Institute for Public Policy Research

BETTER THAN CURE

INJURY PREVENTION POLICY

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ABOUT THIS PAPER

This report fulfils IPPR's educational objective by publishing research to inform the public on the role of injury prevention in the public health, wellbeing and wealth of the country. It also fulfils IPPR's charitable objectives to advance physical and mental health, relieve those in need by several reasons, and advance environmental protection and sustainable development, by providing recommendations to prevent injury across a range of settings.

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SUMMARY

Injuries[1] are the leading cause of preventable death in children and young people, and of preventable years of life lost up to age 65. As such, they present a significant cost to individuals, society, and the economy. They also contribute to injustice, with children from poorer backgrounds being more likely to die as a result of an injury.

Crucially, injuries are preventable. Although the UK has been a world leader in injury prevention policy, austerity and a lack of strategy have hampered further improvement. In a post-pandemic society, the government should act on the renewed focus on public health to address the disconnect between the importance of injury prevention and its neglect in terms of funding, enforcement and strategy, to make the safety of the people the highest law.

The Covid-19 pandemic has raised the profile of public health and health and safety on the political and public agendas. In May 2020, six out of 10 people wanted the government to prioritise health and wellbeing over GDP after the pandemic has subsided. Coming out of the crisis, this political context should facilitate a renewed focus on injury prevention, and occupational health in particular, as the return to workplaces creates new infection risks.

The UK in the 21st century is facing a new risk profile in various areas. Our vulnerability as individuals and the vulnerability of our social and economic systems have been thrown into sharp relief by the Covid-19 pandemic. A new society-wide focus on resilience and preparedness for future shocks and challenges is paramount. An effective injury prevention strategy is part of this, for its own sake and to free up resources for other challenges.

Overall, the goal of injury prevention policy should not be to engender a risk-averse society, but quite the opposite – to empower and give confidence to people in the UK to live happy, healthy lives in all contexts.

1. IMMEDIATE ACTION IS NEEDED TO PREVENT COVID-ERA WORKPLACE INJURIES

The UK is one of the safest places to work in the developed world, with low levels of workplace fatalities compared to European neighbours. But 111 people died at work in 2019/20, with a further 92 people killed as a result of someone else's work, and rates of injury and physical illness are over twice as high in lower earning groups than higher earning ones. The Covid-19 pandemic has exacerbated existing structural and health inequalities among key workers, and presents many direct and indirect workplace injury risks, especially now that more workers are returning to the workplace.

Pandemic workplace safety

- Enable enforcement bodies to take action by urgently increasing in funding for local authorities and the Health and Safety Executive.
- Increase and widen the scope for statutory sick pay, so workers can self-isolate, avoiding a difficult choice between compliance and financial insecurity.
- Promote and empower trade unions to help workplaces become safe.

1 Defined in this report as physical or psychological harm.

- Require business with 50 employees or more to promptly publish their Covid risk assessments
- Support small businesses to make workplaces Covid-secure, with funding distributed by local government.

Safe workplaces long-term

We also consider more long-term issues and make the following recommendations:

- Strengthen whistleblower policy by providing more support for those who disclose unsafe working practices.
- Independently monitor Post-Brexit departures in health and safety legislation to hold government accountable for the decisions it makes.
- Enable a social partnership model to help heal the fractured relationship between the Health and Safety Executive and employers, building trust and ultimately making workplaces safer.

2. A NEW CROSS-SECTOR INJURY PREVENTION STRATEGY

The UK is one of the safest countries in the world by several metrics, including workplace and road safety. But deaths and serious injuries still occur: excluding transport, deaths from injuries have risen since 1990. Injury prevention efforts have seen reduced funding and enforcement in various areas. Public health is a priority among the general public, and it is time for a renewed focus on injury prevention to better serve public health.

Government should treat injury prevention as a public health priority, and introduce a high-level cross-sector injury prevention strategy

- Rather than the piecemeal and disjointed policy we currently have, a high-level cross-sector injury prevention strategy is needed, to identify possible conflicts and inconsistencies and optimise resource use.
- Key features of this strategy should include political leadership, involving stakeholders, creating cross-sector ownership, and determining mechanisms to ensure action and accountability.
- Establishing a new role of injury prevention commissioner would help to ensure the visibility and practical implementation of the strategy, play an important role in coordinating the range of stakeholders involved in the field, and ensure action across government.

