and the Chief Executive representing the sector on various Taskforces, Steering Groups, Workforce Development Partnership Boards and Training Bodies.

2. The Legislative Framework

2.1 The health and welfare of vulnerable people receiving services must be paramount in the delivery of the service. The Health and Safety at Work Act 1974 and the subsequent regulations have played an important part in protecting vulnerable service users in the social care sector and the care staff.

2.2 Legislation however, must also recognise that the promotion of independence for clients is an integral part of the agenda.

2.3 A balance must therefore be reached at individual service user level through individual risk assessment.

2.4 Issues surrounding the safety of staff at work are a taxing matter as it has a direct impact on the cost of insurance for providers.

2.5 The litigious culture, which is developing in the United Kingdom, has had some negative impact on the provision of the service.

2.6 There is no doubt that awareness of issues raised by the Health and Safety Executive (HSE) and the Health and Safety Commission (HSC) have had an impact on the care sector.

2.7 What is rarely addressed however is the financial implications of the requirements.

2.8 For the sector the Care Standards Act 2000 places some responsibilities on the Commission for Social Care Inspection to ensure that Health and Safety legislation is being met. Some inspectors take this to mean that they should enforce the regulation. This leads to unnecessary conflict and should be addressed as soon as possible.

3. Achieving Outcomes

3.1 Prevention is always better than enforcement and with this in mind, the HSE must work more closely with providers to give expert help and advise rather than use the carrot and stick method.

3.2 Hazards at work, such as smoking policies and stress are challenging; the sector faces many dilemmas, and the recruitment and retention of staff has the greatest impact on this.

3.3 There are real concerns within the sector at the levels at which penalties for non-compliance is set. There is no doubt that consistent offenders should receive appropriate penalties, however there must be greater clarity around this.

3.4 It is important that independent and voluntary sector providers are considered to be equal partner in the delivery of a safe service.

3.5 Often the legislation, when considered, does not allow representatives of the sector to add their voice to the debate. This often leads to a difference in interpretation of parts of the legislation.

3.6 There is a need to ensure legislation does not disadvantage choice, as we believe that this can create a conflict for providers, which if discussed at an early stage could be easily resolved.

3.7 Good practice is the key to the delivery of safe care for vulnerable people. It is clear that training at all levels for staff and managers will be the most effective tool to create and promote good practice.

3.8 The difficulty for the sector is that training is expensive and Health and Safety training is one of the more expensive courses. There are also concerns within NCHA at the consistence of training available. There are occasions when trainers even disagree.

3.9 The issue already discussed about the recruitment and retention of staff has an impact with trained staff being more marketable and so being lost to the National Health Service.

3.10 NCHA would like to stress the importance of the HSE's position on the training of staff within the sector and how this can be delivered at a cost that is affordable, as we believe that this is the most effective method to cascade down good practice.

3.11 The health of service users must be the primary concern in all the work we do and their safety plays an essential role in this. However, it must be recognised that individual service users have the right to be able to access and take risks.

3.12 In entering care facilities they should not be expected to give up smoking, eat runny eggs, have bolts on their windows etc. All this should be considered on the basis of individual need and choice, as failure to do so will have an impact on their health!

4. Resources

4.1 The HSE holds an important position within the Social Care field, and yet there is limited dialogue with the sector at any level.

4.2 NCHA believe that it is imperative that there is open dialogue with the sector, which should result in the promotion of good practice.

4.3 It is our belief that prevention is better than enforcement, and partnership working would look at prevention strategies, which would benefit the service users and the staff who deliver front line services.

4.4 In view of the growing financial crisis within the sector NCHA believes that clarity and a unified approach will assist to stabilise the growing financial burden placed on providers by the insurance industry as a direct result of issue addressed.

5. Conclusions

5.1 NCHA has never questioned the necessity for Health and Safety regulation to protect both service users and staff.

5.2 Regulators need to be sure that for people living in care homes the requirements placed on the proprietors and managers do conflict with the basic rights of the individual service user.

5.3 When a risk has been identified if the risk is minimal then the cost of implementing any change must be taken into account when decisions are made as to whether or not to make changes.

5.4 Only one regulating body should be responsible for inspection and enforcement in the care sector.

5.5 The promotion of the independence of service users must be maintained at all times.

National Care Homes Association

12 May 2004

Memorandum submitted by Amicus Health, Safety and Working Environment

Summary

Survey Method

1288 questionnaires were issued to three categories of lab staff safety reps. The sample comprised NHS, private sector chemicals and pharmaceuticals and university labs.

143 responses were received, giving an 11.1% response rate. This seems about average for postal questionnaires with no follow up to increase the response rate.

Dangerous Chemicals and Hazardous Substances

7.7% of our private sector labs sample reported technicians' health had suffered through coming into contact with dangerous chemicals or biological agents.

About 67% of employers (according to sector) failed to make provision for workers at risk. Around 10 per cent of employers failed to provide the necessary training to workers handling potentially dangerous chemicals and biological agents.

6% of our responding sample believed safety measures were not adequate in their laboratories.

12.5% said there was unwillingness by their employer to spend money on improving safety with regard to dangerous chemicals and biological agents. There was little evidence enforcement in this area by the HSE.

Radioactive Substances

13% of safety reps said their employer did not provide annual health surveillance for workers handling radioactive substances. 13% said their employer did not make adequate safety provisions for radiation workers.

Only two examples of reprimands by the HSE were recorded in respect of radioactive substances.

Materials and Organisms Causing Allergies

23.5% of the responding sample said adequate training was not provided for staff working with substances that could be the source of allergens.

12.4% said that adequate safety measures were not being taken to reduce allergen risks.

4.5% reported that their employers were unwilling to spend money to protect employees from developing allergies.

74.6% said that there was no annual surveillance scheme to check staff who handle potential allergens. Only one instance was reported of the HSE issuing a reprimand in relation to potential allergens.

WRULDs/RSI

44% of labs reported no annual surveillance of workers in relation to WRULDs/RSI and a bare majority believed training was adequate to minimise risks of WRULDs/RSI.

99.2% said that measures taken to reduce the risk of developing an upper limb disorder were inadequate.

18% of labs reported an unwillingness to spend money on improving safety with regard to WRULDs/RSI. A similar proportion claimed that there had never been a reprimand administered by the HSE in respect of WRULDs/RSI.

Work Related Stress

Stress related illnesses were the most frequent cause of serious work related ill health among lab workers. 15% of private sector respondents reported that technicians had left or changed their positions due to stress and 12% of university respondents reported similarly. 13.1% of NHS labs reported that scientists had been similarly affected.

69% said that stress was taken seriously by their employer (31% said the contrary). However a meagre 4.6% respondents believed their employer was adopting adequate measures to reduce the sources of stress.

Mechanical and Electrical Hazards

15.5% of our respondents said adequate training of workers was not provided in respect of mechanical and electrical hazards. A large majority felt adequate measures were being taken to reduce accidents from this source.

Only 4.6% of respondents reported employer unwillingness to spend money on improving safety with regard to mechanical or electrical hazards.

The HSE is apparently more strictly interventionist, in enforcing regulations with regard to mechanical and electrical hazards, with three cases (2.3%) being reported of reprimands being issued.

Conclusions

There is a need for more active insistence on the enforcement of rules by the regulating authority—the Health and Safety Executive.

The Government's "Revitalising Health and Safety" strategy, set bold targets for reducing absenteeism arising from accidents and work related ill health. The most effective way of making significant progress towards the realisation of these targets would be to vigorously enforce the law in the form of all the various regulations and Approved Codes of Practice issued in respect of health and safety at work.

1. Introduction and Methodology

1.1 *Regulating Workplace Health and Safety in the United Kingdom*

The system of health and safety regulation in the UK is described as being based on "self-regulation," with the Health and Safety Executive/Health and Safety Commission being the principal enforcing authority. Nowadays the framework of legal obligations centres on general duties of management to make risk assessments and take reasonably practicable steps to minimise the risks to workers. This is strengthened and detailed by various rules and statutory instruments.

This framework is complex but embodies Approved Codes of Practice (ACoPs), guidance from the HSE, and regulatory instruments dealing with specific hazards, drawing on standards set by European Directives. These latter regulations cover such areas as chemicals and other hazardous substances, radiological hazards, working at heights, machinery, noise in the workplace, use of display screen equipment and many more. However, in the approaches of all these instruments, the spirit of self-regulation with statutory oversight remains.

As the Work and Pensions Select Committee of Parliament reviews the effectiveness of the HSE/HSC, it is necessary to consider empirical evidence which reflects on how this system operates in practice. Many observers would argue that the system is holding up well, though there are widespread concerns about the HSE's resource limitations and its consequent inability to inspect workplaces on anything but a minimal scale. This issue is directly related to the question of how actively the HSE chooses to use its enforcement powers to support the rules and legislation it is there to regulate. Prosecutions of employers are few and far between. Decisions to issue improvement notices or prohibition notices are also relatively infrequent. The HSE prefers in the main to work by giving advice and guidance to employers and generally urging them to follow good standards.

According to the HSE's model, encouragement and advising appear to be more important than enforcement *per se*. This is presumably justified on the basis that what employers do or fail to do, will probably have more impact on health and safety in practical terms than any amount of enforcement using legal sanctions, improvement notices and so on. However it is arguably equally important for the ultimate sanctions of the enforcing authorities to be visible to employers. How otherwise are they to believe that if they do not take their responsibilities seriously, there will be penalties in the form of improvement or prohibition notices and possibly criminal proceedings? And if they do not have this belief, are we not simply relying on the good employers to do the "decent thing," while the bad employers ignore the law with impunity?

As is well known, accidents do happen and many thousands of workers experience diseases and illnesses caused by their work. A wealth of statistical material based on reported accidents and self-reported work-related ill health, brings home the point that work can still be a dangerous and unhealthy business and of course, many accidents and illnesses are probably not caught in the statistics. The general perception that UK workplaces are, in the main safe places to be, needs therefore to be set alongside an understanding of how robust and reliable our health and safety systems are. How far do employers invest in measures and equipment to reduce risks from their systems of work? Alternatively, how much do they rely instead on the skills and good sense of workers to "keep out of trouble" whilst working in inherently dangerous circumstances? If the emphasis is more on the latter approach, human error will be an inevitable weakness and probably more commonplace than failures in equipment.

These issues then form a context in which Amicus has surveyed its members in scientific laboratories. Hopefully, our survey will provide some answers to the question; how far are people "Working Safely in the Lab?" If it leads to a better understanding of the HSE's role in enforcing safety regulations relating to lab workers, this may be useful in appraising our system of health and safety regulation more generally, though we cannot of course make any presumption of the wider application of our findings.

