The management of health, safety and welfare issues for NHS staff

New edition, 2005

A part of the NHS Confederation working on behalf of the NHS

NHS Employers

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CHAPTER 1: INTRODUCTION

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Chapter 1: Introduction

The management of occupational health and safety in the NHS has come a long way since the launch in 1998 of the 'Blue Book', *The management of health, safety and welfare issues for NHS staff*.

Occupational health in the NHS has seen the number of consultants double and the introduction of a new association for NHS occupational health nurses. We have also seen the launch of NHS Plus which, we hope, has led to an increase in investment in NHS occupational health services.

High-profile cases on the health and safety front have seen a substantial rise in the number of qualified health and safety managers in NHS organisations, particularly in the developing primary care sector.

We have also seen a rise in expectations of what the service can and does provide. The roll-out of occupational health and safety services to general practitioners and their staff, and subsequently to dental practitioners, has seen NHS occupational health, and health and safety units, develop new ways of delivering services to meet the needs of a dispersed and fragmented client base.

A successful campaign to recruit more staff for the NHS, including those from abroad, has seen the development of protocols for assessing fitness for work and an upsurge in the testing of staff for blood-borne viruses.

New issues for occupational health assessments – and increased responsibility – have arisen from:

- work-related stress rising to the top of the political agenda
- the full introduction of the Disability Discrimination Act 1995
- targets for reducing ill-health retirement
- a greater emphasis on rehabilitation.

An increasing awareness of the need for multi-function working, to deal with issues such as stress, has seen occupational health professionals, and health and safety professionals, working more closely than ever before and the development of truly multi-professional teams.

Occupational health smart cards (OHSCs) for doctors in training have focused the minds of occupational health staff on what information they are prepared to accept from other occupational health units and what proof they should require to ensure the validity of data.

The Association of NHS Occupational Health Practitioners (ANHOPS) and the Association of NHS Occupational Health Nurses (ANHONS) came together for the first time to develop a protocol for all of their members for validating samples. Occupational health staff will be closely involved in the extension of the OHSC to all medical grades during 2004–6.

Yet the NHS continues to change. The role of the Department of Health has changed irrevocably as it passes control to front-line staff and new agencies, and takes on a more advisory role rather than a guiding one.

Responsibility for the healthy workplace now sits with NHS Employers, the new employers' organisation for the NHS in England, which is part of the NHS Confederation.

Our aim is to provide advice and guidance to NHS organisations on a wide range of healthy workplace issues, including health and safety, occupational health, mental health, stress, musculoskeletal disorders (MSDs) and the management of sickness absence.

This document is a response to the requests from colleagues in the field for updated guidance and to the latest report by the National Audit Office (NAO) and the Public Accounts Committee (PAC).

We have tried to:

- provide information on what the NAO and PAC expect the NHS to do to improve occupational health and safety management
- give summaries of already-printed guidance on the major issues facing NHS employers
- point people in the direction of further help and assistance.

We have included the issues that are currently considered the most important, such as MSDs, slips and trips, and stress. The perennial favourites, latex and needlesticks, have their place as well.

Most importantly, we have tried to provide a view of what the service should look like and what it should aim to achieve as it moves forward.

The NHS is constantly changing and the occupational health and safety services that work within it, have to change and adapt with it. This guidance is also available on the NHS Employers website at www.nhsemployers.org where we will incorporate subsequent updates.

We are already looking at better, more effective ways of providing a service across the whole of the NHS that is consistent in its standards and its delivery. I hope that this document will assist you in reaching this goal.

Julian Topping
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NHS Employers

CHAPTER 2:
MAIN ISSUES HIGHLIGHTED BY THE NATIONAL AUDIT OFFICE REPORT

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Chapter 2: Main issues highlighted by the National Audit Office report

Introduction

In April 2003 the National Audit Office (NAO) issued their report on health and safety in the NHS (*A safer place to work: improving the management of health and safety risks to staff in NHS trusts*). It looked at the management of health and safety issues in the NHS and how it had improved since the previous report in 1998.

This chapter forms part of the response to the recommendations made by the NAO, and later accepted by the Public Accounts Committee. It highlights the main issues raised and advises NHS staff of the response made on their behalf.

Sickness absence figures

The NAO collected sickness absence figures from all NHS acute, ambulance and mental health trusts in England. These figures showed that in 2001 the average sickness absence rate was 4.9 per cent.

NHS employers were set a target of reducing the levels of sickness absence by 20 per cent by 2001, and by 30 per cent by 2003, from a baseline set in 1999. This target was set as part of the public sector accounts targets for the public sector. The NAO has identified that at the end of 2001, trusts were 0.6 per cent off meeting the target.

The NAO gives average sickness absence figures for all public administration, education and health employees of 3.7 per cent, compared with the 4.9 per cent for the NHS.

The latest figures available for the public sector as a whole are 7.86 per cent in 2002.

Sickness absence rates

Target/ out turn	All NHS trusts	Acute trusts	Mental health trusts	Ambulance trusts
2000 Target	4.6	4.3	4.9	5.7
Out turn	5.1	4.8	5.4	7.1
2001 Target	4.3	4.1	4.5	5.3
Out turn	4.9	4.5	5.1	6.8

Accident figures

The NAO shows that in 2001/02 the number of accidents per 1000 staff per month was 18. This equates to a total of 135,172 accidents during the year.

NHS employers were set a target of reducing the levels of accidents to staff:

- by 20 per cent by 2001
- by 30 per cent by 2003 from a baseline set in 2001/02.

Some 23 per cent of trusts have met the 20 per cent target, while the total number of accidents has risen by 24 per cent.

The Department of Health, NHS Employers and the NAO agree that much of this increase is due to better reporting and awareness. It is also the case that the NAO figures for 2001/02 are based on a 99 per cent return, while those for previous years were only based on returns in the lower 80 per cent range.

Accidents to staff

Year	Number of accidents	Number per 1000 staff
1998/99	120,474	19
2000/01 (baseline)	108,742	13
2001/02 (1st target)	135,172	18

Accidents range from minor slips or trips to major accidents resulting in time off work. Returns to the Health and Safety Executive (HSE) for accidents reportable under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR) have fallen by 255 over the last five years, indicating that the numbers of more serious accidents are being reduced.

Ambulance trusts have the highest rate of accidents, at 28 per 1000 staff, per month.

Risk assessments and reporting procedures

The NAO found that all NHS trusts have now adopted or developed an accident recording system. Most have taken action to encourage staff reporting, including fostering a 'just and fair' or 'blame-free' culture.

Four-fifths of NHS trust health and safety leads rate the effectiveness of their reporting systems and the completeness of their data as above average. However, HSE statistics suggest that only 42 per cent of reportable injuries were reported. The NAO report on violence and aggression in the NHS also found a level of under-reporting of around 39 per cent.

Further work needs to be done to ensure that:

- staff understand how and why they should report accidents
- trusts provide support to those who do.

The NAO highlighted the difference in type and quality of risk assessments done by 84 per cent of trusts that currently do them regularly. The 16 per cent of trusts who do not currently carry out risk assessments, and those who only perform them once every three years, need to revise their risk assessment to comply with the law.

While compliance with health and safety legislation has improved, both the NAO and HSE have found a widening gap between the best and worst performing trusts. The NAO noted that the best performing trusts in improving their health and safety compliance were those that had the active commitment and support of the chief executive and senior staff.

Integration of clinical and non-clinical risk management

The NAO found that most NHS trusts have improved their overall approach to health and safety risk management. However, there are still constraints on adopting an integrated approach to risk assessment, covering both clinical and non-clinical risk.

Staff training

The NAO highlighted concerns about the quality and content of training given to new staff and the inconsistent provision of in-service re-training. Once the current pilot scheme is completed, NHS Employers will work with colleagues in the Welsh Assembly to assess the merits of adopting a scheme similar to their health and safety passport. Trust boards will need to decide locally whether they wish their staff to be involved in any scheme that might be launched.

Costs

The NAO found that despite the requirement for trusts to collect data, so that they can estimate the cost of accidents, sickness absence, ill health retirements and occupational ill-health, only 9 per cent of trusts had attempted to comply. Further work needs to be done to ensure that trusts collect data and work to identify these costs.

The NAO has attempted to assess the broad direct costs to the NHS of accidents to staff and has estimated, using the best data available, that these will be in the range of £173 million a year.

They also state that the estimate of work-related sickness is low, at 7.6 per cent, and could be as much as 15 per cent.

Fast-tracking

The NAO states that staff absence has a direct impact on the ability of the NHS to treat patients. This can cause an increase in costs through using bank and agency staff. At the same time, they point to research that shows early access to rehabilitation services

means a speedier return to work. It also identifies the issue within the NHS about fast-tracking staff for treatment, to speed up their rehabilitation and return to work.

While some 68 per cent of trusts have developed a fast-track treatment programme, there is still a strong belief in the NHS that this is in some way depriving patients of care. The Department of Health welcomed the NAO raising this issue so that it can be debated within the NHS. It believes that a properly managed fast-track system would place employers in a better position to provide quality services to patients, through maximising staff resources.

Occupational health provision

The NAO reports that while all NHS staff now have access to occupational health and counselling services, the quality and accessibility of services varies widely. The Department of Health accepted the NAO recommendation to review the way these are provided to the NHS, and to look at whether funding from NHS Plus is being used to improve NHS services as intended.

A submission on the way forward for the NHS has already been put to ministers for consideration.

Stress

The NAO identified stress as a major cause of sickness absence and a major concern of staff and unions. The Department of Health has accepted the importance of dealing with the issue of stress in NHS staff. It has also agreed with NHS Employers that while continuing to address the underlying causes through the Improving Working Lives initiative, there will be a major initiative on managing work-related stress in 2005.

NHS Employers will consult widely with NHS employing organisations, the health trade unions and the HSE to raise the profile of this issue further. NHS employers will be reminded of the need to assess for risk of stress and to take appropriate action to reduce these risks wherever possible.

Health and safety of contractors

The NAO identified confusion in the NHS about responsibility for information and training on health and safety issues for contractors working on NHS premises. The NAO identified over 28,000 contract staff working in 140 NHS trusts in 2001/02.

Chapter 10 provides guidance on the interface between trusts and contractors in relation to health and safety issues.

Ambulance trusts

- Sickness absence rates in ambulance trusts are higher than in any other part of the NHS.
- Ambulance trusts are smaller than most other trusts and therefore the effect of long-term sickness absence on their absence rates is more pronounced.

- Ambulance staff have historically suffered higher rates of back injury and musculoskeletal disorders (MSDs) than staff in other parts of the NHS, and these often result in long-term sickness absence.
- Over 80 per cent of ill-health retirements from the ambulance service are related to back injuries and MSDs.
- The Ambulance Services Association Health, Safety and Risk Management Committee (which includes representatives from Department of Health and HSE) is working on a national policy for manual handling and lifting.
- There are some good examples of work by ambulance trusts that has been done to reduce the risks of MSDs and back injuries.
- Some trusts are now working on the development of policies for rehabilitating front-line staff back into work (For example, East Anglia using external physiotherapy and getting paramedics back to work in four weeks, where previously it would have taken six months or they might never have returned to the same job.)

Detailed response from the Department of Health to the National Audit Office report

Introduction

In May 2003 the Public Accounts Committee received evidence from Sir Nigel Crisp, NHS Chief Executive, and Andrew Foster, Director of Human Resources, in support of the findings of the National Audit Office report, *A safer place to work: improving the management of health and safety risks to staff in NHS trusts*.

The National Audit Office made a series of recommendations for improvements to the management of occupational health and safety in the NHS. These were followed in October by further recommendations from the Public Accounts Committee.

The Department of Health has accepted all the recommendations on behalf of the NHS, and they are set out below in bold text, together with details of the actions arising from them. Department of Health responses are given after each recommendation, followed by any further comments from NHS Employers.

General response

'The health and safety of staff working in the NHS is paramount. We therefore welcome the publication of this report, which recognises the progress made in managing health and safety in the health service since the last report, and rightly highlights where more needs to be done.

'As the NAO has acknowledged, a significant programme of work has been taken forward during the last six years to improve compliance with health and safety legislation in the NHS. The Department of Health continues to see compliance with legislation and the provision of high quality occupational health services for NHS staff as

a high priority and will ensure that the progress already made by health service employers is built upon.

'The NAO study has highlighted some important issues and we are making sure that appropriate action is taken to address them. In particular, the Department accepts the importance of strengthening reporting and risk assessment arrangements and ensuring that employers are managing both clinical and non-clinical risks effectively. The importance of ensuring appropriate training and re-training in risk assessment and health and safety is also recognised. Similarly there are clear benefits from ensuring that all staff have access to quality occupational health services and are rehabilitated back into work as quickly as possible. For this reason we welcome the NAO comments on the issue of fast-tracking and the opening up of this subject for wider discussion within the service.

'The Department accepts the importance of dealing with the issue of stress in NHS staff and will continue to address the underlying causes through its Improving Working Lives initiative. We will also consult widely with NHS employing organisations, the health trade unions and the Health and Safety Executive to further raise the profile of this issue.

'Further work highlighted by the NAO study will be taken forward in partnership with NHS employers, the health trade unions, the Health and Safety Executive and the NHS Litigation Authority. Occupational health and safety is a key element of the Improving Working Lives Standard and the IWL accreditation process will be used to ensure that NHS trusts implement the NAO's recommendations and continue to improve.'

NAO detailed recommendations and Department of Health response by areas

NAO recommendation

The Department of Health should:

a) issue further guidance on the need for a more consistent approach to identifying and recording accidents with measures for tackling under-reporting, drawing on the experiences of those NHS trusts that have introduced good practice reporting systems

Department of Health response

The Department has made it clear in guidance that trusts should be carrying out regular risk assessments to identify risks and that records should be kept of all accidents. A common definition of an accident was issued in HSC 1999/229 in October 1999.

We accept that there are still wide variations in what is recorded by NHS trusts and that in many cases there is room to improve on under-reporting of accidents. We believe, with the NAO, that the latest figures mask a complex position, with numbers rising in some trusts because of better reporting and falling in others because of better risk management.

We are pleased to see the examples of good practice in the report and are disseminating them to the field in this guidance. This guidance also highlights the need for a more consistent approach to managing risk and improving incident reporting.

NAO recommendation

b) ensure that the new clinical accident reporting system being developed by the National Patient Safety Agency and the decision to transfer responsibility for reducing violence and aggression to the new Counter Fraud and Security Management Service do not undermine progress in developing integrated risk management systems

Department of Health response

We will work closely with the National Patient Safety Agency to ensure that systems introduced for both patient and staff safety are compatible with, and feed into, integrated risk management systems.

We will work closely with the new NHS Counter Fraud and Security Management Service to ensure this work is transferred smoothly and that its development is compatible with integrated risk management systems. Reducing violence against NHS staff will remain part of the Improving Working Lives strategy and the Department is currently developing the criteria for accrediting NHS organisations to the Practice Plus level of the Standard.

NAO recommendation

c) use the opportunity presented by the new performance monitoring arrangements under Shifting the Balance of Power, to encourage the new strategic health authorities and workforce development confederations to work with NHS trusts to set priorities and local targets for reducing accidents to staff, based on agreed definitions

Department of Health response

We will share information with strategic health authorities from the 2001/02 survey of reported accidents. This should enable strategic health authorities to set individual targets for each trust for reducing levels of accidents.

Workforce development confederations, through the Improving Working Lives (IWL) Leads, are already involved in local activities to tackle the problem of violence.

For consistency in data, trusts should use only the common definition issued by the Department for the purposes of recording accidents.

NAO recommendation

d) encourage the new Commission for Health Audit and Inspection to include questions in its national staff survey on staff's experience of health and safety, including the support provided, and to disseminate the results and examples of good practice

Department of Health response

The Department is working closely with CHI/CHAI on the development of the new national staff survey, which will be introduced from 2004/05. CHI/CHAI intend that the survey will seek the views of staff on all elements of the Government's human resources in the NHS Plan strategy. A key pillar of the strategy is to make the NHS a model employer, which includes full compliance with health and safety legislation.

NAO recommendation

e) help NHS trusts to prioritise actions for reducing accidents, by ensuring that the new NHS electronic staff records system is developed to capture information on reasons for work-related staff sickness absences and turnover

Department of Health response

The new NHS electronic staff record system will allow NHS employers to record the causes of sickness absence, including work-related reasons.

NAO recommendation

f) work with the NHS Litigation Authority and the Health and Safety Executive to support the development of a robust costing methodology for assessing the financial impacts/outcomes of accidents. Full appreciation of the impacts and costs should help NHS trusts to prioritise actions and develop sound business cases for investment in interventions

Department of Health response

We will approach the NHS Litigation Authority and the Health and Safety Executive to explore developing robust costings. Hopefully the introduction of the electronic staff record system will support this progress.

NAO recommendation

NHS trusts should:

g) review their health and safety policies to ensure they support a clear, unambiguous reporting culture in which staff understand the need for, and are confident in making, accurate and timely accident reports

Department of Health response

This is exactly the approach that is advocated by the Department. Guidance issued by the Department of Health and by the Health and Safety Executive makes it clear that trusts should involve staff in drawing up, managing and monitoring health and safety policies. This involvement not only encourages staff to buy into the policies, but also helps to ensure that they act as advocates for them in their particular area of work, thus increasing the likelihood of better reporting.

This guidance reminds trusts of the need to ensure that staff buy into their health and safety policies and that this includes providing a clear reporting structure that staff can follow with confidence.

NAO recommendation

h) review their accident-reporting systems to ensure that information requirements are properly defined, and staff are clear as to why the data is being collected and how it will be used

Department of Health response

Departmental guidance has consistently made it clear to trusts that they should establish robust, uncomplicated reporting systems to encourage staff to record details of accidents.

This guidance reminds trusts that staff need to be confident that accident reports are followed up and, where necessary, new risk assessments are carried out.

NAO recommendation

i) ensure that staff surveys include questions about health and safety management issues and constraints to reporting, and feed the results into action plans

Department of Health response

Many trusts do include questions on accidents and health and safety issues in their local staff surveys. The Department is working closely with CHI/CHAI on the development of the new national staff survey, which will be introduced from 2004/05. CHI/CHAI intend that the survey will seek the views of staff on all elements of the Government's human resources in the NHS Plan strategy. A key pillar of the strategy is to make the NHS a model employer, which includes full compliance with health and safety legislation.

NAO recommendation

j) ensure exit interviews identify cases where staff leave due to concerns about, or experience of, poor response to health and safety issues, and identify any action needed

Department of Health response

Departmental guidance has made it clear that trusts should be using exit interviews, involving a confidential face-to-face meeting, to allow staff to express concerns about work or work practices and that they should be reviewing the information collected regularly to establish what issues need to be addressed.

This guidance draws this recommendation to the attention of trust managers and reminds them of the need to collect and act upon this information.

NAO recommendation

k) use the opportunity presented by the new electronic staff records system to ensure that information on the extent and reasons for work-related sickness absence are captured, including absence due to health and safety accidents, and interventions prioritised accordingly

Department of Health response

The new electronic staff record system will enable trusts to identify the causes of sickness absence, including whether it is the result of a workplace accident. This information will assist employers in identifying causes of accidents and prioritising the necessary action to reduce or eliminate the risk.

NAO recommendation

l) set up a system to monitor the cost of work-related ill health retirements, legal fees incurred and compensation awards due to health and safety accidents, and ensure that this information is reported to the trust board at least once a year

Department of Health response

This recommendation is drawn to the attention of NHS trusts. However, under *Shifting the balance of power* the establishment of such systems is a matter for local decision.

NAO recommendation

The Department of Health should:

m) consider developing a national health and safety strategy to co-ordinate existing and new initiatives, including the work of the Employment Policy Branch, the Controls Assurance Unit, NHS Estates, strategic health authorities, workforce development confederations and relevant special health authorities

Department of Health response

The Department has asked NHS Employers, working with the HSE and other key stakeholders, to publish a new occupational health and safety strategy for the NHS in England.

NAO recommendation

n) review the approaches taken by NHS trusts to evaluate compliance with the health and safety controls assurance standard and consider the need for a more consistent approach to evaluation

Department of Health response

The controls assurance standard was not introduced as a means of performance management but rather as a self-help tool to assist NHS managers in identifying areas of good and poor performance against the key control standards they are expected to meet.

The Department recognises that NHS trusts do not take a standard approach to measuring their compliance with the standards, but feels that this is part of the flexibility that is inherent in a self-assessment process intended to be used as a learning tool. We will investigate whether it is possible to produce guidance that would encourage a more consistent approach to evaluation.

NAO recommendation

o) encourage NHS trusts to integrate their strategies for managing health and safety into their risk management arrangements and provide good practice guidance on integrating clinical and non-clinical risk management

Department of Health response

The Department already makes the case for integration of all risk management arrangements, clinical and non-clinical, into an integrated strategy, with a single reporting line to the trust board, in this guidance, and offers a good practice example.

NAO recommendation

p) commission and disseminate evidence-based guidelines, including lessons learned from other public and private sector service industries, which could help NHS trusts to improve the management of health and safety risks and the impact of interventions on stress, sickness absence and staff retention

Department of Health response

The Department already publishes good practice guidance to the NHS and, in the case of managing sickness absence, has taken on board and published lessons from both the private and public sector where it was felt they would be useful to NHS managers.

NHS Employers will identify further interventions that we feel could be of use to NHS trusts.

NAO recommendation

q) provide guidance on the expected content and coverage of health and safety induction and refresher training, and consider whether this is something that the NHS University could take on board, and at the same time consider the merits of adopting the health and safety training passport, which is being piloted in Wales

Department of Health response

The Department will consider whether health and safety issues can be included in the induction training that is being developed by the NHS University. Once the current pilot scheme is completed, we will work with colleagues in the Welsh Assembly to assess the merits of adopting a scheme similar to their health and safety passport.

NAO recommendation

r) liaise with workforce development confederations to ensure that they commission sufficient training places to meet the needs of the NHS for appropriately trained occupational health professionals, and encourage the wider employment by NHS trusts of trained health and safety professionals

Department of Health response

The Department will share this recommendation with the strategic health authorities and workforce development confederations and consider what action they can take to improve the commissioning of occupational health professional training.

NAO recommendation

s) review the resources available to occupational health and consider whether there are more cost-effective ways of providing the service, including evaluating the operation of NHS Plus and the extent to which income is being re-invested in occupational health services

Department of Health response

The Department is reviewing the role and management of occupational health services in the NHS and looking at more effective ways of providing a service to NHS staff. The role and operation of NHS Plus is under continuous review, as is the extent to which income is being re-invested in occupational health services for NHS staff.

NAO recommendation

t) remind trusts of their responsibilities under health and safety legislation for all staff on their sites, and commission research to determine the main challenges and solutions in managing contractors, with a view to promulgating guidance on managing the interface between trusts and contractors

This guidance reminds trusts of their responsibilities under health and safety legislation for all staff on their sites and provides guidance on the interface between trusts and contractors in relation to health and safety issues.

NAO recommendation

All NHS trusts should:

u) review their policies on health and safety risk management to ensure they reflect the views of staff and staff-side representatives and consider the extent to which clinical and non-clinical risk assessments should be integrated, including a single reporting line to the trust board

Department of Health response

This is exactly the approach that is advocated by the Department. Guidance issued by the Department of Health and by the Health and Safety Executive makes it clear that trusts should involve staff in drawing up, managing and monitoring health and safety policies, including those on risk management. This involvement not only encourages staff buy-in to the policies but also helps to ensure they act as

advocates for them in their particular area of work, thus increasing the likelihood of better reporting.

This guidance reminds trusts of the need to ensure staff buy-in to their health and safety policies and to ensure that this includes providing a clear reporting structure that staff can follow with confidence.

NAO recommendation

v) this guidance makes the case for integration of all risk management arrangements, clinical and non-clinical, into an integrated strategy, with a single reporting line to the trust board. Trusts should also ensure that they have an appropriate number of competent persons with expertise in health and safety, to assist the trust's compliance with health and safety legislation, and that they have the training, knowledge and experience to equip them for the role

Department of Health response

Departmental guidance already states that NHS employers should appoint competent persons to assist them in complying with health and safety legislation. Competent is defined as: 'someone with sufficient training, experience and knowledge to enable proper assistance to be given' and: 'not only technically competent, but also holding a management position where they are able to influence others in the organisation'. Membership of appropriate professional institutions is recommended.

NAO recommendation

w) adopt a strategic approach to induction and other training and development, based on an annual training needs analysis for all clinical and support staff, and ensure that responsibility for maintaining staff training records is clarified and that records are kept up to date

Department of Health response

The Department has made it clear in guidance that NHS trusts should carry out assessments of health and safety risks and that these should inform training needs. Training should be up-to-date, relevant and purposeful; it should be backed by evidence and provide scope for feedback from staff. Trusts will be reminded of the need to regularly review and update training and of the need to maintain accurate, up-to-date training records for all staff.

NAO recommendation

x) measure compliance with the occupational health and safety service standards and ensure that there is a documented long-term strategy, supported by annual plans, with priorities for action

Department of Health response

Compliance with the occupational health and safety service standards is already measured as part of the Improving Working Lives Standard. The Department is currently developing more rigorous criteria for accrediting NHS organisations to the Practice Plus level of the Standard.

This guidance draws the attention of NHS trusts to the need for developing a documented, long-term strategy for occupational health provision, supported by annual plans and priorities for action.

NAO recommendation

y) review their strategies for managing work-related stress and for providing counselling and other support to staff. Any arrangements should reflect departmental guidance on good practice and the option for fast-tracking should be fully explored and a clear, unambiguous strategy implemented

Department of Health response

The provision of counselling services for NHS staff (August 2000) set out the minimum service delivery standard for staff-counselling services and required employers to provide access to counselling for staff involved in traumatic incidents. The counselling provided should include defusing (reassurance and support), debriefing (assisting process of recovery) and, where necessary, post-trauma counselling. *The effective management of occupational health and safety services in the NHS* (November 2001) introduced a service delivery standard that counselling must be made available to staff within 48 hours of their requesting it.

The Department accepts the importance of dealing with the issue of stress in NHS staff and will continue to address the underlying causes through its Improving Working Lives initiative. We will also consult widely with NHS employing organisations, the health trade unions and the Health and Safety Executive to further raise the profile of this issue. NHS employers will be reminded of the need to assess for risk of stress and to take appropriate action to reduce these risks wherever possible.

The Department recognises that many trusts have already instituted arrangements for fast-tracking of staff who are absent from work due to sickness and also that, through fast-tracking, staff are able to return to their jobs more quickly. We will take action to identify best practice and to disseminate it to all NHS employers.

NAO recommendation

z) develop a robust system for recording and monitoring the health and safety performance of contractors, and be proactive in ensuring that contractors have appropriate health and safety arrangements, including training in risk assessment

Department of Health response

The Department will draw this recommendation to the attention of NHS trusts and will provide guidance on how they should ensure that their contractors have appropriate health and safety arrangements.

CHAPTER 3: HEALTH ASSESSMENT

3

Chapter 3: Health assessment

Introduction

Historically, NHS employers have carried out pre-employment checks alongside the appointment process. This has meant that the results of occupational health and Criminal Records Bureau checks often became available after a person had taken up their appointment.

In light of a number of high-profile cases, the Department of Health issued a direction from the Secretary of State[1] requiring that employers should not allow individuals to begin work until all the necessary checks have been completed.

Many managers in the NHS still see the occupational health service as being there only to provide pre-appointment health checks. In fact, the service's role is to:

- address the impact of work on health and of health on work
- reduce the incidence of illness and injury caused by work in the NHS
- ensure that work in the NHS fits the worker
- assist in ensuring that all staff are able to achieve their full capabilities at work.

It is true that pre-appointment health checks do play an important part in the work of the occupational health professional, but their remit is much greater.

The greatest contribution to the smooth and efficient running of the organisation is made by carrying out in-service health assessments. By doing this and by providing confidential, professional advice on issues such as rehabilitation and redeployment of staff who cannot carry out their full range of duties, the occupational health service makes a major contribution to staff retention.

This chapter sets out the reasons for carrying out pre-appointment checks and in-service health assessments. It also gives suggestions on how the process should be managed.

Pre-appointment health assessment

Pre-appointment health assessments are carried out:

- to ensure that prospective staff are physically and psychologically capable of carrying out the work proposed, taking into account any current or previous illness

[1] *Pre- and post- employment checks for all persons working in the NHS in England*, HSC 2002/08

- to ensure that anyone likely to be at excess risk of developing work-related diseases from hazardous agents present in the workplace is identified
- to ensure, as far as is possible, that the prospective employee does not represent a risk to patients and that the work is suitable and safe for the prospective employee.

All assessments must be made taking into account the requirements of the Disability Discrimination Act 1995 (DDA) and adjustments made, when reasonable, to ensure that people can work in the NHS regardless of physical impairment or learning disabilities.

Guidance issued in May 2002 (HSC2002/08), *Pre and post appointment checks for all persons working in the NHS in England*, under cover of a direction from the Secretary of State for Health, requires NHS employers to:

- prevent persons working in the NHS without an occupational health and/or risk assessment being carried out to ensure that:
  - they are capable of carrying out the work to which their prospective appointment relates, taking into account any current or previous illnesses and the obligations imposed by equal opportunities legislation; and/or
  - anyone likely to be at risk of developing work-related diseases from hazardous agents present in the workplace is identified.

The role of the occupational health service

Although responsibility for recruitment ultimately rests with the referring manager, the occupational health service's role is to provide specialist confidential advice to the employer and the applicant.

This role has to be taken forward while recognising that the occupational health professional has a duty not only to the potential employee, to whom they are providing a professional service, but also to that applicant's potential employer, patients and colleagues.

Responsibility for taking up references, including information about absence behaviour, and for making registration checks, rests with the referring manager.

No applicant should be refused employment on health grounds unless:

- expert occupational medical advice has been sought
- the applicant has had the opportunity to discuss issues raised with an occupational health professional
- the employing manager has given full consideration to all of the facts.

The employing manager decides whether to employ the applicant in the light of reports from the occupational health service and other relevant information. The referring manager may choose to employ an applicant despite concerns expressed by the occupational health service, but will need to be able to fully justify such a decision.

Timing of assessments

All NHS staff should have a pre-appointment health assessment carried out fairly, objectively and in accordance with equal opportunities legislation and good occupational health practice on:

- taking up their first post, whether or not this is preceded by a period of training
- subsequent appointment with new NHS employers
- job change, where this involves a significant change of duties.

Close attention should also be paid to the stage at which a pre-appointment health assessment is made to ensure that the process is not contrary to the requirements of the DDA. Good practice says that pre-appointment assessments should be made between the interview and job offer stage, although it is acceptable to make an offer of employment subject to the successful completion of checks.

Key points to consider in the assessment process

Throughout the process, it is essential to consider the following points.

- Patient safety is and should always be paramount.
- Risk assessment is individual and not based on diagnosis.
- Decisions must be based on evidence, not prejudice.
- The process must be transparent.
- Applicants need to understand:
  - how information about them will be used
  - to whom it will, or may, be disclosed
  - how decisions are made and on what grounds.
- The process requires trust and honesty from all parties.

Format of the assessment

The assessment should include:

- a health questionnaire completed by the applicant when applying for the post
- an interview with an occupational health nursing adviser, if the questionnaire answers need clarification
- onward referral to an occupational health physician, if this is appropriate.

The initial nurse interview may be carried out by telephone if it obtains the information required.

The questionnaire

The questionnaire should find out whether there are grounds for further investigation.

It is likely that in the majority of cases the occupational health questionnaire will be passed first to an occupational health nurse adviser or other suitably qualified person for consideration. They will then arrange an interview with the applicant to assess their fitness for the post.

An occupational health nursing adviser or a physician should carry out this interview. If an occupational health nursing adviser feels that they have not been able to get a clear and unequivocal picture of the applicant's past medical history from the questionnaire and the interview, they should refer the matter to an occupational health physician for further consideration.

