Risk control

Refuse Booklet

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In partnership with

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Risk Management Partners
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Refuse Booklet

Contents

Introduction

Refuse collection is a key risk of a local authority and arising out of our involvement in a number of high profile incidents in this area we arranged a series of workshops which looked at the main areas of risk flowing from refuse collection activities. The workshops provided a forum at which we discussed with delegates how to appropriately manage the risks from this service area and legislation that could be involved in these types of incident.

This booklet is the result of five interactive workshops delivered to clients, drawing together the key learning points and building upon the foundations of the presentations. The topics covered included:

1. Why refuse risks are of such interest to insurers?
2. How to recognise and respond to the challenges posed by the use of refuse vehicles.
3. How to determine which insurance policy responds to a claim.
4. The behavioural and cultural aspects of driving and their relevance to refuse vehicles in particular.
5. Health & Safety.
6. Corporate Manslaughter and the Health and Safety Executive (HSE) sentencing guidelines.
7. Preventative steps which all fleet owners can take to improve their risk profile and reduce the frequency and severity of accidents.

The Workshops

RMP developed the content for the workshops and we were supported by colleagues in the field of risk management and claims management from Gallagher Bassett. External support was provided by a number of solicitors who dealt with the topic of Corporate Manslaughter and the relevant HSE sentencing guidelines.

Following the presentations delegates were then given a scenario based on a real claim and asked to consider the following points:

a) Legal aspects
b) The claim itself
c) What went wrong
d) How could the event have been prevented?
e) What would delegates take away and apply to their own workplace?

In delivering the workshops Risk Management Partners would like to express it's thanks to all who participated either as presenters or delegates who contributed so much to make the workshops the success they proved to be.

As a final note and as part of the information flow and skills exchange we have also taken the opportunity to include within the appendices some work topics which we think you will find to be of interest and which can come into this field from time to time.

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Particular thanks to Laurie and Anthony who kindly supplied the section within this booklet on Corporate Manslaughter.

The Delegates

There are too many delegates to list but we owe an enormous thanks to all the delegates who contributed so readily to the event(s).

Workshops

The workshops took place in Cardiff, London, Manchester, Glasgow and Birmingham. Over 200 delegates attended the workshops and were drawn from a range of disciplines. Attendees included Insurance Officers, Claims Management Officers, Transport Managers, Health & Safety Officers, Legal representatives and Insurance Brokers.

Shared Learning

At each event we discussed a refuse accident scenario which had resulted in personal injury to an operative. We debated the consequences of the incident for the employee, the refuse crew, the organisation and the insurer. We combined the outcomes of the exercise from all the events and the following are the common learning points:

- **Examples of evidence that would need to be captured/preserved following an incident to support insurers/claims handlers in respect of liability and quantum:**
  - Maintenance records
  - CCTV if available including nearby buildings, streets, other vehicles
  - Weather forecast
  - Policy and procedures in place at the time of the incident
  - Medical, occupational health, driving licence and training records
  - Risk assessments
  - Witness statements and photographs of the scene
  - PPE and safety equipment
  - Police records and reports
  - Telematics – if any are available
  - Information on the injured party and their dependents
  - Employee records (pre incident)
  - Results of any drug and alcohol tests undertaken.
- **Dealing with the effect on employees involved in a serious incident:**
  - Counselling and/or rehabilitation
  - Compassionate leave
  - Communicate with employees on investigation progress
  - Counsel others in a similar role who may be impacted by colleagues being involved in an incident
  - Union engagement
  - Management and Member/Councillor involvement
  - Long term employee support
  - Support for staff in the event that police interview or caution them.
- **Key risk prevention strategies that organisations should have in place:**
  - Policy and procedures
  - Risk assessment
  - Training
  - PPE
  - Claims reviews
  - Analysis of near miss incidents
  - Safety systems of specific tasks
  - Drug and alcohol testing
  - Being aware of personal circumstances in employees' lives that may affect their performance
  - Open and honest communication.

