House of Commons

Work and Pensions Committee

The work of the Health and Safety Commission and Executive

Fourth Report of Session 2003–04

Volume I

HC 456-I

House of Commons

Work and Pensions Committee

The work of the Health and Safety Commission and Executive

Fourth Report of Session 2003–04

Volume I

Report, together with formal minutes

Ordered by The House of Commons
to be printed date 14 July 2004

HC 456-I
Published on 23 July 2004
by authority of the House of Commons
London: The Stationery Office Limited
£0.00

The Work and Pensions Committee

The Work and Pensions Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department for Work and Pensions and its associated public bodies.

Current membership

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

Powers

The committee is one of the departmental select committees, the powers of which are set out in House of Commons Standing Orders, principally in SO No 152. These are available on the Internet via www.parliament.uk.

Publications

The Reports and evidence of the Committee are published by The Stationery Office by Order of the House. All publications of the Committee (including press notices) are on the Internet at http://www.parliament.uk/parliamentary_committees/work_and_pensions_committee.cfm.

Committee staff

The current staff of the Committee are Philip Moon (Clerk), Mick Hillyard (Second Clerk),Maxine Hill and Djuna Thurley, (Committee Specialists), Louise Whitley (Committee Assistant), Emily Lumb (Committee Secretary), John Kittle (Senior Office Clerk).

Contacts

All correspondence should be addressed to the Clerk of the Work and Pensions Committee, House of Commons, 7 Millbank, London SW1P 3JA. The telephone number for general enquiries is 020 7219 5833; the Committee's email address is workpencom@parliament.uk

Contents

Report

Summary

- The Committee views with concern the limited progress that appears to have been made in reaching targets and does not believe that there is any realistic prospect of achieving the 2004 targets. In its view this lack of progress must, inevitably, raise questions about the present system's capacity to secure significant future improvements in standards of workplace health and safety. (Paragraph 50)

- The Committee is concerned at the length of time it is taking the Government to resolve any outstanding issues concerning reforms of the law on corporate killing and recommends that by 1 December 2004, the Government publishes a Bill on corporate killing. (Paragraph 53)

- We endorse the view of Prospect that the number of inspectors in HSE's Field Operations Directorate should be doubled (at a cost estimated by them as £48 million a year after 6 to 7 years).We recommend that substantial additional resources are needed in the next three years. (Paragraph 82)

- The evidence supports the view that it is inspection, backed by enforcement, that is most effective in motivating duty holders to comply with their responsibilities under health and safety law. We therefore recommend that the HSE should not proceed with the proposal to shift resources from inspection and enforcement to fund an increase in education, information and advice. (Paragraph 142)

- Given the HSE's limited resources, if safety representatives were empowered to enforce health and safety law in the workplace, we believe this would have a powerful effect in improving standards. We also believe this power to take action, should include not just criminal prosecutions but also improvement and prohibition notices, subject to the usual right of appeal to the Employment Tribunal and as to terms on legal costs. (Paragraph 176)

- The Committee shares HSC's concern that there is a 'huge job' to do on health. It is concerned, therefore, that a reduction in HSE's in-house expertise has raised major questions as to its capacity to show leadership on the issue. We recommend the Government reviews the resources available for this work to enable the HSE to fulfil this growing role. (Paragraph 266)

Other recommendations

- We recommend that, in context of Spending Review 2004, the HSE inspectorate be recognised as a front-line service and protected. (Paragraph 20)

- The Committee recommends that the HSE use an annual workplace health and safety survey to obtain data to enable it to publish evidence of trends on such issues as the proportion of employers (a) conducting risk assessments, (b) providing occupational health support and (c) training on health and safety issues. (Paragraph 41)

- The Committee is also concerned that the Public Service Agreement target to 'improve health and safety outcomes' by 2008 appears to be vague and

unmeasurable. We recommend that the Government produces and publishes specific details of what this target is and how it is to be measured. (Paragraph 51)

- The Committee recommends that commitments to legislate made in Revitalising Health and Safety in 2000 should be honoured by a Government Bill in the next session of Parliament. (Paragraph 55)

- The Committee recommends that the Government reconsiders its decision not to legislate on directors' duties and brings forward proposals for prelegislative scrutiny in the next session of Parliament. (Paragraph 60)

- The Committee recommends a wide ranging and open review of the role and effectiveness of HSC's Industry Advisory Committees to help to address concerns that they are being downgraded. (Paragraph 72)

- The Committee recommends that HSE should actively promote joint resource planning, risk prioritisation and programme working across the devolved legislatures in Great Britain. (Paragraph 88)

- The Committee recommends the HSE adopts a more proactive approach to enforcement action towards employers who disproportionately rely on temporary agency workers. (Paragraph 98)

- We recommend that, for all its major procurement contracts, the Government sets a good example and only buys from suppliers who have proved to the Government that they comply with UK health and safety legislation and who have satisfactory health and safety procedures and practices in place. (Paragraph 105)

- The Committee is seriously concerned at the level of risk to which migrant workers are currently exposed. We recommend that urgent research is needed to improve our understanding of the occupational health and safety risks faced by migrant workers so that a targeted strategy to manage those risks for this particularly vulnerable group can be effectively implemented as soon as possible. (Paragraph 111)

- The Committee is concerned that there does not appear to be an all-embracing strategy to address the changing world of work and recommends that such a strategy must be developed as a matter of urgency. This should include, in particular, measures to reduce the health and safety risks faced by agency workers and migrant workers. By 31 December 2005, clear, comprehensive and appropriate guidance should be published by the HSC/E on health and safety where the workplace is a private home. In particular, and more urgently, local authorities should issue guidance on the Employer's Liability (Compulsory Insurance) Act 1969 to those employing carers directly in their own homes, and assist in arranging appropriate cover. (Paragraph 120)

- The Committee is concerned both at the low level of incidents investigated and at the low level of proactive inspections and recommends that resources for both are increased (see paragraph 82). (Paragraph 150)

- The Committee believes that before adopting a policy of reduced inspection for employers with an established record of good practice, there is a need for clear and thorough evidence-based analysis to ensure that the reduction does not lead to negative outcomes such as improper pressures to achieve a reduction in accident reporting. (Paragraph 153)

- The Committee recommends that the Government identifies resources to build on the success of its pilot of a new prosecution model. (Paragraph 177)

- The Committee recommends that maximum penalties should be increased by means of a Bill in the next session of Parliament and further recommends that proposals to introduce alternative an innovative penalties in addition to those already available to the courts should be examined and the reasoned conclusions thereof published by 1 May 2005. (Paragraph 182)

- The Committee recommends that HSE undertakes and publishes by 1 October 2005 a thorough audit of the performance of local authorities. The Committee further recommends that additional powers should be made available to allow HSC/E to take actions against any local authority manifestly failing in its duty of enforcing health and safety regulations. (Paragraph 198)

- The Committee recommends that the Department by 1 October 2005 reviews its strategies to ensure national consistency and rigour in enforcement of health and safety regulations throughout Great Britain. If this review finds substantial support for current criticisms, it is further recommended that the demarcation of enforcement activity between HSE, local authorities and other enforcement agencies be examined, the case for a unified health and safety enforcement authority investigated and the reasoned conclusions thereof be published by 1 October 2006. (Paragraph 204)

- The Committee recommends that resources should be allocated to enable all key publications to be made available free of charge on the internet. (Paragraph 216)

- The Committee recommends that the HSE is provided with the necessary resources to enable it to enforce effectively its existing guidance on work-related road safety, particularly in relation to preventative measures. (Paragraph 224)

- The Committee recommends that at-work road traffic incidents should be required to be reported pursuant to RIDDOR. (Paragraph 226)

- The Committee recommends that, by 1 October 2005 the HSC/E should carry out a review of the case for an ACoP on work-related road safety, and publish its reasoned conclusions. (Paragraph 228)

- The Committee recommends that, by 1 October 2005, HSC publishes proposals to develop improved rights to consultation for employees, particularly in non-unionised workplaces, including rights of enforcement through its Employment Tribunal and private prosecution routes.(Paragraph 241)

- The Committee is disappointed at the plans and progress to date to establish national cover of occupational health services. It recommends that this is given

higher priority than it has received to date and that HSC/E is provided with the necessary resources to enable it to make progress towards the 2010 targets on occupational health. (Paragraph 251)

- The Committee recommends that the HSC should, by 1 October 2005, develop and publish an Approved Code of Practice defining the standards of competence employers are required to use to ensure they comply with health and safety requirements. (Paragraph 253)

- We endorse the suggestion of NHS Plus that the NHS is ideally placed to provide third party occupational health advice to employees and employers. This does not mean that they would provide all the service, but they could "serve as honest broker". (Paragraph 254)

- The Committee welcomes these steps to improve our understanding of the nature and extent of the problem of workplace ill-health. (Paragraph 259)

- The Committee recommends that inspectors should have the resources that they need to be able to identify health issues, recommend remedial action to be taken by employers and define satisfactory outcome measures. Resources are also required to enable proactive research work to be done on combating newly emerging risks, like passive smoking. The risk assessment criteria should be reviewed to ensure they are able to identify workplaces where occupational health risks are high. The results of this review should be published by 1 October 2005 (paragraph 277).

- The Committee recommends that the Government reviews the experience of the ban on smoking in the workplace recently introduced in Ireland. Measures to deal with passive smoking in the workplace should be included in the forthcoming White Paper on improving health (paragraph 278).

- The Committee recommends that HSC reviews international evidence on the efficacy of requiring employers to set out their approach to, and provision of, rehabilitation to determine whether lessons can be learned and introduced in the UK The results of the review to be published by 1 October 2005. (Paragraph 286)

1 Introduction

1. It is only necessary to open a newspaper or watch a news bulletin in the days, weeks and months following a major accident or incident to realise that the issue of health and safety touches all of us in our daily lives and, wrongly or inadequately implemented, can bring the lives of those closest to us to an end or cause serious injury.

2. In undertaking this inquiry the Committee is not responding to any single event, although several major incidents did occur during the short lifetime of the inquiry.[1] But away from the headlines there are some disturbing statistics. For example in 2002/03, 226 workers were fatally injured, there were 28,426 reported major injuries and 126,004 reported over-3-day injuries. [2] Moreover these figures do not include death and injuries arising from occupational road accidents.

3. The Government is aware of the seriousness of the situation and in June 2000 launched its *Revitalising Health and Safety* Strategy Statement *(Revitalising)*. This set targets to reduce the number of working days lost from work-related injury and ill health, reduce the incidence of fatal and major injury accidents and reduce the rate of work-related ill health.

4. The Committee resolved to see whether these ambitious targets were likely to be met, while reaching a judgment on the adequacy of the resources provided. The inquiry was announced on 14 January 2004 with the aim of examining 'the work of the Health and Safety Commission and Health and Safety Executive, and the effectiveness of current arrangements to promote high standards of health and safety.'

5. As a result of the announcement we received 66 written submissions and took oral evidence from 27 organisations over 7 sessions. The response was in itself an indication that the subject needed the kind of detailed examination provided by a Select Committee.[3] The oral evidence sessions included employers, trade unions, professional bodies, organisations representing victims, central and local government and the Minister for Work.[4] During the course of the inquiry we undertook brief study visits - to Madrid, to look at the Spanish health and safety system, to Bilbao, to visit the headquarters of the European Agency for Safety and Health at Work and to the European Commission in Brussels. We also visited, and took evidence in, Scotland, to look at how HSC/E had responded to devolution. We are very grateful to all those who submitted memoranda, to those who gave oral evidence and to those who helped the Committee in its work.

1 The explosion at the plastics factory at Grovepark Street Glasgow on 11 May 2004 (www.scotland.gov.uk/pages/news/extras/00020600.aspx) the death of 19 cockle pickers in Morecambe Bay on 5 February (new.bbc.co.uk/2/hi/uk news/England/Lancashire/3465109.stm-36k); and the death of three agricultural workers in Norfolk on 12 July (http://news/bbc.co.uk/hi/england/norfolk/3886925)

2 HSC, *Health and Safety Statistics Highlights 2002/03,* National Statistics. Examples of major injuries include: fractures (except to fingers, thumbs or toes), amputations, dislocations (of shoulder, hip, knee and spine) and other injuries leading to resuscitation or 24-hour admittance to hospital. Over-three-day injuries are injuries that lead to workers being absent from work or unable to do their usual job for over three days. Provisional statistics provided by HSC who that there were 30,000 reported major injuries and 96,733 over-three day injuries in 2003/04, see Volume II, (Ev 38).

3 Responsibility for HSE and HSC transferred from the Department for Transport, Local Government and the Regions to the Department for Work and Pensions in 2002.The Environment. Transport and Regional Affairs Committee produced a report on The Work of the Health and Safety Executive in 2000.

4 A full list of witnesses is at page 108

6. The inquiry set out to examine the work of the Health and Safety Commission (HSC) and Health and Safety Executive (HSE) and the effectiveness of current arrangements to promote high standards of health and safety. Within HSE, we focused principally on the work of the Field Operations Directorate. However we decided that it would help the inquiry and our understanding of the issues, if we focussed on health and safety in two sectors of employment. We therefore agreed that our inquiry would include case studies of two problematic sectors: the construction industry and health and social care.

7. Throughout the inquiry the Committee has benefited greatly from the expert assistance of our three Specialist Advisers: Professor Jouni Jaakkola of Birmingham University, Professor Philip James of Middlesex University Business School and Professor David Walters of Cardiff University. The subject of the inquiry was new to the Committee and was an area in which some of us had no previous experience. We are therefore hugely grateful to the Advisers for identifying issues and people meriting our attention and explaining the more technical topics to us.

2 Background

8. The twin bases of the health and safety system in Great Britain are the Health and Safety at Work etc. Act 1974 (HSWA) and regulations enacted under the Act, often pursuant to the European Union's health and safety directives. Legislative responsibility for Health and Safety is reserved to the UK Parliament, while responsibility for policy areas such as health and education is devolved to the Scottish Parliament and the Welsh Assembly. HSE's structure has developed to enable it to work with the devolved institutions.[5] Northern Ireland has its own Health and Safety Executive and separate legislation. The HSWA imposes duties on a range of people and organisations. It takes a 'goal setting' rather than a 'prescriptive' approach. Regulations can be supported with Approved Codes of Practice (ACOP) that advise how employers can comply with law. Failure to comply with an ACOP can be taken into account during criminal and civil proceedings as evidence of failure to comply with the legislation.

9. The Health and Safety Commission (HSC) and the Health and Safety Executive (HSE)[6] were established by the HSWA. HSC is composed of between six and nine members, appointed by the Secretary of State following consultation, advertisement and open competition.[7] HSC's role is to advise Ministers on health and safety issues, including proposals for new legislation and standards. The HSE assists and advises the Commission and has statutory responsibility to make adequate arrangements for the enforcement of the Act and other relevant statutory provisions. About 80% of the HSC/E budget is provided by the DWP, and about 20% is raised through charges.

10. Health and safety law is mainly enforced by HSE. Local Authorities are largely responsible for premises such as offices, shops, retail and wholesale distribution centres,

5 Volume III (No. 36)

6 These bodies are closely linked and are often referred to in this report as HSC/E

7 Volume III (No. 36)

leisure, hotel and catering premises.[8] Some other discrete areas, such as aviation, are dealt with by other bodies (see Chapter 11).

11. Injury levels have fallen significantly since the introduction of the HSWA. For example, as HSC/E pointed out in their written evidence, while there were 651 fatal injuries to employees in production and some service industries in 1974, the comparable figure for 2002/03 was 182, a reduction of over 70%[9], at a time when the workforce has expanded by 12%.[10] And Great Britain's record compares well on an international basis. Looking at the annual rate of workplace fatalities, Great Britain has the second lowest rate, at 1.7 per 100,000 workers, compared with the EU average of 2.8. Sweden has the lowest rate.[11] Nonetheless, the statistics make disturbing reading. In 2002/03, excluding road accidents, 226 workers were fatally injured, there were 28,426 reported major injuries and 126,004 reported over-three-day injuries.[12] The average rate of injuries to workers reportable under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) was estimated to be 1,510 per 100,000 in 2001-02. The estimate for the level of reporting for non-fatal injury under RIDDOR based on the Labour Force Survey is 41.3%.[13] The incidence of self-reported work-related ill health prevalence in Great Britain stood at 2.3 million people in 2001/02, accounting for 33 million working days lost.[14]

12. In 1999 the Government announced a strategic reappraisal of the UK's health and safety framework, resulting in the publication of its *Revitalising Health and Safety Strategy Statement* in June 2000.[15] The aims of this were to

- inject new impetus into the health and safety agenda;
- identify new approaches to reduce further rates of accidents and ill health from work;
- ensure this country's approach remains relevant to the changing world of work over the next 25 years; and
- gain maximum benefit from links between occupational health and safety and other Government programmes.

Ambitious targets were set to reduce working days lost, reduce the incidence of fatal and major injury accidents and reduce rates of work-related ill health (see Chapter 4). These targets were underpinned by a strategy statement and an action plan consisting of 44 action points. HSC/E have recently published a paper detailing the current position, achievements

8 HSC (2002), The health and safety system in Great Britain, Sudbury: HSE Books

9 Volume III (No. 36)

10 National Statistics, series DYDC, workforce jobs seasonally adjusted.

11 Volume III (No. 36). HSC points out that care needs to be taken in comparing figures for different countries. Figures are for 2000.

12 HSC, Health and Safety Statistics Highlight 2002/03, Sudbury: HSE Books

13 HSC, Health and Safety Statistics Highlight 2002/03, Sudbury: HSE Books. NB. The National Audit Office (in NAO (2004), *Improving Health and Safety in the Construction Industry.* HC 531. London: The Stationery Office) says HSE has estimated from surveys that employers only report around 46% of reportable non-fatal injuries and the self-employed report less than 5%.

14 HSC, Health and Safety Statistics Highlight 2002/03, Sudbury: HSE

15 HSC (2000), Revitalising Health and Safety Strategy Statement. June 2000. London: DETR

and next steps relating to the 44 action points.[16] Some witnesses to the inquiry argued that effective implementation of these action points is what is needed.[17]

13. Shortly after the publication of *Revitalising,* the Government produced its occupational health strategy, *Securing Health Together: A long-term occupational health strategy for England, Scotland and Wales.* The aims of this were to reduce ill health of workers and the public caused or made worse by work, help people who have been ill to return to work and use the work environment to help people maintain health. Targets were set, for example, to achieve a 20% reduction in the incidence of work-related ill-health by 2010.[18]

14. By 2003, HSC/E considered it to be 'clear that more had to be done'.[19] It therefore undertook another consultation exercise and, in February 2004, published its *Strategy for Workplace Health and Safety to 2010 and Beyond.*[20] The main themes in this are a) developing and working in close partnerships; b) focusing on those interventions that have the greatest impact; c) rising to the challenge of occupational health and d) promoting the benefits of health and safety.[21] Key points arising from these themes are:

- The need to target limited resources where they can have greatest impact.

- A 'downplaying' of further regulatory solutions, although HSC continues to press for higher fines, a new law on corporate killing and the removal of crown immunity.

- The need to forge greater strategic partnerships, especially with those who can stimulate action by others.

- The need to win 'hearts and minds', through effective communication and demonstration of the business and moral case for health and safety.

- Recognition of local authorities as key strategic partners, both in their enforcement role and as employers.

- Continuance of enforcement as a key tool and one that has underpinned success to date.

15. Sponsorship of HSC/E has rested with a number of Government Departments since 1974. It transferred to the Department for Work and Pensions (DWP) from the Department for Local Government and the Regions in 2002.[22] HSC/E's work on health and safety fits well with DWP's own agenda of keeping people in work and rehabilitation for getting people back to work. The need for joined-up policy on these issues, particularly between HSE's work to promote health and safety standards and DWP's work on rehabilitation, was highlighted by a number of witnesses to the inquiry[23]. And as DWP

16 HSC/E, Revitalising Health and Safety (RHS), Implementing RHS – Progress Report, www.hse.gov.uk

17 See, for example, Volume II (Ev 34, Q117)

18 HSC, etc (2000), Securing health together: A long-term occupational health strategy for England, Scotland and Wales. London:HSE Books

19 Volume III (No. 36)

20 HSC (2004), A strategy for workplace health and safety in Great Britain to 2010 and beyond. London: HSE

21 Volume III (No. 40)

22 Volume III (No. 40)

23 Volume III (Nos. 5, 30, 31) Volume II (Ev 101,Q391)

point out, a number of other government departments have an interest in the specific activities of HSC/E.

16. A further question is how HSE fits into the overall regulatory framework. In Budget 2004, the Chancellor announced that he had asked Philip Hampton, former finance director of Lloyds TSB, BT and British Gas[24], to consider with business, regulators, and in consultation with the Better Regulation Task Force, the scope for promoting more efficient approaches to regulatory inspection and enforcement while continuing to deliver excellent regulatory outcomes.[25] The Budget document noted that:

> 'The enforcement activity of regulatory bodies is a significant driver of business compliance costs. As the Better Regulation Task Force recognised in their 2003 report, *Independent Regulators,* well targeted inspection programmes are vital, not only to deliver the outcomes society demands, but also to minimise the costs borne by compliant firms.'

17. A paper entitled *Becoming a Modern Regulator* was discussed at a meeting of the Health and Safety Commission on 6 April 2004.[26] This states that the 'regulatory framework in the UK has grown up over centuries in a piecemeal fashion' and that as a result, the overarching architecture 'lacks a coherent and consistent style…the canvass is inconsistent and overcrowded.'

18. The document notes that there are over 100 independent regulators and that 'greater brigading would harmonise approaches, reduce burdens on business and avoid duplication and might be a logical step forward.' It argued that a 'one stop shop' argument was 'probably unachievable' given 'the enormity of the task and the differing needs and wishes of stakeholders.' It was recognised that there was limited joint agenda-setting and planning but HSE was said to be exploring how this could be done more effectively. The minutes of the meeting at which the paper was discussed note that 'it was believed that the government had a desire to consolidate regulators.'[27]

19. The Hampton Review put out a call for submissions from business on 23 June 2004 (with a deadline of 15 September).[28] This stated that the Review Team was 'particularly keen to hear from businesses that have significant concerns about the ways in which inspection and enforcement regimes operate, and also any ideas for beneficial changes that could be introduced.' Questions posed include:

- which regulators the business has dealings with (for example, HSE, Environment Agency, Food Standards Agency, Local Authorities);
- whether businesses would prefer to have visits from a generalist inspector who could draw in specialist expertise as required;
- whether regulators are sufficiently tough in cracking down on poor performers;

24 Philip Hampton was recently appointed as chairman of Sainsbury's.(Times, 2.07.2004)

25 HM Treasury (2004) Budget 2004, Prudence for a purpose: A Britain of stability and strength. HC 301, para 3.57

26 http://www.hse.gov.uk/aboutus/hsc/meetings/2004/060404/c53.pdf

27 http://www.hse.gov.uk/aboutus/hsc/meetings/2004/110504/cm04.pdf

28 http://www.hm-treasury.gov.uk/consultations_and_legislation/hampton/consult_hampton_index.cfm

- whether good practice is recognised sufficiently;
- whether the regulator takes sufficient account of risk and past performance in deciding where to focus resources;
- whether the regulator acts consistently; and
- whether it provides a useful source of advice and guidance.

20. Spending Review 2004 will also have implications for HSE:

- A new target was set to improve health and safety outcomes by 2008 through progressive improvement in the control of risks in the workplace.[29]
- The Secretary of State for Work and Pensions is to report on a review of the management of long-term sickness absence in the public sector by autumn 2004.[30]
- DWP is to 'realise total annual efficiency gains of at least £960 million by 2007-08.' As part of this, by 2007/08, DWP will reduce its workforce by 30,000, redeploy 10,000 posts to front-line roles and reduce its administration budget in real terms by 3.0 per cent per year.[31]

We recommend that in the context of Spending Review 2004 the HSE inspectorate be recognised as a front-line service and protected.

3 Challenges

The broad context

21. HSC/E points out that the rate of improvement in fatal injuries gradually slowed to a plateau during the 1990s.[32] It also recognises that there is a huge job to do to tackle occupational ill-health, which accounted for 33 million days lost out of 40 million in 2001/02.[33] This has generated discussion of change to more effective preventive strategies. In the context of the present inquiry, it would seem that there are considerable challenges facing future regulation of occupational health and safety. These include changes in the organisation of work, changes in society's expectations and the wider context, in terms of the regulation of economic activity, into which policy responses must fit.

22. At the same time, regulatory approaches in the UK are also obliged to comply with the model of risk management established by EU Framework Directive 89/391. This sets out employers' overall responsibility for prevention, defines the 'competencies' they must use

29 HM Treasury (2004), *2004 Spending Review, Public Service Agreements 2005-2008,* July 2004. Cm 6238.Norwich: The Stationary Office, p38

30 HM Treasury (2004), *2004 Spending Review, New Public Spending Plans,2005-2008,* July 2004. Cm 6237.Norwich: The Stationary Office, p 18

31 HM Treasury (2004), *2004 Spending Review, New Public Spending Plans 2005-2008, July 2004, Cm 6237. Norwich: The Stationery Office. Page 160;* Spending Review 2004, Press Notice PNA13, Improved Work and Pensions Services.www.hm-treasury.gov.uk

32 Volume III (No. 36)

33 HSC (2004), Strategy for Workplace Health and Safety on Great Britain to 2010 and beyond. Sudbury: HSE Books

and requires the participation of workers and their representatives. The Framework Directive was influenced by the goal-setting approach of the HSWA, but also draws on the traditions of other countries in the EU, especially in its emphasis on the use of prevention services and on representative worker participation.[34] Adopting the systematic approach required by the Framework Directive, therefore, poses a special challenge in the UK, because of its different traditions and approaches to these subjects. As a result, as some witnesses to the inquiry have attested, there is still room for debate on the extent to which the UK regulatory framework fully implements EU requirements.[35]

The challenge of change in the structure and organisation of work

23. The Lisbon European Council stressed that Europe was going through a transition to a 'knowledge-based economy', marked by profound changes affecting society, employment and health and safety at work.[36] The current European Commission strategy notes a rise in diversified forms of employment with particularly strong growth in temporary employment relationships, which are associated with higher health and safety risks. The tragic consequences of this for individuals who are made particularly vulnerable because of their position in the labour market has been explicitly drawn to the attention of the Committee by the evidence from the Simon Jones Memorial Campaign.[37]

24. Changes in the way work is organised, such as more flexible ways of organising working time and the management of human resources on an individual level, based more on obligation to achieve a fixed result are, it is said, 'having a profound effect' on health and well-being at work.[38] National and international surveys show a rising incidence of stress-related conditions and musculoskeletal disorders. Furthermore, these point to a substantial incidence of work related ill-health that is not reported by conventional statutory reporting requirements, leading to estimates that 25,000 people are believed to leave employment each year as a result of work-related injury and illness.[39] Such ill-health and injury has been said to be responsible for the loss of over 25 million working days annually.[40] It is also widely acknowledged that evidence of much of the possible consequences of current changed work structure — the potential occupational health and safety epidemics of the future — remains hidden. At the same time, survey evidence such as that collected in the European Foundation series, for example,[41] demonstrates that traditional occupational

34 Walters D (2002), Regulating Health and Safety Management in the EU, Brussels: Peter Lang

35 See for example, Volume II (Ev 100,Q386), Volume III (No.11)

36 Commission of the European Communities, Adapting to change in work and society: a new Community strategy on health and safety at work 2002-2006. Brussels, 11.03.2002 COM (2002) 118 final

37 Volume III (No. 28)

38 Commission of the European Communities, Adapting to change in work and society: a new Community strategy on health and safety at work 2002-2006. Brussels, 11.03.2002 COM (2002) 118 final

39 Health and Safety Commission/ Department of Environment, Transport and the Regions (1999) *Revitalising Health and Safety*, Consultation Document, London: Dept. of the Environment, Transport and the Regions.

40 Jones, J.R., Hodgson, J.T., Clegg, T.A. and Elliot, R.C (1998) *Self reported work-related illness*, Sudbury: HSE Books

41 See the series of surveys conducted by the European Foundation — European Foundation for the Improvement of Living and Working Conditions (1992) *First European Survey on the Work Environment 1991-1992*, EF/92/11/EN;

European Foundation for the Improvement of Living and Working Conditions (1997) *Second European Survey on the Work Environment*, both Luxembourg: Office for Official Publications of the European Communities;

Paoli, P. and Merllie, D. (2001) *Third European Survey on Working Conditions* 2000, European Foundation for the Improvement of Living and Working Conditions, Luxembourg: Office for Official Publications of the European Communities.

health issues have by no means disappeared. In the case of past exposures to harmful agents in the work environment, such as asbestos for example, negative health consequences are continuing to exert a mounting toll of mortality and morbidity that is likely to continue well into the present century. The European Agency for Safety and Health at Work is there to act as a driving force in terms of raising awareness of emerging risks and is establishing a 'risk observatory' for this purpose.[42]

25. The existence of large numbers of small and medium enterprises (SMEs)[43] also creates challenges for the HSC/E. A recent literature review conducted for HSE, to form an evidence base for its strategy, found that many – but not all, SMEs have relatively low levels of awareness.[44] They are also 'hard to reach, less receptive to awareness-raising activities, too numerous to secure compliance via inspection and often unreceptive to the 'business case' due to the intangibility of costs and benefits.' They are also unlikely to have in-house health and safety expertise and coverage of occupational health support in the sector remains low (see Chapter 15).

26. The so-called supply chain and the role of intermediary processes and actors in the wider economic (and sometimes social) environment in which work takes place are now better understood as potentially important influences on the health and safety of workers. There may be positive aspects of such development and, as its current strategy makes plain, HSC/E intends to use these relationships as levers to improve health and safety performance.[45] However, the literature review conducted for HSC identified some important gaps in knowledge in terms of what is effective in this area. For example, there is uncertainty about the extent to which financial, reputational and supply chain levers influence employers in higher versus lower sectors; about the relative benefits of working with alternative intermediaries (such as trade associations) to get the message across and whether this can water down HSE's brand. [46]

27. There are also important gender considerations to bear in mind when contemplating the effects of the changing world of work on health.[47] In particular, women still carry out the majority of unpaid housework and caring responsibilities (even when working full-time) and this can add to work-related pressures. They are also more likely to be in low-paid, low-skilled and less secure jobs and typically have less control and autonomy over their work. The relevance of these issues to the wider aims of family-friendly approaches to employment in current government and EU policy cannot be overlooked.