The Clothier Report and the 'two-year rule'

An opinion expressed to the Clothier Report on the case of Beverley Allitt suggested that 'no applicant for a post in the NHS, who had a previous mental health problem, should be accepted for employment unless they had been free of drugs and other support for a period of at least two years'.

This proposition was not accepted by the Department of Health. However, this opinion has become accepted by some occupational health professionals and used as a reason for recommending that some applicants be refused posts.

The Department's guidance, *Mental health and employment in the NHS*, states that all cases should be judged on an individual basis and that it is not acceptable to use the 'two-year rule' as a reason for refusing employment.

In-service health assessment

An occupational health service is a proactive and preventative service rather than a treatment service. Its aims include the prevention of occupational ill health and injury by:

- hazard identification
- risk assessment
- elimination or control
- an audit of effectiveness.

Staff are bound to benefit from the availability of a competent, confidential service, with resulting improvement in morale. Work in these areas contributes significantly towards helping employers reduce occupational illness and injury. In turn, it improves the service to patients and reduces costs. Patients will benefit from being:

- cared for by staff who are appreciated
- protected from staff who might otherwise represent a hazard.

In the course of its work, an occupational health service will discover illnesses and injuries amongst staff that require treatment. An occupational health service does not

normally provide a treatment service and it is important, with the employee's consent, to inform the GP where such problems are identified.

The Department of Health has said that whenever possible staff should have fast track access to secondary treatment services.

The work of the occupational health service will be enhanced by:

- developing professional links with clinical colleagues in other disciplines
- liaising with the Employment Medical Advisory Service of the Health and Safety Executive
- maintaining strong professional links with other occupational health staff employed by the NHS and such colleagues employed outside the NHS
- playing a full part in the work of professional organisations, such as the Faculty and Society of Occupational Medicine, the Association of NHS Occupational Physicians, the Association of Occupational Health Nurse Practitioners (UK) and the Royal College of Nursing Society for Occupational Health
- developing close working links with colleagues in health and safety, human resources and health promotion departments.

The work aims to develop integrated staff health, safety and welfare policies in NHS organisations.

Management referral

Managers may wish to seek medical advice about an existing employee where there is an employment or management issue involving health matters. A manager may refer an employee because of the possibility of the occurrence of an occupational disease. This will be done as part of the management of sickness absence or in consideration of early retirement on the grounds of ill health.

This referral system should not be used simply to obtain a second opinion. That, where necessary, should be arranged in the normal manner through a GP.

Managerial referrals to an occupational health service must be in writing. It is essential that both the employee and the occupational health service know the reason for the referral. Managers should ensure that explicit questions are asked of the occupational health service, preferably on a standard form, and a copy should be made available to the employee.

It is good practice for the manager to obtain the employee's consent for referral. The occupational health service must ensure that the employee's consent has been obtained before the employee is seen.

Managers need to be aware that employees may divulge information to an occupational health professional that they want to be kept in confidence. Such information will play a part in shaping the occupational health recommendations, but the information on which the advice is based will not be divulged to the manager.

The only exception to this rule will be if the occupational health professional considers that it is necessary to breach medical confidentiality, in line with the guidance provided by the General Medical Council and the United Kingdom Central Council for Nursing, Midwifery and Health Visiting.

The occupational health advice should be provided in writing and must be in accordance with the requirements of the Access to Medical Reports Act 1988 and the Access to Health Records Act 1990.

Assessment for ill-health retirement

When considering early retirement on the grounds of ill health, care must be taken to distinguish between advice on whether or not the individual is capable of continuing in employment and advice on the early payment of pension benefits.

The occupational health service advises on the medical aspects of suitability for continued employment. Whether or not an individual remains in employment is decided by the manager, taking into account relevant information that includes the advice of the occupational health service.

The NHS Pensions Agency decides whether an individual is entitled to the early payment of pension benefits on the grounds of ill health. While it is usual to try to make the two decisions at the same time, they are separate matters (see chapter 17).

Retention of records

Information given by the applicant, or obtained with the applicant's consent from previous employers or education providers, about his or her medical history (including sickness absence, relevant hospital admissions and medications) should be recorded. This information should, if the person is recruited, form part of his or her occupational health records. A catalyst for this procedure is the Occupational Health Smart Card (OHSC).

NHS Occupational Health Smart Cards

Doctors in substantive, recognised training posts across the NHS in England have been selected to participate in a Department of Health-sponsored project to test the use of personal data smart cards as they move from one NHS trust to another on their training rotations (see chapter 4). The project was introduced on a rolling programme from 2001 to 2004, with card issue based on postgraduate deanery areas.

The programme is now its second phase – 2004 to 2007. The scheme is being extended to career-grade doctors, medical students and locum doctors. One key aim of the project is to improve the effectiveness of the trust's occupational health service by standardising procedures for recording health checks, and transferring information to other trusts, as doctors move around the NHS for training or career purposes.

Operational guidelines have been published for occupational health services at the instigation of the professional organisations, the Association of National Health Occupational Physicians (ANHOPS) and the Association of NHS Occupational Health Nurse Advisors (ANHONA), to help with data entry onto the cards. These guidelines,

together with further information on OHSC, are available on the Department of Health website under Occupational Health and the NHS Employers website at www.nhsemployers.org Further information can also be obtained from Barbara.Levy@nhsemployers.org

Getting GP assistance

In a small number of cases, when the amount or nature of sickness absence, or other factors, suggest that the applicant may be unsuitable for the post offered, further information about the applicant's past medical history may be obtained from the applicant's GP.

This process will require the applicant's signed consent. They must be told precisely what information is being requested and why, before their fully-informed consent can be obtained. A copy of the applicant's consent, together with a copy of their occupational health questionnaire, should be sent to the GP with a request for specific information.

The occupational health service should clarify what information they want, taking account of the Access to Medical Reports Act 1988 and Access to Health Records Act 1999, advising the applicant of their rights and respecting the confidentiality of any clinical information obtained.

Because it falls outside the provision of general medical services, GPs can charge employers for this service. Direct arrangements for meeting their fees must be clear.

In line with the DDA, clinical judgements must be based on justifiable occupational health standards.

Further guidance

Further guidance on pre-appointment health assessment can be found in the HSC publication, *The management of occupational health services for healthcare staff*, paragraphs 23-28 and 35-38. This publication also includes an example of a health questionnaire in Annex 1.

CHAPTER 4:
THE OCCUPATIONAL HEALTH SMART CARD

4

Chapter 4: The Occupational Health Smart Card

Introduction

The Occupational Health Smart Card (OHSC) initiative started in 2001 with a remit to introduce smart cards to doctors in training across the NHS in England.

The cards contain personal and contractual information, together with the details of General Medical Council (GMC) registration status; results from criminal records checks; and occupational health details. Currently, more than 30,000 doctors in recognised training posts across the NHS have been issued with occupational health smart cards.

The introduction of the card has acted as a catalyst for looking at occupational health practice. As a result, the Association of NHS Occupational Health Practitioners (ANHOPS) and Association of NHS Occupational Health Nurses (ANHONS) have agreed a protocol for some of the data required on the card. A copy of the protocol can be found at the end of this chapter.

The OHSC is designed to:

- strengthen pre-employment procedures
- improve induction procedures
- free up the time of NHS occupational health services.

It records, in standard format, the outcome of essential pre-appointment checks on hospital doctors in training before they can be declared fit and safe to treat patients within their employing trust. Encrypted data is stored securely within the smart card, making the information available during staff appointment and induction to authorised local medical personnel.

Confirmation of a doctor's health clearance will save staff time and enable a doctor to start work immediately. The portability of the card will speed up the transfer of essential data between trusts.

Data access and security

Access to the data is on a dual-pin-entry basis. This is designed so that each level of card holder will have specified access to certain data screens only.

No one outside occupational health will have access to personal and confidential health data. An additional secure read-only database function allows prospective employing trusts to check summary occupational health status, previously recorded elsewhere.

Data is stored securely at a national database centre in West Yorkshire. Individuals can see what information is stored about them and any new information, or amended information, has to be validated by the doctor. Under the Data Protection Act 1998, staff can view or request a paper printout of their smart card data at any time. Trust staff can print out selected data relevant to their access rights and export that data electronically to other compatible databases.

Security has always been a very important consideration in the OHSC programme, and the technical solution meets industry-wide smart card standards laid down by the Government's Office of the e-Envoy.

The cards and card-issuing procedures (based on supra-trust postgraduate medical deaneries) have been designed to offer high levels of security that protect the data on the card and the integrity of the system as a whole.

Every card contains a photograph of the card holder so that, even if a pin number falls into the wrong hands, the trust operator is able to visually check that the person presenting the card is the person whose details are being accessed.

Protocols and information

A set of guidance and information leaflets has been produced.

Guidance from the Department of Health on procedures for trusts' medical staffing and occupational health users are currently available on a CD-ROM resource pack, on:

- the Department of Health's website
  www.doh.gov.uk/occupationalhealth/index.htm
- the NHS Employers website at:
  www.nhsemployers.org/employmentpractice/occupational_health_smart_cards

The guidance takes into account the various ways different trusts operate and offers guidelines on ways of working, but allows trusts to adapt the advice to fit their unique situation.

Other documents on the CD-ROM and website include good practice guides, Q&As for doctors and current newsletters.

The future

The smart card is currently being used by doctors in training throughout England. The GMC has already established links to work with the scheme and other grades of doctors can now access the cards through their local deanery.

Throughout 2005 the card will start to be issued to final-year medical school students.

Further solutions to accessing data and widening the remit of the OHSC are now being explored with the Department of Health and the GMC.

ANHOPS/ANHONS recommended standards for data entry onto Occupational Health Smart Cards (OHSCs)

1 It is recognised that it is a considerable responsibility putting data on a smart card that will be accepted by other NHS Occupational Health Departments on behalf of their employing trusts. This is especially relevant when dealing with hepatitis status in healthcare workers, including doctors in training, performing exposure-prone procedures[1].

Hepatitis B and Hepatitis C – use of identified and validated samples

2 It is important that those commissioning laboratory tests for Hep B and Hep C should ensure that samples tested are from the healthcare worker in question. Healthcare workers should not provide their own specimens.

3 The following standards for occupational health data recording have been agreed by the Association of NHS Occupational Physicians (ANHOPS) and the Association of NHS Occupational Health Nurse Advisors (ANHONA) as the two relevant professional bodies.

- Laboratory test results required for clearance for undertaking exposure-prone procedures must be derived from an identified, validated sample (IVS). Results should not be recorded in occupational health records, including the doctor's Occupational Health Smart Card, if not derived from an IVS.
- An IVS is defined according to the following criteria.
  - The healthcare worker should show a proof of identity with a photograph, eg trust identity badge, new driver's photo-licence, photo-credit cards or passport, when the sample is taken.
  - The sample of blood should be taken in the occupational health department.
  - Samples should be delivered to the laboratory in the usual manner, not transported by the health care worker.
  - When results are received from the laboratory, check that the sample was sent by the occupational health department.
  - Laboratory tests should be carried out in accredited laboratories, which are experienced in performing the necessary tests, and which participate in appropriate external quality assurance schemes.

4 In view of these recommendations, it may be necessary for individual occupational health units to do extra checks on some data, or repeat results before they are satisfied that the result can safely be entered on to the doctor's Occupational Health Smart Card at the initial data entry stage. It is vital that trusts feel confident collectively to make good and safe use of these cards – both during the implementation period and beyond – to save time, cost and duplication of effort,

[1] Guidance on Hepatitis B infected healthcare workers is contained in HSG (93)40, its addendum in EL(96)77 and in HSC/2000/020. More recently, HSC/2002/010, issued on 14 August 2002, provides detailed guidance on the management of Hepatitis C infected healthcare workers.

to make life easier for the doctors as they move around NHS training posts, and to provide a secure, accurate and up-to-date record of doctors' fitness to work with patients in the NHS.

Rubella and varicella antibodies

5 ANHOPS and ANHONA recommend that occupational health units accept data from a recognised UK or European laboratory or UK occupational health department. The varicella antibody field should only be used to record a laboratory result: a separate field is provided to record a past history of varicella infection (chickenpox or shingles).

Tuberculosis – check for BCG scars

6 In accordance with British Thoracic Society guidelines, the tuberculosis (TB) health check should include personal or family history of TB, symptoms compatible with TB, check for BCG history or scar, and – if skin test is positive (Heaf Grade 2-4) and no evidence of current TB – inform the person of TB risk and symptoms to be aware of.

7 The presence of a BCG scar must only be recorded if the scar has been seen by a member of the occupational health service. Small scars may be difficult to identify and, if in doubt, an experienced colleague should be asked for further advice. Although a history of BCG vaccination and scar formation is helpful, the presence of a BCG scar must not be recorded on the basis of history alone. The size of the scar is not relevant and need not be recorded.

Smart card data entry

8 Occupational health units should liaise closely with their trust human resources and medical staffing colleagues to ensure that initial bulk data entry, from existing paper or electronic records, is carried out as soon as possible after receiving cards from the issuing postgraduate deanery. The cards should then be passed on speedily to the doctors in training for validation in good time, before they move on to new training posts elsewhere. Local trust operating protocols will also need to be devised to handle card updates for staff arriving with an existing smart card received in a previous training post or placement.

CHAPTER 5: MANAGING SICKNESS ABSENCE

5

Chapter 5: Managing sickness absence

National Audit Office report

The National Audit Office (NAO) report of April 2003, *A safer place to work, improving the management of health and safety risks to staff in NHS trusts*, reported the following results.

- There had been consistent reductions in the levels of sickness absence in the NHS.
- The NHS had still failed to meet the target of reducing absence by 30 per cent by the end of 2003.
- However, the NHS had maintained its reductions at a time when other public sector organisations have seen their absence levels rise.

This chapter republishes guidance that was issued in 2000 and includes examples of good practice to support NHS employers in continuing to reduce absences in the NHS. It is also intended to help the NHS secure improvements in the quality of patient services, the quality of working life for NHS staff, and NHS productivity and efficiency.

The ministerial task force on health, safety and productivity, set up by the Government in the summer of 2004, will set new targets for reducing levels of absence among all staff. It will also look at the impact on absence rates of:

- effective health and safety management
- better access to rehabilitation for those who have been long-term sick
- improved management of workplace stress.

Occupational health and safety professionals have a major role to play in reducing sickness absence in the NHS. Reductions in the levels of accidents and of violence and aggression to staff, together with action to tackle workplace stress, can significantly reduce absence levels. These are areas where occupational health and safety professionals may influence policies.

National progress targets

The targets previously set as part of the public sector productivity targets ended in 2003. The Department of Health has agreed that until the ministerial task force sets specific targets, the NHS will work towards those set by the Health and Safety Executive as part of revitalising health and safety.

Costs

The NHS is Europe's largest employer. Manpower costs account for over two-thirds of the NHS total revenue budget in England. In 1997, the Nuffield Trust[1] estimated that the cost of sickness absence in the NHS was in the region of £714 million.

Management responsibility

Senior management involvement

In organisations where sickness absence levels are low, there is a strong senior management involvement and the board and chief executive are updated on a regular basis.

In these organisations, the board is also seen to participate actively in the process and the organisation's sickness absence rates are published alongside the rest of its rates. Managers must continually report progress on managing sickness absence and be seen to be fully involved in the process. More importantly, the same rules apply to managers as to all staff in the management of sickness absence.

Fieldwork and research[2 3 4] indicate that unless senior managers are fully engaged in managing sickness absence, and keep it at the top of their list of priorities, levels creep back up. The management of sickness absence has to be constantly monitored. The most senior managers in the organisation can best do this.

Senior managers will need to develop the policy for managing sickness absence, to be used throughout the organisation, in partnership with staff and unions. This needs to include:

- how the process is managed
- who is responsible for managing it
- how it will be monitored
- how reports will be made to board level.

The problem of multi-site trusts

Senior managers in multi-site trusts should ensure that a high level of supervision and support is provided to staff who are responsible for managing sickness absence in outlying sites.

Research suggests[5 6] that levels of sickness absence increase with the size of the organisation but that management action to reduce this is easier to take in a large organisation.

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[1] Williams, Michie, Pattani *Improving the health of the NHS workforce* Nuffield 1998

[2] Seccombe *Measuring and monitoring absence from work* IES Report 288, 1995

[3] Swansbro *Absenteeism – an issue in the American workplace* Business Topics 1997

[4] *Reviewing attendance in the NHS* HaWNHS/HEA 1999

[5] *Managing absence* CBI 1998

[6] *Sickness absence – a survey of 182 employers* IRS 1998

The NHS seems to bear out this finding, except in those trusts that are spread out over many sites. Large trusts on two or three sites generally manage absence well. When the sites are small and widespread, problems arise. These multi-site trusts generally have higher levels of absence.

Management accountability

With many small sites, it is more difficult to ensure that managers are controlling sickness absence in accordance with trust policy. The senior manager in each site is in a position equivalent to that of one of the senior managers in a large trust. The management of sickness absence depends on how much they are involved and what priority they give to it.

In trusts with multiple sites, it is essential that someone on each site (or group of sites) is given responsibility for receiving reports of absence, recording data, reporting up line and conducting return-to-work interviews. In this way, with greater supervision from the centre, it should be possible to overcome the problems associated with these large trusts.

The nominated person must have the authority to manage the process and must have the backing of senior managers.

Senior managers should produce and publish the trust's policy for managing sickness absence in partnership with staff and unions. The policy should be understood by all staff.

Senior managers must ensure a higher level of supervision of the process if it is managed in this way.

All managers must have the management of sickness absence as one of their personal objectives.

Oversight of process

In trusts where sickness absence levels are low, there is generally a higher level of monitoring by the human resources (HR) function. This allows HR staff, with responsibility for particular parts of the organisation, to notice any trends not identified by first-line managers.

In multi-site trusts, the use of the HR function can help in picking up trends and in supporting the local sickness absence manager when dealing with problems. NHS trusts with multiple sites should involve the HR function in a more direct way in managing sickness absence.

All other trusts should consider involving the HR function in a more direct way in managing sickness absence.

Pre-appointment checks

Another area in which HR can play a major role in the management of sickness absence is in carrying out pre-appointment checks (see chapter 3). All current research suggests that previous sickness absence records are a good indicator of future attendance.

Absence risk can be assessed at recruitment stage by:

- requesting absence data from previous employers
- asking about absence record at interview
- carrying out health screening[7].

Commitment to a healthy workforce

The Cabinet Office[8] recommended that action should be taken to address levels of sickness absence in the public sector. This included:

- encouraging staff to make full and effective use of welfare and counselling services in order to minimise absence
- reviewing the scope for more flexible working
- reviewing whether policies responded sympathetically to exceptional demands on staff from outside work
- considering introducing progressively earlier referral to occupational health services, to address cases of workplace injury or sickness.

These recommendations are based on the Cabinet Office assessment of good practice that works in both the public and private sectors.

Definitions

Absence[9]

A common definition of absence needs to be used across the organisation and must be based on the equation:

- hours lost compared to hours available.

It is essential that all staff involved in managing sickness absence are made aware of what the term covers.

It should not cover:

- maternity leave
- carer's leave
- any periods of absence agreed under family-friendly policies.

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[7] Current NHS Executive guidance, in line with Audit Commission reports, recommends pre-employment health screening and a check on previous absence records for all successful candidates before they start their employment.

[8] *Working well together – managing attendance in the public sector* HMSO 1998.

[9] Use of the equation of hours lost compared to hours available allows for the calculation of percentage of time lost and also for aggregating days lost for comparison with most public sector bodies. This method also circumvents the confusion caused by calculations using shifts (which may vary in length), days (which may vary considerably), or part days/shifts – all of which are currently used in the NHS.

It should cover:

- all unauthorised absence from work due to sickness
- long-term sickness (see below for definition).

All staff must be included in the reporting system (from chief executive to cleaner and including all grades of staff) and this should include medical staff.

Long-term absence

The definition of long-term sickness absence is important because it acts as a trigger for action that may include involving the human resources function, or the occupational health service, for giving advice on rehabilitation or redeployment.

There has been no common definition of long-term sickness absence in use within the NHS. The definition varies from four weeks to three months, and in one case to 'when it becomes apparent there is something seriously wrong'.

Those trusts that are dealing most effectively with their long-term sickness absence problems take action after four weeks.

It is recommended that:

- all trusts and health authorities should use a common definition for long-term sickness absence of four weeks
- after this period, action should be taken to address the problem.

Reporting

The essential foundation for successfully managing sickness absence is to ensure that the reporting system, by which staff report their absence and managers record and pass the information up the line, is set out clearly and maintained across the organisation by all staff.

Responsibilities must be made clear to all involved and where necessary training should be given to managers on how to fulfil their role.

Management must take the following steps.

- Set a time by which staff must report in – best practice suggests within one hour of the shift starting.
- Nominate a person to report sickness to, by telephone – best practice suggests the line manager. If the line manager works away from site or on a different shift pattern, then nominate a single person for all staff in that unit to report to. They will be responsible for reporting up line, and may be responsible for carrying out return-to-work interviews.
- Ensure that staff know that:
  - they must report in or it will be assumed they are absent without leave (a relative or friend may phone in if necessary)
  - they must report to the nominated person – not a friend on the same shift

  - they must provide brief details of their ailment and how long they expect to be absent
  - they must provide a certificate if they are absent for more than one week
  - they will have a return-to-work interview with their line manager or the nominated person on their return – even if they are absent for only one day.
- Ensure that line managers (or nominated persons) know that:
  - they must note details of absent staff when they report in
  - they must note the expected date of return
  - they must note the reason for absence
  - it is essential that a return-to-work interview is carried out for all staff when they return – even after one day
  - they must keep accurate and up-to-date records of sickness absence for all the staff they are responsible for
  - they must pass on information on absent staff to the central collating point, as soon as it is available. (If possible this should be done daily, but where this is not possible, then on a weekly basis. Monthly absence returns are not acceptable.)

Letting staff know the costs

It is essential to let staff know how much sickness absence is costing the organisation each year. They will then have a clearer idea of the effect on the day-to-day running of the organisation. It is also useful in reducing ad hoc sickness absence.

Selling the problem to staff

If staff are involved, it will help the organisation to resolve the problem through peer pressure, reducing the possibilities of staff feeling 'picked on' when they have return-to-work interviews, and putting management actions into an understandable framework.

- Senior managers should ensure that all staff know the reasons for actions being taken to manage sickness absence and the costs of not doing so.
- Line managers should be aware of the costs of absence of those staff they are responsible for.

Monitoring

The most successful sickness absence management includes a high level of monitoring, both by the HR function and by first-line managers. It is essential that the process includes the following provisions.

- There must be clear lines for reporting absence up line, so that it is recorded centrally.
- Senior managers must set a level of absence after which further action needs to be taken – usually involving a senior manager or personnel department.
- At any given time, first-line managers must be aware of who is absent and why.

- First-line managers must keep their own records that they can refer back to.
- If appropriate, line managers should discuss the use of the occupational health service or referral to the employee's own GP as a means of dealing with underlying health problems.
- Line managers should look for patterns of absence to enable them to approach staff if a pattern is apparent. This may be due to caring responsibilities, family pressures or just Friday/Monday syndrome.
- Line managers should be aware of the number and length of absences that staff have, before the problem is referred up the line to a more senior manager or personnel.
- The central data collection point/HR should be able to identify trends among those staff who have passed the agreed cut-off point for a review of sickness. They should bring these to the attention of line managers where they have been missed.
- First-line managers must conduct return-to-work interviews and find out the reason for absence and if there is an underlying health problem.

Information systems

An important part of keeping track of sickness absence levels is the quick reporting of data up line to the central collection point. Ideally, reports should be made on a daily basis[10]. This is easier where there is widespread use of IT and departments are linked to central functions by computer.

- Staff must ensure data is recorded on a daily basis.
- Data must be reported up line quickly, preferably on a daily basis.
- Reporting weekly is acceptable, provided data is recorded on a daily basis.

Audit Commission

The Audit Commission has identified accurate, accessible and well-presented information as a prerequisite for effective absence control. It states:

> Supervisors and line managers cannot control absence without the appropriate information and there is little point in setting corporate targets to reduce absence if actual performance cannot be monitored to see if it meets the target.

Accuracy

The central data collection point/HR must ensure that all staff are aware of the importance of collecting accurate data. Data that is only collected from part of an organisation – for example, data that leaves out doctors or is only collected for a percentage of staff – is no use. Aggregating data to allow for under-collection provides a false picture of the state of the organisation.

[10] *Managing best practice – maximising attendance* IRS 1997

Trigger points

One of the main uses of sickness absence data is to highlight staff on whom managers should focus attention. An increasingly common way of doing this is to set parameters or triggers that can help to determine where and when action is needed. The attendance records of individual employees can then be monitored against set criteria.

Triggers fall into two broad categories.

- Informal arrangements where periodic reviews of an employee's sickness absence pattern are carried out and it is left to the manager to determine whether action is required.
- Where more tightly-specified absence thresholds are used to identify when managers should introduce a formal review, counselling, reference to occupational health service or the taking of disciplinary action.

Typical triggers may be:

- cumulative number of days absence in a set period
- number of spells of absence in a set period
- combination of days and spells
- pattern-related absences.

Efficient and careful collection of sickness absence data will allow feedback to line managers, and give them sufficient information on trigger points, or allow the recording department to notify them if a trigger point has been reached.

This will support managers in taking action to review the absence record with the member of staff concerned or to make a referral to the occupational health service.

Bradford scores

Bradford scores allow managers to assess the irregularity of attendance of staff by combining measures of frequency and duration of absences. They show whether an individual's sickness absence record is made up of a few, or many, spells of short or long duration. They are most commonly used to monitor trends in sickness absence and to provide trigger points.

Costs

Line managers should be given details of the total absence costs for their work area. Research shows that it is essential for all staff to appreciate the costs of absence to the organisation.

Where first-line managers have been aware of the costs to their part of the organisation of an employee being absent, they have been more active and effective in managing absence.

Based on research carried out in the private sector[11 12], the basic data set for calculating sickness absence costs should include:

- salary cost
- replacement costs
- administration costs.

The following steps will help employees and managers to appreciate the costs of absence to the organisation.

- Basic calculations should be made for each grade, using the data set given above, and then made available to line managers.
- Line managers should be given details of total absence costs for their units on a regular basis.

To ensure involvement at senior manager and board level, the costs for each directorate or business area should be provided to its senior managers on a regular basis.

Training

The fieldwork and research[13 14] suggest that managers whose main responsibilities are clinical will require additional training, if they are to carry out their duties in respect of managing sickness absence. There are several strands to this, which are addressed below.

Managerial adequacy and responsibility

Managers will need to be trained to manage staff and to raise their skills to ensure that they can manage sickness absence. There will be an issue concerning the areas of responsibility that managers are being asked to assume and how best to explain them to the staff they are managing.

Managers will need to be made aware of:

- the process for managing sickness absence
- the costs to the organisation
- the effects it has upon the organisation.

They will need to be able to pass this information on to their staff as part of the management process.

They must be trained in return-to-work interview techniques. Managers should be given management training and time management training.

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[11] *Managing best practice – maximising attendance* IRS 1997

[12] Seccombe *Measuring and Monitoring Absence from Work* IES Report 288 1995

[13] Ibid

[14] Swansbro *Absenteeism: an issue in the American workplace* Business Topics 1997

Induction

Induction is the ideal first opportunity for new staff to be told what is expected of them in relation to the management of sickness absence. Trusts with lower levels of sickness absence all used induction as the first opportunity to inform staff of their responsibilities in this area.

The use of a printed staff code, given to all staff at induction, which included details of trust policy on sickness absence and the responsibilities of staff for reporting it, added weight.

- All managers should be given training in time management.
- All managers should be given management training.

A suitable management development programme should be aimed at developing management skills such as:

- leadership
- assertiveness
- conflict and confrontation
- performance coaching
- dealing with difficult people
- time management.

Occupational health

The Human Resources Framework for the NHS set a target for all NHS employers to 'have in place occupational health services and counselling, available for all NHS staff'.

The role of the occupational health department is to provide advice and education, particularly for the prevention of ill-health and the promotion of a healthier lifestyle. It can also contribute to managing sickness absence through:

- pre-appointment checks
- monitoring staff health through regular assessments
- recommendations for, and assistance with, rehabilitation and redeployment.

Bradford scores

Using Bradford scores, an employee's irregularity of attendance can be assessed by combining measures of absence frequency and duration. The scores show whether an individual's sickness absence record is made up of a few or many spells of short or long duration. They can be used to monitor trends in sickness absence, to provide trigger points for further action, and to provide comparisons with absence rates for the organisation as a whole.

The basic formula for calculating a Bradford score is S x S x D.

- S = the number of spells of absence in a specified period.
- D = the number of days (or hours) of absence in that period.

The following example illustrates the Bradford scores for three employees with the same annual absence of 12 days.

- One absence of 12 days, Bradford score = 1 x 1 x 12 = 12 points
- Six absences of 2 days each, Bradford score = 6 x 6 x 12 = 432 points
- 12 absences of 1 day each, Bradford score = 12 x 12 x 12 = 1728 points

The following example shows how the Bradford scores have been used by one trust.

South Devon Healthcare NHS Trust produces quarterly manpower reports for each clinical directorate, locality and staff group. In each case the report shows:

- percentage of staff with less than 300 points
- percentage of staff with 300 – 499 points
- percentage of staff with 500 or more points
- percentage of staff with five or more spells of sickness absence in a rolling 52 week period.

Sickness absence rates and average Bradford scores can be compared and can help to target action. For instance, the contrasting position of speech therapists and physiotherapists in the trust can be identified.

A high absence rate and a low Bradford score indicate a small number of staff with long absences. Low absence and a high Bradford score show a small number of staff with frequent short absences.

It is important to stress that any absence measure must be used with discretion. Best practice is to use a variety of absence indices providing information on different aspects.

Further information can be found in *Managing sickness absence in the NHS* published by the Health Education Authority as part of the Health at Work in the NHS project.

CHAPTER 6: MANAGING RISK

6

Chapter 6: Managing risk

Introduction

The National Audit Office (NAO) report of April 2003, *A safer place to work: improving the management of health and safety risks to staff in NHS trusts*, identified major failings in the identification and management of risk by NHS organisations. Its authors believed that the number of accidents in the NHS each year could be drastically reduced by effective risk assessment and improved risk management. To achieve this, NHS employers would have to place greater emphasis on training all staff in risk assessment procedures.

What is risk assessment?

Risk assessment is:

- identifying what hazards exist in a workplace
- assessing how likely these hazards are to cause harm to workers and others
- deciding what prevention or control measures are needed.

It is part of the systematic approach that employers are legally required to adopt in order to manage health and safety effectively.

What does the law say?

There has always been an implied requirement under the Health and Safety at Work etc Act 1974 for an employer to carry out risk assessment because the act lays down that 'reasonably practicable' precautions have to be taken to ensure the safety of staff and others on an employer's premises.

The Management of Health and Safety at Work Regulations 1992 impose specific risk assessment requirements. The main requirements are given below.

- All employers and self-employed persons must carry out an assessment of health and safety risks to employees and to others who would be affected.
- There must be a specific assessment of work that may put at risk the health of a new or expectant mother, or her baby, where women of child-bearing age are employed (Management of Health and Safety at Work [amendment] Regulations 1999).
- If there are five or more employees, the significant findings must be recorded.

- Risk assessment data must be shared with others (employees and other relevant persons) and, in specified circumstances, assessments must be reviewed as appropriate.

It is therefore necessary to carry out risk assessments, in order to identify actions that need to be taken to comply with the requirements and prohibitions imposed by, or under, the relevant statutory provisions.

Who is responsible?

On behalf of the employers, the chief executive of the organisation has the overall statutory and operational responsibility for managing health and safety. A board member (ideally an executive director) should be allocated clear responsibility for overseeing health and safety risk management across the whole organisation. This will show the board's commitment to the health and safety of staff, patients and visitors, and to the effective management of risk.

In addition, all employees have a responsibility to understand their role in managing health and safety risks, both present and potential, not only to themselves but also to others who may not seem to be directly affected.