— **Following an incident, the response expected from an insurer, claims handling agent and risk control team:**
  - Prompt response and early engagement
  - Support and ‘sensible’ discussion
  - Confirmation of cover in place
  - Be both a critical friend and part of the team
  - Assist with communications and media management
  - Share lessons
  - Dedicated handler
  - Support with the Health and Safety Executive if required
  - Lead/steer the investigation and work closely with the Council.

From the workshop exercise; common causes of accidents emerged from the discussions – all of which, proactive organisations should be giving thought to the causes most likely for them and the measures they have and may need to have in place to mitigate such an event.

The view from the Authorities….

1. Lack of communication between the crew.
   A refuse vehicle is a mobile factory; there are people undertaking different tasks within and all-round the vehicle at all times and clear communication is essential to ensure a safe working environment is maintained.
2. Human error remains the single greatest accident cause - be that from familiarity with route and operations, lack of attention and focus or making assumptions rather than checking and communicating with the crew. Less common causes that emerged from discussions, but still important were ineffective PPE, lack of visibility and medical conditions.
3. Lack of or ineffective training in reversing and what to do in the event of a collision or incident. Drivers at both ends of the experience spectrum can have an impact – newly qualified drivers may lack confidence whilst experienced drivers may be complacent.
4. Agency drivers and operatives were of particular concern. Undertaking robust checks when on-boarding new agency staff is vital to ensure the safety of both the crew and the public. It is important that agency workers understand the policy and procedures of YOUR organisation as this may differ from their last assignment.
5. Accommodating for adverse weather conditions and adapting your ‘normal operation’ if you have difficult driving conditions, poor visibility, speed restrictions etc. was raised by delegates as an important consideration.
6. Narrow roads and cul-de-sacs can pose just as many hazards for refuse crews as fast-flowing main roads. There can be a lack of empathy by other road users who are keen to continue their journey, particularly considering the usual time of day for collection is early morning. Street furniture can also create difficulties for manoeuvring refuse vehicles and low speed accidents with such obstacles is not uncommon.

Key Messages

Positive safety culture filters down from the top of the organisation and managers and supervisors often underestimate how powerful their influence can be over their workforce in instilling a culture which is safety aware and compliant.

Those organisations which adopt a proactive safety regime put themselves in the strongest position to create a shift in culture and raise the levels of safety compliance across their refuse activities. Such a regime may include – reactive investigations, proactive spot checks, record checks, audits and data reviews.

What delegates told us they would take back to their organisations…

Corporate Manslaughter and Health & Safety Sentencing Guidelines

At each workshop some of the leading industry solicitors presented a session on the potential legal consequences of a personal injury accident arising from refuse collection activities. The following is a summary of the material presented by Plexus Law.

Background

Criminal prosecutions in the UK for Health and Safety (H&S) offences and Corporate Manslaughter can be extremely high profile due to the significant levels of fine imposed and the lasting damage to the organisation's reputation. H&S criminal prosecutions can also be brought against individuals in an organisation with the most serious offences resulting in imprisonment.

The sentencing guidelines for H&S and Corporate Manslaughter offences came into force for all cases sentenced in the Criminal Courts on or after 1 February 2016 irrespective of when the incident/breach of duty occurred. These guidelines apply in England and Wales and the Scottish Criminal Courts also have full regard to them when handing down fines following successful prosecutions.

These new guidelines are highly significant as they allow for far higher, potentially multi million pound fines, for large organisations. The highest fines can be up to

£20 million for high culpability Corporate Manslaughter cases.

Sentencing Guidelines – in operation

The guidelines and how they operate for both companies and individuals can be found at the following here:

https://www.sentencingcouncil.org.uk/wp-content/uploads/Health-and-Safety-Corporate-Manslaughter-Food-Safety-and-Hygiene-definitive-guideline-Web.pdf

The guidelines make clear that:

"A fine imposed on an organisation must be *sufficiently substantial to have a real economic impact* which will bring home to both management and owners the need to comply with Health and Safety legislation."

The Court must first assess the overall seriousness of the offence based on the:

Level of culpability	Very High, High, Medium or Low
The seriousness of the harm risk	Levels A, B or C
The likelihood of harm	High, Medium or Low
Harm Category	1, 2, 3 or 4

An important point to note is that H&S prosecutions by the HSE/EHO can also be brought based purely upon the risk of harm without any incident or loss/damage ever occurring.