1. 2 *The Laboratory—A Risky Place to Work?*

Why look at laboratories? Careers in science are not always well rewarded, but lab workers are typically committed to their work. Many thousands of Amicus members are employed as lab workers. As a union we have a responsibility to do all that it possible to protect their health and safety. Most lab staff, in our experience, take health and safety issues very seriously. Lab safety constitutes an important part of basic training of scientists and technicians at university or elsewhere. However, there is always another side, and anyone who has worked in a lab will have seen examples of dedicated scientists or technicians who regularly put themselves at risk, supposedly in the interests of their research.

The existence of chemical, biological and radiological hazards in confined spaces and often in close proximity, in itself poses questions about safety that need to be dealt with. Without proper rules, training of workers and knowledge of the nature of the risks people are facing, laboratories can be very dangerous places indeed. On the other hand, there is no reason why these risks cannot be assessed, identified and to a very large extent, brought under control, just as they can in other work situations.

Diseases and injuries associated with lab work are common, from the allergy inducing effects of working with laboratory animals, to cancers caused by handling carcinogenic substances or exposure to radiological hazards. It was with this state of knowledge that we decided to investigate the safety of laboratory workers and the extent to which we can feel confident their workplaces are indeed safe places to work.

1.3 *Methodology and Response Rate*

Our survey questionnaire was sent to Amicus workplace representatives in three of the laboratory areas in which our members are employed. These were private research and quality control labs (belonging to chemicals and pharmaceuticals companies) university research and teaching laboratories, and laboratories in the National Health Service. 133 questionnaires were sent to chemicals and pharmaceuticals company

safety reps (46 pharmaceutical companies, 87 chemicals), 325 went to university safety reps and 833 went to NHS reps. The response rates were 19.6% private sector (chemicals and pharmaceuticals), NHS 10.1% and 10.15 Universities. It is not clear why there was a significantly higher response from the private sector sample, but it was probably in part at least, a result of more accurate targeting.

2. Dangerous Chemicals and Biological Agents

2.1 *Health Impact of Contact with Dangerous Substances*

The Control of Substances Hazardous to Health Regulations 2002 (The COSHH Regulations) require employers to control exposure to hazardous substances to prevent ill health. We therefore asked our survey participants to report on whether the health of any staff member in their laboratory had suffered as a result of coming into contact with a dangerous chemical or biological agent. Separate responses to this question were requested in respect of scientists, technicians and others including students.

Scientists seem to have been least affected with 4.8% of workplaces reporting that a scientist member of staff had suffered through contact, but no such reports in the private sector or university labs for this grade of employee. Technicians and students/others appear more vulnerable, with positive reports of them suffering health effects of contact with chemicals in all three sectors. Table 1 summarises the results obtained.

Table 1:

Response to Question: "Has the Health of Any Member of Staff Suffered as a Result of Coming Into Contact With Any Potentially Dangerous Chemicals or Biological Agents?"

	Scientists						*Technicians*						*Students/Others*					
	NHS		*Private*		*University*		*NHS*		*Private*		*University*		*NHS*		*Private*		*University*	
Yes	4	4.8%	0	0%	0	0%	4	4.8%	2	7.7%	1	3.0%	3	3.6%	1	3.8%	1	3.0%
No	52	61.9%	19	73.1 %	19	57.6%	45	53.6%	17	65.4%	20	60.6%	36	42.9%	17	65.4%	17	51.5%
N/A	28	33.3%	7	26.9%	14	42.4%	35	41.7%	7	26.9%	12	36.4%	45	53.6%	8	30.8%	15	45.5%
Tot	**84**	**100%**	**26**	**100%**	**33**	**100%**	**84**	**100%**	**26**	**100%**	**33**	**100%**	**84**	**100%**	**26**	**100%**	**33**	**100%**

2.2 *Surveillance of Employees in Contact with Substances Likely to Cause Ill Health*

Where they are exposed to one of the substances in schedule 6 of COSHH or where the employee is working in the manufacture of one of these substances the regulations require employers to carry out health surveillance of employees. This can be especially important in a number of contexts—eg in the manufacture of benzene—where there is a reasonable likelihood of an identifiable disease or adverse health effect as a result of such contact. Also, health surveillance is required where the employee is exposed to a substance (whether or not it is listed in schedule 6) which is linked to a particular disease or adverse health effect, and it is possible to identify such health effect. Whatever it is that causes a health effect, if it is possible to identify that effect, surveillance should be arranged.

A general practitioner or occupational health physician might typically provide surveillance, and records of such surveillance are supposed to be kept for at least 40 years. As can be seen, the regulations are fairly demanding, but justifiably so.

Faced with a high level of legal requirement for surveillance of the employees in danger of health effects from hazardous substances, one would expect a similarly high level of provision by employers. Safety reps were asked whether their employer had an annual surveillance scheme in their department to check staff who handled potentially dangerous chemicals. Table 2 summarises their responses.

Table 2:

Responses to Question, "Is There an Annual Health Surveillance Scheme in Your Department Which Checks Staff who Handle Potentially Dangerous Chemicals or Biological Agents for Possible Contamination-related Conditions?"

	NHS		*Private*		*University*	
Yes	23	27.4%	13	50%	11	33.3%
No	57	67.9%	11	42.3%	20	60.6%
N/A	4	4.8%	2	7.7%	2	6.1%
Total	**84**	**100%**	**26**	**100%**	**33**	**100%**

A generous explanation of the above might offer that perhaps only a minority of the laboratories in question required employees to handle potentially dangerous chemicals or biological agents. However, knowledge of the work situations in question, suggests that this is unlikely to be the case. It seems likely therefore that there is a significant under provision of health surveillance of laboratory workers taking place across all of the sectors covered by our survey.

2.3 *Training for Workers Handling Potentially Dangerous Chemicals*

The provisions of the COSHH Regulations are supplemented by an Approved Code of Practice (ACoP) as well as an HSE guidance leaflet on COSHH. The aim of the regulations combined with the ACoP and the guidance booklet is to minimise risks to workers handling potentially dangerous substances. A careful reading of these documents makes it clear that training of workers plays a vital part in their protection. It is unambiguously the responsibility of the employer to provide that training. The HSE advisory leaflet states, 'COSHH requires that you provide your employees with suitable information, instruction and training...' It then proceeds to list the areas that should be covered by the training. These include informing employees of the measures they should take to protect themselves, how to use personal protective equipment, results of exposure monitoring and health surveillance, the emergency procedures which should be followed in the event of contact with the substance in question and a number of other areas.

We asked our survey participants whether adequate training was provided in their department/institute to people who handle potentially dangerous chemicals and biological agents. Their responses are summarised in table 3.

Table 3:

Responses to Question, "Is Adequate Training Provided in Your Department/Institute to People Who Handle Potentially Dangerous Chemical and Biological Agents in Order to Minimise Risk?"

	NHS		*Private*		*University*	
Yes	71	84.5%	21	80.8%	28	84.8%
No	8	9.5%	3	11.5%	3	9.1%
N/A	5	6.0%	2	7.7%	2	6.1%
Total	**84**	**100%**	**26**	**100%**	**33**	**100%**

As can be seen, more than 9.5% to 11.5% of safety reps (according to sector) reported that adequate training was not provided. Any failure to provide training to handle hazards is likely to leave employees or others in a laboratory situation, vulnerable to exposure and serious consequences. Failing adequate training, there could be an inadequate response to an exposure. In some cases, this could be dangerous to members of the general public and not simply those within the confines of the laboratory. If roughly ten per cent of labs have failed to provide the necessary training to comply with their legal duties (as our survey responses suggest) this is a matter for serious concern.

2.4 *Risk Reduction Measures in Relation to Harmful Chemicals and Biological Agents*

The COSHH Regulations and the associated ACoP and guidance, make it clear that the main responsibility of employers is to reduce risks in relation to harmful chemicals and biological agents. An eight-stage approach is outlined in the HSE guidance. This includes assessing the risks, deciding what precautions are needed, preparing plans to deal with accidents, incidents and emergencies, and finally ensuring that employees are properly informed, trained and supervised. All of the foregoing are essential steps to reduce the risk of accidents involving potentially harmful chemicals and biological agents.

We asked our survey participants whether adequate safety measures were in fact in place. Table 4 shows details of responses. As can be seen, some 4.8% of NHS safety reps believed their employer had not put adequate arrangements in place and 9.1% reported similarly among university reps.

Table 4:

Responses to Question: "Are Adequate Safety Measures in Place in Your Department to Reduce Risk of Accidents Involving Potentially Harmful Chemical & Biological Agents?"

	NHS		*Private*		*University*	
Yes	76	90.5%	23	88.5%	26	78.8%
No	4	4.8%	1	3.8%	3	9.1%
N/A	4	4.8%	2	7.7%	4	12.1%
Total	**84**	**100%**	**26**	**100%**	**33**	**100%**

2.5 *Sanctions by Regulator Concerning Chemicals and Biological Agents*

We invited reports on whether departments or institutes had been reprimanded by a regulatory agency in the past three years for breaches in relation to harmful chemicals or biological agents. (Sanctions could be taken to include issuing of an improvement notice or prohibition notice, both of which HSE inspectors are empowered to administer.)

Table 5:

Response to Question, "Has Your Department been Reprimanded by a Regulatory Agency Concerning the Handling of Potentially Dangerous Chemicals and Biological Agents in the Past 3 years?"

	NHS		*Private*		*University*	
Yes	*3*	*3.6%*	*0*	*0%*	*2*	*6.1%*
No	*78*	*92.9%*	*24*	*92.3%*	*30*	*90.9%*
N/A	*3*	*3.6%*	*2*	*7.7%*	*1*	*3.0%*
Total	**84**	**100%**	**26**	**100%**	**33**	**100%**

2.6 *Improving Health and Safety in Relation to Chemicals and Biological Agents*

We asked about the experience of respondents in relation to spending by their employers on health and safety measures. Table 6 sets out the responses we received to this question based on a three-year reference period. The responses in indicate a perception by safety representatives of little unwillingness to spend money on health and safety measures.

Table 6:

Responses to Question: "Has Your Department Been Unwilling to Spend Money on Measures Concerning Potentially Dangerous Chemicals and Biological Agents Safety in the Last Three Years?"

