A REVIEW AND EVALUATION OF THE EFFECTIVENESS OF THE HEALTH AND SAFETY (FIRST-AID) REGULATIONS 1981: FAW

ANALYSIS OF RESPONSES RECEIVED TO DISCUSSION DOCUMENT DDE21

OPTIONS AND QUESTIONS (BACKGROUND INFORMATION & GENERAL, LEGISLATIVE ISSUES Q.1 to Q.7)

BACKGROUND INFORMATION

Of the 508 completed questionnaires received by HSE before the closing date of 30 November 2003, the highest number were submitted by health and safety managers, and qualified first-aiders. Employers, first-aid equipment suppliers and manufacturers and individuals made up the remainder.

Responses were spread evenly across a range of industries and sectors, apart from a relatively low return rate in the leisure and retail sector. The high number who classified themselves in the “Other” category - sector (114) & role (80) – can be identified mainly as consultants, interested individuals, and those working in healthcare professions.

A half of responses were received from individuals who are working in organisations with more than 500 employees, followed next in size by the smallest companies with 1 to 5 workers.

Copies of responses that were not marked confidential may be read at the HSE Infocentre.

SUMMARY

Key findings from analysis of responses to these questions

In general, the responses to these questions and additional comments are to be anticipated, and confirm all the findings of the Casella research into the effectiveness of the regulations. For example, there is a decisive rejection of incorporating FAW into other regulations. Equally, we expected to be told that HSE guidance needed to be clarified. Regarding extending legislation to the public opinions were not so divided. However, a majority expressing either preference admit that there are difficulties in such action while acknowledging the need for better guidance from HSE.

In your view how well does this document identify and address the key issues?

Respondents feel that the document identifies and addresses the key issues well or very well by a very wide margin. Less than 20 replied that key issues had not been covered well.

Is there anything you particularly liked or disliked about this exercise?

Likes

- an important and valuable consultation to reconsider the whole subject that is long overdue
- good to have a say and help to direct future legislative requirements, especially the smaller operators, and addresses highly pertinent issues and concerns that many have had for some time
- all clearly explained e.g. background to the proposed changes and options and well constructed with clear division into different topics and flexibility built into the process
- concise, focuses the mind in addressing every aspect of first aid provision
- adequate depth and detail to cover the majority of issues that need to be addressed
- consequences of decisions e.g. where changes to legislation would be required well thought-out
- easy to respond online– good range of alternatives
- summary, options and comments boxes were particularly helpful
- opportunity to meet face-to-face to discuss the evaluation was very helpful
- realistic timescale was set for the return of comments from stakeholders
- addresses all the key players in the first aid industry and beyond
- simple to follow the reasoning and methodology
- a good easy mode of consultation
- refinements offered to system welcomed
- training identified as a key issue at last
- use of research findings paving the way to inform options/ questions raised in the discussion document very effective
- recognises that first-aid provision must now be compatible with modern needs and developments in pre-hospital care
- encouraging to see the scope of the review going further than the minimum
- attempts to standardise the industry at last

Dislikes

- the review and evaluation exercise is becoming somewhat protracted and the drifting timetable created degree of uncertainty
- aspects are confusing; more clarity to certain items needed. The meaning of some items under discussion is not always clear

- the discussion document should have been sent automatically to every approved first-aid training organisation not only distributed on request
- concerns over the late introduction of standards setting as this was not discussed at the consultation meetings
- in certain areas the range of options needs to be extended to more variants
- Form Design: drop-down boxes are confusing – you select the relevant menu nothing appears in the boxes
- options are limited to ticking one box where more than one answer or a different answer or narrative reply or options extended to more variants is required e.g. q.7
- questions restricted to a ‘yes’ only answer or leave untouched if ‘no’ – no way of knowing that the question wasn’t missed accidentally & how many were replying “yes” by default
- your written reply cannot be saved & printed, and the boxes too small to view text
- no recommendations or guidance on issues outside implicit scope of FAW e.g. supplementary information on what AED is and its usefulness so that employers can make an informed decision
- the need for change is clear but it appears that there may be a hidden agenda of foregone conclusions e.g. less HSE involvement planned
- bias steer to responses e.g. questions 11 & 12
- the proposals do not go far enough. Not enough questions addressed. Fundamental change is required in first-aid provision, since treatments, equipment and management styles have changed out of recognition over the past 20 years. The contents of the Discussion Document will not address the present situation or in future.
- While credit is due to HSE for trying to obtain all views it seems that the VAS ‘big hitters’ will always do things their own way with no intervention from HSE
- The first rule of health and safety is not addressed – the duty of care that an employer holds to everyone on the premises
- No explanation of the situation in Northern Ireland. The same law on FAW exists by “order of council”.
- A bit long and convoluted but realise it takes a reasonable length to explain
- Areas for discussion missed – role of ongoing assessment in refresher courses; minimal training for instructors holding equivalent qualifications

The Regulatory Structure

Q1 Should FAW be incorporated into other health and safety management regulations?

Two-thirds (66%) of responses indicate that FAW should remain stand-alone regulations and not be brigaded with other regulations covering the management of workplace health and safety. Approximately a third (28%) favour incorporation into other regulations. 6% express no opinion.

There is no discernible difference in responses according to role; however, responses analysed by size of organisation indicate that small and medium-sized enterprises (SMEs) are more likely to favour keeping FAW intact as opposed to the larger companies who seem more ready to accept legislative change.

The responses concur with the findings of the Casella research that the benefits to be gained from integration would be limited.

Arguments supporting the status quo with discrete and separate FAW regulations

- The Regulations are important in their own right and benefits extend beyond the workplace
- Retains prominence and weight they deserve – integration could lead to dilution of the emphasis
- Focuses employers' minds on the need for such provision – otherwise they may 'forget' to address
- New regulations require a lot of work that may outweigh any of the benefits to be gained

Arguments supporting incorporation of FAW into other arrangements

- one less regulation to worry about
- allows for a more risk-based approach
- simple 'one-stop-shop' for busy SMEs
- reinforces obligations

Q2 What benefit, if any, would this be to employers in assessing and making their first aid provision?

Those favouring a merger concentrate on MHSWR as the most appropriate vehicle which would take FAW into the general health and safety remit, re-emphasising the mandatory nature of first-aid provision at work and raising the profile of FAW for managers. Many state that they would find the transition straightforward as they already build first-aid into their total health and safety provision, and system of general risks assessment, accident reporting, and emergency procedures. A clear link between risks assessment and the appropriateness of first aid provision i.e. the first aid needs assessment, would simplify the process and make FAW part of the total risk control process. Small businesses argue that they struggle to cope with the mass of legislation put before them. Therefore, any attempts to reduce the burden and simplify tasks to achieve appropriate first aid provision to reduce the burden are to be welcomed. It was argued that a uniform approach within a better-known legislative base such as MHSWR or some other structure involving fewer legal requirements would encourage compliance and assist with more effective planning of health and safety according to their circumstances and need.

The “No” responders identified that the importance of FAW could be diluted or lost if subsumed into MHSWR that is already a complicated set of regulations. Standalone regulations are clear and identifiable, and focus the attention of employers on provision. Merger would serve only to confuse roles and responsibilities further and ultimately weaken the existing provisions of FAW.

Benefits to employers when assessing and making first aid provision if FAW were incorporated into other health & safety management regulations

- more account taken of the actual working environment
- raising first aid as an automatic component part of any workplace assessment would make the topic easier to understand and more acceptable to employers if regulations about the full range of their health and safety responsibilities reside in the same place
- profile of first aid raised within the management structure and safety departments of companies and organisations
- improved and more easily recognised standards to work to and detailed information/instructions provided if linked to other risk assessments
- ambiguities cleared up around what HSE “recommends” or what HSE “requires”
- planning of health and safety provision in workplaces addressed more efficiently, effectively & cohesively
- assessment needs and decision tree process made clearer and therefore less reliance on outsiders to assist them
- thorough consideration of provision needs prompted

- coverage and links of FAW to other regulations made known e.g. confined spaces, electricity at work
- it would remove over-reliance on the first-aid needs checklist and prescriptive content of many training courses that were often hampering employer efforts to ensure adequate provision

Main drawbacks

- incorporating FAW into general legislation could reduce the effectiveness of a proven system and unravel achievements made. Levels of understanding and compliance are reported high – “if it ain’t broke, don’t fix it”
- Employers would then consider first aid to a lesser degree than other more ‘important’ legislation-driven requirements in the workplace – or completely avoid it
- the first aid requirements would get lost amid other content and lead therefore to lesser standards
- The issues and details of MHSWR are confusing enough to follow without adding to them
- More notice is taken if kept as a standalone ACoP
- Good idea for certain legislation maybe but FAW is too specific to make such an approach worthwhile
- Preparing and passing new legislation would take a long time and resource efforts better concentrated on elsewhere
- Change would increase the complexity in an area where there is already a fair level degree of confusion amongst employers e.g. concerning where FAW intersects with other legislation
- FAW needs can already be assessed using the existing framework in MHSWR as a guide
- First aid is an important provision but it is allied to health and safety matters not central to it
- The universal coverage of first aiders and/or appointed persons in all workplaces required at present would be jeopardised
- Any perception that first aid was now marginalized would make it more difficult for employer/employees to justify expenditure and training up the line to superiors
- It would lead to drop in the number of first-aiders because employers would view first aid as advisory only
- sensible to maintain a clear distinction between “after the event” actions such as first-aid, and more involved strategies in prevention and risk control. FAW is a reactive measure dealing with what risk assessment cannot prevent – not management and prevention, so merger poses little in the way of potential benefits
- undesirable outcome if you use the methodology of risk assessment as the identification of a low level of previous injuries, places the company in a low risk category and therefore no provision of first aid is strictly necessary.
- Difficulty in demarcation and knowledge retention as most first-aiders are not necessarily involved in other health and safety

management in their workplace. Employers and first-aiders would become distanced from the tasks

- Present system allows employers to access the information easilyI
- FAW relies at present on volunteers from the workforce. Relying on the results of risks assessments would mean compulsion, first-aider duties written into contracts etc as employers are duty bound to act on the results of a risk assessment.
- The strong sense of first-aid as a moral service and a welfare issue would be corroded
- Fine tuning the extensive guidance that exists on how to comply with FAW would really suffice

Effectiveness of the Regulations and Guidance

Q3 Does FAW make clear the roles and duties of employers, first-aiders and appointed persons?

Responses here are more evenly split. 44% agree that the roles and duties are easy to understand. 51% state that the regulations do not make the designated roles clear.

A theme running through the additional comments is that more detail is required that will cut down on differences in interpretation.

Q4 What additional guidance should HSE give on making a first aid needs assessment?

Many felt that the guidance in the present ACOP on needs assessment was sufficient but roughly a quarter of respondents, especially smaller organisations, provided examples of extra guidance that they would like to see included. The present checklist of 14 aspects is seen as helpful and sufficient to determine needs but there is room to introduce more definite statements that would reduce confusion.

The key suggestions for improvement to HSE advice on the needs assessment were: to make the wording simpler; providing case studies, pro-forma or flow chart explaining principles; clarify the role of appointed person, and, guidance on categories of risk and how to identify the number of first- aiders required.

Detailed advice that respondents wanted to see

- Explanation and amplification of the roles and responsibilities especially “appointed person” confusing halfway house at present
- What level of training must appointed persons receive?
- Is another level needed of specialist first-aider e.g. offshore & diving industry?
- Help in calculating the numbers of appointed persons and first-aiders required in relation to square footage or staffing levels, unusual circumstances – multi-occupancy, coping with longer-term absence of qualified first-aiders
- A guide to the assessment process positioned more prominently in guidance & supported with user-friendly design to reduce problems of individual interpretation e.g. flow chart of principles, tick lists, decision trees, case studies & worked examples comparing low risk to high risk, available online & photocopiable. Especially useful for small and lower risk workplaces
- Factors involved in selection of first-aiders e.g. disability & DDA covered & how to deal with treatment of children, vulnerable groups, and section 3 duties (the public)

- How to deal with specific work/sectors and specific risks encountered e.g. in specialised industries, transport, chemicals, construction
- Categorising risk – where a good safety record may predicates a "low" assessment of need
- Clarify how far first-aider can administer treatment in an emergency situation- remote working and hostile environments where it is expected that there will be delays in accessing paramedic/medical aid
- Use and positioning of special equipment e.g. defibrillators
- Third parties who are not employees e.g. contract staff
- Rights and protection for first-aiders who may make mistakes
- What information needs to be recorded after treatment of an incident
- How often assessment of provision should be revisited

Q5 What other areas of first aid at work does HSE need to clarify or provide new guidance on?