The Court is also required to consider the organisation's turnover and the guidelines then give the starting point and range of any potential fine once the Harm Category has been determined. For local authorities and other public sector organisations, the Annual Revenue Budget (ARB) is used as the equivalent of turnover being the best indicator of the size of the authority. If alternative financial criteria are relied on, evidence from the local authority will be required to demonstrate to the Court why the ARB is not the appropriate financial measure.

The Court will also "step back", review and, if necessary, adjust the initial fine based on turnover/ARB to ensure that it is proportionate to the means of the offender. Other factors that the Court takes into consideration include aggravating and mitigating features and co-operation with the prosecution. There is also a one third discount off any fine for a guilty plea at the earliest available opportunity.

For local authorities and other public sector organisations the ARB could be huge but handing down significant fines based on that figure could be detrimental to the public and council tax payers generally. Large fines could also impact on a local authority's ability to improve conditions in the local community and thus negatively impact the public and the local economy. Such adverse consequences should not be the objective of sentencing. The sentencing guidelines therefore specifically state that:

"Where the fine will fall on public or charitable bodies, the fine should normally be substantially reduced if the offending organisation is able to demonstrate that the proposed fine would have a significant impact on the provision of its services."

A local authority should therefore take the following steps when faced with an H&S/Corporate Manslaughter prosecution:

— Obtaining the ARB and consideration of alternative financial criteria to evidence turnover;
— Obtaining evidence to demonstrate the impact that a large fine would have on the provision of services to the public and local community e.g. specific examples of how a large fine would reduce public services to any extent and the economic and social impacts;
— Witness statements in support from the Chief Executive or Senior Managers providing evidence of the positive impact of the local authority's work in the community and how that could be adversely affected;
— Consideration of early expert evidence in respect of both breach of duty and financial impacts to minimise the organisation's exposure and reduce the severity of any fine/sentence.
— Early legal advice affecting legal professional privilege.

For any additional information or advice please contact:

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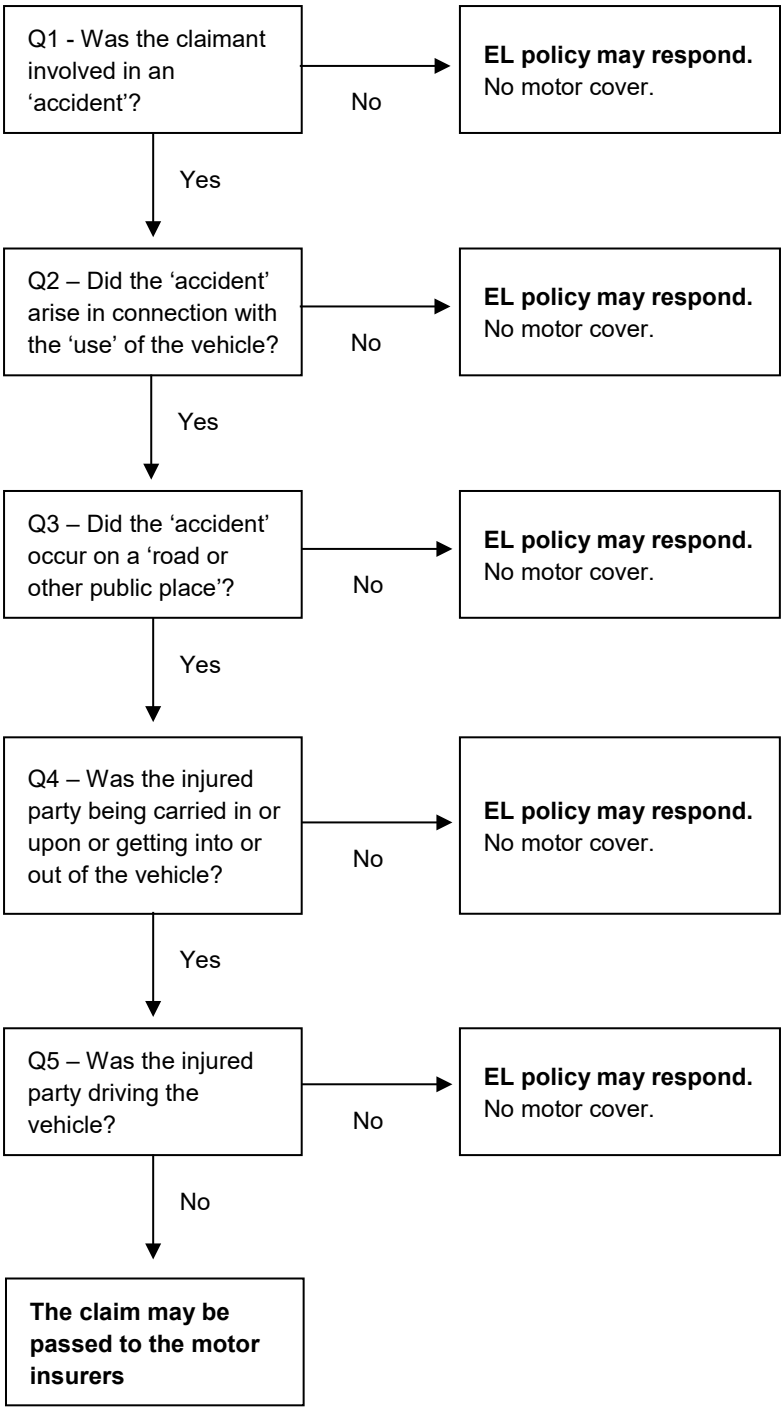
Motor and Employers' Liability Claims