	NHS		*Private*		*University*	
Yes	*7*	*8.3%*	*0*	*0%*	*4*	*12.1%*
No	*71*	*84.5%*	*24*	*92.3%*	*4*	*12.1%*
N/A	*6*	*7.1%*	*2*	*7.7%*	*25*	*75.8%*
Total	**84**	**100%**	**26**	**100%**	**33**	**100%**

2.7 *Accidents through Exposure to Chemical or Biological Agents*

According to respondents, there had been no detrimental health effects of accidents exposing survey participants to dangerous chemicals or biological agents in any of the sectors.

Table 7:

Responses to Question: "Has the Health of Any Staff Member Involved in an Accident Suffered as a Result of Exposure to Dangerous Chemicals and Biological Agents in your Institute/ Department?"

	Scientists						*Technicians*						*Students/Others*					
	NHS		*Private*		*University*		*NHS*		*Private*		*University*		*NHS*		*Private*		*University*	
Yes	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
No	28	33%	14	53.8%	18	54.5%	26	31.0%	14	53.8%	17	51.5%	26	31.0%	14	53.8%	17	51.5%
N/A	56	66.7%	12	46.2%	15	45.5%	58	69.0%	12	46.2%	16	48.5%	58	69.0%	12	46.2%	16	48.5%
Tot	**84**	**100%**	**26**	**100%**	**33**	**100%**	**84**	**100%**	**26**	**100%**	**33**	**100%**	**84**	**100%**	**26**	**100%**	**33**	**100%**

The above responses do not of course indicate that no accidents occurred leading to exposures, but that the health of workers did not (so far as is known) suffer as a result. There could have been some accidents in which exposure took place but the consequences of them may not be known for some time to come. For these reasons, care is needed in dealing with table 7.

2.8 *Comment on Survey Findings in Relation to Dangerous Chemicals and Biological Agents*

7.7% of our private sector labs sample reported technicians' health had suffered through coming into contact with dangerous chemicals or biological agents, with NHS and universities participants reporting 4.8% and 3% respectively. Students and others were affected in smaller but still worrying proportions—between 3 and 3.8% according to sector. Health surveillance on the other hand is poorly provided for, with up to 67% of employers according to sector failing to come up with such provision for workers at risk. Around 10% of employers failed to provide the necessary training to workers handling potentially dangerous chemicals and biological agents.

While some 94% of the whole sample believed their employers were putting adequate safety measures in place to reduce the risk of accidents involving potentially harmful chemicals and biological agents, some 6% of our responding sample believed safety measures were not adequate in their laboratories. In face of such evidence, one feels obliged to wonder too about the levels of safety to the general public.

There is little evidence in the survey, of lab workers involved in accidents with chemical or biological hazards, having suffered directly. However, it is sometimes in the nature of dangerous substances that their consequences are apparent over time. Some 12.5% of the whole sample reporting, said there was unwillingness by their employer to spend money on improving safety with regard to dangerous chemicals and biological agents.

In light of these findings, one might imagine that there would be considerable activity by the HSE to enforce the legal duties laid on employers. There was evidence of some enforcement in the form of a total of five reports of sanctions being issued on grounds of inadequate arrangements for handling dangerous chemicals or biological agents. Compare this however with the 125 respondents who believed that safety measures were inadequate in their laboratories, and it appears that insufficient enforcement activity is taking place in laboratories.

3. Radioactive Substances

3.1 *Legal and Other Provisions Regarding Radioactive Substances*

The main legal provisions concerning the use of radioactive substances in the workplace are the Ionising Radiations Regulations 1999 (IRR99). As with the COSHH Regulations, there is an ACoP and guidance supporting IRR99, and the obligations and duties of employers are outlined in these documents. A series of information sheets deal with the specific problems and issues of dealing with ionising radiations and handling radioactive substances, and there is specific guidance for pregnant women and breastfeeding mothers. Employers handling radioactive substances must be registered for this purpose.

The guidance on working with radioactive substances is detailed. It lays considerable responsibility on management for the setting of rules and procedures, carrying out risk assessments, the employment of suitably qualified people to ensure compliance with authorisation conditions and much more. A Radiological Protection Adviser has to be consulted (and possibly appointed) to advise on all aspects of the storage and handling of radioactive substances. Complex and detailed rules exist in relation to the disposal of radioactive substances. Proper and detailed accounting procedures have to be put in place. Records have to be maintained in relation to checks on stored substances, equipment has to be tested with regard to leaks etc and there are strict rules with regard to the moving and transporting of radioactive substances.

It will be clear from the foregoing, that there is an immense range of questions that could have been asked in relation to the safe use of radioactive substances in the workplace. Our survey was more modest and restricted and asked only the questions listed below.

3.2 *Health Surveillance in Relation to Radioactive Substances*

We asked participants about the existence of an annual health surveillance scheme for staff who handle radioactive substances. Table 8 summarises their responses.

Table 8:

Responses to Question: "Is There an Annual Health Surveillance Scheme in Your Department, to Check Staff Who Handle Radioactive Substances?"

	NHS		*Private*		*University*	
Yes	28	33.3%	7	26.9%	19	57.7%
No	4	4.8%	4	15.4%	0	0%
N/A	52	61.9%	15	57.7%	14	42.3%
Total	**84**	**100%**	**26**	**100%**	**33**	**100%**

Four out of 32 (12.5%) NHS safety reps offering responses (ie other than "not applicable") to this question said that no surveillance scheme was in place to check staff who handled radioactive substances. In the private sector the corresponding figure was four out of 11 responses (36%). Such an absence of surveillance is a matter for concern. Radioactive substances can cause dangerous cancers as well as other unpleasant health effects, and the fact that NHS and private sector employers are deficient in providing surveillance could be placing the health of employees at serious risk. The university respondents, it will be noted, offered evidence of a much better track record than the NHS and private employers in this area.

3.3 *Safety Measures in Relation to Radioactive Substances*

The Ionising Radiation Regulations 1999 describe in detail the safety measures that should be adopted by "radiation employers." Work with ionising radiation must not be carried out unless the radiation employer has made an assessment of the hazards with potential to cause a radiation accident and the risks to employees and others of the nature and magnitude of any risks. Where the assessment shows that a radiation risk exists, the employer must take all reasonably practicable steps to prevent such accidents, limit the consequences should such an accident occur and provide employees with the information, training and equipment necessary to limit their exposure. It will therefore be seen that for employers using radioactive substances, there is a significant responsibility to reduce risk and take all practicable measures to avoid accidents occurring.

We asked our survey participants whether in their view, their employer had taken adequate measures to reduce the risk of accidents involving radioactive substances. Table 9 sets out their responses.

Table 9:

Responses to Question: "Are Adequate Safety Measures Being Taken to Reduce Risk of Accidents Involving Radioactive Substances?"

	NHS		*Private*		*University*	
Yes	27	32.1%	8	30.8%	19	57.5%
No	5	6.0%	3	11.5%	0	0%
N/A	52	61.9%	15	57.7%	14	42.5%
Total	**84**	**100%**	**26**	**100%**	**33**	**100%**

With large percentages of our sample returning a "not applicable" response the "yes" and "no" figures above are distorted downwards. If we ignore the "not applicable" responses we find the following.

Table 9a:

Responses to Question: "Are Adequate Safety Measures Being Taken to Reduce Risk of Accidents Involving Radioactive Substances?" ("Not applicable" responses ignored)

	NHS		*Private*		*University*	
Yes	27	84.41%	8	72.7%	19	100%
No	5	15.6%	3	27.3%	0	0%
Total	**32**	**100%**	**11**	**100%**	**19**	**100%**

The size of the sub-samples have been much reduced by this stage, but it should nonetheless be of concern that 15% of NHS and 27% of private sector radiation employers identified in our sample, produce the above verdicts from union safety reps in their laboratories handling radioactive substances.

3.4 *Reprimands by Regulatory Authority Concerning Radioactive Substances*

Each of the sub-sets for NHS and University laboratories produced a single report of a reprimand by a regulatory agency in respect of handling of radioactive substances in the three years prior to the survey. Given the views summarised in the previous section, this suggests that some employers are adopting inadequate risk control measures in relation to radioactive substances in their laboratories, but are not finding themselves brought to heel by the HSE.

Table 10:

Responses to Question: "Has Your Department been Reprimanded by a Regulatory Agency in the Past Three Years Concerning the Handling of Radioactive Substances?"

	NHS		*Private*		*University*	
Yes	1	1.2%	0	0%	1	3.0%
No	40	47.6%	12	46.2%	20	46.2%
N/A	43	51.2%	14	53.8%	12	53.8%
Total	**84**	**100%**	**26**	**100%**	**33**	**100%**

3.5 *Improving Health and Safety in Relation to Handling Radioactive Substances*

In the light of concerns by lab safety reps about radioactive substances described in tables 9 and 9a above, one might expect that there would be a willingness by employers to spend money on improvements of safety relating to radioactive substances.

Table 11:

Responses to Question: "Has Your Department Been Unwilling To Spend Money on Measures to Improve Safety in Relation to Radioactive Substances in the Past Three Years?"

	NHS		*Private*		*University*	
Yes	0	0%	1	3.8%	0	0%
No	30	35.7%	10	38.5%	21	63.6%
N/A	54	64.3%	15	57.7%	12	36.4%
Total	**84**	**100%**	**26**	**100%**	**33**	**100%**

There is little sign here of safety reps being concerned in relation to an unwillingness to spend money to remedy problems concerning hazards caused by radioactive substances. Only one employer (in the private sector) displayed unwillingness to improve health and safety by making money available to do so.

3.6 *Comment on Survey Findings Relating to Radioactive Substances*

The story with regard to radioactive substances is not dissimilar to our survey findings in relation to chemical and biological agents. Most of the provisions of the Ionising Radiations Regulations 1999 are probably being observed by most employers, but still some 13% of all our safety reps who responded said that their employer did not provide annual health surveillance for workers handling radioactive substances. 87% responding said that their employers were providing adequate safety measures for radiation workers, but this left 13% taking a directly contrary view. Only two examples of reprimands being administered by the HSE were recorded in respect of radioactive substances. There was little evidence of employers being unwilling to spend money on measures to improve safety in relation to radioactive substances, but clearly there were areas where practice fell short of the requisite standards and it is troubling that these defaulting employers appear to be going unsanctioned. There therefore appears on the evidence of this survey, to be a need for a more active inspection approach by the HSE to enforce regulations in relation to the use of radioactive substances in labs.