Most suggestions concern the need to elaborate or update existing guidance. The main areas highlighted by respondents were – extra advice on minimum contents of first aid boxes both quality & quantity (how to make additional provision e.g. hospitals, and what not to supply); use of additional first aid equipment especially defibrillators & Oxygen Admin kits; clarification of the role of appointed persons; and advice on first aid for the public and liability concerns.

Other frequently raised issues noted:

- advice for specific work scenarios e.g. lone & shift worker arrangements, peripatetic and voluntary workers, laboratory workers and security staff
- providing cover when first-aiders are absent
- Where a first-aider should not get involved
- Completing RIDDOR returns where required
- How to liaise with emergency services in establishing response times
- Description of a typical first aid room
- Rough guide to costs of implementing FAW in typical workplace

Implementation Costs of the Regulations

Q6 Should HSE guidance include examples of comparative costs?

Two-thirds of replies express a view that examples of costing first-aid provision are not required. The rest feel that some attempt to assist with information of this kind would be worthwhile.

There was no space given to express supporting opinions beneath this question. However, the following points of relevance to Q.6 were added in the additional comments box of questionnaires:

Yes

- Providing examples of costs incurred in meeting their duties would help employers assess the costs of first aid at work in the same way that they currently measure costs incurred in meeting their other obligations to protect the health and safety of their employees adequately
- Low risk & SMEs would benefit from information that would help them in determining the level and quantity of first-aid or appointed persons personnel required & value for money, and encourage take-up - bearing in mind, however, that expense was not the sole guiding principle

No

- Costs will vary widely from organisation to organisation according circumstances so accurate estimates of cost were unlikely
- Stark figures may discourage employers from securing adequate and appropriate provision
- The costs guidelines (and hence the guidance & ACOP) would require frequent amendment
- Meaningless as some providers are subsidised in different ways whereas others pay the full cost themselves
- Too much of the calculations would be driven by assumption
- It would shift the emphasis from the benefits onto the costs of provision
- Guidance on costs is not the case for any other regulations

Application of FAW to other than employees

Q7 Should first aid for the public be provided on a voluntary basis as at present or should this be compulsory through new legislation requiring employers to make provision?

A majority (54%) respond that a continuation of the existing voluntary approach is the best option, with slightly over a third (39%) favouring a move toward compulsion. 7% express no opinion either way. There was an even spread across role, size and sector.

Arguments in support of the status quo

- FAW and guidance result in a good voluntary response already
- the passage of legislation would be time-consuming and resource-intensive, and lead ultimately to more pressures on smaller businesses struggling to comply with the requirements
- first-aiders would be put in the invidious position of having to deal with emergencies without foreknowledge or warning
- a goldmine for lawyers if mistakes occur
- fewer would come forward to train as first-aiders if the element of goodwill is lost and a compulsory element was introduced especially in retail sector
- mandatory first-aid cover for members of the public would mean that first-aid duties may have to become compulsory – written into work contracts with no regard for capabilities
- company insurance rates would rise as not all insurance companies extend cover to non-business related accidents
- simple enough to include provision to public in employer's needs assessment if really wishing to extend to help public
- most organisations & companies with a large public interface already include public in their provision on a 'customer care' basis. Exercising choice not to extend to public is more likely in smaller workplaces where visitors and contractors are less commonplace anyway
- explore value of offering financial assistance for those volunteering to conduct substantial face-to-face assistance with the public in the way that NHS first responder volunteers and staff now operate
- complicated scenarios e.g. a farmer's responsibility for the first aid needs of visiting fruit pickers
- the definition of public is drawn too widely or loaded with exemptions such as those taking ill with pre-existing conditions
- better spending time and money to concentrate on honing current provision

Arguments for compulsory provision for the public:

- It is an emotive issue when a first-aider is prohibited from tending to a member of the public in need of assistance owing to company rules
- arrangements for covering public can always be kept to a minimum e.g. limited to summoning emergency assistance
- paying visitors to sports centres, entertainment complexes etc. have a right to assume first- aid help if needed as part of a duty of care
- isn't extending to public consistent with employer duties under HSWA Section 3 & MHSWR?
- nothing to lose provided a sensible level of numbers or situations is set before implementation
- voluntary arrangements will not ensure it is provided or operated properly

Additional Comments on this section of the Discussion Document not covered above

- a retrograde step to give voluntary associations a further opportunity to dominate in the training, training standards, and knowledge field. Smaller training organisations in the independent sector should also have a say.
- more provision should be made to offer training and guidance in languages other than English
- FAW should be kept locked into a NGO system in order to stop the proliferation of supposed safety experts giving flawed advice
- constant little changes e.g. to the UK resuscitation guidelines cause much confusion
- The Armed services should be taken into the scope of FAW
- update the first aid pages of HSE website with lessons learnt from incident reports
- if the record keeping of first aid incidents was linked to the statutory reporting of accidents a catalogue of prevention techniques could be created
- there are foregone conclusions in the discussion document and a hidden agenda to get rid of small independent first aid providers who in the main provide excellent training
- employers should be encouraged to read the guidance that is already available and more thought given to how the material is publicised
- start to enforce FAW requirements more firmly stringently where employers cannot be bothered to maintain adequate provision

FURTHER STATISTICAL ANALYSIS OF THIS SECTION OF DISCUSSION DOCUMENT

Q1 – Should FAW be incorporated into other health and safety management regulations?

Table 1 – Responses to Q1

	TOTAL	**%**
No	337	*66*
Yes	143	*28*
No Opinion	28	*6*

Table 2 – Responses to Q1 by Sector

	No	**%**	**Yes**	**%**	**No opinion**	**%**
No opinion	2	*0.4*	0	*0*	1	*0.2*
Agriculture	7	*1.4*	7	*1.4*	0	*0*
Construction	9	*1.8*	6	*1.2*	0	*0*
Education	117	*23*	39	*7.8*	9	*1.8*
Manufacturing	23	*4.5*	13	*2.6*	2	*0.4*
Other	70	*13.8*	36	*7.1*	8	*1.6*

Public	49	9.7	20	3.9	0	0
Retail	8	1.6	2	0.4	1	0.2
Services	20	3.9	9	1.8	3	0.6
Electronics	4	0.8	0	0	1	0.2
IT	1	0.2	0	0	0	0
Outdoor	2	0.4	0	0	0	0
Facilities Management	2	0.4	0	0	0	0
Research & Consultancy	3	0.6	2	0.4	0	0
Engineering	4	0.8	1	0.2	1	0.2
Transport	1	0.2	1	0.2	0	0
Printing	1	0.2	0	0	0	0
Media	1	0.2	0	0	0	0
Chemical	5	1.0	2	0.4	1	0.2
Nuclear	1	0.2	0	0	0	0
Charity	2	0.4	2	0.4	0	0
Extractive & Utility Supply	1	0.2	1	0.2	0	0
Leisure	4	0.8	1	0.2	1	0.2
Communication	0	0	1	0.2	0	0
Total	**337**	66.5	**143**	28.4	**28**	5.6

Table 3 – Responses to Q1 by Size

	No	%	Yes	%	No Opinion	%
1-5	56	11	27	5.3	6	1.2
6-10	28	5.5	11	2.2	3	0.6
11-25	19	3.7	14	2.8	1	0.2
26-50	12	2.4	9	1.8	1	0.2
51-100	16	3.2	6	1.2	2	0.4
101-500	54	10.6	11	2.2	5	1
Over 500	145	28.5	62	12.2	5	1
N/A	7	1.4	3	0.6	5	1
Total	**337**	66.3	**143**	28.3	**28**	5.6

Table 4 – Responses to Q1 by Role

	No	%	Yes	%	No Opinion	%
No opinion	4	0.8	1	0.2	1	0.2
Employer	7	1.4	1	0.2	1	0.2
First Aider	41	8.1	29	5.7	5	1
Health and Safety Manager	85	16.7	20	3.9	2	0.4
Other	42	8.3	34	6.7	4	0.8
Training Organisation	137	27	39	7.7	8	1.6
Public	0	0	1	0.2	0	0
Union	3	0.6	5	1	0	0

Trade Association	8	*1.6*	3	*0.6*	1	*0.2*
First Aid Trainer	10	*2*	10	*2*	6	*1.2*
Total	**337**	*66.5*	**143**	*28.2*	**28**	*5.6*

Q3 – Does FAW make clear the roles and duties of employers, first aiders and appointed persons?

Table 5 – Responses to Q3

	TOTAL	**%**
No	258	*51*
Yes	223	*44*
No Opinion	27	*5*

Table 6 – Responses to Q3 by Sector

	No	**%**	**Yes**	**%**	**No opinion**	**%**
No opinion	2	*0.4*	0	*0*	1	*0.2*
Agriculture	4	*0.8*	10	*2*	0	*0*
Construction	5	*1*	10	*2*	0	*0*
Education	81	*16*	75	*14.8*	9	*1.8*
Manufacturing	13	*2.6*	23	*4.5*	2	*0.4*
Other	46	*9.1*	60	*11.8*	8	*1.6*
Public	34	*6.7*	35	*6.9*	0	*0*
Retail	3	*0.6*	7	*1.4*	1	*0.2*
Services	14	*2.8*	15	*3*	3	*0.6*
Electronics	4	*0.8*	1	*0.2*	0	*0*
IT	1	*0.2*	0	*0*	0	*0*
Outdoor	0	*0*	2	*0.4*	0	*0*
Facilities Management	1	*0.2*	1	*0.2*	0	*0*
Research & Consultancy	3	*0.6*	2	*0.4*	0	*0*
Engineering	3	*0.6*	2	*0.4*	1	*0.2*
Transport	1	*0.2*	1	*0.2*	0	*0*
Printing	1	*0.2*	0	*0*	0	*0*
Media	1	*0.2*	0	*0*	0	*0*
Chemical	2	*0.4*	5	*1*	1	*0.2*
Nuclear	0	*0*	1	*0.2*	0	*0*
Charity	2	*0.4*	2	*0.4*	0	*0*
Extractive & Utility Supply	1	*0.2*	1	*0.2*	0	*0*
Leisure	1	*0.2*	4	*0.8*	1	*0.2*
Communication	0	*0*	1	*0.2*	0	*0*
Total	**223**	*44.2*	**258**	*51*	**27**	*5.4*

Table 7 – Responses to Q3 by Size

	No	**%**	**Yes**	**%**	**No Opinion**	**%**
1-5	40	*7.9*	41	*8.1*	8	*1.6*
6-10	24	*4.7*	15	*3*	3	*0.6*

11-25	17	3.4	16	3.2	1	0.2
26-50	13	*2.6*	8	*1.6*	1	*0.2*
51-100	7	*1.4*	15	*3*	2	*0.4*
101-500	30	*5.9*	38	*7.7*	2	*0.4*
Over 500	88	*17.3*	119	*23.4*	5	*1*
N/A	4	*0.8*	6	*1.2*	5	*1*
Total	**223**	*44*	**258**	*51.2*	**27**	*5.4*

Table 8 – Responses to Q3 by Role

	No	%	Yes	%	No Opinion	%
No opinion	4	*0.8*	1	*0.2*	1	*0.2*
Employer	3	*0.6*	5	*1*	1	*0.2*
First Aider	41	*8.1*	30	*5.9*	4	*0.8*
Health and Safety Manager	38	*7.5*	67	*13.2*	2	*0.4*
Other	39	*7.7*	37	*7.3*	4	*0.8*
Training Organisation	88	*17.3*	88	*17.3*	8	*1.6*
Public	0	*0*	1	*0.2*	0	*0*
Union	3	*0.6*	5	*1*	0	*0*
Trade Association	2	*0.4*	10	*2*	0	*0*
First Aid Trainer	5	*1*	14	*2.8*	7	*1.4*
Total	**223**	*44*	**258**	*50.9*	**27**	*5.4*

Q6 – Should HSE guidance include examples of comparative costs making first aid provision?