3. REDUCE MEDICAL INJURIES TO HELP PATIENTS AND CONSERVE NHS RESOURCES

The NHS Patient Safety Strategy estimates 11,000 deaths per year resulting from patient safety incidents. Lack of learning from mistakes, insufficient funding and staffing, and a hierarchical culture that is not open to learning are among the reasons for a lack of progress on patient safety. As lockdown restrictions lift and routine services resume, the NHS will be under huge pressures to deal with backlogs while minimising risk of Covid-19 infections, which may endanger patient safety.

Commit to long-term safe staffing

Staff shortages over the last decade have significantly impacted their ability to provide a quality service.

- A legal duty to account for safe staffing levels should be placed on the secretary of state for health and social care – to help build political capital for a long-term and sustainable approach.
- The Care Quality Commission (CQC) should have the power to open legal proceedings against the secretary of state, where it identifies funding or political will as a barrier to achieving staff staffing levels.

Share best practice through patient safety networks

Danger to patients can be reduced further by improving ways of working. Systems like the NHS work best when they have designated networks, collaborations, and peer support.

- Patient safety networks should be established between NHS organisations to identify and share best practice, provide peer support, and champion success.
- Designating outstanding performers as 'anchor institutions' would speed up the improvement of patient safety. These would partner with other providers and lead performance improvement, and should be given small amounts of funding to pilot new interventions.

4. EXPAND ACTIVE TRAVEL AND PUBLIC TRANSPORT TO REDUCE ROAD DANGER AND ACHIEVE ENVIRONMENTAL TARGETS

The UK is viewed as having safe roads: measured by number of road deaths per million inhabitants, the UK is the third safest country in Europe. But progress has slowed in recent years, as funding and enforcement have fallen.

Our roads are an environmental hazard as well as a risk for injury. Surface transport is the largest carbon emitting sector in the UK, and air pollution is a significant public health threat. By prioritising a people focussed, multi-modal, and zero carbon transport system, government can achieve road danger reduction in an environmentally sustainable way.

A complete re-design of urban transport

- A reduction in private car use would reduce road danger and improve public health – 44 per cent of road deaths in 2018 were car occupants, and 1,750 air pollution deaths have been avoided in lockdown due to reduced traffic. For businesses, e-cargo bikes provide an alternative to vans and delivery vehicles, and some electric vehicles can be used where necessary.
- An increase in active travel is needed to avoid a sharp increase in car use as people seek alternatives to public transport while social distancing is in place. Pandemic response measures should be embedded to become permanent infrastructure change.

An expansion and electrification of public transport and measures to improve affordability

- Subsidising an expanded low-carbon public transport system could improve safety compared to car use, reduce incentives to drive, provide greater access to jobs, learning and local support services for the poorest while improving quality of life for everyone.

INTRODUCTION

"The safety of the people shall be the highest law"

Marcus Tullius Cicero

Injuries causing death, serious injury and long-term disability present a significant cost to individuals, society, and the economy. In 2018, 10,106 avoidable deaths due to injuries were recorded in the UK (ONS 2020a). Injuries are the leading cause of preventable death in children and young people (ONS 2020b), and the Royal Society for the Prevention of Accidents (RoSPA) calculates they are also the leading cause of preventable years of life lost (PrYLL)[2] up to the age of 65 (RoSPA 2018). In 2018/19, injuries accounted for at least three in 10 of A&E attendances in England (NHS Digital 2019).

10,106

Avoidable deaths due to injuries recorded in the UK in 2018

Injuries have a sizeable impact on disability in the UK and are a significant cause of the loss of healthy years of life due to ill-health, disability, or early death, or the 'disability-adjusted life year' (DALY). Taken together, unintentional injuries, and transport injuries accounted for the 7th largest cause of DALYs in 2017 (latest available data), rising from 8th in 2016 (IHME 2020). Injuries also contribute to inequalities, with those on low incomes more likely to suffer an injury, exacerbating existing inequalities, such as Covid-19 infection rates among health workers of ethnic minorities.