28. Trade unions have operated at a number of levels to make workplaces safer. However, trade union membership in the UK has declined substantially since its peak in the 1970s –

42 Commission of the European Communities, Adapting to change in work and society: a new Community strategy on health and safety at work 2002-2006. Brussels, 11.03.2002 COM (2002) 118 final

43 According to the Small Business Service, 99% of firms have less than 50 employees. www.sbs.gov.uk

44 Wright M, Marsden S and Antonelli A (2004), Building an evidence base for the Health and Safety Commission Strategy to 2010 and beyond: A literature of interventions to improve health and safety compliance, Sudbury: HSE Books

45 HSC (2004), Strategy for Workplace Health and Safety on Great Britain to 2010 and beyond. Sudbury: HSE Books

46 Wright M, Marsden S and Antonelli A (2004), Building an evidence base for the Health and Safety Commission Strategy to 2010 and beyond: A literature of interventions to improve health and safety compliance, Sudbury: HSE Books

47 European Agency for Safety and Health at Work (2003), *Gender issues in safety and health at work: a Review.* Bilbao: European Agency for Safety and Health at Work

in fact, it has nearly halved.[48] The HSC's *Collective Declaration on Worker Involvement* notes that while there is evidence of the positive impact trade unions have on health and safety performance, there is less evidence of successful methods of consultation in small businesses where trade unions are not recognised or are without safety representatives for any other reason.[49] There is a risk that consultation by employers with workers on health and safety issues may reduce significantly.

Societal perceptions of risk and social justice: the challenge of change

29. The literature review also found that the social and moral case is an important factor in justifying regulations, creating reputational risk and increasing society's (employees, customers and members of the public) expectations in the arena of health and safety.[50] There is a changing public perception of occupational risk and a drop in public confidence in governmental, corporate and expert decisions on risk management.[51] This has been accompanied by demands for more visible social justice for the victims of accidents and disasters and greater retribution for those perceived to be responsible for them. The Committee identified a significant gap between the expectations of some of the witnesses to the inquiry and HSC/E's strategy on inspection and law enforcement.[52] Reconciling their expectations with their perceptions of HSC strategy in this field remains a challenge.

The challenge to regulation and control

30. The developments outlined above represent enormous challenges to improving health and safety standards. On the positive side, policy responses have emphasised integration between occupational health and safety and broader issues of public health, regulation, employment and social welfare. On the negative side, the implications of reduced resourcing for inspection make it debatable whether HSE is able adequately to undertake its functions of inspection and control in regulating the changing work environment (see Chapter 8).

31. A significant issue for the future is the review of regulatory inspection and enforcement being conducted by Philip Hampton and announced in Budget 2004[53] (see Chapter 2). This looks set to raise fundamental questions about HSC/E's approach and whether there should be some consolidation or streamlining of approach with other regulators. For individual inspectors, there is the question as to whether they should have responsibility for more than one regulatory area.

---

48 National Statistics, *Labour Market Trends*, March 2004 and July 1999

49 HSC (2004) A Collective Declaration on Worker Involvement, www.hase.gov.uk/workers/involvement/statement.htm

50 Wright M, Marsden S and Antonelli A (2004), Building an evidence base for the Health and Safety Commission Strategy to 2010 and beyond: A literature of interventions to improve health and safety compliance, Sudbury: HSE Books, p75

51 Walters D (1999), *Change and continuity: Health and safety issues for the new millennium,* Institution of Occupational Safety and Health Journal, Volume 3, Issue 1.

52 See, for example, Volume III (Nos. 30, 28 and 41)

53 http://www.hm-treasury.gov.uk/consultations_and_legislation/hampton/consult_hampton_index.cfm

4 Targets

32. The *Revitalising* strategy statement published against the background of a perceived plateau in health and safety performance, set out a number of targets for improvement that were to be achieved by 2010 and detailed a range of recommended actions intended to support the achievement of the targets.[54] These targets are detailed below, along with a consideration of their perceived appropriateness. Progress towards their achievement is then assessed.

The 'Revitalising' targets

33. Four targets for improvement were detailed in *Revitalising*. They were to:

- reduce the number of working days lost per 100,000 workers from work-related injury and ill health by 30% by 2010;
- reduce the incidence rate of fatal and major injury accidents by 10% by 2010;
- reduce the incidence rate of cases of work-related ill health by 20% by 2010; and
- achieve half of the improvement under each of the above targets by 2004.

34. Spending Review 2000 set Public Service Agreement Targets to reduce:

- the incidence rate of fatal and major injury accidents by 5% per 100,000 workers;
- the number of working days lost from work-related injury and ill health by 15% per 100,000 workers; and
- the incidence rate of work-related ill health by 10% per 100,000 workers

by 2004, compared to the average for 1999-2000.[55] Spending Review 2004 set a target to 'by 2008, improve health and safety outcomes in Great Britain through progressive improvement in the control of risks in the workplace.' [56] This appears to be less specific and less measurable than the targets set for 2004.

35. Evidence submitted to the Committee raised a number of concerns about the *Revitalising* targets. In its written evidence the Confederation of British Industry, while acknowledging that targets can be an important motivator for improvement, went on to note that it is not possible to 'determine what they are telling us' unless they are based on robust statistics and baselines.[57] It also went on to express concern that in developing its current strategy, HSC did not grasp an important opportunity to review whether the targets are, or ever were, appropriate. In a similar vein, the EEF, in its oral evidence,

54 HSC (2000), Revitalising Health and Safety: Strategy Statement. June 2000. Wetherby: DETR

55 DWP Autumn Performance Report 2003, Progress against Public Service Agreement Targets, London: TSO

56 HM Treasury (2004), *2004 Spending Review, Public Service Agreements 2005-2008,* July 2004. Cm 6238.Norwich: The Stationary Office, p38

57 Volume III (No. 42)

although voicing support for the targets also voiced uncertainty about 'the base from which they came'.[58]

36. In its oral evidence, the CBI further noted that the *Revitalising* targets constitute 'lagging indicators' in the sense that they measure ultimate outcomes rather than 'leading indicators' of health and safety performance, such as the amount of training being provided.[59] RoSPA, in its written evidence, similarly called for the creation of 'upstream' targets, as well as 'downstream' ones, and suggested that one such target could be that 'all managers in UK PLC must have some health and safety training by 2010'.[60]

37. In contrast, the DWP, in its evidence stated that the *Revitalising* targets were 'the right ones', but noted that it did 'not think that they told the whole story'.[61] It went on to point out that, in recognition of the fact that a large and vital part of HSE's work involves major hazards, targets for these had now been developed.

38. The written evidence from the HSC/E highlighted that there were difficulties with establishing baseline data that could be used to assess progress towards achieving the *Revitalising* targets and stated in oral evidence that they are 'taking steps to improve [their] statistical information'.[62] However, Mr Gareth Williams of the Department for Work and Pensions told us that HSE was introducing a new workplace survey, which would give better quality improved data on workplace ill-health 'to get a better handle on both the starting position and the causes and principal contributory factors.'[63] In addition, HSE is planning to pilot a two-tier workplace survey which will include interviews with management and the workforce at a sample of workplaces to ascertain accident and ill health levels in the construction industry.[64]

39. The National Audit Office (NAO) notes that HSE estimates from surveys that employers only report around 46% of non-fatal injuries that are reportable under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) and that, in this context, the above survey could provide a more accurate and cost effective way of obtaining more reliable and representative data on accident and ill health trends.[65] However, in common with some of the evidence reported earlier, it also recommended that the HSE develop a broader programme of evaluations of its initiatives which encompasses not just 'outcome improvements', but also 'changes in stakeholder awareness and practice (for example, through independent surveys of employers and employees, and through follow-up site visits), and measurement of the impact of publicity and media success particularly in relevant trade and local media as well at a national level (for example, measuring changes in stakeholder attitudes)'.

---

58 Volume II (No. 33)

59 Volume II (Ev 48, Q142)

60 Volume III (No. 14)

61 Volume III (No. 40)

62 Volume III (No. 36)and Volume II (Ev 128, Q490)

63 Volume II (Ev 150, Q585)

64 National Audit Office (2004), *Improving health and safety in the construction industry.* HC 531 Session 2003-2004, London: The Stationery Office, para 1.11

65 National Audit Office (2004), *Improving health and safety in the construction industry.* HC 531 Session 2003-2004, London: The Stationery Office, para 1.11

40. In the light of the evidence submitted, the Committee does not see any reason to question the use of 'outcome' targets such as those detailed in the *Revitalising* strategy. It does, however, consider that the use of overall targets for improvements in health and safety performance could usefully be supplemented by 'upstream' targets on such matters as the proportion of employers conducting risk assessments and providing certain types of occupational health support, and the scale of health and safety training provided by them.

41. **The Committee recommends that the HSE use an annual workplace health and safety survey to obtain data to enable it to publish evidence of trends on such issues as the proportion of employers (a) conducting risk assessments, (b) providing occupational health support and (c) training on health and safety issues.**

Progress against targets

42. Following the setting of the *Revitalising* targets, a detailed analysis was conducted within the HSE as to how performance against the three main targets could be assessed.[66] In general, this analysis revealed that major difficulties existed with regard to assessing trends in respect of each of the three areas of 'outcome' encompassed by them: incidence of fatal and major injury accidents; working days lost as a result of work-related injuries and ill health; and the incidence of work-related ill health. Pending the acquisition of more adequate sources of data, data from various sources is being looked at in combination.

43. In their written evidence the HSC/E stated that 'there is no conclusive evidence as yet of the extent of progress towards the target relating to the incidence of fatal and major injury accidents' and that, as regards the overall incidence of work-related ill health, 'the balance of evidence suggests that it is likely to have risen since 1999/2000, although this may be due to an increasing awareness of work-related ill health problems such as stress that previously may not have been attributed to work'.[67] As regards the working days lost target, the HSC/E observed that 'it is not yet possible to make a judgement on progress as figures are available for one year only'. More generally, the HSC/E observed that the 'conclusion at present must be of limited progress towards targets, based on currently available hard evidence'.

44. In order to support the achievement of the *Revitalising* targets, the HSE has identified nine areas for priority action.[68] One of these concerns the theme of 'Government setting an example', while the other eight encompass a focus on particular sectors of employment and types of hazard. The sectors concerned are agriculture, construction, and health services and the hazards are slipping, tripping, falls from height, workplace transport, musculoskeletal disorders, and stress, depression and anxiety.

45. Because of the likely time lag that might occur between actions taken and response in terms of progress towards targets, the HSE has identified some proxy indicators built around the above nine areas of priority action for the purposes of quarterly reporting to

66 HSE, Achieving the Revitalising targets: statistical notes on progress measurement. Epidemiology and Medical Statistics Unit, June 2001, www.hase.gov.uk

67 Volume III (No. 36)

68 HSC (2004), HSC Annual Report and HSC/E Accounts 2003/04. Norwich: The Stationery Office

Ministers on progress towards the *Revitalising* targets.[69] These proxy indicators provide a range of interesting information on HSE activity and provide some 'upstream' measures of changes in employer activity in relation to a small number of issues, such as the number of construction workers holding Construction Skills Certification Scheme cards; the number of lift truck drivers undergoing training and trends on risk control; indicators relating to musculoskeletal disorders; falls from height, and 'hits' on HSE web pages concerned with stress, manual handling and workplace transport.[70] In their evidence the HSC/E observed that trends in some of these indicators are 'starting to show signs of some early gains'.[71] This observation was found by the Committee to be supported by the contents of the last quarterly report provided to Ministers.[72]

46. The Committee questions how much reliance can be placed on the 'early gains' measured against HSC/E's proxy indicators. It questions whether the range of issues covered by these indicators is sufficiently broad and whether there is evidence showing a direct link between them and workplace health and safety performance. One option would be to use the new workplace survey to gather information to address this.

47. The HSC/E's rather downbeat assessment of progress was broadly echoed in the DWP's evidence, where it was observed that current 'available evidence indicates that while the interim safety targets for 2004 may be met, it is unlikely that the health targets will be met'.[73] It was also echoed in the evidence provided by several other organisations. The Institution of Occupational Safety and Health noted that ' according to Health and Safety Statistics 2002-03…evidence suggests that the overall incidence of work-related ill health is likely to have risen since 1999/2000, the base year of Revitalising….information suggests work-related stress is rising, while musculoskeletal disorders – the other major cause of ill health – shows no change…'.[74] Mr Roger Bibbings, Occupational Safety Adviser for the Royal Society for the Prevention of Accidents, stated that 'We think progress has been achieved in some sectors particularly, but overall progress towards the targets has not been as fast as we would have liked'[75], and the Scottish Trades Union Congress noted with concern that 'HSE statistics for Scotland show that for the last four reporting years the amount of fatal injuries to employed and self-employed workers has actually increased'.[76]

48. In its report on health and safety in the construction industry, the NAO notes that the industry had set its own targets for improving its health and safety which were more challenging than those detailed in the *Revitalising* strategy statement.[77] These targets and the corresponding national ones, along with an assessment of industry's progress towards achieving them, are detailed in the following table taken from the NAO's report.

---

69 Volume III (No. 36)

70 Volume III (No. 38)

71 Volume III (No. 36)

72 Volume III (No. 38)

73 Volume III (No. 40)

74 Volume III (No. 25)

75 Volume II (Ev 1, Q2)

76 Volume III (No. 11)

77 National Audit Office (2004), *Improving health and safety in the construction industry.* HC 531 Session 2003-2004, London: The Stationery Office. Figure 7

	Construction industry targets – percentage reduction		Percentage reduction for construction industry	National targets – percentage reduction	
Target	By 2004-05	By 2009-10	As at 2002-03	By 2004-05	By 2009-10
Reduce the incidence rate of fatal and major injury accidents	40%	66%	5% against baseline figures for 1999-2000	5%	10%
Reduce the number of working days lost per 100,000 workers from work-related injury and ill-health	20%	50%	Baseline figures were established in 2001-02	15%	30%
Reduce the incidence rate of cases of work-related ill health	20%	50%	Baseline figures were established in 2001-02	10%	20%

49. Overall, on the basis of the above data, the NAO concludes that it is unclear whether the construction industry will meet the targets it has set itself. Its report does, however, point out that, in January 2003, the HSE reported that the rate of fatal and major injury in the industry was 12% below the baseline figure established for 1999-2000.[78]

50. While recognising the statistical problems that exist in assessing progress against the 2000 *Revitalising* targets and the evidence on proxy indicators provided by the HSC/E, **the Committee views with concern the limited progress that appears to have been made and does not believe that there is any realistic prospect of achieving the 2004 targets. In its view this lack of progress must, inevitably, raise questions about the present system's capacity to secure significant future improvements in standards of workplace health and safety.**

51. The Committee is also concerned that the Public Service Agreement target to 'improve health and safety outcomes' by 2008 appears to be vague and unmeasurable. **We recommend that the Government produces and publishes specific details of what this target is and how it is to be measured.**

5 Legislative framework

52. The evidence we received, both written and oral, indicated that there is broad support for the principles of the HSWA, with some caveats.[79] There were concerns that the emphasis on goal setting could make compliance and enforcement difficult, particularly for

78 National Audit Office (2004), *Improving health and safety in the construction industry.* HC 531 Session 2003-2004, London: The Stationery Office. Para 1.14

79 See, for example, Volume III (Nos. 5, 33 and 42)

small businesses, and that HSE is not always sufficiently proactive in filling the gap with the sort of clear guidance that would help.[80]

53. HSC/E argued that some limited legislative changes are needed - on higher fines, corporate killing and the removal of crown immunity.[81] The Department for Work and Pensions supports HSC in promoting the case for higher fines, and other more imaginative penalties. The Department for Work and Pensions is working with other Departments to progress the Government's commitments to reform the law on corporate killing and to remove crown immunity for health and safety offences. The Government has been committed to introducing legislation on corporate killing for some time.[82] Private Members Bills aimed at increasing penalties for health and safety offences and to introduce a new offence of corporate killing have repeatedly failed.[83] On 20 May 2003, the Government announced that it would publish a draft Bill.[84] While this was expected by the end of 2003[85], it has yet to be produced. In oral evidence, Mr Gareth Williams of the Department for Work and Pensions told us that the principle of introducing legislation on corporate killing was agreed, although it was important to ensure there was an effective means of applying it.[86] The principle about whether and how to apply it to the Crown had yet to be resolved. The Home Secretary is hoping to publish a draft Bill before the end of the session.[87] **The Committee is concerned at the length of time it is taking the Government to resolve any outstanding issues concerning reforms of the law on corporate killing and recommends that by 1 December 2004, the Government publishes a Bill on corporate killing.**

54. These areas apart, HSC's current strategy involves a 'downplaying of further regulatory solutions.'[88] Other regulatory changes proposed in *Revitalising,* for example on private prosecutions,[89] are still under consideration. Mr Williams of the Department for Work and Pensions told us that the need for regulation was looked at on a case by case basis as part of the Regulatory Impact Assessment. The Minister for Work, told us that making directors' duties for health and safety statutory was not the agreed way forward at this time.[90] On legislation to respond to the changing world of work[91] HSE has come to the conclusion that existing health and safety legislation offers adequate legal protection for all workers, regardless of employment status.[92] Action Point 31 of *Revitalising* was that HSC should

80 See, for example, Volume III (No. 20)

81 Volume III (No. 36)

82 See for example, *Official Report*, 7, November 2002, col 817W; *Official Report*. 17 March 2003, col 587W

83 See for example, the Health and Safety at Work (Offences) Bill [Bill 26, 1999/2000], Corporate Homicide Bill [Bill 114, 1999/2000]; Health and Safety at Work (Offences) Bill [Bill 38, 2002/03]

84 Home Office Press Release, Government to tighten laws on corporate killng. 20 May2004

85 *Official Report,* 11 June 2003, 17 June 2003

86 Volume II (Ev 153, Q600, Q604)

87 Volume II (Ev 159), The Minister for Work subsequently reported that the aim was to produce a draft Bill towards the end of 2004. *Official Report*, 14 July 2004, col445WH

88 Volume III (No. 40)

89 HSC (2000), Revitalising Health and Safety Strategy Statement. June 2000. Wetherby: DETR, Action Point 10

90 HSC/E (2004), Implementing Revitalising Health and Safety – Progress Report. April 2004 Update. www.hse.gov.uk

91 HSC (2000), Revitalising Health and Safety Strategy Statement. June 2000. Wetherby: DETR, Action Point 16

92 Volume II (Ev 145, Q547)

consult on whether the duty on employers to ensure the continuing health of employees, including action to rehabilitate where appropriate, could be usefully strengthened. However, 'as there were no immediate legislative opportunities', it has been decided that HSE should continue working in partnership with DWP and [the Department for Health] to take forward the job retention and rehabilitation agenda.[93]

55. The Committee does not believe that the strategy of 'downplaying…further regulatory solutions' is the right approach. The relative Departmental inactivity in these areas of possible legislation is regrettable and demonstrates a worrying lack of commitment. **The Committee recommends that commitments to legislate made in *Revitalising Health and Safety* in 2000 should be honoured by a Government Bill in the next session of Parliament.**

Directors' duties

56. The HSE recognises that, in organisations that are good at managing health and safety, it is a board room issue and a board member takes direct responsibility for co-ordination of that effort.[94] Action Point 11 of *Revitalising Health and Safety* was that HSC would advise Ministers on how the law needed to be changed to make these responsibilities statutory, so that directors are clear about what is expected of them in their management of health and safety. It was the intention to legislate on these matters when Parliamentary time allows, as the weight of evidence suggests that the imposition of legally binding duties on directors would increase the likelihood of directors taking ownership of health and safety problems[95], positively impact on the current levels of preventable work-place death and injury and create more of a level playing field between those directors who take their health and safety responsibilities seriously and those who do not.

57. The CBI supported the idea that there should be a director for health and safety who is 'a champion, a reporting person, a motivator and a facilitator for good health and safety performance' but was concerned that it would move quickly to that same person being 'pinpointed to take a claim.' [96] Because of this, it was important to be 'careful about the wording.'

58. The Government appears to have changed its mind since *Revitalising,* however, and has no current plans to legislate. The Minister, told us that HSE had published guidance on the issue in July 2001[97]. The evidence since then suggested that 'increasingly, companies were directing health and safety at board level and that better guidance to companies is needed rather than legislation or further regulation.' A survey published in 2003, showed that the number of companies in which health and safety was being directed at board level had increased from 58 to 66 per cent. The Minister concluded that this progress diminished the need to regulate.[98] Alternatively, it is worth noting that the perceived threat

93 HSC/E, Implementing Revitalising Health and Safety – Progress Report. April 2004 Update. www.hse.gov.uk

94 HSC (2000), Revitalising Health and Safety Strategy Statement. June 2000. Wetherby: DETR, Action Point 10, para 69

95 See, for example, Hillage J et al (2001), *The impact of the HSC/E: A review,* London: HSE Books, page 29

96 Volume II (Ev 55, Q181)

97 Volume II (Ev 145, Q549)

98 Volume II (Ev 146, Q554)

of legislation in this area might have led some employers to put such arrangements in place in order to pre-empt the need for legislation.

59. The Centre for Corporate Accountability argued that it is not clear that directors are giving leadership and direction on the issue.[99] It says that HSC has acknowledged that in some cases board level involvement is 'fairly superficial.' Furthermore, it argues that the survey referred to by the Minister does not paint a straightforward picture of progress. While an increasing number of organisations were directing health and safety at board level, the study also showed that board level involvement on some issues actually decreased.

60. **The Committee recommends that the Government reconsiders its decision not to legislate on directors duties and brings forward proposals for prelegislative scrutiny in the next session of Parliament.**

European Union

61. Concern is also expressed, particularly by employer groups, that recent legislation coming from the EU has not been subject to an adequate regulatory impact assessment. For example, legislation on 'whole body vibration' which HSC acknowledged would not deliver health and safety improvements, was criticised by EEF, the manufacturers' organisation.[100] DWP argued that it was trying to work within the EU along the Regulatory Impact Assessment model in order to get more clarity about the purpose of individual directives.[101] On its visit to Brussels, the Committee was told that the EU health and safety directives were due for review. This could provide an opportunity to ensure that both current and future directives are necessary, reasonable and practical.

62. The European Commission has issued a Reasoned Opinion alleging under-implementation of the Framework Directive relating to the use of the wording 'so far as is reasonably practicable'.[102] The CBI is concerned that this principle is under threat.[103] Dr Janet Asherson told us that the CBI valued the flexibility it gave companies to achieve health and safety objectives and was well-established.[104] The Scottish Trades Union Congress told us that it continued to 'be concerned that the inclusion of reasonable practicability is an economic measure of health and safety' and viewed it as 'a contravention of the European Health and Safety Framework Directive.'[105] Mr Gareth Williams of the Department for Work and Pensions told us that the Government thinks the approach adopted in the UK, in the context of UK law is robust and that the UK's comparatively good performance on health and safety demonstrated its value.[106] The

99 Volume II (Ev 40)

100 Volume III (No.30)

101 Volume II (Ev 158, Q 626)

102 Volume III (No. 36)

103 Volume III (No. 42)

104 Volume II (Ev 49, Q143)

105 Volume III (No. 11)

106 Volume II (Ev 158, Q626)

Government has responded to the Commission and awaits its response[107]. This is a matter to which the Committee may wish to return.

6 Health and Safety Commission and Executive Constitutional Framework

63. Under the Health and Safety at Work Act, the Health and Safety Commission has overall responsibility for policy on health and safety at work and, in this capacity, advises Ministers on relevant standards and regulations, as well as making arrangements for conducting research and providing information and advice. The Health and Safety Executive advises and assists the HSC and has a statutory duty to make adequate arrangements for the enforcement of the Act and other relevant statutory provisions in Britain.

64. The constitutional roles of the HSC and HSE, as well as the relationship between them, have received a good deal of support in the evidence submitted to the Committee. The CBI, for example, said that the legal requirement to consult 'has been the trigger for a culture of openness and consultation which has benefited all stakeholders.'[108] Those who have to deliver health and safety performance were engaged in the process of developing policy. There were some sectors which felt they were not involved. The Institution of Occupational Safety and Health argued that the Commission needed to be 'more representative of…..the changed world of work, and particularly it should include at least one competent health and safety practitioner'.[109] RoSPA recommended a 'consultative mapping exercise' was needed to provide a firmer foundation for partnership working between the HSE and others.[110]

65. HSE was much praised for the quality of its staff and its output. UCATT, for example, said the advice, guidance and research provided by HSE and HSC 'are excellent, and reflect the qualified and committed staff they employ'. [111]

66. Some submissions to the Committee questioned the continued value of the division between the HSC and HSE and raised concerns about the role of the HSC (although others were supportive[112]). In particular, Alan Osborne, who was appointed in November 2002 as a member of the HSE Board with responsibility for rail safety, and subsequently resigned in October 2003, reports that, in his view, HSE/C is 'dysfunctional across its policy and inspectorate functions, not listening to its stakeholders, lacking in modern corporate governance processes and grossly inefficient'.[113] In particular, he argues that the 'two-tier structure of the HSC/E is extremely cumbersome and old fashioned', that the composition of the Commission means that it involves ' a group of people coming together to develop

107 Volume III (No. 36)

108 Volume III (No. 42)

109 Volume II (Ev8,Q26)

110 Volume III (No. 14)

111 Volume III (No. 35)See also Volume III (Nos. 4, 5, 20 and 26); Volume II (Ev 50, Ev 50, Q148)

112 See, for example, Volume III (Nos. 33 and 42)

113 Volume III (No. 2)

their patches rather than being a cohesive group developing a shared vision'. He argued that the entire process of governance of HSC/E 'requires a fundamental review before it can begin to function as an effective and modern regulator.'

67. The HSC operates by seeking consensus. This is seen by some to be a strength – the involvement of employer and employee representatives seen as leading to legislation which is workable[114]. Lack of consensus was a key factor leading to regulations to improve consultation with employees being dropped, for example (see Chapter 14). However, the Committee was concerned that the decision to seek consensus may act as an effective veto to legislation to improve health and safety standards in disputed areas.

68. HSC has a range of advisory groups relating to particular industries or topics. These committees are serviced by HSE to help achieve the outcomes in the Commission's strategic plan.[115] They may recommend standards and guidance, comment on policy issues, or recommend an approach to a particular new problem. Each includes a balance of people nominated by employer and employee organisations and, where appropriate, public interest representatives and experts in the area. Many witnesses to the inquiry considered these committees to be an important part of the HSC's tripartite approach and were concerned that their role was being downgraded. [116]

69. The Graphical, Paper and Media Union (GPMU), for example, described Industry Advisory Committees (IACs) as an important way of maintaining and developing trade union input and one of the best vehicles HSE had to use to give advice but 'a structure that HSC and HSE senior managers continue to attack'.[117] The Royal College of Nursing considered that the disbandment of the Occupational Health Advisory Committee compounded a sense of a lack of coherence, leadership and accountability on occupational health issues in the health service. [118] In the construction sector, both the employer (the Construction Confederation) and union side (the GMB) were concerned that HSC was reducing the scale of its consultation in the industry by downgrading the relevant Industry Advisory Committees.[119]

70. In oral evidence, Mr Bill Callaghan, Chair of the HSC, told us that he had looked at the range of existing committees and how they worked. He was not sure they all performed as well as they could, although there were some very good examples, such as the Paper and Board Advisory Committee (interestingly, one in which the GPMU is involved).[120] On the subject of the Occupational Health Advisory Committee, work was underway to engage a wider range of partners to develop new ways of working and in this context, HSC felt it more appropriate to get input from former members of the committee as part of a wider group of experts.[121]

---

114 Volume III (No. 42)

115 www.hse.gov.uk/aboutus/iacs/index.htm

116 See, for example, Volume II (Nos. 26 and 4)

117 Volume III (No. 4)

118 Volume III (No. 13)

119 Volume III (No. 20), Volume II (Ev 107,Q401)

120 Volume II (Ev 133, Q519)

121 Volume II (Ev 140), Note 4

71. Overall, the Committee notes that HSC/E's tripartite approach has strong support from those involved but questions how much evaluation has been done to demonstrate the outcomes such an approach actually produces.

72. **The Committee recommends a wide ranging and open review of the role and effectiveness of HSC's Industry Advisory Committees to help to address concerns that they are being downgraded.**

Resources

73. HSE charges for some aspects of its work – mainly in relation to regulating the major hazard industries and through sale of publications.[122] Otherwise the budget is set through the Spending Review process. HSC/E explained that following a period of modest increase in resources, Spending Review 2002 set a baseline which rose slightly in 2003/04 and 2004/05 and drops back in 2005/06. It said that 'when rising costs are taken into account, this represents a significant reduction in spending power.'

Table 1. HSE's budgetary position for the years 201/02 to 2007/08

	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08
	£m	£m	£m	£m	£m	£m	£m
Gross Budget	254	262	278	279	271	271	271
Income	51	52	58 Forecast	Income level subject to further work on charging			
Gross Spend	255 (outturn)	256 (outturn)	260 Forecast				

Source: Health and Safety Executive

Notes1. SR2004 projected budget (06/07 and 07/08) assumes roll forward of 2005/06 baseline. 2.The ring-fenced Cullen funding of £4m is included in figures for each of years 03/04 and 04/05.

74. Spending Review 2004 commits the Department for Work and Pensions to 'realising total annual efficiency gains of at least £960 million by 2007-08.' As part of this, by 2007/08, DWP will reduce its workforce by 30,000, redeploy 10,000 posts to front-line roles and reduce its administration budget in real terms by 3.0% per year.[123] The Secretary of State for Work and Pensions described this as a 'challenging but deliverable settlement' for the Department.

75. In oral evidence, the Minister referred to an opportunity to consider how HSE uses its funds:[124]

> "Whilst every organisation can do more, and spending ministers can always use more money, we can always make a case for more money, we also have to look at

122 Volume III (No. 36)

123 HM Treasury (2004), 2004 Spending Review: New Public Spending Plans 2005-2008. July 2004. Cm 6237. London: TSO, page 160; Spending Review 2004, Press Notice PNA13, Improved Work and Pensions Services.www.hm-treasury.gov.uk

124 Volume II (Ev147, Q557)

> maximising the value that we are getting from the money that we are spending and that is why we strongly support the HSE's strategy, because we believe it very much measures the work of the HSE and gives us an opportunity to look at their performance in terms of the funds that they receive".