Table 9 – Responses to Q6

	TOTAL	%
No	312	*61*
Yes	171	*34*
No Opinion	25	*5*

Table 10 – Responses to Q6 by Sector

	No	%	Yes	%	No opinion	%
No opinion	1	*0.2*	1	*0.2*	1	*0.2*
Agriculture	7	*1.4*	7	*1.4*	0	*0*
Construction	11	*2.2*	4	*0.8*	0	*0*
Education	115	*22.6*	43	*8.5*	7	*1.4*
Manufacturing	19	*3.7*	17	*3.4*	2	*0.4*
Other	66	*13*	41	*8.1*	7	*1.4*
Public	44	*8.7*	25	*4.9*	0	*0*
Retail	8	*1.6*	2	*0.4*	1	*0.2*
Services	14	*2.8*	15	*3*	3	*0.6*
Electronics	2	*0.4*	2	*0.4*	1	*0.2*
IT	1	*0.2*	0	*0*	0	*0*
Outdoor	2	*0.4*	0	*0*	0	*0*

Facilities Management	1	*0.2*	1	*0.2*	0	*0*
Research & Consultancy	5	*1*	0	*0*	0	*0*
Engineering	4	*0.8*	1	*0.2*	1	*0.2*
Transport	2	*0.4*	0	*0*	0	*0*
Printing	1	*0.2*	0	*0*	0	*0*
Media	1	*0.2*	0	*0*	0	*0*
Chemical	4	*0.8*	3	*0.6*	1	*0.2*
Nuclear	0	*0*	1	*0.2*	0	*0*
Charity	3	*0.6*	1	*0.2*	0	*0*
Extractive & Utility Supply	0	*0*	2	*0.4*	0	*0*
Leisure	1	*0.2*	4	*0.8*	1	*0.2*
Communication	0	*0*	1	*0.2*	0	*0*
Total	**312**	*61.6*	**171**	*33.9*	**25**	*5*

Table 11 – Responses to Q6 by Size

	No	**%**	**Yes**	**%**	**No Opinion**	**%**
1-5	55	*10.8*	27	*5.3*	7	*1.4*
6-10	31	*6.1*	8	*1.6*	3	*0.6*
11-25	27	*5.3*	6	*1.2*	1	*0.2*
26-50	10	*2*	11	*2.2*	1	*0.2*
51-100	11	*2.2*	11	*2.2*	2	*0.4*
101-500	46	*9.1*	22	*4.3*	2	*0.4*
Over 500	124	*24.4*	84	*16.5*	4	*0.8*
N/A	8	*1.6*	2	*0.4*	5	*1*
Total	**312**	*61.5*	**171**	*33.7*	**25**	*5*

Table 12 – Responses to Q6 by Role

	No	**%**	**Yes**	**%**	**No Opinion**	**%**
No opinion	3	*0.6*	2	*0.4*	1	*0.2*
Employer	3	*0.6*	5	*1*	1	*0.2*
First Aider	33	*6.5*	37	*7.3*	5	*1*
Health and Safety Manager	76	*15*	29	*5.7*	2	*0.4*
Other	39	*7.7*	38	*7.5*	3	*0.6*
Training Organisation	133	*26.2*	44	*8.7*	7	*1.4*
Public	1	*0.2*	0	*0*	0	*0*
Union	6	*1.2*	2	*0.4*	0	*0*
Trade Association	8	*1.6*	4	*0.8*	0	*0*
First Aid Trainer	10	*2*	10	*2*	6	*1.2*
Total	**312**	*61.6*	**171**	*33.8*	**25**	*5*

Q7 – Should first aid provision for the public be provided on a voluntary basis as at present or should this be compulsory through new legislation requiring employers to make provision?

Table 13 – Responses to Q3

	TOTAL	**%**
Voluntary	275	*54*
Compulsory	199	*39*
No Opinion	34	*7*

Table 14 – Responses to Q7 by Sector

	Voluntary	**%**	**Compulsory**	**%**	**No opinion**	**%**
No opinion	1	*0.2*	0	*0*	2	*0.4*
Agriculture	13	*2.6*	1	*0.2*	0	*0*
Construction	9	*1.8*	4	*0.8*	2	*0.4*
Education	74	*14.6*	82	*16.1*	9	*1.8*
Manufacturing	23	*4.5*	12	*2.4*	3	*0.6*
Other	67	*13.2*	38	*7.5*	9	*1.8*
Public	39	*7.7*	30	*5.9*	0	*0*
Retail	7	*1.4*	3	*0.6*	1	*0.2*
Services	14	*2.8*	15	*3*	3	*0.6*
Electronics	3	*0.6*	1	*0.2*	1	*0.2*
IT	1	*0.2*	0	*0*	0	*0*
Outdoor	2	*0.4*	0	*0*	0	*0*
Facilities Management	1	*0.2*	1	*0.2*	0	*0*
Research & Consultancy	4	*0.8*	1	*0.2*	0	*0*
Engineering	4	*0.8*	1	*0.2*	1	*0.2*
Transport	0	*0*	2	*0.4*	0	*0*
Printing	1	*0.2*	0	*0*	0	*0*
Media	1	*0.2*	0	*0*	0	*0*
Chemical	5	*1*	1	*0.2*	2	*0.4*
Nuclear	0	*0*	1	*0.2*	0	*0*
Charity	2	*0.4*	2	*0.4*	0	*0*
Extractive & Utility Supply	2	*0.4*	0	*0*	0	*0*
Leisure	2	*0.4*	3	*0.6*	1	*0.2*
Communication	0	*0*	1	*0.2*	0	*0*
Total	**275**	*54.4*	**199**	*39.3*	**34**	*6.8*

Table 15 – Responses to Q7 by Size

	Voluntary	**%**	**Compulsory**	**%**	**No Opinion**	**%**
1-5	44	*8.7*	37	*7.3*	8	*1.6*
6-10	17	*3.4*	21	*4.1*	4	*0.8*
11-25	20	*3.9*	12	*2.4*	2	*0.4*
26-50	8	*1.6*	14	*2.8*	0	*0*

51-100	8	*1.6*	12	*2.4*	4	*0.8*
101-500	43	*8.5*	26	*5.1*	1	*0.2*
Over 500	130	*25.6*	74	*14.6*	8	*1.6*
N/A	5	*1*	3	*0.6*	7	*1.4*
Total	**275**	*54.3*	**199**	*39.3*	**34**	*6.8*

Table 16 – Responses to Q7 by Role

	Voluntary	**%**	**Compulsory**	**%**	**No Opinion**	**%**
No opinion	3	*0.6*	1	*0.2*	2	*0.4*
Employer	5	*1*	2	*0.4*	2	*0.4*
First Aider	39	*7.7*	32	*6.3*	4	*0.8*
Health and Safety Manager	75	*14.8*	29	*5.7*	3	*0.6*
Other	43	*8.5*	32	*6.3*	5	*1*
Training Organisation	90	*17.7*	83	*16.3*	11	*2.2*
Public	0	*0*	1	*0.2*	0	*0*
Union	4	*0.8*	4	*0.8*	0	*0*
Trade Association	9	*1.8*	1	*0.2*	2	*0.4*
First Aid Trainer	7	*1.4*	14	*2.8*	5	*1*
Total	**275**	*54.3*	**199**	*39.2*	**34**	*6.8*

KEYWORD STATISTICAL ANALYSIS

Q4 – What additional guidance should HSE give on making a first aid needs assessment?
Q5 – What other areas of FAW does HSE need to clarify or provide guidance on?

Table 1 – Additional guidance (level 3 keywords)

	Total	% 1016	
Equipment	69	6.8	
Medicines	11	1.1	
Needs Assessment	58	5.7	
No change	13	1.3	
No of FA	70	6.9	
Public FA	31	3.1	
Risk Assessment	1		
Roles	140	13.8	
Sector	28	2.8	
SMEs	12	1.2	

Table 2 – Additional guidance (level 3 keywords) by Sector

	Equipment		Medicines		Needs assessment		No change		No of FA		Public FA		Roles		Sector		SMEs	
Other	17		3		13		3		18		10		33		6		2	
No Opinion	0		0		1		0		0		0		2		0		0	
Agriculture	1		0		0		1		0		0		1		0		0	
Charity	0		0		1		0		2		1		0		1		0	
Chemical	1		0		0		0		3		0		3		1		1	
Communication	0		0		0		0		0		0		0		0		0	
Construction	1		1		0		0		0		1		1		1		3	

Education	24		4		21		17		17		27		56		6		3	
Engineering	2		0		2		0		1		0		1		0		0	
Facilities Management	0		0		0		0		0		0		0		0		0	
IT	0		0		0		0		1		0		1		0		0	
Leisure	0		0		0		0		0		0		1		0		0	
Manufacturing	5		1		1		0		5		0		9		3		1	
Media	0		0		1		0		0		0		0		0		0	
Outdoor	0		0		2		0		0		0		0		0		0	
Printing	0		0		1		0		0		0		1		0		0	
Public	13		2		9		2		9		7		18		5		1	
Research & Consultancy	1		0		1		0		0		1		0		1		0	
Retail	1		0		1		0		0		0		2		1		0	
Services	3		0		5		1		6		2		11		3		1	
Transport	0		0		0		0		1		0		0		0		0	
Total	11		2		50		13		47		14		79		26		11	

Table 3 – Additional guidance (level 3 keywords) by size

	1-5		**6-10**		**11-25**		**26-50**		**51-100**		**101-500**		**Over 500**		**N/A**	
	Total	%	Total	%	Total	%	Total	%	Total	%	Total	%	Total	%	Total	%
Equipment	10		8		3		1		6		9		31		1	
Medicines	4		2		0		0		1		1		3		0	
Needs assessment	11		3		7		3		0		5		28		1	
No change	1		2		1		0		2		1		6		0	
No of FA	6		8		6		4		3		10		32		1	

Public FA	5		2		4		1		2		5		7		2	
Risk assessment	0		0		0		0		0		0		1		0	
Roles	27		16		11		9		5		18		51		3	
Sector	1		1		1		4		1		5		15		0	
SMEs	3		0		0		1		0		3		5		0	

Table 4 – Additional Guidance (level 3 keywords)

	Equipment		**Medicines**		**Needs assessment**		**No change**		**No of FA**		**Public FA**		**Roles**		**Sector**		**SMEs**	
	Total	%	Total	%	Total	%	Total	%	Total	%	Total	%	Total	%	Total	%	Total	%
Other	6		0		14		1		15		3		24		4		4	
No opinion	2		0		0		0		1		0		4		0		0	
Employer	1		0		2		0		0		0		1		1		0	
First Aid Trainer	3		1		0		2		0		0		3		0		1	
First Aider	9		2		8		1		16		5		18		5		0	
Health & Safety Manager	15		2		6		1		12		13		23		12		2	
Public	1		0		0		0		0		0		0		0		0	
Trade Association	2		0		3		0		2		0		4		0		1	
Training Organisation	27		6		24		7		23		10		58		5		4	
Union	3		0		1		1		1		0		5		1		0	

OPTIONS FOR FIRST AID TRAINING ARRANGEMENTS Q.8

Key findings from the analysis of responses

- 62% of responses were in favour of Option 2 – retaining an appointed person as a basic requirement, or if needed, providing a first aider that has successfully completed a course in emergency first aid or first aid at work.
- Further analysis of responses by role of respondent, size of organisation and sector type, generally showed a consistent pattern with Option 2 favoured in almost every case.
- Several respondents, mainly First Aid Training Organisations, questioned whether the proposed initial 16 hour first aid at work course would be too short and suggested 18 or 21 hours as an alternative.
- There was widespread support for annual refresher training of first aiders although some suggested retraining should be conducted every 6, 18 or 24 months.
- Some respondents felt that annual refresher training would place an increased burden on employers.
- There was support for raising the profile of automated external defibrillator use by incorporating it into first aid at work courses or through provision of additional guidance.
- Any First Aid Training Organisation offering the proposed emergency first aid course should be approved by HSE for this purpose as is currently the case for the first aid at work course.
- Consideration should be given to the use of training methods other than instructor based techniques, especially for non-practical aspects of first aid.

Numerical analysis

Of the 508 responses received by HSE, nearly two-thirds were in favour of Option 2 and one-fifth in favour of Option 3 (see Table 1). A small number of respondents supported the flexibility of Option 2 but wished to see it combined with Option 3 so every workplace would have at least one qualified first aider.

Table 1 Distribution of responses on options for first aid training arrangements

Response	Number	Percentage
Option 1	60	11.8
Option 2	315	62.0
Option 3	102	20.1
No opinion	31	6.1
Total	508	100.0

The responses were analysed in more detail by role of respondent, size of organisation and sector type (Tables 2-4). The distribution of responses in most categories was broadly similar to that shown in Table 1. Exceptions to this were (i) organisations containing 51-100 employees where Option 3 was most popular (10 out of 24 responses received (41.7%)); (ii) the agriculture sector where Option 1 was most popular (9 out of 14 responses received (64.3%)).