It is often difficult to determine which policy is triggered by a complex claim involving personal injury to an employee arising from refuse collection activities.

Whilst each claim must be treated on its own merits and circumstances, answering the following questions should assist in determining whether the Motor or Employers' Liability policy should respond.



Below are some examples of claim scenarios and an explanation as to the most likely policy to respond to the incident:

1 A refuse operative alights a cab as the vehicle is still moving, albeit slowly. Upon making contact with the ground the operative slips and his foot/ankle are crushed by the moving vehicle.

Generally speaking if the operative still has one foot on the vehicle and the other on the ground the claim is most likely to be treated as a motor claim. If both feet are off the vehicle and the operative has taken even the smallest of steps forward it is likely the claim will become an Employers' Liability claim.

2 A refuse operative alights the vehicle and makes good their movement towards collecting a wheelie bin. Whilst moving the bin they sustain a strain.

Employers' liability.

3 As a refuse operative removes a wheelie bin from the back of the refuse vehicle they let the bin slip from the mechanism and it hits a member of the public.

This is most likely to be a motor claim and not a possible public liability claims as the claim arises from the use of the vehicle including loading and unloading.

4 As per (3) only this time the refuse operative is moving the wheelie bin to the side of the road and they hit a member of the public with the bin

This claim could be either a motor or public liability claim and it would turn on the precise facts of the incident. If the unloading of the bin was completed then the claim is public liability and however if the incident occurred whilst still in the motion of removing the bin from the vehicle mechanism it could be argued it is motor - a break in the process could move the claim to nearer to a public liability claim.

5 Whilst the operative is collecting the wheelie bin from the side of the house they knock the fence/wall and cause damage –

Public liability as the incident does not occur on the highway.

6 An operative is attempting to enter the cab and the driver moves forward injuring their colleague.

Motor claim.

7 The driver is injured in an accident in which they are driving the refuse vehicle as a result of a defective braking system due to lack of maintenance.

This is most likely going to be an Employers' liability claim as there is no provision for driver injury under the motor policy.

8 As per (7) but there are injuries to passengers in the cab and also a third party in another vehicle is injured.

Motor claim.

Please note that while these are common interpretations of incidents, each claim would always need to be treated on the facts of the case and the applicable policy wording.

Behavioural Risk Factors

Driver safety doesn't end at the induction of drivers. As the driver is ultimately responsible for the rest of the crew and with the complex environment within and around the vehicle, the need to ensure risks are effectively managed is crucial. This following section is an extract from the behavioural risk factors presentation from the workshops which offered delegates advice on how to instil a safe working culture across their refuse and fleet departments.