76. A key aspect of HSC's current strategy, therefore, is to 'be clear about our priorities and focus our activities on our core businesses and the right interventions. This means concentrating more on the areas and interventions where we can make the greatest impact and developing new ways to exert influence.'[125] Some of the evidence the Committee received agreed that HSE was not yet sufficiently focused. For example, EEF, the manufacturers' organisation, questioned HSE's desire to engage in corporate social responsibility agenda with 'the great and the good' when it should be focusing on the smaller, harder to reach businesses. [126] Alan Osborne argued that 'in the context of the need to do things differently in the future, it was difficult to consider whether the budget needed to increase'.[127]

77. However, the majority of organisations giving evidence to the Committee suggested that lack of resources was having a negative impact on HSE's capacity to ensure compliance with health and safety legislation.[128] The Construction Confederation said that constraints posed by a lack of resource, were leading HSE to concentrate on short-term policing rather than genuinely trying to help the industry with a long term strategic improvement and to HSE delays in issuing important pieces of guidance. [129] Furthermore, driven in part by lack of resources, HSE had been increasingly 'unable to provide sufficient prescription in regulations and guidance'.[130] The Institution of Occupational Safety and Health (IOSH) supported increased resources to allow HSE to 'adequately discharge its statutory duties and to establish and implement evidence-based interventions, ensuring competent stewardship of an effective occupational health and safety system for Great Britain.'[131]

78. Concerns about the reductions in HSE's in-house expertise (reduced staffing levels in the Employment Medical Advisory Service and the abolition of the Chief Medical Officer) were raised by a number of organisations.[132] EEF pointed to reductions in the National Engineering Group, a unit set up to provide expert advice on difficult or complex engineering issues to front-line inspectors. This is, they said, 'no longer effectively resourced, which is detrimental to the consistency of inspection and prevents a strategic approach being taken by HSE in this sector.' [133]

---

125 Volume III (No. 36)

126 Volume II (Ev51, Q151)

127 Volume III (No. 2)

128 Volume III (Nos. 4, 5, 11, 12, 14, 15, 17, 25, 26, 30, 35, 41, 45, 50 and 51)

129 Volume III (No. 20), Volume II (Ev 119, Q455). See also Volume III (No. 51)

130 Volume III (No. 20)

131 Volume III (No. 25)

132 See, for example, Volume III (Nos. 12, 30, 32 and 33); Volume II (Ev95, Q360)

133 Volume III (No. 33); Volume II (Ev50,Q148)

79. The impact of resources on HSE's ability to enforce the legislation was a key concern for many organisations, including trade unions and some employers.[134] Organisations such as the Centre for Corporate Accountability and Prospect point to a direct link between HSE's resources and the number of inspectors. This in turn, it was argued, was resulting in a 'resource driven enforcement strategy'[135] (see Chapter 9).

80. There was some criticism that HSC does not campaign openly for increased resources.[136] The Institution of Occupational Safety and Health, for example, was disappointed to see an assumption that resources cannot increase running through HSC's draft strategies.[137] The Committee asked HSC/E, if more resources were made available, what they would spend them on. Mr Bill Callaghan, Chair of the HSC, said that a 'strong case' had been put to Ministers for more resources and that priorities were occupational health support and communications (see Chapters 12 and 15).[138] Contrasted with the evidence we received on the core functions that are being cut back due to lack of resources, these demands seem far too modest.

81. The Royal Society for the Prevention of Accidents argued that HSC/E and HM Treasury should consult stakeholders 'on macro economic 'spend to save' projections, comparing additional HSC/E inputs with the savings that might be achieved as a result of meeting the agreed targets.[139] It was also argued that if the Government believed there was a 'business case' for health and safety, this should apply equally to its own spending plans.[140] The 2004 Spending Review Settlement, announced on 12 July, set the Government's spending plans for 2006/07 and 2007/08 and confirm the spending plans which were set for 2005/06 in the 2002 Spending Review[141] (see paragraph 74).

82. The Committee received some evidence that HSE could make better use of the resources it has and such arguments need to be examined carefully by HSC/E. However, the overwhelming view was that HSE is a high quality organisation, constrained by inadequate resources, seriously adversely affecting its ability to deliver adequately core activities such as inspection, which have a direct impact on ensuring compliance. **We endorse the view of Prospect that the number of inspectors in HSE's Field Operations Directorate should be doubled (at a cost estimated by them as £48 million a year after 6 to 7 years).**[142] **We recommend that substantial additional resources are needed in the next three years.**

---

134 Volume III (Nos. 5, 11, 12, 14, 17, 25, 26, 30, 35, 41, 45, 50 and 51)

135 Volume III (Nos. 41 and 30)

136 Volume III (No. 41)

137 Institution of Occupational Safety and Health, response to HSE's second consultation on HSC's draft strategic plan for 2004-2010. 01.12.2003

138 Volume II (Ev 137, Q539)

139 Volume III (No. 14)

140 The Institution of Occupational Safety and Health, Response to HSC's draft strategic plan, *A Strategy for Workplace Health and Safety in Great Britain to 2010 and heyond.*

141 www.hm-treasury.gov.uk/spending_review

142 volume II (No. 30). Prospect explains that the cost of employing an additional 700 inspectors in FOD would cost 'something like £48million after say 6 to seven years' (Volume II, Ev39). There were some 700 frontline inspectors in FOD in 2003 (Volume III, No. 41).

7 Devolution

83. Legislative responsibility for health and safety is reserved to Westminster. Related areas, such as health, transport, education and justice are devolved to the Scottish Executive[143]. The Welsh Assembly has power to develop and implement policy for health, education and transport.[144] The lead organisation in Northern Ireland is the Health and Safety Executive for Northern Ireland (sponsored by the Department for Enterprise, Trade and Investment.) and the key piece of legislation there is the Health and Safety at Work (Northern Ireland) Order 1978.[145]

84. The Committee visited Scotland to look at how the Health and Safety Executive had responded to devolution. HSC/E has formalised its relations with the Scottish Parliament, through a Concordat.[146] HSE has also established a Scotland Director. This Director has operational responsibility for the Field Operations Directorate in Scotland and, more generally, advises on relations with the Scottish Executive. The health of the nation is one of the Scottish Parliament's main priorities and HSE is working with the Health Department in its role of raising the standards of health of the Scottish population as a whole. The Scottish Executive has recently established a post of Minister for Health and Safety, currently held by Lewis Macdonald.[147]

85. HSE considers that the comparative figures for rates of accident, injury and ill-health for England, Scotland and Wales reveal anomalies.[148] Fatal injury rates, for example, are higher in Scotland than for the rest of Great Britain, although so far, no definitive reasons have been found for this. On the other hand, rates of self-reported illness are lower. HSE is exploring these anomalies.[149]

86. The Federation of Small Business (FSB) in Scotland reported improvements in joined-up working on health and safety issues since devolution.[150] Devolution was said to have brought 'focus' to the question of workplace health in small businesses, resulting in the establishment of the Safe and Healthy Working pilot. The FSB and the Scottish Hazards Campaign Group (SHCG) both considered this a very good example of joint working between a wide range of partners.[151] FSB was also positive about joint working around the *Healthy Working Lives* initiative, considering it a good step forwards towards focusing on the economic outcomes of improving Scotland's health. The establishment of the Scottish Centre for Healthy Working Lives, which will pull together various health initiatives into a single, integrated organisation, was considered a welcome integration and rationalisation of organisations as public sector support to small and medium enterprises (SMEs).

143 Volume III (No. 37)

144 ww.wales.gov.uk/pubinfaboutassembly/content/powers-e.htm

145 www.hseni.gov.uk

146 Volume III (No. 37)

147 Volume II (Ev 93,Q351)

148 Volume III (No. 37)

149 See Appendix 1

150 Volume III (No. 57)

151 Volume II (Ev84, 320); Volume III (No. 57)

87. Both the Scottish Trades Union Congress (STUC) and SHCG argued that more should be done to take advantage of the opportunities provided by devolution.[152] STUC argued the HSE Field Operations Directorate should be given more autonomy in the context of devolution, to allow more constructive relationships with a range of stakeholders and to take account of differing economic and industrial trends.[153] The Convention of Scottish Local Authorities reported initial difficulties in getting key stakeholders around the table. However, it considered that the naming of Lewis Macdonald as Minister for Health and Safety provided a positive opportunity to plan a joined-up approach.[154] It argued for the 'formation of a formal partnership between local authorities and HSE Scotland on the basis of joint national resource planning, risk prioritisation and programme working, against jointly agreed and fully resourced outcome targets.'[155] The Royal Society for the Prevention of Accidents said it favoured the idea of setting up new Welsh, Scottish and English Regional fora to bring together key H&S promoters at this level. However, experience suggests the need for 'strong leadership, involvement of HSE staff and adequate resourcing.'[156]

88. The fact that health and safety legislation is reserved to Westminster while the Scottish Executive and Welsh Assembly are responsible for health policy and for the funding of local authorities means that joint planning and working has become increasingly important. Evidence to the Committee was that there had been positive developments in Scotland such as the Safe and Health Working pilot. However, it was also suggested that there was much to be gained from an increased emphasis on joint resource planning, risk prioritisation and programme working. **The Committee recommends that this process would be assisted if HSE actively promote joint resource planning, risk prioritisation and programme working across the devolved legislatures in Great Britain.**

8 Changing world of work

89. The European Commission's current health and safety at work strategy identifies changes in the world of work as a key challenge.[157] It comments that the labour market is seeing increasingly diversified forms of employment, with particularly strong growth in insecure employment or contingent work. This includes self-employed sub-contractors, (including many mobile or home-based workers), temporary (including on-call), leased (or labour hire) or short-term fixed contract workers and some micro-small business workers and part-time workers and migrant workers.[158]

90. The increase in such forms of work poses a serious challenge to the effective management of health and safety risks. Temporary workers are more likely to suffer an

152 Volume III (Nos. 17 and 11)

153 Volume II (Ev 102)

154 Volume II (Ev89, Q338)

155 COSLA's consultation response to the Review of the Relationship between Health and Safety Executive and Local Authorities

156 Volume III (No. 14)

157 Commission of the European Communities, Adapting to change in work and society: a new Community strategy on health and safety at work 2002-2006. Brussels, 11.03.2002. COM (2002) 118 final

158 Johnstone R, Quinlan M and Walters D, Statutory Workplace Arrangements for the Modern Labour Market

accident, particularly in the construction industry or health and social services[159]. Part-time work and working non-standard hours can also add to the degree of risk, due to factors such as lack of proper training, psychosomatic problems caused by shift or night work, lack of awareness on the part of managers and a lack of motivation on the part of workers in an insecure working relationship.

91. *Revitalising* registered concern that the current legislative framework did not deal adequately with the 'apparently self-employed', homeworkers, peripatetic workers and volunteers. The shift to more flexible forms of working means the link between the place of work and the work to be done is weakening. The employer is responsible for health and safety no matter where the work is done and has to take steps to prevent risk at different sites. And a large majority of respondents to the *Revitalising* consultation saw the need for clearer guidance on health and safety responsibilities in contractual chains. Action Point 16 of *Revitalising* committed the HSC to considering whether the HSWA should be amended in response to the changing world of work, in particular to ensure the same protection is applied to all workers regardless of their employment status. In oral evidence, the Minister told us that the HSC/E had decided that the legislation was adequate and that the best route to clarify knowledge and uncertainty was through clear advice backed up, where necessary, by enforcement action.[160]

92. The Committee wished to look at the extent to which HSE was able to ensure that health and safety risks were adequately managed for all workers. We looked, in particular, at the construction industry and the health and social care sectors. The way in which health and safety standards are protected through the contractual chain is an issue in both public and private sectors, and has been a particular concern in the health service. In the construction sector, particular groups of workers may be at higher risk, such as agency workers and migrant workers. The way in which social care is changing has created particular challenges, with care increasing contracted out by local authorities; or purchased by individuals, a trend set to continue and expand through changes in social services legislation.

Contractual chains

93. The Health and Safety at Work Act places employers under a duty to ensure the health, safety and welfare at work of their employees[161] and also to ensure that people not in their employment are not exposed to risks to their health and safety.[162] This means that there are situations in which responsibilities are complex and overlapping. A large majority of respondents to the consultation preceding *Revitalising* saw the need for clear and simple guidance to ensure a better understanding of health and safety in contractual chains.[163] Only 19% considered themselves clear about who held what duties. 81% felt the need for clarification, with about a tenth of these commenting that the law was only clear when the

159 Commission of the European Communities, Adapting to change in work and society: a new Community strategy on health and safety at work 2002-2006. Brussels, 11.03.2002. COM (2002) 118 final

160 Volume II (Ev146, Q553)

161 Section 2, Health and Safety at Work Act 1974

162 Section 3, Health and Safety at Work Act 1974

163 HSC (2000), Revitalising Health and Safety Strategy Statement. June 2000. Wetherby: DETR para 76

Construction, Design and Management (CDM) Regulations applied. *Revitalising* therefore, committed the HSC to advising Ministers on how the principles of good management promoted by the CDM regulations could be encouraged in other key sectors.[164] The Committee heard evidence on the effectiveness of measures to control health and safety risks to workers where they are employed by an agency or where work is contracted out.

Agency workers

94. Agency workers were identified in evidence to the Committee as a group at risk in terms of health and safety, in part due to a lack of clarity about where responsibilities lie. The Simon Jones Memorial Campaign argued that there were low levels of awareness of health and safety responsibilities among employment agencies and the requirement to conduct a risk assessment is 'commonly flouted.'[165]

95. HSE research published in 2000 suggested that only a small minority of employers, less than one in ten, were using or have used agency workers in the last 12 months.[166] Employers using agency workers tended to be large and tended to use them for temporary positions. Workers tend to be inexperienced young people, placed in lower-skilled occupational areas, often in production and construction firms and particularly manufacturing. Around half of all recruitment agencies did not have measures in place to ensure they were fulfilling their health and safety obligations. Ignorance of health and safety law suggested that some may be unaware of their health and safety responsibilities. A significant minority of respondents was unaware of their duties to ensure that workers have the necessary capabilities and training to perform the job safely, to ensure that temporary workers are provided with information about features of their jobs affecting health and safety and any special qualifications or skills required to carry out the jobs safely.

96. The Simon Jones Memorial Campaign considered that there had been a lack of progress on HSE's part in tackling this issue. Mrs Anne Jones told us that a 1996 consultation on the implications of changing patterns of employment had identified agency workers' health and safety as an area needing more work.[167] Other than publishing research on the issue in 2000, HSE had 'made no suggestions as to how the situation can be remedied.'[168]

97. The Committee heard evidence indicating some good practice in this area. NHS Professionals came into being in April 2004 and is responsible across the NHS in England for the employment of temporary workers.[169] The Construction Confederation told us that, for sites run by their members, 'whatever happens at the recruitment end as soon as they

164 HSC (2000), Revitalising Health and Safety Strategy Statement. June 2000. Wetherby: DETR, action point 16

165 Volume III (No. 28)

166 Wiseman J and Gilbert F (2000), *Survey of the recruitment agencies industry.* HSE Contact Research Report 284/2000. Sudbury: HSE Books

167 Volume II (Ev38, Q138)

168 Volume III (No. 28)

169 Volume III (No. 51)

get on site they are properly inducted and they do not actually get on to site until we make absolutely sure that they are safe to do so.'[170]

98. More generally, the CBI said that changing patterns of employment had thrown up some challenges but that the current regulatory system could be applied more effectively by 'targeting guidance and by directing the HSE's promotional activities to these areas.'[171] However, it is important that any guidance is backed with the potential for enforcement action. At present, there is little visible evidence of this. For example, in 2002/03 there were only two enforcement notices issued under regulation 15 of the Management of Health and Safety at Work Regulations (which deals with temporary workers).[172] **The Committee recommends the HSE adopts a more proactive approach to enforcement action towards employers who disproportionately rely on temporary agency workers.**

Procurement

99. A key area in which the Government has identified that it can make progress is in taking health and safety into account in its procurement procedures.[173] This recently become a priority area for HSE.[174] The National Audit Office pointed out that the health and safety policy of contractors had emerged as a significant risk in the health service in recent years.[175] At the time of the NAO report in 2003, over a third of trusts said they believed they had limited control over contractors' health and safety policy.

100. The Office of Government Commerce (OGC) has issued guidance on how central government can achieve excellence in health and safety in construction procurement.[176] It recognises that as major construction clients, government has a crucial role to play in improving health and safety through the supply chain. The guide provides a summary of some of the initiatives and recommendations that departments should consider adopting. This includes carrying out rigorous assessments of potential suppliers to assess, for example, their commitment to continuous health and safety performance and their compliance with the Construction Skills Certification Scheme. Mr Trevor Walker of the Construction Confederation told us that:[177]

> "The biggest impact the Government could have on this discussion is to ensure it only gives its work (and it is 40 per cent of our business) to those contractors who are operating safety regimes like CSCS."

---

170 Volume II (Ev 120 Q458)

171 Volume III (No. 42)

172 Volume III (No. 38). 4 enforcement notices were issued under regulation 12 which requires host employers to ensure all those working in the premises have relevant information on health and safety risks. It should also be noted that the DTI's Employment Agency Standards Inspectorate has responsibility for enforcing the Conduct of Employment Agencies and Employment Businesses Regulations. These regulations also include a requirement on agencies to seek information on health and safety risks but many other issues are also covered.

173 Volume II (Ev154, Q607)

174 http://www.hse.gov.uk/aboutus/hse/meetings/2003/040603/b038s.pdf

175 National Audit Office (2003), A Safer Place to Work: Improving the management of health and safety risks to staff in NHS trusts. HC 623 Session 2002-2003. London: The Stationery Office

176 Office of Government Commerce. Achieving Excellence in Construction. Procurement guide 10. Health and Safety

177 Volume II (Ev 123, Q474)

101. The Construction Confederation considered that the OGC guidance was not tough enough. It wanted the Government to go further and demand that departments only give work to those contractors who can demonstrate that they have a fully qualified workforce.[178] The Minister said that the Government intended to look at encouragement and guidance first and, would consider something stronger if that did not work.[179]

102. The National Audit Office points out that HSE had targeted eight public bodies centrally to encourage the adoption of best client practice in relation to health and safety.[180] Departments were positive about these contacts. However, the direct expenditure of some Government departments is small compared to the money distributed through smaller non-departmental bodies, meaning the parent departments' influence over operational issues, such as health and safety, was limited. NAO recommended that as well as considering broadening the scope of the initiative across the range of different types of government client, HSE should consider whether this type of intervention would be appropriate for private sector clients.

103. There is also the question as to what the HSE can do to encourage or ensure good practice in procurement in the private sector. One possibility is to extend the approach taken in the CDM Regulations, which clarifies health and safety duties in contractual chains, to other sectors. It is clear that some employers recognise the importance of following good practice in procurement. Mr Keith Sexton of the CBI told us that:[181]

> 'We sub-contract an awful lot of our work, and we realise the risk and liability to our reputation lies in the supply chain….we realise our success at winning the next contract is based upon us not screwing up the existing contract, and much of that reputational risk is in the hands of people who we have sub-contracted in. It is a pure business decision that we have a fairly rigorous process to control those people.'

104. However, he accepted the fact that it might only be at the top end of the supply chain that this applied. The Committee supports the NAO's recommendation that HSE should extend, across the range of different types of government client (and possibly in the private sector) its work to encourage the adoption of best client practice in relation to health and safety in construction.

105. **We recommend that, for all its major procurement contracts, the Government sets a good example and only buys from suppliers who have proved to the Government that they comply with UK health and safety legislation and who have satisfactory health and safety procedures and practices in place.**

Migrant workers

106. Managing health and safety risks is particularly complex when there are communication difficulties because, for example, workers do not speak English as a first

178 Volume II (Ev 124)

179 Volume II (Ev154, Q607)

180 NAO (2004), Health and Safety Executive. Improving health and safety in the construction industry. HC 531 Session 2003-2004: 12 May 2004

181 Volume II (Ev 58, Q201, 202)

language and sometimes have a different cultural background, especially in terms of safety at work. This issue arose on the Committee's visit to Madrid, where we were told that an influx of unskilled migrant workers was a contributory factor to high accident rates in the Spanish construction sector.[182] In the UK, the recent events in Morecambe Bay provide a stark demonstration of the possible consequences. The HSC/E told us that it recognised that there are an increasing number of people 'for whom communication in English is a difficulty.'[183] A recent HSE research review of the occupational health and safety of Britain's ethnic minorities comments that 'clearly migrant labour from other parts of the EU and eastern Europe is becoming increasingly important in areas such as agriculture and construction.'[184] However, the research was unable to discuss work-related health and safety issues for groups such as refugees/asylum seekers and migrant workers because data was not available. The evidence base on immigrants and injuries or accidents at work (mostly from France) was found to be limited; some studies report higher rates of injury and others lower rates, but these are not systematically corrected for occupation. Research in New Zealand and Australia had identified lack of language and poor communication as possible factors for higher injury rates and poorer treatment outcomes.

107. Migrant workers are particularly vulnerable, often being unaware of their rights at work, especially on health and safety issues; are less likely to be unionised than indigenous employees; and are less likely to be in a position to stand up for themselves when expected by employers to work in unsafe conditions.

108. HSE is currently considering recommendations arising from the findings of recent research focused on language issues.[185] This showed there are greater concentrations of ethnic minorities in certain industries such as construction and agriculture. Its current policy is to 'effectively translate targeted messages' and maximise the impact of this by considering the most appropriate means of distribution, promotion and presentation.

109. Mr Steve Kay of Prospect highlighted the important role to be played by inspectors in getting the message across. The difficulty with getting in touch with migrant workers was that they often did not attend seminars or pick up information.[186] He said that the only way is to 'have inspectors going out and targeting them, visiting those workplaces, advising, making sure the conditions are right and making sure the law is not being broken, and it needs bodies out there doing the work.' It is worth noting, however, that only a very small proportion (some 4%) of HSE inspectors is from a minority ethnic group.[187] Only around a third speak a language other than English and in many cases, this is a European language.

110. Mr Kevin Curran of the GMB felt that, overall, HSE had been slow to respond[188]:

> 'The problem I have is if you look at the agency's policy document to 2010 it does not mention migrant workers, it has not got a policy for them. I find that quite

182 Volume III (No. 61)

183 Volume II (Ev 137, Note 1)

184 Szczepura A et al (2004), Review of the occupational health and safety of Britain's ethnic minorities. HSE Books

185 Volume II (Ev 137, note 1)

186 Volume II (Ev 28, Q84)

187 *Official Report,* 27 May 2004, col 1800W

188 Volume II (Ev 111, Q418)

incredible. It is the same with the changing economy and emerging employment trends. The HSE has not moved on since 1974 in terms of responding to the very different social and economic environment we are in now.'

111. The Committee is seriously concerned at the level of risk to which migrant workers are currently exposed. **We recommend that urgent research is needed to improve out understanding of the occupational health and safety risks faced by migrant workers so that a targeted strategy to manage those risks for this particularly vulnerable group can be effectively implemented as soon as possible.**

Social care

112. Social care comes in many forms, such as care at home, in day centres or by way of residential or nursing homes. [189] Its delivery is changing in ways that create particular challenges for HSE in ensuring health and safety risks are managed effectively. According to the Audit Commission, some one million people work in various care settings, including in other people's homes. [190] Two-thirds work for some 25,000 employers in the independent sector. About one third work in the statutory sector for local authorities.

113. The Employer's Organisation for Local Government (EO) points out that the way that social care is provided and the role of local authorities in its delivery has been subject to significant and continuing change.[191] There has been a move away from local authorities (LAs) as providers of care to an emphasis on contracting out functions to private and voluntary sectors and the establishment of partnerships with the NHS, private and voluntary organisations. Enforcement of health and safety in this context is complex and is split between HSE (who inspect local authority delivered services) and local authorities (who inspect private and voluntary sector provision).The Commission for Social Care Inspection (CSCI) is responsible for ensuring service user safety. A memorandum of understanding is being developed to mark out the boundaries between HSE, LAs and CSCI.

114. Musculoskeletal disorders are a significant cause of absence from work in the health and social care sectors.[192] A key issue arising from the evidence was a potential tension between protecting staff who are at risk of injury and providing care recipients with a service that meets their wishes and needs. Both the National Centre for Independent Living (NCIL) and the United Kingdom Home Care Association (UKHCA) are concerned that in some cases an over-restrictive interpretation of health and safety legislation is taken.[193] The National Centre for Independent Living points to a court judgement (R (on the application of A, B, X and Y) v East Sussex County Council) which held that risk assessments must be based on consideration of individual needs and circumstances, including the physical, emotional, psychological and social impact on the disabled person of any proposed manual

189 www.dh.gov.uk/PolicyAndGuidance/HealthandSocialCareTopics/SocialCare

190 Audit Commission (2004), *All Our Lives. Social Care in England 2002-3003.* London: Audit Commission

191 Volume III (No. 46)

192 Volume III (No. 50)

193 Volume III (Nos 48 and 52)

handling arrangement. NCIL argues that it will be a challenge to bring day-to-day practice into line with the East Sussex judgement. Bill McClimont, a consultant to UKHCA said:[194]

> "In social care, we are attempting to encourage the independence of the individual, encourage their empowerment, to get them to take risks. It is an oddity that the standards for care in home care are specific: that you must encourage a user to take risks. That sits uneasily with a health and safety approach which says you must minimise risks. I feel that health and safety ought to be a balance. I think the legislation probably is a balance. Unfortunately, many people who interpret that legislation balance that far too far on the precautionary side."

115. UKHCA argue that a number of factors make achieving this balance a particular challenge in a home care situation:[195]

- There is no clear legal responsibility on third party purchasers of care for health and safety. They have 'no legal responsibility but have tight budgetary constraints. The provider has almost total legal responsibility but cannot decide basic matters such as the number of workers required to do the job.' The most common dispute is over the need for more than one worker to perform manual handling tasks.

- In the experience of UKHCA 'attempts by non-experts to codify and define working practices too often result in inappropriate 'blanket' rulings, which can be inadequate or excessive to the circumstances. Health and safety experts, on the other hand, often come from industrial or commercial situations and give advice that is 'often impractical or out of all proportion when applied to home care.'

- The law apparently fails to take account of some of the complications which can arise from private homes being workplaces. For example, the care recipients may not be in a position to make adaptations to the home in order to make it safe, may have little or no understanding of health and safety law and may be uninsured.

116. The situation becomes more complex still with the recent extension of direct payments to a wider range of disabled people. Direct payments are made by local authorities to people eligible for care services, as an alternative to having care services arranged for them. Recipients often use them to pay for care workers. In doing so, they can find themselves taking on all normal employment responsibilities, including full responsibility for health and safety. Mr Bill McClimont told the Committee:[196]

> "How do we get health and safety regulations into the home? I think the sad thing is they are already there. Effectively, they apply to an individual as an employer in exactly the same way as they would apply to ICI. The trouble is that that individual as an employer does not know that."

117. The situation was described as a disaster waiting to happen. The chance of an accident is 'aggravated severely by the absence of proper information and support for the individuals as employers' and is likely to be rendered more acute by the absence of

194 Volume II (Ev 73,Q278)

195 Volume III (No. 48)

196 Volume II (Ev72, Q275)

insurance in most cases.[197] Direct payment support schemes ought to assist with these issues but it remains to be seen whether they will be adequate.

118. Evidence to the Committee suggests HSE has been slow to address this issue. UKHCA had been trying for some years to persuade the Health and Safety Executive that they should be addressed but had been unable to get a response.[198] The National Care Homes Association said that, while HSE holds an important position within the social care field, there was 'limited dialogue with the sector at any level.'[199] This was said to lead to differences in interpretation and difficulties in promoting good practice.

119. The Committee supports the United Kingdom Home Care Association's view that that HSC/E should develop guidance in consultation with care providers, purchasers and recipients on health and safety where the workplace is a private home and believes that local authorities should ensure that schemes to provide individuals with direct payments for care include the support necessary to comply with their duties under health and safety law.

120. **The Committee is concerned that there does not appear to be an all-embracing strategy to address the changing world of work and recommends that such a strategy must be developed as a matter of urgency. This should include, in particular, measures to reduce the health and safety risks faced by agency workers and migrant workers. By 31 December 2005, clear, comprehensive and appropriate guidance should be published by the HSC/E on health and safety where the workplace is a private home. In particular, and more urgently, local authorities should issue guidance on the Employer's Liability (Compulsory Insurance) Act 1969 to those employing carers directly in their own homes, and assist in arranging appropriate cover.**

9 Inspection and Enforcement

121. HSE inspectors have a range of tools at their disposal. They may offer advice, serve improvement and prohibition notices, withdraw approvals, vary licence conditions or exemptions, issue formal cautions and prosecute. HSE defines 'inspection' as the proactive mechanism used to assess the extent to which duty-holders have discharged their duties and to motivate them to do so.[200] It usually involves a visit to the workplace to look at how health and safety is managed. An 'investigation' is an inquiry into a set of circumstances, most usually those surrounding either an incident or a complaint. Inspectors are not just engaged in inspections. Those in the construction sector, for example, are involved in safety and health awareness days as well as in interacting with designers and clients.[201]

122. The term 'enforcement' has a wide meaning and applies to all dealings between enforcing authorities and those on whom the law places duties (employers, the self-

197 Volume II (Ev73, Q276)

198 Volume II Ev 71, Q271

199 Volume III (No. 58)

200 http://www.hse.gov.uk/aboutus/hse/meetings/2003/030903/item7.pdf

201 Volume II (Ev132, Q514); Oral Evidence session with Public Accounts Committee. Monday 24 May 2004, HC 639-I Q122

employed, employees and others.) The principles HSC expects enforcing authorities to follow are set out in an Enforcement Policy Statement.[202] A consultation document on HSE's 'interventions strategy' is due to be published in September 2004.[203]

123. Since the Environment, Transport and Regional Affairs Committee reported on the issue in 2000[204], a number of measures have been introduced (such as a new enforcement policy statement) which it is considered should help to improve the quality, rigour and consistency of HSE's enforcement decisions.[205] A number of key issues emerged in the course of the current inquiry, including whether HSE has sufficient resources available for enforcement and the emphasis HSE places on the different aspects of its intervention strategy.