Table 2 Analysis of responses on options for first aid training arrangements by role of respondent

Role	**Option 1**		**Option 2**		**Option 3**		**No opinion**		**Total**
	No.	**%**	No.	**%**	No.	**%**	No.	**%**	
No opinion	-	**-**	3	**50.0**	1	**16.7**	2	**33.3**	6
Employer	2	**22.2**	6	**66.7**	-	**-**	1	**11.1**	9
First aider	18	**24.0**	32	**42.7**	22	**29.3**	3	**4.0**	75
Health and Safety Manager	16	**15.0**	66	**61.7**	22	**20.6**	3	**2.8**	107
Other	7	**8.9**	61	**77.2**	7	**8.9**	4	**5.1**	79
Training Organisation	15	**8.2**	119	**64.7**	39	**21.2**	11	**6.0**	184
Public	-	**-**	-	**-**	1	**100.0**	-	**-**	1
Union	-	**-**	7	**87.5**	1	**12.5**	-	**-**	8
Trade Association	1	**8.3**	8	**66.7**	2	**16.7**	1	**8.3**	12
First Aid Equipment Manufacturer/ Supplier	-	**-**	-	**-**	-	**-**	1	**100.0**	1
First Aid Trainer	1	**3.8**	13	**50.0**	7	**26.9**	5	**19.2**	26

Table 3 Analysis of responses on options for first aid training arrangements by size of organisation

Size of organisation	Option 1		Option 2		Option 3		No opinion		Total
	No.	%	No.	%	No.	%	No.	%	
1-5	13	**14.6**	47	**52.8**	21	**23.6**	8	**9.0**	89
6-10	3	**7.1**	27	**64.3**	10	**23.8**	2	**4.8**	42
11-25	5	**14.7**	22	**64.7**	4	**11.8**	3	**8.8**	34
26-50	1	**4.5**	14	**63.6**	7	**31.8**	-	**-**	22
51-100	3	**12.5**	8	**33.3**	10	**41.7**	3	**12.5**	24
101-500	9	**12.9**	42	**60.0**	15	**21.4**	4	**5.7**	70
Over 500	26	**12.3**	147	**69.3**	33	**15.6**	6	**2.8**	212
N/A	-	**-**	8	**53.3**	2	**13.3**	5	**33.3**	15

Table 4 Analysis of responses on options for first aid training arrangements by sector type

Sector type	Option 1		Option 2		Option 3		No opinion		Total
	No.	%	No.	%	No.	%	No.	%	
No opinion	-	**-**	1	**33.3**	-	**-**	2	**66.7**	3
Agriculture	9	**64.3**	2	**14.3**	3	**21.4**	-	**-**	14
Construction	2	**13.3**	9		4		-	**-**	15

			60.0		**26.7**				
Education	15	**9.1**	107	**64.8**	35	**21.2**	8	**4.8**	165
Manufacturing	6	**16.2**	22	**59.5**	7	**18.9**	2	**5.4**	37
Other	12	**10.5**	68	**59.6**	27	**23.7**	7	**6.1**	114
Public	6	**8.7**	48	**69.6**	13	**18.8**	2	**2.9**	69
Retail	4	**36.4**	5	**45.5**	-	**-**	2	**18.2**	11
Services	1	**3.1**	25	**78.1**	4	**12.5**	2	**6.3**	32
Electronics	1	**20.0**	3	**60.0**	-	**-**	1	**20.0**	5
IT	-	**-**	-	**-**	1	**100.0**	-	**-**	1
Outdoor	-	**-**	-	**-**	2	**100.0**	-	**-**	2
Facilities Management	-	**-**	2	**100.0**	-	**-**	-	**-**	2
Research and Consultancy	-	**-**	5	**100.0**	-	**-**	-	**-**	5
Engineering	-	**-**	3	**50.0**	2	**33.3**	1	**16.7**	6
Transport	-	**-**	1	**50.0**	1	**50.0**	-	**-**	2
Printing	-	**-**	1	**100.0**	-	**-**	-	**-**	1

Media	-	**-**	1	**100.0**	-	**-**	-	**-**	1
Chemical	1	**12.5**	5	**62.5**	1	**12.5**	1	**12.5**	8
Nuclear	-	**-**	-	**-**	1	**100.0**	-	**-**	1
Charity	1	**25.0**	2	**50.0**	1	**25.0**	-	**-**	4
Extractive and Utility Supply	1	**50.0**	1	**50.0**	-	**-**	-	**-**	2
Leisure	1	**16.7**	3	**50.0**	-	**-**	2	**33.3**	6
Communication	-	**-**	1	**100.0**	-	**-**	-	**-**	1
Manufacturers	-	**-**	-	**-**	-	**-**	1	**100.0**	1

Analysis of specific comments

The following notable comments were recorded by some respondents:

- The current first aid at work (FAW) course is too long.
- The current FAW course is too short.
- The proposed shorter FAW course of 16 contact hours (Option 2) is of an appropriate duration.
- 16 hours is possibly too short for an FAW course - 18 or 21 hours may be more appropriate (mainly from First Aid Training Organisations).
- Annual refresher training is a good idea although retraining every 6, 18 or 24 months might be more appropriate.
- Annual refresher training will place an increased burden on employers, mainly because of the need to release employees from work.

- Annual refresher training will result in a significant increase in administration for organisations with large numbers of first aiders.
- Automated external defibrillators (AEDs) should be covered as part of the FAW course.
- HSE should produce additional guidance on AED use.
- The short course in emergency first aid, currently recommended for appointed persons, should only be offered by First Aid Training Organisations approved by HSE for this purpose.
- Consideration should be given to the use of training methods other than traditional instructor based techniques, especially for non-practical aspects of first aid.

There is considerable confusion over the respective roles and duties of employers, first aiders and appointed persons (see analysis of responses to Question 3). In particular, there seems to be uncertainty over the role of the appointed person, a view supported by the findings of the research conducted for HSE by Casella Winton. It was originally developed to ensure every workplace at least had someone who could take charge of first aid arrangements, including looking after the equipment and facilities and calling the emergency services when required. While HSE recommends that appointed persons undergo training in emergency first aid, it is not mandatory. While an appointed person may still have a valid role, better definition of this role and clearer terminology should help remove much of the confusion that currently exists.

The concept of having two levels of first aid training (Option 2) was supported by the majority of respondents and will assist employers in ensuring that first aid provision is proportional to their needs. No major differences were seen when data were further analysed by role of respondent, size of organisation or sector. There is considerable agreement on the need for shorter, more frequent first aid courses. However, there needs to be recognition that such courses should provide first aiders with all the skills and knowledge required to carry out their duties in the workplace. Equally any changes to the present arrangements should take into account the cost implications for employers. Slightly extending the initial 16 hour FAW course proposed in the Discussion Document and reducing refresher training to a half day every 12 months should help both first aiders and employers.

This is consistent with Casella Winton's recommendation for employers to have more 'first aider options' available to them to ensure first aid provision is proportional to the risks of injury and illness in the workplace. To help achieve this they recommended introducing a 'basic first aider', intermediate in status between an appointed person and first aider, who is competent to carry out cardiopulmonary resuscitation. Casella Winton also suggested more frequent refresher training which could be combined with a shorter initial FAW course.

OPTIONS FOR FIRST AID AND MEDICAL STANDARDS Q.9, Q.10, Q.10a

Key findings from the analysis of responses

Chapter 4 – First Aid Training

Q 9 – Would there be any benefits to employers and training organisations in changing the training standards currently accepted?

The answer was in the form of tick boxes for yes and no, thus responses could be coded as “yes”, “no” or “no opinion” (neither box ticked).

Q 10 – If yes, which is your preferred option?

Option 1: ***No change – HSE continues to accept standards set by external bodies (UK/European Resuscitation Councils, Voluntary Aid Societies and medical/scientific research.***

Option 2: ***HSE only accepts standards set by the UK Resuscitation Council and the Voluntary Aid Societies.***

Option 3: ***HSE should increase the list of specific standards accepted to include, for example, those from ambulance authorities or medical Royal Colleges.***

Option 4: ***First aid industry develops its own standard setting body for first aid at work.***

Four tick boxes were provided. Answers could be coded to one of the 4 options or to “no opinion” if none of the 4 boxes were ticked.

In principle these questions are linked, in that a respondent who answered “no” to Q9 should have omitted to answer Q10 (i.e. no opinion). However this was not explicitly specified in the instructions, so respondents who answered “no” to Q9 were free to tick a box for Q10. If they truly understood the existing standards it would be expected that such respondents would tick Option 1 (No change). However it was not uncommon for such respondents to tick options 2, 3 or 4, suggesting that they did not actually understand the current position.

It was equally likely that respondents who answered “yes” to Q9 would select option 1 in Q10, again suggesting that they did not understand the current position.

Such incompatible responses were somewhat more frequent among respondents representing industry than among those representing the first aid training industry, but this was by no means a consistent pattern.

One of the main conclusions from this section of the discussion document must therefore be that there is poor understanding, throughout both the training industry and employers, of the standards currently accepted by HSE. There is therefore an obvious need to make our guidance clearer.

As will be shown by the detailed numerical analysis of the responses to the two questions, the proportion of respondents who preferred no change (either “no” to Q9 or “Option 1 to Q10) was similar for both of the questions. This suggests that the general opinion, across all of the responses, may be similar regardless of which question is considered of primary importance. It must be remembered, however, that the responses are not necessarily consistent at the individual level.

Therefore, to a certain extent, there is a case to be made for suggesting that the responses to the discussion document are invalid.

Results

Numerical analysis – Q9

Of the 508 responses received by HSE, there was a relatively small majority (57%) in favour of changing the current arrangements for accepted standards.

Table 1 Distribution of responses to question 9

Response	**Number**	**Percentage**
Yes	290	**57.1**
No	191	**37.6**
No opinion	27	**5.3**
Total	508	**100.0**

The responses were analysed in more detail by role of respondent, size of organisation and sector type (Tables 2-4). The distribution of responses in most categories was broadly similar to that shown in Table 1. Differences are discussed in the text following each table.

Table 2 Analysis of responses to question 9 by role of respondent

Role	**Yes**		**No**		**No opinion**		**Total**
	No.	**%**	No.	**%**	No.	**%**	
Not stated	3	**50.0**	2	**33.3**	1	**16.7**	6
Employer	1	**11.1**	7	**77.8**	1	**11.1**	9
First aider	43	**57.3**	29	**38.7**	3	**4.0**	75
Health and Safety Manager	53	**49.5**	51	**47.7**	3	**2.8**	107
Other	48	**60.8**	29	**36.7**	2	**2.5**	79
Training Organisation	111	**60.3**	64	**34.8**	9	**4.9**	184
Public	1	**100.0**	-	**-**	-	**-**	1
Union	5	**62.5**	3	**37.5**	-	**-**	8

Trade Association	6		6		-		12
First Aid Equipment Manufacturer/ Supplier	-	**-**	-	**-**	1	**100.0**	1
First Aid Trainer	19	**73.1**	-	**-**	7	**26.9**	26
Total	290	**57.1**	191	**37.6**	27	**5.3**	508

N.B. – the category "other" is largely composed of health care professionals and related occupations. They have not been classified as "first aiders" or "trainers" because they are not actively undertaking one of these roles. However the majority of this category may be considered to have a professional interest in first aid standards.

It is clear that first aiders, their training organisations, and health care professionals (represented by "other") have a view consistent with the overall opinion that the accepted standards should be changed. Individual trainers are even more strongly in favour of change. Health and Safety managers are very much ambivalent and employers are strongly against any change. It could reasonably be argued that, on the whole, those respondents who are likely to have the greatest practical knowledge of first aid are broadly, though not strongly, supportive of some change to the current arrangements.

Table 3 Analysis of responses to question 9 by size of organisation

Size of organisation	**Yes**		**No**		**No opinion**		**Total**
	No.	%	No.	%	No.	%	
1-5	60	**67.4**	22	**24.7**	7	**7.9**	89
6-10	25	**59.5**	14	**33.3**	3	**7.1**	42
11-25	22	**64.7**	11	**32.4**	1	**2.9**	34
26-50	15	**68.1**	7	**31.8**	-	**-**	22

51-100	11	**45.8**	10	**41.7**	3	**12.5**	24
101-500	40	**57.1**	29	**41.4**	1	**1.4**	70
Over 500	109	**51.4**	95	**44.8**	8	**3.8**	212
N/A	8	**53.3**	3	**20.0**	4	**26.7**	15
Total	290	**57.1**	191	**37.6**	27	**5.3**	508

This table shows a tendency for the smaller organisations to be more in favour of change than the larger ones, though it is unlikely that a formal statistical analysis would demonstrate a significant difference. The trend is perhaps understandable because the largest organisations include the Voluntary Aid Societies (e.g. St. John, Red Cross, St. Andrew's), whose standards already have a prominent place in the existing system. The VAS themselves constitute only a very small proportion of the 212 large organisations, so the postulated explanation would have to assume that many of the larger organisations are already aligned with the position of the VAS.