4. Materials and Organisms Causing Allergies

4.1 *Extent of Work Related Allergies Among Lab Workers*

Increasing publicity about conditions like asthma have made the public far more aware of the problems caused by materials with which we make contact or breathe through the air around us. Between 1,500 and 3,000 new cases of occupational asthma are reported each year. If you include cases of asthma made worse by working conditions, these figures rise to 7,000 a year. The Self Reported Work Related Illness survey gives a figure of 3,900 cases of work related skin disease being reported each year in Britain, with some 39,000 cases representing the estimated prevalence of work related skin disease overall. Around 150 workers each year are assessed as having some level of disablement under the industrial injuries scheme, due to industrial dermatitis. Allergies are not a trivial matter, and for each of these individuals, the consequences are likely to be profound.

Our survey participants were asked whether anyone in their laboratory had been forced to leave or change his or her position as a result of developing an allergy to materials or organisms encountered at work.

Table 12:

RESPONSE TO QUESTION: "HAS ANYONE HAD TO LEAVE OR CHANGE THEIR POSITION AS A RESULT OF DEVELOPING AN ALLERGY TO MATERIALS OR ORGANISMS?"

	Scientists						*Technicians*						*Students/Others*					
	NHS		*Private*		*University*		*NHS*		*Private*		*University*		*NHS*		*Private*		*University*	
Yes	1	1.2%	0	0%	0	0%	0	0%	2	7.7%	3	9.1%	0	0%	0	0%	1	3.0%
No	5	66.7%	1	53.8%	25	75.8%	5	64.3%	14	53.8%	2	69.7%	4	50%	1	57.7%	2	66.7%
	6		4				4				3		2		5		2	
N/A	2	32.1%	1	46.2%	8	24.2%	3	35.7%	10	38.5%	7	21.2%	4	50%	1	42.3%	1	30.3%
	7		2				0						2		1		0	
Total	**8**	**100%**	**2**	**100%**	**33**	**100%**	**8**	**100%**	**26**	**100%**	**3**	**100%**	**8**	**100%**	**2**	**100%**	**3**	**100%**
	4		**6**				**4**				**3**		**4**		**6**		**3**	

The number of cases of workers having been forced to move or leave their jobs as a result of allergies having been developed is shown; one case from our NHS sub-set, two from the private sector and four from the universities. (Again, the percentages are increased by discounting the "not applicable" responses.) 11.5% of university responses (discounting "not applicable" returns) indicate that technicians had been forced to move or change their positions. These responses suggest a significant health hazard for a section of our lab workforce. It must be remembered that the question has set a high threshold of severity for inclusion of individual cases. Only those cases which resulted in someone leaving or involved in a job change are counted.

4.2 *Health Surveillance for Staff Handling Potential Allergens*

Where workers are working with substances likely to cause allergic reactions, regular surveillance is essential. Similar advice is given in relation to occupational asthma and dermatitis. In both cases, prompt action is needed to prevent harm to the workers concerned and to minimise the severity of their complaint, if they are unfortunate enough to develop an allergy. Survey participants were asked whether there was an annual surveillance scheme in their department or institute to check staff who handle potential allergens.

Table 13:

RESPONSES TO QUESTION: "IS THERE AN ANNUAL SURVEILLANCE SCHEME IN YOUR DEPARTMENT TO CHECK STAFF WHO HANDLE POTENTIAL ALLERGENS?"

	NHS		*Private*		*University*	
Yes	15	17.9%	7	26.9%	9	27.3%
No	60	71.4%	10	38.5%	21	63.6%
N/A	9	10.7%	9	34.6%	3	9.1%
Total	**84**	**100%**	**26**	**100%**	**33**	**100%**

As can be seen from table 13, there is a low level of provision of surveillance for staff handling potential allergens. Discounting the "not applicable" responses gives more worrying percentages.

Table 13a:

RESPONSES TO QUESTION: "IS THERE AN ANNUAL SURVEILLANCE SCHEME IN YOUR DEPARTMENT TO CHECK STAFF WHO HANDLE POTENTIAL ALLERGENS?" ("NOT APPLICABLE" RESPONSES DISCOUNTED)

	NHS		*Private*		*University*	
Yes	15	20%	7	41%	9	30%
No	60	80%	10	59%	21	70%
Total	**75**	**100%**	**17**	**100%**	**30**	**100%**

4.3 *Training for Staff Handling Potential Allergen Sources*

There are a large number of potential allergens, many of which may be met in a laboratory setting. Laboratory animals are one example. The proteins from their fur and urine may get airborne (eg during cage cleaning). Knowing safe procedures to clean cages and use of the proper protective equipment is important. Latex gloves may cause problems. High protein, powdered gloves, release powder when they are taken off. This problem is often found in the health sector but other sectors using gloves are also at risk. Training in how to deal with the wide range of potential allergens found in a lab setting, using the necessary protective equipment and so on, is vital to minimise the risks to those involved. It is the responsibility of employers to

ensure their employees have all the necessary training protect themselves and avoid the long term consequences of contracting an allergy from substances encountered in their work. We asked our survey participants about the training provided by their employers.

Table 14:

RESPONSES TO QUESTION: "IS ADEQUATE TRAINING PROVIDED TO STAFF WHO WORK WITH MATERIALS AND SUBSTANCES THAT COULD BE A SOURCE OF ALLERGEN TO MINIMISE RISK?"

		NHS		*Private*		*University*
Yes	55	65.5%	13	50%	25	75.8%
No	19	22.6%	4	15.4%	5	15.2%
N/A	10	11.9%	9	34.6%	3	9.1%
Total	**84**	**100%**	**26**	**100%**	**33**	**100%**

Once more, if we discount the 'not applicable' responses, we get a more emphatic picture.

Table 14a:

RESPONSES TO QUESTION: "IS ADEQUATE TRAINING PROVIDED TO STAFF WHO WORK WITH MATERIALS AND SUBSTANCES THAT COULD BE A SOURCE OF ALLERGEN TO MINIMISE RISK?" ('NOT APPLICABLE' RESPONSES DISCOUNTED)

		NHS		*Private*		*University*
Yes	55	74%	13	76.5%	25	89.3%
No	19	25.7%	4	23.5%	5	10.7%
Total	**74**	**100%**	**17**	**100%**	**28**	**100%**

23.5% of those responding stated that adequate training was not provided to ensure staff minimised the risk of working with potential allergens. University lab workers seem to be getting the best deal here, whilst significant minorities of those in the NHS and the private sector are not getting the training they require. Despite generally good standards, it seems there is a substantial short fall below the necessary standard of protection.

4.4 *Safety Measures to Reduce Risks from Allergens*

Dermatitis and asthma brought on by allergic reactions to substances in the working environment, are both entirely preventable diseases. Becoming allergic to a substance encountered at work, on the other hand, can have profound consequences for the employee. He or she may be a chronic asthma sufferer as a result of particles breathed in during routine day to day work in the lab. Wherever possible, potential allergens should be replaced by safer substances. Where this is not possible, adequate isolation, ventilation and protection for the worker concerned are all part of the package of safety measures that need to adopted in any given situation. Solutions can be specific to substances and contexts. Whatever is done, has to be preceded by a thorough inspection and assessment and careful advice from reliable sources. Participants in our survey were asked whether their employers had adopted adequate safety measures to reduce risks posed by potential allergens. Table 15 gives responses.

Table 15:

RESPONSES TO QUESTION: "ARE ADEQUATE SAFETY MEASURES BEING TAKEN IN YOUR DEPARTMENT TO REDUCE RISK POSED BY POTENTIAL ALLERGENS?"

		NHS		*Private*		*University*
Yes	62	73.8%	16	61.5%	26	78.8%
No	12	14.3%	1	3.8%	3	9.1%
N/A	10	11.9%	9	34.6%	4	12.1%
Total	**84**	**100%**	**26**	**100%**	**33**	**100%**

Large majorities of respondents in all sectors were able to report that adequate safety measures were being taken in their departments to reduce risks posed by potential allergens. On the other hand, 16% of those providing a response other than 'not applicable' said that the safety measures taken to prevent allergenic reactions were not adequate. Clearly, this is a significant minority.

4.5 *Regulator Reprimands in Respect of Potential Allergens*

Only one safety rep reported a reprimand being administered to his/her employer in respect of arrangements concerning the handling of potential allergens in the past three years. Responses are summarised in the following table.

Table 16:

RESPONSES TO QUESTION: "HAS YOUR DEPARTMENT BEEN REPRIMANDED BY A REGULATORY AGENCY CONCERNING THE HANDLING OF POTENTIAL ALLERGENS IN THE PAST THREE YEARS?"

	NHS		*Private*		*University*	
Yes	1	1.2%	0	0%	0	0%
No	75	89.3%	17	65.4%	31	93.9%
N/A	8	9.5%	9	34.6%	2	6.1%
Total	**84**	**100%**	**26**	**100%**	**33**	**100%**

Comparing the above table with the information summarised in table 15, it seems that employers who (in the opinions of safety reps) are defaulting on safe practice in handling of allergens, have largely escaped the attention of the regulatory authorities.

4.6 *Improving Health and Safety in Relation to Handling Potential Allergens*

How far have employers been willing to spend money on safety measures to improve the safety of workers placed at risk of contracting allergies? By now the pattern of our questions will be familiar. We posed this question to our survey participants. Table 17 summarises responses.

Table 17:

RESPONSES TO QUESTION: "HAS YOUR DEPARTMENT BEEN UNWILLING TO SPEND MONEY ON SAFETY MEASURES FOR EMPLOYEES AT RISK OF CONTRACTING ALLERGIES IN THE PAST THREE YEARS?"

	NHS		*Private*		*University*	
Yes	3	4.7%	0	0%	2	6.1%
No	61	72.6%	18	69.2%	27	81.8%
N/A	20	23.8%	8	30.8%	4	12.1%
Total	**84**	**100%**	**26**	**100%**	**33**	**100%**

As can be seen, employers have not in general reflected unwillingness to spend money on safety measures in relation to the dangers of allergies. On the other hand small minorities of employers did reflect unwillingness, in both the university sector and the NHS.

4.7 *Comment on Survey Findings Regarding Allergens*

Little evidence was found of workers actually leaving their jobs as a result of allergies developed by contact with materials or organisms in the lab. However, there was a worrying story in relation to various other indicators of good or bad practice. 23.5% of the whole responding sample said that adequate training was not provided for staff working with substances that could be the source of allergens. 12.4% overall said that adequate safety measures were not being taken to reduce allergen risks, and 4.5% reported that their employers were unwilling to spend money on measures to protect employees from developing allergies. Only one instance was reported of the HSE issuing a reprimand in relation to potential allergens and a massive 74.6% said that there was no annual surveillance scheme to check staff who handle potential allergens. If these figures approach a representative statement of the state of affairs concerning surveillance of employees at risk, they amount to widespread defaulting of the responsibilities of employers under the COSHH Regulations. Hence, whilst most labs observe good practice most of the time, there appears to be widespread defaulting of legal responsibilities (particularly in relation to surveillance) which is not incurring the attention of the HSE other than in isolated cases.