When is risk assessment necessary?

A risk assessment should be done wherever there is a risk to the health and safety of staff, patients or the public.

Good risk management begins with hazard identification. When seeking to identify risks, it is essential to avoid the mistake of overlooking the obvious. The fact that some activities may have been undertaken for long periods without incident does not mean they are risk-free.

When hazards have been identified, risks should be assessed and appropriate action taken to remove, minimise and control them.

What should be done?

The appointed director, working on behalf of the chief executive and board, should be responsible for ensuring that appropriate risk management strategies and systems are in place, and that properly trained health and safety advisers are employed. Regular reports should be made to the board giving details concerning health risks and health and safety performance, noting emerging trends and recommending action as necessary. The board should ensure that sufficient time is allocated to discuss them.

For an employer, the main risk assessment duties include:

- making a suitable and sufficient assessment of the risks to the health and safety of employees and the risks to others, such as patients, who may be affected
- identifying the preventative and protective measures needed to improve workplace health and safety
- introducing the preventative and protective measures needed

- reviewing the assessment if there is reason to believe that it is no longer valid, for instance, if the process has changed, the building has been refurbished or an experienced member of staff has left
- keeping a written record of the findings of the assessment and any groups of employees particularly at risk
- having arrangements in place for the effective planning, organisation, control, monitoring and review of the preventative and protective measures
- providing any health surveillance identified in the risk assessment
- appointing competent people to assist the employer
- establishing procedures to be followed in the event of serious and imminent danger
- providing effective health and safety information, instruction and training for all employees on a regular basis, and ensuring that the training is updated and repeated on a regular basis
- consulting regularly with safety representatives and staff.

What is meant by 'competent persons'?

The NAO report found that only 43 per cent of NHS health and safety staff were accredited to the level of membership of the Institute of Occupational Safety and Health. A further 16 per cent held a general certificate in health and safety and 6 per cent held an NVQ in health and safety management. Furthermore, 17 per cent held various other qualifications at certificate level and 18 per cent had no qualification at all.

The Department of Health has accepted the NAO recommendation that all NHS employers should aim to have competent persons responsible for the day-to-day health and safety of their organisation, who are accredited IOSH members.

NHS employers should consider the following when looking at this role.

- The persons may be employees or outside consultants.
- They must be familiar with the work of the NHS and with the special problems associated with managing a 24-hour, 365-days-a-year service.
- It is advisable for NHS employers to have their competent health and safety advisers in-house rather than buying in services from external organisations that have little experience of the NHS.
- There must be sufficient competent people to carry out the work.
- They must be given adequate time and resources to carry out their functions, as well as having adequate decision-making authority.

NHS trusts will be able to achieve this by working in partnership with IOSH.

Further details can be obtained from:

The Institute of Occupational Safety and Health
The Grange
Wigston
Leicestershire
LE18 1NN

Tel 0116 257 3100
Web www.iosh.co.uk

Eliminating risk

In an organisation as large and as complex as the NHS, it will never be possible to eliminate risk completely. However, NHS employers should aim to eliminate as many unnecessary risks as possible. Where this is not possible, they need to reduce risk to a level that is considered acceptable by:

- combating risks at the source
- adapting work practices to make them safer
- taking into account any health factors affecting the work of individuals
- giving priority to measures that protect the whole workforce
- ensuring all staff are appropriately trained and aware of their responsibilities.

What risks should be assessed?

There is very little that takes place in an NHS organisation, whether it is a major acute trust or a general practitioner's surgery, that could not be assessed. However, an experienced health and safety practitioner will identify those areas that pose the greatest risk to safety and prioritise them for assessment. There are tools available to assist in identifying the areas of greatest risk and these are referred to later in this chapter.

When assessing risk, some of the main topic areas that should be considered are:

- manual handling
- control of substances hazardous to health (COSHH)
- violence and aggression
- slips, trips and falls
- needlesticks
- winter safety.

The risk assessment process

Risk assessment provides information on the nature of the problem, the stress-related hazards and how they might affect the health of those exposed to them and the healthiness of their organisation. Adequately completed, risk assessment allows the key features of the problem to be identified and prioritised in terms of the nature and size of their possible effects, or the number of people who may be exposed.

This, and the evaluation, will be an ongoing tool for continuous improvement and a source of key learning points for future risk management projects.

More detail on the process of risk assessment can be found in chapter 7.

Keeping records

When risk assessment takes place, NHS employers must ensure that records are kept and maintained to a satisfactory standard, to avoid risks recurring.

Under the Management of Health and Safety at Work Regulations 1992, it is a legal requirement, where there are five or more employees, to:

- record the significant findings of the risk assessment
- record the arrangements for planning, organisation, control, monitoring and review of the measures taken
- establish procedures for serious and imminent danger and for danger areas.

The records employers are required to keep will vary in range and will depend on the division of duties between different staff and departments, and the way in which information is communicated. In general, however, the records kept have four distinct functions, which are outlined below.

- They ensure legal compliance, in particular, the requirement to keep risk assessments on file for inspectors' visits.
- They provide a guide to safe working practices within the organisation, identifying additional precautions that need to be implemented to provide a safe place and system of work.
- They act as a pointer to issues that need to be addressed when devising staff training, for induction, skill-training and the promotion and development of supervisory and managerial staff.
- They become a baseline against which the work of the organisation can be audited. Documenting safe working arrangements provides a template against which actual performance can be judged.

The records themselves could be as simple as:

- including a list of core and other activities undertaken by staff
- identifying those that represent a significant risk and have therefore been assessed as such
- risk assessment forms and staff training records.

Each major risk assessment should include, in the records, the next time the work or task is to be reviewed. The records must be securely held, in compliance with the Data Protection Act 1998.

Benchmarking

Many organisations find it useful to measure their performance both within the organisation, area against area, and externally against other similar organisations. National benchmarking clubs already exist in the NHS, covering a number of areas of work such as health and safety, occupational health and hotel services.

Further details of these and other benchmarking groups can be obtained from:

The National Performance Advisory Group (NPAG)
87 Coval Lane
Chelmsford, Essex
CM1 1TQ

Tel 01245 544600
Fax 01245 544610
Web www.npag.org.uk
Email info@npag.org.uk

CHAPTER 7: THE PROCESS OF RISK ASSESSMENT

7

Chapter 7: The process of risk assessment

Introduction

Before a problem can be addressed, it should be analysed and understood, and an assessment made of the risk that it presents. Harm could be done, and resources squandered, if impulsive action is taken on the assumption that the problem is obvious and understood.

Most problems, even those that appear simple, are complex and not always what they seem. Some form of analysis and risk assessment is always required.

The risk assessment provides information on:

- the nature of the problem
- the stress-related hazards
- the way they might affect the health of those exposed to them
- the healthiness of the organisation.

Adequately completed, the risk assessment allows the key features of the problem to be identified and prioritised in terms of the nature and size of their possible effects or the number of people exposed.

This data could be used to inform the development of an action plan to address the problems at source, whenever it is reasonably practicable to do so.

Translating the findings

The way in which the information from the risk assessment is discussed, explored and used to develop an action plan has been termed ‘translation’. This is the translation of the risk assessment information into a reasonable and practical action plan to reduce risk.

Usually, the discussion and exploration of the problems and likely risk, facilitates the discovery of any underlying organisational pathology – major problems that may be hidden but give rise to the problems and likely risk factors. There is a clear analogy here with the general practitioner exploring the patient’s symptoms and discovering an underlying disease. This often makes intervention easier, as the underlying organisational pathology can be targeted instead of, or as well as, its symptoms (the problems and likely risk factors).

The development of the action plan, based on the evidence from the risk assessment, involves deciding on:

- what is being targeted
- how and by whom
- who else needs to be involved
- what the time schedule will be
- what resources will be required
- how the action plan will be evaluated.

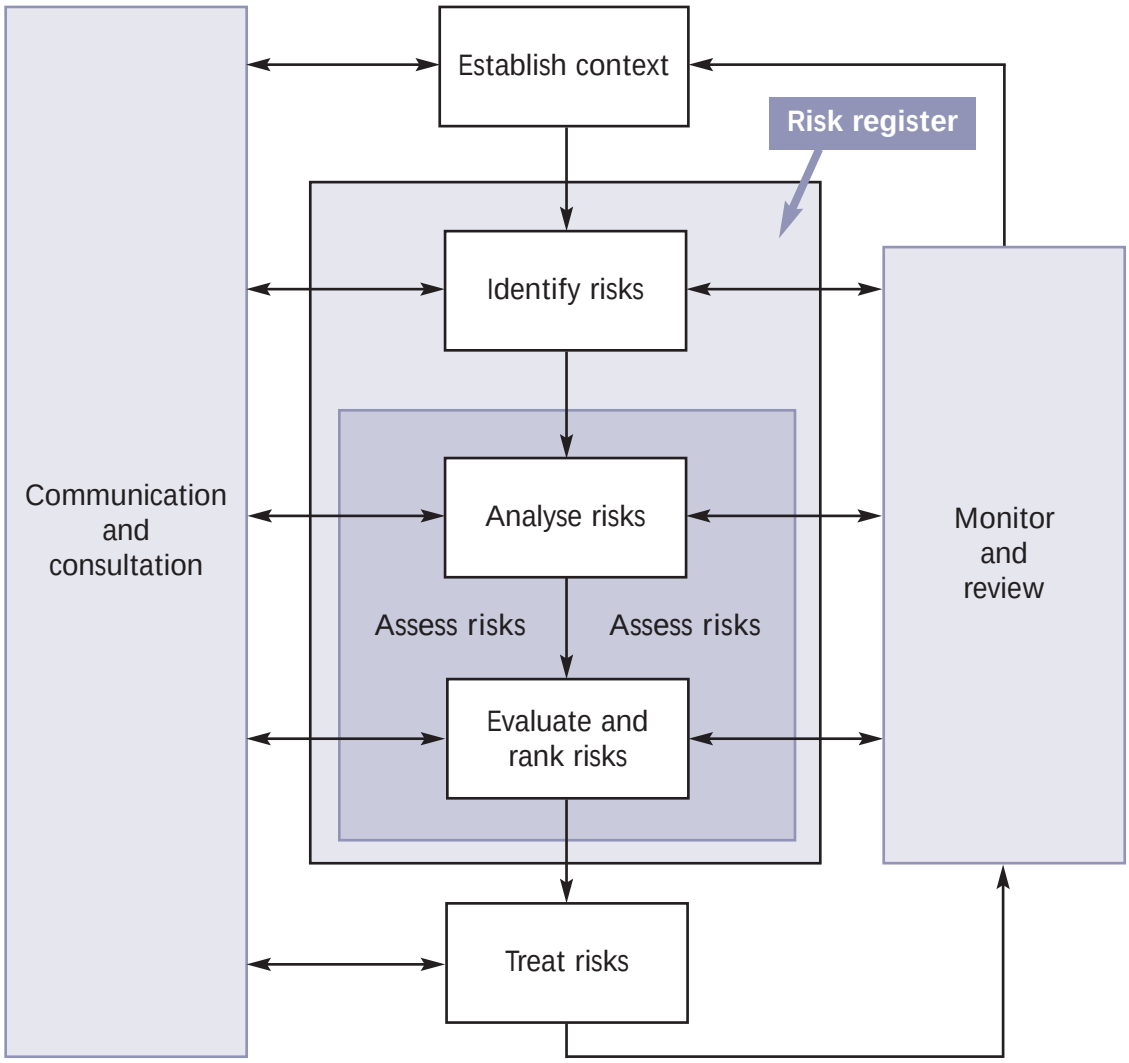
Evaluation of the risk assessment process

If properly handled, planning to reduce risk in relation to work stress is no different from any other management activity. The action plan is then implemented as planned, its progress monitored and reviewed, and the processes involved and their outcomes eventually evaluated. The evaluation of action plans is an important step but one that is often overlooked or avoided.

Not only does it tell the organisation how well something has worked in reducing stress, it also allows the re-assessment of the whole situation, providing a basis for organisational learning. Essentially it establishes a continuous process for improvement. Managing work-related stress is not a one-off activity but part of the ongoing cycle of good management of work and the effective management of health and safety.

In many ways, good management is stress management. This four-step process of risk management, from risk assessment to evaluation, is presented in diagrammatic form on the next page.

Organisational framework



CHAPTER 8: SLIPS, TRIPS AND FALLS

8

Chapter 8: Slips, trips and falls

Introduction

Accidents are not an inevitable part of the healthcare industry – they can and should be prevented wherever possible. Where this is not achievable, the risk should be reduced to the minimum acceptable level.

Slips and trips resulting in falls are the most common causes of major injuries in all workplaces in Great Britain and the second biggest cause of over-three-day injuries. Each year over 2,000 injuries to employees in healthcare are reported, which are attributed to slips and trips.

Occasionally they lead to fatal accidents.

Legal requirements

As employers, NHS bodies have a responsibility for the health and safety of all NHS employees. The Management of Health and Safety at Work Regulations 1992 (amended in 1999) specify five steps (see chapter 7) for effective risk control arrangements and employee duties, as well as training and consultation with safety representatives.

The regulations contain specific requirements relating to floor surfaces. Even small levels of contamination (in most circumstances just a single drop) can substantially increase the danger to staff working in the area. Prevention of contamination must be thorough and a full assessment of the suitability of floor surfaces must be carried out in all areas.

The Workplace Regulations contain the following requirements.

- The floor construction should be:
  - non-slippery, with effective drainage
  - even under foot, non-slopping and free of holes.
- So far as is reasonably practicable, floors should be kept free of obstructions and any article that may cause a person to trip.
- Floors should also be free from accumulated waste materials, except where there are suitable receptacles.

Suppliers of equipment

Under the Provision and Use of Work Equipment Regulations 1998 (PUWER), suppliers of equipment provided for use at work (including machinery) have a duty to ensure the

safety of their products, so far as is reasonably practicable, and to provide information to users.

National Audit Office report

In April 2003, the National Audit Office (NAO) published a report, *A safer place to work: improving the management of health and safety risks to staff in NHS trusts*, which examined the way the Department of Health and NHS trusts manage and monitor health and safety risks to NHS staff. It found that slip and trip accidents accounted for 48 per cent of major injuries.

The main causes of these injuries were poor cleaning techniques, slippery surfaces or failure to mop up liquid spillages quickly, and poor working practices, such as trailing electrical cable leads across floors.

Other findings

The Health and Safety Executive's reported data for the health sector over five years includes the following statistics.

- 22 per cent of slips were due to slippery substances and surfaces, and a further 15 per cent were due to wet surfaces.
- 17 per cent were caused by trips over obstructions and 10 per cent by tripping on an uneven surface.
- 68 per cent of slipping and tripping injuries involved on-site transfer, while 10 per cent occurred during nursing processes.
- 25 per cent of major slipping and tripping accidents happened to nurses.

Why NHS trusts need to take action

In their report of April 2003, the NAO highlighted slips and trips as one of the major causes of accidents to workers and patients. The report recommended that NHS trusts should review their health and safety risk-management policies, and improve accident-reporting systems.

Slips, trips and falls are also especially important in a healthcare setting because they affect the public as well as staff.

- Injuries to healthcare workers and members of the public are frequent occurrences.
- Trips account for almost 62 per cent of major injuries to members of the public.
- Generally, trips are believed to account for between 25 and 30 per cent of all slips, trips and falls.
- They also cause 8 per cent of fatalities to members of the public in the healthcare industry.

This list is by no means exhaustive, and other factors may increase the risk to staff, including poor lighting, external glare and human factors such as lack of awareness or carelessness. Each trust should ensure that every effort is made to eliminate the causes of slips and trips by using an appropriate risk assessment.

Cost implications

Over the last four years, the total estimated cost of reported civil injuries for slips, trips and falls involving employees and the public, in or on NHS premises in England, exceeds £25 million. Typical claims average around £5,000. Some have been as high as £600,000.

These accidents can be cut dramatically through good planning, positive management and good housekeeping. Robust risk assessment, which includes consultation with employees, who have useful experiences to draw on, should form an essential part of the trust's management process. The consequences of not doing this are increased risks of:

- serious injuries to patients and staff
- higher medical costs and longer waiting lists
- staff absences due to sickness
- other associated costs, such as staff replacement.

Preventative measures

When dealing with the causes of slips, trips and falls, NHS trusts as employers are best placed to put into practice preventative measures. Health and safety managers and staff should be aware of where the risks arise, such as floor contamination or inherent slip resistance not adequately maintained. They should also be able to identify the measures to control the risks. The following are examples of measures that could be taken.

- Eliminate contamination in the first place by maintaining equipment and clearing liquid leakages as soon as possible.
- Maintain resistance of floor surfaces by using appropriate cleaning methods and 'cleaning in progress' signs.
- Maintain adequate lighting in all areas of the hospital.
- Ensure that environmental conditions, such as glare, shadows and temperature extremes, do not distract the attention of staff, patients and visitors away from the condition of the floor.
- Train and re-train staff on a regular basis so that they understand the dangers of lifting heavy loads, restricted views and other moving and handling issues, and ensure that they operate within their individual capacity.

Managing slips, trips and falls

The practical measures that can be taken will vary for each occurrence and need to be identified, assessed appropriately and matched to practical control measures. Management arrangements should ideally attempt to identify and implement necessary control measures for each situation.

Five steps to managing

1. Plan your overall arrangements to manage slips, trip and falls. In most cases the risks will justify setting these arrangements out separately and specifically within the overall safety policy document. Assess the risk and identify what more you need to do. Gain the commitment of others such as senior management and staff.
2. Organise so that staff know what to do. Establish systems for inspection, maintenance, training and consultation with safety representatives.
3. Control risks by taking preventative measures that you identify.
4. Record all incidents involving slips, trips and falls and ensure appropriate incidents are reported to the HSE as required by the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR 1995).
5. Monitor your successes as well as failures to ensure that you are making progress and remember to review your plan regularly to ensure its validity.

CHAPTER 9: MANUAL HANDLING

9

Chapter 9: Manual handling

Introduction

This chapter gives an update on current issues and should be read in conjunction with guidance provided by the Back in Work campaign and by the National Back Exchange (NBE).

Musculoskeletal disorders (MSDs) are a serious problem in the NHS. Manual handling accidents account for 40 per cent of all sickness absence in the NHS, resulting in a cost somewhere in the region of £400 million each year. For some members of staff, manual handling accidents can result in long periods of sick leave and for others it can even lead to the end of their career.

In the past, the accepted response to back pain was bed rest. Evidence now shows that rest does not aid recovery. It is much better to keep as normally active as possible. Trying to reduce the pain by avoiding movement slows recovery and can lead to long-term back pain. Manipulation can sometimes help to ease the pain and aid recovery.

Research also shows that the longer someone stays off work because of back pain, the less likely they are ever to go back.

Legal aspects

All NHS employers have a legal responsibility to ensure the health and safety at work of their staff, and this includes the prevention of accidents and work-related ill health such as MSDs, back pain and upper limb disorders (ULDs). The Health and Safety at Work etc Act 1974 places general duties on employers and others.

There are also other regulations that impose specific requirements including:

- Management of Health and Safety at Work Regulations 1999
- Workplace (Health, Safety and Welfare) Regulations 1992
- Manual Handling Operations Regulations 1992
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995.

As well as making good sense, consulting employees on health and safety matters is a legal requirement. If there are known safety representatives appointed by trade unions, the law requires employers to consult with them. If there are none representing employees at risk from undertaking manual handling, employers should consult the employees themselves or any representative they have elected for health and safety.

NHS employers' duties

To reduce manual handling accidents, NHS employers should:

- avoid the need for hazardous manual handling, as far as is reasonably practicable
- assess the risk of injury from any unavoidable hazardous manual handling
- reduce risks to the lowest level that is reasonably practicable
- ensure that assessment and action plans are written, and are available to all
- develop, implement and communicate a policy and local codes of practice relating to manual handling in the workplace
- employ a competent person such as a back care adviser
- monitor policy and codes of practice, and take action if they are not properly applied.

NHS employees' duties

NHS employees also have duties. They should:

- follow appropriate systems laid down for their safety
- be aware of and understand their organisation's manual handling policy
- make proper use of equipment provided for their safety
- co-operate with their employer on health and safety matters
- inform their employer if they identify hazardous handling activities or any dangerous defects in equipment
- take care to ensure that their activities do not put others at risk.

Why introduce a safer handling policy?

NHS organisations should do all they can to make working practices as safe as possible. Introducing and planning a safer manual handling policy will help this.

The NHS employer should aid employees in changing their working practices and help employees to realise the benefits of protecting themselves at work.

Through this process, the NHS employer will be:

- complying with legislation
- avoiding the associated costs of non-compliance
- benefiting the patients and the quality of their care.

No one working in a hospital, nursing home or community setting should need to put their safety at risk when lifting patients manually. Hoists, sliding aids and other specialised equipment mean that staff should no longer have to risk injury while doing their job.

Patients can often do a lot for themselves if encouraged, or shown, and this will benefit them too. With a safer handling policy, staff must continue to assess the capabilities

and rehabilitation needs of the patient in order to determine which methods and/or handling aids should be used. In all cases, the handler's physical effort should be minimal and well within their skills and capacity. Adequate resources should be made available for the purchase of equipment needed for risk reduction, following a risk assessment, and also for the maintenance of the equipment.

A survey carried out by the Royal College of Nursing in July 2002 found that 95 per cent of respondents had a safer patient-handling policy, although in many organisations it is called by a different name.

Thirty-two per cent of those responding said that they had full compliance within their trust, although this response was not tested further. Of the 68 per cent who did not claim full compliance, the reasons given were:

- lack of enforcement of policy 78.6 per cent
- lack of resources – low staffing levels/quick turnover 78.6 per cent
- peer pressure 64.3 per cent
- lack of training 35.7 per cent
- lack of equipment 35.7 per cent
- lack of knowledge 35.7 per cent.

The main reasons for non-compliance are lack of supervision or enforcement and a perception that it is quicker to handle patients manually when there are low staffing levels, or time pressures. It is essential that these issues are addressed in any training and that monitoring is done as part of the overall policy framework.

Occupationally related MSDs – an example

Consideration should be given to risks resulting from specific tasks which particular health professionals undertake, and to the risk reduction measures that can prevent MSDs unique to their profession.

Sonographers, for instance, experience a high level of musculoskeletal symptoms. Studies[1] have shown that 20 per cent of this group leave the profession or take premature retirement options because of persistent pain problems.

It has been recognised that, with a collaborative effort, the prevalence of these complaints amongst sonographers can be reduced and, in turn, personal, social and fiscal losses are also significantly reduced. Findings show that this group of professionals regularly has to adopt unnatural postures. There is habitual slouching and twisting of the spine, excessive reaching forward, arm abduction and forceful gripping of a tool in the operating hand. Three components of prevention have been identified.

- Primary – stop the problems developing in the first place.
- Secondary – when problems develop, what action can be taken to treat the complaint and reduce the likelihood of long-term morbidity or chronicity developing?

[1] *Industry standards for the prevention of work-related musculoskeletal disorders in sonographers*, The Society of Diagnostic Medical Sonographers

- Tertiary – when the complaint has been effectively dealt with, what can be done to reduce the chance of a relapse occurring?

Adjustable equipment used at the correct height and in the correct manner, adequate rest breaks and early intervention, all form the basis for the prevention of musculoskeletal disorders for this group of professionals.

Recommendations can be found in *Industry standards for the prevention of work-related musculoskeletal disorders in sonography*
www.sdms.org/pdf/wrmsd2003.pdf

Training

There are many ways of delivering training to staff. A large number of NHS employers will already have programmes in place that can deliver continuing manual handling instruction to their staff.

Employers must have access to competent help in applying the provisions of health and safety law, including that relating to manual handling. They should consider appointing one or more people to provide the necessary help.

Manual handling is a core competency for staff caring for patients. The first in the front-line level of management will be the clinical managers. Other personnel should include a manual handling supervisor/manager/key worker. This named supervisor is responsible for the supervision of manual handling in their area and must have all the necessary competencies to fulfil this role and adhere to the standards set. The chart on page 9.6 shows the levels of roles and responsibilities.

Training should take place regularly to refresh, update and re-emphasise the information received on earlier training courses.

Back care advisers

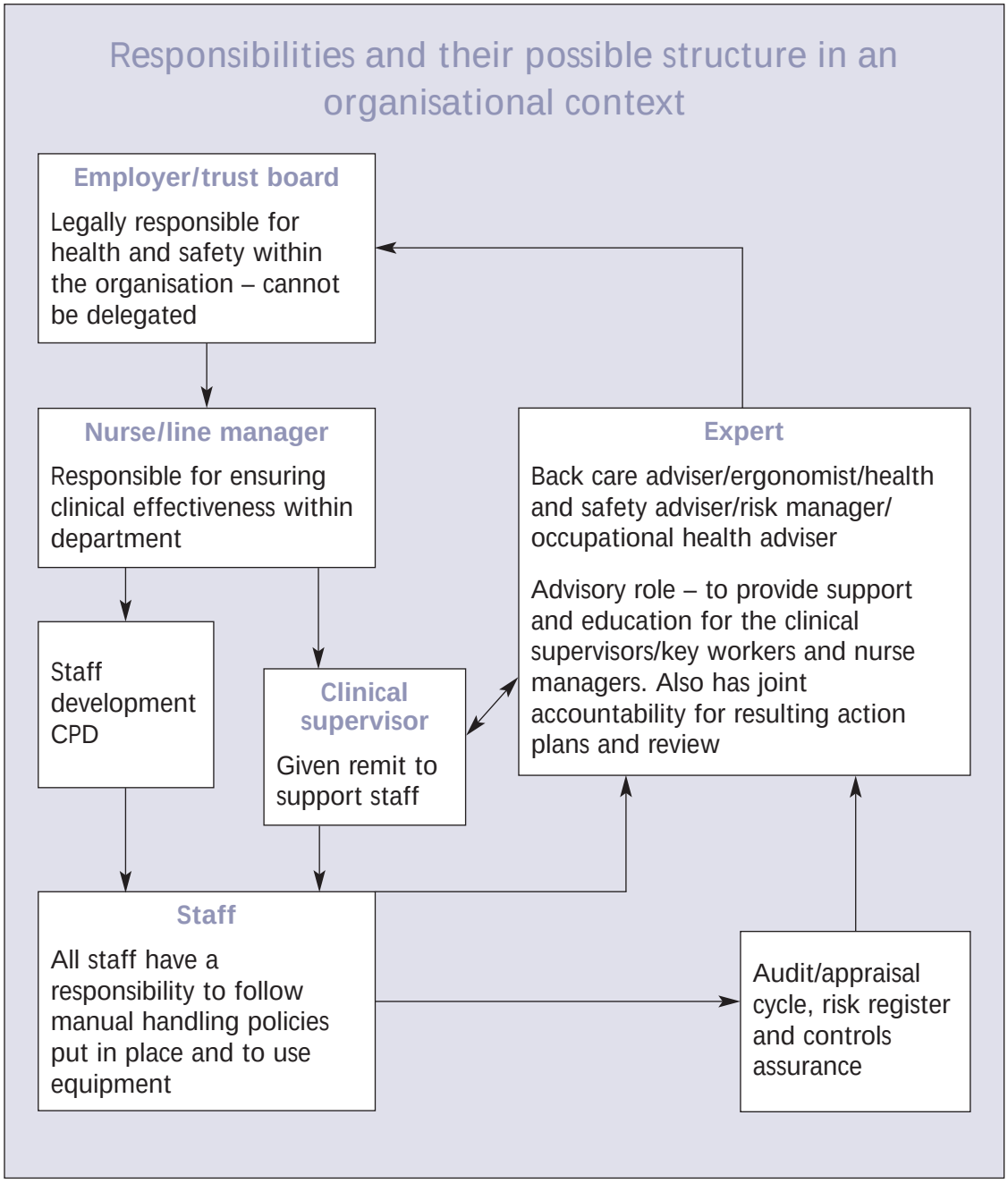
Whoever is responsible for managing manual handling within an NHS organisation should have access to competent advice and the expertise of a back care adviser (BCA), or manual handling expert, who should also arrange the necessary education. Risk managers, ergonomists, occupational health advisers and health and safety advisers can also contribute to education if they are appropriately qualified.

The BCA, working with others involved in the management of risk, should advise the employer on the application of health and safety legislation, especially the law related to manual handling.

The role of the BCA is mainly advisory and should include facilitating a holistic approach to safer patient handling and manual handling in the organisation. They should also collaborate with other risk management colleagues in formulating strategy.

Competencies

The Royal College of Nursing has published a set of competencies for back care advisers and manual handling supervisors in its guidance, *Safer staff, better care*, as part of the 'working well' initiative in February 2003.



The competencies fit into three areas of practice development needs:

- management of risk
- creation of safe systems of work
- professional effectiveness and the maintenance of standards.

Each area contains written competencies to be achieved by staff. The guidance also specifies both the competency required and the performance criteria necessary to demonstrate it.

The competencies should be used to:

- underpin education plans and supervisory sessions
- identify educational needs or skills gaps and to assess competence
- establish the curriculum and learning outcomes for formal and informal education or training sessions.

They can also be used to:

- record achievements and reflect on their practice development needs
- develop standards for audit.

Back in Work campaign

Launched in 2002 by the Secretary of State for Health, the national Back in Work campaign is aimed at everyone who works in the NHS whether in an acute hospital, the community or the local GP practice.

It is intended to address all staff. The remit for the campaign moved to NHS Employers in November 2004 and musculoskeletal disorders will continue to be one of the organisation's key areas of work.

Back pain and musculoskeletal problems can affect anyone – nurses at 23 or chief executives at 55. The effect can be devastating and life-changing.

This campaign aims to show that it benefits everyone in the NHS to address the problem and that NHS users, in turn, benefit from healthier, happier staff who are fit for work. It is also important to reiterate that lifting heavy loads is not the only cause of back injuries. They can easily happen, for example, to staff carrying awkward loads or using equipment incorrectly, if they have not been trained properly in moving and handling.

The campaign website

The campaign has a website which can be found at: www.nhs.uk/backinwork

This site allows people to download copies of the latest guidance and posters for the campaign. Copies of the entries for the Back in Work Awards winners are posted here alongside details of proposed workshops and events.

A back pack guide to combat the key issues of MSDs was developed by the Department of Health with the help of interested stakeholders. This is now distributed by NHS Employers and can be obtained from Mary.Newsome@nhsemployers.org

CHAPTER 10:
THE USE OF CONTRACTORS AND SUB-CONTRACTORS

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Chapter 10: The use of contractors and sub-contractors

Introduction

The Department of Health is aware that NHS trusts are increasingly using both contractors and sub-contractors. The National Audit Office (NAO) report, *A safer place to work: improving the management of health and safety risks to staff in NHS trusts*, has brought this very important issue to light.

While both the NHS employer and the contractor have specific responsibilities under health and safety law, NHS employers are responsible for protecting contractors and sub-contractors from harm caused by work activities. The increased use of contractors can lead to confusion about the responsibility for delivering information and training on health and safety, for providing equipment and protective clothing or undertaking risk assessment (see chapter 6). As a result, temporary staff are placed in greater danger due to their lack of appropriate knowledge or familiarity with NHS employers' policies[1].

Legal responsibilities

When dealing with contractors and sub-contractors, NHS employers have a legal responsibility to ensure the health, safety and well-being of those members of staff. The Health and Safety at Work etc Act 1974 states that it is the duty of every employer to ensure, so far as is reasonably practicable[2], the health, safety and welfare of all their employees.

It is also the duty of every employer to conduct their undertaking in such a way as to ensure, so far as is reasonably practicable, that persons not in their employment, who may be affected by activities, are not thereby exposed to health and safety risks.

Areas to consider

When dealing with contractors, NHS employers should consider the following areas.

1. Identify the job

All NHS employers need to identify all aspects of the work they want contractors to carry out, including work falling within the preparation and completion phases. NHS employers will need to assess the level of risk involved and training required for all staff involved. At this stage, NHS employers will need to decide on levels of co-operation, consultation and supervision between all parties to ensure compliance with legislation.