The maxim that 'prevention is better than cure' holds in economic as well as health terms. A 2010 estimate suggested the annual overall cost to the country of workplace, road, leisure, and home injuries was more than £150 billion (RoSPA 2011). Rather than weakening economic performance, effective measures that prevent injury can promote economic activity, by reducing costs to business and government of injury such as financial compensation, welfare payments, and lost working days. In general, regulation ensures that vulnerable people and less powerful businesses can participate in the economy, preventing exploitation, and boosting the economy (Van Lerven and Welsh 2018).

Since the new millennium, the phrase 'health and safety'[3] has become a by-word for needless bureaucracy, a drain on businesses, the decline of common sense and personal responsibility, and the butt of political jokes. A persistent media narrative has arisen that the UK's health and safety requirements are excessive and burdensome, an interference of the 'nanny state'. Numerous myths have confused the issue, such as the requirement for children to wear goggles to 'play conkers', or candy floss on a stick being banned to prevent impalement (HSE 2010). Although health and safety stories in the media gain much attention, research suggests that the UK public has an overall robust, positive attitude towards health

2 The fact that death rates and numbers tend to be higher among older people can bias a focus on risks that predominantly affect older populations. The 'PrYLL' metric emphasises the loss of potential contribution younger individuals can make to society, and draws more attention to the causes of death that affect younger populations, and that are preventable. See RoSPA outputs for more information.

3 Although used by practitioners to refer specifically to workplace safety for workers, in the public debate 'health and safety' refers to safety more widely, including pass-times and public spaces. See Almond P and Esbester M (2018), *Health and Safety in Contemporary Britain*

and safety, broadly defined, and an attachment to the idea of the 'right to be safe' (Almond and Esbester 2018).

This media narrative has been mirrored in political attitudes. In 2009, Boris Johnson wrote an article entitled 'Health and safety fears are making Britain a safe place for extremely stupid people' (Johnson 2009). In 2012, the then prime minister David Cameron promised to "kill off safety culture" (PMO 2012), saying that excessive health and safety culture had become an "albatross around the neck of British businesses" (ibid).

Another target for criticism has been systems of redress after safety failings have occurred. Discussion of "compensation culture" persists in various areas. Media coverage of clinical negligence focusses on the financial support paid to victims by the NHS, rather than the impact of the harm done, or the reasons for poor patient safety (for example see Blanchard 2019). Sums paid out by the NHS are framed as 'unsustainable', presented as a trade-off between pay-outs and health provision, or pay-outs as costing the public purse, rather than looking at the cost-effectiveness of improving patient safety and reducing negligence (Slawson 2018). The UK is claimed to suffer from an excessive and increasing number of fraudulent whiplash insurance claims – the 'whiplash capital' – far more than other countries (Oliphant 2016), despite unclear evidence, and the Association of British Insurers (ABI) finds only 1 per cent of claims are confirmed as fraudulent.[4] Measures "intended to control the number and cost of whiplash claims" arising from road traffic collisions, commonly known as the 'whiplash reforms', are due to be implemented from April 2021 (Buckland 2020), despite heated debate over the evidence of excessive claims, and without concurrent examination of how to reduce the incidence of injuries in the first place.

What has not been central to media and political narratives, is the importance of safety and the health and economic benefits of danger reduction. The 2010 Lord Young report, commissioned by the prime minister to make recommendations for improving the way health and safety is applied and tackling the compensation culture, was criticised by the Trades Union Congress (TUC) as it did not "contain a single proposal that will reduce the high levels of workplace death, injuries and illness" (Barber 2010).

The 2020 Covid-19 pandemic has changed the tone of the health and safety debate beyond recognition. Insufficient supplies of personal protective equipment, a delayed lockdown decision, and failure to act on the 2016 NHS simulation exercise which found that the UK was ill prepared for a pandemic (Pegg et al 2020) have been topics for criticism. The visceral reality of over 45,000 deaths, at least 19,000 of which were care home residents and including the deaths of over 540 health and social care workers, have brought the importance of health and safety to the forefront of public and political debate (ONS 2020c, Amnesty 2020). As more workplaces reopen, health and safety considerations will be paramount in the minds of many employees. In a post-pandemic society, the government should address the disconnect between the importance of injury prevention across society and how it has been deprioritised in terms of funding, enforcement, and strategy. It should then refocus resources on prevention (rather than the former focus on deregulation and redress), to make the safety of the people the highest law.