5. Work Related Upper Limb Disorders

5.1 *Nature and Extent of Problem*

Repetitive movements by keyboard operators or others doing work of a mechanical kind, can cause a range of illnesses, from carpal tunnel syndrome to RSI. There are various regulations relevant to the prevention of these forms of illness, eg the Health and Safety (Display Screen Equipment) Regulations and the Manual Handling Operations Regulations. Laboratory workers use keyboards for the purpose of recording their work, and there are various other items of laboratory equipment which entail repetitive movements by the operator. The question of whether staff members in laboratories have had to leave or change their positions as a result of developing upper limb disorders, would therefore seem a poignant one to ask. The following responses were received.

Table 18:

Response to Question: "has anybody had to leave or change their position as a result of developing an upper limb disorder in your institute/department?"

	Scientists						*Technicians*						*Students/Others*					
	NHS		*Private*		*University*		*NHS*		*Private*		*University*		*NHS*		*Private*		*University*	
Yes	2	2.4%	1	3.8%	0	0%	2	2.4%	2	7.7%	0	0%	2	2.4%	0	0%	1	3.0%
No	55	65.5%	19	73.1%	24	72.7%	52	61.9%	20	76.9%	24	72.7%	54	64.3%	19	73.1%	25	75.8%
N/A	27	32.1%	6	23.1%	9	27.3%	30	35.7%	4	15.4%	9	27.3%	28	33.3%	7	26.9%	7	21.2%
Totals	**84**	**100%**	**26**	**100%**	**33**	**100%**	**84**	**100%**	**26**	**100%**	**33**	**100%**	**84**	**100%**	**26**	**100%**	**33**	**100%**

As can be seen, small proportions of safety reps reported people leaving or changing their positions as a result of developing WRULDs in their laboratories. Evidence will emerge in later tables, suggesting far greater levels of concern among workers about WRULDs/RSI than a casual examination of the above table might suggest. One possible explanation is that for every worker who has to leave or change his or her job because of WRULD/RSI, there are others who experience a disorder at a lower level of severity. After consideration of the total data, the above table should be interpreted with this "tip of an iceberg" flavour to it.

5.2 *Surveillance of Workers in Relation to RSI/WRULDs*

Health surveillance in relation to workers who may be at risk of developing WRULDs/RSI is essential to ensure that any problems are identified early on. Our question identified a higher level of provision than we had anticipated might be the case, across all sectors of labs, as shown below. As can be seen, approximately half of NHS labs and 60% of university labs appear to be covered by health surveillance schemes which check for the development of WRULDs/RSI.

Table 19

Response to Question: "Is there an annual health surveillance scheme to monitor the health of staff in relation to RSI/WRULDs?"

	NHS		*Private*		*University*	
Yes	42	50%	14	53.8%	20	60.6%
No	33	39.3%	10	38.5%	10	30.3%
N/A	9	10.7%	2	7.7%	3	9.1%
Total	84	100%	26	100%	33	100%

5.3 *Training to Help Minimise Risks of Developing RSI/WRULDs*

Training and instilling healthy working practices are important in preventing the onset of conditions like RSI. Similarly, workers who are involved in repetitive physical movements and are therefore at risk, should be taught how to avoid the onset of disease by taking regular breaks, changing their posture frequently, avoiding repeated movements from an uncomfortable position and so on. Training in conjunction with ergonomic assessments, the provision of suitable equipment and regular surveillance can go a long way to help avoid the onset of problems associated with RSI/WRULDs. Our question about training provision produces responses summarised below.

Table 20

"RESPONSE TO QUESTION: IS ADEQUATE TRAINING PROVIDED TO HELP PEOPLE MINIMISE THE RISK OF DEVELOPING RSI/WRULDs?"

	NHS		*Private*		*University*	
Yes	42	50%	14	53.8%	20	60.6%
No	33	39.3%	10	38.5%	10	30.3%
N/A	9	10.7%	2	7.7%	3	9.1%
Total	84	100%	26	100%	33	100%

The fact that 50 to 60% of labs reported the existence of adequate training to avoid WRULDs/RSI problems at work, demonstrates that the message of prevention has reached many employers. On the other hand, the verdict from between 30 and 38% of safety reps (according to sector) that the level of training provided is inadequate, suggests concerns about the problem of WRULDs/RSI are widespread in the lab community.

5.4 *Measures to Reduce the Risk of Developing WRULDs*

Having regard to the foregoing arguments, the following table provides a confirmation of an underlying problem of WRULDs/RSI among laboratory workers. Why otherwise would nearly 100% of those responding (other than to return "not applicable") say that measures taken to reduce the risk of WRULDs/RSI were inadequate? Table 21 provides profoundly worrying data, which we had not particularly expected, and which confirms the "tip of an iceberg" interpretation of table 18.

Table 21

RESPONSE TO QUESTION, "ARE ADEQUATE MEASURES BEING TAKEN TO REDUCE THE RISK OF DEVELOPING AN UPPER LIMB DISORDER?"

	NHS		*Private*		*University*	
Yes	0	0%	0	0%	1	3.0%
No	77	91.7%	24	92.3%	29	87.9%
N/A	7	8.3%	2	7.7%	3	9.1%
Total	84	100%	26	100%	33	100%

5.5 *Reprimands from Regulator on WRULDs/RSI*

In light of the foregoing, one might expect that laboratory workers would be protected by some noticeable measure of intervention from the HSE. Only one of our respondents (a university safety rep) reported that there had been a reprimand administered regarding incidents relating to WRULDs/RSI in the past three years however.

Table 22

RESPONSE TO QUESTION, "HAS YOUR DEPARTMENT BEEN REPRIMANDED BY A REGULATORY AGENCY REGARDING INCIDENTS RELATING RSI/WRULDs IN THE PAST THREE YEARS?"

	NHS		*Private*		*University*	
Yes	0	0%	0	0%	1	3.0%
No	77	91.7%	24	92.3%	29	87.9%
N/A	7	8.3%	2	7.7%	3	9.1%
Total	84	100%	26	100%	33	100%

5.6 *Measures to Reduce WRULD/RSI Risks*

There is a wealth of information available to guide employers in reducing the risks of their employees contracting WRULD/RSI conditions. Making ergonomic assessments, ensuring the correct positioning of screens and keyboards and purchasing equipment that is specifically designed to ensure comfort to the worker and the avoidance of damage from uncomfortable working and repeated movements from such positions, is all part of a package that is widely available. Often suitable improvements entail the purchase

of better chairs, desks or other equipment. The question therefore, of whether lab workers are being protected by adequate measures to help them avoid contracting WRULDs/RSI, is likely to be better understood once we know how far their employers have been willing to invest in such equipment improvements. Table 23 provides a disturbing answer to this question.

Table 23

RESPONSES TO QUESTION, "HAS YOUR DEPARTMENT BEEN UNWILLING TO SPEND MONEY ON SAFETY MEASURES IN THE PAST THREE YEARS IN RELATION TO THE RISK OF RSI OR WRULDS?"

	NHS		*Private*		*University*	
Yes	16	19.0%	3	11.5%	3	9.1%
No	53	63.1%	18	69.2%	24	72.7%
N/A	15	17.9%	5	19.2%	6	18.2%
Total	84	100%	26	100%	33	100%

Re-calculating the above figures eliminating the "not applicable" responses, gives the following picture.

Table 23a

RESPONSES TO QUESTION, "HAS YOUR DEPARTMENT BEEN UNWILLING TO SPEND MONEY ON SAFETY MEASURES IN THE PAST THREE YEARS IN RELATION TO THE RISK OF RSI OR WRULDS?" ("NOT APPLICABLE" RESPONSES DISCOUNTED)

	NHS		*Private*		*University*	
Yes	16	23.2%	3	14.2%	3	11.1%
No	53	76.8%	18	85.8%	24	88.9%
Total	69	100%	21	100%	27	100%

5.7 *Comment on WRULDs/RSI Risks*

While small proportions of labs reported workers being forced to leave their positions as a result of an upper limb disorder, it seems likely that there were many more cases of illnesses having developed that did not reach this level of severity. 44% of labs reported no annual surveillance of workers in relation to WRULDs/RSI and a bare majority (51% of those responding) commented that training was adequate to help staff minimise the risks of WRULDs/RSI, with 49% affirming the contrary. A huge majority (99.2% of those responding) said that measures taken to reduce the risk of developing an upper limb disorder were inadequate while a virtually identical proportion claimed that there had never been a reprimand administered by the HSE in respect of WRULDs/RSI in the past three years. Minorities of labs in each sector reported an unwillingness to spend money on improving safety with regard to WRULDs/RSI, giving 18% overall of reporting labs in this category. It seems plain that here is a significant hazard to lab workers, where employers appear to be doing insufficient to protect their employees' health, widespread defaulting of good practice and legal obligations is apparent and yet there is virtually no evidence of active enforcement taking place.

6. STRESS RELATED PROBLEMS IN LABORATORIES

6.1 *Extent of the Stress Problem*

We know stress makes us ill. Recent years have seen a huge increase in interest in this issue. Nearly one in three of Europe's workers, more than 40 million people, report that they are affected by stress at work. In the European Foundation's 1996 and 2000 surveys of working conditions, 28% of workers reported stress-related problems. How far is stress a problem then among lab workers? We asked our survey participants whether anyone in their department/institute had left or changed their position as a result of developing stress-related problems.

Table 24

RESPONSE TO QUESTION, "HAS ANYBODY LEFT OR CHANGED POSITION AS A RESULT OF DEVELOPING STRESS RELATED PROBLEMS IN YOUR INSTITUTE/DEPARTMENT?"