Safety climate and behaviour in refuse operations

Beyond the recruitment, induction and training environment, it is clear that the employer has a significant degree of influence on refuse crews' attitudes and perceptions of safety and also on their actual safety behaviours in the field. If safety short-cut taking by crew members is common and unchallenged – or even encouraged, then it becomes part of routine operating norms or culture.

The risk of a poor safety climate developing is greater when personnel work in close groups, where peer-pressure or 'group influence' is present e.g. refuse crews. Therefore strong safe promotion, oversight and communication is crucial.

Safety culture

A positive safety culture is one that is able to demonstrate overt commitment towards safety, with the motivation and resources to pursue and effectively communicate safety goals and information.

Refuse operations must create an atmosphere where involvement in safety is the norm for their crews. It must be shown that lessons have been learned from previous incidents and should not simply engage in attaching blame to individuals when things go wrong. Furthermore, it is vital to acknowledge the contribution of organisational procedures and practices in incident causation as well as failure to comply with safety rules, including a routine acceptance of non-compliance or safety shortcut taking.

Safety culture is largely determined by management practices and leadership. The key to organisational safety practice lies in clear, demonstrated commitment to safety leadership throughout the management chain, but especially in front-line management who are most in contact with crews.

The degree to which management are observed or perceived to be overtly committed to and involved in safety behaviour is the primary factor that affects individual employee 'safe behaviours'. An effective safety culture has the total commitment of senior management and welcomes the involvement of all its members' efforts to improve safety.

Symptoms of a negative organisational safety culture can include:

— Widespread and routine procedural violations
— Failure to comply with the organisation's own Safety Management Systems (although both of these can also be due to the poor design of procedures)
— Management decisions that appear to consistently put production or cost before safety.

Organisations can be identified as having one of the following attitudes toward driving at work safety:

Pathological: "who cares about safety as long as we're not caught?"

Reactive: "Safety is important: we do a lot every time we have an accident"

Calculative: "We have systems in place to manage all risk - but workers think procedures are not that important"

Proactive: "We try to anticipate safety problems before they arise - workers are acquiring beliefs that safety is worthwhile"

Generative: "We know achieving safety is difficult; values and safety-behaviour fully internalised as beliefs, almost to the point of invisibility"

Crews may feel their views are ignored and that issues raised about safety are not responded to or acted upon. With regards to communication, there may be mixed messages concerning management commitment to safety. Are managers trained in effective safety communication?

Research shows that the main problem in influencing crew behaviours is a perception by them of management not fully backing up policy and desired safe operating procedures with actual practices, leading to a mixed message for the workforce. Please see references below:

1 Arboleda, A., Morrow, P. C., Crum, M. R., & Shelley, M. C. (2003). Management practices as antecedents of safety culture within the trucking industry: Similarities and differences by hierarchical level. Journal of Safety Research, 34(2), 189-197.

2 Clarke, S. (1998). Organizational factors affecting the incident reporting of train drivers. Work & Stress, 12(1), 6-16.

3 Cohen,A. (1977). Factors in successful occupational safety programs. Journal of Safety Research, 9, 168-178.

4 Diaz, R., & Cabrera, D. (1996). Safety climate and attitude as an evaluator of organisational safety. Accident Analysis and Prevention, 29, 643-650.

5 Dwyer, Y., & Raftery, A.E. (1991). Industrial accidents are produced by social relations of work: A sociological theory of industrial accidents. Applied Ergonomics, 22, 167-179.

6 Hofmann, D.A., & Stetzer, A. (1996). A cross-level investigation of factors influencing unsafe behavior and accidents. Personnel Psychology, 49, 307- 339.

7 Mattila, M., Rantanen, E., & Hyttinen, M. (1994). The quality of work environment, supervision and safety in building construction. Safety Science, 17, 257-268.

8 Oliver, A., Cheyne, A., Tomas, J.M., & Cox, S. (2002). The effects of organizational and individual factors on occupational accidents. Journal of Occupational and Organizational Psychology, 75, 473–488.