In this report, we refocus squarely on prevention: how to reduce injuries in the first place. We find that, although the UK has been a world leader in injury prevention policy, austerity and a hostility towards further regulation (and even towards some existing regulation) have hampered further improvement. Having conducted a literature review, undertaken original quantitative analysis, and interviewed

4 Analysis by Association of Personal Injury Lawyers of 'Detected Fraud - Motor Insurance 2018-2019', Copyright Association of British Insurers.

stakeholders across civil society, personal injury law, insurance, and trade unions, we set out the benefits of treating injury prevention as a public health priority, and how public policy can help prevent injuries and unnecessary harm, looking at the overall system and looking in depth at three particular areas: workplace injuries, medical injuries and road injuries.

Overall, the goal of injury prevention policy should not be to engender a risk-averse society. With the reality of human error, it may be impossible to eliminate all risk of injury. The level of injury we currently experience, however, is not inevitable. Rather, it is preventable by changing the environment, individual behaviour, products, social norms, legislation, and governmental and institutional policies to reduce or eliminate risks and increase protective factors (Curry et al 2011). Effectively managing risk is a key individual, organisational, and societal skill. Instead of 'as safe as possible', the goal should be 'as safe as necessary', in order for people in the UK to live happy, healthy lives in all contexts – whether at work, in healthcare settings, in the home, while travelling, or at leisure (RoSPA 2018).

1. THE SYSTEMS VIEW

Injuries are often seen as an inevitability of life. From recreational activity injuries, to falls at home, to car crashes, they form the background noise, and sometimes the pivotal moments, of our lives. The UK is one of the safest countries in the world by several metrics, including workplace and road safety (HSE 2013, DfT 2019a). But deaths and serious injuries still occur, are a key public health issue, and have huge impacts on individuals, families, businesses, health services, and the economy.

Injuries can be life-changing, but they are also preventable. Disease prevention to tackle public health challenges like obesity, cancer, and mental ill-health require slow behavioural change, whereas injury prevention can produce rapid results through education and behaviour change. As such, injury prevention can be referred to as the 'low-hanging fruit' of public health (RoSPA 2012).

THE UK HAS MADE SIGNIFICANT PROGRESS IN INJURY PREVENTION, OFTEN LEADING INTERNATIONALLY

The UK has traditionally enjoyed a reputation as a safe place, particularly to work and drive. The UK ranks third in Europe for road safety in 2017, exceeded only by Norway and Sweden (ranked by number of road deaths per million inhabitants) (DfT 2019a). The UK consistently has one of the lowest rates of fatal occupational injury across the EU – lower than other large economies such as France, Germany, Italy, and Spain (HSE 2019h). In 2013, 1.9 per cent of UK workers reported taking time off work due to one or more work-related health problems, lower than many European countries including Spain, Germany, France, and Poland (ibid). The UK also has one of the best combined workplace health and safety records in the world, and many other countries have used the UK model as a basis for their own framework (HSE 2013). Injury prevention features in the list of supporting indicators which measure short term progress in public health, although there appear to be no specific targets to reduce them (PHE no date).

TABLE 1.1: PUBLIC HEALTH OUTCOMES FRAMEWORK INDICATORS THAT RELATE DIRECTLY TO UNINTENTIONAL INJURIES (PHE 2019B)

Indicator	Description
B10	Killed and seriously injured (KSI) casualties on England's roads
C11a	Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years)
C11b	Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24 years)
C29	Emergency hospital admissions due to falls in people aged 65 and over
E13	Hip fractures in people aged 65 and over

Source: Authors' update of RoSPA analysis

THE INJURY PREVENTION SYSTEM NEEDS IMPROVEMENT TO SERVE PUBLIC HEALTH

The real picture is mixed, however. Although deaths from transport injuries in the UK have fallen, combined deaths from other unintentional injuries have risen by over 40 per cent since 1990 (IHME 2020). And home and leisure injuries, in particular, are understood to be growing.[5] In a 2010 study using the Department for Transport (DfT) method to calculate the cost of road injuries,[6] home and leisure injuries were costed at nearly £95 billion per year (not including deaths and GP treated casualties) (TRL 2010).