	Scientists						*Technicians*						*Students/Others*					
	NHS		*Private*		*University*		*NHS*		*Private*		*University*		*NHS*		*Private*		*University*	
Yes	11	13.1%	1	3.8%	2	6.1%	6	7.1%	4	15.4%	4	12.1%	5	6.0%	3	11.5%	2	6.1%
No	52	61.9%	17	65.4%	23	69.7%	46	54.8%	16	61.5%	23	69.7%	44	52.4%	15	57.7%	25	75.8%
N/A	21	25%	8	30.8%	8	24.2%	32	38.1%	6	23.1%	6	18.2%	35	41.7%	8	30.8%	6	18.2%
Totals	**84**	**100%**	**26**	**100%**	**33**	**100%**	**84**	**100%**	**26**	**100%**	**33**	**100%**	**84**	**100%**	**26**	**100%**	**33**	**100%**

As we have already seen, affirmative answers to this question would seem to only identify the worst cases in respect of the hazard in question, and it must be presumed that this is the case in respect of our question about stress. The above figures are therefore a source of concern, showing quite high proportions of labs reporting that someone in the different occupational categories had been forced to leave or change their post due to occupational stress. To take the most extreme result from each sector, we could say that 13.1% of NHS labs, 15.4% in the private sector and 12.1% of university laboratories had seen workers leave or change their jobs as a result of occupational stress.

6.2 *How Seriously is Stress Taken?*

Whatever problems are posed by stress at the workplace, a shortage of advice on how to deal with it has not been one of them. It sometimes seems as though stress has given rise to an industry of its own, as stress counsellors, employee assistance schemes and various therapeutic remedies set out their stalls and offer hope to thousands. Sadly, much that is said is wide of the mark, though there is good advice available too. The HSE's managers' guide to stress and a series of draft management standards on the avoidance of stress are all useful starting points for any employer wishing to reduce the levels of stress experienced by his/her employees. Believing that the problem of stress is serious, is an important first step towards dealing with its causes, though alone it will not be sufficient. We posed the question of our survey members, 'Is stress taken seriously by your managing department or institute?' Table 25 provides responses.

Table 25

RESPONSE TO QUESTION: "IS STRESS AMONG STAFF TAKEN SERIOUSLY BY YOUR MANAGING DEPT/INSTITUTE?"

	NHS		*Private*		*University*	
Yes	48	57.1%	16	61.5%	17	51.5%
No	29	34.5%	6	23.1%	12	36.4%
N/A	7	8.3%	4	15.4%	4	12.1%
Total	**84**	**100%**	**26**	**100%**	**33**	**100%**

As can be seen, significant minorities of our sample members believed their employers did not take the problems of stress seriously. The private sector labs appeared somewhat more likely to manifest serious intent, whilst rather more than one third of safety reps in universities and the health service believed that this was the case.

6.3 Adequacy of Measures to Reduce Sources of Stress

Perhaps on reflection we should have been more specific with the next question, rather than pose it in the generalised form we did. Measures to reduce stress would in practical terms need to address the sources of stress. This in turn would be likely to mean examining the way work is organised, the resources available to do it, the length of time that people are spending at work, the volume of work, and a large number of factors around the human relations and management style adopted in the laboratory. Without really understanding why people experience stress, managements are unlikely to tackle the problem. That they are under a duty to deal with the problem, is however clear, as a number of recent legal decisions have demonstrated.

Table 26

RESPONSE TO QUESTION: "ARE ADEQUATE MEASURES BEING TAKEN IN YOUR DEPARTMENT/INSTITUTE TO REDUCE THE SOURCES OF STRESS?"

		NHS		*Private*		*University*
Yes	26	31.0%	0	0%	0	0%
No	51	60.7%	23	88.5%	30	90.9%
N/A	7	8.3%	3	11.5%	3	9.1%
Total	**84**	**100%**	**26**	**100%**	**33**	**100%**

6.4 *Reprimands by Regulator Regarding Stress Related Problems*

Clearly, stress is seen by safety reps as a serious problem. How actively has the HSE intervened to correct the omissions and failings of managements of labs then? The evidence of table 27 is not encouraging.

Table 27

RESPONSE TO QUESTION: "HAS YOUR DEPARTMENT BEEN REPRIMANDED BY A REGULATORY AGENCY CONCERNING STRESS-RELATED PROBLEMS IN THE PAST THREE YEARS?"

		NHS		*Private*		*University*
Yes	1	1.2%	0	0%	0	0%
No	77	91.7%	23	88.5%	30	90.9%
N/A	6	7.1%	3	11.5%	3	9.1%
Total	**84**	**100%**	**26**	**100%**	**33**	**100%**

As can be seen, there was a single report of the regulator intervening to issue a reprimand concerning stress-related problems at work.

6.5 *Comment on Stress Related Problems in the Laboratory*

Stress related illnesses appear to have been the most frequent cause of serious work related ill health among lab workers. 15% of private sector respondents reported that technicians had left or changed their positions due to stress and 12% of university respondents reported similarly. Among scientists, NHS workers with 13.1% of respondents reporting that someone had been forced into a job change or departure, were the worst affected. 69% of those responding said that stress was taken seriously by their employer (31% said the contrary) but respondents believing their employer was adopting adequate measures to reduce the sources of stress totalled a meagre 4.6% and were entirely comprised of workers in NHS labs (33% of respondents in this category).

Against this, there was only one single case of a department or institute that had been reprimanded by the HSE for stress related problems in the last three years. Hence, we have an interesting though disturbing symmetry in the above tables. A hundred per cent of safety reps in the university and private sector laboratories reported their employers were not acting adequately to reduce stress at work, while a similar percentage from the same sectors reported an absence of any sanction by the HSE in respect of stress problems in the previous three years. Again, one is struck by the gap between expectation and reality. Reports of the insufficiency of employers' responses to the risks of stress would lead one to expect many examples of strong intervention by the HSE. The reality was that the very opposite was the case.

7. MECHANICAL AND ELECTRICAL HAZARDS

7.1 *Regulations Concerning Mechanical and Electrical Hazards*

Work equipment covers a very wide range spanning process machinery, machine tool, office machines, hand tools, ladders and pressure washers. In the laboratory many of these types of work equipment are likely to occur and may be in regular use. There may be complex test rigs, autoclaves, centrifuges and a thousand and one other devices needed in either routine work or more specialised scientific research and development. Labs may involve workers using ladders to work at heights. There may be machinery requiring moving parts to be guarded, or other safety precautions to be taken particularly when it is being cleaned or maintained. Lab workers may use hand tools including screwdrivers, knives, hand saws, cleavers, hammers and so on, all of which are capable of causing physical harm if not used with sufficient care and skill. Lifting equipment such as pulley blocks and power driven hoists may be in use. All these work processes require proper care and control in the way they are conducted and a competent person needs to be available in most cases to ensure that the proper safety precautions have been taken.

Several sets of statutory regulations govern the use of such equipment with the purpose of ensuring that it is safe for lab workers. The Provision and Use of Work Equipment Regulations 1998, the Lifting and Lifting Equipment Regulations 1998, and the Supply of Machinery (Safety) Regulations 1992/94 are all relevant. Various guides to these regulations are published by the HSE. Electrical safety regulations are found elsewhere. Various European Directives have given rise to appropriately named sets of regulations which enact their provisions in the UK. The Electrical Equipment (Safety) Regulations 1994 enact the provisions of the Low Voltage Directive (73/23/EC) controls on the design, manufacture and supply of low voltage electrical equipment (50—1,000 volts AC or 75—1,500 volts DC). The Electricity at Work Regulations 1989 require precautions against the risk of death of injury from electricity during work on or with electrical systems and equipment. Despite all this regulation, about 1,000 electrical accidents are reported each year to the HSE. About 15 of these are fatal. These hazards commonly exist to one extent or another for lab workers. How far they had given rise to accidents, which resulted in damage to the health of the worker, was the subject of our next question. The results are shown in table 28 below.

Table 28:

RESPONSE TO QUESTION: "HAS THE HEALTH OF ANY STAFF MEMBER IN YOUR DEPARTMENT/INSTITUTE SUFFERED AS A RESULT OF AN ACCIDENT CAUSED BY A MECHANICAL OR ELECTRICAL HAZARD?"

	Scientists						*Technicians*						*Students/Others*					
	NHS		*Private*		*University*		*NHS*		*Private*		*University*		*NHS*		*Private*		*University*	
Yes	0	0	1	3.8%	0	0%	0	0%	2	7.7%	1	3.0%	0	0%	1	3.8%	0	0%
No	43	51.2	17	65.4%	16	48.5%	41	48.8%	16	61.5%	18	54.5%	33	39.3%	15	57.7%	17	51.5%
N/A	41	48.8	8	30.8%	17	51.5%	43	51.2%	8	30.8%	14	42.4%	51	60.7%	10	38.5%	16	48.5%
Totals	**84**	**100%**	**26**	**100%**	**33**	**100%**	**84**	**100%**	**26**	**100%**	**33**	**100%**	**84**	**100%**	**26**	**100%**	**33**	**100%**

As can be seen, only a small number of respondents reported that the health of staff members in their departments had suffered as a result of accidents caused by mechanical or electrical hazards. With low positive responses across all sectors it would be wrong to dwell strongly on sector comparisons, but the private sector labs seem marginally more risky places to be in terms of electrical or mechanical accidents than the NHS and the universities.

7.2 *Training to Deal with Mechanical or Electrical Hazards*

Each of the sets of regulations concerning the use of electrical or mechanical hazards at work as well as the over-riding responsibility of the employer to ensure a safe workplace and a safe system of work, depends on their being adequate training of the workers concerned. Training of workers to minimise the risks of working with potential mechanical and electrical hazards is therefore essential. We asked our safety representatives to give their views on the adequacy of the training provided by their employer. Table 29 summarises responses.

Table 29

RESPONSE TO QUESTION, "IS ADEQUATE TRAINING PROVIDED IN YOUR DEPARTMENT TO MINIMISE RISKS TO THOSE WHO ARE EXPOSED TO POTENTIAL MECHANICAL OR ELECTRICAL HAZARDS?"

	NHS		*Private*		*University*	
Yes	64	76.2%	17	65.4%	28	84.8%
No	11	13.1%	5	19.2%	4	12.1%
N/A	9	10.7%	4	15.4%	1	3.0%
Total	84	100%	26	100%	33	100%

Whilst clearly, most respondents felt training offered to minimise the risks of potential mechanical or electrical hazards was adequate, significant minorities were more critical.