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[1] From *A safer place to work: improving the management of health and safety risks to staff in NHS trusts* NAO report 2003

[2] 'Reasonably practicable' implies that a balance must be sought and as an NHS employer, you must have good reason for doing or not doing a particular activity.

2. Select a suitable contractor

NHS employers need to satisfy themselves that contractors are competent, that is, that they have sufficient skills and knowledge to do the job safely, without posing risks to health and safety. The degree of competence required by NHS employers depends on the job. NHS employers must ensure that contractors are aware, at the start, of what is expected of them regarding training, competencies and general behaviour in the workplace. To do this NHS employers should explain health and safety arrangements, procedures, and policy statements.

In order to determine a prospective contractor's ability[3] to complete a job, NHS employers should draw up a list of the main points to be considered. These are some of the questions to ask.

- Do they have experience of the type of work you require?
- What are their health and safety policies and practices?
- What is the history of their recent health and safety performance? (How many accidents have they had?)
- What are their qualifications and skills?
- What are their selection procedures for sub-contractors?
- Do they have a safety method statement?
- What health and safety training and supervision do they provide?
- What are the arrangements for consulting their workforce?
- Are their competencies individually assessed?
- Are they members of a relevant trade or professional body?

Both NHS employers and contractors must complete a risk assessment (see chapter 7). NHS employers should already have risk assessments for the activities of their own work. The contractor must assess the risk attached to the job. Both parties should then consider the resulting risks from each other's work and ensure the health and safety of their own staff, and also the safety of anyone else who may be harmed by the activities being carried out.

NHS employers and contractors should agree the risk assessment for the contracted work and the preventative and protective measures that each party will take.

3. Provide information, instruction and training

Under the Health and Safety at Work etc Act 1974, all employers have a duty to give employees information, instruction and training on anything that may affect their health and safety. This is no different for NHS employers and contractors. NHS employers should consider what information their contractors need and ensure they get appropriate instruction and training. The information must be specific to the work being carried out and NHS employers must inform contractors and other parties of risks, such as asbestos, which may be unknown to the other party.

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[3] See Appendix 1 for an example of a contractors competence appraisal form.

4. Management and supervision

NHS employers must decide what they need to do in order to manage and supervise the work of contractors. The greater the impact the contractor's work has on the health and safety of anyone affected, the greater the supervisory and management responsibilities of the NHS employer are. In all circumstances, NHS employers need sufficient knowledge and expertise to manage and supervise the contracted work. It is essential that the nature of the controls exercised by the employer is agreed before the work starts.

When employing a contractor, NHS employers may need to agree with contractors how the work will be done and what precautions need to be taken. Relevant issues could include:

- what equipment should or should not be used or worked on
- personal protective equipment to be used and who will provide it
- working procedures, including any permits-to-work
- procedures for reporting accidents and safekeeping of records and plans.

Throughout working practices, NHS employers, contractors and, where applicable, sub-contractors should monitor health and safety performance. This means checking whether the risk assessment is up to date and that control measures are working. To protect the health, safety and welfare of all concerned, NHS employers should check a contractor's performance to see if the work is being done in the manner that was agreed. NHS employers should also encourage contractors and sub-contractors to carry out day-to-day checks to ensure that the work is being done safely.

5. Investigating and complying with health and safety

The Department of Health recognises that it is good practice to investigate all injuries, cases of work-related ill health and 'near misses' to find out what went wrong and why they were not prevented. NHS employers and contractors should share the lessons learnt from monitoring and investigations undertaken, to ensure that the risk of accidents is minimised.

Where health and safety requirements are not met, the NHS employer and the contractor should find out why this is happening and put matters right. NHS employers will need to stop the contractor working on the job if health and safety performance does not meet requirements. Upon completion, both the NHS employer and the contractor should review the work in order to assess what went well and to see where performance could be improved for future projects.

CHAPTER 11:
DANGEROUS SUBSTANCES IN THE WORKPLACE

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Chapter 11: Dangerous substances in the workplace

Chemical hazards and poisons

The chemical hazards and poisons division of the Health Protection Agency (HPA) provides comprehensive expert advice and support for chemical incidents across England and Wales.

Such potential health threats might involve chemical fires, chemical contamination of the environment, or the deliberate release of chemicals and poisons.

The agency will also provide information and support to the NHS and health professionals on toxicology.

The HPA is developing a national programme for the surveillance of chemical hazards and their health effects, national poisons information databases, and a database of laboratories.

The HPA will also give advice on a wide range of issues, including:

- personal protective equipment
- decontamination and evacuation
- toxicological and epidemiological advice on likely health effects
- the appropriateness of industrial operational conditions
- clinical advice on antidotes and medical treatment.

The National Poisons Information Service (NPIS) has six poisons' centres (Belfast, Birmingham, Cardiff, Edinburgh, London and Newcastle) providing a year-round 24-hour service for healthcare staff on the diagnosis, treatment and management of patients who may have been poisoned.

For further information look at www.phls.org.uk and www.hpa.org.uk

CHAPTER 12: ALCOHOL AND DRUGS

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Chapter 12: Alcohol and drugs

Introduction

The Department of Health's guidance, *Taking alcohol and other drugs out of the NHS workplace*, February 2001, states that 'drug or alcohol misuse by anyone working in the NHS is wholly unacceptable'.

The NHS is Europe's largest employer and it employs very large numbers of younger people. It is possible that some of its staff will be users of recreational drugs and alcohol. This chapter provides guidance for trusts on how to manage the problem.

Substance misuse

Misuse refers to the use of illegal drugs and the misuse, whether deliberate or unintentional, of other drugs, including alcohol and substances such as solvents.

Substance misuse can harm the misuser both physically and mentally and, through the misuser's actions, other people and the environment.

It is important that NHS employers consider this area because drug or alcohol misuse:

- represents a hazard to the health and safety of patients, staff and visitors to the NHS
- influences the quality of the service provided by the NHS
- impairs employees' work performance
- affects the welfare of employees by impairing their physical and psychological health, thereby contributing to social, economic and domestic problems.

Misuse covers three main areas:

- inappropriate use, where use may aggravate an existing condition or situation, or is done in potentially dangerous or inappropriate circumstances
- habitual use, where the individual becomes dependent on the effects of the substance to the extent that the desire for these effects becomes a dominant concern, to the detriment of other aspects of their lives
- excessive use, which can lead to physical and mental illness, or antisocial behaviour.

NHS Employers is committed to helping employers ensure the safety of all patients, employees and visitors to NHS premises. The approach of the NHS to employee health is based on 'fitness for work', and there is already a range of occupational health and health and safety guidance in support of this aim.

Prescribed medicines

Prescribed or over-the-counter medicines might cause impairment to an individual's performance at work. Individuals should seek advice from their GP or pharmacist on any medicines they are taking. If appropriate, they should be encouraged to discuss any problems with their occupational health service if they feel this would be helpful, and/or they should inform their line manager of any possible side-effects of their medication.

Substance misuse policy

There are several key elements to consider in implementing a substance misuse policy.

1. Raising awareness

All NHS staff (including those in the primary care sector) should be made aware of the dangers of drug and alcohol misuse, to ensure misuse and its consequences do not occur within the NHS workforce. Local managers at all levels and in all professions in the NHS, working with unions and professional organisations, should promote health education programmes to emphasise the potential dangers of such misuse, both for the health of individual employees and for their work performance.

2. Recognition of problems

Where possible, line managers and those in a supervisory position should get appropriate training on how to recognise, deal with and act on drug and alcohol problems – known or suspected – in their staff.

3. Self-referral

Staff should be encouraged to seek help through their GP for the provision of confidential advice and assistance. Employees at all levels and in all professions should be made aware that they can consult their local occupational health service to discuss any matter associated with drug or alcohol misuse.

The contact details of local organisations that can provide assistance to staff members, who may feel unable to consult their own occupational health service, should be prominently displayed and readily available to all staff.

Employers should not automatically invoke disciplinary action for voluntary referrals where the employee successfully undergoes a programme of treatment.

NHS employers should aim to deal with instances of drug misuse in a supportive way, by offering help to resolve the problem.

4. Criminal activity

The possession of illegal drugs with the intention to deal is illegal and should be reported to the police. Managers will need to be aware of this when drafting their policies.

If, as a result of internal or police inquiries, a manager or supervisor has reason to believe that illicit drugs are on NHS premises or in the possession of NHS staff while they are on NHS business, or that drug misuse is a threat to the safety of NHS patients, they should reserve their right to take whatever further measures they deem appropriate. Such measures may include the searching of NHS premises and, where the police become involved, the use of drug screening.

Random testing of staff, as a tool for managing substance misuse, is not appropriate for NHS employers.

5. Advice and help

The best way of dealing with the real or potential effects of drugs and alcohol at work in the NHS is to make expert advice and help readily available. NHS employers should make the necessary provision to assist employees to avoid problems and resolve them when they arise.

6. Treatment and rehabilitation

Referrals for treatment and rehabilitation should generally be through the employee's own GP who will, in consultation with the employee, take steps to arrange for counselling, treatment and rehabilitation, with periodic testing if appropriate.

The rehabilitation programme will be agreed with the patient and involve their written consent. This may involve referral to an external agency to obtain appropriate and confidential treatment for the employee. Monitoring, as required, is done by the occupational health service acting as liaison for the employer, who should keep line management informed of fitness for duty. Trade unions or professional organisations may also be involved in the rehabilitation programme.

Where an occupational health service is not the most appropriate conduit, then liaison may be direct with the line manager. Allocation to other duties during and after rehabilitation may be appropriate, depending on the circumstances and specialism of the employee.

Time off for treatment is recommended. At the manager's discretion, while receiving medical treatment the employee should be given sickness provisions in the normal way, as well as additional sick leave for rehabilitation.

It should be made clear that the major aim of treatment and rehabilitation is to ensure optimum recovery and return to work.

Relapse after treatment for substance misuse is common. Employers should be aware that, despite counselling and follow-up, this might still occur. The circumstances of the relapse and the individual's response will influence how the employer should respond. The safety of patients and other staff, and the quality of care delivered, will be affected if individuals relapse frequently. Employers should therefore discuss with the employee, and those involved with their treatment, the extent to which rehabilitation can acceptably take place in their current workplace.

7. The role of occupational health services

Occupational health may be where the problem is acknowledged first. This may be through self-referral, management referral or when another issue has been raised. Occupational health is concerned with the health of the entire workforce. Referrals by management, or from colleagues, will allow a dialogue between occupational health and the employee with a suspected problem. However, not all occupational health services will have the appropriate experience and knowledge to enable them to deal with this problem.

The occupational health service will normally liaise with the GP, who should arrange treatment, involving specialists in the management of alcohol or drug misuse. Occupational health staff may be able to help GPs arrange appropriate referrals.

The second role of occupational health is managing the employee's return to work. Those treating substance misuse are not always aware of the occupational implications and there is a role for occupational physicians in ensuring a suitable and satisfactory return to work. In the majority of cases, the employee should be returning to the same work they were doing before the problem was recognised.

8. Fitness for duty

If employees acknowledge an alcohol or drug problem, they should be referred to the occupational health service. Non-compliance with the referral and action recommended by the occupational health service might lead to disciplinary action.

On referral to the occupational health service, an assessment should be made of the employee's fitness for duty. This should be a specialist comprehensive medical assessment. Following assessment, the occupational health service should advise the line manager of the employee's fitness for work on medical grounds.

9. Representation

Employees are entitled to representation by a colleague or friend, or by a union or professional organisation representative, at any stage of the management process that has been outlined. Management has the right to the support of the human resources department.

10. Implementation, monitoring and evaluation

Previous guidance issued by the Department of Health said that 'NHS employers should have a suitable policy, in line with this guidance, in operation by 1 April 2001'.

Having agreed a policy for the identification and management of substance misuse, NHS employers should ensure that measures are in place to monitor and evaluate the policy and its effectiveness.

CHAPTER 13: A SMOKE-FREE NHS

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Chapter 13: A smoke-free NHS

The recent white paper, Choosing Health, announced that the NHS would be smoke-free by the end of 2006. This is the final stage in a programme to reduce smoking in NHS premises, which the NHS has been working towards since 1992.

Smoking remains the largest single cause of death and disease in England and the harm caused by passive smoking, a proven carcinogen, is now well established.

The NHS, as the foremost health-promoting and treatment organisation in the UK, and the largest employer in Europe, will further highlight these dangers and demonstrate strong leadership by becoming smoke-free.

Issued on behalf of the Department of Health by the Health Development Agency, Guidance for Smoke-Free Hospital Trusts draws on lessons learned from successful case studies, surveys and consultations with hospital trusts.

It takes NHS employers through the steps needed to implement smoke-free policies. It is about where people smoke and not whether they smoke. However, it includes advice about how patients, visitors and staff may access services to help them quit smoking if they want to.

Rather than issue two sets of guidance, NHS Employers has worked closely with the Health Development Agency on the content of the new guidance, which it has issued.

It is available from the Health Development Agency and online from www.hda-online.org.uk

CHAPTER 14: MENTAL HEALTH

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Chapter 14: Mental health

Introduction

People with mental health problems frequently suffer discrimination in the workplace. This forms one of the greatest barriers to social inclusion – not being able to work is an obstacle to independence generally.

Unemployment affects those with long-term mental disorders more than any other group of people with disabilities[1] – only 13 per cent are in employment, compared to over a third of people with disabilities generally[2]. Discrimination is unlawful where a person with mental health problems has a disability that is protected by the Disability Discrimination Act 1995 (DDA).

In Spring 2003 the guidance, *Mental health and employment in the NHS*, was published by the Department of Health. It gave advice to NHS employers on the retention and future employment of people who have experienced, or who are experiencing, mental health problems. This chapter contains a brief reiteration of the most important points from the guidance.

As the largest public sector employer in the country, the NHS should be making a significant contribution to delivering the objective outlined in the guidance. It is a key objective to enable all disabled people, including those with mental health problems, to make the most of their abilities at work and in society in general.

NHS employers' duties

The guidance sets out a clear message that NHS managers and occupational health professionals should set an example, demonstrating these principles.

- Discrimination against individuals with a mental health problem is taken seriously and should be eradicated.
- Mental health should not be the cause of derision and ridicule.
- People with mental health problems have the same right as everyone else to be treated fairly and with respect.

NHS managers and occupational health professionals have the tools to identify and assess the suitability of an individual for employment, including those with a mental

[1] Office of National Statistics 1998

[2] Labour Force Survey 1997/98

health problem. Careful risk assessment should be done by the occupational health service, weighing up the merits and suitability of the person, without prejudice and irrespective of whether or not the individual is afforded the protection of the Disability and Discrimination Act 1995.

The general principles laid out in *Mental health and employment in the NHS* are as follows.

- Selection should be based on the best person for the job. Appropriate procedures should be implemented so that people with disabilities are not placed at a substantial disadvantage, compared to non-disabled persons, in the arrangements made for determining who should be offered employment in the NHS.
- Every assessment for a post is specific to that situation.
- All NHS staff should have a pre-appointment health assessment.
- NHS employers should ensure that their policies and procedures comply with the DDA.
- No applicant should be refused employment on health grounds, unless expert occupational medical advice has been sought.
- No person should be refused employment, or have their employment terminated on mental health grounds, without the NHS employer first having made any reasonable adjustments in relation to that person, in accordance with any duty placed upon them by the DDA.
- All NHS staff need help to develop an awareness of their own mental health, when to seek help and from whom.
- The NHS needs to develop a culture where staff can be open about their mental health status, are treated fairly and are encouraged to seek help when it is needed.
- The 'two-year rule' (suggested by the Clothier Report) is no longer used in the NHS.

NHS managers should be aware that the DDA makes it unlawful to refuse employment or to terminate the employment of a disabled person, for a reason relating to that person's disability, without justification. The reason for that decision must be one that cannot be removed by any reasonable adjustment made by or on behalf of the employer.

Employee responsibilities

It is important that NHS staff with mental health problems who are undergoing treatment are aware of, and respect, the legitimate considerations of employers. They need to:

- be aware of their own responsibilities for managing and planning their treatment
- understand the need to continue their treatment if that is the course of action they have decided on with their doctors
- be aware that they should not discontinue their treatment just because they feel well and settled in their job

- understand that the maintenance of treatment of a stable condition should not be a bar to recruitment or continued employment.

Perceptions about individuals with mental health problems

There is a stigma attached to those who have a mental health problem, which is partly caused by ignorance and also by fear of the unknown. All the evidence indicates that most people with a mental health problem wish to live as normal a life as is possible and secure ordinary employment within an ordinary workplace.

The majority of individuals with a mental health problem are no more violent than the rest of the population. Better indicators of a propensity to violent behaviour would be drug or alcohol addiction and gender.

While the stigma of mental health problems persist, many of those who have experienced and recovered from a psychiatric episode feel that they have benefited from the experience. It is not unusual for people to describe a growth in personal awareness and the added advantage that they can sympathise with, and help other individuals suffering from, a similar problem.

There is no evidence that people with a mental health problem necessarily make poor health workers; their experience can benefit other people.

Impact in the workplace

Employees and potential employees who may experience mental health problems are entitled to expect that confidential information about them will be treated sensitively, appropriately and in accordance with the ethics of confidentiality. A person's decision to tell their fellow workers about their illness is purely personal.

In circumstances where fellow workers are ignorant of the causes and effects of mental health problems, it is possible that they will ridicule and ostracise that colleague. The encouragement of a culture of awareness and support will allow employees with mental health problems to confide in close colleagues and to advise them as to what action they wish to be taken if difficulties arise.

However, staff will need to recognise that absolute confidentiality is not possible in a situation where staff are being supported in their posts due to their health problems. Clearly, the line manager will need to know about the support being given and it is possible that, over time, colleagues working closely with supported staff may become aware of the support being offered. Employers should consider training and education for staff who will need to work with, and support, a member of staff who has a mental health problem.

The role of occupational health services

In the United Kingdom, the occupational health physician who advises an enterprise has statutory responsibility under health and safety legislation (The Health and Safety at Work Act 1974) for the competence of medical advice given regarding the safety and improvement of the health of employed persons seeking or training for employment.

The key role of the occupational health physician is to act as an impartial assessor and adviser. They ensure that information flows appropriately so that employment decisions are based on full medical information, and risk assessment, and reflect good employment practice. They also ensure that employers are alerted to the applicability of the DDA.

In all cases, before a final recommendation is made on fitness to undertake duties, the occupational physician should ensure that a full assessment of the facts has been carried out, taking into account any views expressed by the client or on their behalf. This should include, where necessary, obtaining information from the employee's GP or psychiatrist. In some situations, an independent psychiatrist assessment, specifically to assess fitness for work, may be needed.

Occupational physicians should seek advice from mental health professionals, particularly in complex cases, unless they are themselves clinically competent to assess the condition in question. They should also be asked to provide advice concerning whether or not the DDA applies to:

- work capacity
- recommended restrictions
- time-scales
- suitable work place adjustments.

The role of occupational health is becoming increasingly more important in a wide range of employment issues. It is important that NHS occupational health services publicise their role and services to all staff and managers, to ensure they are aware of their role in delivering safer, healthier workplaces.

Recruitment and assessment

Health issues should be addressed by the process of pre-appointment checks carried out by the occupational health service, taking into account any duty to the applicant under the DDA, to make reasonable adjustments.

Selection should mean the best person for the job, taking into account any references supplied. Sickness data from any previous employer is essential. However, applicants must not be rejected for employment because of their absence record and without regard to the obligations imposed by the DDA. The candidate should not start work until all health checks are completed and satisfactory.

Occupational health services and employers should appreciate that a diagnosis of mental health problems may only be useful in predicting the future course of the illness and problems that may occur. Where appropriate, they should liaise with the individual's own doctor to obtain a clearer and fuller picture.

There is also an important role for the occupational health service in the rare situation where a mental health professional, who is responsible for a healthcare worker, has doubts about that person's fitness to work.

Patient safety is paramount. Where this may be in jeopardy, it may be helpful for the mental health professional to discuss the case with an occupational health physician.

This is particularly the case where the patient's right to confidentiality may need to be breached in the public interest. Further information on this issue is contained in the guidance *Mental health and employment in the NHS*.

Where an individual is not suitable for a particular post, it should be because their mental health problem puts the person, patients or service, at serious risk, in spite of any reasonable extra effort that could be made to support them.

Where the DDA imposes a duty on the employer it should be clear that no reasonable adjustment could be made that would enable that person to do the job or to work in another vacant post.

The risk assessment must be specific to the person and the post.

Pre-appointment screening

All NHS staff should have a pre-appointment health assessment carried out:

- fairly
- objectively
- in accordance with equal opportunities legislation and good occupational health practice.

The purpose of a pre-appointment assessment is to ensure that prospective staff are capable of carrying out the work proposed. This should take into account any current or previous health problems and any duty to make reasonable adjustments under the DDA.

Anyone who is likely to be at extra risk of developing work-related problems from hazardous agents present in the workplace, is identified. The assessment should also ensure, as far as possible, that an individual does not present any risk to patients, colleagues or themselves, and that the work is suitable and safe for the individual concerned.

There should not be any tests carried out by occupational health services to detect conditions that are not likely to be relevant to the person's ability to undertake the post applied for.

In order for occupational health services to carry out a full assessment of the individual, they must have the following information:

- a copy of the person and job specifications
- the health and safety risks associated with the post
- sickness absence record obtained from previous employer
- any relevant information obtained in the recruitment process, including any information provided by the applicant or on their behalf.

When the initial occupational health assessment identifies a serious or potentially significant mental health problem, the occupational physician must carry out a detailed risk assessment that, in most cases, will involve seeking further information from mental health professionals.

The occupational physician will need to make an assessment of the individual's health problem and its effect. This will initially be done by the normal process of medical assessment, followed by information collection.

The risk assessment process for potentially significant mental health problems

The following points will need to be considered.

- The nature of the health problem, including diagnosis.
- How does this affect the individual?
- Is there any reason why this person poses a risk to others in the workplace, such as:
  - inattention, loss of concentration, drug effects
  - particular behaviours, for example, loss of control, risk of violence, deliberate acts
  - their degree of insight (do they have strategies to manage their mental health difficulties?)
- Could this problem give rise to other problems in the workplace, such as:
  - frequent sickness absence
  - inability to make decisions or cope with emergencies
  - seeking therapeutic relationships with colleagues.
- Is this condition treatable, controllable, and is maximum control being achieved?
- How does the individual intend to manage his/her health in the new post?
- Is this work likely to harm this individual's health?
- Is there evidence of how well the individual has managed in previous employment and can this be taken into account as part of the decision-making process?
- If the DDA applies, are there any steps that can be taken so that the person can do the job or work in another vacant post?

Seeking additional information

Where a mental health problem is identified, further information is usually required, for example from a psychiatrist or other mental health professional. It should always be sought in cases where the applicant's fitness for work may be affected.

The Access to Medical Reports Act 1988 applies and the process will require the applicant's signed consent. They must be told precisely what information is being requested and why, before their fully informed consent can be obtained.

To avoid a possible conflict of interest, the GP or psychiatrist should be asked only specific questions that are designed to assess the applicant's suitability for the post.

Applicant's clinicians should not usually be asked simply to comment on the person's fitness for the proposed post, because that decision is the responsibility of the occupational physician and ultimately the employer.

At the end of this process the occupational physician will have a clear picture of the impact of the individual's illness on their employment. They will be in a position to

advise the employer on suitability for employment and modification to the work to accommodate the individual, where appropriate.

More in-depth information about pre-appointment screening is available in chapter 3.

Rehabilitation

Rehabilitation is dealt with in more depth in chapter 16. However, there are specific issues that are relevant to mental health conditions, which are outlined in this chapter.

Individuals recovering from illnesses such as depression may be left with residual symptoms such as:

- low self-esteem
- loss of confidence
- vulnerability
- feelings of helplessness and pessimism.

They, and other individuals who have suffered a serious psychiatric episode, will probably require additional care and support in their re-entry into work.

Lack of confidence is a common problem and there may be setbacks or withdrawal from work in the early days of returning to work. Flexible working options may help these individuals to cope with returning to work in a demanding work environment.

The occupational health team and the individual's line manager should be central to this process. Individuals should be honest in declaring any health problems. Failure to disclose health problems may result in dismissal. It also hinders managers from taking a positive and sympathetic approach in helping them return to work.

The more serious the problem encountered by the employee, the greater the challenge to return to a normal way of life and work. This also places a greater onus on the employer and occupational health services to assess their responsibilities to the individual, and any duty to make reasonable adjustments under the DDA.

More in-depth information on NHS employees with mental health problems is available in the guidance *Mental health and employment in the NHS*.

Entry into training

Students entering vocational training courses in healthcare (medicine, dentistry, nursing, physiotherapy, radiography, occupational therapy, clinical psychology etc) will work on placements in NHS environments during their course. At the end of that course, they will be expected to be suitable for employment in the NHS.

The educational institutions should reflect this assumption that the institution is training healthcare professionals for the NHS in their occupational health procedures.

This process – as well as occupational health services and training establishments – ensures:

- fitness to work in the NHS at the end of the course
- the ability to complete the course and undertake placements in NHS establishments as part of that course.

Health screening

Students should be health-screened on acceptance on to these courses, in the same way as healthcare workers applying to work in the NHS. This screening is designed to ensure:

- fitness to undertake the course
- fitness for placement in the NHS during the course
- fitness for employment in the NHS upon successful completion of the course.

The process is essentially the same as the one for new employees in the NHS. The same standards of fitness should be applied, but there are certain considerations.

The scope for modification of the course to accommodate health problems may be limited by the academic and competence requirements of the qualifications to be obtained.

The occupational physician should be aware of these. However, the educational institution makes the final decision on whether or not any restrictions or modifications can be accommodated in each case.

Timings of health screenings

Students should not start the course until health screening is completed.

In order to help an otherwise capable student, it may be reasonable to make special arrangements to extend the assessment over a longer period, during the course of training.

The occupational health service provides advice but the ultimate decision sits, in this case, with the educational institution.

Where this is not recognised, differences of opinion sometimes arise between the occupational health service advising the institution and the one advising the first employer. A person who may have been fit for training, or who was taken on to a course despite occupational health service reservations, may not be fit for the kind of work involved in their first post, or subsequent posts. The right to refuse a candidate in these circumstances belongs with the employer.

Careful assessment by the occupational health service at recruitment, and managing health problems arising in students during their studies, should reduce the risk. Occupational health services who advise educational institutions should be familiar with NHS working environments and health standards.

Overseas students and staff

Overseas students should be screened to the same standard as other students. Although they may not be employed in the NHS on completion of their studies, they will be carrying out placements in the service.

Overseas students may not have family doctors on the UK model. In cases where it is not possible to obtain information about their previous health record, the occupational health service may suggest ongoing health monitoring during their training.

Mental health issues – employment

When an employee's behaviour in the workplace causes the employer concern, the question of whether or not this is health-related often arises. The process should be no different for staff experiencing mental health problems from that for any other form of health problem affecting performance.

To inform the process, the employer may also need information on:

- the extent to which any identified health condition may be amenable to treatment
- whether modification of the work activities is needed to facilitate clinical management of the employee's health
- whether there are reasonable measures that can be made both to support the healthcare worker in the workplace and to ensure that patient protection is accomplished
- whether the person is disabled under the terms of the DDA.

This clearly requires detailed risk assessment.

The occupational health service has a key role in this in:

- collecting the required information
- carrying out the risk assessment
- giving the employer relevant information while ensuring that medical information is kept appropriately confidential.

Questions to the occupational health service should be phrased in a way that does not require the doctor to disclose details of sickness or disability, without the person's express consent.

The principles of this process, in the context of behaviour at work that is, or may be, attributable to mental health problems, are the same for all employees.

Triggers to referral

The triggers for a manager to refer an employee might include any or all of the following:

- sickness absence
- poor performance
- unusual behaviour
- complaints

- untoward incidents
- employee asking for help.

Managers will also want to take account of local disciplinary procedures as appropriate.

Adjustments may be required to the disciplinary process to take into account employers' obligations under the DDA.

Further mental health assessment

In some cases, detailed assessment by a psychiatrist or clinical psychologist may be required. This will determine whether or not the employee has a mental health problem and will inform prognosis and treatment.

In this situation, the occupational physician has an important role in asking the clinician the right questions. They also need to ensure that the mental health practitioner is aware of the full background to the case, especially if the employee cannot or will not recognise the employer's concerns.

Where specific referral to a consultant psychiatrist or psychologist is made for the assessment in an employment context, and not for therapeutic reasons, the occupational physician may refer directly. However, this would constitute a private referral and would have to be funded by the employer, unless there are local arrangements.

The report would form part of the employee's confidential occupational health record.

Report

Having collected all the relevant information, the occupational physician will be able to advise the employer in non-medical terms, and without breaching the confidentiality of the individual's medical information, on the following points:

- whether or not the individual has a health condition
- how this will impact on their ability to do their job, both in the short and the longer term
- where a treatable long-term condition is identified
- any work place adjustments that would enable the person to do the job. (Where an employer's occupational health adviser knows that a person has a disability, as defined by the DDA, the employer is obliged to comply with the Act. This places a requirement on the occupational health service to advise management of any adjustments, even where the employee wishes the disability to remain confidential.)

Supporting the employee

If a health problem is identified, the occupational physician has a key role in ensuring that the employee is receiving appropriate healthcare. This may be particularly important for medical staff, both to overcome any reluctance to recognise health problems and to seek help, and in facilitating out-of-area treatment if appropriate.

Managers, working with the patient and occupational health staff, will want to encourage the employee to make use of both in-house and more informal support systems. They should also aim to be as flexible as possible in helping the employee to manage their own time and needs, in a way that works best for them.

Subsequent management

Depending on the nature of the health problem, the occupational physician may have a role in:

- supervising adherence to ongoing treatment
- assessing the impact of treatment on employment, for example where behaviour is changed in response to treatment
- assisting with the development of rehabilitation programmes, working with the clinicians responsible for the employee's care.

Where treatment and rehabilitation are not an option, the occupational physician will be able to advise the employer on the eligibility for ill-health retirement. The employer may wish, or may have to consider, other exit strategies, for example termination of employment.

The key role of the occupational physician is to act as an impartial assessor and adviser, ensuring that:

- information flows appropriately to ensure that employment decisions are well founded (based on full medical information and risk assessment)
- actions reflect good employment practice
- employers are alerted to the applicability of the DDA.

Management of mental health problems in doctors

The principles of management of these situations in medical staff are no different from those in other employees. However, doctors do raise special considerations.

- They pose a higher degree of risk to patients.
- There may be strong denial of health problems.
- There may be hostility to management processes.
- They may have a poor understanding of their responsibilities to their employer.
- They may be difficult patients for other doctors to deal with.

In providing a service to a doctor, the occupational health service should normally be consultant-led or have access to a consultant occupational physician, who can work with the employee, in accordance with this guidance.

CHAPTER 15: STRESS MANAGEMENT

15

Chapter 15: Stress management

Introduction

Work-induced stress is now widely recognised as a significant problem in the health service as well as in all other sectors. The costs of stress can involve high levels of sickness absence, accidents, errors, low morale and poor performance.

Work-related stress is conditioned by, and contributes to, major environmental, economic and health problems. It has a significant impact on the well-being of staff, their productivity and effectiveness, and much of it is likely to be preventable.

Two EU-wide surveys have shown that a substantial proportion of the 147 million workers in the EU labour market are exposed to a variety of work-related demands or stressors that are known, or highly suspected, to induce stress and disease.

Work-related stress was found by the National Audit Office to be the second highest cause of work-related sickness absence in the NHS, accounting for 30 per cent of lost time.

In summer 2000, *Revitalising health and safety*, together with the occupational health strategy, *Securing health together*, highlighted the commitment of the Department of Health to improving health and safety in this country and set targets to be achieved by all employers, by 2010. These targets are:

- to reduce the incidence of work-related ill health by 20 per cent
- to reduce by 30 per cent the number of working days lost from work-related ill health
- to ensure that people who are not working due to ill health or disability are given opportunities for rehabilitation back into work, or offered opportunities to prepare for and find employment.