Injury prevention efforts have seen reduced funding and enforcement in various areas. In the period 2009/10–2017/18[7]:

- the Health and Safety Executive (HSE)'s funding fell by 53 per cent in real terms, and its staff by 33 per cent
- spend on health and safety by English local authorities fell by 42 per cent in real terms
- proactive health and safety inspections by local authorities in England, Scotland, and Wales fell by 93 per cent
- total local authority health and safety visits in England, Scotland, and Wales fell by 73 per cent
- the number of health and safety improvement notices[8] served by local authorities in England, Scotland, and Wales fell by 66 per cent
- funding for fire authorities in England fell by around 23 per cent (from 2010/11)
- Highways England spend on maintaining major roads fell by 30 per cent (from 2010/11 to 2016/17)
- spend on road maintenance by English local authorities fell by 21 per cent in real terms.

Resourcing cuts for injury prevention are a false economy, however. In 2018, road deaths and injuries in Great Britain were estimated to cost society over £35 billion (ONS 2019a), and, in 2017/18, workplace injuries and new cases of work-related ill health in Great Britain cost £15 billion (HSE 2019i). The cost of unintentional injuries within the under-five age group accounts for 7 per cent of all hospital emergency treatment (RoSPA 2019a). In 2018/19 over £800 million was paid out in industrial injuries disablement benefit to those who have become ill or disabled at work (DWP 2020).

Injuries continue to contribute to severe health inequalities, highlighted by the Marmot review in 2010 (Marmot 2010). Children from poorer backgrounds are five times more likely to die as a result of an injury than those from better off families (RoSPA 2013). The most deprived population decile sees 1.4 times as many emergency hospital admissions for unintentional injuries in the under-fives as the least deprived decile (PHE 2019a). The Covid-19 pandemic has shone a light on racial injustice in workplace safety among key workers; in June 2020, it was found that healthcare workers of Bangladeshi ethnicity had around twice the risk of death if they contracted the disease compared to people of white British ethnicity, and people of Chinese, Indian, Pakistani, other Asian, Caribbean, and other black ethnicity had between 10 and 50 per cent higher risk of death when compared

5 Data on these injuries exist only up to 2002, in the Home and Leisure Accident Surveillance System (HASS/LASS), from sample hospitals recording injuries serious enough to warrant a visit to an accident and emergency department. Funding was withdrawn in 2003.

6 The values include an amount to reflect the pain, grief and suffering, lost output, emergency services, and medical costs.

7 Data collection carried out by Unchecked.

8 Served by health and safety inspectors when they find evidence that a person is contravening relevant statutory provisions, requiring the person to remedy the contravention.

to white British people (PHE 2020). Further, surveys show that almost double the proportion of BAME doctors (64 per cent) have felt pressured to work in settings with inadequate PPE when compared to white doctors (BMA 2020).

The political environment and received economic wisdom have been hostile to safety measures, and their importance has been under-recognised. Since the 1970s, dominant economic philosophy has held that regulation prevents higher growth and employment, and that deregulation and tax reductions are the best way to solve stagnation or reduce unemployment, as profit boosts encourage investment and hiring. Deregulation, therefore, is key to the belief that the state should get out of the way so that the market can solve society's problems. According to this approach, the purpose of regulation is to protect competition and individual rights, rather than environmental or human welfare directly (Van Lerven and Welsh 2018).

For example, as the housing minister in 2014, Brandon Lewis, said: "We believe that it is the responsibility of the fire industry, rather than the government, to market fire sprinkler systems effectively and to encourage their wider installation", which was the focus of much attention in the wake of the Grenfell Fire disaster in 2017 (Hansard 2014).

Under successive governments, then, there has been a focus to reduce the 'burden on business' of undue health and safety regulation, with several initiatives including: the 2005 Hampton review *Reducing administrative burdens*; and the 2010 Lord Young review of health and safety, which aimed to "free businesses from the unnecessary bureaucratic burdens and the fear of having to pay out unjustified damages", among others (Hampton 2005, Cabinet Office 2010).

RoSPA cites a lack of consistency across the country in both the quantity and quality of policy interventions to reduce injuries, and some local areas are served better than others (RoSPA 2018). Initiatives have been 'stop start' over time, with political changes undermining sustained efforts. Reports have been written but not put into action, united action called for but not seized (ibid 2011).