7.3 *Safety Measures to Reduce Risks of Accidents from Mechanical or Electrical Hazards*

When considering the nature of the hazards posed to users of mechanical or electrical equipment in laboratories, a number of simple rules can be followed. Risk assessments and inspections need to be performed with the necessary frequency. Equipment needs to be maintained, repaired and replaced with such frequency as to maximise safety to the user. Dangerous equipment should not under any circumstances be used, but should be replaced by new updated equipment of adequate design, fit for the purpose it is intended to serve. Accidents are caused when people use inappropriate tools for the job, old, faulty or worn equipment that no-one has had the time or money to replace or repair, or equipment that does not contain

the necessary "fail-safe" devices. Where personal protective equipment should be worn, failure to provide it, or failure to wear it, may leave the operator vulnerable. It is attention to detail that is so necessary in the anticipation and avoidance of accidents. Adequate safety measures can reduce the risk of accidents, and therefore reduce dramatically the numbers that actually occur.

Table 30

RESPONSE TO QUESTION, "ARE ADEQUATE SAFETY MEASURES BEING TAKEN TO REDUCE RISK OF ACCIDENTS OF A MECHANICAL OR ELECTRICAL NATURE?"

	NHS		*Private*		*University*	
Yes	69	82.1%	20	76.9%	28	84.8%
No	6	7.1%	3	11.5%	3	9.1%
N/A	9	10.7%	3	11.5%	2	6.1%
Total	84	100%	26	100%	33	100%

As can be seen, there is a strong response from all three sectors of our sample to the effect that adequate safety measure were being taken in their laboratories to reduce the risks of accidents of a mechanical or electrical nature. Minorities of 7% to 11.5% believed that the safety measures adopted were not adequate to reduce risks from this category of hazards.

7.4 *Reprimands for Mechanical or Electrical Hazards*

The evidence suggests there is less reason for concern in relation to mechanical or electrical hazards in the lab than with some of the other hazards covered by the survey. Nevertheless, we our sample members about the administration of reprimands and the following table provides their responses.

Table 31

RESPONSE TO QUESTION, "HAS YOUR DEPARTMENT BEEN REPRIMANDED BY A REGULATORY AGENCY CONCERNING MECHANICAL OR ELECTRICAL HAZARDS IN THE PAST THREE YEARS?"

	NHS		*Private*		*University*	
Yes	2	2.4%	1	3.8%	0	0%
No	73	86.9%	20	76.9%	32	97.0%
N/A	9	10.7%	5	19.2%	1	3.0%
Total	84	100%	26	100%	33	100%

7.5 *Spending on Measures to Improve Mechanical and Electrical Safety*

Our now familiar question was posed in respect of electrical and mechanical hazards. Table 32 provides responses.

Table 32

RESPONSE TO QUESTION, "HAS YOUR DEPARTMENT BEEN UNWILLING TO SPEND MONEY ON IMPROVING SAFETY IN RESPECT OF MECHANICAL OR ELECTRICAL HAZARDS IN THE LAST THREE YEARS?"

	NHS		*Private*		*University*	
Yes	4	4.8%	1	3.8%	0	0%
No	58	69.0%	18	69.2%	27	81.8%
N/A	22	26.2%	7	26.9%	6	18.2%
Total	84	100%	26	100%	33	100%

There appears only limited evidence here of a lack of willingness to spend money on safety improvements in relation to mechanical or electrical hazards. The NHS would seem to be the worst offender with four out of 62 (6.5%) responses in the "unwilling" category once the "not applicable" responses have been discounted. In general, mechanical and electrical hazards appear to be taken seriously and employers are willing to spend money on rectifying them.

7.6 *Comment on Electrical and Mechanical Hazards*

Most labs appear to provide adequate training for their workers in matters relating to avoidance of mechanical and electrical hazards, but 15.5% of our respondents said that this was not the case. A large majority felt that adequate measures were being taken to reduce risks of accidents of a mechanical or electrical nature with only 9.3% stating the opposite and three cases (2.3% of those responding) said that measures were inadequate. In only five cases (4.6% of those responding) was there a report of employer unwillingness to spend money on improving safety with regard to mechanical or electrical hazards. Against this fairly impressive background of self-regulation in the case of electrical and mechanical hazards, we find that the HSE is apparently more strictly interventionist, with three cases (2.3%) being reported of reprimands being issued in respect of such hazards. Interestingly therefore, it seems that there is as much, if not more evidence of intervention by the HSE in respect of mechanical or electrical hazards where the level of accidents and reported concerns is very low, as in the case of hazards like stress, where the concerns of safety reps is far higher.

8. Concluding Comments

The health hazards facing those who work in laboratories are not insignificant. This survey has confirmed and highlighted some of the problem areas. Most tellingly, there are worrying mismatches between the hazards and unsatisfactory practices identified by our survey and the issues on which the HSE has been most active in relation to health and safety in the laboratory. Dangerous chemicals and biological agents, potential allergens, WRULDs and stress are the sources of the largest number of actual cases of ill-health, together with a worrying absence of surveillance which broadly coincides with these areas. On the other hand, it is in precisely these areas where there is the lowest level of evidence of HSE intervention. Interestingly, in the case of mechanical and electrical hazards, fewer of our safety reps perceived problems and there was evidence of more active enforcement by the HSE. This is the single most important factor to emerge from the survey, though the reader is directed to the commentary offered under each section for additional conclusions concerning the survey findings and the hazards in question.

Overall, it seems clear that there is a need for more active insistence on the enforcement of rules by the regulating authority—the Health and Safety Executive. As outlined in our introductionary section, the HSE/HSC is seen to be doing excellent work in providing advice and information on best practice in health and safety, devising approved codes of practice and feeding into the formulation of detailed regulations covering hazards at work dealt with under European legislation. Despite this however, it is not as effective as it should be in enforcing the legislation. This would entail more inspection and more active administration of sanctions to employers who are in default of their legal duties. The Government's "Revitalising Health and Safety" strategy, set bold targets for reducing absenteeism arising from accidents and work related ill health. The most effective way of making significant progress towards the realisation of these targets would be to vigorously enforce the law in the form of all the various regulations and Approved Codes of Practice issued in respect of health and safety at work. This need emerges clearly from our survey of laboratories. That there is a wider and more generalised cause for concern in relation to the need for more effective inspection and enforcement is well known. We suspect that similar studies of other groups of workers would bear this out, though as will be clear, our empirical evidence does not allow this generalised conclusion at this stage.

Amicus Health, Safety and Working Environment

May 2004

Memorandum submitted by ABI

ABI is a trade association which represents over 400 insurance companies. ABI has been asked to submit evidence to the Work and Pensions Committee on the following points:

— The relationship between insurance premiums and the claims record of a company or industry. We are interested both in an outline of the current position and any proposals ABI has for change.

— Whether insurance could or should play a role in encouraging support for rehabilitation into work following injury or ill-health.

1. How Insurance Companies set Premiums

The focus of this inquiry is health and safety at work; therefore the following comments will focus on how Employers' Liability insurers operate. Employers' Liability insurance is compulsory: most businesses are required to take it out. Employers' Liability insurance covers employers against their legal liabilities to pay damages to their employees if they are injured or become ill because of their work.

2. The operation of the Insurance Market Cycle

The insurance market in the UK is both competitive and cyclical. It goes through "hard" and "soft" phases of the cycle. In a hard market, premiums will rise and capacity, or the "supply" of insurance is limited. In a soft market, competition is fiercer and rates will level off or even fall. The period 2001–04 has seen a hard market for most commercial classes of insurance and particularly for liability insurances. Prior to 2001 there was a relatively soft market for these insurances and premium income had stagnated since the early 1990s. The dynamics of this competitive market must be taken into account when considering how insurers set their premiums.

3. Underlying Costs

Like all businesses, insures must take into account their costs when deciding what they are going to charge their customers for their products. This is where the cost of rising personal injury inflation over recent years has had a significant impact. Research commissioned by ABI has found that the average cost of an Employers' Liability insurance claim rose threefold between 1996 and 2002. This research, which was carried out by Greenstreet Berman and is attached, identified a number of factors which had contributed to this increase. These factors included:

- — the falling discount rate;
- — the introduction of "no win no fee" arrangements; and
- — higher compensation awards following Law Commission recommendations.

Most liability insurers had been paying more out in claims costs than they were receiving in premiums during the soft market of the 1990s, so these increased claims costs eventually had to be passed on through higher premiums.

4. Investment Income

Liability insurance is a "long-tail" class of business; that is there can be a long time lag between the paying of the premium and all the claims being notified to the insurer. In the case of asbestos related diseases this can be a matter of decades. The problem with long tail business is that it is very difficult to predict, and Employers' Liability insurance in particular is a very unattractive class of business. The positive aspect of long tail business is that insurers can invest the premium income they receive and can therefore make returns on these investments. In the 1990s investment returns made a significant contribution to insurers' income, but recent economic conditions have been more difficult. In recent years, insurers have been putting far greater emphasis on trying to make an underwriting profit rather than relying on investment income.

5. Technical Pricing

Most insurance companies are now emphasising the need for accurate underwriting, with the emphasis on correct "technical" pricing. Much greater effort has been made to accurately assess likely claims development over a long period. Actuaries are much more actively involved in setting rates than in previous years. Where insurers are competing there is greater reluctance to offer cover at rates below what the insurer considers to be the technical price. This strategy will however be tested as the market softens over the coming months.

6. Setting Premiums

The factors that are described above have an impact on market conditions for liability insurance. However, they do not describe the process whereby an insurer actually underwrites a particular risk. This will depend on a number of factors, including:

- — size of the business, turnover, etc
- — trade or sector
- — claims experience
- — risk management features

Larger businesses will be rated in a different way to smaller businesses. Because larger businesses will have a "claims experience" insurers are much more capable of underwriting these businesses individually. They can predict the future number, type and cost of claims based on past experience. The larger the firm the more emphasis will be placed on individual underwriting. It will also be economically viable to send an insurance risk assessor to visit these firms, get to know the management and make recommendations for risk improvement. With a small business, whose premium may be measured in hundreds of pounds, it is often not viable or cost effective for the insurer to send a surveyor to the premises. Some insurers have hundreds of thousands of business customers and, like the HSE, they do not have the resources to visit them all.

However, insurers will still need to decide what rate to charge. In order to do this individual insurers have collated claims experience for groups of firms, usually by sector or trade. This allows the insurer to predict the number of claims which a sector is likely to generate. It should be remembered that many small businesses may not make a claim for many years, but if they are in a trade which generates a lot of claims they will still have to make their contribution.

The Department of Work and Pensions, in its review of Employers' Liability insurance, has emphasised that more effort should be made by insurers to link premiums to health and safety. Individual insurers have recently developed questionnaires and software to try and better understand the efforts being made by SMEs to manage their risks. The competitive insurance market is also a driver for insurers to assess and price risk as accurately as possible. The ABI and member companies are also successfully operating the Making the Market Work initiative (details attached) which assesses the health and safety performance of trade associations. These assessments are then circulated to all insurers who have agreed to take them into account when underwriting.