In June 2001, the Health and Safety Executive (HSE) issued new guidance, *Tackling work-related stress: a manager's guide to improving and maintaining employee health and well-being*.

This encourages a proactive approach and highlights the major role managers can play in reducing the problems of stress.

The HSE has now issued management standards of good practice, which employers will be able to use to measure their performance in tackling a range of key stressors. One NHS trust has already been issued with a compliance notice for failing to have a policy in place and not carrying out any assessment of the risks to staff of work-related stress.

What is stress?

The HSE defines stress as: 'people's natural reaction to excessive pressure. It is not a disease. But if stress is excessive and goes on for some time, it can lead to mental and physical ill health (eg depression, nervous breakdown, heart disease).'

Work-related stress might also be defined as a pattern of emotional, cognitive, behavioural and physiological reactions to adverse and noxious aspects of work content, work organisation and work environment. It is characterised by high levels of arousal and distress, and often by feelings of not coping.

Stress is not an illness in itself and it should not be seen as an indicator of psychological problems or an inability to do a job properly. However, if left unaddressed, it can lead to physical and mental ill health.

The HSE fact sheet, *Myths and facts*, adds the following points.

- Work-related stress is not good for people. Ill health because of work-related stress is now one of the most common types of workplace health problems.
- Work-related stress is something anyone can suffer from and is not something that only happens to 'wimps'.
- Research has shown that support at work, particularly from managers for their staff, has a protective effect and that frontline prevention by the organisation is better than third-party cures.
- There is a lot that employers can do to prevent work-related stress. As a first step, they can consult with their staff or trade unions to identify problems and work towards agreed solutions.

More information is available on the HSE website at www.hse.gov.uk

There are two other definitions of stress which add to or support the HSE definition.

> That which arises when the pressures placed upon an individual exceed the perceived capacity of that individual to cope.
> (Confederation of British Industry)

> Stress occurs where demands made of individuals do not match the resources available or meet the individual's needs and motivation... stress will be the result if the workload is too large for the potential number of workers and time available. Equally a boring or repetitive task which does not use the potential skills and experience of some individuals will cause them stress.
> (Trades Union Congress)

The causes of stress

Stress is caused by a poor match between the worker and the work, by conflicts between roles at work and outside it, and by not having a reasonable degree of control over work and life balance. Stress at work can be caused by a multitude of stressors.

In *Tackling work-related stress: a manager's guide to improving and maintaining employee health and well-being*, the HSE identified seven broad categories of risk factors for work-related stress:

- Culture
  - lack of positive response to stress or health concerns
  - lack of staff involvement
  - poor communication
  - lack of consultation and participation in decision-making
  - long work hours or lack of rest breaks
- Demands
  - lack of challenge and pressure
  - exposure to violence or aggression
  - work overload
  - poor physical environment
  - lack of training
  - lone working
  - fast pace of work
- Control
  - low level or lack of control over task design
  - non-participation in decision-making
- Relationships (interaction)
  - bullying/harassment
  - low levels of support
  - violence
- Change
  - changing market demands
  - new technology
  - restructuring
- Role
  - role conflict
  - role ambiguity
- Support, training and 'individual' factors
  - lack of adequate training
  - mismatch between person and job
  - lack of support or feedback
  - lack of constructive advice.

Is stress dangerous?

The answer is yes – and no.

Stress is potentially disease-provoking when:

- occupational demands are high and the worker's influence over his or her conditions of work is low
- there is insufficient social support from management and fellow-workers
- the reward offered to the worker in terms of remuneration, esteem or status does not match the effort invested.

The potential for provoking disease is increased when the conditions referred to above are intensive, chronic and/or often repeated. Common end-results include a wide range of physical and mental morbidity.

The answer is more likely to be no if workers are:

- allowed – within reasonable limits – to manage their own workload
- encouraged to take control over their own work conditions
- offered adequate social support
- given reasonable rewards for efforts invested.

When people feel in control, stress becomes a challenge rather than a threat – the 'good' stress that is often referred to.

Common effects of work-related stress

The following are examples of the more common effects associated with work-related stress, for organisations and for individual workers.

- For organisations:
  - rising levels of absenteeism
  - increased staff turnover
  - increased recruitment costs
  - poor public image
  - low staff commitment
  - under-performance
  - low staff morale
  - low productivity
  - increased accidents and mistakes
  - poor relationships with clients
  - possible compensation claims.

- For individuals:
  - high levels of anxiety
  - low self-esteem and low self-confidence
  - inability to concentrate
  - difficulty in thinking rationally
  - being prone to accidents
  - headaches or migraine
  - depression
  - panic attacks
  - demotivation
  - chest pains
  - stomach problems
  - relationship problems.

Research has indicated that constant exposure to work-related stress may result in either mental or physical illness. In the most serious cases, illnesses that have been linked to work-related stress include:

- cancer
- ulcers
- asthma
- diabetes
- alcoholism
- nervous breakdown.

The legal position

The Health and Safety at Work etc Act 1974 states that 'every employer should ensure, so far as is reasonably practicable, the health, safety and welfare at work of all of their employees'.

The Management of Health and Safety at Work Regulations 1992 require employers to adopt modern risk management techniques such as those given below.

- Identify any hazards and assess all the risks to the health and safety of employees, and record the findings of the assessment. Stress should be considered along with other work hazards.
- Review and modify risk assessments at regular intervals and also when there are developments or changes in the work or if 'adverse events' have taken place.
- Provide health surveillance where the risk assessment shows that adverse health conditions have occurred or are likely to occur under the particular conditions of work. This may aid early detection of stress.

- Apply the following principles or hierarchy to preventative and protective measures.
  1 Avoid the risk altogether.
  2 Combat risks at source.
  3 Wherever possible, adapt work to the individual.
  4 Implement improved working methods and technological changes, where these can make work safer.
  5 Incorporate risk prevention strategies as part of a coherent policy.
  6 Give priority to those measures that protect the whole workplace.

Benefits of tackling stress

Stress affects the health and quality of life of staff. On average, it currently accounts for 30 per cent of a trust's sickness absence bill.

The benefits of tackling work-related stress are the obvious ones of more staff at work more of the time, and the reduction in sickness absence and its associated costs. It also demonstrates the organisation's commitment to its workforce and to addressing their health needs. This in turn affects how the organisation is perceived by both staff and the local community in terms of being a good employer.

The individual

'Individual' is the most important word in the field of stress management for the following reasons.

- What will cause stress for an individual will differ in every case.
- The signs showing that an individual is experiencing stress will also differ.
- The action that must be taken to prevent or manage stress will vary from person to person.

Improving Working Lives

The problem of work-related stress cannot be solved overnight. The stressors that cause it are often part of the way an organisation is run and these cannot be changed quickly.

The Department of Health sees the introduction of the Improving Working Lives (IWL) Standard as the cornerstone of its long-term strategy to address workplace stress. More information is available on the Department of Health website at www.dh.gov.uk

IWL is the process of 'creating a well-managed, flexible working environment that supports staff, promotes their welfare and development and enables a productive balance between work and life outside of work'. Through IWL, the NHS is working towards providing a better working environment for staff, including:

- team-based self-rostering
- annual hours arrangements

- carers' support and career breaks
- childcare support
- availability of reduced hours options
- changes to the long hours culture in the NHS.

This is starting to give NHS staff the freedom to manage their own work/life balance and to be in control. The NHS is committed to providing a healthy workplace and IWL can help in this aim.

However, meeting the IWL Standard is only part of the answer to the problem of work-related stress. NHS managers will need to work with colleagues from across the professions to address the immediate issues of work-related stressors and the resulting stress in staff.

Minimising organisational stress

Developing a strategy

From a management perspective, NHS trusts need to consider the causes of work-related stress in their organisation and set out a strategy for addressing the causes.

The stakeholders in developing a strategy to alleviate work-related stress should include:

- back care/manual handling advisers
- infection control staff
- occupational health advisers
- occupational therapists
- clinical risk assessors
- health and safety advisers
- staff side representatives
- management representatives
- human resources representatives
- finance representatives.

This work will involve identifying the major stressors for staff through the risk assessment process.

It might also be useful to consider the following when drawing up a strategy for the organisation:

- better infrastructure
- involving medical and nursing staff fully in decisions, such as the way they work
- clear lines of responsibility and management
- clear channels of communication, for example for expressing staff concerns.

Ways of working

Looking at this issue from an interprofessional perspective, it would prove useful to consider:

- measures to alleviate the intensity of the working lives of staff
- development of team-working within and across professional groups of staff
- understanding the pressures and constraints under which other groups are working.

Having assessed the risks to staff and identified the organisational causes of stress, the trust will want to consider:

- introducing changes to structures and procedures which are identified as causing stress
- introducing policies and procedures for handling stress
- reviewing and developing support systems for staff needing guidance and help.

Occupational health

The role of occupational health in taking this work forward is to:

- identify organisational aspects of stress and assist in change management
- identify and support stressed employees on a confidential basis
- intervene at an early stage to prevent problems and, where problems exist, prevent them getting worse
- facilitate the establishment of stress awareness and stress management programmes.

Practicalities

Trusts may also want to consider practical strategies such as:

- clinical leadership structures supported by good information
- leadership and management training and mentoring for all
- rigorous, supportive clinical governance
- job planning and appraisal
- identifying and managing 'poor performance' in a supportive framework.

This list is by no means exhaustive. Trusts should try to ensure that they take stress seriously and demonstrate understanding for people who admit to being under too much pressure. To help with this, trusts should ensure fairness and consistency, try to vary working practices where applicable and show an understanding attitude.

The role of managers

> Work-related stress is a huge occupational health problem facing Britain today, inflicting a heavy toll both in terms of financial cost and human suffering. Managers have a key role to play in reducing this toll – there is so much they can do which is both simple and effective.
> (Health and Safety Executive)

The HSE guidance, *Tackling work-related stress: a manager's guide to improving and maintaining employee health and well-being*, cites research that says effective people-management and development policies and practices are key tools in good performance. With work-related stress on the increase, it is important that all managers at all levels of the organisation are equipped with the skills to be able, wherever possible, to prevent work-related stress occurring among their employees, and to manage it if it does.

As well as understanding the issue of work-related stress and the organisational commitment to addressing it, managers should be able to do the following things.

- Understand the legal implications of stress in the workplace and be equipped with the necessary skills to ensure that they are doing everything to comply with health and safety law.
- Implement the up-to-date HSE guidance and conduct ongoing risk assessments for stress.
- Address and, where possible, correct any problem areas identified by the risk assessments.
- Recognise signs of stress in their staff.
- Know how to approach an employee exhibiting signs of stress and listen properly to what they are really saying. This, of course, includes the need for confidentiality for the member of staff.
- Recognise that they are not failing if they are unable to help an individual and have to pass them on to someone more qualified to help. Failure to do this could only compound the problem and could double the number of individuals suffering from stress.
- Provide information and guidance about in-house support services and external providers such as Relate, Alcoholics Anonymous, Samaritans etc. Not all members of staff feel confident in following the organisational route.
- Recognise how they themselves may be contributing to the stress levels of staff and how they could perhaps change, for the benefit of all.

Counselling and support

The NHS now provides counselling services to all NHS staff and has done so since April 2000. In most cases, counselling is not going to relieve the effects of organisational stress on staff, but it will show that an NHS employer recognises that there is a problem and is willing to provide staff with help when they need it.

Counselling denotes a professional relationship between a trained counsellor and an individual, with the objectives of the relationship varying depending on the client's needs. In the NHS, counselling may be concerned with developmental issues, addressing and resolving specific problems, decision-making, coping with crisis, working through conflict or even improving working relationships.

Some of the services provided by the NHS, which come under the general heading of staff counselling and support services, may include advice on financial and career

management and on a range of other issues. Counselling is likely to deal not only with psychological or mental health issues, but also with a wider range of issues that affect the working lives of staff.

Workplace stress and the courts

On 1 April 2004, the House of Lords published its judgement in the landmark case on workplace stress, Barber v Somerset County Council.

The leading judgement set out the following principles, which will probably be applied in future cases.

- Employers must keep up to date with the developing knowledge of occupational stress and the probable effectiveness of the precautions that can be taken to meet it.
- An 'autocratic and bullying style of leadership' which is 'unsympathetic' to complaints of occupational stress is a factor that courts can take into account in deciding whether there has been a breach of the employer's duty to an employee.
- Once employers know that an employee is at risk of suffering injury from occupational stress, they are under a duty to do something about it. This duty continues until something reasonable is done to help the employee.
- Employees who complain do not need to be forceful in their complaints and need not describe their troubles and symptoms in detail. They may be suffering from depression, making it more difficult to complain. Their complaints should be listened to sympathetically.
- Certified sickness absence due to stress or depression needs to be taken seriously by employers. It requires an enquiry from the employer about the employee's problems and what can be done to ease them. Employees should not be brushed off with instructions to reprioritise work without the employer taking further steps to consider the situation.
- A management culture that is sympathetic to employees suffering from occupational stress, and is prepared to act to alleviate it, may make a real difference to the outcome. Monitoring employees who are known to be suffering from occupational stress is mandatory. If they do not improve, then more robust steps may need to be taken to help them.
- There is a statutory duty to carry out risk assessments.

Relevant cases

Walker v Northumberland County Council (1995)

This was an early case concerning occupational stress in the workplace. Mr Walker was a social worker who experienced two nervous breakdowns because of the pressure from his job. The second breakdown happened after he returned to work from sick leave and faced a continuing overload of work. He was awarded £175,000 in an out-of-court settlement. The true cost of the case to his employers was certainly nearer to £500,000 when legal costs, sick pay and pension were included, and substantially more if the management costs for the process are taken into consideration.

Beverley Lancaster v Birmingham City Council (1999)

Birmingham City Council became the first employer in the UK to admit liability for a stress-related illness in this case, which resulted in a compensation payment of £67,000.

North v Lloyds TSB (2002)

Leslie North, a financial adviser with Lloyds TSB, received a £100,000 settlement after a seven-year fight for compensation, during which he became so depressed that he attempted suicide. After his section was cut from 14 members to five, he regularly worked until 2am to keep on top of administration. He complained to managers that intolerable demands were being placed on him, but no action was taken. Mr North was diagnosed with post-traumatic stress disorder.

In all cases, NHS employers should consult their own legal representatives and should not rely on previous case histories quoted here.

CHAPTER 16:
REHABILITATION AND REDEPLOYMENT

16

Chapter 16: Rehabilitation and redeployment

Introduction

Rehabilitation into work is one area where the National Audit Office found in its report (*A safer place to work: improving the management of health and safety risks to staff in NHS trusts*) that the NHS was not taking advantage of its own services, such as physiotherapy.

As a result, a major part of NHS sickness absence is long-term and results from periods – often running into several months – caused by stress and musculoskeletal disorders that should have been dealt with at a much earlier stage.

The report said:

> Staff absence has a direct impact on the ability of NHS trusts to treat patients, and can increase costs through the use of bank or agency staff. There is therefore a strong incentive for trusts to ensure effective and speedy rehabilitation of staff. Furthermore, research shows that employees should not take long periods of time off work to recover from low back pain as, the longer the worker is off, the lower the chances of them ever returning to work.

Fast-tracking

A recent survey of the scope for rehabilitation of workers identified early intervention to prevent acute conditions becoming chronic. For example, interventions could include occupational therapy, physiotherapy or counselling, as the most important element likely to secure a successful rehabilitation.

There are now 68 per cent of NHS trusts that have developed some form of fast-track treatment programme to get staff back to work more quickly. However, there is still some unease in the NHS about whether such procedures should be applied, to allow staff to be fast-tracked for treatment.

The National Audit Office and the Public Accounts Committee agree that:

> All NHS trusts should review their strategies for managing work-related stress and for providing counselling and other support to staff, with any arrangements reflecting departmental guidance on good practice. The option for fast-tracking should be fully explored and a clear, unambiguous strategy implemented.

NHS trusts not currently using a fast-track strategy may want to consider the work carried out by West Suffolk Hospitals NHS Trust, which introduced a system of fast-track referrals to a local physiotherapist for injured staff. In the first nine months of operating the system, these were the results.

- 104 staff were referred.
- The number of days lost by comparison with the previous year was reduced by 40 per cent.
- The direct costs of musculoskeletal injuries to the trust were reduced by more than £170,000.
- This was done at a cost of only £21,000.

Rehabilitation

Long-term sickness is defined in the NHS as being any sickness absence longer than four weeks.

It is considered good practice for NHS employers to institute a review of the case at the four-week stage[1], which may involve contacting the patient's GP to discuss the course of action to be taken to rehabilitate their patient back into work. Evidence from clinical studies suggests that, at four weeks, patients are still sufficiently engaged with their workplace to be anxious to return. However, at two or three months, they have begun the process of mental disengagement that makes a successful return more difficult to achieve.

Where rehabilitation is considered possible, the occupational health service and human resources will plan to manage the return in whatever manner is considered best for the individual. In most cases, this is likely to be in a staged manner, with a change of duties if this is considered necessary. Pay issues relating to the phased return to work will need to be decided locally, but it would seem reasonable that the patient should remain on full sick pay, if they are entitled to it, as they would be entitled to full pay at home.

Phased rehabilitation allows the member of staff to start contributing to the smooth running of the organisation at an early stage and research suggests that it also aids recovery. Times allowed for rehabilitation vary from trust to trust, but the accepted time across the service seems to be two months on full pay, working up to a full return to work at the end of this period. This does, of course, depend upon the original cause of the absence and will need to be decided on a case-by-case basis.

The benefits of rehabilitation are twofold.

- For the trust's management, they have a member of staff back earlier than expected, performing at least some of their duties. The organisation has shown that it cares for the member of staff and values their contribution.
- The member of staff feels valued by a caring employer and will, in all probability, recover more quickly when back in the working environment, than at home.

Research in the USA and UK has shown that staff rehabilitated into work recover more quickly than those left at home.[2]

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[1] Whiston/Edwards *Managing absence in an NHS hospital* IRS

[2] Swansbro: *Absenteeism – at issue in the American workplace*, Business Topics 1997

Staged return

Line managers and occupational health professionals should discuss the best course of action with the employee, considering:

- the nature of the condition the employee is suffering from
- what level of work they can do
- how many hours they are reasonably capable of doing
- over what period of time they should work towards achieving a full-time return to work
- any modifications that would help them return to work faster, including special equipment or re-training
- time needed to continue any ongoing medical treatment such as physiotherapy, counselling, hospital/GP visits
- regular reviews of the situation
- compliance with the Disability Discrimination Act 1995.

Disability Discrimination Act

The Disability Discrimination Act lays a duty upon employers to: 'look at what changes or reasonable adjustments they could make to the workplace or the way the work is done which would overcome the effects of disability'.

There is an ongoing discussion around a definition of disability. The Disability Discrimination Act defines a disabled person by the following criteria.

- A disabled person is someone who has a physical or mental impairment.
- The impairment has an adverse and substantial effect on his or her ability to carry out normal day-to-day activities.
- The effect of the impairment is long-term.

The Disability Rights Taskforce also recently reviewed the Act's definition, and has recommended that it should include people with HIV and cancer, when it has a significant effect on their lives. As part of an organisation that is aiming to become an exemplary employer in the field of staff health and welfare, NHS organisations will want to have policies in place for rehabilitation, which recognise the needs of the individual and their past and future contribution to that organisation.

The Disability Rights Commission recommends that an organisation: 'take any steps which it is reasonable for it to have to take, to reduce or remove any substantial disadvantage which a physical feature of the premises or the organisation's employment arrangements cause a disabled member of staff, compared to a non-disabled person'.

In returning members of staff into work, it may be necessary to treat them as if they were suffering from a disability, for the sake of making reasonable adjustments.

Reasonable adjustments to a job can include:

- changes to duties, shifts or hours
- changes to the place of work
- adjusting the features of a building or access to it, including its fixtures, fittings and design.

Redeployment

Many trusts using rehabilitation as part of their sickness absence management policies have found that it is not always possible to rehabilitate staff back into their original post in the short term.

This may be due to job-loading or to the nature of their illness; for instance, musculoskeletal problems, which need time to heal without the risk of further damage.

In these circumstances, an alternative that is widely used is that of redeployment. This is usually short-term, while an employee is recovering from the ailment, before returning to their usual job full-time. For staff who have no likelihood of returning to their original job, it can become a permanent move.

In some cases, this redeployment requires re-training, and it is good practice for this to be provided as part of a package devised and managed by the occupational health service and human resources.

Recommendations

- NHS employers should treat rehabilitation of staff back into work at an early stage as a priority.
- If this is not a possibility, they should consider redeployment of staff at an early stage in their absence, as a means of returning them to the workplace.
- The role of occupational health is to contribute to the rehabilitation and redeployment process by assisting and making recommendations to facilitate the process.
- In order to make recommendations and facilitate a return to work, the occupational health professional will need to be in possession of all the facts. Contact may need to be made with the employee's GP or consultant, to ask specific questions about their illness.
- Written informed consent must be obtained from the employee when an occupational health professional wishes to contact their GP or consultant for information regarding them. The employee must be told what information is being sought about them and why, and should be advised of their rights under the Access to Medical Records Act 1998.
- Confidentiality of any clinical information obtained must be respected.
- Fast-tracking to the appropriate health professional, particularly in musculoskeletal disorders and stress, can reduce long-term sickness absence substantially.

- Getting employees back into work at the earliest opportunity reduces long-term sickness absence. Evidence has shown that the longer a person stays away from work the less likely they are to return at all.
- Rehabilitation and redeployment can save money because
  - staff are back in work and contributing to the organisation
  - less money is spent on casual/replacement labour
  - there is less likelihood of an employee claiming Permanent Injury Benefit.
- Review scope for flexible working practices wherever possible.
- Managers should be trained in staff management so that they know how to manage sickness absence and return-to-work issues correctly.
- They should be aware that these are sensitive issues and be sure to follow the correct procedures, to support their colleague to make a full return to work.

CHAPTER 17:
THE NHS PENSION SCHEME AND NHS INJURY BENEFIT SCHEME

17

Chapter 17: The NHS Pension Scheme and NHS Injury Benefit Scheme

The NHS Pension Scheme

Introduction

The NHS Pension Scheme (NHSPS) was set up in 1948 to provide pension benefits for NHS employees and their dependants.

The Treasury Review of Ill Health Retirements in the Public Sector was published in July 2000. The Secretary of State for Health signalled his broad acceptance of the findings on 7 June 2000, but lodged some reservations about charging employers and on the pooling of staff for redeployment.

The Treasury Review set the following target for the reduction in numbers of ill-health retirements in the public sector, which NHS employers were expected to work towards achieving:

> For all employers to aim to achieve rates of ill-health retirement which are comparable or better than the current best quartile of employers (3.96 per thousand employees) by 2005.

This target has since been met and exceeded.

NHS Employers is leading a Review of the NHS Pension Scheme, in partnership with NHS trade unions. The Review has recommended that there should be a further review of sickness and ill-health provision in the NHS. This would consider, among other issues, ill-health retirement provision and the NHS Injury Benefit Scheme.

The review of ill-health retirement provision would take account of the recommendations in the Treasury report that public sector schemes should introduce two-tier arrangements. Any changes are unlikely to be introduced before 2007.

The National Health Service Pension Agency (NHSPA) has, from 1 April 2002:

- published league tables showing numbers of ill-health retirements by trust
- ensured that data from NHS trusts showing numbers of ill-health retirements by trust is published in the trust accounts
- monitored the progress of trusts towards achieving a level of just under four employees per 100, retiring on ill health grounds.

The NHS ill-health pension regulations

Although most NHSPS members retire on age grounds, the NHSPA scheme provides for retirement on ill-health grounds. This is where individuals are permanently incapable of efficiently discharging their duties due to ill health. In order to qualify for the 'in-service' health pension, NHSPS regulation E2 must be satisfied. This states:

> A member who retires from pensionable employment because of physical or mental infirmity that makes him permanently incapable of efficiently discharging the duties of that employment, shall be entitled to a pension under this regulation if he has at least two years qualifying service.

Ultimately, the decision on whether the member qualifies for the ill-health pension rests with the Secretary of State for Health (represented by the NHSPA), not the individual or the employer.

When the Agency's medical advisers are considering entitlement to the ill-health pension, they look at the individual's particular duties and consider whether he or she is permanently[1] incapable of efficiently discharging them due to ill health.

The role of occupational health

The occupational health service plays a major role in providing medical evidence and opinion in relation to an ill-health pension application. Consequently, occupational health needs to have a clear understanding of the criteria to be met.

Guidance on this role was published in *Managing ill-health retirement in the NHS*, 2001.

The management process

The following process comprises the actions to be taken in order to meet the standard for managing ill-health retirement set out in *The effective management of occupational health and safety in the NHS* as part of the Improving Working Lives Standards.

Trigger point for management action/referral to occupational health

When a member of staff has been absent due to sickness for four weeks, their absence becomes classified as 'long-term'. At this stage, the manager should:

- assess the situation
- determine the appropriateness of a referral to occupational health for health assessment
- ascertain whether it is possible to initiate action to facilitate a return to work.

[1] Permanently incapable means that staff will not be able, through their medical condition, to work before the normal retirement age of the scheme (age 60).

Occupational health assessment

The occupational health service will assess:

- the nature of the condition, the current and possible treatment and its likely effects and the likely prognosis of the medical condition
- the likely duration of sickness absence
- whether or not the individual will be fit to return to their own job without modification or rehabilitation
- whether job modification or rehabilitation in the short term would facilitate an earlier return to work
- whether job modification or redeployment may be necessary indefinitely on return to work
- whether the individual will be permanently incapable of carrying out any work, however modified.

They will then make recommendations on whether the member of staff is fit to carry out their normal duties or advise on modifications to the job – long-term or short-term – which would allow them to return to work.

It is not always possible for these decisions to be made at the start of the period of sickness absence and the situation may need to be reviewed over a period of time before the response to treatment and likely prognosis, with its attendant implications for work, can be assessed. The occupational health service will need to make this clear to the employer at an early stage and make recommendations for the follow-up regime.

To be able to make these recommendations, the occupational health service needs all the facts and may need to contact the employee's GP or consultant. The clinician should be asked specific questions relating to the illness including, where relevant, proposed treatment, likely effects and prognosis. Written informed consent, obtained from the employee, must be forwarded to the clinician with the request for a report.

The employee must be told what information is being sought, why, and should be advised of their rights under the Access to Medical Records Act 1988. Confidentiality of any clinical information obtained must be respected.

Occasionally it may be necessary to refer an employee to a consultant for specific assessment to guide the occupational physician. This rare situation requires a private referral (ie not through normal NHS referral routes) and the consultant will charge for the consultation. The occupational health service should ensure that the employee understands the reason for the referral ie that it will not give rise to treatment, and that the GP is aware of the referral and the reasons for it, and is provided with a copy of the report.

Identification of suitable posts

On receipt of recommendations from the occupational health service, the employer will need to:

- decide whether it is possible to make the suggested modifications to an employee's post
- identify suitable alternative posts, if they accept a recommendation to redeploy
- ensure that they comply with the duty laid out in the Disability Discrimination Act 1995 to, 'look at what changes or reasonable adjustments they could make to the workplace or the way the work is done which would overcome the effects of disability'.

Failure to identify suitable posts

If the employer is unable to identify suitable posts or to make reasonable adjustments to facilitate the return to work, the process will need to be reviewed again by both the human resources and occupational health departments, working together.

They will need to consider the following questions.

- Is the employee's health likely to improve enough, with time and treatment, to allow them to be rehabilitated back into employment?
- What further action can the employer take to facilitate the speedy return to good health of the employee?
- Is it likely that there will ever be any posts that will be medically suitable for the employee to fill? The post should fit the person (and not the person fit the post).

If, at this stage, it becomes obvious that there is no likelihood of the employee being rehabilitated into the workplace, their employer will need to discuss the options for the future with them.

Members' rights

Every NHSPS member in pensionable employment has a right to apply for the 'in-service' ill-health pension, and trusts, as employers, cannot deny them this right.

If an application for ill-health retirement is successful, the member and their employer should agree on the last day of service and, if possible, all documentation should be completed before the employee goes onto a nil-pay situation.

If a member is initially unsuccessful, they can appeal up to three times under the NHSPA's internal appeals procedure. The NHSPA views this procedure as 'good and fair practice' and realises that this more than meets the requirements of the 1995 Pensions Act, under which pension schemes are required to operate a two-stage internal disputes resolution (IDR) process.

The NHS Injury Benefit Scheme

Until 1974, the NHS Injury Benefit Scheme (NHSIBS) was part of the NHS Pension Scheme. The move to being a separate scheme, with its own set of regulations, ensured that all NHS employees were covered by the NHSIBS, regardless of whether they were members of the NHSPS or not.

The NHSIBS regulations

The injury benefit scheme is part of the terms and conditions of service for the majority of employees. NHS trusts are legally bound to adhere to the regulations, regardless of the financial implications. The following are the key provisions of the regulations.

- NHS employees[2], practitioners, chairmen and honorary post-holders are covered by the NHSIBS.
- The injury or disease must be wholly or mainly attributable to the NHS employment.
- The individual must have suffered a loss of earnings to qualify for temporary injury allowance (TIA) while still employed.
- The individual must have suffered a permanent reduction in earnings ability of more than 10 per cent to qualify for permanent injury benefit (PIB).

Temporary injury allowance

Temporary injury allowance is paid while the individual is off sick and still employed in the NHS. It should not be paid indefinitely by the employer. It ends when the individual returns to work or retires/resigns from their NHS employment.

Permanent injury benefit

Permanent injury benefit can only be considered if an individual retires or permanently moves to another, lower-paid employment. If successful, the applicant would be guaranteed an income for life. A reduced permanent injury benefit is payable to the family if the injury results in death.

The role of occupational health in relation to injury benefits

In most cases the trust, with the assistance of its occupational health service, will decide on entitlement to TIA without involving the NHSPA. However, if the employee, or the trust as employer, wishes, they can refer the TIA claim to the NHSPA.

Entitlement to PIB is always determined by the NHSPA.

When submitting a claim to the Agency, the employer must ensure that all relevant medical notes are sent with the application. The trust or their occupational health units are entitled to provide an opinion on whether the injury is wholly or mainly attributable to the NHS duties.

[2] Not covered are freelance GP locums, GMS/PMS GPs injured while carrying out locum GP work, GP practice staff, staff employed by a 'direction' body and reservists injured while on duty with the Armed Forces.

CHAPTER 18: BLOOD-BORNE VIRUSES

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Chapter 18: Blood-borne viruses

Introduction

Blood-borne viruses (HIV, Hepatitis B and C) can be transmitted in the healthcare setting from patient to healthcare worker, patient to patient, or healthcare worker to patient. In general, the risks of transmission of blood-borne viruses in the healthcare setting arise from exposure to blood and in certain exceptions, other body fluids or body tissues from an infected person.

Listed below are the body fluids that should be handled with the same precautions as blood:

- cerebrospinal fluid
  peritoneal fluid
  pleural fluid
  pericardial fluid
  synovial fluid
  amniotic fluid
  semen
  vaginal secretions
  breast milk
- any other body fluid containing visible blood, including saliva in association with dentistry
- unfixed organs or tissues.

Surveillance of occupational exposure to blood-borne viruses in healthcare workers

Since 1984 the Communicable Disease Surveillance Centre of the Health Protection Agency (HPA) has undertaken passive surveillance of occupational exposure to blood-borne viruses in healthcare workers. The scheme was revised in 1997 to an enhanced surveillance system.

Exposures to blood-borne viruses should be reported to the Health Protection Agency surveillance co-ordinator – tel 020 8200 6868.

The first documented HIV seroconversion due to an occupational exposure in a healthcare worker occurred in the UK in 1984. There have been three reports of

seroconversions for Hepatitis C in the five years since the start of enhanced surveillance in 1998. However, in the past 12 months another six seroconversions have been reported to the HPA. This figure is regarded as an underestimate because:

- Hepatitis C is more common than HIV (8-10 fold)
- it is more transmissible than HIV from needlestick injuries (5-10 fold)
- like HIV, it may not be recognised unless the healthcare worker reports an injury and has the relevant blood test (ie it is mostly asymptomatic at initial acquisition).