It is well known that some of the smaller training companies consider that a small number of these large organisations have an excessive influence in the present system, thus preventing small companies, who may have novel ideas appropriate to the needs of employers, from having an adequate voice in the process. This must be balanced against the opinion of employers, noted above, that they consider the present standards adequate for their needs. It must, however, be noted that the employer is not necessarily best placed to assess whether their first aid needs are properly addressed, even though that is what the law expects of them.

Table 4 Analysis of responses to question 9 by industry sector.

Sector type	**Yes**		**No**		**No opinion**		**Total**
	No.	%	No.	%	No.	%	
Not stated	-	**-**	2	**66.7**	1	**33.3**	3
Agriculture	8	**57.1**	6	**42.9**	-	**-**	14
Construction	7	**46.7**	8	**53.3**	-	**-**	15
Education	99	**60.0**	58	**35.2**	8	**4.8**	165

Manufacturing	19	**51.4**	16	**43.2**	2	**5.4**	37
Other	66	**57.9**	42	**36.8**	6	**5.3**	114
Public	38	**55.1**	30	**43.5**	1	**1.4**	69
Retail	6	**54.5**	4	**36.4**	1	**9.1**	11
Services	24	**75.0**	5	**15.6**	3	**9.4**	32
Electronics	1	**20.0**	4	**80.0**	-	**-**	5
IT	-	**-**	1	**100.0**	-	**-**	1
Outdoor	-	**-**	2	**100.0**	-	**-**	2
Facilities Management	1	**50.0**	1	**50.0**	-	**-**	2
Research and Consultancy	2	**40.0**	3	**60.0**	-	**-**	5
Engineering	3	**50.0**	2	**33.3**	1	**16.7**	6
Transport	2		-	**-**	-	**-**	2
Printing	1	**100.0**	-	**-**	-	**-**	1
Media	-	**-**	1	**100.0**	-	**-**	1
Chemical	4	**50.0**	3	**37.5**	1	**12.5**	8
Nuclear	-	**-**	1	**100.0**	-	**-**	1
Charity	3	**75.0**	1	**25**	-	**-**	4
Extractive and Utility Supply	2	**100.0**	-	**-**	-	**-**	2
Leisure	2	**33.3**	1	**16.7**	3	**50.0**	6
Communication	1	**100.0**	-	**-**	-	**-**	1
Manufacturers	1	**100.**	-	**-**	-	**-**	1

		0					
Total	290	**57.1**	191	**37.6**	27	**5.3**	

***N.B.** – The large total for "education" is because the majority of first aid training organisations considered themselves to fall within this sector. The "other" category, as noted above, is dominated by individuals and organisations with a professional interest in first aid standards.*

This table must be treated with extreme caution as the large number of sectors means that the majority of row totals are too small for the results to be statistically meaningful. It may be noted, however, that all the sectors which returned a total of more than 10 responses, with one exception, broadly reflected the overall distribution of the responses. The exception was services, which expressed a notably higher preference for change. This may, perhaps, reflect a greater tendency to consider first aid requirements for the public in that sector, but the findings are not reflected in other sectors with a large public interface, such as retail or the public sector. It may be that this is an entirely spurious finding.

Numerical analysis – Q10

In principle it would be expected that the number of respondents favouring option 1 (i.e. no change) would be the same as those answering "no" to Q9. In practice the number was rather lower, 180 (35.4%) compared with 191 (37.6%). Similarly the total of all those recommending options 2, 3 or 4 (284, 55.9%) was a little lower than the number answering "yes" to Q9 (290, 57.1%).

The differences are not large, and might at first be thought to be due to the rather higher proportion opting for "no opinion" on question 10. This would be expected, as the logical structure of the questionnaire suggests that a "no" answer to question 9 might lead the respondent to skip question 10, which would therefore be coded as "no opinion". Unfortunately this explanation is not entirely satisfactory, for the reasons described at the beginning of this annex. In reality the majority of respondent answering "no" to Q9 offered an option for Q10. These responses were not always consistent, although the overall proportions favouring change as opposed to no change were similar.

Table 5 Distribution of responses to question 10

Response	Number	Percentage
Option 1	180	**35.4**
Option 2	50	**9.8**
Option 3	141	**27.8**
Option 4	93	**18.3**
No opinion	44	**8.7**
Total	508	**100.0**

Thus the overall preference is in favour of retaining the present system, followed, in descending order, by Option 3 (HSE accepts a wider range of defined standards), Option 4 (an industry standard setting body) and Option 2 (RC(UK) and VAS standards only). The proportion preferring Option 3 is not really very far behind Option 1. Option 4 is clearly less popular and Option 2 is very clearly the least popular choice.

If one considers that “no opinion” can arise from a logically valid decision by those who answered “no” to Q9 omitting to answer Q10 then the overall preference for “no change” could be as high as 44%

As for Q9, the responses were analysed in more detail by role of respondent, size of organisation and sector type (Tables 6-9).

Table 6 Analysis of responses to question 10 by role of respondent

Role	Option 1		Option 2		Option 3		Option 4		No opinion		Tot al
	No.	%	No.	%	No.	%	No.	%	No.	%	
Not stated	2	**33.**	-	**-**	1	**16.7**	2	**33.3**	1	**16.7**	6

		3									
Employer	4	**44.4**	1	**11.1**	1	**11.1**	1	**11.1**	2	**22.2**	9
First aider	33	**44.0**	11	**14.7**	18	**24.0**	9	**12.0**	4	**5.3**	75
Health and Safety Manager	39	**36.4**	13	**12.1**	36	**33.6**	12	**11.2**	7	**6.5**	107
Other	26	**32.9**	9	**11.4**	25	**31.6**	13	**16.5**	6	**7.6**	79
Training Organisation	66	**35.9**	13	**7.1**	47	**25.5**	48	**26.1**	10	**5.4**	184
Public	-	**-**	-	**-**	-	**-**	1	**100.0**	-	**-**	1
Union	-	**-**	1	**12.5**	2	**25.0**	2	**12.5**	3	**37.5**	8
Trade Association	4	**33.3**	1	**8.3**	1	**8.3**	4	**33.3**	2	**16.7**	12
First Aid Equipment Manufacturer/ Supplier	-	**-**	-	**-**	-	**-**	-	**-**	1	**100.0**	1
First Aid Trainer	6	**23.1**	1	**3.8**	9	**34.6**	2	**7.7**	8	**30.8**	26
Total	180	**35.4**	50	**9.8**	141	**27.8**	93	**18.3**	44	**8.7**	508

Comparison of this table with Table 2 immediately reveals the inconsistent nature of the response to questions 9 and 10, as described at the beginning of this annex. The size and nature of the inconsistency varies greatly between roles and no useful information can be gained from analysing these differences in detail. At best it would merely confirm that there is generally poor understanding of what the currently accepted standards are.

What is somewhat more productive is to examine the groups that had the largest influence on the overall total for each option. This can be done by excluding the responses of a group from both the numerator and denominator of the percentage calculation for each option. If the resulting percentage differs greatly from the original it can be assumed that the result was particularly influenced by that group. In statistical terms this process is called a **sensitivity analysis**, as it examines how sensitive the overall result is to the inclusion or exclusion of a particular subset of respondents.

This is only worth doing formally for groups that are individually large enough to have altered the overall distribution noticeably. In the present case this suggests that the analysis should be limited to the 4 largest groups (see Table 6) which individually include at least 10% of the respondents and, between them, represent more than 87% of the total response. The other groups all represent 5% or less of the responses and are simply not large enough to make any material difference to the results.

Four useful analyses are therefore possible, as follows:

Option 1:

First aiders may appear, from Table 6, to have had an excessive influence on the conservative suggestion to retain Option 1, the current system. (Employers had an equally strong preference for this option but their numbers were very much smaller) We therefore exclude first aiders by subtracting 33 from the total of 180 in favour of Option 1, so

Numerator = 180 – 33 = 147.

We then adjust the denominator from all response (508) to all response minus first aiders. i.e. 508 – 75 = 433.

The overall percentage of respondents favouring Option 1 is therefore (147/433) x 100, which gives 33.9 %. This is minimally different from the overall percentage, including first aiders, of 35.4%, so one can conclude that, despite the apparent anomaly in the table, the preferences of first aiders had little influence on the overall result.

Option 2

It appears possible that first aiders, health and safety managers, or “others” (as described above) could have excessively influenced the overall result here. It is not proposed to describe the calculations in detail, but using similar methodology to that described under “Option 1”, above, it is possible to demonstrate that each of these groups has a limited influence on the overall result. Excluding the combination of all three, however, would reduce the overall percentage in favour of this option to 6.9%. These three groups in combination, therefore, explain a substantial proportion of that overall result.

Option 3

In this case the question is whether the result was significantly influenced by the apparently strong preferences of Health and Safety Managers and “others”. In fact excluding both of these groups from the analysis only reduces the overall percentage favouring the option to 24.8%, which is a relatively small change. It may therefore be concluded that, despite initial appearances, the views of these groups was not a major factor in determining the overall result.

Option 4

The major questions here are whether the result was influenced to a large extent by training organisation and/or “others. The exclusion of training organisations, according to the mathematical principles described above, reduces the overall result to 13.9%, which suggests that they had a substantial influence on the overall result. Additionally excluding “others” only reduces the result by a further 0.5%, so it does not appear that the “others” opinion was a major factor in the overall result.

The overall results of these analyses suggest that a combination of the views of individual first aiders, health and safety managers and “other” health related professionals may have increased the preference for concentrating on the standards of the Resuscitation Council (UK) and th

Voluntary Aid Societies. Conversely the views of training organisations may have increased the preference for having standards set by an industry wide standard setting body. To a large extent these results confirm what one might intuitively expect.

Table 7 Analysis of responses to question 10 by size of organisation

Size of organisation	**Option 1**		**Option 2**		**Option 3**		**Option 4**		**No opinion**		**Total**
	No.	**%**	No.	**%**	No.	%	No.	**%**	No.	**%**	
1-5	29	**32.6**	3	**3.4**	29	**32.6**	18	**20.2**	10	**11.2**	89
6-10	15	**35.7**	2	**4.8**	12	**28.6**	10	**23.8**	3	**7.1**	42
11-25	9	**26.5**	3	**8.8**	10	**29.4**	10	**29.4**	2	**5.9**	34
26-50	9	**40.1**	2	**9.1**	8	**36.4**	3	**13.6**	-	**-**	22
51-100	11	**45.8**	2	**8.3**	4	**16.7**	3	**12.5**	4	**16.7**	24
101-500	28	**40.0**	12	**17.1**	18	**25.7**	10	**14.3**	2	**2.9**	70
Over 500	75	**35.4**	24	**11.3**	57	**26.9**	38	**17.9**	18	**8.5**	212
N/A	4	**26.7**	2	**13.3**	3	**20.0**	1	**6.7**	5	**33.3**	15
Total	180	**35.4**	50	**9.8**	141	**27.8**	93	**18.3**	44	**8.7**	508

In many respects this is quite consistent with the findings in Table 3. The smallest end of the industry is clearly in favour of change, either in the form of Options 3 or 4, which would diminish the influence of the Voluntary Aid Societies in the present standards. This is entirely consistent with the generally increasing tendency to choose Option 2 as organisational size increases. The larger organisations, with a break point somewhere between 26 and 100 members, are distinctly less in favour of change.

It must be noted that this tendency cannot be explained by the views of the voluntary aid societies themselves contributing to the results for the largest organisations. They are only a very small fraction of the 212 organisations with more than 500 members. Furthermore the tendency to choose Option 2 is even more pronounced in the organisation with 101-500 members, and this group does not include responses from the VAS.

Sensitivity analyses are relatively unhelpful here because the largest group is those with over 500 members. These suggest a profile of options generally similar to the overall picture, so it would not be expected that excluding them would greatly change the overall picture. In fact it only does so to the extent that the preference for Option 2 would be reduced slightly, to 8.7%. A similar result is obtained by excluding organisations with 101-500 members. (Their preference for option 2 is even more pronounced, but there are fewer of them, so the effect is similar.)