Whether insurance could or should play a role in encouraging support for rehabilitation into work following injury or ill-health.

Insurers already play a role in rehabilitation, in particular in the Motor and Employers' Liability insurance environments. However, coverage is inconsistent and limited; recent ABI work suggests around 8% of EL claimants that would benefit from rehabilitation actually receive it. At the same time, research has shown that rehabilitation could save 10–40% of the cost of compensation (a result borne out by a major rehabilitation services provider in motor insurance). ABI also estimates that comprehensive rehabilitation could save the taxpayer around £1.2bn per year in reduced benefit payments and higher tax revenues as claimants return to work (excluding any rehabilitation infrastructure investment by the Government).

If the benefits are potentially so great, why is rehabilitation relatively underdeveloped? Firstly, insurers are not involved in every workplace injury and illness. EL insurance only compensates cases where an employer is found negligent. In fact, EL claims account for only 7.5% of workplace absence.

Secondly, the EL system is fault-based, so the process of settlement is adversarial and lengthy. Often, it can be too late to make an offer of effective rehabilitation because the condition has deteriorated while fault is being established. Insurers also need to be confident that an offer of rehabilitation is cost effective. One option which could be considered is to compel claimants to accept rehabilitation where it is available and meets agreed standards, and/or offsetting the rehabilitation against the final settlement.

Insurers have already tried to develop products that combine rehabilitation as part of the EL package. Some have offered no-fault rehabilitation services, reckoning that the cost of providing such services would be more than offset by reduced claims frequency and damages. Although the response from larger businesses is reasonable, smaller employers are reluctant to invest in rehabilitation without better understanding of the costs and benefits, even when it is part of the EL offering.

Ultimately, insurance could and should play a role, and insurers already do. However, there needs to be recognition that other stakeholders, including Government and employers, would benefit substantially from rehabilitation and should bear part of the cost of its provision, either directly or through other mechanisms, including insurance.

ABI

April 2004

Visit to Brussels

27 to 29 APRIL 2004
Note of the Visit

TUESDAY 27 APRIL 2004

Briefing Dinner with Anne Lambert, Deputy Permanent rep and Kevin Dench UK rep

UK was perceived as having generally good health and safety. The EU was taking a more holistic view and was not seeking to legislate continually. Much of the administration for EU Health and Safety matters was based in Luxembourg or Bilbao. Advisory Committees on Health and Safety had been set up with representatives from each country's employers, employees and Health and Safety organisations.

New Member States were expected to comply with relevant legislation on May 1. The process for non-compliance would be a warning letter, then a reasoned opinion, case brought to court, (ECJ), judgement and if proved, fines (on a daily basis could be demanded). The UK opt out of the Working Time Directive is under consideration. Recent decisions of the European Court of Justice (Simap and Jaeger) had created difficulties regarding implementation of the Working Time Directive, particularly regarding hospital doctors on call and, possibly, offshore workers.

WEDNESDAY 28 APRIL 2004

Andrew Fielding, Deputy Head of Cabinet to Commissioner Dimas

The health and safety systems in new Member States may take time to establish and require additional finance. Employment strategy was agreed via the Open Method of Co-ordination (OMC) using data provided by EUROSTAT. A current trend was to merge topics such as employment, education and economic affairs.

The process involved, initially, comparison between states; agreement on the principles; agreement on the indicators: agreement on incentives. The reports on results are then published resulting in peer pressure. The new Member States might have to pass new legislation in the new regime of Commissioner DIMAS. He was expected to be a commissioner for some five and a half years, but not necessarily in the same post, the new President will decide responsibilities after the elections in June. A high level group has been set up to conduct a mid-term review of the Lisbon employment strategy in 2005. Its remit is to make proposals to the Commission to give renewed stimulus to the strategy and improve delivery.

The Employment Council on 1 June was expected to agree Social Security regulations giving authority for an EU Health Insurance card, with data held at national level. Legislation on optical radiation to is yet to be completed. It was unlikely that any progress would be made on the pensions and insurance aspects of article 15 of the proposed directive concerning the principle of equal treatment between women and men in access to and supply of goods and services. There was one major difference with the UK in the Health and Safety policy area concerning the use of the wording "so far as is reasonably practical" in legislation. A reasoned opinion had been issued. If unresolved, the next step is the European Court of Justice. Apart from this there were only minor irregularities.

BERNHARD JANSEN—DIRECTOR RESPONSIBLE FOR HEALTH AND SAFETY AT DG/EMPLOYMENT

European legislation and strategy on health and safety is an attempt to create a level playing field for Member States by setting minimum standards. Otherwise, there is autonomy at national level. Policy priorities are changing as a result of sociological and demographic changes. We need to know more about risks for older workers, there are a higher proportion of people working in service industries and more women in the labour market. The Commission keeps track of implementation of European legislation by Member States. There is a senior labour inspectors committee that looks at what can be learnt from experience in other countries. The Commission has an interest in seeing legislation enforced in a comparable way across Europe. In accession countries, there is a need to bring about a culture change, to create a prevention culture. The European Agency for Health and Safety at Work has established a risk observatory and aims to spread good practice. There are also twinning arrangements between different countries.

They are trying to take a sectoral approach and getting trade associations to agree guidelines and are looking at financial incentives. The current strategy is an attempt to create an overarching strategy and is different to the emphasis on legislative programmes in the past. The emphasis now is less on new legislation than on implementation. There is concern among employers at complexity of legislation and need for simplification. The UK does well on fatal accident statistics but there are issues about reporting levels more generally.

LIZ LYNNE MEP

Liz Lynne is the Health and Safety spokesperson for the Liberal Democrats. She was also shadow raporteur on the Working Time Directive. Despite intense negotiations, the European Parliament had voted against the UK's retention of its opt-out on this. Other recent activities had included work on whole vibration, physical agents directive and on noise.

STEPHEN HUGHES MEP

MEPs were keen to see an action plan to implement the European Commission strategy, with a timeline and resources allocated. The Commission had agreed instead to give a detailed account and report of what had happened. Most of the directives have a five year review clause and most are overdue for review. When this begins, there should be a major opportunity for simplification, possibly both at European and UK level. Work was underway to deal with the results of Simap/Jaeger cases and on how to deal with issues such as stress through the design of the workplace. Occupational health is important to the Lisbon employment agenda. It is important that accession countries are up to speed. At UK level, codes of practice and guidance in the UK tend to be reasonable, but more may be needed on training and more action on rehabilitation, in particular. Ensuring duties are complied with by micro companies is an important issue across Europe. Asbestos continues to be an issue.

Marc Sapir—European Trade Union Confederation (ETUC)

The European Trade Union Confederation (ETUC) was set up in 1973. In 1989, it established the European Trade Union Technical Bureau (ETUTB) to monitor the drafting, transposition and application of directives coming out of the 1986 Single European Act to regulate the working environment.

The harmonisation exercise was limited in scope and should have gone further, to cover state duties rather than just employer duties. The UK concept of risk assessment is key. UK legislation includes the "as far as reasonably practicable" concept. This needs to be clarified and there are questions as to whether this can co-exist with risk assessment. ETUTB is trying to see what has been happening at a national level. Health and Safety is under-prioritised at European level because of autonomy left to Member states.

The context in which health and legislation operates is changing. Emerging health issues such as stress are now big issues to deal with. The organisation of work and work/life balance issues are relevant. There was also a question of responsibility, as the supply chain makes this more complicated. The qualitative aspects of work are a growing question. These are complex issues and we need to build up issues to address this. There are questions about whether the UK has the right environment for sustainable delivery. While it has one of the most advanced national strategies, coverage of occupational health services very low.

Reaching small and medium enterprises is difficult and there is no one answer as to how this should be done. There are different models. For example, Denmark concentrates on sector-based technical expertise, but there is a question as to who is part of the sector. Finland has broad coverage but there are questions as to quality.

Ms Natasha Waltke, Director UNICE

Recent work was concerned with stress and energy risk. The debate needed to take account of traditional risks. Stress and musculoskeletal disorders were a different nature of risk and more difficult to tackle. While some directives were partially relevant, the legislation doesn't seem entirely appropriate.

Article 138/9 allows negotiation of agreement under the relevant health and safety Article (137). New Member States would take some time to adjust to their new roles and responsibilities in the health and safety area.

There were concerns that new legislation is being passed without evaluation of old. Directives now coming through (eg on noise and whole body vibration) which pre-date the current strategy and are considered to be distant from reality and scientific evidence. The Legislation is complex and practical implementation is difficult. There is a need to focus more on establishing a prevention culture and understanding of requirements. There is no need to revisit the framework directive, which is sufficiently general and leaves implementation to Member States. However, some of the individual directives might benefit from review. It was important that accession countries have sufficient support for implementation so that we have a level playing field.

Thursday 29 April

Mr Jerome Vignon, Director, Social Protection and Social Integration, EU DG in Employment and Social Affairs

The mid-term review of National Action Plans was due in 2005. The UK plays a special role. The initiatives of the Lisbon Council were a milestone comparable with the 1992 Delors Social model. The use of OMC had meant that a treaty change was not necessary.

Since Lisbon, the emphasis had shifted away from the labour market. The UK had been a forerunner in issues such as social integration. The new leaders in various EU states had brought more liberated ideas leading to a flexible labour market with equal access. Many provisions agreed at Lisbon had not however been implemented and investment in training had diminished.

Luisella Pavan Woolfe, Director, Horizontal and International Issues

Remit is to address gaps in the situation of women across Europe. A recent Report to the Council covered: pay, unemployment, work and family life and decision making in parliament.

Draft Article 13 is to help Member states follow up UN Beijing agreements and prepares Member States for Bejing + 10 next year, by creating a European position. Makes existing legislation easier to interpret and implement for both judges and citizens. Modernises text to take into account advances eg Access to Employment Directive

The proposed directive implementing the principle of equal treatment between women and men in the access to and supply of goods and services. This confronts discrimination outside of the labour market ie access to goods and services not employment and education. It proposes, for example, that in insurance, there should not be risk assessment according to Gender (for example, in health insurance premiums where women currently pay greater premiums). This has been discussed in a council working group for a year. The

timetable for the future is that Members have their first orientation debate on the substance (not details) in June 2004. Further work will be done between June and December. The aim is to have the text ready at the beginning of 2005. There will be a long transitional period of 2–6 years to allow industry to adapt.

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