The HPA Communicable Diseases Surveillance Centre now collects information on Hepatitis B seroconversions. The vast majority of healthcare workers are immunised against Hepatitis B and this should provide protection if a needlestick injury occurs which involves an infected person.

Surveillance[1] shows the following facts:

- Nurses report a higher number of significant exposures to blood-borne virus infection than any other group, followed by doctors.
- Together they account for 78 per cent (43 per cent nurses, 35 per cent doctors).
- Most exposures (58 per cent of reported incidents) occurred during the procedure.
- 37 per cent occurred after the procedure had been performed, or during/after disposal.

These later incidents are clearly preventable with adherence to universal precautions and safe disposal of sharps. National and international guidance has recommended this for many years.

It has been suggested that compliance with current guidance on the disposal of sharps could potentially eliminate one-third of needlestick injuries.

Testing

Testing for blood-borne viruses should take place in the following circumstances:

Hepatitis B

Healthcare workers who will perform exposure-prone procedures should be tested for Hepatitis B infection at the pre-appointment check and at the time of immunisation. This is because it is now recognised that a Hepatitis B antibody (anti-HBs) response measure, after a course of vaccine, may occur in individuals who have a current infection. Relying on anti-HBs response to vaccine to indicate non-infectivity may not be secure, since some infectious carriers of the virus could be missed.

Hepatitis C

Testing is recommended for healthcare workers intending to begin professional training for a career that relies upon the performance of exposure-prone procedures. New

[1] Health Protection Agency, Communicable Disease Surveillance Centre. *Surveillance of significant occupational exposure to blood-borne viruses in healthcare workers: six-year report.* March 2004. www.dh.gov.uk/infections/topicsaz/bbv/sreport

guidance on Hepatitis C/Serious Communicable Diseases is due shortly and may change this guidance.

HIV/Hepatitis B and C

Testing should take place after:

- a healthcare worker to patient blood-exposure incident
- a patient to healthcare worker incident
- a sharps injury
- exposure to body fluids.

Immunisation

Immunisation is no substitute for good infection-control working practices. Healthcare workers can be immunised against Hepatitis B[2] and in most cases, this is standard procedure in NHS trusts. However, you cannot offer immunisation against all blood-borne viruses.

Guidance soon to be published by the Department of Health, *Health clearance for serious communicable diseases: new health care workers*, recommends that pre-appointment health checks for new workers should include:

- checks for TB disease/immunity
- offer of Hepatitis B immunisation, with post-immunisation testing of response
- a reminder to them of their professional responsibilities in relation to serious communicable diseases
- an offer of testing for Hepatitis C and HIV.

All new healthcare workers who will perform exposure-prone procedures need to have both standard and additional health clearance for serious communicable diseases, before appointment or starting training. It is recommended that this includes medical students as well as qualified clinicians – although not nursing students.

Guidance concerning medical students and serious communicable diseases is expected to be published in early 2005.

Employers should be satisfied that all staff working for the NHS who do exposure-prone procedures, have had the necessary tests and immunisations to enable them to undertake their duties with the minimum of risk to themselves and others. These include:

- healthcare workers returning from research experience, voluntary service with medical charities, sabbaticals, exchanges or periods of unemployment
- medical students returning from electives in countries where there is a high prevalence of blood-borne viruses

[2] HSG (93) 40: *Protecting health care workers and patients from Hepatitis B* (18 August 1993)

- locum and agency staff
- overseas healthcare workers applying for employment or a training place in the NHS, including those applying under international recruitment arrangements.

Guidance on international recruitment is available on the Department of Health's website: www.dh.gov.uk/international-recruitment/index/htm

Healthcare workers in the independent healthcare sector

NHS trusts and primary care trusts that arrange for NHS patients to be treated by non-NHS hospitals, health establishments or private consultants in the UK, should ensure they adhere to the guidance in Independent Health Care: National Minimum Standards Regulations.

Healthcare workers in the independent health sector should comply with professional codes of practice and Department of Health guidelines on healthcare workers infected with blood-borne viruses.[3]

Standard and additional health checks

In line with the proposed new guidance in *Health clearance for serious communicable diseases: new health care workers*, new healthcare workers should be offered:

- testing for TB
- Hepatitis B immunisation
- a check for Hepatitis C/HIV.

Full details of these checks are available in the new guidance (see above). Additional health checks for staff undertaking exposure-prone procedures include more in-depth checks for Hepatitis B[4], Hepatitis C[5] and HIV[6]. Again, full details of the checks are included in the proposed guidance.

It is important that those commissioning laboratory checks for HIV, Hepatitis B and C should ensure that the samples tested are from the relevant healthcare worker. Healthcare workers should not provide their own samples, and samples must be validated to prevent fraud.

There is currently no routine requirement for the testing of healthcare workers other than doctors for blood-borne viruses. However, if they think they have been exposed, healthcare workers have a professional duty to seek medical advice on the need to be tested for blood-borne viruses.

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[3] *Independent Health Care: National Minimum Standards Regulations*. Department of Health 2002 www.dh.gov.uk/ncsc/independenthealthcare.pdf. The standards apply to independent hospitals, independent clinics and independent medical agencies. (As defined by section 2 of the Care Standards Act 2000)

[4] Guidance for Hepatitis B includes: HSG (93) 40: *Protecting health care workers and patients from Hepatitis B* (18 August 1993) and its Addendum under cover of EL(96)77 (26 September 1996) and HSC 2000/20: *Hepatitis B infected Health Care Workers* (23 June 2000). www.dh.gov.uk/nhsexec/hepatitisb.htm

[5] More guidance on Hepatitis C can be found in: HSC 2002/010: *Hepatitis C infected health care workers*. www.dh.gov.uk/hepatitisc (14 August 2002)

[6] More guidance on HIV can be found in: HSC 1998/226: *Guidance on the management of AIDS/HIV infected health care workers and patient notification.* www.dh.gov.uk/aids/htm

If they are subsequently found to be infected, they should then seek occupational health advice on the need to modify their working practices to protect patients.

The UK Advisory Panel for Health Care Workers Infected with Blood-borne Viruses (UKAP) is a source of advice for occupational health staff and individual healthcare workers on:

- the management of healthcare workers with blood-borne viruses
- working practices
- the need for patient notification exercises.

UKAP can be contacted through its secretariat, which is based at the address below:

Dr Fortune Ncube
Medical Secretary
UKAP
Communicable Disease Surveillance Centre
Health Protection Agency
61 Colindale Avenue
London NW9 5EQ

Tel 020 8200 6868

Precautions against exposure to blood-borne viruses

There is a range of measures that can be taken to avoid exposure to blood-borne viruses. These can include wearing non-powdered latex gloves and other protective clothing and the safe handling and disposal of sharps. If followed correctly, in line with the guidance available from the Department of Health's website (see Annex A for list of documents), they should protect both the healthcare worker and the patient.

Management of blood exposure incidents and post-exposure prophylaxis

Needlestick and other exposures to blood in the healthcare setting are unnecessarily common at present. Many result from a failure to follow recommended procedures and from careless disposal of waste. However, there will always be occasions where exposure occurs, despite careful attention to the correct procedures.

All high-risk exposure incidents should be reported to the surveillance scheme as well as the trust's occupational health department, and they should be reviewed to consider how to prevent recurrence.

Health workers or any other person in the healthcare setting exposed to infected blood or body fluids, and in some cases to HBV infection, should be offered appropriate post-exposure prophylaxis. All healthcare workers should be aware of local post-exposure prophylaxis policies and procedures, in particular the need for prompt action following a known or potential exposure to HIV.

Currently, there is no effective post-exposure prophylaxis against Hepatitis C infection. Nevertheless, there is some evidence that early treatment of acute Hepatitis C infection may prevent chronic Hepatitis C infection. This underlines the need for careful management and follow-up of occupational exposures and early referral for specialist occupational medicine and gastroenterology/hepatology/infectious disease assessment if infection has been transmitted.

Healthcare workers infected with blood-borne viruses

Blood-borne virus transmission can happen if infected healthcare workers injures themselves and bleed into a patient's open tissues. Therefore it is only sensible that infected healthcare workers are restricted from performing exposure-prone procedures[7]. Reference to the relevant guidance is in Annex A.

[7] Exposure-prone procedures are those where there is a risk that injury to the health of the healthcare worker could result in their blood contaminating a patient's open tissue. These include procedures where the worker's gloved hands may be in contact with sharp instruments, needle tips or sharp tissues (eg spicules of bone or teeth) inside a patient's open body cavity, wound or confined anatomical space where the hands or fingertips may not be completely visible at all times. Exposure-prone procedures occur mainly in surgery (including some procedures in minor surgery carried out by GPs), obstetrics and gynaecology, dentistry, midwifery and some aspects of specialist nursing eg some duties in operating theatre nursing.

CHAPTER 19: NEEDLESTICK MANAGEMENT

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Chapter 19: Needlestick management

Introduction

The National Audit Office (NAO) report of April 2003, *A safer place to work – improving the management of health and safety risks to staff in NHS trusts*, and the subsequent Public Accounts Committee hearing, highlighted the need for the better management of needlestick and sharps incidents in the NHS.

The report stated that needlestick and sharps injuries accounted for 17 per cent of accidents to NHS staff and were the second most common cause of injury, behind moving and handling at 18 per cent.

Contaminated needles can transmit more than 20 dangerous blood-borne pathogens, including hepatitis B, hepatitis C and HIV.

During 2005, the Department of Health will be working with the Health and Safety Executive (HSE) and the Safer Needles Network (SNN) to produce an NHS-wide strategy for safer needle management. In the meantime, this chapter gives guidance on what NHS employers should do to reduce the risks of needlestick and sharps injuries to staff.

Needlestick and sharps injuries can have devastating effects on the members of staff concerned.

- At least four UK healthcare workers are known to have died following occupationally acquired HIV infection.
- Since 1996, the Health Protection Agency has received reports of nine healthcare workers who have been infected with HCV because of occupational exposure.

For this reason, NHS employers should look at the following in relation to needlesticks:

- risk assessment
- risk management
- training
- where indicated, the provision of medical devices incorporating sharps protection mechanisms.

With 40,000 reported incidents a year, and at least as many unreported, needlesticks and sharps injuries are a significant issue. They should be managed as part of a trust's integrated risk management policy.

The legal situation

The Health and Safety at Work etc Act 1974 places a legal duty on employers to provide for the health and safety of their employees. NHS trusts have been subject to the full requirements of this legislation since 1991.

These duties were extended under the Management of Health and Safety at Work Regulations 1992, which require employers to:

- assess risks to the health and safety of their employees
- arrange for implementing a comprehensive system of safety management.

Trusts can be in breach of health and safety regulations because of reported needlestick injuries, and many have settled such cases, resulting in substantial legal expenses and compensation payments.

There are, additionally, three EU Council Directives relevant to the health and safety of workers (EU Council Directive 89/391/EEC, EU Council Directive 89/655/EEC and EU Council Directive 2000/54/EC).

The Control of Substances Hazardous to Health Regulations 2002 (COSHH) specifically include micro-organisms in the definition of substances that are hazardous to health. The law requires employers to make a suitable and sufficient assessment of the risks to the health of workers exposed to such substances, with a view to preventing or adequately controlling the risks. This includes the proper use of protective equipment and regular monitoring of exposure.

Under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR), exposures to hepatitis B or C, or HIV, are reportable to the HSE as a dangerous occurrence ('accidental release of a biological agent likely to cause severe human illness') using form F2508, rather than as an injury (unless the exposure results in three or more days absence from work). Reports can be made online at: www.riddor.gov.uk

Managing the risks

Data, record-keeping and monitoring

One of the major problems associated with the management of needlestick incidents, identified by the NAO in their report, and confirmed by the HSE, is the lack of hard evidence relating to the actual numbers of incidents in trusts. This is due to the under-reporting of exposure incidents, which some studies have identified as being as high as 85 per cent. The NAO identified data collection and record keeping, together with the monitoring of those records, as a key area that requires more work.

All exposure incidents should be reported promptly, following local reporting arrangements (usually to the trust's occupational health service). This is important for three reasons.

- It ensures appropriate management to reduce the risk of blood-borne virus transmission.

- It documents the incident and the circumstances, in case of later claim for occupational injury or infection.
- It provides accurate surveillance, so that collective data analysis can inform measures to reduce the risk of further exposures.

Managing exposure incidents

Guidance on managing blood and body-fluid exposure incidents can be found in these publications.

- Ramsay, M. E. 1999: *Guidance on the investigation and management of occupational exposure to hepatitis C, Communicable Disease*. Public Health, 2, 258-62.
- *Guidelines for pre-test discussion on HIV testing*. Department of Health, 1996.
- *HIV Post-Exposure Prophylaxis: Guidance from the UK Chief Medical Officers' Expert Advisory Group on AIDS*. Department of Health, February 2004.
- *Immunisation against infectious disease*. Department of Health, HMSO 1996.

(See appendix 2: Needlestick injury)

Surveillance systems

All cases of occupational exposure to blood or body fluid from patients infected with HIV, HCV or HBV, and all incidents where PEP for HIV has started (whatever the HIV status of the source), should be reported to the Health Protection Agency national surveillance scheme.

The anonymity of the healthcare worker is maintained through unique identifier codes. The scheme aims to record:

- the numbers of healthcare workers being exposed to these viruses
- the circumstances contributing to occupational exposures
- the clinical management of those exposures, including HIV exposures
- whether the healthcare worker had PEP
- the side-effects and outcomes.

Further information about the scheme can be found at:
www.hpa.org.uk/infections/topics_az/bbv/bbmenu.htm

It is unlikely that there will be a compulsory national surveillance scheme in the NHS, but it may be that the work being done by the HSE, Department of Health and the SNN will result in a nationally agreed format for collecting data locally. Trusts interested in devising a format for collecting their data might wish to refer to the SNN or to one of the health service unions, who all have experience in this area.

For example, the Royal College of Nursing has worked on establishing a national study on the prevalence and causes of needlestick and sharps injuries, using the EPINet™ surveillance system.

Assessing the risk

Risk assessments should be made of all situations where a healthcare worker may be exposed to blood or other potentially infectious material. This will:

- identify which technologies could be used to eliminate exposures
- allow consideration of possible alternatives
- eliminate the unnecessary use of sharps by implementing changes in practice and providing, where practicable, sharp-free devices or safer needle technologies which retract or shield needles after use.

Further information on blood-borne viruses is in the chapter on this subject (see chapter 18). A list of publications relating to blood-borne viruses is in annex A.

Identifying alternatives

Independent studies show that a combination of training, safer working practices and the use of medical devices incorporating sharps protection mechanisms can prevent more than 80 per cent of needlestick and sharps injuries.

Numerous, cost-effective alternatives are available on the market in the UK. The Department of Health, HSE, NHS unions, SNN and others have contributed to the setting up of an interactive website to allow for the exchange of information on new alternatives and how to source them. This can be found at www.pasa.nhs.uk

Training

Trusts should include specific time within training programmes and at induction for all staff to cover:

- the risks associated with blood and body-fluid exposures
- the correct use and disposal of sharps
- the use of medical devices incorporating sharps protection mechanisms.

Refresher training should be made available on a regular basis.

Improved sharps disposal

Studies in the United States and Europe have also shown significant reductions in the numbers of needlestick injuries from improving sharps disposal. It is not acceptable, particularly for cost reasons, to reduce the number of sharps bins to such an extent that staff are forced to carry used needles to the sharps bin to dispose of them.

There should be enough portable sharps bins for staff at all times, to allow the used needle to be disposed of safely at the point of use. This should also reduce the number of incidents resulting from needles being left in bedding.

Summary

The provision of training, education and safer technology will lead to a significant reduction in the incidence of blood and body-fluid exposures. This can be achieved by:

- implementing proper surveillance and reporting procedures
- ongoing training and education, locally and nationally, of healthcare workers in preventative measures and safer working practices
- the availability of safety-engineered devices to all healthcare workers in the workplace, where proper and ongoing risk assessment has identified that such devices will reduce the risk of blood and body-fluid exposure.

CHAPTER 20: HANDLING INFECTED CADAVERS

20

Chapter 20: Handling infected cadavers

Introduction

Handling infected cadavers may pose a risk to healthcare workers, funeral directors and their staff. Guidance on this subject has been poorly implemented, resulting in inconsistent advice and inappropriate practices. This is compounded by individual hospitals having differing policies and practices for the handling of the deceased.

The Department of Health has issued guidelines on handling bodies with infections (see appendix 3). However, this guidance applies to specific infections and requires a degree of microbiological understanding to be effective. This lack of effective guidance poses a risk, not only to funeral directors but also to the family of the bereaved, who may wish to view (or touch) their loved one.

Modern funeral practices put complex demands on practitioners and funeral workers, who need a wide knowledge of disposal procedures and regulations. The objective of this guidance is to provide consistent information and guidelines for dealing with infected cadavers.

A model code of practice was evaluated at a West Midlands teaching hospital by Dr Surinder Bakhshi, working for the Birmingham Health Authority, with the co-operation of local funeral directors. The code of practice developed by Dr Bakhshi provides the basis for this guidance.

Code of practice

The body of a deceased person passes through a complex chain of events from death to final rest. This code of practice ensures the safety of health/funeral workers when handling a cadaver.

Patient confidentiality continues after death, and it is important that the processes put in place respect this duty. Such confidentiality does not prevent the use of sensible rules to protect the health and safety of staff.

A model code of practice should be the starting point for the development of a local policy in an NHS trust.

Legal position

The following regulations lay down how infected bodies should be dealt with.

- The Control of Substances Hazardous to Health Regulations (COSHH) 2002 require

risk assessment, from exposure to hazardous substances (including microbiological agents) and also control measures to be applied.

- Sections 2 and 3 of the Health and Safety at Work etc Act 1974 require that all work activities are conducted to ensure the safety of employees and members of the public.
- The Public Health (Control of Diseases) Act 1984, Section 10, names notifiable diseases.
  - Under Section 43 a registered medical practitioner, or a medically qualified officer appointed by the local authority, may prevent removal of a body associated with a notifiable disease from a hospital, except to a mortuary, cemetery or crematorium.
  - Section 44 places responsibility on the owner of the premises where a notifiable disease was the cause of death to prevent others being exposed to the body.
  - Section 45 forbids wakes to be held if the deceased had a notifiable infection.
- Regulation 3 and Schedule 1 of the Public Health (Infectious Diseases) Regulations 1988 define the additional 24 infectious diseases, which must be notified.
- Regulation 14, Cremation Regulations, England 1993, gives power to a medical referee to order cremation if the death was due to a notifiable disease.

In line with these legal requirements, a guidance form should accompany the body when released from the mortuary. It should list:

- the reasons for the use of a body bag (if used)
- whether the bag may be removed at the funeral home to enable the preparation of the body for burial or cremation
- procedures such as embalming, or access to the deceased
- information on transmission routes and the precautions that should be taken.

This will ensure that medical confidentiality is preserved after death. See appendix 4 for an example of a guidance form and table of biohazard management.

Risk assessment

A survey to discover the knowledge, attitude and behaviour in relation to the management of HIV, hepatitis B and tuberculosis of Consultants in Communicable Disease Control (CsCDC) in England, revealed the following statistics.

- Two-thirds of those consulted had no policy for funeral workers and one sixth had no policy for hospitals.
- Policies that did exist mainly related to deaths associated with HIV infection or tuberculosis.
- Two-thirds of CsCDCs allowed unrestricted viewing of bodies with the three infections.
- Most CsCDCs could not recall being consulted by a funeral worker. They expressed the view that putting bodies in bags was excessive.

- There was consensus that a national policy should be developed to manage the deceased after death.

Practical risk assessment

In general, few organisms in a cadaver pose an infection risk. However, there are some important hazards to be considered. A practical risk assessment should include the following three categories of infections.

1 Infections that pose minimal transmission risk and are preventable with hygienic practice. Usually there is available prophylaxis or treatment for such infections. Examples are: chicken pox, influenza, measles, meningitis, mumps, rubella, scarlet fever and whooping cough.

2 Infections causing severe human illness, but with limited or no transmission risk. Such infections have intermediate insect and animal vectors, which are rarely met with in the UK. These infections may, however, be transmitted by accidental blood inoculations, transplantation or in research work. Examples are: yellow fever, rabies, malaria and anthrax.

3 Infection hazards such as those listed below, which present a quantifiable risk.

- Airborne droplets or particles – Tuberculosis.
- Discharges from body orifices – Typhoid and paratyphoid fevers, amoebic or bacillary dysentery and food poisoning.
- Inoculation risks – HIV infection, hepatitis B and C infections, leptospirosis and brucellosis.
- Skin lesions – Staphylococcus aureus and streptococcus pyogenes.
- Skin infestations – Body lice and scabies.

In all cases, universal precautions against infection must be used. In addition, before being released, the cadaver should be labelled with the appropriate actions that need to be followed in a particular case.

Conclusion

In all cases, a safe working environment is a greater safeguard against infection than relying on the use of body bags in all circumstances. The body bag should be viewed as an adjunct to safe practice, rather than a requirement for all cadavers.

Communication is vital for the protection of health workers, funeral directors, their staff and relatives of the deceased. Information about any infection which poses a threat should be passed on to the funeral director and his staff.

Advice should be given on body preparation, bagging, examination or storage in the mortuary and funeral home. The family of the deceased should be asked about their requirements before starting the body preparation. Some relatives may wish to perform ritual preparation of the body of their loved one.

CHAPTER 21: LATEX

21

Chapter 21: Latex

Introduction

The Management of Health and Safety at Work Regulations, 1992, places duties on employers to systematically assess all workplace risks and to take all reasonably practicable action to minimise those risks. This includes exposure to natural rubber latex (NRL).

As NRL is hazardous to health, the Control of Substances Hazardous to Health Regulations 2002 (COSHH) also applies to employers because they require employers to assess any substances used at work that are hazardous to health.

The proteins naturally present in NRL can cause allergies, either through direct contact with the skin or by inhalation of powder from powdered latex gloves. Exposure to latex in gloves can produce skin and respiratory problems. Reactions range from non-allergic irritation of the skin to a permanent allergy that produces a severe reaction and offers the potential for anaphylactic shock.

The risks

In a healthcare setting, NRL affects not only employees but also patients. NHS employers must therefore be aware that NRL can affect many people, including:

- healthcare workers
- individuals undergoing multiple surgical procedures
- individuals who have a history of certain food allergies such as banana, avocado or chestnut
- individuals with atopic allergies disease
- individuals exposed to NRL on a regular basis, such as workers in car maintenance/mechanics, catering and electronics.

Use of natural rubber latex

NRL is a widely used and cost-effective material, with many unequalled benefits, which for the majority of the population does not represent a clinical risk. (Currently only around 1–6 per cent of the general population are thought to be potentially sensitised to NRL.) The importance of risk assessment (see chapter 6) is to make an informed decision as to whether NRL products are essential for the task.

However, it is important to realise that there are suitable alternatives available and that gloves are not necessary to complete all tasks, for example, activities where there is no contact with blood or body fluids.

Medical equipment

Many items contain NRL but are often not labelled to advise staff and patients of the content. A much more serious reaction may occur[1] when these instruments come into contact with a sensitised person. It is important for those who are sensitised to NRL to inform the correct people so that only NRL-free equipment is used. NHS employers can still treat and employ individuals who are NRL-sensitive.

Types of latex allergy

There are two types of allergy related to NRL. One is caused by the natural proteins and the other by the chemicals that are used to convert the NRL to a usable item. They are respectively called Type I and Type IV allergy.

Type I allergy

Type I NRL allergy is an immediate allergic reaction to NRL proteins and is potentially life threatening. Deaths have occasionally been reported due to latex allergy.

Symptoms of Type I allergy

Urticaria (hives) and hay-fever-type symptoms are common, as well as asthma. Though rare, more severe symptoms may occur, such as anaphylaxis (a condition where there is a severe drop in blood pressure leading to a possible loss of consciousness or severe breathing difficulty).

Months or even years of exposure without symptoms may precede onset of clinical symptoms of Type I allergy. In many cases, symptoms become progressively severe on repeated exposure to NRL allergens, so it is important for sensitised individuals to avoid further contact with NRL proteins.

NRL allergens attach to cornstarch used in powdered latex gloves. This powder acts as a vehicle, making the NRL proteins airborne when these gloves are used, enabling the allergens to be inhaled. This means that NRL-sensitised individuals may experience symptoms of an allergic reaction by being in a room where powdered NRL gloves are used, even though they are not in direct contact with the gloves.

Management of Type I allergy

Avoidance of the allergen is the best treatment option, as there is no cure for the NRL allergy. However, medications are available to treat symptoms of NRL allergy once it develops.

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[1] A case reported on radio highlighted the potential of exposing NRL-sensitive patients to rubber latex. On 8 March 2002 at The Edith Cavell Hospital an elderly woman suffered an allergic reaction to latex gloves and subsequently passed away because of the exposure. The trust is now facing a High Court inquest into the circumstances surrounding the lady's death.

Type IV allergy

Some people react to the accelerator chemicals used in the manufacturing process. The chemicals most likely to cause a reaction are thiurams, dithiocarbamates and mercaptobenzothiazoles (MBT). The reaction is a delayed hypersensitivity that occurs 6-48 hours after exposure.

Symptoms of Type IV allergy

The main symptom is a red, itchy, scaly rash, often localised to the area of use (wrists and forearms with glove use) but which may spread to other areas.

Management of Type IV allergy

Occupational health or medical advice should be sought and sensitised individuals should avoid the specific chemicals in future.

Products containing NRL

Many medical and consumer products contain NRL. NHS Employers recognises that the NHS must ensure latex-free medical supplies are available for use on, or by, sensitised individuals. Products containing NRL may include:

- **Medical equipment**

  Examination and surgical gloves
  Dental dams
  Endotracheal tubes
  Intravenous tubing
  Surgical masks
  Rubber aprons
  Catheters
  Injection ports
  Bungs and needle sheaths on medicines
  Oral and nasal airways
  Wound drains
  Anaesthesia masks
  Blood-pressure cuffs
  Syringes
  Stethoscopes
  Tourniquets
  Electrode pads

- **Consumer items**

  Swimming caps and goggles
  Rubber bands
  Balloons
  Adhesives
  Tyres*
  Underwear elastic
  Shoe soles*
  Sports equipment (i.e. gym mats and hand grips)
  Erasers
  Washing-up gloves
  Condoms
  Contraceptive caps
  Baby teats
  Hot water bottles*
  Stress balls

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* products containing dry rubber

Reporting incidents

Under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR), NHS employers have a duty to report incidences of occupational dermatitis and asthma attributable to NRL, to the Health and Safety Executive (HSE). NHS employers should also have in place the correct reporting mechanisms, perhaps through occupational health or the health and safety officer, for employees to be referred or diagnosed.

Employers' responsibilities

NHS employers should provide all employees, patients and other members of staff with necessary guidance and information to ensure their protection from the risks to health associated with NRL products.

Where possible, employers should provide alternative products and encourage staff not to use NRL products and to consider alternatives.

NHS employers should also provide employees with regular health checks (see chapter 3) to identify early warning signs of any reaction to NRL.

Preventative measures

Sensitised individuals should avoid contact with NRL at all times. This can be done by:

- avoiding contact with NRL gloves or products where possible
- informing employers of NRL allergy
- avoiding areas where inhalation of powder from NRL gloves worn by others, may occur
- using Medic-Alert bracelets, stating NRL allergy.

NHS employers cannot eradicate NRL from healthcare settings, but they can help to control it. As NRL is a potential asthmagen, health surveillance (see chapter 3) can be used to control NRL.

Occupational health departments are ultimately responsible for advising employees who have developed an allergy on how NRL can be managed within the workplace. However, NHS employers should implement policies and risk-assessment procedures in relation to the use of NRL.

Guidance

Further guidance can be obtained from:

- *Latex sensitisation in a healthcare setting*, MDA DB 9601 April 1996, Medical Devices Agency
- *Latex and you*, INDG320 April 2000, Health and Safety Executive
- HSE website on latex allergy at www.hse.gov.uk/latex

CHAPTER 22: VIOLENCE AGAINST NHS STAFF

22

Chapter 22: Violence against NHS staff

Introduction

One in seven of all reported injuries at work in NHS trusts are physical assaults by patients or visitors. Those who are particularly vulnerable to aggressive behaviour include nurses, ambulance and A&E staff, and carers of psychologically disturbed patients. GPs and their staff are also victims of assaults.

The definition of work-related violence is not subjective. 'Violence' means: any incident where staff are abused, threatened or assaulted in circumstances related to their work, involving an explicit or implicit challenge to their safety, well-being or health.

The cost in human terms of violence against NHS staff can be great. Some victims suffer physical and/or psychological pain. Confidence can be irrevocably eroded, while stress levels rise.

The financial costs to the NHS from violence can also be considerable and include:

- sick pay, if the member of staff has to take time off work
- the additional cost of temporary staff
- fees for legal action
- counselling, if required
- loss of experience and the cost of the training, should the member of staff leave the profession.

Legal responsibilities

NHS employers and managers are committed to caring for the health and safety of all their staff. As with other employers, they have duties regarding the management of work-related violent incidents, as outlined in national and European health and safety legislation, and by their common-law duty of care. A summary of the requirements placed on employers, under health and safety legislation, is contained in *Safer working in the community*, which was issued jointly by the Department of Health and the Royal College of Nursing in September 1998[1].

[1] *Safer working in the community* 1998, published jointly by the Department of Health and the Royal College of Nursing, provides a guide for NHS managers and staff on reducing the risks from violence and aggression.

The NHS zero tolerance zone campaign

In October 1999, the Government launched the NHS zero tolerance zone campaign, which had two principal aims:

- to make the public aware that violence against NHS staff is unacceptable and the Government (and the NHS) is determined to stamp it out
- to tell all staff that violence and intimidation is unacceptable and it is being tackled.

By April 2003, NHS trusts should have been accredited as putting the Improving Working Lives Standard into practice. This includes applying zero tolerance on violence against staff.

Primary care trusts are expected to be accredited by April 2004.

Since the launch of the campaign, the Department of Health has issued guidance, including specific information for staff working in high-risk settings such as mental health, the ambulance service, the community and general practice. It also contains information for NHS managers and staff on:

- risk assessment and prevention
- staff training
- how to make best use of the criminal justice system
- support and counselling for staff
- examples of good practice.

The guidance also stresses the importance of establishing closer working relationships with other agencies, including the police and the Crown Prosecution Service.

One of the key objectives of the zero tolerance campaign has been to improve reporting levels to ensure that local risk assessment processes accurately reflect the true risk staff face in the workplace. A common definition of violence for reporting purposes must include verbal abuse and should be adopted by all NHS trusts.

A safer place to work

In March 2003, the National Audit Office (NAO) published *A safer place to work: protecting NHS hospital and ambulance staff from violence and aggression*. This report commended the approach that the Department of Health has taken through the NHS zero tolerance zone campaign. The report also acknowledges the significant progress made in tackling violence in the NHS since the last NAO enquiry in 1996.

The NAO said that the main reason violence against NHS staff is decreasing is improved reporting rates and, in particular, the increased reporting of verbal abuse. However, they also highlighted areas where more work needs to be done, and this work will be taken forward with the relevant government departments, NHS employers, the health trade unions and the Health and Safety Executive as part of the zero tolerance initiative.

Counter Fraud and Security Management Service (CFSMS)

From 1 April 2003, the Counter Fraud and Security Management Service (CFSMS) took over the lead responsibility for tackling violence against NHS staff. The CFSMS will be leading a programme of work to consider how best to implement the recommendations contained in the NAO's recent report.

These include recommendations:

- to improve the risk assessment process
- to standardise the training staff receive to deal with violence
- to ensure that NHS employers are managing the problem of violence within a clear legal framework.