Inspector numbers

124. HSE employed the following number of inspectors in the years 1995 to 2004:[206]

Number of inspectors employed by HSE As at 1 April	Field Operations Directorate	Other	Total
1995			1,478
1996			1,466
1997	780	662	1,442
1998	783	654	1,437
1999	853	644	1,497
2000	898	609	1,507
2001	954	580	1,534
2002	955	670	1,625
2003	962	689	1,651
2004	901	704	1,605

125. According to Prospect, 540 of the 901 Field Operations Directorate staff employed in 2004 are grade 3 and 4 staff working in the front-line doing inspection and investigation work.[207] The remainder are managerial staff, or in policy or support roles. Some work on specific sectors, for example, acting as the main contact point for industry associations, providing industry specific training or trying to influence industry practice.

202 HSC (2002), Enforcement policy statement. www.hse.gov.uk

203 HSE, Discussion paper for views on 'areas where HSE and LAs will not be proactive'

204 Environment, Transport and Regional Affairs Committee, *The Work of the Health and Safety Executive,* Fourth Report. Session 1999-2000. Volume 1. HC 31-1

205 Volume III (No. 41)

206 Adapted from Official Report, 17 May 2004, col 734W. 'Other' includes, for example, the Nuclear Safety Directorate and Hazards Installations Directorate

207 Volume III (No. 30)

126. The Centre for Corporate Accountability and Prospect pointed to the direct relationship between resources, the number of inspectors HSE is able to employ and the enforcement activity it is able to carry out.[208] The Committee was told that inspector numbers rose during a period of increased financial resources (2001/02 – 2003/04) and fell in 2004 following a freeze on recruitment as a result of the 2002 Spending Review settlement.[209]

Inspectors' qualities and skills

127. The quality of HSE staff was praised in much of the evidence to the inquiry.[210] A paper presented to the HSC on *Becoming a Modern Regulator*, raises the question as to whether inspectors should have responsibility for more than one regulatory area.[211] However, the importance of inspectors having expertise in their area was noted. Mr Gary Booton of EEF, the manufacturer's organisation, noted that, recently there had been concerns that a 'relatively inexperienced fieldforce' was relying 'on systems to reach decisions rather than using their discretion.'[212] Prospect, the union representing HSE professional staff, notes an inspection role requires trained and qualified staff:[213]

> 'Experience shows that even the seemingly most straightforward visit can turn into a complex situation when, for example, asbestos contamination is discovered, or there is a serious fire risk. These types of situations require training so that problems can be identified and dealt with.'

128. The Local Government Association told us that while the involvement of local authorities in enforcement provided an opportunity to use 'multi-functional inspectors',[214] in larger authorities there was almost invariably a health and safety specialist section and there has been a move away from generalist inspectors.[215]

Balance between inspection and information/advice

129. In written evidence, HSC/E told us that 'there is strong evidence to support the continuation of a balanced mix of advice (persuasion), enforcement and business incentives. Enforcement is an effective way of securing compliance. It creates an incentive for self-compliance and a fear of adverse business impacts, such as reputational damage in all sectors and sizes of organisations…There is some evidence that advice and information are less effective in the absence of the possibility of enforcement.'[216]

---

208 Volume III (Nos. 30 and 41)

209 Volume III (Nos. 30 and 41); Volume II (Ev 34 Q118)

210 See, for example, Volume III (Nos. 5, 20, 26 and 35)

211 //www.hse.gov.uk/aboutus/hsc/meetings/2004/060404/c53.pdf

212 Volume II (Ev 50, Q148)

213 Volume III (No. 30)

214 Volume II (Ev 9, Q32)

215 Volume II (Ev 9, Q33)

216 Volume III (No. 36)

130. The appropriate balance of these activities emerged as an important question in the evidence to the inquiry. According to the National Audit Office, out of a net expenditure of £202 million in 2002/03, HSE spent £111 million on securing compliance with the law and a further £26 million on improving knowledge of and understanding of health and safety issues through the provision of information and advice.[217]

131. A discussion paper presented to an HSE board meeting on 3 September 2003, proposed putting more emphasis on the 'educate and influence' aspects of their work.'[218] It is said that this will mean using a smaller proportion of the total front line resource for inspection and enforcement. This reflects a belief that 'altering the balance in this way will help [HSE] to climb off the current plateau in safety performance and to tackle the increases in ill health.' However, it is acknowledged that at present the evaluation of the effectiveness of different approaches and techniques is not sufficiently well developed to allow it to be more than a belief. The Centre for Corporate Accountability (CCA), on the other hand, argued that the 'HSE's new evolving policy on enforcement – to move away from inspection, investigation and formal enforcement – contradicts overwhelming international and HSE evidence that it is inspection, investigation and formal enforcement that works best.' [219]

132. A literature review was conducted for HSC/E by way of building an evidence base for the current strategy.[220] This found that enforcement was an effective means of securing compliance, creating an incentive for self-compliance and a fear of adverse business impacts such as reputational damage in all sectors and sizes of organisations. The leadership role provided by HSE and local authorities was an important element in prompting major firms to manage health and safety. The literature review also found some evidence that advice and information is less effective in the absence of the possibility of enforcement.

133. Awareness raising, incentives and enforcement are important, mutually supportive and reinforcing aspects of HSE's work.[221] Awareness raising is particularly important for small and medium enterprises (who may have lower levels of awareness) and is a pre-requisite for compliance. However, as the study points out, awareness does not, in itself, necessarily lead to action in the absence of regulatory or other motives. Furthermore, education, advice and information activities were found to have most impact on those who were already receptive or proactive on health and safety and was less effective with 'reluctant' compliers. Face-to-face contact, in the form of seminars and direct contact by inspectors, is the most effective way of getting the message across.[222]

---

217 National Audit Office (2004), *Improving health and safety in the construction industry.* HC531 Session 2003-2004: 12 May 2004

218 http://www.hse.gov.uk/aboutus/hse/meetings/2003

219 Volume III (No. 41)

220 Wright M, Marsden S and Antonelli A (2004), Building an evidence base for the Health and Safety Commission Strategy to 2010 and beyond: A literature review of interventions to improve health and safetycompliance. HSE Books

221 Wright M, Marsden S and Antonelli A (2004), Building an evidence base for the Health and Safety Commission Strategy to 2010 and beyond: A literature review of interventions to improve health and safetycompliance. HSE Books, page 36 and 71

222 Walters D (2001), *Health and safety in small firms,* Brussels: Peter Lang, 217-275

134. The literature review commented that the 'many organisations are not motivated by the business benefits to improve health and safety'.[223] The Ambulance Service Association told the Committee that making the business case is difficult 'when the objective evidence and data to support them are not readily available.'[224] Difficulties arise 'through the conflict of immediate demands on resources for operational services against investment in longer term control measures where the benefits are difficult to measure and may not be seen for some time, even years.' However, it was 'hoped that with the continuing integration of risk management systems and use of risk registers in the development of organisational strategies and business plans, that these priorities will come to the fore.'

135. In evidence to the inquiry, employers expressed varying views on the importance of the enforcement function. The NHS Confederation told us it played an important role in ensuring health and safety was prioritised:[225]

> "Health and safety legislation is best understood by the professionals in the field. However, arguably, this understanding dilutes as one moves up through the managerial hierarchy. Regrettably, health and safety is still seen by some as a potentially expensive nuisance in balancing a range of conflicting resource demands…..There is no doubt that the use of improvement notices by the HSE is a powerful method of forcing an internal review of priorities and raising health & safety up the NHS Board agenda."

136. The Ambulance Service Association reported positive results from a comprehensive round of inspections undertaken by HSE over a period of some six years.[226] A committee had also been set up to lead a programme of improvement. It was felt that HSE representation on that committee had been of great benefit both in terms of helping ambulance services meet the requirements of health and safety legislation and in improving HSE's understanding of, and inspection processes for, ambulance services.

137. The Construction Confederation argued that more inspectors were needed to enable HSE to devote more time to sites where there is most risk of accidents happening.[227] The importance of enforcement action in the construction sector was highlighted, in the Committee's view, by the outcomes of inspection 'blitzes' carried out by HSE. These blitzes involved concentrating inspection effort by bringing resources together in one place at one time, to focus on one theme. Despite the fact that employers were notified of visits in advance, significant levels of non-compliance with health and safety legislation were revealed. For example, a blitz was carried out in May 2002 in Scotland and the North of England looking at falls from height, workplace transport and welfare. [228] 444 sites were visited, 259 notices issued and there were 10 possible prosecutions.

---

223 Wright M, Marsden S and Antonelli A (2004),

224 Volume III (No. 49)

225 Volume III (No. 51)

226 Volume III (No. 49)

227 Volume III (No. 20)

228 National Audit Office (2004), *Improving health and safety in the construction industry.* HC 531 Session 2003-2004: 12 May 2004

138. EEF, the manufacturers' organisation, said it was unclear whether there was a correlation between increased enforcement and improved health and safety performance.[229] It also considered that increased enforcement action in recent years may have had a negative impact on the way employers view inspectors.[230]

139. In oral evidence, the Minister confirmed the Government's view was that the emphasis on advice and information, rather than inspection and enforcement, needed to increase:[231]

> "I think the Health and Safety Executive would share the view that it is engaging industry and business in safety, getting them to recognise the importance of safety, that brings them a greater degree of success than straight enforcement of a set of regulations. It is about winning hearts and minds, it is about persuading people of the importance of safety."

140. In its memorandum to the Inquiry, HSC/E argued that work being done by the National Audit Office (NAO) might 'provide an insight into the HSE's wider regulatory approach and achievements.'[232] In the event, the NAO report concluded that HSE needed more evidence on the effectiveness of its various interventions and recommended a programme of evaluation.[233] The Committee wrote to Mr Bill Callaghan, Chair of the HSC, asking on what basis they had decided that occupational health communications should be a higher priority for extra resources than inspection. In response, Mr Callaghan said that they believed there was sufficient evidence to carry forward pilots in these areas, although 'we accept it is not hard or unequivocal.'[234] A number of points were made regarding the work on communication. For example, the 'Good Health is Good Business' campaign and safety and awareness days had been found to have some positive effects. The Food Standards Agency's campaign to promote action on healthy food and diet was considered to have triggered the kind of national debate and awareness likely to foster changes in behaviour.

141. An either/or choice as to whether to emphasise guidance or enforcement in policies for achieving compliance is too simplistic a decision to make about what works best and quite clearly, they both have their place. Equally, it is important that innovative approaches to achieving better compliance and, in the words of the HSC, 'winning hearts and minds', are developed. The real challenge would seem to be to find ways to achieve this, without developing one strategy at the expense of reducing the role of the other.

142. **The evidence supports the view that it is inspection, backed by enforcement, that is most effective in motivating duty holders to comply with their responsibilities under health and safety law. We therefore recommend that the HSE should not proceed with**

229 Volume III (No. 33)

230 Volume II (Ev 50, Q148)

231 Volume II (Ev 145, Q547)

232 Volume III (No. 36)

233 National Audit Office (2004), *Improving health and safety in the construction industry,* HC531 Session 2003-2004: 12 May 2004, para 14 iv

234 Volume III (No. 38)

the proposal to shift resources from inspection and enforcement to fund an increase in education, information and advice.

Inspections versus investigations

143. HSC/E's primary aim is prevention. Its memorandum explains that this approach was endorsed in an inquiry into the work of HSE by the Environment, Transport and Regional Affairs Committee in 2000, which also urged HSE to increase investigation and prosecution rates. [235] The Government accepted the recommendation and HSE undertook to increase the number of investigations by 50% from 6.8% in 1999/00 to 10% in 2001/02. The number of incidents investigated peaked at 9.4% in 2000/01 and has since fallen to 5.6%.[236] HSE considers that achieving this change has 'created conflict with the intention to maintain a largely preventive focus'. The ratio of time on proactive and reactive work, which had been 70:30 in 1997/98, fell to 50:50 in 2002/03. HSE explains that this was not felt to be the best balance taking the time devoted to each activity as an approximation for the best mix of the two activities in terms of preventive impact.' Accordingly, it has taken steps to streamline and improve investigation procedures through revised accident selection criteria with the aim of re-establishing a 60:40 time ratio of proactive to reactive work.

144. HSC investigates all fatal injuries.[237] In 2003/04, it investigated 11.4 per cent of major injuries (see Appendix 2).[238] This is higher than it was in 1997/8 (6.4 per cent), but a considerable reduction compared to 15.1% in 2001/02. 5.6 per cent of all incidents reported under RIDDOR were investigated, compared to 8.1% in 2001/02. This figure also has to be seen in the context of underreporting under RIDDOR (see paragraph 11). The Centre for Corporate Accountability (CCA) and Unison estimate that on average, a registered premise will receive an inspection once every 20 years.[239] HSC/E figures show that 6.4 per cent of workplaces falling within the jurisdiction of the Field Operations Directorate were inspected in 2003/04, up from 5.8 per cent in 2001/02.

145. Analysis by the CCA indicates the serious nature of some of the incidents HSE is unable to investigate. It points out that the 80% of major injuries not investigated in 2000/01, included '16 out of 62 amputations to either hands, arms, feet or legs and 69 out of 178 major injuries involving electricity'. [240] It considers that constrained resources are leading to a 'misleading debate about 'inspections' versus 'investigations' and said that 'it is difficult to see how the 'balance has gone too far towards investigations when, despite the shift, so many serious incidents were still not being investigated.'[241]

235 Volume III (No. 36)

236 Volume III (No. 38)

237 Volume II (Ev 130, Q505)

238 Volume III (No. 38); Figures for 2003/04 are provisional

239 Centre for Corporate Accountability, Unison (2002), Safety Last? The Under-enforcement of Health and Safety Law

240 Volume III (No. 41)

241 Volume III (No. 41)

146. In order to achieve the shift towards proactive work, HSE is piloting new criteria to reduce the number of incidents investigated.[242] Under the new criteria, for example, scalpings are not to be investigated and amputations of digit(s) past the first joint only 'where the incident involved potential for more than one finger or for hand/arm amputation.'[243] Inspectors currently have discretion to investigate an incident where, for example, they consider there may have been a serious breach of the law. This will no longer be the case. In oral evidence, Mr Steve Kay of Prospect gave us an example of the sort of accident that would not be investigated under the new criteria[244]:

> "A few years ago I investigated an accident to a man whose hand was caught in the platens of an injection moulding machine, a heated injection moulding machine because it cures the rubber at very high temperatures. The guards on this machine were defective; he touched it and it closed on his hand so he could not get his hand out and it was effectively cooking his hand at oven sorts of temperatures. He could not get his hand out and his work-mates had to prize the moulds open using bars, so his hand was in there for a period of minutes. Under the new selection criteria that will not be investigated because burns to less than 10% of the body are not to be investigated, and that is of serious concern to us….If an employer has breached the law in such a blatant way and there is a serious outcome as a result, that should be investigated as a moral issue."

147. A paper to a meeting of the HSE Board noted that the revised criteria had reduced the number selected for investigation 'by more that was initially intended' and that amended criteria were to be piloted until the end of June 2004 before consulting with the Commission on how to proceed.[245]

148. Asked about the proportion of major accidents investigated, Mr Timothy Walker, Director General of the HSE said[246]:

> "We would not agree that it is too low a number. Not all accidents will benefit from an HSE investigation and we think we need to concentrate our investigation skills and experience both on those cases that are likely to lead to prosecution or where there is considerable learning involved either for that company or for other companies."

149. However, this begs the question as to how, in the absence of an investigation, HSE can be confident that a case is unlikely to lead to prosecution or to have considerable learning involved.

150. The number of proactive inspections is also low. HSC/E told us that 6.4% of premises within the remit of HSE's Field Operations Directorate were inspected in 2003/04[247]. Ms

242 HSE (July 2003), Improving health and safety: some developments and new approaches to incident investigation management and a revision of incident selection criteria

243 HSE (2003), Improving Health and Safety; Some Developments and New Approaches to Incident Investigation Management And A Revision of the Incident Selection Critieria

244 Volume II (Ev 26, Q71.)

245 *The new Model for FOD,* Health and Safety Executive Board Paper.For meeting on 31 March 2004. www.hase.gov.uk/aboutus/hse/meetings/2004/31304/6035.pdf

246 Volume II (Ev 130, Q503)

247 Volume III (No. 38)

Mary Boughton of the Federation of Small Businesses told us that 'the majority of small businesses never have an inspection.'[248] Dr Janet Asherson, of the CBI told us that 'statistically, enforcement and inspection across the piece of all British business is a rare event.'[249] **The Committee is concerned both at the low level of incidents investigated and at the low level of proactive inspections and recommends that resources for both are increased (see paragraph 82).**

Targeting resources

151. One of the 'key drivers for change' in HSC's recently published strategy document is to target HSE and local authority resources where they can have most impact.[250] This means 'discouraging HSE and local authorities from putting resources into issues where the risks are of low significance, well understood and properly managed.' A recent internal discussion document issued by the HSE indicates that this may be difficult to achieve in practice.[251] One option is for HSE not to intervene in particular employment sectors or in particular activities or processes such as office work or light assembly. However, it is noted that this 'would make no allowance for variation in duty holder performance and it is difficult to see how 'proper management' of risk could be ensured.' Deciding not to cover particular hazards would have the same drawback, although to an extent it already operates through the concentration on priority programme areas. A further option is to allow specific duty holders 'earned autonomy' to manage health and safety risks without routine intervention from enforcement agencies. Such a programme has been operated in the US in the form of a 'Voluntary Protection Programme.' The paper comments that this system appears to be complex and bureaucratic.

152. The idea of putting higher performers 'on trust' was supported by organisations such as the Institution of Occupational Safety and Health and the Royal Society for the Prevention of Accidents.[252] The TUC, however, was concerned that employers might respond by putting a lot of effort into reducing accident reporting.[253] Prospect pointed out that HSE already use a risk targeting approach and good employers are not inspected anywhere near as often as those with poor health and safety records.[254]

153. **The Committee believes that before adopting a policy of reduced inspection for employers with an established record of good practice, there is a need for clear and thorough evidence-based analysis to ensure that the reduction does not lead to negative outcomes such as improper pressures to achieve a reduction in accident reporting.**

248 Volume II (Ev 50, Q148)

249 Volume II (Ev 53, Q161)

250 HSC (2004), A strategy for workplace health and safety in Great Britain to 2010 and beyond, page 3

251 HSE, Discussion paper for views on 'areas where HSE and LAs will not be proactive'.

252 Volume III (No. 14); Volume II (Ev 6, Q19)

253 Volume II (Ev 28, Q81)

254 Volume II (Ev 28, Q82)

Low levels of enforcement of certain aspects of the legislation

154. There is concern that certain important aspects of the legislation are not enforced. Mr Hugh Robertson of the TUC told us that the 'two twin pillars' of health and safety culture – involvement of the workforce and risk assessment – are 'not there at the moment.'[255] These fundamental aspects of the legislation are rarely enforced. For example, there was concern from trade unions at the lack of enforcement action on the regulations dealing with consultation with employees and safety representatives (see Chapter 14).[256] Levels of enforcement of the regulations requiring employers to conduct risk assessments are also very low. In 2002/03, there were only 109 informations laid (leading to 66 convictions) under regulation 3 of the Management of Health and Safety at Work Regulations 1999. Given the lack of awareness of these regulations (some 43% of employers[257]), this seems a very low level. (See Appendix 3)

155. The issue around whether an employer was using competent persons to assist them in complying with their duties under health and safety law was another area in which more enforcement is said to be needed.[258] Figures from HSC/E show that in 2002/03, there were one conviction and 81 improvement notices issued under the relevant regulation (regulation 7 of the Management of Health and Safety at Work Regulations 1999.)

156. The Royal Society for the Prevention of Accidents told the Committee that [259]:

> "Very importantly, HSE need to prioritise their enforcement effort towards the rectification of underlying health and safety management weaknesses such as the absence of professional advice, absence of appropriate management and skill [in] H&S training, absence of risk assessment, absence of active and reactive monitoring, absence of consultation and performance review etc"

157. Given that risk assessment, the use of competent persons to assist with health and safety requirements and worker participation is crucial to implementing European health and safety legislation, the Committee believes that HSE should increase the visibility of its enforcement action in those areas.

Public safety

158. This is not an issue into which the Committee was able to enquire in detail during the inquiry. However, we note that employers have a duty to conduct their undertaking so as not to expose the public to health and safety risks[260]. In 2003/04, HSE investigated 6.9 per cent of injuries to the public reportable under RIDDOR.[261] This is an increase compared to

255 Volume II (Ev 31, Q93)

256 See, for example, Volume III (Nos. 4, 5, 26 and 35)

257 Hanson MA et al (1998), Evaluation of the Six-Pack Regulations 1992. Contact Research Report 1771/1998. Sudbury: HSE Books.

258 Volume II (Ev 32, Q104)

259 Volume III (No. 14)

260 Section 3, Health and Safety at Work Act 1974

261 Volume III (No. 38)

1997/98, when only 2.4% were investigated but is a reduction compared to 9.1 per cent in 2001/02.

159. HSC/E has announced its intention to 'determinedly move away from intervening in those areas of public safety that are better regulated by others or by other means.'[262] The Centre for Corporate Accountability (CCA), however, argued that no other body has the power to enforce section 3 of the Health and Safety at Work Act. A death in custody, may, for example, be a result of inadequate working practices or training and such organisational matters would not be considered by the police.[263] CCA has obtained a legal opinion on the question as to whether the policy is in breach of HSE's duty to 'make adequate arrangements for the enforcement of these duties.'[264] This concluded that the policy was *ultra vires* and was extremely likely to lead to unlawful decisions that would be amenable to legal challenge. If this is the case, HSE may not be able to rely on withdrawing from areas of public safety as a means of freeing up resources for other activities.

Does HSE need more inspectors?

160. The Committee received evidence on enforcement activity in two of HSE's priority programme areas – construction and the health service. In the context of the construction industry, the National Audit Office (NAO) found that there was one HSE inspector for every 3,333 construction sites.[265] The NAO described the strategic approach taken by HSE to maximise the effectiveness of its work in the construction industry. Steps taken included working with other stakeholders in the supply chain (such as clients and designers), supplementing its usual site inspections with blitzes concentrating on particular risks, and initiatives targeted at workers, such as Safety and Health Awareness Days. Nonetheless, both employers and unions in the sector told the Committee they considered HSE to be under-resourced in terms of being able to carry out the level of inspections needed in the industry, The Construction Confederation, for example, told us that HSE only had sufficient resources to be reactive after the event and needed another 50 inspectors to be able to devote more time to those sites where there was the highest risk of accidents happening.[266]

161. The NHS Confederation told us that it did not feel HSE was sufficiently well resourced to meet its objectives within the NHS.[267] In 2003/04, HSE had carried out 201 inspections within the health service, where nearly 1.3 million staff are employed in many thousands of workplaces. Concerns about lack of resources for enforcement were echoed by the Royal College of Nursing and Unison.[268]

---

262 HSC (2004), A strategy for workplace health and safety in Great Britain to 2010 and beyond. Sudbury: HSE Books

263 Volume II (Ev 40)

264 Opinion from Michael Fordham and John Halford prepared for the Centre for Corporate Accountability in the matter of sections 3 and 18 of the Health and Safety at Work Act 1974

265 National Audit Office (2004), *Improving health and safety in the construction industry,* HC531 Session 2003-2004: 12 May 2004, para 3.11

266 Volume III (No. 20). See also Volume III (Nos. 26 and 35)

267 Volume III (No. 51)

268 Volume III (Nos. 12 and 50)

162. Evidence also suggested that HSE inspectors were under considerable pressure. Mr Gary Booton of EEF told us that inspectors appeared to be 'under time pressures not to dig into what has happened…but simply to say, 'Right, there is one more job, one more to tick off.' [269] Mr Steve Kay of Prospect said that in order to be able to focus limited resources on priority areas, inspectors were being told to ignore other areas unless they became matters of evident concern.[270] This pressure on inspectors' time has been recognised by the head of the Field Operations Directorate (FOD), who has noted that increasing the contact time inspectors have with duty holders was a continuing concern in FOD.[271]

163. One of HSE's responses to this has been to pilot new approaches, using visiting administrative staff working alongside inspectors in frontline roles, to deliver key health and safety messages.[272] There are now some 60-70 such administrative staff and their work enables inspectors to spend more time targeting the duty-holders most in need of HSE attention. Prospect, the union representing HSE professional staff, was, however concerned at untrained and unqualified staff having a 'quasi-inspection role when what is needed is a trained and qualified person to exercise their judgement.[273]

164. Mr Bill Callaghan, Chair of the HSC, did tell the Committee that HSC had put a 'strong case to ministers for more resources' in respect of occupational health support and communications but was more equivocal when asked whether HSE needed more inspectors.[274] Mr Gareth Williams of the Department for Work and Pensions said[275]:

> "if you ask the HSE, as you did, had they more resources, where would they put them, the answer would not be inspectors, it would be around the advice and communication and prevention upfront. Even if you sought to improve that ratio with the additional funding to that order of magnitude, you still would not cover every company, you would still only inspect them on a limited number of occasions and the advice would depend on the day you turned up."

165. However, the fact that even if the number of inspectors increased, you would not cover every company, is not an argument for not increasing the number of inspectors. The recent literature review on the effectiveness of HSE's interventions found some evidence that higher levels of enforcement would prompt organisations to make further health and safety improvements.[276] Furthermore, evidence shows that face to face contact is the most effective way of providing information and advice, particularly for small firms[277] and inspectors are ideally placed to do this.

---

269 Volume II (Ev 53, Q162)

270 Volume II (Ev29, Q85)

271 Volume II (Ev 40)

272 Volume III (No. 36)

273 Volume III (No. 30)

274 Volume II (Ev 137, Q539; Ev 131 Q507)

275 Volume II (Ev 147, Q559)

276 Wright M, Marsden S and Antonelli A (2004), Building an evidence base for the Health and Safety Commission Strategy to 2010 and beyond: A literature review of interventions to improve health and safety compliance. Sudbury: HSE Books: page 12,13

277 Walters D (2001), *Health and Safety in Small Firms,* Brussels: Peter Lang, pp 217-275

166. The Committee believes that the number of inspectors needs to be increased in order that HSE can increase the number of incidents investigated and the number of proactive inspections. A further question is what level of increase HSE should be aiming at. EEF, the manufacturers organisation, argued that[278]:

> "We simply do not know whether the appointment of say 50 more health and safety inspectors would lead to improvement x in health and safety performance and therefore secure saving y for all concerned."

167. A number of other organisations provided us with suggestions as to the level of increase HSE should aim at. Prospect argued that the number of inspectors should be doubled so that each workplace can be inspected at least every five years and so that each new workplace is inspected in its first year of operation.[279] It estimates that the cost of an additional 700 inspectors in the Field Operations Directorate 'would rise to something like £48 million after 6 to 7 years.'[280] The Institution of Occupational Safety and Health suggested that as the majority of existing inspectors was focused on safety, additional inspectors were needed to concentrate on health issues.[281] It proposes doubling the number of inspectors in HSE (at an eventual cost of some £77.3 million a year) and employing an additional 150 full-time investigators to concentrate on work-related road safety (at an estimated cost of £7.25 million pa.)

168. The Centre for Corporate Accountability suggested that HSE should have sufficient resources to[282]:

- Adequately enforce section 3 of the Health and Safety at Work Act, in relation to responsibility of employers not to expose the public to health and safety risks;
- Investigate all major injuries falling into certain categories, all dangerous occurrences, all cases of industrial disease reported to it;
- Inspect all workplaces in certain hazardous industries (manufacturing, agricultural workplaces, for example) at least once a year and all workplaces at least once every five years;
- Investigate all deaths in a prompt manner;
- Introduce independent legal oversight for prosecutions;
- Employ a number of family liaison officers to work with families at the time of death; and
- Increase resources available for monitoring local authority enforcement activity.

278 Volume III (No. 33)

279 Volume III (No. 30)

280 Volume II (Ev39)

281 Volume II (Ev 21)

282 Volume II (Ev 40)

169. As previously stated, the Committee believes that a substantial increase in resources is needed for inspection (see paragraph 82).

10 Prosecution

170. Inspectors have important statutory powers to enforce health and safety legislation. If unsatisfied by the levels of health and safety standards being achieved, there are several means of obtaining improvements, including advice, improvement or prohibition notices and prosecution in the criminal court.[283] The overall purpose is to ensure duty holders take action to deal with serious risks, to promote and achieve sustained compliance with the law and to ensure that duty holders who breach the requirements or fail in their responsibilities are held to account.[284] Research evidence overwhelmingly suggests that prosecution is an effective part of the toolkit for achieving compliance.[285] The recent literature review on interventions to improve compliance found there was little research on the role of prosecutions or preventive enforcement (such as Improvement Notices) as precedent-setting or awareness raising activities.[286]

Prosecution levels

171. Evidence to the Committee suggests there is concern at the low level of prosecutions, particularly among trade unions.[287] The Environment, Transport and Regional Affairs Committee report in 2000 concluded there was an urgent need to increase the level of prosecutions undertaken by HSE.[288] HSE figures show that the number of 'informations laid' has since fallen (from 2,115 in to 1999/00 to 1,688 in 2002/03) and the number of convictions from 1,616 to 1,260.[289] Over the same period, the number of enforcement notices issued by HSE has risen to 13,263, up from 11,304 in 1999/00.