The obvious difference of opinion between the small and large organisations raises the question of whether the size of the responding organisation is related to its role. This is
analysed below.

Table 8 Analysis of size of organisation by role

	Size of organisation								
Role	**1-5**	**6-10**	**11-25**	**26-50**	**51-100**	**101-500**	**Over 500**	**N/A**	**Total**
Not stated	-	1	-	-	-	1	2	2	6
Employer	1	1	-	-	-	1	6	-	9
First aider	15	2	3	10	8	12	22	3	75
Health and Safety Manager	2	2	1	2	6	23	69	2	107
Other	4	-	7	2	3	10	52	1	79
Training Organisation	52	35	22	8	6	17	41	3	184
Public	1	-	-	-	-	-	-	-	1
Union		1					6	1	8
Trade Association	-	-	-	-	-	3	9	-	12
First Aid	-	-	-	-	1	-	-	-	1

Equipment Manufacturer/ Supplier									
First Aid Trainer	14	-	1	-	-	3	5	3	26
Total	89	42	34	22	24	70	212	15	15

This demonstrates quite clearly that size and role are not independent. The organisations with 1-25 members are predominantly first aid training organisations while the views of organisations with 101 or more members are represented predominantly by Health and Safety Managers and, for those with more than 500 members “others” (in practice often occupational health professionals)

This means that the analysis of preferences by size is fairly consistent with the analysis by role (Table 6) The sensitivity analyses showed that training organisations (which are often small) skewed the result towards the most extreme end of the change spectrum (Option 4), while the H&S managers and “others” skewed it towards the most restricted option (Option 2).

Table 9 Analysis of responses to question 10 by sector.

Sector type	**Option 1**		**Option 2**		**Option 3**		**Option 4**		**No opinion**		**Total**
	No.	**%**	No.	**%**	No.	%	No.	**%**	No.	**%**	
Not stated	2	**66.7**	-	**-**	-	**-**	-	**-**	1	**33.3**	
Agriculture	12	**85.7**	-	**-**	2	**14.3**	-	**-**	-	**-**	14
Construction	5	**33.3**	2	**13.3**	3	**20.0**	2	**13.3**	3	**20.0**	15
Education	57	**34.5**	14	**8.5**	45	**27.3**	37	**22.4**	12	**7.3**	165
Manufacturing	12	**32.4**	2	**5.4**	13	**35.1**	6	**16.2**	4	**10.8**	37
Other	41	**36.0**	14	**12.3**	28	**24.6**	20	**17.5**	11	**9.6**	114
Public	21	**30.4**	11	**15.9**	22	**31.9**	11	**15.9**	4	**5.8**	69
Retail	4	**36.4**	-	**-**	3	**27.3**	2	**18.2**	2	**18.2**	11
Services	7	**21.9**	3	**9.4**	11	**34.4**	8	**25.0**	3	**9.4**	32
Electronics	1	**20.0**	2	**40.0**	1	**20.0**	-	**-**	1	**20.0**	5
IT	1	**100.0**	-	**-**	-	**-**	-	**-**	-	**-**	1
Outdoor	2	**100.0**	-	**-**	-	**-**	-	**-**	-	**-**	2
Facilities Management	1	**100.0**	-	**-**	-	**-**	-	**-**	-	**-**	1
Research and Consultancy	3		1		1		-	**-**	-	**-**	5
Engineering	2		-	**-**	1		2		1		6
Transport	-	**-**	-	**-**	2	**100.0**	-	**-**	-	**-**	2
Printing	-	**-**	-	**-**	1	**100.0**	-	**-**	-	**-**	1
Media	1	**100.**	-	**-**	-	**-**	-	**-**	-	**-**	1

		0									
Chemical	2		-	**-**	4		1		1		8
Nuclear	1	**100.0**	-	**-**	-	**-**	-	**-**	-	**-**	1
Charity	1		1		2		-	**-**	-	**-**	4
Extractive and Utility Supply	-	**-**	-	**-**	-	**-**	2	**100.0**	-	**-**	2
Leisure	3		-	**-**	1		1		1		6
Communication	1	**100.0**	-	**-**	-	**-**	-	**-**	-	**-**	1
Manufacturers	-	**-**	-	**-**	1	**-**	-	**-**	-	**-**	1
Total	180										

This is probably the least informative table in the whole of this section. As noted on several occasions, above, the small row totals in most sectors preclude any purposeful statistical analysis. The comparative table for Q9 is Table 4. There is some support in Table 9 for the conclusions about the services sector drawn from Table 4. There are also indications that Table 9 may support some of the comments made above about the “education” and “others” sectors. However the general problems of inconsistency between responses to Q9 and Q10 suggest that it would be unwise to over-interpret these results.

Among those sectors returning 10 or more responses the most unusual was agriculture, which had a particularly conservative point of view. This is not, in fact, consistent with the result for agriculture on Q9, but it is in keeping with the responses for that sector on several other questions in the discussion document.

Analysis of specific comments (Mainly Q10a but including Q17a)

The free text response box associated with Q10 was coded as Q10a, but some respondents additionally made relevant comments in the final free text box after Q17, coded as Q17a. All questionnaires which had recorded a “yes” or “no” to Q9, or a preference for a specific option at Q10, were scrutinised by hand for additional relevant comments.

Unfortunately a number of potentially valid comments were lost from the system. A total of 97 questionnaires were returned via the First Aid Café website, to which HSE had made the questionnaire available as an electronic document.The website administrator added some further questions. Unfortunately these were coded as 8a and 10a, codes which had already been allocated to free text data in the HSE analysis software. The result was that when these questionnaires were electronically transferred to the HSE system the free text responses to these two questions were lost and replaced by “Yes/No” replies to additional questions posed by First Aid Café. The author of this section of the report, however, had been directly monitoring responses as they were posted on the First Aid Café website, and believes that no important issue was reported there which did not also appear in the direct responses to HSE.

The comments on each option were examined in turn and grouped as far as possible into common arguments in favour of that option.

Option 1 – Comments

The majority of respondents did not offer any detailed comment, which is probably not surprising as the were not proposing any active change. Among those who responded by far the most common them was “Why change something that appears to work well?”

Rather smaller, but substantial, numbers of respondents indicated that they considered the current standards authoritative or that they minimised the number of acceptable standards. The details of these responses usually indicated that they were based on the premise that the existing situation strongly favours the VAS and RC(UK) standards.

Another common view was that the current HSE position provides adequate control without total rigidity. A related opinion was that the current standards officially recognise the possibility of sound alternative practice derived from research.

Only a small number of individual views could not be fitted into one of these general themes.

Option 2 – Comments

The number of responses without specific comment was small.

The commonest response (about 50%) was that Option 2 offered a universal national standard for first aid. A related, but subtly different theme, was that Option 2 would reduce conflicting requirements for first aiders. This was not to do with conflict between training organisations. The specific examples quoted suggest that there is confusion when first aiders hand over the care of a casualty to an ambulance technician or paramedic, because these people do not undersatnd the limits of first aid. The concept of a single standard for first aiders, which everyone could read, might help to resolve these issues.

There were other, minority responses including:

- most commonly quoted standards in the law courts
- VAS are most experienced in real life first aid practice
- VAS stick to first aid, as opposed to medicine, nursing, etc.
- least effort to implement.

It should be noted that a minority of respodents favoured option 2 as an interim measure, for one or more of the reasons noted above, but suggested that in the longer term the training industry ought to explore either Option 3 or Option 4.

Option 3 – Comments

This was by far the hardest option to analyse. The proportion of respondents giving no specific reason was high, so in a sense all the specific responses could be considered minority views, but the variety of the individual responses at first appeared very wide. A process of succesive regrouping was used to reduce these to a relatively small number of common themes, even though articulated in many different ways.

The commonest them was that a process which involved wide consultation with all the available expert bodies would make the best use of the available knowledge base. It was not always clear whether these respondents envisaged a wide range of standards being accepted or a single set of standards being distilled form all the available opinions. Some respondents certainly took the latter view, as they specifically noted that this option would increase HSE's responsibility and/or authority in setting a single standard, and yet another subgroup clearly stated that option 3 would reduce in consistency. One rather pessimistic response suggested that this could be achieved simply by selecting the lowest common denominator from all the existing standards.

A related theme, almost as common, was that Option 3 would involve the authorities that could be considered to represent best available practice in each topic. There is an implication here that the respondents envisaged a single set of standards being picked out of the variety available, but this was not always explicitly stated.

Another group of related themes concerned flexibility, either in terms of choosing the standards most applicable to an employer's needs and teaching the FAW course accordingly. Alternatively one could simply recognise a wider range of courses as being suitable for FAW purposes. Thus, for example, some respondents thought that military medical courses and ambulance service training should be considered as an alternative to FAW courses. All of the respondents in this group were clearly in favour of diversification of standards rather than unification.

Yet another, relatively small, group felt that standards developed in conjunction with the ambulance services could improve continuity of care during handover. (It was noted that a different solution to the same problem was expressed by some proponent of Option 2.)

Predictably, there was a substantial group who were in favour of this option simply because it reduced a perceived domination of the existing standards by the VAS, who some respondents considered out of touch with current best practice.

There were a few respondent who considered that this option should be a stepping stone towards eventually moving to Option 4.

Option 4 – Comments

The proportion of respondent offering no specific comment was rather less than for Option 3. There was a somewhat larger proportion who supported the option purely because it would diminish the influence of the VAS. However the range of responses was much less than for Option 3 and some clear themes emerged.

There were two equally strong themes, which were often jointly expressed by the same respondents and comprised more than 60% of all the comments. There was a strong feeling that the only way to achieve a single, nationally recognised standards was for the whole of the first aid training industry, including the VAS, independent commercial trainers and expert bodies to work together in concert. Coupled with this was a strong opinion that the industry was now mature enough to move towards self-regulation, and that true self-regulation involved taking responsibility for developing standards. Certain caveats were noted by some respondents, such as a wish that HSE should continue to be the final arbiter or that they specifically wished the RC(UK) to determine the core BLS standards or that the VAS should continue to have a significant input.

The next commonest theme, expressed by about 25% of respondents, was that the industry body was best positioned to set standards dealing specifically with First Aid at Work. In other words they had no objection to organisations such as the VAS setting general standards for public use, but felt that an industry body was best equipped to interact with employers and develop specific standards for use in the workplace. Some other responses, closely related to this theme, thought that an industry body would be better able to review the standards regularly.

Other, minority, comments included:

- would maximise use of the knowledge base
- must be an evidence-based review body
- the regulatory body could not, itself, run any courses
- would be more innovative than academia (such as the RC(UK))
- would reduce the workload for HSE
- would have to be subsidised by the Government.

Responses to Chapter 5 of Discussion Document

A total of 509 individual responses were received although there was a number of duplications and some information was not completed. There was also some evidence showing that comments given did not apply to the option or answer given.

Approval and Monitoring

Of the 461 responses given 58% were in favour of option 1, 39% for option 2 and 3% for option 3.
The breakdown of these figures shows that 155 out of 1100 (14%) individual Training Providers responded where 55% were in favour of option 1 and 45% in favour of option 2. 54 First Aiders responded where results showed that 29 (54%) were in favour of Option 1 whilst 25 (46%) were in favour of Option 2.

239 businesses of various size responded resulting in 153 (64%) were in favour of Option 1 and 86 (36%) were in favour of Option 2. However many of the larger employers (employing over 500) were in favour of Option 2 (this includes employers from within the Retail trade ,Local Government, Central Government Departments as well as Transport companies and Trade Unions).

Looking at individual responses it became clear that a large number of the Independent Providers who responded chose option 1 because HSE gave them the security and credibility needed and were concerned that an Industry Body would be controlled by the Voluntary Aid Societies.

Those in favour of Option 2 expressed a variety of opinions but generally felt that a new Industry Body would be able to raise standards, remove the cowboys and give employers confidence in choosing a Training Provider.

Once we are able to make clear that HSE would ensure that an Industry Body would represent all sectors and all sizes of Training Providers then a large number of Independent Training Providers would change to option 2 as well as Training Providers that did not respond to the Discussion Document.

The responses also clearly show that all the Voluntary Aid Societies, the largest Independent Training Providers as well as the largest private association of Training Providers (AIFAWTO) are in favour of option 2.

If you look at how the original percentages change when you examine the market share of the industry a different picture is painted.