Guidance and website

All guidance issued by the Department of Health is available from the zero tolerance website at www.nhs.uk/zerotolerance or from the NHS Response Line 08701 555 455.

CHAPTER 23:
OCCUPATIONAL HEALTH AND SAFETY IN PRIMARY CARE

23

Chapter 23: Occupational health and safety in primary care

Introduction

It is one of the goals of the NHS that all NHS staff should have access to competent and confidential occupational health services. They should also have a safe environment to work in.

A healthy workplace is:

- a place where health risks are recognised, and controlled, if they cannot be removed
- a place where work design is compatible with people's health needs and limitations
- an environment that supports the promotion of healthy lifestyles
- a place where employees and employers recognise their responsibility for their health and the health of colleagues.

This document assumes throughout that GPs and their staff are an integral part of the wider NHS family and should be treated in the same way as all other staff.

Evidence of the need for occupational health services

Currently GPs tend to treat their own illnesses. Their knowledge of good occupational health practices is patchy and the implementation of this knowledge is generally poor.

Recent studies have found high levels of psychological disturbance in 21 per cent to 50 per cent of GPs[1]. These levels are significantly higher than those for equivalent professional occupations.

In doctors, disturbance ranges from anxiety, through emotional exhaustion to clinical depression and suicide. In many cases, problems are associated with unhealthy lifestyles, for example, excessive alcohol consumption[2]. Anxiety and depression in GPs increased between 1987 and 1990.

Doctors report frequent minor illnesses and self-prescription but most do not take time off work[3]. While a third of junior doctors are not registered with a GP, work-related stress and depression in UK doctors is higher than in US and Australian doctors[4].

Better understanding of the occupational health function by GPs and their staff will be reflected in a greater understanding of the occupational health needs of patients.

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[1] Michie,Williams, Pattani *Improving the health of the NHS workforce* Nuffield Trust 1998

[2] ibid.

[3] ibid.

[4] ibid.

The need for a variety of types of provision

In enabling those who work in primary care to have access to a comprehensive occupational health service, it is important that such a service:

- meets the needs of primary care
- meets the needs of primary care both as a community and an organisation.

It should not be a scaled-down model of the service available to those working in NHS trusts. Primary care is a very different organisation. There is a requirement for a different style of delivery and provision, more appropriate to the needs of small and medium-sized enterprises in primary care.

An occupational health service can help with this risk management in terms of providing competent advice, although other practitioners such as hygienists, safety advisers and others may also be needed.

One specific competence that the occupational health service should be able to provide is the ability to identify, for the primary care employer, whether or not health surveillance is required where employees are exposed to a specific hazard. Examples include the following.

- Exposure to a respiratory sensitiser, despite all controls, would probably generate a need for regular health surveillance to identify the development of occupational asthma.
- Certain sterilising fluids give rise to occupational asthma in staff who handle them.

Advice on safe systems of work can be provided by an occupational health service. In some circumstances, it will be necessary to establish health surveillance for exposed staff.

The occupational health service will be able to run such a programme in accordance with the requirements of the Control of Substances Hazardous to Health Regulations 1994.

Services that will be required

Needlesticks/sharps injuries

Injuries can arise before or during the use of a needle or sharp instrument, while the instrument is being prepared for disposal and during or after disposal.

Many of these injuries can be prevented through training and adherence to good practice, based on usage and disposal methods. If, however, accidents do occur and staff are exposed to blood, immediate access to a treatment programme, including the provision of post-exposure prophylaxis, must be provided for healthcare workers. (See chapter 19 and appendix 2.)

Manual handling

Injuries caused by lifting and handling are the most frequently reported type of accident faced by health staff at work. The correct aids and training are therefore essential to assist these processes.

There is a statutory requirement covering the lifting, lowering, pushing, pulling, carrying or moving of loads, whether by hand or bodily force, which is set out in the Manual Handling Operations Regulations 1992. (See chapter 9.)

Slips, trips and falls

These are amongst the most common causes of injury to staff. Many injuries will be minor but more serious injuries, such as cuts to the head or broken bones, can occur. (See chapter 8.)

Stress at work

Work-induced stress is now widely recognised as a significant problem in the health service. The costs of stress can involve high levels of sickness absence in staff, accidents, errors, low morale and poor performance. (See chapter 15.)

Pre-appointment checks

All staff should have a pre-appointment health assessment carried out fairly, objectively and in accordance with equal opportunities legislation and good occupational health practice.

The assessment aims to ensure, as far as is possible, that the following are achieved.

- The prospective employee does not represent a risk to patients.
- The work is suitable and safe for the prospective employee.
- Prospective staff are physically and psychologically capable of carrying out the work proposed. This should take into account any current or previous illnesses experienced by anyone likely to be at excessive risk of developing work-related diseases from hazardous agents present in the workplace.

(See chapter 3.)

Rehabilitation

For staff who have been on long-term sick leave, the occupational health service may recommend rehabilitation, to enable them to return to work and fulfil their full range of duties. This may include staff returning to work on a staged basis to carry out part of their normal duties while colleagues cover the rest. (See chapter 16.)

Immunisation

Employers are responsible for ensuring that appropriate immunisations are carried out on employees and they should satisfy themselves of the immunisation status of any locum staff.

An occupational health service will keep accurate health and medical records. The diseases of particular concern are tuberculosis, polio, rubella, hepatitis B and HIV. (See chapter 18.)

Health monitoring

An occupational health service is a proactive and preventative service rather than a treatment service.

It aims to prevent occupational ill health and injury by hazard identification, risk assessment, elimination or control, followed by an audit of effectiveness. Staff should expect the service to assist in identifying risks and encouraging better health promotion. (See chapter 3.)

Health promotion, education and training

An occupational health service can play an important role in alerting GPs and their staff to the importance of addressing occupational causes of poor mental and physical health by, for example, providing advice on altering work organisation and jobs to alleviate stress.

The occupational health service should be aware of the organisational and individual causes of work-related stress. It will be able to advise GPs on the drawing up, implementation and monitoring of strategies for dealing with them.

Health promotion through health education should include mental as well as physical health. It should include topics such as stress management and the production of strategies, and be designed with colleagues to:

- reduce the incidence of violence
- provide or arrange counselling for those who have been abused
- provide services to those who are involved in untoward situations such as patient suicide and frequent incidence of death.

See *Violence and aggression to staff in the health services* HSE 1997 and *Safer working in the community* NHS October 1988.

Substance misuse

The working group on the misuse of alcohol and other drugs published a report in February 1998[5] making recommendations for all doctors working directly or indirectly with patients. Both the Chief Medical Officer and the Association of Directors of Medicine, who recommended the setting up of appropriate systems for managing substance abuse, endorsed these recommendations. See also the Academy of Medical Royal Colleges report on drug and alcohol abuse, published in January 1998[6]. (See chapter 12.)

Models of delivery

The delivery of a primary care model of occupational health service may be very different from an NHS trust model. The structure of the primary care sector is based around relatively independent, small and widely dispersed units. Occupational health hazards associated with working in primary care are also quite specific. Both these factors will have an effect on the style of delivery.

Occupational health services for primary care may benefit from having a personal identity. They might be situated in a neutral location and not obviously attached to another organisation, for example an NHS trust or health authority. Along with a small,

[5] Working group on the misuse of alcohol and other drugs by doctors. BMA 1998

[6] *Report on drug and alcohol abuse*. Academy of Medical Royal Colleges January 1998

competent and permanent staff, this would convey an atmosphere of confidentiality and accessibility, but backed up by a network of specialists.

However, there will be an opportunity cost involved in options for service delivery involving sites and structures, separate from existing NHS trust services. Local planners and policy-makers will need to consider this with professional representatives when considering cost-effective and accessible models.

Referral to service

Self-referral facility for employees

Access to occupational health staff must be available to employees on a self-referral basis.

This fact should be published within the employing authority and the confidential nature of the service should be stressed. In particular, staff should be encouraged to refer themselves if they are concerned about their own physical or mental occupational ill health. Early referral is likely to be of maximum benefit to employees.

Provision of an occupational health service must not replace the need for GPs or their staff to register with an external general practice.

Any employee should have access to an occupational health service for telephone advice or for an appointment to see an occupational health professional. This facility should be available for services such as:

- pregnancy at work
- work-related ill health
- psychological support.

An occupational health service should supply an appropriate action plan or prophylaxis treatment following contamination from blood-borne viruses, including hepatitis B, hepatitis C and HIV.

Management referral

A GP or other primary care employer can seek an independent medical opinion from a qualified occupational health physician to assist with health-related management problems. These may include the following:

- frequent short-spell absences attributed to sickness or injury
- long-term sickness absence
- altered or impaired work performance without absence, including behavioural problems
- concern by management about an employee's ability to work before his or her return to work
- the monitoring of a member of staff who is suspected of drug or alcohol misuse
- concern regarding an infection control issue
- ill-health retirement.

Healthcare use by primary care personnel

The Nuffield Hospital Provincial Trust[7] summarised the need for doctors and staff to have ready access to confidential and appropriate healthcare, and encouragement by the Medical Colleges for doctors to obtain medical help from independent GPs. Despite this, many doctors continue to self-diagnose and self-medicate or use partners or close working colleagues. The same is true for GPs' staff, where failure to register with a doctor who is external to their practice can lead to conflicts over line management and confidentiality during sickness.

Every care should be taken to ensure that staff are encouraged to register with GPs away from their place of work, even though this may be less convenient.

Confidentiality

One reason why primary care practitioners are reluctant to use independent GPs and local occupational health services is concern about confidentiality. GPs are few in number and well known in their local healthcare community; attendance by a local GP at a surgery or clinic will not go unnoticed. GPs will already be familiar with their ethical obligations to patients concerning confidentiality in *Duties of a doctor: guidance from the General Medical Council*[8] published by the GMC. However, they may know less about the more detailed additional guidelines for occupational physicians detailed in the Faculty of Occupational Medicine *Guidance on ethics for occupational health physicians*[9].

This handbook details procedures and processes for an ethical approach to confidentiality. This should reassure GPs that knowledge and details of their attendance will not pass informally among colleagues or inappropriately to managers.

Confidentiality of an occupational health service available to GPs and their staff must be ensured if it is to be accepted and used. Ideally, the service supplier should be unknown and not a colleague of the user.

The discretion of exchange arrangements with neighbouring occupational health services should be considered as one means of securing this. Alternatively (where possible), occupational health should be located outside the user's area.

Service delivery – function list

The occupational health service will identify the correct elements that are required to produce the appropriate services. It will maintain a way of working and record-keeping system. This means that staff are able to discuss work-related health problems, confident in the knowledge that information about them will not be given to colleagues or employers, unless they wish to share such details.

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[7] *Improving the health of the NHS workforce* Nuffield Trust 1998

[8] *Duties of a doctor: guidance from the General Medical Council* GMC 1998

[9] *Guidance on ethics* Faculty of Occupational Medicine

A comprehensive occupational health service will include at least the following:

- Advice on managing occupational health in the workplace:
  - health and safety policy
  - needs assessment
  - compliance with statute and common law
  - appropriate systems for size of the organisation.
- Advice on health policies:
  - risk assessment
  - information, instruction and training for health risks at work
  - psychological health management
  - managing attendance at work
  - drug/alcohol abuse
  - use of personal protective equipment.
- Clinical services:
  - self-referrals
  - management referrals
  - pre-employment health assessments.
- Return to work assessments:
  - ill-health early retirement assessment
  - accidental blood exposure treatment programme
  - immunisation
  - health surveillance programmes (statutory and voluntary).
- Non-clinical services:
  - workstation assessments
  - safety audit
  - specific risk assessments for physical, chemical, biological, ergonomic and psychological hazards.

Responsibility of GPs as employers and the health and safety policy

All employers have general duties under Section 2(1) of the Health and Safety at Work etc Act 1974 to ensure, so far as is reasonably practicable, the health, safety and welfare of all their employees.

Under Section 2(3) employers who have five or more employees have to prepare a written statement of their general policy with respect to the health and safety at work of their employees and the organisation, and the arrangements for carrying out that policy. The policy statement and any revisions that are made must be brought to the attention of the employees.

It is recommended that employers with less than five employees follow the same principles.

The policy should contain the following.

- A general statement of the employer's intention to:
  - provide and maintain safe and healthy working conditions for all employees
  - ensure that the health and safety of contractors, members of the public and other visitors to the premises, are not put at risk.
- A clear statement of who has responsibility for health and safety in the practice and what responsibilities other individuals, including employees, have for ensuring that the policy is implemented.
- Arrangements for ensuring the health and safety of employees and others on the premises. To enable this section to be completed the employer will have to carry out risk assessments as required, for example, by:
  - Management of Health and Safety at Work Regulations 1992
  - Display Screen Equipment Regulations 1992
  - Manual Handling Operations Regulations 1992
  - Control of Substances Hazardous to Health Regulations 1999.

These risk assessments will identify the hazards to which employees and others may be exposed and any remedial action the employer may have to take. Any training requirements for managers or employees may form an appendix to the main policy documents. Occupational health services can advise on carrying out risk assessments, staff training and any necessary health surveillance/screening.

- Details of the arrangements for complying with other relevant health and safety legislation, for example, The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR).
- Details of the procedures in place to ensure appropriate revision of the policy, for example annually, or after a significant change in working practices or substances used.

APPENDICES

1 Contractors health and safety competence appraisal form

2 Needlestick injury

3 Department of Health guidelines for handling bodies with infections

4 Management of known or suspected infections which need precautions after death

Appendix 1: Contractors health and safety competence appraisal form

Name of contractor..... Competent? Yes/No			
Assessment item	Accept	Decline	Comments
1 Health and safety policy statement			
a Clear declaration of commitment to protect health and safety of employees and others?			
b Signed by senior management?			
c Regularly reviewed (ie in the last 12 months)?			
d Traceable management structure?			
e Responsibilities clearly defined at each level?			
f Sets out its general arrangements such as accident reporting, investigation, first aid, welfare facilities and emergency procedures?			
g Sets out arrangements for monitoring compliance by duty holders such as regular site inspections and audits?			
h Arrangements for bringing policy to the notice of employees and checking that they understand their duties?			
2 Health and safety services			
a Access to professional health and safety advice or suitable alternative?			
b Membership of group providing health and safety information or advice?			
3 Health and safety performance			
a Prepares health and safety statistics relating to accidents?			
b Accident/safety record compares favourably with industry average?			
c Any prosecutions, prohibitions or improvements notices in the last five years?			
d If yes, has contractor demonstrated that deficiencies have been rectified?			

Assessment item	Accept	Decline	Comments
4 Health and safety training Has training been provided for:			
a Managers?			
b Supervisors?			
c Operatives?			
d New employees?			
e Is effectiveness/appropriateness monitored?			
5 Sub-contractors			
a System for checking of sub-contractors' health and safety policies, accident statistics, training arrangements and site management?			
6 Joint consultation			
a Are safety representatives appointed?			
b Are safety committees established?			
c Do arrangements exist to enable employees to report hazards?			
7 Health and safety plan Will the information in the health and safety plan include:			
a Arrangements to monitor health and safety aspects of the work activities?			
b Measures for specific risks, use of trained personnel, use of method statements etc?			
c Details of management structure and procedures to manage health and safety on site?			
d Arrangements to regulate visitors and exclude unauthorised persons?			

Additional notes – please continue on a separate sheet

Appendix 2: Needlestick injury

Definitions

Needlestick or sharps injuries occur when a needle or other sharp instrument accidentally penetrates the skin. This is called a percutaneous injury. If the needle or sharp instrument is contaminated with blood or other body fluid, there is the potential for transmission of infection, and when this occurs in a work context, the term occupational exposure (to blood, body fluid or blood-borne infection) is used.

When blood or other body fluid splashes into eyes, nose or mouth or onto broken skin, the exposure is said to be mucocutaneous.

The risk of transmission of infection is lower for mucocutaneous exposure than for percutaneous exposures. Other potential routes of exposure to blood or other body fluids include bites and scratches.

This appendix explores the epidemiology, prevention and management of occupational exposure to blood or body fluid, although strictly the term needlestick injury has a narrower definition.

Epidemiology

Needlestick injury most commonly occurs in the context of healthcare, but may also occur in other fields of work such as the prison service, police, parks constabulary, probation services, customs and excise, social work, youth work, car-breaking and the construction/demolition industry.

The major blood-borne pathogens of concern associated with needlestick injury are:

- hepatitis B virus (HBV)
- hepatitis C virus (HCV)
- human immunodeficiency virus (HIV).

However, other infectious agents also have the potential for transmission through needlestick injury. These include:

- human T lymphotrophic retroviruses (HTLV I & II)
- hepatitis D virus (HDV or delta agent, which is activated in the presence of HBV)
  hepatitis G virus (GB virus or GBV-C)
- cytomegalovirus (CMV)
- Epstein Barr Virus (EBV)

- parvovirus B19
- transfusion-transmitted virus (TTV)
- West Nile Virus (WNV)
- malarial parasites and prion agents.

In the United Kingdom, the Health Protection Agency's Communicable Disease Surveillance Centre (CDSC) monitors the transmission of HIV, HCV and HBV from patients to healthcare workers through a national surveillance scheme. Between July 1997 and June 2003:

- 47 per cent of exposures reported to the scheme were to HCV
- 26 per cent to HIV
- 9 per cent to HBV.

During the same period 71 per cent of reported exposures were percutaneous.

Figures for reported exposures include the following.

- The largest occupational group reporting exposures were nurses, midwives and healthcare assistants (43 per cent).
- These were followed by doctors (35 per cent).
- Other groups of healthcare workers at risk of blood-borne virus (BBV) exposure include phlebotomists, operating department practitioners, porters and domestic assistants.
- 58 per cent of incidents were reported to have occurred during a procedure.
- 21 per cent occurred after the procedure, but before disposal of the device.
- 16 per cent occurred during or after disposal of the device[1].

Reported cases of occupational blood-borne virus transmission

There have been five definite cases of occupational HIV transmission reported in the United Kingdom over the past twenty years[2]. Four of the five healthcare workers who acquired HIV occupationally in the UK are known to have died[3]. The first case reported in the world occurred in the United Kingdom in 1984[4]. Nine healthcare workers are known to have acquired HCV occupationally in the UK since 1996[1].

A case of occupational transmission of infection is considered 'definite', when:

- a blood sample from a healthcare worker tests positive following a documented exposure incident, in the absence of other risk factors

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[1] Health Protection Agency, Communicable Disease Surveillance Centre. Surveillance of Occupational Exposure to Blood-borne Viruses in Healthcare Workers: Six-year Report: 1 July 1997 to 30 June 2003

[2] Occupationally acquired HIV-UK update *CDR Weekly* 1 August 2002

[3] Occupational transmission of HIV, summary of published reports, Health Protection Agency June 1999

[4] Anon. Needlestick transmission of HTLV-III from a patient infected in Africa *Lancet* 1984; ii: 1376-7

- a baseline sample of serum, taken and saved at the time of the exposure, is later tested to confirm that the infection was not present at the time of the exposure.

Prevention of blood exposure incidents

Every effort should be made to avoid blood and body fluid exposures occurring, through safe systems of work.

- The principle of following Standard (Universal) Precautions means never assuming that there is no risk. If every patient is assumed to be potentially infected with a blood-borne infection, the same precautions to prevent transmission should be used for every procedure.
- Needles should never be re-sheathed. Re-sheathing needles is a common cause of needlestick injury. The ink mark on an index finger or thumb after inaccurate re-capping of a pen illustrates how easily re-sheathing needlestick injuries occur.
- Cuts and grazes should be covered with waterproof dressings. Non-intact skin is a potential route of entry for blood-borne transmissible agents through contact with infected body fluids.
- Personal protective equipment should be worn when dealing with blood or body fluids:

Gloves

Although a needle or sharp instrument can easily penetrate a glove, the risk of transmission of infection is significantly reduced. It is said that the latex in a surgical glove will remove 80 per cent of the visible blood on the outside of a needle. An inner glove will remove 80 per cent of the 20 per cent of blood not removed by the outer glove.

Double gloving therefore substantially reduces the risk of blood-borne virus transmission from a sharps injury. However, in order to maintain manual dexterity, it is not advisable to wear more than two pairs of surgical gloves simultaneously.

Eye protection

This is important wherever blood or other body fluids could splash into the eye. Ordinary prescription spectacles offer some, but inadequate, protection, as they are not generally designed for this purpose. Eye protection should therefore be worn in operating theatres, endoscopy suites and accident and emergency departments.

Blood may become aerosolised due to surgical drilling techniques, used, for example, in orthopaedic surgery, and mucous membrane exposure may not always be recognised.

There are many designs of safety spectacles now available, many of which will fit over prescription lenses and frames.

Sharps

Sharps should never be passed hand-to-hand and handling should be kept to a minimum[5].

All sharps should be disposed of carefully at the point of use[5]. This means that suitable sharps containers (conforming to British Standard BS 7320) should be portable enough to take to the site of a procedure, and designed specifically to allow needles and sharp instruments to be disposed of easily and safely.

Ideally, sharps bins should be designed to prevent overfilling and accidental spillage of contents. They should be easy to close temporarily and permanently, and there should be no risk of puncture of the container. Cardboard sharps bins should not be used. The need for sharps bins to be portable must be balanced against the importance of sharps bins not being left unattended in areas where patients and visitors (especially children) can get access to them.

Syringes/cartridges should be disposed of intact[5].

In the pressurised work environment of healthcare, staff may be tempted to take short cuts, to save time. This can increase the risk of needlestick injury. It is important that healthcare workers receive constantly updated education and training about safe systems of work with sharps and body fluids. This will ensure that safety becomes embedded into organisational culture and that safe working practices become second nature.

Staff may require specific training in this key area, rather than training being incorporated into induction training.

Safety-engineered devices

In recent years a number of devices with safety-engineered features have become available. These are designed to reduce or eliminate the risk of needlestick injury. These include safety-shielded and retractable needles, safety lancets, blunt needles (eg for suturing), needle-free systems, blunt plastic cannulae and shielded cannulae.

There is a large range of diverse products available, so it is essential to select the most appropriate product for a particular clinical procedure. Details of products available in the United Kingdom can be found on the NHS Purchasing and Supplies Agency website at www.pasa.nhs.uk. It is important that devices are evaluated locally by relevant stakeholders.

The following areas should be considered as part of the selection process:

- fitness for purpose
- user acceptability
- safety and training requirements
- supply
- collection
- delivery

[5] MDA SN 2001 (19), Safe use and disposal of sharps, Medical Devices Agency July 2001

- discounted prices
- single or multiple use
- cleaning and sterilisation.

Evaluation and assessment of fitness for purpose may not be easy, as there is currently a deficiency in evidence of risk reduction, user acceptability and safety for these devices, at least in the United Kingdom.

There is currently no robust evidence to support the efficacy of devices in reducing needlestick injuries (NSIs). There is often concern about the inevitable extra cost of safety-engineered devices.

However, cost-in-use models, using a number of assumptions, suggest that if safety-engineered devices are effective in significantly reducing the incidence of sharps injuries (which are costly in themselves) the initial investment is likely to prove at least cost-neutral.

In the United Kingdom, employers have general and specific legal duties to create safe working environments and to reduce the risks of work as far as is reasonably practicable (Health and Safety at Work Act 1974, Management of Health and Safety at Work Regulations 1999, Biological Agents Directive 2000/54/EC). It is probable that any new national guidelines will suggest that health service employers apply these principles specifically to address the issue of sharps injury.

Management of blood and body fluid exposure incidents

First-aid treatment

- If the mouth or eyes are involved, they should be washed thoroughly with water.
- If skin is punctured, free bleeding should be gently encouraged and the wound should be washed with soap or chlorhexidine and water, but not scrubbed or sucked.

All exposure incidents should be reported promptly. This is important for three reasons:

- to ensure appropriate management to reduce the risk of blood-borne virus (BBV) transmission
- to document the incident and the circumstances of it, in case of later claim for occupational injury or infection
- accurate surveillance, so that collective data analysis can inform measures to reduce the risk of further exposures.

The reporting process should be easily accessible, straightforward and confidential. Depending on local arrangements, body fluid exposures in a healthcare setting may be managed by a number of different departments including occupational health, accident and emergency, infection control, infectious diseases, genito-urinary medicine, sexual health, HIV services, microbiology or virology[6].

[6] Grime PR, Risi, L, Binns C, Carruthers J, Williams S. Pan Thames Survey of Occupational Exposure to HIV and the Use of Post-Exposure Prophylaxis in 71 NHS Trusts. *Journal of Infection* (2001) 42, 27-32

Assessment of the risk of BBV transmission

Average estimated seroconversion risks from published studies and reports are:

- 0.3 per cent for percutaneous exposure to HIV infected blood[7]
- 0.1 per cent for mucocutaneous exposure to HIV infected blood
- 0.5-1.8 per cent for percutaneous exposure to HCV infected blood with detectable RNA[8, 9]
- 30 per cent for percutaneous exposure of a non-immune individual to HBeAg positive source

Factors that may increase the risk, and influence management of the incident are:

- percutaneous injury rather than mucous membrane or broken skin exposure
- injury with a device from a source patient's artery or vein[10]
- blood exposure rather than exposure to blood-stained fluid, diluted blood (eg in local anaesthetic solution) or other body fluid
- injury from hollow bore rather than solid bore needle
- injury from wide gauge rather than narrow gauge needle
- deep rather than superficial injury[10]
- visible blood on the device[10]
- no protective equipment used (eg gloves, double gloves, eye protection)
- first-aid measures not implemented (washing, bleeding)
- HCV RNA detectable in source patient on most recent blood test
- high viral load of HIV in source patient[10]
- HBeAg detectable in source patient blood
- staff member not or inadequately immunised against hepatitis B
- source patient co-infected with more than one BBV.

When a body fluid exposure occurs and is reported, the first priority is to assess how likely it is that the incident will result in blood-borne virus transmission, and then take steps to reduce that risk as far as possible. The initial assessment and management has to be based on the information available at the time.

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[7] Tokars JI, Marcus R, Culver DH, Schahle CA, McKibben PS, Bonden CI et al. Surveillance of HIV infectionand zidovudine use among health care workers after occupational exposure to HIV-infected blood: the CDC Cooperative Needlestick Surveillance Group. *Ann Intern Med* 1993; 118:913-9

[8] Ramsay ME. Guidance on the investigation and management of occupational exposure to hepatitis C, *Commun Dis Public Health* 1999; 2 258-62

[9] Jagger J. Puro V. De Carli G. Occupational transmission of hepatitis C virus. [Comment. Letter] *JAMA* 2002; 288(12): 1469-71

[10] Cardo DM, Culver DH, Ciesielski CA, Srivastava PU, Marcus R et al. A case-control study of HIV seroconversion in health care workers after percutaneous exposure. *N Engl J Med*. 1997; 337: 1485-1490

Relevant information to consider

The source patient

1 Known or unknown?

2 If unknown, is there any indication of the origin of the device or body fluid? For example, was the device from a ward with patients known to have hepatitis B or C or HIV?

3 If known, is the source patient known to be infected with hepatitis B, hepatitis C or HIV? The validity of results varies depending on how long ago they were measured and current risks factors.

4 If the source patient is not known to carry any of these infections, do they have any risk factors for them?

5 The risk of being infected with HIV is increased in people from sub-Saharan Africa, gay men, intravenous drug users, people with HIV-infected mothers or sexual partners.

6 The risk of being infected with hepatitis C is increased by receipt of unscreened blood or untreated plasma products (in the UK prior to September 1991 and 1985 respectively); sharing of injecting equipment whilst misusing drugs; sharps injury or mucous membrane splash exposure to blood from patients known to be infected, or at risk of infection with hepatitis C; involvement as a health care worker or a patient in invasive medical, surgical, dental or midwifery procedures in parts of the world where infection control precautions may have been inadequate; or with populations with a high prevalence of hepatitis C infection (eg Egypt).

7 The risk of being infected with hepatitis B is increased in intravenous drug users, gay men and in people with hepatitis B-infected mothers or sexual partners.

8 If the source patient is known to be infected with HCV, is HCV RNA detectable on most recent test?

9 If the source patient is known to be infected with HIV:

- Has there been a recent/current seroconversion illness?
- Are they terminally ill with HIV-related disease? If so viral load may be high.
- What is the most recently recorded viral load?
- Are they taking anti-retroviral drugs?
- Is there any evidence of viral drug resistance?

10 If the source patient is known to be infected with hepatitis B, are they:

- HBsAg positive?
- HBeAg positive?

The staff member

Hepatitis B immune status:

- unvaccinated?
- one, two, three or more doses of hepatitis B vaccine?
- date of last booster?
- most recent HBsAb result and date?
- HBcAb positive (natural immunity)?

Exposure-prone procedures

When a blood or body fluid exposure incident occurs in the context of an 'exposure-prone procedure', it may be necessary to consider the possibility of transmission of infection from healthcare worker to patient, as well as from patient to healthcare worker.

'Exposure-prone procedures' are those where there is a risk that injury to the healthcare worker could result in the patient's blood or open body tissue being exposed to the blood of the healthcare worker. In practice these include:

- surgery
- midwifery
- dentistry
- physical contact with trauma patients who may have open fractures or glass-contaminated wounds.

Protocol for management of exposures

In all cases:

1 A blood sample from the exposed member of staff should be sent to the virology or microbiology laboratory for serum to be saved and stored. There is no point in testing this sample for blood-borne viruses at this stage, unless the exposed member of staff has reason to believe they may already be infected. The purpose of this sample is to be able to show that, in the unlikely event of subsequent seroconversion, the member of staff was not infected at the time of the exposure, and therefore the infection was occupationally acquired. As occupational acquisition of blood-borne virus infection is fortunately rare, in the majority of cases this sample is never tested.

2 The staff member should be given time to talk about their concerns following the incident and discuss the available information about risks from the exposure. Counselling of the staff member should include information regarding:

   - statistics regarding seroconversion risks
   - risks involved in this particular incident
   - steps to reduce the risk of BBV transmission
   - follow-up procedure and rationale behind it

- 'window period' if the source patient has ongoing risk factors for BBV infection
- infection control precautions ie safe sex during follow-up period, but no additional work restrictions
- establishing support networks: friends, family etc
- allowing time to express anxieties and concerns and to answer questions
- HIV and HCV follow-up tests (and HBV if not immune)
- confidentiality.

3 Follow-up to confirm that occupational blood-borne virus transmission has not occurred.

See Figure 1.

Approaching source patients for blood-borne virus testing

Local policies should indicate whether to approach all source patients involved in needlestick injuries, regardless of risk factors, for consent to test them for blood-borne viruses. The policy should take account of previous local experience, background prevalence of blood-borne virus infections in the community and cultural factors. It can be very helpful to test source patients for HIV, HBV and HCV, unless very recent results are available. Most source patients consent to testing when the policy is explained[5]. Pre-test discussion for HIV antibody testing should be considered part of mainstream clinical care ie should not require specialist counselling training or qualification[11].

Check list for pre-test discussion with source patient

1 The pre-test discussion should be carried out with due sensitivity, and not by the exposed member of staff.

2 Explain what has happened and the local policy for requesting consent for BBV testing. Check understanding of the tests, which are the same as those done for blood donors. Explain confidentiality. The approach is not made on the basis of perceived risk and patients can decline permission for testing.