172. HSC/E point out that formal enforcement action, such as prosecution, is time-consuming, requiring the 'pursuit of all reasonable lines of inquiry'.[290] The Centre for Corporate Accountability (CCA) refers to a study showing that 'resources are a key constraint on decisions to prosecute'. [291] However, CCA also points out that HSE seeks

283 HSC, The Health and Safety System in Great Britain

284 HSC (2002), Enforcement policy statement. HSE Books

285 Haines, F (1997), Corporate Regulation. Oxford: Clarenden Press; Hawkis K (2002), *Law as Last Resort.* Oxford: Oxford Socio-legal Studies; Hutter B M (2001) *Occupational Health and Safety on the Railways.* Oxford: Oxford University Press; Ayres I and Braithewaite J (1992), *Responsive Regulation.* New York: Oxford University Press; Wells C (2001), *Corporations and Criminal Responsibility.* Oxford: Oxford University Press

286 Wright M, Marsden S and Antonelli A (2004), Building an evidence base for the Health and Safety Commission Strategy to 2010 and beyond: A literature review of interventions to improve health and safety compliance. Sudbury: HSE Books

287 Volume III (Nos. 5, 11, 35 and 41)

288 Environment, Transport and Regional Affairs Committee, *The work of the Health and Safety Executive.* Fourth Report. Session 1999-2000, page xxix

289 Table EF7, Proceedings instituted in Great Britain by enforcing authorities by result 1998/99-2002/03, http://www.hse.gov.uk/statistics/causacc/tables.htm#enforcement

290 Volume III (No. 36)

291 Volume III (No. 41)

costs after conviction and is allowed to keep this money.[292] In 2003/04, HSE received £4.017 million in costs (an average, of £4,910 per case prosecuted in England and Wales in that year). CCA comments that this should 'arguably cover a significant amount of the costs of taking prosecutions'. It also comments that most prosecutions arise from investigations into incidents and, therefore, that the current strategy to reduce the number of incidents investigated is likely to result in the number of prosecutions falling still further.

Private prosecutions

173. *Revitalising* states that a Law Commission report published in 1998 found that the requirement to seek the consent of the Director of Public Prosecutions in order to conduct a private prosecution made 'substantial inroads into the ordinary individual's right to set the criminal law in motion.'[293] The Law Commission recommended that consent provisions should exist only for three categories of offences and should otherwise be dispensed with. [294] It was also reported that the Director of Public Prosecutions has to date received no more than a handful of applications in relation to health and safety offences, all of which have been rejected.

174. Action Point 10 of *Revitalising* committed the Government to considering an amendment to the 1974 Act (when Parliamentary time allows) to enable private prosecutions in England and Wales to proceed without the consent of the Director of Public Prosecutions'. A progress report on the *Revitalising* Action Points in April 2004 stated that legislative proposals were being considered.[295] The Minister told us in oral evidence that the Government remained committed to legislating if it proved necessary.[296]

175. The Committee believes that private prosecutions for health and safety offences should be allowed, subject to terms on legal costs in the event of a failed prosecution, without the consent of the Director of Public Prosecution.

176. **Given the HSE's limited resources, if safety representatives were empowered to enforce health and safety law in the workplace, we believe this would have a powerful effect in improving standards. We also believe this power to take action, should include not just criminal prosecutions but also improvement and prohibition notices, subject to the usual right of appeal to the Employment Tribunal and as to terms on legal costs.**

Prosecution pilot

177. The Environment, Transport and Regional Affairs Committee recommended that HSE provide better access for inspectors to legal expertise to assist in the preparation of cases for magistrates courts.[297] The Government's response was that HSE was reviewing

292 email to the Committee from CCA dated 12 July 2004

293 HSC (2000) Revitalising Health and Safety, Strategy Statement. June 2000. Wetherby: DETR

294 The three categories were where a defendant could contend that prosecution would violate the European Convention on Human Rights; where national security or an international element is involved; or where there is a high risk that the right of private prosecution will be abused and cause the defendant irreparable harm

295 HSC and HSE (April 2004), Revitalising Health and Safety (RHS). Implementing RHS – Progress Report.

296 Volume II (Ev 151, Q589)

297 Environment, Transport and Regional Affairs Committee, *The work of the Health and Safety Executive.* Fourth Report. Session 1999-2000, page xv

arrangements for handling complex and defended cases and considering a range of options. A new prosecution model was put in place involving independent legal oversight of the decision to prosecute, separating out the functions of prosecution from investigation. CCA argues that this was in line with recommendations set out in the 1981 Royal Commission on Criminal Justice (The Philips Report) and the 2001 Gover-Hammond Report. CCA reports that this pilot had a number of benefits and limited drawbacks. Both CCA and Prospect report that the pilot is not to be rolled out other than in piecemeal and partial fashion, apparently due to lack of resources (some £10 million pounds).[298] **The Committee recommends that the Government identifies resources to build on the success of the pilot.**

Penalty levels

178. Maximum penalty levels are set out in the section 33 of the HSWA In England and Wales, most prosecutions take place in the magistrates court where there is a maximum penalty of £20,000 for a breach of sections 2-6 of the Health and Safety at Work Act and £5,000 for other breaches of the Act or relevant statutory provisions. In the higher courts, an unlimited fine can be imposed for such offences and imprisonment is available for offences such as failure to comply with an improvement notice.[299]

179. A range of organisations giving evidence to the Committee, particularly trade unions, considered penalty levels to be too low .[300] The average fine per case fell from £11,141 in 2001/02 to £8,828 in 2002/03.[301] In fact, there has been no substantial change in the general level of fines since the Court of Appeal said they were too low in November 1998.[302] HSC/E point out that 'large company health and safety fines [are] up to ten times lower than the general level of financial services fines for larger companies.'[303] In oral evidence, they highlighted higher fines as one of the changes they thought would most help them perform their functions more effectively.[304]

180. In oral evidence, Dr Janet Asherson said that the CBI had 'no problem with the health and safety fines being aligned with the sort of penalties we find in other areas', although she also commented that further training might be more of a motivator for improving performance and preventing recurrence.[305] EEF, the manufacturer's organisation, commented that the case for higher fines would be won only if a correlation with improved workplace health and safety could be made. [306] EEF supports hypothecating fines so that the money would be reinvested in HSC/E to facilitate their driving greater improvement.

---

298 Volume III (Nos. 30 and 41)

299 HSC (2002), *Enforcement policy statement.* Sudbury: HSE Books

300 See, for example, Volume III (Nos. 5, 28, 30 and55)

301 HSE, Health and Safety Offences and Penalties 2002/2003, www.hse.gov.uk

302 HSE. *Health and Safety Offences and Penalties 2002/03,* www.hse.gov.uk . Foreword by Timothy Walker.

303 Volume III (No. 36)

304 Volume II (Ev 137, Q540/541)

305 Volume II (Ev 56, Q192-193)

306 Volume III (No. 30)

181. Another development HSC identified as being helpful was innovative penalties. Mr Bill Callaghan said that, for example, disqualification of directors, forms of community service orders or training could have as big an impact on companies as a fine.[307] *Revitalising* committed HSC to advising Ministers on the feasibility of consultees' proposals in this respect. RoSPA commented that this had not been taken forward and has put forward proposals, (as has the Institute of Occupational Safety and Health[308]) for a new regime of remedial sentencing under which the courts could appoint experts to oversee remedial action, with successful completion linked to the lifting of a suspended sentence.[309]

182. **The Committee recommends that maximum penalties should be increased by means of a Bill in the next session of Parliament and further recommends that proposals to introduce alternative and innovative penalties in addition to those already available to the courts should be examined and the reasoned conclusions thereof published by 1 May 2005.**

11 Inspection and enforcement by other agencies

183. Health and safety law is enforced by HSE and by LAs (who are mainly responsible for premises such as offices, shops, retail and wholesale distribution centres, leisure, hotel and catering premises).[310] Other areas not enforced by HSE include consumer and food safety, marine and aviation safety and pollution.

184. The Chancellor has asked Philip Hampton to consider the scope for 'promoting more efficient approaches to regulatory inspection and enforcement while continuing to deliver excellent regulatory outcomes.'[311] A discussion paper presented to the Health and Safety Commission discusses the relationship of HSE to other regulatory bodies.[312] It notes that there are over 100 independent regulators, who have grown up in piecemeal fashion. The system is said to be designed from the perspective of regulators, 'concentrating on their individual requirements and design processes to give them the greatest chance of being realised'. There is ' a clear government push to consider the system from the perspective of the regulated.' From this perspective, the canvass is 'inconsistent and overcrowded.'

185. Commenting on the way forward, the paper presented to HSC comments that greater 'brigading' of regulatory functions would 'harmonise approaches, reduce burdens on business and avoid duplication and might be a logical step forward.' It argues that the 'one stop shop' argument has been discussed at length but that the enormity of the task and the different needs and wishes of stakeholders have been barriers to progress. It is conceded that there might be scope for some rationalisation of existing regulators but there are

307 Volume II (Ev 137, Q542)

308 Volume II (Ev 3, Q12)

309 Volume II (Ev 17)

310 HSC (2002), The health and safety system in Great Britain, London: The Stationery Office

311 HM Treasury (2004), Budget 2004, *Prudence for a purpose: A Britain of stability and strength.* London: The Stationery Office, para 3.57

312 http://www.hse.gov.uk/aboutus/hsc/meetings/2004/110504/cm04.pdf

questions as to whether this would result in genuine benefits. It is suggested that there may be scope for more joint working including: joint approaches to communications; a single access portal to regulatory information and guidance; a common understanding of what works leading to common intervention strategies; and common approaches to risk management.

186. The current regulatory structure did come in for some criticism in evidence to the Committee. The Confederation of British Industry argued that there is scope for greater co-ordination between HSE and other government departments, particularly where there were overlapping responsibilities.[313] It believes that HSE's approach to risk-based regulation could usefully be applied to other regimes. It argues that health and safety regulations, environment regulations and others are ultimately applied by business to one process and under a coherent set of management standards. This 'needs to be recognised by regulators if they are to avoid conflicting and duplicating requirements'. CBI favours a 'first stop shop approach' which brings together the expertise of a range of officials through a single contact point. Business 'needs regulatory contacts who can provide specialist advice but also needs a simple way of accessing government.' Beyond that, however, the CBI said it believed that 'the separation between policy and enforcement, represented by the HSC and HSE, combined with strong links between the two organisations has resulted in effective and independent policy.' EEF, the manufacturers' organisation, argued that 'the separation of the Commission and Executive have served us well over the last 25 years and should continue to do so.'[314]

187. In the context of the health service, the Royal College of Nursing was concerned that a fragmented structure had developed as a result of the modernisation agenda.[315] This had led to a 'multi-agency approach' with numerous bodies (e.g. the National Patient Safety Agency and the Counter Fraud and Security Management Service) responsible for particular aspects of health and safety.' Overall, there was a sense of 'lack of coherence, leadership and accountability'.

188. The Committee was not able to consider in detail HSE's relationships to a wide range of other regulators. However, we did look in some detail at how it interacts with local authorities, who are the other main body involved in health and safety enforcement.

Enforcement by local authorities

189. The local authority enforced sectors are predominantly made up of small businesses - almost all employ less than 50 employees and over 90% less than 10 employees.[316] The number of workers in the local authority enforced sectors is increasing and the role of local authorities in enforcement will continue to grow in importance.[317] The rate of reported

313 Volume III (No. 42)

314 Volume III (No. 33)

315 Volume III (No. 12)

316 HSC, National Statistics, Health and Safety Activity Bulletin 2003, Inspection and enforcement in local authority enforced sectors. www.hse.gov.uk/lau

317 Health and Safety Commission (2003), Delivering health and safety in Great Britain. Health and Safety Commission Annual Report 2002/03,London: The Stationery Office

injuries in the local authority enforced sector increased between 2001/02 and 2002/03.[318] The Labour Force Survey rate of reportable non-fatal injury has fluctuated, with no real improvement over the past five years. The proportion of people reporting that their illness was caused or made worse by a job in the LA enforced sector is 3.2%, lower than the overall rate for all industries.

190. Evidence to the inquiry suggested that there are advantages to having local authorities involved in enforcement of health and safety.[319] A number of key concerns emerged, however, regarding the nature of the division of responsibility with HSE, the squeezing of resources for health and safety due to competing demands and a lack of consistency in enforcement activity across local authorities.

Resources for local authority enforcement

191. HSC statistics show that the number of inspectors holding and using HSE powers fell by 26.3% from 1,440 in 1997/98 to 1,060 in 2001/02.[320] The rate of local authority inspections declined by 11% between 2002/03 and 2001/02. The rate of visiting has declined steadily since the 1990s and 23 visits per 100 premises were carried out in 2001/02. Both the Convention of Scottish Local Authorities (CoSLA) and the Local Government Association (LGA) argued that resources for health and safety enforcement are squeezed by competing priorities, and in particular, food safety.[321] There were also concerns that local authorities were subject to competing and sometimes conflicting demands from central government.[322] CoSLA also argued for an examination, at both Scottish Executive and Westminster level of the relative priorities in public health terms of all the functions that local authorities undertake.[323] In the absence of this, resource allocation tended to depend on which agency shouts loudest. A further concern was that local authorities had difficulty recruiting and retaining suitably qualified staff.[324]

Consistency of enforcement

192. The Committee received evidence of inconsistency of enforcement across local authorities.[325] A report by Unison and the Centre for Corporate Accountability, based on data for 1999/2000, found 'huge variation between local authorities in levels of inspection, investigations, in enforcement notices and in the numbers of health and safety inspectors.'[326] The LGA argued that there were mistakes in this report. The Centre for

318 HSC/National Statistics (2003). *HELA National Picture 2003. Health and safety in local authority enforced sectors.*Health and Safety Executive. The report notes that the methodology used in estimating reporting of major injuries has been provisionally revised. Using the revised basis, the injury indicator in 2002/03 has dropped since 1999/2000, while the unrevised indicator rises. There is insufficient evidence to choose confidently between the two.

319 Volume III (No. 43), Volume II (Ev 90,Q340)

320 HSC, National Statistics (2003), Health and Safety Activity Bulletin 2003, Inspection and enforcement in local authority enforced sectors. Sudbury, HSE Books, table 2

321 Volume II (Ev93, Q 351) and Volume III (No. 43)

322 Volume III (No. 43)

323 Volume II (Ev 93, Q351)

324 Volume II (Ev 89, Q338)

325 See, for example, Volume III (Nos. 3, 5, 26 and 35)

326 Unison and Centre for Corporate Accountability(2003), Safety Lottery. How the level of enforcement of health and safety depends on where you work. London: Unison

Corporate Accountability provided details of four errors in the detail of the report but told us that, overall, its accuracy had been accepted by HSE.[327]

193. Both CoSLA and LGA were concerned that the narrow focus on the number of inspections done did not reflect other activities carried out by local authorities, such as provision of advice to businesses. They also questioned the link between the number of inspections and improved health and safety outcomes.[328] In oral evidence, CoSLA said that 'we do not have too much evidence at the moment of what interventions work' and pointed to ongoing work to develop a 'more meaningful performance indicator.'[329] The question of whether the impact of enforcement in the local authority sector is the same as in the HSE sector was identified as an issue in the recent literature review on interventions to improve compliance.[330] In the meantime, however, it would appear sensible to use the extensive research evidence on the effectiveness of HSE interventions.

194. CoSLA considered the current level resourcing of HSE monitoring of local authority enforcement activity to be insufficient, with HSE 'only doing selected and obviously failing local authorities.'[331] The Centre for Corporate Accountability told us that HSE uses one person to audit local authorities compared to over 40 employed by the Food Standards Agency.[332] CoSLA also attributed the Food Standards Agency (FSA)'s comparative success as being due to its having kept food safety and hygiene high on the public agenda, having posed a number of strict targets, and having taken a much stronger line on informing councils of their duties under the Food Safety Act.

195. Section 12 of the Food Standards Act 1999, states that the FSA has the 'function of monitoring the performance of enforcement authorities', including by setting standards. The FSA has the power to report on the performance of any enforcement authority and to include guidance on actions to improve performance. It may direct the authority to publish this report and notify the FSA of the action it has taken in response.

196. Section 45 of the Health and Safety at Work Act allows the HSC, where it is of the opinion that an investigation should be made into whether a local authority has failed to perform its enforcement functions, to make a report to the Secretary of State. The Secretary of State may direct that a local inquiry should be held to consider this. Where an authority is subsequently found to be in default, an order may be made requiring the local authority to perform certain functions. Where it fails to do so, performance of enforcement functions may be taken over by HSE.[333] This procedure looks unwieldy compared with that available to the Food Standards Agency, and it is not clear that it has ever been used.[334]

---

327 Volume II (Ev12, Q50 and Ev36, Q131), Two inaccuracies, which emerged after publication, had been corrected immediately and CCA reported that it had been unable to get further details as to the nature of the alleged inaccuracies from LGA. Volume II (Ev40)

328 Volume III (No. 43)

329 Volume II (Ev 90, Q 345 and 346)

330 Wright M, Marsden S and Antonelli A (2004), Building an evidence base for the Health and Safety Commission Strategy to 2010 and beyond: A literature of interventions to improve health and safety compliance. SudburyHSE Books

331 Volume II (Ev 91, Q347)

332 Volume III (No. 41)

333 Section 45, Health and Safety at Work Act 1974

334 Volume II (Ev40)

197. At the moment, the system of auditing is a peer review system which reports back to HSE.[335] CoSLA told us that most local authorities in Scotland would prefer to have a third party auditing system, but that this system should apply to HSE in the same way as to local authorities. The LGA argued that peer review was the best way of auditing local authorities.[336] However, it felt that the performance of both HSE and local authorities should be analysed by HSC.[337]

198. **The Committee recommends that HSE undertakes and publishes by 1 October 2005 a thorough audit of the performance of local authorities. The Committee further recommends that additional powers should be made available to allow HSC/E to take actions against any local authority manifestly failing in its duty of enforcing health and safety regulations.**

Division between local authorities and HSE

199. Both CoSLA and the LGA argued that there were important advantages to having local authorities involved in health and safety, including local accountability, strong and widespread contacts with local businesses and their ability to use other interventions such as licensing, planning and building control, and economic development to influence health and safety awareness practice.[338]

200. The Institution of Occupational Safety and Health (IOSH) told us that the current division was a 'historic anomaly', based on organisations that were covered by the Factories Act on the one hand and the Offices, Shops and Railway Premises Act on the other.[339] Mr St John Holt told us that the Royal Mail, with some of the most advanced mail sorting operations in the world, was largely enforced by environmental health officers 'with some difficulty in terms of their expertise to do that.' CoSLA described the current divisions of responsibility as 'counterproductive and confusing to business.'[340]

201. The current HSC strategy concedes that there is 'no lasting logic' to the current division of responsibility between HSE and local authorities, which are complex, confusing and based on boundaries that suit the needs of the regulator rather than those of business or the workforce.[341] In oral evidence, Bill Callaghan, Chair of the HSC, told us that the local authority role was 'fully recognised', although in the past they had been 'very much the junior partner.'[342] HSC's current strategy is to seek to develop a 'closer partnership based on a mutual understanding of the value of local versus central interventions.'[343] Organisations representing local authorities (the LGA and the CoSLA) agree there is a need for better partnership arrangements.[344] The LGA and LACoRS (Local Authorities

335 Volume II (Ev91, Q347)

336 Volume II (Ev 13, Q52)

337 Volume III (No. 43)

338 Volume III (No. 43 and 55)

339 Volume II (Ev 7, Q23)

340 Volume III (No. 55)

341 HSC (2004), A strategy for workplace health and safety in Great Britain to 2010 and beyond, Sudbury: HSE Books

342 Volume II (Ev134, Q523)

343 HSC (2004), A strategy for workplace heath and safety in Great Britain to 2010 and beyond, Sudbury: HSE Books

344 Volume II (Ev 89,Q 337); Volume III (No. 44)

Coordinators of Regulatory Services) agree that there is 'scope for reviewing the EA [Enforcing Authority] regulations to determine whether the current division of responsibilities makes the best use of the joint enforcement resource.'[345] CoSLA believes there is 'potential for maximising that common resource, through joint planning against jointly agreed and fully resourced outcome targets and with equal access to the technical and scientific resources of the HSE.'[346]

202. Among both employers and unions, however, there was some scepticism as to whether an improved partnership arrangement would make enough of a difference.[347] The CBI was sceptical that , a 'memorandum of understanding' would deliver business' needs for 'consistent and effective enforcement within a clearly identified programme of priorities'. However, it argued that 'an evaluation of the effectiveness of current enforcement arrangements of LAs should be made before decisions can be taken about transferring enforcement/inspection responsibility between HSE and LAs.'[348] A range of organisations, including the Business Services Association, the GMB, the Graphical Paper and Media Union and the Institution of Occupational Safety and Health suggested that it might be advantageous to remove responsibility for enforcement from local authorities and give those powers to the HSE.[349]

203. The TUC did not support any fundamental changes to the current regime (although it did argue that consistency of enforcement needed to be improved and that more resources were needed).[350] The STUC was 'not of the view that a unitary enforcement body would provide better results.'[351]

204. **The Committee recommends that the Department by 1 October 2005 reviews its strategies to ensure national consistency and rigour in enforcement of health and safety regulations throughout Great Britain. If this review finds substantial support for current criticisms, it is further recommended that the demarcation of enforcement activity between HSE, local authorities and other enforcement agencies be examined, the case for a unified health and safety enforcement authority investigated and the reasoned conclusions thereof be published by 1 October 2006.**

12 Information and advice

205. The current HSC/E strategy recognises 'the need to do more to make health and safety and its benefits more widely understood and accepted.'[352] Awareness raising is particularly important for sSmall and medium enterprises (SMEs) who have lower levels of awareness and for whom awareness is a pre-requisite for compliance. There is clearly much to do to

345 Volume III (No. 43)

346 CoSLA draft consultation response to the Review of the Relationship between Health and Safety Executive and Local Authorities. August 2003

347 Volume III (Nos. 42 and 26)

348 Volume III (No. 42)

349 Volume III (Nos. 4, 26 and 32), Volume II (Ev 6, Q23)

350 Volume III (Nos. 5 and 35)

351 Volume III (No. 11)

352 HSC (2004), *Strategy for workplace health and safety in Great Britain to 2010 and beyond.* Sudbury: HSE Books

raise awareness. In a survey conducted for HSE, for example, only 43% of employers said they were aware of the management regulations.[353]

Reaching Small and Medium Enterprises

206. The literature review conducted to underpin HSC's strategy concluded that no one activity (education, incentives, reputational risk, supply chain pressure, inspection and enforcement) is particularly effective for small firms:

> 'small firms are hard to reach, less receptive to awareness raising activities, too numerous to secure compliance via inspection and often unreceptive to the business case for health and safety due to the intangibility of the costs and benefits'

207. A multi-dimensional approach is, therefore, needed. Small firms prefer specific advice and information that they do not need to interpret in order to apply. International evidence suggests that face-to-face contact with health and safety agents (such as inspectors) is what works best.[354] However, the reach of such health and safety agents is limited.

208. A further concern is around the reluctance of small businesses to seek advice for fear of attracting enforcement action. Some argued that HSE's advice and enforcement functions should be separated in order to get around this.[355] Others, such as the GPMU, argued that it was important for the way in which HSE is perceived by business, that it was not seen as just an enforcement agency.[356] HSE inspectors will inevitably continue to play a role in providing advice and information and the recent strategy recognises the importance of this.[357]

209. Given the limitation on resources, HSE has looked at ways of getting its message across. For example, Safety and Health Awareness Days, had benefits in terms of reaching small businesses. Furthermore, attendees reported having made positive and tangible changes to their approach to health and safety (such as purchasing a new safety harness).[358] Another policy measure `which has been shown to be effective, is the use of worker safety advisers. Evaluation of the pilots showed that three quarters of the employers involved in the schemes had made changes to health and safety as a result.[359] Unfortunately, the scheme is very limited in the number of firms it is able to reach (see Chapter 14).

210. HSC's strategy talks about developing 'channels of support and advice that can be accessed without fear of enforcement action while allowing regulators to be tough on those who wilfully disregard the law.'[360] Because of this, and because resources are limited, an

353 Hanson M et al (1998), *Evaluation of the Six-Pack Regulations 1992,* HSE Contact Research Report. Sudbury: HSE Books

354 Walters D (2001), *Health and Safety in Small Firms,* Brussels: Peter Lang, pp 217-275

355 Volume III (No. 26)

356 Volume III (No. 4)

357 HSC (2004), A strategy for workplace health and safety in Great Britain to 2010 and beyond. Sudbury: HSE Books

358 Volume III (No. 38)

359 Shaw N and Turner R, *Worker Safety Advisors (WSA) pilot,* HSE Research Report 144 Sudbury: HSE Books

360 HSC (2004), A strategy for workplace health and safety in Great Britain to 2010 and beyond. Sudbury: HSE Books

important part of HSC/E's strategy is to engage with intermediaries. However, evidence suggests that assumptions that have been made about the willingness, capacity and effectiveness of such intermediaries to act on health and safety issues are not born out.[361] HSC comments that 'these are not easy issues and we will conduct further studies, including the role of small firms' intermediaries before making a decision on how best to achieve this aim'.

211. A further plank of the strategy for providing accessible advice and support is to 'press for the provision of nationally available advice and support focused primarily on occupational health.' The Federation of Small Businesses in Scotland drew attention to the success of the Safe and Healthy Working Project in this respect.[362] This is a '3-year project providing a free telephone helpline and website, backed up by specialist advisors and a team of professionals across Scotland providing occupational health and safety advice, and on-site health audits for SMEs'. Demand for this service is apparently such that it is becoming log-jammed.[363]

212. HSC/E told us that communications were a priority for extra resources. It said it would like to move to 'more strategic campaigns'[364]. An additional £15m over 3 years would, it says, enable it to do more in terms of complementing operational activity by raising levels of awareness of hazards, highlighting sources of advice and publicising prosecutions. It also suggests that a further £25 million over three years would enable it to do more in terms of improving access to occupational health support (see Chapter 15).

213. The GMB has proposed the establishment of a Work Environment Fund.[365] Raised through a small payroll levy, GMB argues that this could provide an equitable means of ensuring that practical advice and assistance is available to employers. It estimates that an increase of twenty pence per week per employee would double the HSE's current budget.

214. The Committee supports HSE's strategy of devoting more resources to developing the role of intermediaries in providing support for small and medium enterprises but believes that this should be in addition to, not at the expense of, resources needed to provide an effective inspection regime for the sector.

Printed information

215. The importance of having access to good quality, accessible guidance was raised by several witnesses. The quality of the information produced by HSE was generally praised.[366] The Construction Confederation was concerned that there had been delays in issuing important pieces of guidance.[367]

---

361 James P, Vickers I, Smallbone D and Baldock R,*'Use of external sources of H&S information and advice: case of small firms' in*'Policy and Practice in Health and Safety', vol 2, issue 1, 2004

362 Volume III (No. 56)

363 Volume II (Ev 89,Q339)

364 volume II (Ev 142, note 6)

365 Volume III (No. 26)

366 See, for example, Volume III (No. 26)

367 Volume III (No. 20)

216. Trade unions were particularly concerned that most publications were priced out of the reach of safety representatives.[368] HSE told us that it publishes some 600 products free of charge and is committed to making more information available online. It said that there are no contractual restrictions to prevent it publishing information free on-line. However, as publications generate £5m income each year, a move to 'publishing all guidance free of charge on-line' would 'have a detrimental impact on HSE's future income.'[369] HSE is currently reviewing its pricing policy with a view to developing a transition plan 'allowing more information to appear on the internet without incurring any business detriment as a result.' **The Committee recommends that resources should be allocated to enable all key HSE publications to be made available free of charge on the internet.**

13 Work-related road safety

217. The Parliamentary Advisory Council for Transport Safety (PACTS) told the Committee that one aspect of the changing world of work is that increasing numbers of people are required to be mobile. If employers are to discharge their responsibility to manage health and safety risks to their employees, they have to manage those faced by employees on the road, as well as by those in fixed workplaces. HSE and local authorities, as enforcing authorities, have a duty to ensure that this happens.

218. The HSC told us that, based on the assumption that between 25-33 per cent of road traffic incidents might be work-related, the range of fatal injuries is approximately 860-1130 a year.[370] This compares to 226 fatal injuries to workers in the "traditional" workplace.[371] The number of serious injuries due to work-related road traffic incidents is estimated to be between 8980 and 11,870 a year.

219. In May 2000, the Government and HSC set up a Work-related Road Safety Task Group to look at what action could be announced within the strategy, signalling Government commitment to see what action can be taken to reduce road traffic incidents connected to work. This group reported in November 2001 and made a number of recommendations for action by HSE.[372]

220. In this context, both PACTS and the Royal Society for the Prevention of Accidents (RoSPA) consider it worrying that HSC's recent strategy document neglected to mention work-related road safety.[373] PACTS added that a recent leaflet on health and safety in road haulage 'most bizarrely' contained no references to work-related road safety, focusing entirely on issues such as loading and unloading. HSE has, as recommended by the Task Group, produced guidance on the issue. RoSPA point out that the guidance explicitly states that work-related road safety is not among HSE's current priorities. [374] Prospect is

368 eg Volume III (Nos. 5 and 26)

369 Volume III (No. 38)

370 Volume III (No. 38)

371 HSC Health and Safety Statistics Highlights 2002/03. National Statistics

372 Work-related Road Safety Task Group (2001), Reducing at-work road traffic incidents, Report to Government and the Health and Safety Commission. HSC, DLTR

373 Volume III (Nos. 14 and 24)

374 Department for Transport, Health and Safety Executive, *Driving at work. Managing Work-related Road Safety*

concerned that this guidance is not going to be enforced.[375] In oral evidence, Mr Bill Callaghan, Chair of the HSC said that:[376]

> "To be blunt, if HSE were to engage in a major enforcement and accident investigation role in this area, that would be a major distortion of our resources. We would not be able to do that and meet all the other things that we would like to do in the construction industry, migrant workers and elsewhere."

221. On the question of resources, the Work-related Road Safety Task Group found that[377]:

> "This initiative, if given the right level of support, is likely to make a significant contribution to meeting the Government's target on reducing road casualties. But money must be there to pay for preventive action…The Task Group believes that considerable societal savings can be made, dwarfing the added funding to enforcing authorities that might be necessary."

It therefore recommended that the Government and HSC should consider what resources are appropriate to implement these recommendations. Mr Bill Callaghan told us that HSE investigation and enforcement of these incidents would require 460-802 staff years.[378] However, the Minister told us that there was a question of policy as well as resources[379]:

> "It is not an area on which the HSE or the Commission take a lead, it is an area where other organisations have a much greater enforcement role. The police, for example, have greater potential for contact with working drivers and employers, contact that the HSE simply could not match and, therefore, should not be trying to duplicate."

222. The Minister also said that it was her view that HSE could not add anything to what was already being done by other agencies.[380] However, the Minister has partly missed the point, which is that the police and HSE have different roles. PACTS points out that the police tend to focus on an individual's level[381] and, as regards injuries, usually become involved after the event. HSE, on the other hand, is responsible for ensuring risk is managed at an organisational level – that is, preventative action before the event. Employers need to assess and manage the risks to their workforce. HSE needs to ensure this happens.