9 Roughton J.E., &. Mercurio J. (2002). Developing an Effective Safety Culture A Leadership Approach. Woburn: Butterworth – Heinnemann

10 Shannon, H.S., Mayr, J., & Haines, T. (1997). Overview of the relationship between organizational and workplace factors and injury rates. Safety Science, 26, 201-217.

11 Smith, M.J., Cohen, H.H., & Cohen, A. (1978). Characteristics of a successful safety program. Journal of Safety Science, 10, 5-15.

12 Varonen, U., & Mattila, M. (2000). The safety climate and its relationship to safety practices, safety of the work environment and occupational accidents in eight wood-processing companies. Accident Analysis and Prevention, 32, 761- 769.

13 Wills, A.R., Watson, B., & Biggs, H.C. (2006). Comparing safety climate factors as predictors of work-related driving behaviour. Journal of Safety Research, 37, 375–383.

14 Zohar, D. (1980). Safety climate in industrial organisations: Theoretical and applied implications. Journal of Applied Psychology, 65, 96-102.

15 Zohar, D. (2000). A group-level model of safety climate: Testing the effect of group climate on microaccidents in manufacturing jobs. Journal of Applied Psychology, 85(4), 587-596.

Recommendations for achieving effective behavioural influence on safety performance

Across the research conducted it can be concluded that there appears to be a complex culture of factors that are responsible for safety violations and incidents despite established safety procedures and policy.

There are three overarching factors implicated:-

1 How people are managed and safety is communicated

2 How people are trained

3 The work and working environment

How people are managed and safety is communicated

People in a position of authority, such as supervisors and managers, must deal with infringements in a consistent manner in order to effect a behavioural change. Ensuring compliance with safety procedures across the workforce would reduce the risk of incidents and help to develop a more positive safety culture.

— **Listening actively**

Questions about safe operating practices should be a part of everyday work conversations. Management should listen actively to what they are being told by employees, and take what they hear seriously and be seen to do so.

— **Safety as a joint exercise**

Build ownership of safety at all levels to exploit the unique knowledge that crews have of their own work. This can include active involvement in workshops, risk assessments. In organisations with a successful positive safety culture, safety is seen as a joint exercise.

— **Gather information on compliance**

Monitor safety regularly e.g. selecting a random representative and good sized sample of refuse crews and interviewing them in a relaxed atmosphere in order to gather information on compliance and practices that may result in safety procedures being compromised.

— **Change the safety message**

Be honest with the workforce about the importance of adherence to safety rules for refuse operations and associated work activities. The first priority of an organisation must be perceived by the workforce to be safe operations followed by compliance with performance targets.

How people are trained

Whilst interventions may be in place in an attempt to address safety concerns, (for example, health and safety audits, driving assessments), these assume that workers hold the belief that 'safety starts with me'. Workers may also be concerned about the implication of being involved in an incident for fear of punishment and therefore fail to report these let alone be open and honest about true causal factors.

It is common practice for organisations to re-train following a vehicle incident, but routinely this involves repetition of known skills as opposed to addressing the behaviours that led to the incident (i.e. for drivers, a driving skills assessment) and incident investigations tend to address surface level issues and fail to provide an in-depth analysis of why the incident took place.

The work environment

Ensure the environment and equipment are as clean and well maintained as possible – this gives the impression of the vehicle as a professional workplace. This will also encourage the workers to take pride in the vehicles and will influence the amount of care taken when loading.

Depot yard and operating locations generating more vehicle damage claims should be surveyed and an analysis of the nature of these collisions and contributing factors should be undertaken. Factors to consider include: time, type of manoeuvre, situational factors (e.g., exceptional activity - such as during periods of disruption where workload is higher) and individual driver factors (e.g., length of service, time on shift and shift changeover) and known behavioural characteristics.

Employers should ensure drivers are provided with sufficient information on remaining comfortable in the driver's seat to reduce strain and possible injury. Vehicle mirrors should be properly configured and adjusted for yard manoeuvres. The drivers need to be suitably trained to set their mirrors correctly to reduce neck craning and stretching to see. Audio and vision based proximity sensors and reversing cameras to reduce collisions at the depot are effective control measures to put in place.