3 Details of the staff member should be kept confidential

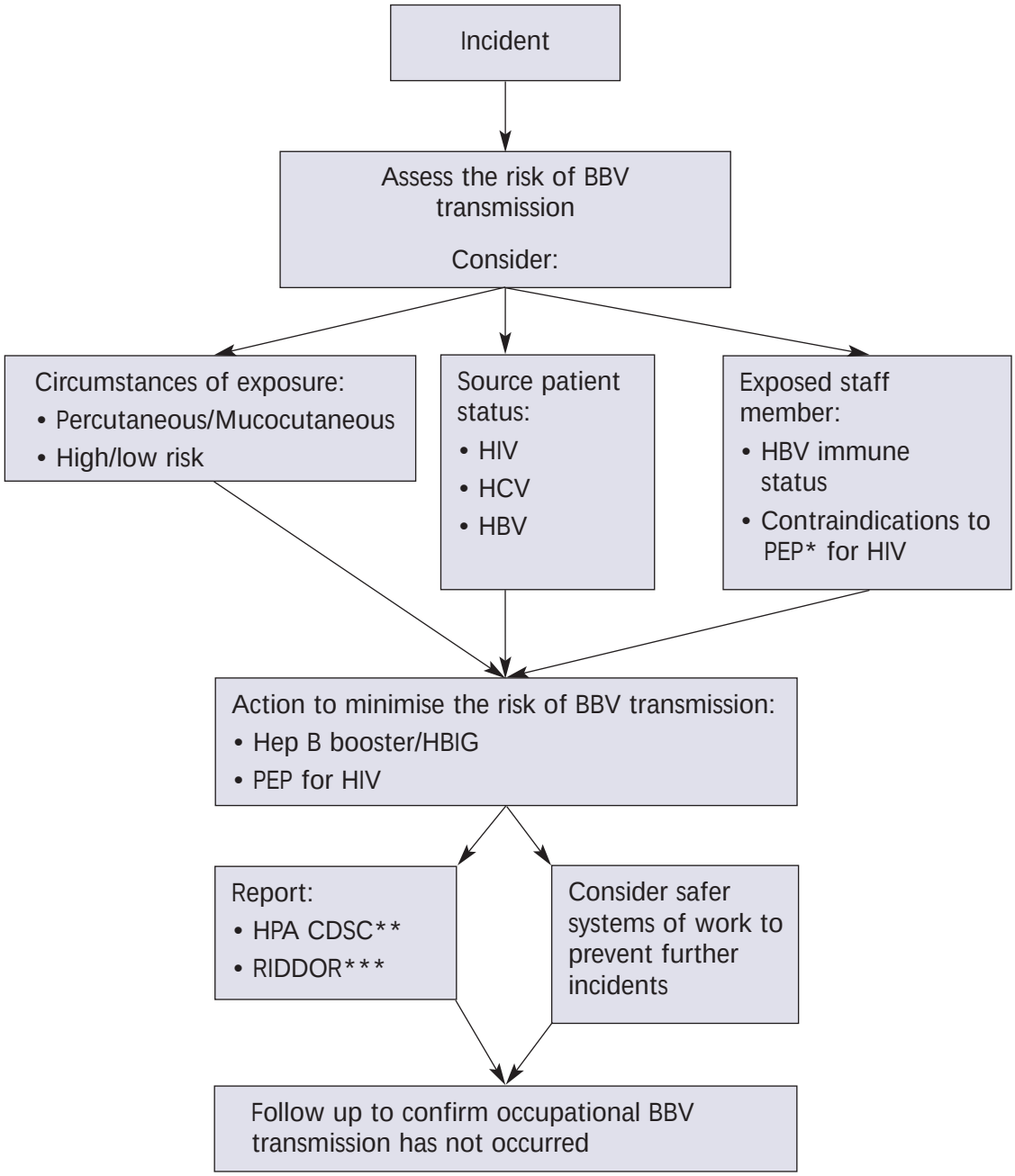
4 Discuss the practical implications of the test and its result (positive or negative) eg sexual relationships, work situations, medical follow-up and life insurance (Association of British Insurers recommend that companies should only ask about positive test results). Remember the potential stigma associated with HIV in many communities.

5 Discuss possible routes of transmission of HIV, HBV and HCV. If high-risk behaviour occurred within the preceding three months (they don't have to say what) explain the 'window period' (6–10 weeks from infection to the detection of measurable antibodies). Consider organising a follow-up test after the window period.

[11] Guidelines for pre-test discussion on HIV testing, Department of Health, 1996

Figure 1

Management of body fluid exposure incidents



* Post Exposure Prophylaxis

** Health Protection Agency Communicable Disease Surveillance Centre

***Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (Health and Safety Executive)

6 Type of device involved: if a needle, was it solid or hollow bore, narrow or wide gauge?

7 Describe the procedure for having blood taken. Ask if the source patient wishes to know the results and, if so, arrange a time to give them the results.

8 Consent may be obtained verbally or in writing.

9 Request HBsAg, HCV antibody and HIV antibody test on the pathology form.

10 Write 'source patient in needlestick incident' for clinical details.

11 Occasionally a patient is unable to give consent. Consent cannot be given by a third party eg next-of-kin. Under these circumstances a decision must be made whether it is appropriate and justifiable to test without consent, with reference to the General Medical Council's guidance on Serious Communicable Diseases (para 8-11)[12].

An explicit note to the effect should be made in the patient's records and signed by the doctor involved. If the source patient is unable or unwilling to consent, it may be considered an assault to take blood for this purpose, and unlawful to test a sample obtained previously.

If the patient refuses consent, if it would be detrimental for the patient to be approached, or there are any other reasons why the testing is not done, this should be recorded and the staff member informed.

If the source patient is infected with HIV[13]

In the case of definite exposures to blood or other high-risk body fluids known or considered to be at high risk of HIV infection, post-exposure prophylaxis (PEP) should be offered as soon as possible, preferably within one hour of the incident.

It may still be worth considering up to two weeks after the exposure, but the relative benefit of prophylaxis diminishes with time.

The current standard recommended regimen for PEP is a 28-day course of:

- Zidovudine 250 mg bd
- Lamivudine 150 mg bd
- Nelfinavir 1250mg bd

Anti-emetics such as metaclopramide, domperidone, cyclizine, ondansetron, and anti-motility drugs, such as loperamide, are often co-prescribed for the side-effects.

Anti-retroviral drugs are not licensed for PEP, so must be prescribed on a 'named patient' basis, by a doctor.

The regimen may need to be modified if there is evidence that the source patient is infected with a virus that is resistant to any of these drugs. In this case, specialist advice should be sought from the HIV physician treating the source patient

[12] Serious Communicable Diseases, General Medical Council, Duties of a Doctor, 1999

[13] HIV Post-Exposure Prophylaxis: Guidance from the UK Chief Medical Officers' Expert Advisory Group on AIDS, Department of Health, February 2004

Anti-retroviral drugs have side-effects including: nausea, vomiting, abdominal pain, lethargy, fatigue, diarrhoea (Nelfinavir), headache, bone-marrow suppression, rashes, liver-function disturbance, pancreatitis, peripheral neuropathy, glucose intolerance (Indinavir) and renal calculi (Indinavir).

The staff member may have relative contraindications to consider eg pregnancy, breast-feeding, a history of anaemia, neutropenia, hepatic or renal failure.

There are also possible drug interactions to consider.

- Astemizole and terfenadine should not be taken with nelfinavir.
- St. John's Wort should not be taken with any of the PEP drugs.
- Aspirin, co-proxamol, co-trimoxizole, phenytoin, sertraline, dexamethasone and prednisolone may interact with PEP drugs.

Exposed staff members should be counselled about the side-effects and the potential risks and benefits of PEP should be considered very carefully, so that staff can make an informed choice whether to take PEP or not. Expert advice may be required. In some cases it may be appropriate to approach the source patient for urgent HIV testing, out of hours, if there are relative contraindications to PEP.

If there is doubt and anxiety, it may be reasonable for the staff member to take the first dose of PEP (unless there are contraindications). This takes away the need for an urgent decision and allows time for further consideration.

In view of the recommendation to start PEP as soon as possible, starter-packs containing enough drugs for 72 hours (to cover weekends and public holidays) should be made available to avoid delay due to dispensing a prescription. However, the cost-benefit balance will need to be carefully considered. The drugs are expensive and starter-packs must be checked regularly to ensure expiry dates are not exceeded.

The staff member should be followed up weekly while taking PEP for:

- repeat prescriptions for the drugs
- psychological support
- blood samples:
  - biochemistry (urea and electrolytes)
  - liver function tests (including gamma GT and amylase)
  - haematology (full blood count)
- monitoring of side effects.

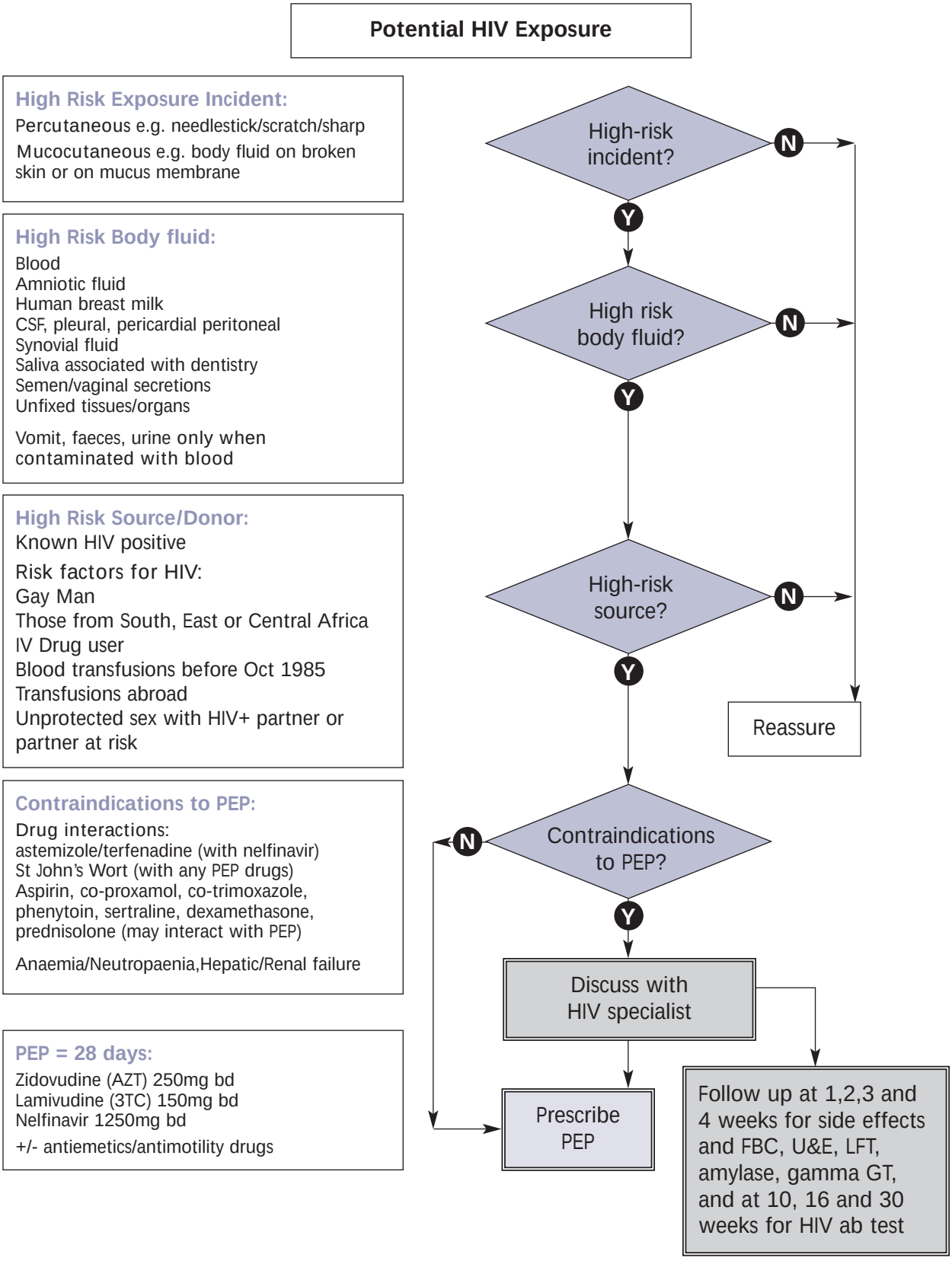
The staff member should return for testing (with informed consent) for HIV antibodies, at six weeks, three months and six months after completing post-exposure prophylaxis.

If the staff member tests positive for HIV antibodies, it will be necessary to test the stored baseline sample and refer them to a specialist in HIV medicine.

See Figure 2 overleaf.

Figure 2

Management of HIV exposures



If the source patient is infected with HCV[8]

There is no prophylaxis available for hepatitis C. Blood should be taken and serum sent for saving and storage. Transmission is unlikely from HCV RNA negative sources.

The staff member should return for blood tests for:

- HCV RNA at six weeks
- HCV RNA and HCV antibodies at 12 weeks
- HCV antibodies at 24 weeks after the exposure.

If any of the results are positive, the baseline sample should be tested for HCV antibodies. It will be necessary to refer the staff member to a hepatologist.

Table 1: Summary of follow-up blood tests for staff member exposed to HCV:

	HCV Antibodies	HCV RNA (PCR)	Serum save
Baseline			•
6 weeks		•	
3 months	•	•	
6 months	•		

If the source patient is infected with HBV

If the staff member is not immune to hepatitis B, the patient's HBsAg status should be requested urgently. (See Table 2 for management of exposures according to immune status of staff member and HBV status of source of exposure). Follow-up blood testing will only be necessary if the staff member was non-immune at the time of the incident. Test for HBsAg at:

- six weeks
- three months
- six months
- and save serum at the time of the incident.

See Table 2 overleaf.

Table 2

Management of HBV exposures[14]

	Significant exposure			Non-significant exposure	
HBV status of person exposed	HBsAg positive source	Unknown source	HBsAg negative source	Continued risk	No further risk
<1 dose HB vaccine pre-exposure	Accelerated course of HB vaccine HBIGx1	Accelerated course of HB vaccine	Initiate course of HB vaccine	Initiate course of HB vaccine	No HBV prophylaxis reassure
>2 doses HB vaccine pre-exposure (anti-HBs not known)	One dose of HB vaccine followed by second dose one month later	One dose of HB vaccine	Finish course of HB vaccine	Finish course of HB vaccine	No HBV prophylaxis reassure
Known responder to HB vaccine (anti-HBs> 10mIU/ml)	Booster dose of HB vaccine	Consider booster dose of HB vaccine	Consider booster dose of HB vaccine	Consider booster dose of HB vaccine	No HBV prophylaxis reassure
Known non-responder to HB vaccine (anti-HBs<10mIU/ml 2-4 months post vaccination)	HBIGx1 consider booster dose of HB vaccine	HBIGx1 consider booster dose of HB vaccine	No HBIG consider booster dose of HB vaccine	No HBIG consider booster dose of HB vaccine	No HBV prophylaxis reassure

NB HBIG = Hepatitis B immunoglobulin

[14] Immunisation against Infectious Disease, Department of Health HMSO 1996

If the source patient is unknown or testing cannot be done

These cases are considered on an individual basis. As much detail about the exposure as possible should be obtained.

There will usually be no follow-up other than the initial serum save and check for HBV immunity (if required) for the staff member, unless there are particular reasons for concern (eg patient strongly suspected to be infected with a blood-borne virus).

If the staff member is very anxious, follow-up testing for HIV, HCV and HBV (if not immune) may help alleviate their anxiety. Hepatitis C PCR testing is not required in these circumstances.

Blood test results should not be given to the staff member over the telephone, because of the difficulty in confirming identity and confidentiality.

Reporting blood exposure incidents

All cases of significant occupational exposure to the blood or body fluid from patients infected with HIV, HCV or HBsAg positive, and where PEP for HIV has been started, whatever the HIV status of the source, should be reported to the Health Protection Agency national surveillance scheme.

The anonymity of the healthcare worker is maintained through the use of unique identifier codes. The scheme aims to:

- assess the numbers of healthcare workers being exposed to these viruses
- the circumstances contributing to occupational exposures
- the clinical management of those exposures, including in the case of HIV exposures, whether the health care worker had PEP
- what the side effects were and the outcomes.

Further information about the material surveillance scheme can be found at: www.hpa.org.uk/infections/topics_az/bbv/bbmenu.htm

The Exposure Prevention Information Network (EPINet) is a computerised database using Microsoft Access, for recording data about needlestick injuries and body fluid exposures. Since 1992, it has been used extensively in the United States and in other countries including the UK, Japan, Canada, Italy and Spain. Further information can be found at: www.med.virginia.edu/medcntr/centers/epinet/home.html

Exposures to hepatitis B or C or HIV are reportable to the Health and Safety Executive, under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR) as a dangerous occurrence ('accidental release of a biological agent likely to cause severe human illness') using form F2508, rather than as an injury (unless the exposure results in three or more days absence from work). Reports can be made online at www.riddor.gov.uk

Preventing further incidents

Consideration of the circumstances of individual exposures may prompt further investigation of working practice and/or equipment with a view to minimising the risk of future incidents.

Appendix 3: Department of Health guidelines for handling bodies with infections

A. Infections notifiable in England and Wales

Infection	Degree of risk[1]	Body bags	Bereaved permitted to touch and spend time with body	Embalming	Hygiene precautions (Cleaning & tidying)
Acute Encephalitis	D	No			
Acute Poliomyelitis	C	Advised			
Anthrax	A	Yes	No	No	No
Cholera	C	Advised		With special care	
Diphtheria	C	Advised			
Dysentery (amoebic or bacillary)	C	Advised			
Food poisoning	C	Advised			
Lassa fever	A	Yes	No	No	No
Leprosy	D	No			
Leptospirosis (Weil's)	C	No			
Malaria	C	No			
Measles	D	No			
Meningitis (non-meningococcal)	D	No			
Meningococcal disease	C	Advised			
Mumps	D	No			
Ophthalmia Neonatorum	D	No			

[1] The 'degrees of risk' (A B C and D) are not absolute and, in most cases, are not specified in law. The advice given in specific cases may be varied if the clinician in charge, hospital control of infection doctor or consultant in communicable disease control decides it is appropriate, after assessing the risks.

A. Infections notifiable in England and Wales continued

Infection	Degree of risk[1]	Body bags	Bereaved permitted to touch and spend time with body	Embalming	Hygiene precautions (Cleaning & tidying)
Paratyphoid fever	C	Advised			
Plague	A	Yes	No	No	No
Rabies	A	Yes	No	No	No
Relapsing fever	C	Advised			
Rubella	D	No			
Scarlet fever	C	Advised			
Tetanus	D	No			
Tuberculosis	C	Advised			
Typhoid fever	C	Advised			
Typhus	B	Yes	No	No	No
Viral haemorrhagic fever	A	No	No	No	No
Viral hepatitis A	C	Advised			
Viral hepatitis B, C & non-A, non-B	B	Yes		No	No
Whooping cough	D	No			
Yellow fever	A	Yes	No	No	No

B. Some infections not notifiable in England and Wales

Infection	Degree of risk[1]	Body bags	Bereaved permitted to touch and spend time with body	Embalming	Hygiene precautions (Cleaning & tidying)
Brucellosis	C	Advised			
Chicken pox/shingles	D	No			
Crytosoridiosis	D	No			
Dermtophytosis	D	No			
HIV/Aids	B	Yes		No	No
Influenza	D	No			
Legionellosis	D	No			
Lyme Disease	D	No			
MRSA	D	No			
ORF	D	No			
Pneumonia/bronchitis	D	No			
Psittacosis	D	No			
Q fever	D	No			
Salmonellosis	C	Advised			
Invasive group A streptococcal infection	A	Yes	No	No	No
Transmissible spongiform encphalopathies (eg Creutzfeldt-Jakob disease	A	Yes	No	No	No

Other conditions requiring body bag and with restriction of contact (except touching face) but should not be removed from bag

- Death in dialysis units
- Known intravenous drug misuser
- Severe secondary infection
- Gangrenous limbs and infected amputation sites
- Large pressure sores
- Leakage and discharge of body fluids likely
- Post-mortem
- Incipient decomposition

Appendix 4: Management of known or suspected infections which need precautions after death

Biohazard guidance table on the management of known or suspected infections which need precautions after death

The table is for use in completing the guidance form, which accompanies the body bag. The form gives important health and safety information to funeral workers and others.

Most infections do not warrant special precautions following death, providing standard safe-working practices are adopted. Advice should be sought from a hospital infection control doctor (HICD) or consultant in communicable disease control (CCDC) if in doubt. Recommendations also apply to deceased children. Use of body bags is recommended for safe transport between the mortuary and funeral home for bodies that impose an infection risk.

Table 1

Infection/specific conditions (infection risk symbol in brackets or circle)	Use body bag	Viewing	Wash	Suitable to embalm	Comments
Blood-borne infection risk (B) Hepatitis B and C HIV infection/AIDS Blood-stained with suspected blood risk Unconfirmed jaundice from abroad Intravenous drug abuse	Yes	Yes	Yes	No	Body bag from mortuary via funeral home to cemetery/ crematorium.
Intestinal infection risk (G) Dysentery Typhoid/paratyphoid fever Profuse diarrhoea/gross faecal soiling Food poisoning	Yes	Yes	Yes	Yes	Body bag from mortuary only to funeral home. If leakage, body bag via funeral home to cemetery/ crematorium.

Infection/specific conditions (infection risk symbol in brackets or circle)	Use body bag	Viewing	Wash	Suitable to embalm	Comments
Neurological infection risk TSE (CJD) Pre post mortem (N) Post mortem (C)	Yes	No	No	No	Body bag from mortuary via funeral home to cemetery/ crematorium.
Respiratory/airborne infection risk ® Meningococcal meningitis/septicaemia Tuberculosis including drug resistant	Yes	No	No	No	Place cloth or mask over deceased's mouth at all times. Body bag to funeral home.
Contact © Invasive group A streptococcus	Yes	Yes	Yes	Yes	Body bag to cemetery/ crematorium.
Fever of unknown origin/jaundice from abroad (B) (C) (G)	*	*	*	*	*Seek advice of microbiologist/ CCDC.
Notifiable disease Plague Typhoid Relapsing fever Cholera	Yes	**	**	**	** CCDC must be contacted for advice under Para 43 of Public Health (Control of Diseases) Act 1984.
Imported Infection Anthrax Diphtheria Rabies	Yes	***	***	***	*** CCDC must be contacted under Public Health (Infectious Diseases) Regulations 1988, Regulation 3 and Schedule 1.
Viral haemorrhagic fevers including yellow fever	Yes	No	No	No	Body bagging and sealed in a coffin before direct delivery to a cemetery/ crematorium.

Responsibility

The lead responsibility lies with the CCDC in conjunction with the hospital infection control officer (HICO) for safety in handling bodies. The CCDC is also responsible for training of funeral workers, while the HICO prepares the hospital policy and trains hospital workers. Expert advice from government and professional institutions is available on biological risks to healthcare and funeral workers.

Biohazard information for healthcare workers

When a body imposes an infection risk, the body should be placed in a bag for transportation from the mortuary to a funeral home. Table 1 classifies infections according to route of transmission and advises on management. Advice depends on the degree of hazard, transmission route and the procedures to be performed. Each body presents a differing degree of hazard, but the general control principles apply to all of them. A physician should complete a guidance form.

Infection control notification sheet (guidance form for funeral workers)

The completed guidance form for funeral workers should accompany the body when it is released from a mortuary. It lists the reasons for the use of the body bag, whether the bag may be removed at the funeral home and whether body preparation may be carried out. If so, it gives advice on body preparation.

The form will advise on procedures, including embalming and access to the deceased. It provides information on infection transmission routes, to explain the need for precautions to be taken. This preserves patient confidentiality while controlling risk. Medical confidentiality is preserved after death. Funeral workers do not have the right to be told of a specific diagnosis.

An example of a guidance form is given in Table 2.

Table 2

Infection control notification sheet

Name of deceased.....

Date and time of death .....

Source hospital and ward .....

_____

The deceased remains are a potential source of infection

YES/NO/UNKNOWN (see note 1 below) Ring as appropriate

If **YES**: (see note 2 below)

The remains present an infectious hazard of transmission by: (Ring as appropriate)

Inoculation (blood-borne virus) **Aerosol** **Ingestion**

Instructions for handling remains – if YES above, tick as appropriate

- ☐ Body bagging is necessary
- ☐ Viewing is not recommended
- ☐ Embalming presents high risk eg blood-borne virus (BBV)

Signed ..... **Print name** .....

On behalf of ..... Hospital/mortuary/GP

Notes

- In hospital cases, the doctor certifying death, in consultation with ward nursing staff, is asked to sign the notification sheet.
- Where a post-mortem examination has been undertaken, the pathologist is asked to sign the notification sheet.
- In non-hospital situations, the doctor certifying death is asked to sign the notification sheet.

Note 1 – Not all infected patients display typical symptoms, therefore some infections (including blood-borne viral infections) may not have been identified at the time of death.

Note 2 – In accordance with health and safety law and the information provided in the Health Services Advisory Committee guidance, *Safe working and the prevention of infection in the mortuary and post-mortem room* (2nd edition 2002).

ANNEXES

Annex A: Further guidance and links

Using and disposing of sharps

- The Health Protection Agency has produced examples of good and bad practice to avoid sharps injuries

  www.hpa.org.uk/infections/topicsaz/bbv/goodbad.htm
  www.hpa.org.uk/infections/topicsaz/bbv/poster.pdf

- Safer Needles Network – Needlestick Forum
  www.needlestickforum.net

Back pain and musculoskeletal disorders

- *Essential back-up* (includes trainer and training advice). Revised 2002

  National Back Exchange
  Linden Barnes
  Greens Norton Road
  Towcester
  NN12 8AW

  Tel 01327 358855

- *Manual handling standard 2004*
  www.nationalbackexchange.org.uk/index.html

- Back in Work campaign
  www.nhs.uk/backinwork/index.htm

- Publications on manual handling issues

  Royal College of Nursing
  20 Cavendish Square
  London
  W1G 0RN

  Tel 020 7409 3333

  www.rcn.org.uk

- Chartered Society of Physiotherapists
  14 Bedford Row
  London
  WC1R 4ED

  Tel 0207 306 6666

  www.csp.org.uk

General

- *Absenteeism – an issue in the American workplace*
  www.stfrancis.edu/ba/qhkickul/stuwebs/btopics/works/absent.htm

- Access to Medical Records Act 1988
  www.hmso.gov.uk

- Control of Substances Hazardous to Health Regulations 2002
  www.hse.gov.uk/hthdir/noframes/coshh/index.htm

- Data Protection Act 1998
  www.hmso.gov.uk

- Display Screen Equipment Regulations 1992
  www.hse.gov.uk/lau/lacs/16-1.htm

- Disability Discrimination Act 1995
  www.hmso.gov.uk

- *Seeking patients' consent: the ethical considerations*. Duties of a doctor series, GMC Publications, November 1998

  Tel 0161 923 6315 or 0845 3579001

  publication@gmc-uk.org

- *Guidance on ethics for occupational health physicians*. May 1999

  The Faculty of Occupational Medicine of the Royal College of Physicians
  6 St Andrews Place
  Regent's Park
  London
  NW1 4LB

  Tel 020 7317 5890

- *Immunisation against infectious disease* (The Green Book) 1996
  www.dh.gov.uk/assestRoot/04/07/30/09/04073009.pdf

- *Guidance for clinical healthcare workers: protection against infection with blood-borne viruses*
  www.dh.gov.uk/assetRoot/04/01/44/74/04014474.pdf

- *Good practice guidelines for renal dialysis/transplantation units: prevention and control of blood-borne virus infection*
  www.publications.dh.gov.uk/cmo/renalguide/dialtransplant.pdf

- Williams S, Michie S, Pattani S. 1998: *Improving the health of the NHS workforce: report of the partnership on the health of the NHS workforce*

  The Nuffield Trust
  59 New Cavendish Street
  London
  W1M 7RD

- Seccombe, 1995: *Measuring and monitoring absence from work*. Institute for Employment Studies Report 288
  www.employment-studies.co.uk

- Office of National Statistics
  www.statistics.gov.uk

- Management of Health and Safety at Work Regulations 1992
  www.hmso.gov.uk/si/si1992/uksi_19922051_en_1.htm

- *Mental health and employment in the NHS*. Department of Health, October 2002
  www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4008361&chk=6gZSv/

- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR)
  www.hse.gov.uk/lau/lacs/72-7.htm
  www.legislation.hmso.gov.uk/si/si1995/uksi_19953163_en_1.htm

- *Reporting of occupational exposure to blood-borne viruses – history and how to report*. Health Protection Agency
  www.hpa.org.uk/infections/topicsaz/bbv/occexp.htm

- *Reviewing attendance in the NHS: causes of absence and discussion of management strategies*. Health Education Authority, 1999

  Health Education Authority
  Trevelyan House
  30 Great Peter Street
  London
  SW1P 2HW

- Leather P, Cox T, Beale D, Fletcher B: *Safer working in the community, a guide for NHS managers and staff on reducing the risks from violence and aggression*
  www.hse.gov.uk/healthservices/violence.htm

- *The misuse of alcohol and other drugs by doctors*. Working group on the misuse of alcohol and other drugs by doctors, British Medical Association, 1998

  British Medical Association
  BMA House
  Tavistock Square
  London
  WC1H 9JP

- *Working well together – managing attendance in the public sector, putting best practice to work*. HMSO 1998
  www.civilservice.gov.uk/management_information/conditions_of_service/occupational_health/working_well_together/index.asp

- Clothier Cecil, 1994: *Independent inquiry relating to deaths and injuries on the children's ward at Grantham and Kesteven General Hospital during the period February to April 1991* (Clothier Report)
  The Stationery Office Books

- Advice on a wide variety of health and safety issues

  UNISON
  1 Mabledon Place
  London WC1H 9AJ

  Tel 0845 355 0845

  www.unison.org.uk

Health and safety

- *A safer place to work – improving the management of health and safety risks to staff in NHS trusts*
  www.nao.gov.uk

- Health and Safety at Work etc Act 1974
  www.hmso.gov.uk

- Management of Health and Safety at Work Regulations 1992 (amended in 1999)
  www.hmso.gov.uk

- Manual Handling Operations Regulations 1992
  www.hse.gov.uk/lau/lacs/56-1.htm
  www.hse.gov.uk/pubns/amnlinde.htm

- Provision and Use of Work Equipment Regulations (PUWER) 1998
  www.legislation.hmso.gov.uk/si/si1998/19982306.htm
  www.hse.gov.uk/lau/lacs/90-3.htm

Hepatitis B

- *Protecting health care workers and patients from hepatitis B*. Health Service Guidelines HSG 93(40)
  www.dh.gov.uk/assetRoot/04/07/93/06/04079306.pdf

- *Hepatitis B-infected healthcare workers and guidance on implementation of HSC 2000(020)*. Health Service Circular HSC 2000(020)
  www.dh.gov.uk/assetRoot/04/01/22/57/04012257.pdf
  www.dh.gov.uk/assetRoot/04/05/75/38/04057538.pdf

- *Exposure to hepatitis B virus: guidance on post-exposure to prophylaxis*. PHLS Hepatitis sub-committee (now part of Health Protection Agency)
  www.hpa.org.uk/cdr/CDRreview/1992/cdrr0992.pdf

Hepatitis C

- Ramsay, M. E. : *Guidance on the investigation and management of occupational exposure to hepatitis C*. Health Protection Agency
  www.hpa.org.uk/cdph/issues/CDPHVol12/no4/guideshepC.pdf

- *Hepatitis C-infected healthcare workers and implementation guidance*. Health Service Circular HSC 2002(010)
  www.dh.gov.uk/assetRoot/04/01/22/17/04012217.pdf
  www.dh.gov.uk/assetRoot/04/05/95/44/04059544.pdf

HIV

- *HIV post-exposure prophylaxis*. Guidance From the UK Chief Medical Officers' Expert Advisory Group on AIDS
  www.advisorybodies.dh.gov.uk/eaga/prophylaxisguidancefeb04.pdf

- *HIV-infected healthcare workers: a consultation paper on management and patient notification*
  www.dh.gov.uk/assetRoot/04/01/85/96/04018596.pdf

Sickness absence

- *Managing sickness absence in the NHS.* Health Education Authority, 2001 (Part of the Health at Work in the NHS project.)
  www.hda-online.org.uk/downloads/pdfs/fwork4act_hawnhs.pdf

- Sickness absence: a survey of 182 employers. *IRS Employee Health Bulletin*, 1998 5:2

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