223. There would also appear to be a tension between Minister's comments and the conclusions of the Work-related Road Safety Task Group, who said that a consequence of allowing road traffic law to take precedence over health and safety at work legislation meant there had been 'little motivation for employers, or the enforcing authorities, to

375 Volume III (No. 30)

376 Volume II (Ev 130 Q499)

377 The Work-related Road Safety Task Group (2001), *Reducing at-work road traffic incidents.* HSC, DLTR, para 77

378 Letter to Committee from Bill Callaghan, 15 June 2004. The figures include a proportion resulting in legal proceedings and are for operational staff time alone. Additional costs would be incurred for accommodation, administrative support, training, travel, subsistence etc

379 Volume II (Ev 149, Q575)

380 Volume II (Ev 150, Q579)

381 Volume III (No. 24)

examine whether a failure in health and safety management systems might have contributed to an incident.'[382] It recommended that 'the various authorities, *led by HSE*, should develop ways of working to investigate at-work road traffic incidents and take appropriate enforcement action.'[383]

224. **The Committee recommends that the HSE are provided with the necessary resources to enable them to enforce effectively its existing guidance on work-related road safety, particularly in relation to preventative measures.**

225. A number of organisations believed that employers should be required to report work-related road incidents under RIDDOR (the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995). This was also a recommendation of the Task Group, which concluded that it was essential in order to build up a statistical database and use reports to target investigations, would not be too burdensome on individual firms and would help to raise awareness of the issue among employers. [384] The HSC told us that the review of RIDDOR was currently underway and would be looking at reporting of at-work road traffic incidents causing injury. [385] A discussion document is to be issued in 2004.

226. **The Committee recommends that at-work road traffic incidents should be required to be reported pursuant to RIDDOR.**

227. A further issue was whether there should be an Approved Code of Practice (failure to comply with which may be taken, in court, as evidence of failure to comply with the legislation). The Work-related Road Safety Task Group recommended that HSE should issue guidance 'as soon as possible' and that the impact of the guidance should be reviewed in Spring 2004, to determine whether to recommend the production of an Approved Code of Practice. In fact the guidance was not published until September 2003.[386] In evidence to the Committee, the Association of Personal Injury Lawyers (APIL) called on the HSE to develop an Approved Code of Practice (ACoP) in this area.[387] When asked about this, Mr Bill Callaghan argued that what was needed was 'to get a better knowledge base of what road accidents have a clear work provenance.'[388]

228. **The Committee recommends that, by 1 October 2005 the HSC/E should carry out a review of the case for an ACoP on work-related road safety, and publish its reasoned conclusions.**

382 The Work-related Road Safety Task Group (2001), *Reducing at-work road traffic incidents.* HSC, DLTR, para 31

383 The Work-related Road Safety Task Group (2001), *Reducing at-work road traffic incidents.* HSC, DLTR, recommendation 13. Emphasis added

384 The Work-related Road Safety Task Group (2001), *Reducing at-work road traffic incidents.* HSC, DLTR, recommendation 12, para 61

385 Volume III (No. 38)

386 HSE press release. HSE published guidance on work-related road safety. E178/03 – 17 September 2003

387 Volume III (No. 15)

388 Volume II (Ev 130,Q499)

14 Consultation with employees

229. Employers are obliged to consult their employees on health and safety matters. This means providing the workforce with information and taking account of their views before making decisions on health and safety. Under the *Safety Representatives and Safety Committee Regulations 1977,* a trade union has a right to appoint a safety representative. The rights and functions of such safety representatives include: a legal right to represent employees in discussions with employers on H&S issues; to investigate hazards, dangerous occurrences and complaints, to carry out inspections of the workplace, and to inspect relevant documents.[389] Employers' legal duties include consulting safety representatives on arrangements for co-operating on health and safety measures, making information available and providing facilities and assistance. Where the 1977 regulations do not apply (for example, in non-unionised workplaces) employers can consult employees directly or can arrange for employees to elect a 'Representative of Employee Safety'.

230. The HSC has recently produced a '*Collective Declaration on Worker Involvement*', endorsed by the TUC, the Royal Society for the Prevention of Accidents and employer representatives such as the Confederation of British Industry, the Federation for Small Businesses and The Institute of Directors. [390] This states that there is evidence of the positive impact trade unions have on health and safety performance and that trade union safety representatives, through their empowered role in consultation, show the strongest relationship with safety compliance. There is, however, less evidence of successful methods of involvement and consultation in small businesses where trade unions are not recognised.'

231. The *Collective Declaration* notes that there has been a significant decline in trade union membership in recent years. 7.5 million members of the workforce are now trade union members and 17.5 million are not.[391] The declaration states that changes in the way Great Britain works mean that there are now not enough employers who properly involve and consult workers on health and safety and not enough workers who feel able to come forward and take on health and safety responsibilities:

> "With changes to work patterns there is now a danger of significant reductions in consultation with workers by employers on health and safety. It is our belief that this reduction will eventually undermine work to improve health and safety and stop us from achieving our targets."

232. Trade unions giving evidence to the Committee regarded safety representatives as an important and under-used resource, there to help business to achieve its goals.[392] A number of changes were felt to be needed, including a strengthening of safety operatives' rights, an increased emphasis on enforcing the regulations where an employer fails to consult, more contact with safety representatives during HSE inspections and improvements in the information available.

389 www.hse.gov.uk/workers/safetyreps.htm

390 HSC (2004) A Collective Declaration on Worker Involvement; www.hse.gov.uk

391 HSC (2004) A Collective Declaration on Worker Involvement; www.hse.gov.uk

392 Volume II (Ev30, Q93)

233. Regarding the rights of safety representatives, the TUC argued that they should be given rights to inspect all premises where safety reps have members. It also wished to see a duty on employers to respond to issues raised by safety representatives and greater clarity and enforcement of the rights to training and information.[393] A further suggestion was that safety representatives should be able to issue a Provisional Improvement Notice [394] (as is done in Australia and Sweden). This would allow a safety representative to require an employer to stop a potentially dangerous activity pending a visit by an HSE inspector.

Enforcing the regulations

234. Failure to enforce the 1977 Safety Representatives and Safety Committee regulations was a 'major concern' for trade unions giving evidence to the Committee.[395] The GMB told us that as of January 2000, 'HSE inspectors had served just one improvement notice under the 1977 regulations – that's one in 22 years.'[396] HSC told us that, since April 2001, there have been 24 enforcement notices issued under the Health and Safety (Consultation with Employees) Regulations 1996 and 3 under the Safety Representatives and Safety Committees Regulations 1997. There were no prosecutions. (These figures compare to 13,263 enforcement notices issued and between 1,688 'informations laid' by HSE in 2002/03).[397] Mr Graeme Henderson of Prospect told us that[398]:

> "HSE's line on that is essentially that it is an industrial relations issue, and the instructions given to inspectors since 1977 are basically to steer well clear of them."

235. If HSE does not have the resources to enforce the safety representative regulations itself, one option is to enable trade unions to do so. Private prosecution could be used, for example, as a tool by unions to enforce the rights of safety representatives. Currently, there is a requirement to seek the consent of the Director of Public Prosecutions for a private prosecution to proceed. We believe this requirement should be abolished, although Mr Gareth Williams of the Department for Work and Pensions questioned whether this might change the nature of the relationship between employer and safety representative.[399] Another option, considered in a HSC discussion document on worker involvement issued in 2000, would be to give Employment Tribunals powers to hear cases in which safety representatives or workers claim that employers have demonstrated a sustained failure to consult.[400]

Employees in non-unionised workplaces

236. There is particular concern at the apparent lack of consultation with employees in non-unionised workplaces. In such workplaces, employers can choose to consult directly

393 Volume II (Ev 30, Q93)

394 Volume II (Ev30, Q92), Volume III (No. 26)

395 See, for example, Volume III (Nos. 35 and 26)

396 Volume III (No. 26)

397 HSE, Health and Safety Offences and Penalties 2002/03, www.hse.gove.uk

398 Volume II (Ev31, Q102)

399 Volume II (Ev 152, Q591)

400 HSC discussion document. Employee Consultation and Involvement in Health and Safety. 2000. www.hse.gov.uk

with the workforce and there is no requirement that there should be a safety representative. An option under consideration, in order to strengthen the position of workers in such workplaces, was to harmonise two sets of regulations on consultation with employees.[401] This was identified as a beneficial move by HSC in 2000.[402] One of the effects of this would have been to have had the effect of giving employees in non-unionised workplaces the right to elect a safety representative. Mr Hugh Robertson of the TUC told us that the proposed regulations would have been an important step forward.[403] Unfortunately, the HSC was unable to reach a consensus on the regulations.[404] *The Committee is concerned that the lack of such concensus has become a block on this reform.*

237. Alternative steps currently being taken by HSC to improve consultation with employees include the development of a *Workers' Safety Adviser Challenge Fund* to help promote involvement in workplaces with no employee representation. HSE has also placed on its website some information about the role of safety representatives and the importance of employee involvement and wishes to do some more work promoting that in summer 2004.[405]

238. The Challenge Fund is designed to increase worker involvement and consultation, through the intervention of a Worker's Safety Adviser (WSA).[406] £3 million has been made available over a period of three years from July 2004. Applications are particularly welcomed from the construction, hospitality, retail and voluntary sectors. It is focused on small firms, of between 1 and 250 employees. There are just under 1,218,000 firms of this size in the UK.[407] A pilot scheme which ran for nine months in 2002-03 showed some benefits. Over three quarters of the 88 employers involved, reported having made changes to health and safety (and over half of these considered these to have resulted from involvement in the pilot). Over two thirds of employees reported having seen increased discussion on health and safety issues.

239. While the experience of the pilot gives reason to believe that the Challenge Fund will help to deliver some benefits in terms of health and safety improvements, the Committee has two areas of concern. Firstly, the level of funding suggests it is only likely to be able to reach a very small proportion of small businesses in the UK. There will be 28 WSAs in the first year.[408] If each WSA can expect to have an average caseload of 100 enterprises (as in the evaluation), this would cover approximately 2,800 enterprises, less than 3% of the target group.

240. Secondly, the Challenge Fund seems unlikely to reach those enterprises where health and safety improvements are most needed. The evaluation of the pilot concluded that if the

401 HSC discussion document. Employee Consultation and Involvement in Health and Safety. 2000. www.hse.gov.uk. The regulations referred to are the Safety Representative and Safety Committee Regulations 1977 and the Health and Safety (Consultation with Employees) Regulations 1996

402 HSC/03/83

403 Volume II (Ev 31, Q94)

404 Volume II(Ev 132Q515)

405 Volume II (Ev 132, Q515)

406 HSC/E, The Workers' Safety Adviser Challenge Fund. Information Pack. 8 March 2004.

407 Small Business Service,UK Whole Economy, Table 1, www.sbs.gov.uk

408 HSC Press Release (30 June 2004), Grant scheme to drive improvements in health and safety

intention is 'to bring in line the worst behaving enterprises, a voluntary scheme is not likely to have significant impact.' Success would depend to a 'significant extent on the ability to secure the agreement of employers to participate.' This had been a significant issue in the pilot.

241. **The Committee recommends that, by 1 October 2005, HSC publishes proposals to develop improved rights to consultation for employees, particularly in non-unionised workplaces, including rights of enforcement through its Employment Tribunal and private prosecution routes.**

15 Occupational health support

242. In oral evidence, the Minister emphasised the importance of ensuring good information and advice was out there to support employers in protecting employees from occupational health risks.[409] In other EU countries, legislation requires employers to use some form of occupational health and/or safety specialists to assist them in their provision of a safe and healthy working environment. Such provision is further endorsed as a key requirement of the EU Framework Directive (89/391) in which employers are required to manage the work environment according to a set of prevention principles, together with workers or representatives and with the support of either internal or external prevention services.[410] A number of key issues came up in the course of the Committee's inquiry. These included: progress in improving the coverage of occupational health and safety support since the publication of *Securing Health Together*; the extent to which employers are required to use such support; and the importance, from the employee's point of view, of having access to services which are independent of the employer.

Progress since *Securing Health Together*

243. *Revitalising* contained a commitment to encourage better occupational health support.[411] The Government's long-term occupational health strategy, *Securing Health Together*[412], published in July 2000, aimed to ensure appropriate mechanisms were put in place to deliver information, advice and other support on occupational health. It was to do this by identifying the support needed; setting up suitable frameworks and delivering them to the right people and raising awareness of the existence of these frameworks and what they can deliver.

244. Despite this, evidence suggests that coverage of occupational health support is low. HSE research found that 3% of all firms were covered by occupational health activities (defined as including training, job engineering, risk measurement and health monitoring). 15% were covered by a minimal service (including risk identification, risk management

409 Volume II (Ev 148 Q564)

410 Commission of the European Communities, Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions, on the practical implementation of the Health and Safety at Work Directives. Brussels, 05.02.2004. COM (2004) 62 final

411 HSC (2002), Revitalising Health and Safety. Strategy Statement. June 2000. Wetherby:DETR Action point 29

412 HSC et al (2000), Securing Health Together. A long-term occupational health strategy for England Scotland and Wales. Sudbury: HSE Books

and information).[413] One witness raised a question as to whether provision was so low as to make the UK vulnerable to challenge in the European Court[414].

245. In the absence of such provision, Mr Simon Pickvance described primary care as having to act as a 'default occupational health service.' However, he argued that it was ill-equipped to pick up this role. GPs and nurses have too many other priorities to be in a position to offer the full range of occupational health advice. Furthermore, there is 'no secondary referral service for occupational health problems from primary care.'[415] Patients are referred to consultants who are able to deal with symptoms but are not trained to look for causes and whether there are factors at work that caused something to happen. Dr Kit Harling told us that previous attempts to get occupational health training into schools of nursing and medical schools had not been very successful.[416]

246. The literature review conducted for HSC/E to provide an evidence base for the strategy, concluded that there was significant scope for improvement in the provision of occupational health and rehabilitation advice and support in the UK.[417] HSC's current strategy explains that it will explore ways to promote access to and take-up of, authoritative health and safety advice and guidance, and press for the provision of nationally available advice and support, initially focused on occupational health. [418] HSC aims to develop the provision of such support through innovative partnerships in the public and private sectors. [419] It recognises the need, at the same time, to raise awareness and stimulate demand for these services.

247. Three pilots are currently planned or under way to test a model for occupational health support, developed collaboratively by HSE and stakeholders.[420] General features of these programmes include free advice on various occupational health issues directed to both employers and employees and collaboration of HSE with partners in the health sector.[421]

248. In oral evidence, HSC/E highlighted occupational health support as a priority for extra spending.[422] It further explained that an additional spend of £25 million over 3 years would enable it to use innovative partnerships to pilot occupational health, safety and rehabilitation support regionally, locally or by sector, to evaluate what works best in changing behaviour and to assess how much difference such support makes in improving

413 Pilkington A et al (2002), *Survey of use of Occupational Health Support.* HSE Contract Research Report 445/2002. Sudbury: HSE Books

414 Volume II (Ev 100, Q386)

415 Volume II (Ev98, Q376)

416 Volume II (Ev 98, Q375)

417 Wright M et al, Building an evidence base for the Health and Safety Commission Strategy to 2010 and beyond: A literature review of interventions to improve health and safety compliance, Report Report196 page 76

418 HSC (2004), A strategy for workplace health and safety in Great Britain to 2010 and beyond. Sudbury: HSE Books

419 HSC (2004), A strategy for workplace health and safety in Great Britain to 2010 and beyond. Sudbury: HSE Books

420 Volume II (Ev 141)

421 Volume II (Ev 141)

422 Volume II (Ev 137 Q 539)

health and reducing sickness absence.[423] It will then be able to evaluate the benefits of further investment to roll out support across the country .

249. Evidence suggests that, in any case, provision will take some time to develop. The Royal College of Nursing suggested that a lack of suitably qualified staff may be an obstacle to the provision of occupational health services. However, Dr Kit Harling argued that the gap between need and supply would drop if occupational health physicians did not do activities for which they are over-qualified[424]. The important thing was to focus on what needed to be done and then look at the 'competencies' needed to do this.

The Employment Medical Advisory Service

250. A number of organisations giving evidence to the Committee make critical reference to the loss of the post of Chief Medical Officer and the reduced staffing of the Employment Medical Advisory Service (EMAS)[425]. This is designed to help reduce risk and protect people at work by providing advice and guidance on how to comply with the law, inspecting workplaces, investigating disease and illness complaints and taking enforcement action where necessary. EMAS supports all HSE's front-line activities and provides occupational health advice directed to employers and employees. The Committee was told that HSE now employs just 15 doctors/occupational physicians and 27 nurses compared to 120 staff (split roughly evenly between doctors and nurses) 12 years ago.[426] Mr Timothy Walker, Director General of the HSE, reported that EMAS staff considered their staffing levels were correct for the role they had to play, which was to provide guidance.[427] Both TUC and Prospect call for proper resourcing of EMAS in order to enable it to drive forward occupational health in Britain.[428] Prospect argues that the proposal to set up a new organisation, using partners (as is being explored in the pilots), is very likely in any case to require considerable public funding.

251. **The Committee is disappointed at the plans and progress to date to establish national cover of occupational health services. It recommends that this is given higher priority than it has received to date and that HSC/E is provided with the necessary resources to enable it to make progress towards the 2010 targets on occupational health.**

Competencies

252. It is a key requirement of the EU Framework Directive 89/391 that employers are required to manage the work environment according to a set of prevention principles, together with their workers and with the support of either internal or external prevention services. Great Britain pursues a largely voluntary system in which employers still have maximum discretion over the extent to which they choose to involve occupational health

423 Volume II (Ev 142)

424 Volume II (No. 13), Volume II (Ev 98, Q375)

425 Volume III (Nos. 25, 30, 32 and 33)

426 Volume III (No. 31)

427 Volume II (Ev 135. Q530)

428 Volume III (Nos. 5 and 30)

and safety specialists. Employers in Great Britain are required to appoint a 'competent' person to assist them in complying with health and safety requirements. However, there is a lack of clarity of the meaning of competence. EEF, the manufacturers' organisation, told the Committee that employers often only find out that they have failed to meet the required standard in the course of litigation[429]. Mr Simon Pickvance of Sheffield Occupational Health Service argued that the requirements of occupational health services, including definition of competence, could be clarified in an Approved Code of Practice.[430]

253. **The Committee recommends that the HSC should, by 1 October 2005, develop and publish an Approved Code of Practice defining the standards of competence employers are required to use to ensure they comply with health and safety requirements.**

A service for employees

254. Several witnesses pointed out that employees suffering from work-related illness do not have employment security, which may influence the identification and the treatment of the illness.[431] Employees do not want to talk about their health problems with their employer if they are potentially work-threatening. There is a need for a third party advice for both employees and employers. People should feel that can get clear, honest advice that is not tainted one way or another. **We endorse the suggestion of NHS Plus that the NHS is ideally placed to provide third party occupational health advice to employees and employers. This does not mean that they would provide all the service, but they could "serve as honest broker".** [432]

16 Occupational health

255. The HSC recognises that tackling occupational ill-health is a significant challenge.[433] A number of issues arose in the course of our inquiry: the adequacy of data on the extent and nature of occupational ill-health, 'emerging' risks such as those associated with passive smoking and occupational stress, HSC/E's approach to tackling the issue, the availability of occupational ill-health and the role and nature of inspection in this area.

Health data

256. Work-related illness constitutes a substantial proportion of the total burden of illness in Great Britain. Although there is no nationwide registration system, there are figures which describe the extent of the problem. In 2001/02 an estimated 2.3 million people in Great Britain were suffering from an illness, which they believed was caused or made worse by their current or past work and in 2000-02 an estimated 40 million working days were lost overall, 33 million due to work-related ill health.[434]

429 Volume III (No. 33)

430 Volume II (Ev 100, Q386)

431 Volume III (No. 44), Volume II (Ev 99, Q379)

432 Volume II (Ev 100, Q383)

433 HSC (2004), Strategy for workplace health and safety in Great Britain to 2010 and beyond, Sudbury: HSE Books

434 HSC, National Statistics (2003), *Health and Safety Statistics Highlights 2002/03.* Sudbury: HSE Books

257. The regulations require employers to report all cases of a defined list of 47 occupational diseases occurring among their employees where they receive a doctor's written diagnosis and the affected employee's current job involves the work activity specifically associated with the disease.[435] Comparison of these figures with those for disablement benefit for the corresponding DWP prescribed diseases suggests that there is still substantial under-reporting under RIDDOR, particularly for diseases with long induction periods (for example, the pneumoconiosis and occupational cancers). In addition, poor access to occupational health services and compromised knowledge of occupational health in primary care is likely to result in under-diagnosis of occupational disease.

258. At present there are no data-collection systems by which HSE inspectors and Environmental Health inspectors can locate cases of occupational morbidity. The RIDDOR system is discredited as a method of locating cases (there is likely to be an inverse relationship between use of the system and need – only well-managed firms will use it).[436] For example, Mr Simon Pickvance of the Sheffield Occupational Health Advisory Service (SOHAS) told us that in a Yorkshire city of 200,000 people, one of the enforcement agencies received just one case of occupational illness under RIDDOR last year.[437] There is no system of data collection through the health care system though primary care occupational health projects that could provide this in the future the Sheffield scheme sees 1200 patients with occupational health problems for the first time each year.

259. However, HSE is introducing a new workplace survey which, Mr Gareth Williams of the Department for Work and Pensions told us 'will give us statistics of National Statistics quality on workplace ill-health in order that we can get a better handle on both the starting position and the causes and principal contributory factors, so as to improve our evidence base'. In addition, HSE has secured funding to pilot a two-tier workplace survey to improve its understanding of accident and ill-health levels in the construction industry.[438] **The Committee welcomes steps being taken by HSE to improve our understanding of the nature and extent of the problem.**

HSC/E's approach

260. HSC issued a long-term occupational health strategy in 2000. This included targets to, by 2010:

- Achieve a 20% reduction in the incidence of work-related ill health;
- A 20% reduction in ill health to members of the public caused by work activity;
- A 30% reduction in the number of work days lost due to work-related ill health
- Everyone in employment but off work due to ill health or disability to be made aware, of opportunities for rehabilitation into work as early as possible; and

435 www.hse.gov.uk/statistics

436 Volume III (No. 44)

437 Volume III (No. 44)

438 Volume II (Ev 150, Q585), National Audit Office (2004), *Improving health and safety in construction industry,* HC 531 Session 2003-2004 para 1.11

- Everyone currently not in employment due to ill health or disability is, where necessary and appropriate, made aware of and offered opportunities to prepare for and find work.

261. HSC's current strategy indicates that a reasonable job has been done on safety issues, 'but there is still a huge job to do on health'.[439] It sees the need for a 'more strategic and partnership-based approach.' This will include creating partnerships to develop the provision of occupational health and safety support, raising awareness of and stimulating demand for these services and placing a greater emphasis on rehabilitation.[440]

262. Dr Kit Harling of NHS Plus told the Committee that while HSE had now recognised the scale of the problem, the next step was to move to 'actually implementing some positive policies that are going to help the delivery of occupational health care in its broadest sense'.[441] He argued that the fact that health and safety have been linked over many decades has led to a false assumption that the systems for managing the risk of accidental injury and occupational disease are similarly identical.[442] His view was that important differences emphasised the need for a different approach. Firstly, occupational safety focuses on preventing injuries through preventing accidents, whereas occupational illness may be the cause of some long-term feature of a normally operating system and there is no 'instantaneous cause'. Secondly, occupational illness often has various causes. Thirdly, it is rare that occupational illnesses are exclusively attributable to workplace factors.

263. Several witnesses pointed out that the HSE cannot manage the risks of occupational illness on their own or in isolation.[443] Dr Kit Harling suggested that what was needed was a multifaceted approach based on the development of partnership working.[444] He argued that as HSE itself was not likely to be able to do all the multi-disciplinary parts of the job that need doing, it should adopt a leadership role, looking at how the different components can work together.[445] In addition to its traditional partners, it needs effective links to the expertise of the health community – primary care organisations, secondary care, public health, local authorities and the private & voluntary sector. Mr Simon Pickvance of SOHAS, on the other hand, was concerned that a 'partnership' approach might not deliver:[446]

> "I think 'partnership' just sounds like some meetings at which people talk to one another, it does not sound like the kind of concrete action that is needed. I have a sense of urgency about this. I see people who are losing their jobs day by day. I have done this job for 25 years and have seen very little change. In many areas, things have got a lot worse… Partnership is not enough for me, there has got to be a concrete co-ordination of effort."

---

439 Volume III (No. 36)

440 HSC (2004), Strategy for workplace health and safety in Great Britain to 2010 and beyond, Sudbury: HSE Books

441 Volumr II (Ev 95, Q359)

442 Volume III (No. 55)

443 Volume III (Nos. 55 and 57)

444 Volume II (Ev 95, Q359 and 361)

445 Volume II (Ev 95,Q361)

446 Volume II (Ev 96, Q365)

264. He argued that the problems of occupational ill health were difficult but not intractable:

> "I would have thought that if you wanted to achieve those targets you would identify the workplaces in your area that were creating the problems and you would address each one asking what is going to achieve this: 'If the process line works at a rate at which people get injured, something big has got to change, some big investments are going to have to go in….I think we have to face up to how big these tasks are if we are serious, otherwise we might as well go home and say, 'health and safety is an area we cannot handle, society cannot deal with it."

Availability of occupational health expertise

265. Improving the coverage of occupational health support is a crucial part of the strategy to ensure that employers have access to the advice and support they need to protect their employees from health risks (see Chapter 15). However, coverage of occupational health support is low and the Government is only now conducting and evaluating pilots. Furthermore, reduced funding for EMAS, especially at a time of growing awareness of the scale of emerging risks, is said to have considerably reduced HSE's capacity to provide advice on occupational health issues. Furthermore, a range of witnesses to the inquiry suggested that reductions in HSE's in-house expertise on health issues sent out the wrong message.[447] EEF, the manufacturers' organisation, said:[448]

> The occupational health specialism within HSC/E – EMAS – is significantly under-resourced particularly [since] a major part of the future strategy concerns itself with health-related issues. To be credible in the agenda they will need to have access to high quality occupational health advice.

266. The Faculty and Society of Occupational Medicine was particularly concerned at the demise of the post of Chief Medical Officer.[449]**The Committee shares HSC's concern that there is a 'huge job' to do on health. It is concerned, therefore, that reduction in HSE's in-house expertise has raised major questions as to its capacity to show leadership on the issue. We recommend the Government reviews the resources available for this work to enable the HSE to fulfil this growing role.**

The role and nature of inspection

267. A number of organisations (such as Prospect and TUC) are critical of a lack of proactive enforcement action by HSE with regard to occupational health issues.[450] The TUC, for example, points out that in 2002/03, the regulations most frequently used for securing a conviction were construction, work equipment and gas safety regulations (leading to over 85 convictions). In contrast, only one person was successfully prosecuted

447 Volume III (Nos. 30, 32 and 33)

448 Volume III (No. 33)

449 Volume III (No. 32)

450 Volume III (Nos. 5 and 30)

under the noise regulations and one under the manual handling regulations, despite 'the epidemic of back, pain, stress, hearing loss and RSI that we have seen in recent years.'[451]

268. Figures provided to the Committee by HSE show that in 2003/04, there were 14 enforcement notices under the Health and Safety (Display Screen Equipment) Regulations 1992, 243 under the Manual Handling Operations Regulations 1992 and 202 under the Noise at Work Regulations 1989.[452] This compares to some 13,263 enforcement notices issued by HSE in 2002/03.[453] Research also suggests that prosecution may be under-used for health issues.[454]

269. It should also be noted that health problems such as musculo-skeletal disorders and stress are connected to the way in which work is organised. The 'principles of prevention' set out in existing legislation (which refer to adapting work to the worker and avoiding repetitive and monotonous work) should, if applied effectively, help to reduce such problems.[455] Yet, just 103 relevant enforcement notices were issued in 2002/03[456].

270. Evidence to the Committee suggested a low level of enforcement action in relation to stress, one of HSE's priority programme areas and one which evidence to the inquiry suggests employers find difficult to tackle. A small survey of social services departments conducted by the Employers' Organisation for Local Government (EO) found that while 10 out of 14 respondents were taking action to reduce stress, in only 2 cases was the action considered to be effective. [457] A survey of lab workers by Amicus found that stress-related illnesses were the most frequent cause of serious work-related ill health among lab workers[458]. Over two-thirds (69%) of respondents thought their employer took the issue seriously but only 4.6% thought their employer was taking adequate steps to deal with the issue. Despite this, there was only one case of a department or institute that had been reprimanded by the HSE for stress problems in the last three years. (The NHS Confederation and the EO did, however, report that HSE was helping to encourage employer action on stress, with the EO pointing to a 'rolling programme of auditing of local authorities for their stress management techniques, practices and procedures.' [459])

271. Asked about the low levels of enforcement action in this area, the Minister emphasised the importance of ensuring employers had the advice and guidance they needed:[460]

---

451 Volume III (No. 5)

452 Volume II (Ev 139 note 2)

453 HSE (2003), *Health and Safety Offences and Penalties, 2002/2003*. A Report by the Health and Safety Executive, www.hse.gov.uk

454 Wright M, Marsden S and Antonelli A (2004), Building an evidence base for the Health and Safety Commission Strategy to 2010 and beyond. A literature review of interventions to improve health and safety compliance. HSE Books.Page 15

455 Regulation 4 and Schedule 2, The Management of Health and Safety at Work Regulations 1999. No 3242

456 Volume III (No. 38)

457 Volume III (No. 46)

458 Volume III (No. 59)

459 Volume III (Nos. 51 and 46)

460 Volume II (Ev 148, Q564)

> 'Before we put emphasis on enforcement for health, we need to ensure that there is good information and advice out there being given to employers before we then require them to implement it. The HSE is doing this, it is running a number of pilots which will then be evaluated.'