The UK does not have a cross-sector injury prevention strategy. Although injury prevention has been recognised as a public health priority in the past (mentioned in the Coalition government's 2010 white paper, *Healthy Lives, Healthy People*, for example), it is not among Public Health England's 10 priorities (SoS for Health 2010, PHE 2019a). Although government departments refer to injuries within the specific remit of their own work (see table 1.1), the cross-sector nature of injuries is not reflected in a joined-up policy response.

Despite intermittent 'peaks' of recognition, insufficient attention to injury prevention in public policy has a long history. Unlike 'disasters', which transform environments and lead to social change, so-called 'accidents' are commonplace and measurable (Cooter and Luckin 1997). These have come to be seen as random, inevitable, and insignificant, having been 'statistically normalised' and legitimised during 19th century industrialisation, when automated machinery was in the ascendancy and when historians have argued "both business and the state accentuated the normalization of the accident" (ibid).

What gets measured gets managed, and the UK's injury data collection is insufficient. Some speculate, for example, that home and leisure injuries are on the increase, but relevant data is not currently collected. Until 2002, the former Department of Trade and Industry collected this data through the Home and Leisure Accident Surveillance Systems (HASS/LASS). The last annual figures revealed that 2.7 million people in the UK visited hospital after injuries at home and 2.9 million people following leisure injuries (RoSPA 2020).

GOVERNMENT SHOULD TREAT INJURY PREVENTION AS A PUBLIC HEALTH PRIORITY, AND INTRODUCE A HIGH-LEVEL CROSS-SECTOR INJURY PREVENTION STRATEGY

It is time for a renewed focus on injury prevention. Public health is a priority among the general public: in a May 2020 survey, eight in 10 wanted government to prioritise health and wellbeing over GDP during the coronavirus crisis, and six in 10 wanted this to continue after the pandemic has subsided, too, indicating a long-term culture shift (Positive Money 2020). Coming out of the crisis, this political context can facilitate a renewed focus on injury prevention. Expending fewer NHS resources on treating needless injuries would free up time and attention for other, less easily preventable health challenges.

Rather than a piecemeal approach, a high-level cross-sector injury prevention strategy is needed. Coherence and visibility at the political level helps identify possible conflicts and inconsistencies and optimise resource use (WHO 2006). Injury risk is a complex issue, spanning all ages, demographics, and activities. For reduction efforts to be successful, there must be a shared vision, objectives, and strategies. WHO recommends multisectoral and multidisciplinary contributions at all levels of governance – this requires high level political leadership. Developing comprehensive policies for injury prevention is a means to coherently organise the efforts of different sectors towards a shared objective (Racioppi and Sethi 2009).

Evidence from other countries shows this approach is effective. The WHO attributes injury death rate reductions in high income countries to concerted and sustained injury prevention efforts, including national strategies or programmes, with especially effective examples in Australia, Canada, and France (WHO 2006). In the US, states with more injury prevention policies in place have lower rates of death from injury (Kaufman and Wiebe 2016).

Injury reductions do not happen automatically, but take planning and coordination. This is not to deny the importance of personal responsibility, but to empower people with information and safer settings, as history shows that a lack of coordinated action to prevent injury results in more injuries and deaths. Road casualties have reduced dramatically over the past 25 years, for example, following a coordinated national plan. Home and leisure injuries, however, for which there is no strategy, are understood to have increased.

Other countries provide examples of how a national injury prevention strategy can be implemented. The Finnish strategy for the prevention of home and leisure injuries 2014–2020, for example, sets a series of actions, with a coordination group designating responsibility. The targets include reaching a good safety level in all environments and a 25 per cent reduction in the number of serious injuries by 2025 (MSAH 2014). Australia is currently updating its national injury prevention strategy for the next ten years, which will aim to reduce injury across all age groups, include a set of joint actions for government, business and civil society, and cover a wide range of sectors (AGDOH 2020). It is focussed on vulnerable groups including young children and older people – a previous strategy focussed on Aboriginal and Torres Strait Islander peoples (NPHP 2005).