Although we do not have totally accurate figures of how many first aiders are trained if we assume 900,000 being trained over a 3 year period or 300,000 per year. The figures that we have obtained show that the between the Voluntary Aid Societies and the largest IndependentTraining Providers (including (AIFAWTO) train around 261,000 per year. In percentage terms this shows 87% of the whole market all of whom are in favour of Option 2.

National Register

Of the 509 responses a total of 400 responded in favour of a national register for trainers and assesors.
The general view was that this would increase the standard of both trainers and assessors and give easier access to individuals or organisations requiring them.

Clearer Guidance

Of the 509 responses 267 indicated that more detailed and prescriptive guidance was needed particularly if an industry body was introduced.

<u>CONTENTS OF FIRST AID BOXES Q.14 & Q.15</u>

Key findings from the analysis of responses

Background

This section provides a detailed evaluation of responses to the following questions in the Discussion Document

> ***Q 14 – Which option do you think will help employers identify the most appropriate contents for a first aid box in their particular workplace?***
>
> ***Option 1:*** ***Retain the current arrangements: HSE provides guidance and advice to help employer decide on contents of first aid kits (i.e. no prescriptive list from HSE).***
>
> ***Option 2:*** ***As Option 1 but guidance includes supporting examples based on case studies.***
>
> ***Option 3:*** ***HSE provides a prescriptive list of the contents of first aid kits.***

Three tick boxes were supplied. Answers could be coded to one of the 3 options or to “no opinion” if none of the 3 boxes were ticked.

Results

Numerical analysis

Of the 508 responses received by HSE, more than half were in favour of Option 2. Opinions were equally divided on options 1 and 3, with a small proportion having no opinion.

Table 1 Distribution of responses on options for first aid boxes

Response	Number	Percentage
Option 1	95	**18.7**
Option 2	286	**56.3**
Option 3	95	**18.7**
No opinion	32	**6.3**
Total	508	

Another way to consider this is that Option 3 is the only prescriptive one, thus less than a fifth of respondents favoured a prescriptive regime. Both Options 1 and 2 are non-prescriptive. If we add these together we find that three quarters of all respondents favour a non prescriptive regime and, of these, about three quarters want more detailed guidance.
The responses were analysed in more detail by role of respondent, size of organisation and sector type (Tables 2-4). The distribution of responses in most categories was broadly similar to that shown in Table 1.

Table 2 Analysis of responses on options for first aid boxes by role of respondent

Role	Option 1		Option 2		Option 3		No opinion		Total
	No.	%	No.	%	No.	%	No.	%	
Not stated	-	**-**	2	**33.3**	1	**16.7**	3	**50.0**	6
Employer	1	**11.1**	5	**55.5**	2	**22.2**	1	**11.1**	9
First aider	25	**33.3**	35	**46.7**	10	**13.3**	5	**6.7**	75
Health and Safety Manager	20	**18.7**	64	**59.8**	20	**18.7**	3	**2.8**	107
Other	13	**16.5**	44	**55.7**	17	**21.5**	5	**6.3**	79
Training Organisation	30	**16.3**	110	**59.8**	35	**19.0**	9	**4.9**	184
Public	-	**-**	-	**-**	1	**100.**	-	**-**	1

						0			
Union	1	**12.5**	6	**75.0**	1	**12.5**	-	**-**	8
Trade Association	1	**8.3**	8	**66.7**	2	**16.7**	1	**8.3**	12
First Aid Equipment Manufacturer/ Supplier	-	**-**	-	**-**	1	**100.0**	-	**-**	1
First Aid Trainer	4	**15.4**	12	**46.2**	5	**19.2**	5	**19.2**	26
Total	95	**18.7**	286	**56.3**	95	**18.7**	32	**6.3**	508

N.B. *– "Others" is a group mainly consisting of health related professional, e.g. occupational health nurses, who have not described themselves as being actively involved in the practise or teaching of first aid but who could be considered to have a professional interest.*

There are no important differences between the individual roles and the overall result. Employers and "others" are slightly more likely to prefer a prescriptive system. A third of first aiders are happy with the present arrangements, presumably through familiarity, but a larger number would prefer more guidance.

Table 3 Analysis of responses on options for first aid boxes by size of organisation

Size of organisation	**Option 1**		**Option 2**		**Option 3**		**No opinion**		**Total**
	No.	**%**	No.	**%**	No.	**%**	No.	**%**	
1-5	19	**21.3**	40	**44.9**	24	**27.0**	6	**6.7**	89
6-10	10	**23.8**	18	**42.9**	11	**26.2**	3	**7.1**	42
11-25	11	**32.4**	16	**47.1**	5	**14.7**	2	**5.9**	34
26-50	6	**27.3**	12	**54.5**	3	**13.6**	1	**4.5**	22
51-100	3	**12.5**	14	**58.3**	5	**20.8**	2	**8.3**	24

101-500	12	**17.1**	46	**65.7**	11	**15.7**	1	**1.4**	70
Over 500	32	**15.0**	135	**63.7**	34	**25.2**	11	**5.2**	212
N/A	2	**13.3**	5	**33.3**	2	**13.3**	6	**40.0**	15
Total	95	**18.7**	286	**56.3**	95	**18.7**	32	**6.3**	508

There appears to be a tendency for the smaller organisations to have a slightly smaller preference for option 2 than the larger ones, though they seem divided on whether they want to retain the current system or make it more prescriptive.

We know from Table 8 in the analysis of Q10 that the smaller organisations are more likely to be first aid training organisations. It is perhaps not surprising that they consider themselves sufficiently familiar with first aid material not to require additional guidance. On the other hand Health and Safety managers, who are a high proportion of the respondents in the two largest size groups, would appear to welcome such advice.

These results tend to support those in Table 2.

Table 4 Analysis of responses on options for first aid boxes by sector type

Sector type	**Option 1**		**Option 2**		**Option 3**		**No opinion**		**Total**
	No.	%	No.	%	No.	%	No.	%	
Not stated	-	**-**	-	**-**	-	**-**	3	**100.0**	3
Agriculture	9	**64.3**	5	**35.7**	-	**-**	-	**-**	14
Construction	4	**26.7**	7	**46.7**	4	**26.7**	-	**-**	15
Education	26	**15.6**	98	**59.4**	33	**20.0**	8	**4.8**	165
Manufacturing	8	**21.6**	20	**54.1**	6	**16.2**	3	**8.1**	37
Other	16	**14.0**	66	**57.9**	23	**20.3**	9	**7.9**	114
Public	14	**20.3**	40	**58.0**	14	**20.3**	1	**1.4**	69

Retail	3	**27.2**	5	**45.5**	1	**9.1**	2	**18.2**	11
Services	5	**15.6**	22	**68.8**	3	**9.4**	2	**6.3**	32
Electronics	1	**20.0**	1	**20.0**	2	**40.0**	1	**20.0**	5
IT	-	**-**	1	**100.0**	-	**-**	-	**-**	1
Outdoor	-	**-**	2	**100.0**	-	**-**	-	**-**	2
Facilities Management	-	**-**	2	**100.0**	-	**-**	-	**-**	2
Research and Consultancy	3	**60.0**	2	**40.0**	-	**-**	-	**-**	5
Engineering	1	**16.7**	3	**50.0**	1	**16.7**	1	**16.7**	6
Transport	-	**-**	2	**100.0**	-	**-**	-	**-**	2
Printing	-	**-**	-	**-**	1	**100.0**	-	**-**	1
Media	-	**-**	1	**100.0**	-	**-**	-	**-**	1
Chemical	2	**25.0**	2	**25.0**	3	**37.5**	1	**12.5**	8
Nuclear	-	**-**	-	**-**	1	**100.0**	-	**-**	1
Charity	1	**25.0**	2	**50.0**	1	**25.0**	-	**-**	4
Extractive and Utility Supply	1	**50.0**	1	**50.0**	-	**-**	-	**-**	2
Leisure	1		2		2		1		6
Communication	-	**-**	1	**100.0**		**-**	-	**-**	1
Manufacturers	-	**-**	1	**100.0**	-	**-**	-	**-**	1

Total	95	**18.7**	286	**56.3**	95	**18.7**	32	**6.3**	508

As with the analysis by sector in relation to other questions, many of the line totals are too small to give statistically valid results. For most sectors with more than 10 responses the distribution of preferences is broadly in line with the overall pattern. An exception is agriculture, where there is a clear preference for retaining the present arrangements.

Analysis of specific comments (Q15)

One of the commonest comments was that employers need clear and unambiguous advice on the appropriate contents of a first aid box suitable for their workplace. A related, fairly common, comment was that the current guidance is phrased in legal jargon, presumably (according to the commentators) to protect HSE from legal responsibility. There were also some answers which referred to the general need for more guidance on how to conduct a needs assessment, referring to both the provision of suitably trained personnel and the equipment with which they should be provided.

Those who sought to justify the selection of Option 2 mostly suggested that it would provide for more flexible arrangements that would be adaptable to the needs of the individual workplace.

About a third of respondents offered some suggestions on how, rather than why, Option 2 should be implemented. A common suggestion was a basic minimum list of items plus either a range of permitted extras that might be of use in particular circumstances or recommendations on extras that might be considered “good practice” in certain circumstances. Some people strongly felt that some sort of absolute minimum prescriptive list was necessary in order to force employers to maintain a minimum standard.

At the opposite end of the scale were a number of respondents who thought that what was needed was a list of what was specifically not allowed, i.e. was beyond the scope of the regulations, and that otherwise all items could be presumed to be allowed. A small number sought information on the provision of advanced equipment, such as defibrillators and oxygen equipment.

The suggestion of case studies, as suggested in the Discussion Document, was considered by several respondents to be of particular value to small companies. Some smaller companies also thought they needed professional advice from HSE

Some of the respondents from larger companies suggested that appropriate industry or sector guidance might already be available, or could be produced in consultation with trade associations or similar bodies. Some large firms felt they had adequate in-house expertise to decide on their requirements.

A small number of respondents, mainly training providers, thought that the training organisations should be able to advise their clients on suitable first aid boxes. There were also a small number of responses to Q15 suggesting that the first aiders themselves were best placed to decide what materials they needed.

Some respondents felt that the present suggested list was actually quite adequate as a starting point for selecting suitable materials provided it was made much clearer that it was not a prescriptive list. A related theme was that the current guidance is frequently misquoted by vendors of first aid materials to support the claim that their kits are “HSE approved”.

A number of practical suggestions were of interest. Common themes were that the needs assessment should consider the worst reasonably foreseeable incident on the premises, the commonest predictable incidents and the past history of usage of first aid materials.

FIRST AID TRAINING - USE OF MEDICINES BY FIRST AIDERS
QUESTIONNAIRE ANALYSIS Q16, 17, 17a

Key findings from the analysis of responses

Medicines in the workplace

> ***Q 16 – Are there any circumstances in which first aiders should be responsible for the distribution of over-the-counter medicines to employees?***

The answer was in the form of tick boxes for yes and no, thus responses could be coded as “yes”, “no” or “no opinion” (if neither box ticked).

Results

Numerical analysis

Of the 508 responses received by HSE the majority (344, almost 68%) gave the answer “no”, i.e. that there were no circumstances in which first aiders should be responsible for the distribution of OTC medicines. If the 25 respondents who did not answer the question are excluded the percentage rises to over 71%. Thus more than two thirds of respondents are opposed to giving first aiders responsibilty for distributing over the counter medications.

Table 1 Distribution of responses on Question 16

Response	**Number**	**Percentage**
Yes	139	**27.3**
No	344	**67.8**
No opinion	25	**4.9**
Total	508	**100.0**

The responses were analysed in more detail by role of respondent, size of organisation and sector type (Tables 2-4). The distribution of responses in most categories was broadly similar to that shown in Table 1. Comments on the exceptions appear below each table.