Summary

Refuse vehicles can be considered mobile factories, with a number of operatives working in and around the vehicle at all times. The crew are continuously undertaking dynamic risk assessments and making quick judgements in order to manage the risks around them to protect themselves and their colleagues. The authority has a duty to ensure they have been provided with the appropriate training, guidance, equipment and supervision to enable them to operate safely to protect themselves and the public who are going about their daily business all around them.

We learned a great deal from the workshop attendees who are responsible for these operations, for health and safety in their organisation and from leading the risk and insurance functions. The feedback from those who participated was that they recognised this was a high risk activity, of interest and concern to insurers and that one accident could have significant financial and reputational consequences for them.

We hope you find the booklet useful in supporting your existing risk management practices in this area.

Appendix A: Workshop

RMP – Refuse Vehicle Event Worksheet – Fictional

Narrative:

8:30am Monday morning, cold, wet and windy day

Mr Perryman was at the wheel of a 65 plate Dennis refuse vehicle.

Mr Thomas was collecting the refuse and Miss Davies was acting as a banks person.

Circumstances:

Mr Thomas has finished collecting the last wheelie bin in the cul-de-sac before the next collection point. Before the next collection he returned to the vehicle opening the door in one movement and placing his left foot on the foot plate. At that point the vehicle moved off causing Mr Thomas to fall under the vehicle and the rear wheels to run over his legs.

Parties involved and incidentals:

Dave Thomas – bin operative

30yr male- married with 2 children, both minors. Employee of the insured

Injuries- significant crush injuries to left leg resulting in a below knee amputation.

Michael Perryman – driver 60yr male

Employee of the insured No injuries

Has an ongoing medical condition.

Susan Davies: bin operative 32yr female

Agency worker No injuries

Witnessed the incident

Mr and Mrs Tyson:

Members of the public – witnesses

Police

Local police attended the scene and an accident investigation was carried out

Vehicle

65 plate Dennis refuse truck- vehicle has CCTV, front, rear and flanks along with GPS and telematics fitted. Regularly serviced. The vehicle usually has a reversing alert to warn pedestrians and other drivers that the vehicle was reversing. On this occasion the alert was not working.

Witness statements:

Mr Thomas…

'I had just collected the last wheelie bins before we moved on to the next batch, which I usually walk to and Mr Perryman drives ahead. I realised I had forgotten my gloves so returned to the vehicle to get them. As I returned to the vehicle it was stationary so I opened the door in one swift move and placed my left foot on the footplate. As I leant forward into the vehicle to get my gloves the vehicle moved off. That is all I can remember.'

Mr Perryman…

'I reversed into the cul-de-sac at around 5mph. Miss Davies had already alighted the vehicle and acting as banks person, guiding me in to a tight spot. She was positioned to the rear driver side of the vehicle. Mr Thomas had also got out of the vehicle in preparation to collect the wheelie bins. I successfully completed the reversing manoeuvre and waited for Mr Thomas to load the refuse. I cannot recall if he was wearing his high visibility jacket or not. Miss Davies signalled that the last refuse had been loaded. It is usual practice for Mr Thomas to walk to the next collection. I knew the vehicle moved but thereafter my recollection is blank.'

Miss Davies…

'I was standing to the rear driver side of the vehicle and successfully guided Mr Perryman into position. Mr Perryman remained at the window and we were talking about my recent holiday. I saw Mr Thomas load the last bin so I indicated to Mr Perryman the way was clear. There was a short pause and the vehicle moved forward. I then heard some distressing noises coming from the passenger side of the vehicle. I ran around the vehicle and saw Mr Thomas under the rear wheel of the vehicle, he was clearly very distressed. I noticed he did not have his high visibility jacket on, which is unusual for him.'

Questions:

1 What evidence needs to be captured/preserved in respect of liability and quantum? What would you report and provide to your claims handling agent or insurer?