A successful injury prevention strategy may promote a holistic focus on the person across their life course, within personal relationships and in different contexts – a 'whole person, whole life' approach. This is promoted by the national injury prevention charity RoSPA, who suggest designing injury prevention strategies bearing in mind that:

- injury prevention needs are different at different stages of the life course
- injuries have 'ripple effects' across the course of a person's life, particularly injuries sustained at an early age

- death or life changing injury may affect not just the person but often whole families such as through loss of earnings or increased care requirements
- 'people are the same' wherever they are, for example older people may be prone to falls at home just as much as in the workplace (RoSPA 2013 and 2018).

The Public Health England 'All Our Health' resource demonstrates this approach by promoting healthy lifestyles for workers, for example (PHE 2019c). A further holistic approach would be a '360 degree' approach to injury prevention, whereby everyone is equally empowered to halt unsafe activity, regardless of age or job role. For example, the 'Stop Work Authority' policy exists in some workplaces to provide employees with the responsibility and obligation to stop work when they perceived unsafe conditions or activity (LWI 2012).

ACCESS TO JUSTICE

It is everyone's responsibility, both legally and morally, not to injure people needlessly. When injuries do occur we must have a system that provides access to litigation so injured people can obtain care, rehabilitation and full redress to ensure, as far as is possible, that the person is put back into the position that they were in before the injury occurred.

In a fair society, this route must be available to all regardless of ability to pay upfront costs. Existing inequalities are likely to be exacerbated if those who are most likely to be injured are not able to seek redress. Our earlier analysis shows that those on lower rates of pay are more likely to be injured or ill from work, and we have highlighted other evidence that lower income groups are at higher risk of injury in a variety of settings.

However, fears of a 'compensation culture' have inspired the government to reform the system, despite there being 'no evidence for...its existence' according to the influential Löfsted review of health and safety (Löfstedt 2011) . Although such reforms may be well-intentioned, the government must ensure that genuine claims from people on low incomes are not locked out from accessing justice through any such changes, and any proposed reform should pass this test.

WHO recommends three phases to develop a cross-sector strategy (WHO 2006).

1. Initiating the policy development process: assessing the situation, raising awareness, identifying leadership and fostering political commitment, involving stakeholders and creating ownership.

For example, policy gaps revealed in a UK policy review are likely to include mental ill-health at work, additional lockdown workplace injuries, injuries in the home and at leisure, and a lack of systems approach to investigating road collisions. Stakeholders include government departments, charities and civil society organisations, local communities, trade unions and injury survivor groups, manufacturers, regulators, and industry bodies. As well as political leadership and a lead coordinating government agency, civil society leadership and ownership of the agenda can help ensure public awareness and take up (ibid).

2. Formulating the policy: defining a framework, setting objectives and selecting interventions, ensuring that policy leads to action.

Setting a mission statement, goals and a timeframe give the strategy a shape and direction. Guiding principles, such as promoting social justice or public health, contextualise the strategy and make it relevant to public concerns. Targets and interventions might include the following.

Target	Intervention
Reductions in the exposure to risk and prevention of incidents	Adoption of safer behaviours and safer environments
Reductions in the severity of injuries	Designing and implementing protective mechanisms
Reductions in the consequences of injuries	Post-event care (eg emergency care, essential trauma care, physical and psychological rehabilitation)

Creating monitoring and evaluation mechanisms is also crucial in this phase.

3. Seeking approval and endorsement: stakeholder approval, government approval, state endorsement.

The advised sequence of approval is from stakeholders, then government, and finally from parliament. For stakeholders, this should be an iterative process of consultation, negotiation, and revisions.

Establishing **a new role of injury prevention commissioner would help to ensure the visibility and practical implementation of the strategy**. The commissioner would play an important role in coordinating the range of stakeholders involved in the field and ensure action across government. This builds on the recent call from the Independent Medicines and Medical Devices Safety review for a patient safety commissioner (see chapter 3).