Table 2 Analysis of responses to Question 16 by role of respondent

Role	**Yes**		**No**		**No opinion**		**Total**
	No.	%	No.	%	No.	%	
Not stated	2	**33.3**	3	**50.0**	1	**16.6**	6
Employer	1	**11.1**	7	**77.8**	1	**11.1**	9
First aider	28	**37.3**	44	**58.7**	3	**4.0**	75
Health and Safety Manager	19	**17.7**	86	**80.4**	2	**1.9**	107
Other	20	**25.3**	55	**69.6**	4	**5.1**	79
Training Organisation	58	**31.5**	118	**64.1**	8	**4.3**	184
Public	-	**-**	1	**100.0**	-	**-**	1
Union	3	**37.5**	5	**62.5**	-	**-**	8
Trade Association	-	**-**	11	**91.7**	1	**8.3**	12
First Aid Equipment Manufacturer/ Supplier	1	**100.0**	-	**-**	-	**-**	1
First Aid Trainer	7	**26.9**	14	**53.8**	5	**19.2**	26

There is a suggestion here that individual first aiders, trade unions and (less markedly) training organisations are rather more enthusiastic than the respondents as a whole about first aiders administering medicines. In each case, however, they are generally fairly markedly against the principle. Employers, trade associations and health and safety managers (all of which could be said to represent employer interests) are even more strongly opposed. The single responses from the public and equipment manufacturers must be regarded as entirely spurious in a statistical sense.

Table 3 Analysis of responses to Question 16 by size of organisation

Size of organisation	**Yes**		**No**		**No opinion**		**Tot al**
	No.	%	No.	%	No.	%	
1-5	26	**29.2**	58	**65.1**	5	**5.6**	89
6-10	13	**31.0**	25	**59.5**	4	**9.5**	42
11-25	11	**32.4**	22	**64.7**	1	**2.9**	34
26-50	6	**27.2**	15	**68.2**	1	**4.5**	22
51-100	9	**37.5**	13	**54.2**	2	**8.3**	24
101-500	20	**28.6**	47	**67.1**	3	**4.3**	70
Over 500	49	**23.1**	159	**75.0**	4	**1.9**	212
N/A	5	**33.3**	5	**33.3**	5	**33.3**	15

There is no obvious trend with size for organisations with 500 or fewer personnel. The more pronounced opposition to first aiders distributing medicines in the very largest organisations probably may reflect the fact that this group includes the Voluntary Aid Societies, which have a standard policy on the role of medicines in first aid, together with several large organisations which base their own standards on those of the VAS.

Table 4 Analysis of responses to Question 16 by sector type

Sector type	Yes		No		No opinion		Total
	No.	%	No.	%	No.	%	
Not stated	-	**-**	2	**66.7**	1	**33.3**	3
Agriculture	9	**64.3**	5	**35.7**	-	**-**	14
Construction	3	**20.0**	12	**80.0**	-	**-**	15
Education	44	**26.7**	114	**69.1**	7	**4.2**	165
Manufacturing	10	**27.0**	25	**67.6**	2	**5.4**	37
Other	29	**25.4**	77	**67.5**	8	**7.0**	114
Public	18	**26.1**	51	**73.9**	-	**-**	69
Retail	1	**9.1**	9	**81.2**	1	**9.1**	11
Services	12	**37.5**	17	**53.1**	3	**9.4**	32
Electronics	2	**40.0**	3	**60.0**	-	**-**	5
IT	-	**-**	1	**100.0**	-	**-**	1
Outdoor	-	**-**	2	**100.0**	-	**-**	2
Facilities Management	1	**50.0**	1	**50.0**	-	**-**	2
Research and Consultancy	-	**-**	5	**100.0**	-	**-**	5
Engineering	3	**50.0**	2	**33.3**	1	**16.7**	6
Transport	1	**50.0**	1	**50.0**	-	**-**	2
Printing	-	**-**	1	**100.0**	-	**-**	1
Media	-	**-**	1	**100.0**	-	**-**	1
Chemical	2	**25.0**	5	**62.5**	1	**12.5**	8

Nuclear	-	**-**	1	**100.0**	-	**-**	1
Charity	1	**25.0**	3	**75.0**	-	**-**	4
Extractive and Utility Supply	-	**-**	2	**100.0**	-	**-**	2
Leisure	2	**33.3**	3	**50.0**	1	**16.7**	6
Communication	1	**100.0**	-	**-**	-	**-**	1
Manufacturers	-	**-**	1	**100.0**	-	**-**	1

N.B. *The large total for "education" is because the majority of first aid trainers or training organisations considered themselves to be in this sector. The "other" category is largely composed of health care related professionals who could be considered to have a professional interest in first aid, even though they are neither first aiders nor trainers.*

This table must be treated with extreme caution as the large number of sectors means that the majority of row totals are too small for the results to be statistically meaningful. Nevertheless, with one exception, all the sectors which returned a total of more than 10 responses broadly reflect the overall preference that first aiders should not be responsible for distributing medications. The single exception is agriculture. This may be a genuine reflection of the particular circumstances of that occupation, with relatively small numbers of people, often self-employed, working in relative isolation.

Q 17 – If medicines were made available for supply by first aiders, where should they be kept?

The answer was in the form of tick boxes for first aid box, separate container and other (please specify). The answer would be coded as "no opinion" if no response was indicated in any of these three boxes.

This question immediately preceded the las section of the questionnaire, which was a box for recording, as frre text, any additional comments the respondent wished to make. It was intended, and was mostly used, as a general purpose response box on all aspects of the questionnaire. However, because of its juxtaposition to Q17, some respondents used it mainly to expand their answer to question 17 in some detail.

Results

Numerical analysis

Of the 508 responses received by HSE only 48 (about 9%) suggested that medications should be kept in the first aid box. However there was no clear opinion on what the alternative should be.

Table 5 Distribution of responses on Question 16

Response	**Number**	**Percentage**
First Aid box	48	**9.4**
Separate container	216	**42.5**
Other	128	**25.2**
No opinion	116	**22.8**
Total	508	**100.0**

The distribution of responses by role, size of organisation and sector was very similar to the overall distribution, with a single exception as described below. Detailed tables are not presented here as this is, from a regulatory perspective, a subsidiary question to Q16 and the detailed prefences only become important if the answer to Q16 was positive, which was not the case.

The single exception was the agriculture sector, where 9 of 14 respondents (64.3%) expressed a preference for keeping medicines in the first aid box. This once again suggests that the first aid requirements of the agriculture sector may be unique in some respects It was noted above that there were also 9 respondents in agriculture who answered “yes” to Q16. It might be expected that these were the same 9 people, but this was not the case. Only 6 of the nine respondents who answered “yes” to Q16 preferred that the medicines shuld be kept in the first aid box. This means that there are 3 agricultural respondents who wish first aiders to supply medicines, but do not wish these to be kept in the first aid box, and a further 3 who do not think first aiders should supply medicines but that, if they do, the medicines should be kept in the first aid box.

The lack of logical correspondence between the answers given to questions 16 and 17 was not unique to agriculture. The wording of the question did not prevent respondents who was strongly antagonistic to the idea of first aiders disrtibuting medicines from, nevertheless, having an equally strong opinion on where such medicines should be kept if his/her first opinion was rejected. We have therefore got many unusual and partly inconsistent responses. The only figures worth quoting are these:

Of those who answered “yes” to Q16, 15.1% thought the medicines should be kept in the First Aid box. Of those who answered “no” to Q16 only 7.8% thought the medicines should be kept in the first aid box.

The disparity between those two figures is to be expected. What is perhaps more interesting is that regardless of the answer to Q16 only a minority of respondents indicated that medicines should be kept in the First Aid box.

Analysis of specific comments (Mainly Q17a)

All of the questionnaires where a reponse was given to Q16 or Q17 were individually scrutinised for relevant additional material. The logical flow of the analysis was as follows:

- If Q16 = “Yes”, what medicines should be supplied and why?
- If Q16 = “No”, why should first aiders not administer medicines?
- If Q17 = “Other”, what is the preferred location.

In practice it was found that some individuals who answered “yes” to Q16 nevertheless expressed reservations, while some people who answered “no” suggested certain specific exceptions. These were taken into account in the analysis.

Answer to Q16 = “Yes”

A total of 63 specific comments were made relating to First Aid at Work. The commonest of these (20/63, 31.7%) was that aspirin should be available for supply by first aiders as it was required in the treatment of suspected myocardial infarction. A further 2 respondents suggested aspirin only but did not give a reason.

A further 14 respondents (22.2%) suggested that first aiders should be limited to prescribing paracetamol, aspirin or other simple analgesics. Another 2 added simple antacids to this list.

Nine respondents (14.3%) suggested that first aider should be able to supply any General Sale List (i.e. over-the-counter) medication as long as they were under the supervision of a health professional, for example through standing orders issued by the occupational health department of the company.

Five respondents (7.9%) specifically wished for first aiders to be permitted to use Epipens where there was a known person susceptible to anaphylaxis in the workplace. Some further, individual, similar suggestions were made with regard to bronchodilator inhalers, rectal diazepam and medical gases.

Four respondents felt that if any reponsible adult was capable of deciding for themselves to take an OTC medicine then surely a first aider must be at least equally capable of deciding whether to supply it to them.

The 5 remaining responses were various combinations of suggestions that the VAS and/or HSE should (or already did) provide appropriate guidance.

In addition to these 63 comments there were several other suggestions which did not relate specifically to First Aid at Work. These concerned the special needs of schools, camping trips, expeditions and visits to remote locations. The general theme of these suggestions was that if a

health professional was not available the first aider would be the most appropriate person to supervise the supply of medications, but OTC and prescribed, though most respondents recognised that they would need additional training for this role.

Answer to Q16 = "No"

Many non-specific responses were given to this question, simply reiterating the current advice by either the VAS and HSE that the administration of medicines is not considered to be within the normal scope of first aid.

There were 95 more specific comments. These were very wide ranging in scope but can be grouped into a number of common themes.

The largest group (27, 28.4%) expressed in various ways the concern that first aiders were not sufficiently qualified to undertake the supply of medicines. This might be because they did not have the diagnostic skills to recognise situations where medical referral was appropriate, the di not understand the potential dangers of OTC medicines, they would not be able to assess the possibility of interactions with the patient's prescribed medications and so forth. All were well articulated and valid arguments.

The next largest group (26, 27.4%) were concerned about the risks of litigation, against either the first aider, the employer or both. Some respondents pointed out that even if the first aider was only responsible for distributing the medicines on request, and not prescribing them, they could still be held liable for issues such as checking that stocks were in date, that manufacturers information leaflets were supplied to the user, that appropriate records were kept and so forth. The validity of these arguments is largely untested, as first aiders rarely administer medicines at present.

Twenty respondents (21.1%) drew attention to the fact that the supply of medicines exceeded the legal duties of either the first aider, the employer or both. In a sense these could be considered a further, large, extension of the group concerned about litigation, though they did not express the concern directly in those terms. They were more concerned with offering practical solutions to the problem, such as the sale of medicines from vending machines, or that employees should provide their own medications.

Eleven respondents (11.6%) believed that while, in principle, it might be possible for first aiders to supply OTC medicines they would require considerable additional training, and this was not a practicable proposition.

In 9 cases (7.4%) the respondents were concerned about various possible abuses of the system, such as employees acquiring an overdose of a medication by approaching several first aiders in turn and the requirement of a very robust record and communications sytem to avoid this. Two people drew attention to the possibility of theft of first aid boxes or attacks on first aiders in the hope of obtaining substances of abuse.

A single respondent pointed out that there was no foreseeable situation in which an OTC medicine was required to preserve life, which is the primary aim of first aid. A further single individual noted that the legal status of General Sale List medicines prevents a first aider from supplying them except in the original, unopened manufacturer's packaging. (This is a little known fact, but is correct according to the MHRA.)

Answer to Q17 = "Other"

The questionnaire did not invite additional comment on the options "separate container" or "first aid box" so it was anticipated that it would only be necessary to analyse the reponses from those who answered "other". During the scrutiny of the questionnaires, however, it was noticed that a few respondents had qualified their reply of "first aid box" or "separate container". These responses were included in the following analysis.

There were 81 relevant comments in total .The majority of these (58, 71.6%) were recommendations, in varying degrees of detail, that the medicines should be stored in a lockable and secure facility. Often there was an additional recommendation regarding record keeping. About a third of these recommendations (19) specified that the keys should only be held by the first aider. As one would expect, these responses were from people who had answered "yes" to Q16.

Another 13 respondents (16.0%) suggested that the "other" location should be a vending machine, which was not the responsibility of the first aider. There were also 4 suggestions that the location should be clearly outside the first aid room (e.g. in the manager's desk or the general office) to emphasise that the first aider was not responsible for the medicines.

There were 4 suggestions that the medicines should be kept on the person of the first aider. These were from respondents whose main concern was that aspirin should be available for administration to MI victims.

There was one comment which did not really concern drugs distributed by the first aider, but recommended that employers should provide a designated refrigerator for employees who needed to store temperature sensitive prescription medicines, such as insulin.

Finally there was a single comment that the appropriate location for medicines was the local hospital!