272. Coverage of occupational health support for employers is low (see chapter 15) and developing this is a crucial part of HSE's strategy in the longer-term. However, in the meantime, there must be cases in which enforcement action is appropriate. The Sheffield Occupational Health Advisory Service (SOHAS), for example, told the Committee that there were firms in Sheffield that have caused substantial health problems for years.[461] Furthermore, it seems that enforcement can be effective in prompting action in this area. Mr Julian Topping of the Department of Health told us that the improvement notice issued on West Dorset General Hospitals NHS Trust in relation to stress had helped ensure that HSE guidance on stress had been 'picked up very well by people across the NHS'[462] The extent of occupational health problems, such as musculoskeletal disorders and stress, suggests that enforcement action on these issues could be increased substantially, with beneficial results.

273. The question is then whether HSE is able to identify cases where action needs to be taken, whether it is sufficiently resourced to do this and whether its inspectors are equipped for the job. SOHAS argued that a major problem is that enforcement agencies lack the means to achieve their targets.[463] In order to play a major role, they must be able to identify where cases are occurring, have the intervention methods that they need to bring about change in the workplace and the monitoring systems to make sure that change has occurred.

274. In terms of identifying cases of occupational ill-health that need investigating, SOHAS pointed out that employment insecurity and confidentiality issues limit the data collected at workplace level that enforcement agencies could use.[464] SOHAS perceived a reluctance on the part of employees to reveal health problems to managers because of the risk to their jobs and considered that greater employment protection than that provided by existing employment and disability legislation was needed. It suggested that non-legal solutions might include the development of secure communication systems between workers and enforcement agencies, or the development of alternative sources of data collection not currently available.

275. In terms of identifying the kinds of premises that would benefit from a proactive inspection, CoSLA pointed to a need to review the criteria used by local authorities to enable this to be done.[465] It argued that in doing this, increased emphasis needed to be given to health issues which had traditionally 'not featured too highly' in a local authority

461 Volume II (Ev 96, Q366)

462 Volume II (Ev 76, Q291)

463 Volume III (No. 44)

464 Volume II (Ev 99. Q379)

465 The guidance currently used by local authorities is Local Authority Circular, LAC 67/1

context and account should be taken of initiatives currently being undertaken by HSE on stress in the public sector and in call centres.[466]

276. SOHAS argues that inspection systems fall down when it comes to looking for occupational health problems and their causes. Missing guards and helmets are obvious, occupational stressors, or an assembly line speed that is too fast or a bench that is the wrong height for some members of staff, are not. At the very least much more probing and time-consuming inspection techniques would be required. SOHAS also points to the difficulty of defining satisfactory compliance outcomes for inspection visits and argues that this is likely to be one reason for the small number of prosecutions reported each year for failure to comply with health related regulations.

277. **The Committee recommends that inspectors should have the resources that they need to be able to identify health issues, recommend remedial action to be taken by employers and define satisfactory outcome measures. Resources are also required to enable proactive research work to be done on combating newly emerging risks, like passive smoking. The risk assessment criteria should be reviewed to ensure they are able to identify workplaces where occupational health risks are high. The results of this review should be published by 1 October 2005.**

Passive Smoking

278. Analysis by Professor Konrad Jamrozik of Imperial College found that every week a worker in the hospitality industry dies from passive smoking and that environmental tobacco smoke in the workplace generally, caused about 700 deaths each year in the UK.[467] In the Republic of Ireland, a ban on smoking in the workplace came into effect in March 2004.[468] In Great Britain, on the other hand, there has been little progress. HSC published proposals for an Approved Code of Practice (ACoP) in September/October 2000. This recommended that every employer should have a smoking policy – this could be to ban smoking, but the concept of reasonable practicability meant other measures could be looked at, such as restricting the amount of time people had to work in smoky areas.[469] However, Mr Bill Callaghan told us the debate had since moved on, and was now "much more a public health issue". EEF, the manufacturers' organisation, argued that the workplace had a role to play but should not be in the vanguard of changing social policy. The same restrictions on smoking should be 'placed on the general public at the same time'.[470] A White Paper on improving health, to be published in autumn 2004, will outline how the Government intends to tackle problems such as smoking.[471] **The Committee recommends that the Government review the experience of the ban on smoking in the workplace recently introduced in Ireland. Measures to deal with passive smoking in the workplace should be included in the forthcoming White Paper on improving health.**

---

466 Volume II (Ev 92,Q350)

467 Royal College of Physicians Press Release, One hospitality worker dies every week from passive smoking, 17 May 2004.

468 www.eu2004.ie/templates/standard.asp?sNavlocator+3,232,455. 12/07/2004

469 Volume II (Ev 130 Q501)

470 Volume III (No. 33)

471 HM Treasury (2004), *2004 Spending Review, New Public Spending Plans 2005-2008,* July 2004. Cm 6237. Norwich The Stationary Office, p 92

Rehabilitation

279. Each year, some 3,000 people are forced to give up work because of prolonged illness, injury or disability.[472] 80% do not return to work within 5 years and many never work again. Support for rehabilitation is key to achieving the aim of reducing the number of working days lost due to injury and ill health. DWP itself is considered to be doing valuable work to support rehabilitation.[473] Since April 2003, DWP's Job Retention and Rehabilitation pilot has been testing the effectiveness of different ways of helping people who have been off work because of sickness, injury or disability to get back into or remain in work. At present there is too little data to enable conclusions to be drawn. DWP has also, as part of its review of Employers Liability Insurance, published a discussion document on *Developing a Framework for Vocational Rehabilitation.*[474] The aim is to describe the scope of vocational rehabilitation, present an overview of current provision, highlight the basic principles and approaches taken, summarise the current evidence base on successful interventions, introduce new work and highlight new areas of analysis to consider. The intention is to make better use of existing resources rather than to establish a comprehensive national service.

280. Key issues arising in the course of evidence to the inquiry were how to encourage employers to do more and whether this should be by introducing statutory requirements or through Employer's Liability insurance.

281. In some other countries, employers are under certain legal obligations regarding rehabilitation. For example, in New South Wales in Australia, employers are required to appoint workplace rehabilitation co-ordinators.[475] In the Netherlands and Sweden, they are required to develop rehabilitation plans. Organisations such as the TUC argue that in Great Britain there should be a legal requirement for employers to have a policy framework on rehabilitation in place.[476] Action Point 31 of *Revitalising* stated that HSC should consult on whether the duty on employers to ensure the continuing health of employees, including action to rehabilitate where appropriate, can be usefully strengthened. For example, it notes that 'organisations might be required to set out their approach to rehabilitation within their health and safety policy.' In the absence of legislative opportunity, however, the job retention and rehabilitation agenda is being taken forward by HSE, working in partnership with DWP and the Department of Health.'[477]

282. On the question of the potential role for the insurance industry, the Committee saw, on its visit to Spain, some interesting work being done by the social insurance organisations, the 'Mutuas de Accidentes'. These provide financial support to those off work due to occupational injury or ill health and also provide medical services, support for rehabilitation and advice on prevention.

---

472 Note provided to the Committee by DWP, 17 May 2004

473 Volume II (Ev 101, Q388)

474 http://www.dwp.gov.uk/publications/dwp/2004/elci/voc_rehab_2004.pdf

475 James P, et al (2002), Absence Management: The issues of job retention and return to work, Human Resource Management Journal 12 (20), 18-94

476 TUC paper on rehabilitation

477 HSC/E. Revitalising Health and Safety. Implementing RHS – Progress Report

283. *Revitalising* emphasised the potential role of insurance in motivating employers to rehabilitate workers.[478] The Association of British Insurers (ABI) told us that insurers in the UK do play a role (particularly in Motor and Employer's Liability insurance environments).[479] However, this is limited and inconsistent - only around 8% of those Employer Liability insurance claimants that would benefit from rehabilitation actually receive it. A reason for this, in ABI's view, is that insurers are only involved in a small proportion of workplace accidents. Furthermore, because the process of settlement is adversarial and lengthy, it can often be too late to make an effective rehabilitation offer because of deterioration in, or chronicity of, the claimant's condition. In addition employers' fear of being blamed for ill-health can act as a barrier to this sort of action.[480] Some insurers have offered no-fault rehabilitation services, but found smaller employers reluctant to invest without better understanding the costs and benefits.

284. The ABI told us that insurers could and should play a role in this and already do so to a limited extent. However, it argued that 'there needs to be recognition that other stakeholders, including Government and employers, would benefit substantially and should bear part of the cost. It estimates that rehabilitation could save 10-40% of the cost of compensation and that comprehensive rehabilitation could save the taxpayer around £1.2 billion a year in reduced benefit payments and higher tax revenues.

285. A number of organisations pointed to the importance of ensuring that the recent emphasis on rehabitation does not detract from work that needs to be done on the prevention side. SOHAS' work in Sheffield and experience in the Netherlands (when pressure came on to reduce the number of disability claims) showed that it 'sucked all the energy out of prevention, so what were supposed to be prevention services became rehabilitation services.'[481] Prevention needs to be protected. Capacity for rehabilitation also needs to be increased. [482]

286. **The Committee recommends that HSC reviews international evidence on the efficacy of requiring employers to set out their approach to, and provision of, rehabilitation to determine whether lessons can be learned and introduced in the UK The results of the review to be published by 1 October 2005.**

17 Insurance

287. The question as to whether insurance can play a greater role in improving health and safety standards arose in the course of evidence to the Committee. The Association of Personal Injury Lawyers (APIL) talked about the case for making the compensation system an express part of health and safety and referred to fear of compensation claims as a lever in encouraging schools to adopt anti-bullying policies.[483] Concerns were expressed to the

478 HSC (2000), Revitalising Health and Safety Strategy Statement. June 2000, Wetherby:DETR para 116

479 Volume III (No. 60)

480 See also Volume II (Ev 101, Q390)

481 Volume II (Ev 101, Q391)

482 Volume II (Ev 101, Q394)

483 Volume II (Ev 63, Q224)

Committee that a 'compensation culture' was developing in the UK. [484] The Committee notes, however, that a recent report of the Government's Better Regulation Task Force, found this not to be the case.[485] This was confirmed in evidence to the Committee by the then Minister for Work, Des Browne.[486] Figures from the Compensation Recovery Unit (which records personal injury claims made to general insurers and then related to employers' liability claims specifically) show that between 2000/01 and 2002/03, the number of claims in this area actually fell by 16% from just over 219,000 to just over 183,000.

288. *Revitalising* stated that 'major reform of the compensation, benefits and insurance system presents the prospect of a powerful new lever to raise health and safety standards.' [487]One way of using insurance as a lever to encourage good practice on health and safety is to link a company's insurance premiums to its risk levels. The Association of British Insurers told us that insurance companies were able to do this with larger companies who have a 'claims experience' on which to base this.[488] Furthermore, it was viable for the insurance company to visit the firm, get to know the management and make recommendations for risk improvement. With smaller business, this is often not viable or cost effective, particularly when the insurance company has hundreds of thousands of customers. ABI explains that in the case of smaller companies, therefore, the approach is to base the premium on the claims experience of groups of firms, usually by sector or trade.

289. The Department for Work and Pensions, in its review of Employer's Liability insurance, has emphasised that more effort should be made to link premiums to health and safety[489]. Individual insurance companies have developed questionnaires to help them better understand efforts being made by SMEs to manage risks. The ABI and member companies are successfully operating the *Making the Market Work* initiative, which assesses the health and safety performance of trade associations.

18 Conclusion

290. Evidence presented to the Committee suggested that there is strong support both for the current legislative structure and for the Health and Safety Commission and Health and Safety Executive. Great Britain has one of the best health and safety records in Europe. The Committee's concerns centre around evidence as to the impact of a real-terms reduction in resources on HSE's capacity to ensure compliance with health and safety legislation, their mediocre performance against 2004 targets, the lack of progress made on commitments for legislative change made in *Revitalising Health and Safety,* inadequate coverage of occupational health support and inadequate strategies to reverse the threatened decline in consultation with workers by employers on health and safety issues.

484 Volume II (Ev 55, Q176)

485 Better Regulation Task Force (2004), *Better routes to redress.* London: The Cabinet Office

486 Evidence to the Committee 15 October 2003, Q7

487 HSC (2000), Revitalising Health and Safety Strategy Statement. June 2000, Wetherby,para 116

488 Volume III (No. 59)

489 Department for Work and Pensions (2003), *Review of Employers' Liability Compulsory Insurance, First Stage Report.* Department for Work and Pensions. www.dwp.gov.uk

291. In oral evidence, the Minister expressed the view that, because improvement in health and safety had plateaued in the mid-90s, new approaches were needed. This implies that enforcement of occupational health and safety standards through inspection at a constant level has been tried and tested at a constant level and found wanting. HSC argues that greater attention (and resources) needs to be directed to other approaches. This has led to an increased emphasis on promoting the 'business case' for health and safety and on developing 'partnership' approaches to dealing with health and safety matters. While there is little to fault such ideas, the Committee doubts whether there is tangible evidence of their success as strategies for improving the work environment for workers in the UK. At the same time, the Committee believes there is strong evidence to support the view that inspection, backed up by formal enforcement action where necessary, is effective in persuading employers to adopt appropriate occupational health and safety arrangements. Therefore, as several witnesses have argued, in a situation where resources are both limited and finite, promotion of untested approaches that emphasise information and guidance in preference to inspection and enforcement flies in the face of existing evidence of what works.

292. The HSC has identified crown immunity, corporate killing and higher fines as areas in which it believes legislative change would help it achieve its targets. Alongside these, the Committee considers that there needs to be progress on some of the key legislative commitments made in *Revitalising*. The Committee would like to see progress made on these issues in the form of a Bill in the next session of Parliament.

293. HSC has identified occupational health support as a priority for resources. The Committee agrees and is concerned at the lack of progress in developing coverage of such support since the publication of *Securing Health Together*. A concerted effort is needed to address this. Another area identified by the HSC as being key to reaching its targets, is consultation with workers by employers on health and safety issues. The Committee is unconvinced that the *Collective Declaration* and *Challenge Fund* are sufficient to reverse the risk of a significant reduction in such consultation. More urgent action is needed and the Committee recommends that HSC publishes proposals to develop improved rights to consultation for employees, particularly in non-unionised workplaces.

294. A lack of consistency in enforcement nationally emerged as a concern in evidence to the Committee. The Committee recommends that a more thorough audit is undertaken of local authority performance in this area and that strategies to deliver consistency and rigour in enforcement of health and safety regulations across Great Britain should be reviewed.

295. The Committee will watch with interest the progress of the Hampton Review of regulatory inspection and enforcement. It believes that the views of the full range of 'stakeholders' should be taken into account, including employers, trade unions, health and safety practitioners and representatives of health and safety victims. Overall, evidence to the Committee showed the Health and Safety Commission (HSC) and Health and Safety Executive (HSE) have strong support from a wide range of stakeholders. There are concerns about the practical implementation of the system, but many of these are attributed to inadequate resources. The Committee believes that its recommendations, if adopted should address many of the concerns raised and believes that very serious

consideration should be given before any fundamental change is made to the health and safety system in Great Britain.

Conclusions and recommendations

1. We recommend that, in context of Spending Review 2004, the HSE inspectorate be recognised as a front-line service and protected. (Paragraph 20)

2. The Committee recommends that the HSE use an annual workplace health and safety survey to obtain data to enable it to publish evidence of trends on such issues as the proportion of employers (a) conducting risk assessments, (b) providing occupational health support and (c) training on health and safety issues. (Paragraph 41)

3. The Committee views with concern the limited progress that appears to have been made in reaching targets and does not believe that there is any realistic prospect of achieving the 2004 targets. In its view this lack of progress must, inevitably, raise questions about the present system's capacity to secure significant future improvements in standards of workplace health and safety. (Paragraph 50)

4. The Committee is also concerned that the Public Service Agreement target to 'improve health and safety outcomes' by 2008 appears to be vague and unmeasurable. We recommend that the Government produces and publishes specific details of what this target is and how it is to be measured. (Paragraph 51)

5. The Committee is concerned at the length of time it is taking the Government to resolve any outstanding issues concerning reforms of the law on corporate killing and recommends that by 1 December 2004, the Government publishes a Bill on corporate killing. (Paragraph 53)

6. The Committee recommends that commitments to legislate made in Revitalising Health and Safety in 2000 should be honoured by a Government Bill in the next session of Parliament. (Paragraph 55)

7. The Committee recommends that the Government reconsiders its decision not to legislate on directors duties and brings forward proposals for prelegislative scrutiny in the next session of Parliament. (Paragraph 60)

8. The Committee recommends a wide ranging and open review of the role and effectiveness of HSC's Industry Advisory Committees to help to address concerns that they are being downgraded. (Paragraph 72)

9. We endorse the view of Prospect that the number of inspectors in HSE's Field Operations Directorate should be doubled (at a cost estimated by them as £48 million a year after 6 to 7 years). We recommend that substantial additional resources are needed in the next three years. (Paragraph 82)

10. The Committee recommends that HSE should actively promote joint resource planning, risk prioritisation and programme working across the devolved legislatures in Great Britain. (Paragraph 88)

11. The Committee recommends the HSE adopts a more proactive approach to enforcement action towards employers who disproportionately rely on temporary agency workers. (Paragraph 98)

12. We recommend that, for all its major procurement contracts, the Government sets a good example and only buys from suppliers who have proved to the Government that they comply with UK health and safety legislation and who have satisfactory health and safety procedures and practices in place. (Paragraph 105)

13. The Committee is seriously concerned at the level of risk to which migrant workers are currently exposed. We recommend that urgent research is needed to improve our understanding of the occupational health and safety risks faced by migrant workers so that a targeted strategy to manage those risks for this particularly vulnerable group can be effectively implemented as soon as possible. (Paragraph 111)

14. The Committee is concerned that there does not appear to be an all-embracing strategy to address the changing world of work and recommends that such a strategy must be developed as a matter of urgency. This should include, in particular, measures to reduce the health and safety risks faced by agency workers and migrant workers. By 31 December 2005, clear, comprehensive and appropriate guidance should be published by the HSC/E on health and safety where the workplace is a private home. In particular, and more urgently, local authorities should issue guidance on the Employer's Liability (Compulsory Insurance) Act 1969 to those employing carers directly in their own homes, and assist in arranging appropriate cover. (Paragraph 120)

15. The evidence supports the view that it is inspection, backed by enforcement, that is most effective in motivating duty holders to comply with their responsibilities under health and safety law. We therefore recommend that the HSE should not proceed with the proposal to shift resources from inspection and enforcement to fund an increase in education, information and advice. (Paragraph 142)

16. The Committee is concerned both at the low level of incidents investigated and at the low level of proactive inspections and recommends that resources for both are increased (see paragraph 82). (Paragraph 150)

17. The Committee believes that before adopting a policy of reduced inspection for employers with an established record of good practice, there is a need for clear and thorough evidence-based analysis to ensure that the reduction does not lead to negative outcomes such as improper pressures to achieve a reduction in accident reporting. (Paragraph 153)

18. Given the HSE's limited resources, if safety representatives were empowered to enforce health and safety law in the workplace, we believe this would have a powerful effect in improving standards. We also believe this power to take action, should include not just criminal prosecutions but also improvement and prohibition notices, subject to the usual right of appeal to the Employment Tribunal and as to terms on legal costs. (Paragraph 176)

19. The Committee recommends that the Government identies resources to build on the success of its pilot of a new prosecution model. (Paragraph 177)

20. The Committee recommends that maximum penalties should be increased by means of a Bill in the next session of Parliament and further recommends that proposals to introduce alternative and innovative penalties in addition to those already available to the courts should be examined and the reasoned conclusions thereof published by 1 May 2005. (Paragraph 182)

21. The Committee recommends that HSE undertakes and publishes by 1 October 2005 a thorough audit of the performance of local authorities. The Committee further recommends that additional powers should be made available to allow HSC/E to take actions against any local authority manifestly failing in its duty of enforcing health and safety regulations. (Paragraph 198)

22. The Committee recommends that the Department by 1 October 2005 reviews its strategies to ensure national consistency and rigour in enforcement of health and safety regulations throughout Great Britain. If this review finds substantial support for current criticisms, it is further recommended that the demarcation of enforcement activity between HSE, local authorities and other enforcement agencies be examined, the case for a unified health and safety enforcement authority investigated and the reasoned conclusions thereof be published by 1 October 2006. (Paragraph 204)

23. The Committee recommends that resources should be allocated to enable all key HSE publications to be made available free of charge on the internet. (Paragraph 216)

24. The Committee recommends that the HSE is provided with the necessary resources to enable it to enforce effectively its existing guidance on work-related road safety, particularly in relation to preventative measures. (Paragraph 224)

25. The Committee recommends that at-work road traffic incidents should be required to be reported pursuant to RIDDOR. (Paragraph 226)

26. The Committee recommends that, by 1 October 2005 the HSC/E should carry out a review of the case for an ACoP on work-related road safety, and publish its reasoned conclusions. (Paragraph 228)

27. The Committee recommends that, by 1 October 2005, HSC publishes proposals to develop improved rights to consultation for employees, particularly in non-unionised workplaces, including rights of enforcement through its Employment Tribunal and private prosecution routes. (Paragraph 241)

28. The Committee is disappointed at the plans and progress to date to establish national cover of occupational health services. It recommends that this is given higher priority than it has received to date and that HSC/E is provided with the necessary resources to enable it to make progress towards the 2010 targets on occupational health. (Paragraph 251)

29. The Committee recommends that the HSC should, by 1 October 2005, develop and publish an Approved Code of Practice defining the standards of competence employers are required to use to ensure they comply with health and safety requirements. (Paragraph 253)

30. Employees do not want to talk about their health problem with their employer if they are potentially work threatening. There is a need for third party advice for both employees and employers. We endorse the suggestion of NHS Plus that the NHS is ideally placed to fill this role. This does not mean that they would provide all the service, but they could "serve as honest broker". (Paragraph 254)

31. The Committee welcomes steps being taken by HSE to improve our understanding of the nature and extent of the problem of workplace ill-health. (Paragraph 259)

32. The Committee shares HSC's concern that there is a 'huge job' to do on health. It is concerned, therefore, that a reduction in HSE's in-house expertise has raised major questions as to its capacity to show leadership on the issue. We recommend the Government reviews the resources available for this work to enable the HSE to fulfil this growing role. (Paragraph 266)

33. The Committee recommends that inspectors should have the resources that they need to be able to identify health issues, recommend remedial action to be taken by employers and define satisfactory outcome measures. Resources are also required to enable proactive research work to be done on combating newly emerging risks, like passive smoking. The risk assessment criteria should be reviewed to ensure they are able to identify workplaces where occupational health risks are high. The results of this review should be published by 1 October 2005. (Paragraph 277)

34. The Committee recommends that the Government reviews the experience of the ban on smoking in the workplace recently introduced in Ireland. Measures to deal with passive smoking in the workplace should be included in the forthcoming White Paper on improving health. (Paragraph 278)

35. The Committee recommends that HSC reviews international evidence on the efficacy of requiring employers to set out their approach to, and provision of, rehabilitation to determine whether lessons can be learned and introduced in the UK The results of the review to be published by 1 October 2005. (Paragraph 286)

Appendix 1

Injuries to employees and self employed people, fatal and non-fatal injuries to members of the public as reported to HSE – 1999/2003p

SCOTLAND

Severity of injury	Employment Status	94/95	95/96	96/97	97/98	98/99	99/00	00/01	01/02	02/03p
Fatal	Employees	16	25	28	28	26	23	25	24	26
	Self Employed	10	12	14	9	7	8	12	4	10
	Member of Public	5	6	10	6	8	9	8	7	10
Major	Employees	1389	1323	2010	2337	2400	2695	2758	2783	2796
	Self Employed	103	94	95	32	49	26	40	77	86
	Member of Public	660	606	1988	1373	1270				
Over 3 Day	Employees	11546	10314	9889	10676	10623	11661	11135	10713	10192
	Self Employed	176	193	231	39	48	29	30	70	66
Non Fatal	Member of public						1549	1236	931	767

WALES

Severity of Injury	Employment Status	1999/00	2000/01	2001/02	2002/03p
Fatal	Employee	8	5	13	7
	Self Employed	4	6	4	5
	Member of Public	7	12	8	8
Major	Employee	1848	1534	1626	1528
	Self Employed	43	38	35	74
Over 3 Day	Employee	7330	7460	6984	6826
	Self Employed	29	31	37	46
Non Fatal	Member of Public	840	693	581	484

ENGLAND

Severity of Injury	Employment Status	1999/00	2000/01	2001/02	2002/03p
Fatal	Employee	124	172	157	140
	Self Employed	46	61	37	29
	Member of Public	86	94	73	71
Major	Employee	23623	22780	23102	23626
	Self Employed	564	552	817	905
Over 3 Day	Employee	113408	112408	109028	106256
	Self Employed	568	654	810	816
Non Fatal	Member of Public	19696	15842	10637	8777

Estimated prevalence and rates (%) of self-reported illness caused or made worse by work, by country, for people ever employed 2001/02

Country	Estimated prevalence (thousands)			Rate per 100 ever employed		
		95% C.I.(a)			95% C.I.(a)	
	Central	Lower	Upper	Central	Lower	Upper
England	2019	1957	2082	5.4	5.2	5.5
Scotland	174	156	191	4.5	4.0	4.9
Wales	135	118	151	6.2	5.5	6.9

Estimated prevalence and rates (%) of self-reported musculoskeletal disorders caused or made worse by work, by country, 2001/02

Country	Estimated prevalence (thousands)			Rate per 100 ever employed		
		95% C.I.(a)			95% C.I.(a)	
	Central	Lower	Upper	Central	Lower	Upper
England	980	937	1023	2.6	2.5	2.7
Scotland	85	73	98	2.2	1.9	2.5
Wales	61	50	71	2.8	2.3	3.3

Estimated prevalence and rates (%) of self-reported stress, depression or anxiety caused or made worse by work, by country, 2001/02

Country	Estimated prevalence (thousands)			Rate per 100 ever employed		
		95% C.I.(a)			95% C.I. (a)	
	Central	Lower	Upper	Central	Lower	Upper
England	494	462	525	1.3	1.2	1.4
Scotland	39	31	47	1.0	0.08	1.2
Wales	31	23	38	1.4	1.1	1.8

(a) = 95% Confidence Limits

Appendix 2 - Investigation Statistics for FOD

	1997/98		1998/99		1999/2000		2000/01		2001/02		2002/03		2003/04 provisional	
	Reported (nos)490	Inv'd (%)491	Reported (nos)	Inv'd (%)	Reported (nos)	Inv'd (%)	Reported (nos)	Inv'd (%)	Reported (nos)	Inv'd (%)	Reported (nos)	Inv'd (%)	Reported (nos)	Inv'd (%)
Incidents492	163596	5.1	156369	5.7	154423	6.8	148677	9.4	143871	8.1	135715	7	134756	5.6
Major injuries (MI)493	45623	6.4	39705	7.8	37073	10	34221	14.8	30347	15.1	28401	14.2	30000	11.4
O3D incidents494	104442	2.5	102426	2.8	103852	3.3	102965	4.1	101799	3.6	97196	3.3	96733	2
Dangerous occurrences495	3514	24.1	3569	22.8	3750	24.9	3438	31.3	3684	28.3	3526	26.9	3487	16.2
Injuries to the public496	21725	2.4	16263	3.4	14587	5.9	12536	7.7	7849	9.1	6155	8.8	6078	6.9
Ill health incidents497	1863	24.3	2016	23.4	2386	28	2105	49.4	2033	50.2	1991	35.1	1812498	28.3

[490] Numbers of incidents reportable under RIDDOR that were reported and which fell to FOD in the year

[491] Percentage of those incidents that were investigated

[492] All types of RIDDOR-reportable incidents

[493] Major injuries as defined in RIDDOR

[494] Over-three day incidents as defined in RIDDOR

[495] Dangerous occurrences as defined in RIDDOR

[496] Reported injuries to the public, as defined in RIDDOR

[497] Ill health incidents, as defined in RIDDOR

[498] Data from ICC

	Work places	Insp (%)499	Work places	Insp (%)	Work places	Insp (%)	Work places	Insp (%)	Work places	Insp (%)	Work places	Insp (%)	Work places	Insp (%)
Inspections500	-	8.6	-	7.5	-	7	-	6.2	-	5.8	1.08m	6.4	-	6.4

Source: HSC/E See Volume II Ev 38

[499] Number of inspection contacts in the year expressed as a percentage of the total number of workplaces in 2002 (see note 11)

[500] Workplaces data available only for 2002; inspection percentages for other years based on that figure. In table 1 data relating to sole traders has been excluded. Table 2 includes sole traders - see note (iii) below. Sources: Annual Business Index (ABI) - for Great Britain; Agricultural holdings (DEFRA) - for United Kingdom; and Sole proprietorships (DTI) - for United Kingdom. Further note that (i) the allocation of FOD enforcing activity is an estimate at SIC Division level: as such it does not take into account demarcation arrangements in place between FOD and other HSE enforcing authorities; (ii) the DEFRA estimate for registered agricultural holdings for the United Kingdom has been used, as the ABI dataset (which is derived from the Inter-Departmental Business Register (IDBR) excludes farm based agricultural data contained in SIC92 class 0100; (iii) DTI estimate for the United Kingdom has been used, as the ABI dataset cannot identify sole traders: these are identified under the category "With no employees", which comprises sole proprietorships, partnerships comprising only the self-employed, owner-manager(s), and companies comprising only an employee director.

Appendix 3

Proceedings instituted by HSE in 2002/03 under the Management of Health and Safety at Work Regulations

Informations Laid	Convictions	Total Fines (£)	Average fine per conviction (£)
130	77	182 600	2 371

Source: HSC/E See Volume II Ev 38

Proceedings instituted by FOD in 2002/03 under the Management of Health and Safety at Work Regulations broken down by Regulation

Regulation	Informations Laid	Convictions	Total Fines (£)	Average fine per conviction (£)
Reg 3	109	66	145 850	2 210
Reg 5	8	4	24 250	6 063
Reg 7	1	1	2 000	2 000
Reg 10	2	2	1 000	500
Reg 11	2	2	7 000	3 500
Reg 13	4	1	2 000	2000
Reg 19	1	1	500	500
Total	127	77	182 600	2 371

Number of enforcement notices issued by HSE in 2002/03 under the Management of Health and Safety at Work Regulations

Improvement	Deferred prohibition	Immediate prohibition	Total Notices
1 829	2	81	1 912

Number of requirements on enforcement notices issued by FOD in 2002/03 under the Management of Health and Safety at Work Regulations

Regulation	Improvement	Deferred prohibition	Immediate prohibition	Total Notices
Reg 3	969	-	47	1 016
Reg 4	90	-	13	103
Reg 5	431	2	6	439
Reg 6	10	-	-	10
Reg 7	81	-	1	82
Reg 8	5	-	2	7
Reg 9	3	-	2	5
Reg 10	52	-	2	54
Reg 11	16	-	3	19
Reg 12	3	-	1	4
Reg 13	118	-	3	121
Reg 15	2	-	-	2
Reg 17	4	-	-	4
Reg 19	9	-	1	10
Total	1 793	2	81	1 876

Appendix 4

VISIT TO MADRID AND BILBAO

9-11 March

Meeting at Spanish Labour Inspectorate with Señor Don Javier Minondo Sanz, Gonzalo Jiménez, Mario Grau, Fernando Nolla, Visitación Alvarez and Señora Otilia Crespo.