2 How are you going to manage the employees in response to this traumatic incident?

3 How well prepared are you? What risk prevention methods do you have in place?

4 What response would you expect in such circumstances from your insurer, claims handling agent and risk control team?

5 Why did the accident happen? What was the root cause?

6 Who is liable, why and how much will it cost?

7 Can the Health and Safety issues affect the claims situation?

Appendix B: Contract and Project Management

Contract and Project Management – Working Successfully with Partners

Setting up…

Many local authorities have contracted out their refuse collection service to a third party provider / partner. In doing so, they seek to transfer much of the financial and legal risks associated with the service over to the contractor. This is only effective if the local authority first takes all reasonable steps to assure itself that the contractor is competent to carry out the role on their behalf. Regardless of any transfer arrangements; the local authority remains subject to the Health and Safety at Work Act and the owner of its reputation to its constituents and beyond.

Given the size of contract involved, it is likely that the exercise will be subject to EU procurement regulations. Part of the process should be fusing the experience of operational managers and workers with those skilled in the procurement process, to shape a clear specification that will meet the council's needs with transparent selection and award criteria for bidders.

These partnering arrangements are usually for a minimum of 10 years but can stretch far beyond this. It is a challenge for authorities to know what their waste service may/could look like in that time period and similarly an equally difficult task for contractors to price and design a programme of works for such a lengthy period.

Compliance checking of commissioned services…

A periodic check, stipulated in the contractual agreement with the provider, should be undertaken by the authority to ensure their partner organisation is delivering to the standards set in the contract. This assures the council that value for money is being achieved and its employees and those who come into contact with the service provider are protected.

Advice from the HSE is that when the service provider is appointed, the contract arrangements should include a robust framework for monitoring and review of their health and safety practice and performance. Once the contract commences the following should be evident:

- An on-the-ground monitoring regime, run either independently or in conjunction with your service provider, to ensure that those delivering the service are actually working to the agreed methods, and to review the continuing suitability of those working methods. The monitoring practices should always include observation and questioning and have an agreed compliance/risk scaling consistent with BS 18004:2008 or equivalent. Monitoring should reflect the key health and safety performance indicators detailed in the contract;
- Periodic review of all relevant accidents and incidents, ensuring that appropriate action has been taken, and that lessons have been learned/applied more widely;
- Periodic and formal auditing of the health, safety and welfare standards of your service provider; and
- A suitably authoritative contract safety review committee with representatives from you the client LA (such as senior managers and elected members), your service provider and ideally any other parties affected by the contract, which will include the workforce[1].

[1] http://www.hse.gov.uk/waste/services/management.htm

Further useful information on managing refuse contracts as well as a number of case study examples can be found on the HSE's website at:
http://www.hse.gov.uk/waste/services/index.htm

As the employer, councils must ensure their refuse operations are carried out safely. This includes ensuring the policies and procedures are adhered to and achieving the desired reductions in risk expected. A variety of compliance checks can be employed and some examples of these are detailed below. Regardless of the methodology adopted by the council, it is important that accurate records are maintained which can demonstrate if systems in place are adequate or otherwise.

- **Reactive Investigation** – detailed investigations into incidents and near misses to ensure controls in place at the time met the required standard. Subsequent remedial works should be undertaken and thorough records should be kept.
- **Proactive Spot Checks –** Regular checks to ensure standards, risk assessments, method statements and departmental policy are being adhered to / maintained.
- **Proactive Record Checks –** Check records are accurate, up to date and filled in correctly.
- **Proactive Self Checks –** Annually/Biannually assess your own systems for compliance & effectiveness.
- **Proactive External Audit –** Independent and competent audit of the management systems in use. At least every 3 years.
- **Data Reviews –** Regular system reviews including lag data e.g. accident & claims stats to draw trends.

What about when things go wrong….

The service level agreement and other contractual documentation relating to the outsourcing of the service should set out clearly the process to be followed by both parties in the event of a dispute. This way, both parties understand the steps to be taken and agree to these before the contract goes live. If the issue is unable to be resolved through the remedy process as set out in the agreement; then mediation or other pre-agreed form of negotiated discussion may be the next move.

Learning from colleagues in other authorities who have contracted out their services may also be helpful as they will understand your position and may know which approach worked best for resolving problems.

Further information

For access to further RMP Resources you may find helpful in reducing your organisation's cost of risk, please access the RMP Resources or RMP Articles pages on our website. To join the debate follow us on our LinkedIn page.

Get in touch

For more information, please contact your broker, RMP risk control consultant or account director.

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