The meeting with representatives of the Spanish Government's Labour Inspectorate and the National Institute for Safety and Health and Work provided an overview of health and safety issues in Spain. There are similarities in the position between Spain and the UK – both have applied European law and there are some common issues. The legal systems are different, however, and this needs to be taken into account.

Spain's entry to the European Union had a profound effect as EU law on health and safety was implemented. Almost all Spain's health and safety law comes from Europe. One area on which Spanish law was already more generous was on working time, where the maximum is 40 hours (with some exceptions). The system needed to change from one of protection to one of prevention, with employers given flexibility to decide how to do it. The law has proved difficult to enforce. Levels of awareness are low. Health and safety is not generally taken into account when corporate decisions are made. Employers tend to 'outsource' their prevention so that decisions are taken by external specialists rather than being part of the corporate culture. There is a tendency for compliance to be formal – a matter of 'ticking boxes' - rather than actually being an attempt to improve standards of health and safety for employees. Participation is a particular problem for small and medium enterprises where accident rates are high. Also of concern is the poor record of sub-contractors in the construction industry. A renewed dialogue between Government and social partners in 2002 attempted to address these concerns. The results included an increase in inspection rates and new legal provisions. In particular, there were renewed attempts to embed health and safety in corporate decisions. There is now an obligation on employers where there are certain risks to have preventative resources on site. Measures were introduced to prevent compliance being merely formal.

Accident rates are relatively high and there is public pressure on government to act. The system needs to take root and a preventative culture to take effect. H&S does not feature highly in collective bargaining, where the focus tends to be on pay and working hours. At a national level unions recognise the importance of H&S and are involved in lobbying for change. However, at local level awareness is often lower. Trade unions are predominantly in the public sector and large companies. These tend to have lower accident rates in any case, so this makes it difficult to tell what impact trade unions have on accident rates.

National Institute for Safety and Health and Work (INSHT) is a scientific and technical body. It is involved in a broad range of research activities and provides technical support to government, and training. The structure of the Spanish state is complex. Legislation and health and safety (H&S) inspection are nationwide. Administration and promotion are at regional level. INSHT produces guidance for small employers. INSHT is producing information and guidance and offering training on emerging risks such as stress. Spain is

in agreement with the European Commission strategy regarding emerging H&S risks. Information and guidance is free and there is also a telephone helpline for employers. The 'mutuas', who provide insurance, also provide multi-annual plans and advice and support to small companies.

The Labour Inspectorate has a broad range of responsibilities including working hours, salaries, collective bargaining and H&S. It ensures compliance with collective agreements which have the force of law. The Inspectorate's focus on H&S has increased and is now more than half of its work. It has considerable powers and can require a company to suspend operations if it considers the work imposes a risk. Employers have responsibilities and a breach need not be wilful for penalties to apply. The Labour Inspectorate is not responsible for public safety issues, which are dealt with elsewhere. Another important resource within individual firms are prevention officers (who are linked to trade unions). In December 2002, there were 739 inspectors and 787 deputy inspectors for 13 million employees. Inspectors made 120,000 visits to firms in 2002. Inspectors are obliged to investigate all fatal and serious accidents.

Individuals within companies may be prosecuted for breaches. If criminal prosecution is underway, administrative proceedings are suspended to avoid double jeopardy. Inspectors pass the file to judges. The law applies almost equally to the public and private sectors. Public officials have the same responsibilities as private sector managers. Requirements on small employers are less stringent. Levels of fines are lower as they correspond to the number of employees.

The influx of unskilled immigrant workers was considered to have contributed to high accident rates, especially in the construction sector. A range of factors were considered to contribute to this. In particular, such workers have little access to health and safety training. They are often on short-term contracts, do not have Spanish as a first language and, in some cases, are unable to read in any language. There are also high levels of labour mobility. One of the outcomes of the social dialogue in 2002 was an agreement by employers to provide training for these workers and public organisations have also been set up to do this. Contracts for construction employees are an average of 10 days. Many employees have contracts Monday to Friday. This makes it difficult for them to raise health and safety issues as the contract risks not being renewed for the next week. The inspectorate monitors these contracts and can check whether their short-term nature is justifiable.

Meeting with Fernando Rodrigo, Director of Instituto Sindical de Tradbajo, Tomas Lopez Arias, Head of Work Safety at UGT and Maite Vazquez del Rio (a journalist with ABC).

The legal framework for H&S in Spain is felt to be adequate, the difficulty is with implementation and compliance. A health and safety culture needs to take root in the workplace, among both employees and employers. Penalties are important in improving compliance rates among employers. A desire to cut costs was felt to be the principal reason for non-compliance. 'Prevention officers' are a significant new resource. Their role is focused on monitoring and ensuring enforcement. Levels of inspection are increasing. The challenge is to find the right balance. The authorities need to ask why the construction sector has such high accident rates. Reasons may include high proportions of temporary workers, young people and older workers, high levels of sub-contracting, many people

working on a self-employed basis and high levels of people for whom Spanish is not a first language. These are the problems – solutions need to be found.

Labour relations in Spain were felt to be maturing and health and safety was gaining a higher priority in Spain politically and socially. The key obstacles to improving health and safety are structural – high levels of casual labour and temporary contracts (three times greater than the European average). Also there are high degrees of sub-contracting. Under-recording is a problem. A recent study found that in addition to 33 deaths in one province, 13 deaths were unrecorded, immigrant workers in insecure employment. A further problem is that employers tend to outsource prevention activities so that they are not part of the corporate culture and its difficult for employees to become involved. On the positive side, resources for prevention have increased and there is a growing number of employees active in prevention matters.

There is one Labour Inspector for each 20,000 workers compared to an average of one per 11,000 in the European union. There is a serious problem of inspection resources in Spain. Also, the Labour Inspectors have a wide remit, including hiring and social security. Trade unions argue that among the Labour Inspectors, there should be health and safety specialists. Short-term contracts are a major problem in preventing employees from raising health and safety issues. In 2002, 20% of accidents were sustained by workers with permanent contracts. 80% by those with short-term contracts. These statistics don't include the self-employed and immigrant workers. Prevention officers have some employment protection allowing them to raise H&S issues.

It was argued that the Spanish Government had missed an opportunity to modernize the law to address emerging risks when it implemented European directives. 2002 reforms stemming from social dialogue did not give sufficient weight to trade union perspectives. In strategic sectors, unions have had to use strikes to further the issue. Collective bargaining proposals are frequently rejected. Employers have traditionally seen trade unions as a problem. There are 100,000 Prevention Officers but they are not based in small companies with 2-4 employees (which form 96 percent of Spanish businesses.) Unions are arguing for 'territorial' prevention officers empowered to go into these small firms.

Current classifications of industrial diseases do not include the sorts of health issues women employees tend to face. Spain is the European state with the highest number of industrial accidents and the fewest industrial diseases recognised.

Wednesday 10 March, European Agency for Safety and Health at Work, Bilbao

Alun Jones, Elke Schneider, Sarah Copsey, Markku Aaltonen and Francoise Murillo.

The European Agency for Safety and Health at Work (EASHW) was set up by the European Union in order to serve the information needs in the field of safety and health at work. It has three areas of activity:

- Collecting information through a network of designated experts and organisations.
- Communicating information, particularly through its website – www.ohsa.eu.int

- Developing knowledge on important occupational safety and health themes such as priorities and strategies, the economic impact of occupational safety and health and research priorities.

The Agency has national focal points in EU member states. In the UK, this is the Health and Safety Executive. Copies of the series of power-point presentations are attached to this note.

The work of the Agency contributes to the European Commission strategy on health and safety at work. One of the strands of the strategy for 2002-06 is to strengthen the preventative culture through the development of a genuine culture of risk prevention. The Agency has a key role to play in acting 'as a driving force in matters concerning awareness-building and risk anticipation.' An important part of this is the development of a 'risk observatory' to monitor emerging risks in the changing world of work. Another important part of the Agency's work is the running of annual Europe-wide health and safety weeks. These are information campaigns on specific OSH issues. In 2004, the focus is on the construction sector.

In terms of supporting policy making and implementation, The Agency's workplan for 2004 contained a number of areas of interest to the Committee – the effectiveness of economic incentives in safety and health, corporate social responsibility, including the gender dimension in occupational safety and health (OSH) activities and support for small and medium enterprises.

Monitoring occupational health and safety and the European risk observatory

Key challenges for OSH policy include changes in demography (increasing proportions of women in paid employment and people tending to stay in work for longer) and in the labour market (the organisation and processes of work). The objectives of the risk observatory are to:

- Provide an overview of OSH in Europe;

- Highlight trends in OSH outcomes and risk factors;

- Provide early identification of newly emerging risks in the workplace;

- Identify areas/issues where more information is needed.

The aim is to identify priorities and needs for the future, to assess the efficiency of preventive actions and be better prepared to meet future challenges. Two new forecasts – on biological and chemical risks – are to be published shortly.

Stress at work

Work-related stress affects 28% of workers in the EU. While there are limitations in contemporary research into the management of work-related stress, a research review by the Agency found that work-related stress can be dealt with in the same way as other health and safety issues (by adapting already well-established processes for the assessment and management of the physical risks to the management of stress.) Practical examples of this approach applied to stress at work, exist in several EU countries. Future research should

concentrate on stress management interventions at the organisational level. Success factors in prevention initiatives include adequate risk analysis; thorough planning; a combination of measures covering anticipation, prevention, intervention, support and evaluation; continuing staff feedback; liaison with external bodies (such as the police, where violence is an issue); sustained prevention and top management support and resources.

The gender aspects of health and safety

It is EU policy to increase the participation of women in employment, through the creation of quality jobs. Good quality jobs, with high health and safety standards, are needed to recruit and retain women at work. An Agency research review on gender issues in safety and health at work found that substantial differences in the working lives of men and women affected their occupational safety and health. There are a higher proportion of women in low-paid, low-skilled and precarious jobs, they also typically have less control and autonomy. Men are more likely to suffer deaths or serious accidents at work and to be exposed to noise, but some women do dangerous or noisy work and heavy lifting and are more likely to be exposed to confrontation with violent members of the public. Women are also more likely to work in highly repetitive jobs, suffer work-related allergies (such as dermatitis), be exposed to infectious diseases and to suffer work-related stress. Women still carry out the majority of unpaid housework and caring responsibilities (even when working full-time) and this can add to work-related pressures. The study found that work-related risks to women have traditionally been underestimated and that this has result in less attention and fewer resources being directed towards those risks. Women are also under-represented in decision-making concerning occupational health and safety and need to be more directly involved in formulating and implementing occupational health and safety strategies. Taking a holistic approach, including looking at the work-life interface and the broader issues in work organisation, would improve risk prevention.

Corporate Social Responsibility and economic incentives in safety and health

The minimum responsibilities of employers regarding health and safety are contained in legislation. Although progress has been made, more needs to be done to achieve an overall goal of safe, healthy and productive jobs. A range of Corporate Social Responsibility (CSR) themes are relevant to health and safety:

Human resources management. The prevention aspect of occupational safety and health is a first step towards attaining a positive record on employability of the workforce through avoidance of work-related disability, ill-health and injury.

Prevention in procurement, outsourcing and subcontracting. Increasingly, public authorities apply strict conditions on subcontractors in their procurement processes. In Belgium, for example, this has proved a powerful tool in reaching small and medium enterprises (SMEs). There are also examples in the private sector of large companies applying strict procurement rules to influence the health and safety quality content of services and products provided.

Commitment to the local community. In the UK's 'business as good neighbour scheme', large companies act as mentors to local companies in occupational safety and health matters.

Social responsibility reporting and auditing. Many companies are including figures on absences owing to injury and ill-health, early retirement and staff turnover in annual reports. Health and safety auditing and recognition schemes could play an important role in the field of social auditing.

Social and eco-labels. In Sweden, a label/certificate has been developed as a marketing tool to install consumer confidence in the safety and design of products.

Socially responsible investment. Financial institutions are making increasing use of social and environmental checklists to evaluate the risks of loans to and investments in companies.

The development of the occupational safety and health aspect of CSR, with the full participation of workers and social partners, could add much to the development of a health and safety culture. As most of its elements are voluntary, this would complement the legal requirements. The Agency has done much work to develop thinking in this area. In 2004, it is also undertaking a project to look at the effectiveness of economic incentives to encourage improvements in safety and health. These incentives can include insurance systems, tax systems and subsidy systems. Special attention will be given to the needs of SMEs.

Small and medium enterprises

Here are 19 million small and medium enterprises (SMEs) in the EU. They represent 99 per cent of all EU enterprises and employ nearly 75 million people, 65 per cent of the EU's total working population. SMEs are a diverse group, have fewer resources (in terms of knowledge and capacity) and higher accident rates. The Agency is involved in developing a range of tools to improve occupational safety and health performance in Europe's SMEs. As part of these efforts, it has looked at good practice models. Aspects of an effective strategy include:

-Taking appropriate measures: neither too complex nor too expensive. Tools need to take account of the needs and resources of the enterprise.

- Supporting risk assessment, for example through providing training or consulting in the workplace.

- Involving trade unions and employer associations, who may have practical knowledge of the sector and whose involvement can add credibility.

- Targeting actions at a specific sector or activity proved to be particularly successful.

Thursday 11 March 2004

Mutua Vizcaya Industrial and Arcerlia, Bilbao

Miguel Angel Lujua, Jesús Dalmau Meñica (Mutua Vizcaya), Marta Urrutia (EASHW), Victor Manuel Echenagusía Capelastegui (Arceralia)

The 'Mutuas de Accidentes' (known as the Mutuas) are social insurance organisations that also play an important role in both preventive and compensatory aspects of occupational health. They are associations of employers. They are non-profit making and any surplus

goes back into organisation. They interact with the Spanish social security system. There are 29 Mutuas in Spain, covering 96.6 per cent (11.78 million) of workers in the General Regime of Social Security. The Social Security system covers the remaining 3.4 per cent (638,955) of workers.

Mutuas provide financial support to those of work owing to occupational injury or ill-health, they also provide medical services, support for rehabilitation and advice on prevention. The amount depends on earnings levels and family size, for a maximum of 18 months. There is also a lump sum payment, depending on the extent of any injury. Mutuas get most of their income from the companies who are members. Levels of payment vary according to the worker's job and wage level. Currently, there is no link to the company's safety record. The Government has been working on developing a system whereby companies with good records pay less and those with poor records pay more, but there have been delays in implementing this. Mutuas charge for provision of an 'External Prevention Service' and for health treatment to workers who are not mutual members.

Companies in Spain are required to engage a prevention service if they have more than 500 employees or more than 250 and work in a dangerous activity. Mutuas are also involved in rehabilitation to support employees to return to work. Mutua Vizcaya reported that this had resulted in better recovery rates.

Arcelaria, a steel company, represented locally, but with branches around the world is engaged in a continuous process to improve health and safety standards for employees, including sub-contractors. The cycle is to identify risks, set objectives, implement preventative actions, evaluate results and modify processes on the basis of this. At the moment, Aceralia uses the Mutua for medical treatment services but is privately insured. It is cheaper for it to do this because it is a large company with a good safety record. It will review the position when the Government brings in the system of allowing companies with good records to pay lower premiums.

Formal Minutes

Wednesday 14 July 2004

Members Present:
Sir Archy Kirkwood, in the Chair

Ms Vera Baird	Rob Marris
Miss Anne Begg	Andrew Selous
Ms Karen Buck	Mr Nigel Waterson
Mr Andrew Dismore	

The Committee deliberated.

Draft Report [The work of the Health and Safety Commission and Executive], brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraph 1 read and agreed to.

Paragraph 2 read, amended and agreed to.

Paragraphs 3 to 5 read and agreed to.

Paragraph 6 read, amended and agreed to.

Paragraph 7 read and agreed to.

Paragraphs 8 to 11 read, amended and agreed to.

Paragraphs 12 to 15 read and agreed to.

Paragraph 16 read, amended and agreed to.

Paragraphs 17 to 19 read and agreed to.

A paragraph – (*The Chairman*) brought up, read the first and second time, amended and inserted [now paragraph 20].

Paragraphs 20 and 21 (now paragraphs 21 and 22) read, amended and agreed to.

Paragraph 22 (now paragraph 23) read and agreed to.

Paragraphs 23 and 24 (now paragraphs 24 and 25) read, amended and agreed to.

Paragraph 25 (now paragraph 26) read and agreed to.

Paragraph 26 (now paragraph 27) read, amended and agreed to.

Paragraphs 27 to 29 (now paragraphs 28 to 30) read and agreed to.

Paragraph 30 (now paragraph 31) read, amended and agreed to.

Paragraphs 31 and 32 (now paragraphs 32 and 33) read and agreed to.

A paragraph – (*The Chairman*) – brought up, read the first and second time and inserted (now paragraph 34).

Paragraphs 33 to 38 (now paragraphs 35 to 40) read and agreed to.

Paragraph 39 (now paragraph 41) read, amended and agreed to.

Paragraphs 40 to 47 (now paragraphs 42 to 49) read and agreed to.

Paragraph 48 (now paragraph 50) read, amended and agreed to.

A paragraph – (*The Chairman*) – brought up, read the first and second time and inserted (now paragraph 51)

Paragraph 49 (now paragraph 52) read and agreed to.

Paragraph 50 (now paragraph 53) read as follows:

> HSC/E argued that some limited legislative changes are needed – on higher fines, corporate killing and the removal of Crown Immunity. The Department for Work and Pensions supports HSC in promoting the case for higher fines, and is working with other Departments to progress the Government's commitments to reform the law on corporate killing and remove Crown Immunity for health and safety offences. The Government has been committed to introducing legislation on corporate killing for some time. On 20 May 2003, the Government announced that it would publish a draft Bill. While this was expected by the end of 2003, it has yet to be produced. In oral evidence, Mr Gareth Williams of the Department for Work and Pensions told us that the principle of introducing legislation on corporate killing was agreed, although it was important to ensure there was an effective means of applying it. The principle about whether and how to apply it to the Crown had yet to be resolved. The Home Secretary is hoping to publish a draft Bill before the end of the session.

Amendments made.

An amendment proposed, at end to add the words:

> The Committee is concerned at the length of time it is taking the Government to resolve any outstanding issues concerning reforms of the law on corporate killing and recommends that by 1 December 2004, the Government publishes a Bill on corporate killing. – (*Mr Andrew Dismore*)

Question put that the amendment be made.

The Committee divided.

Ayes, 6	Noes, 1
Ms Vera Baird	Mr Nigel Waterson
Miss Anne Begg	
Ms Karen Buck	
Mr Andrew Dismore	
Rob Marris	
Andrew Selous	

Paragraph 51 (now paragraph 54) read and agreed to.

Paragraph 52 (now paragraph 55) read, amended and agreed to.

Paragraphs 53 to 55 (now paragraphs 56 to 58) read and agreed to.

Paragraphs 56 to 58 (now paragraphs 59 to 61) read, amended and agreed to.

Paragraphs 59 to 62 (now paragraphs 62 to 65) read and agreed to.

Paragraph 63 (now paragraph 66) read, amended and agreed to.

Paragraphs 64 to 66 (now paragraphs 67 to 69) read and agreed to.

Paragraph 67 read, amended, divided and agreed to. (now paragraphs 71 and 72)

Paragraph 68 (now paragraph 73) read and agreed to.

A paragraph – (*The Chairman*) – brought up, read the first and second time and inserted (now paragraph 74)

Paragraphs 69 to 73 (now paragraphs 75 to 78) read and agreed to.

Paragraph 74 (now paragraph 80) read, amended and agreed to.

Paragraph 75 (now paragraph 81) read and agreed to.

Paragraph 76 (now paragraph 82) read as follows:

> The Committee received some evidence that HSE could make better use of the resources it has and such arguments need to be examined carefully by HSC/E. However, the overwhelming view was that HSE is a high quality organisation, constrained by inadequate resources in its ability to adequately support core activities such as inspection, which have a direct impact on its ability to ensure compliance. We recommend that additional resource should be made available over the next three years to increase the ability of HSC/E to meet the targets set for it by central government.

An amendment made.

An Amendment proposed, at end to add the words "This expenditure should be funded from reductions in other areas of the DWP budget." – (*Andrew Selous*)

Question put that the amendment be made.

The Committee divided.

Ayes, 2	Noes, 5
Andrew Selous	Ms Vera Baird
Mr Nigel Waterson	Miss Anne Begg
	Ms Karen Buck
	Mr Andrew Dismore
	Rob Marris

Paragraphs 77 and 78 (now paragraphs 83 and 84) read and agreed to.

Paragraph 79 (now paragraph 85) read, amended and agreed to.

Paragraphs 80 and 81 (now paragraphs 86 and 87) read and agreed to.

Paragraphs 82 to 84 (now paragraphs 88 to 90) read, amended and agreed to.

Paragraph 85 (now paragraph 91) read and agreed to.

Paragraph 86 (now paragraph 92) read, amended and agreed to.

Paragraphs 87 and 88 (now paragraphs 93 and 94) read and agreed to.

Paragraph 89 (now paragraph 95) read, amended and agreed to.

Paragraph 90 (now paragraph 96) read and agreed to.

Paragraphs 91 and 92 (now paragraphs 97 and 98) read, amended and agreed to.

Paragraphs 93 to 98 (now paragraphs 99 to 104) read and agreed to.

A paragraph – (*Rob Marris*) brought up, read the first and second time and inserted (now paragraph 105).

Paragraph 99 (now paragraph 106) read, amended and agreed to.

A paragraph – (*Mr Andrew Dismore*) – brought up, read the first and second time and inserted (now paragraph 107).

Paragraphs 100 to 102 (now paragraph 108 to 110) read and agreed to.

Paragraph 103 (now paragraph 111) read, amended and agreed to.

Paragraphs 104 to 111 (now paragraphs 112 to 119) read and agreed to.

Paragraph 112 (now paragraph 120) read, amended and agreed to.

Paragraphs 113 to 133 (now paragraphs 121 to 141) read and agreed to.

Paragraph 134 (now paragraph 142) read, amended and agreed to.

Paragraph 135 (now paragraph 143) read and agreed to.

Paragraph 136 (now paragraph 144) read, amended and agreed to.

Paragraphs 137 and 138 (now paragraphs 145 and 146) read and agreed to.

A paragraph – (*The Chairman*) – brought up, read a first and second time and inserted (now paragraph 147).

Paragraph 139 (now paragraph 148) read and agreed to.

Paragraphs 140 and 141 (now paragraphs 149 and 150) read, amended and agreed to.

Paragraphs 142 and 143 (now paragraphs 151 and 152) read and agreed to.

Paragraph 144 (now paragraph 153) read, amended and agreed to.

Paragraphs 145 to 147 (now paragraphs 154 to 156) read and agreed to.

Paragraph 148 (now paragraph 157) read, amended and agreed to.

Paragraphs 149 to 153 (now paragraphs 158 to 162) read and agreed to.

A Paragraph – (*The Chairman*) – brought up, read the first and second time and inserted (now paragraph 163).

Paragraphs 154 to 159 (now paragraphs 164 to 169) read and agreed to.

Paragraph 160 (now paragraph 170) read, amended and agreed to.

Paragraph 161 (now paragraph 171) read and agreed to.

Paragraph 162 (now paragraph 172) read, amended and agreed to.

Paragraphs 163 and 164 (now paragraphs 173 and 174) read and agreed to.

Paragraph 165 (now paragraph 175) read, amended and agreed to.

A paragraph – (*Mr Andrew Dismore*) – brought up, read the first and second time and inserted (now paragraph 176).

Paragraph 166 (now paragraphs 177) read, amended and agreed to.

Paragraphs 167 to 170 (now paragraphs 178 to 181) read and agreed to.

Paragraph 171 (now paragraph 182) read, amended and agreed to.

Paragraphs 172 to 187 (now paragraphs 183 to 197) read and agreed to.

Paragraph 188 (now paragraph 198) read, amended and agreed to.

Paragraphs 189 to 193 (now paragraphs 199 to 203) read and agreed to.

Paragraph 194 (now paragraph 204) read, amended and agreed to.

Paragraphs 195 to 203 (now paragraphs 205 to 213) read and agreed to.

Paragraph 204 (now paragraph 214) read, amended and agreed to.

Paragraph 205 (now paragraph 215) read and agreed to.

Paragraph 206 (now paragraph 216) read, amended and agreed to.

Paragraph 207 (now paragraph 217) read and agreed to.

Paragraph 208 (now paragraph 218) read, amended and agreed to.

Paragraphs 209 to 211 (now paragraphs 219 to 221) read and agreed to.

Paragraph 212 (now paragraph 222) read, amended and agreed to.

Paragraph 213 (now paragraph 223) read and agreed to.

Paragraph 214 (now paragraph 224) read, amended and agreed to.

Paragraph 215 (now paragraph 225) read and agreed to.

Paragraphs 216 and 217 (now paragraphs 226 and 227) read, amended and agreed to.

A paragraph – (*Rob Marris*) – brought up, read the first and second time and inserted (now paragraph 228).

Paragraphs 218 to 223 (now paragraphs 229 to 234) read and agreed to.

Paragraphs 224 and 225 (now paragraphs 235 and 236) read, amended and agreed to.

Paragraphs 226 to 229 (now paragraphs 237 to 240) read and agreed to.

Paragraph 230 (now paragraph 241) read, amended and agreed to.

Paragraphs 231 to 238 (now paragraphs 242 to 249) read and agreed to.

Paragraph 239 (now paragraph 250) read, amended and agreed to.

Paragraphs 240 and 241(now paragraphs 251 and 252) read and agreed to.

Paragraphs 242 to 244 (now paragraphs 253 to 255) read, amended and agreed to.

Paragraphs 245 to 247 (now paragraphs 256 to 258) read and agreed to.

Paragraph 248 (now paragraph 259) read, amended and agreed to.

Paragraph 249 (now paragraph 260) read and agreed to.

Paragraphs 250 and 251 (now paragraphs 261 and 262) read, amended and agreed to.

Paragraphs 252 and 253 (now paragraphs 263 and 264) read and agreed to.

Paragraphs 254 and 255 (now paragraphs 265 and 266) read, amended and agreed to.

Paragraphs 256 to 265 (now paragraphs 267 to 276) read and agreed to.

Paragraph 266 (now paragraph 277) read, amended and agreed to.

A paragraph – (*Mr Andrew Dismore*) – brought up, read the first and second time and inserted (now paragraph 278).

Paragraphs 267 to 270 (now paragraphs 279 to 282) read and agreed to.

Paragraph 271 (now paragraph 283) read, amended and agreed to.

Paragraphs 272 and 273 (now paragraphs 284 and 285) read and agreed to.

Paragraphs 274 and 275 (now paragraphs 286 and 287) read, amended and agreed to.

Paragraphs 276 and 277 (now paragraphs 288 and 289) read and agreed to.

Paragraphs 278 to 280 (now paragraphs 290 to 292) read, amended and agreed to.

Paragraphs 281 to 283 (now paragraphs 293 to 295) read and agreed to.

Resolved, That the Report, as amended be the Fourth Report of the Committee to the House.

Ordered, That the Chairman do make the report to the House.

Ordered, That the provisions of Standing Order No. 134 (Select Committees (reports)) be applied to the Report.

Several papers were ordered to be appended to the Report.

Several papers were ordered to be appended to the Minutes of Evidence.

Several Memoranda were ordered to be reported to the House.

[adjourned till Wednesday next at half past nine o'clock

Witnesses

List of written evidence

1 C O Gas Safety
2 Alan Osbourne
3 AIRSAY
4 GPMU
5 TUC
6 Federation of Small Businesses
7 Royal Society for the Promotion of Health
8 British Safety Council
9 PCS
10 Institute of Directors
11 Scottish Trades Union Congress
12 Royal College of Nursing
13 Royal College of Nursing - supplementary
14 RoSPA
15 Association of Personal Injury Lawyers
16 United Kingdom Petroleum Industry Association
17 Scottish Hazards Campaign Group
18 SCA Packaging
19 Retail Motor Industry Federation
20 Construction Confederation
21 Rail Safety Standards Board
22 Police Federation of England and Wales
23 Heating and Ventilators Contractors Association
24 Parliamentary Advisory Council for Transport Safety
25 Institution of Occupational Safety and Health
26 GMB
27 Association of the British Pharmaceutical Industry
28 Simon Jones Memorial Campaign
29 The Ergonomics Society
30 Prospect
31 Prospect - supplementary
32 The Faculty and Society of Occupational Medicine
33 EEF, the manufacturers' organisation
34 Business Services Association
35 UCATT
36 Health and Safety Commission and Executive
37 Health and Safety Commission and Executive - supplementary
38 Letter from Bill Callaghan, Chair of HSC
39 Chemical Industries Association
40 Department for Work and Pensions
41 Centre for Corporate Accountability
42 Confederation of British Industry

43 Local Government Association and Local Authorities Co-ordinators of Regulatory Services
44 Sheffield Occupational Health Advisory Service
45 Employers Organisation for Local Government
46 Employers Organisation for Local Government – supplementary
47 Employers Organisation for Local Government – supplementary (2)
48 UKHCA
49 Ambulance Service Association
50 UNISON
51 NHS Confederation
52 National Centre for Independent Living
53 Association of Directors of Social Services
54 NHS Plus
55 NHS Plus Supplementary
56 Convention of Scottish Local Authorities
57 Federation of Small Businesses in Scotland
58 National Care Homes Association
59 AMICUS
60 ABI
61 Notes of the visit to Brussels
62 CORGI