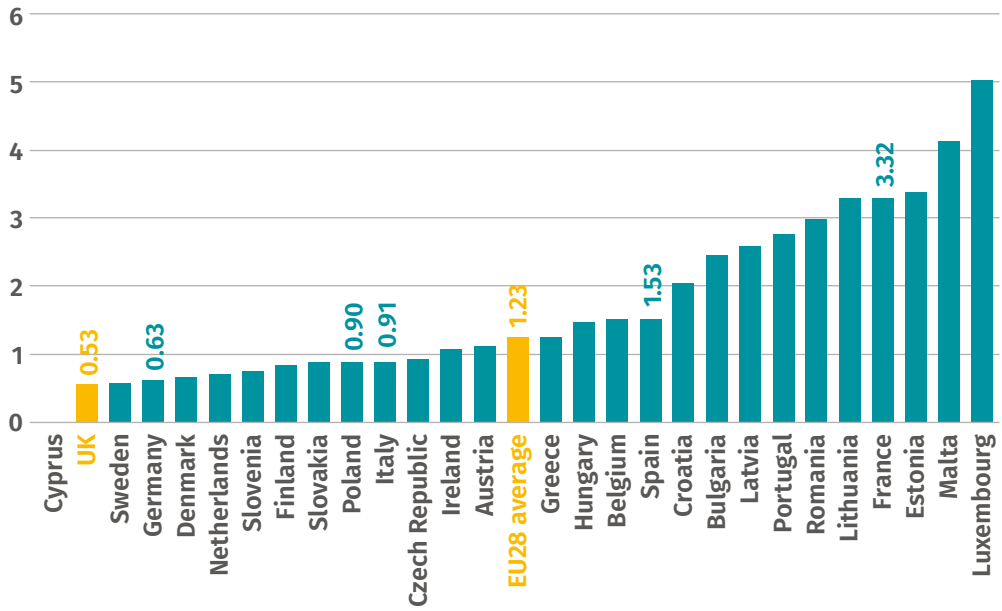
2. WORKPLACE INJURIES AND OCCUPATIONAL HEALTH

THE UK HAS A STRONG WORKPLACE SAFETY RECORD

The UK is one of the safest places to work in the developed world, with low levels of workplace fatalities compared to our European neighbours. This is true even when adjusting for the fact UK workers may be less likely to work in traditionally dangerous occupations.

FIGURE 2.1: FATAL INJURY RATES ARE LOWER IN THE UK THAN IN SIMILAR NEIGHBOURING ECONOMIES

Standardised incidence rates of fatal injuries at work per 100,000 workers for 2016

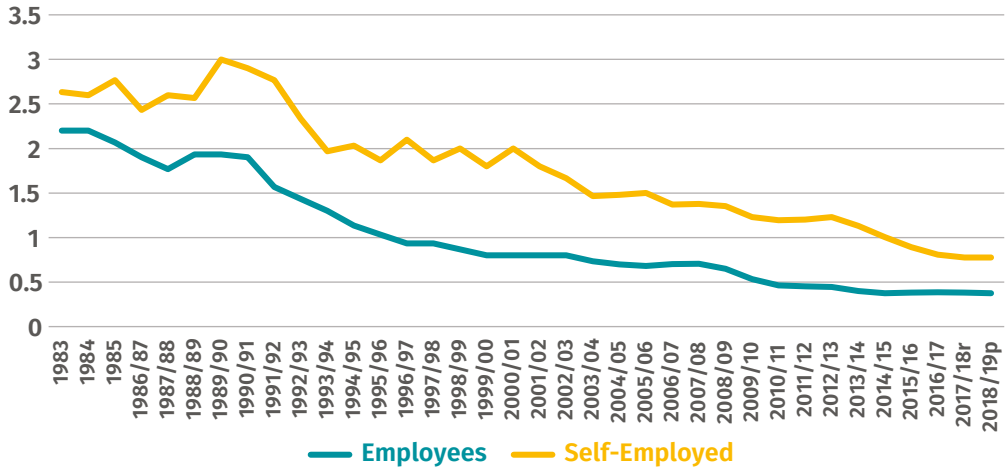


Source: HSE 2019a, using data from Eurostat.
Note: Figures are adjusted for occupational composition in different countries.

This is unlikely to have happened by accident but is a result of legislation in the UK, in particular since the 1974 Health and Safety At Work Act – a trailblazing legislative achievement which brought together disparate laws and regulations into a coherent legal framework for the first time, placing the burden of ensuring safety on the party creating the risk (HSE 2013). Data collected since the 1980s show a large decline in workplace deaths such that employees are over 75 per cent less likely to die on the job today than back in 1983.

FIGURE 2.2: WORKPLACE DEATH REDUCTIONS HAVE SLOWED IN RECENT YEARS

Deaths per 100,000 workers (three-year rolling average)



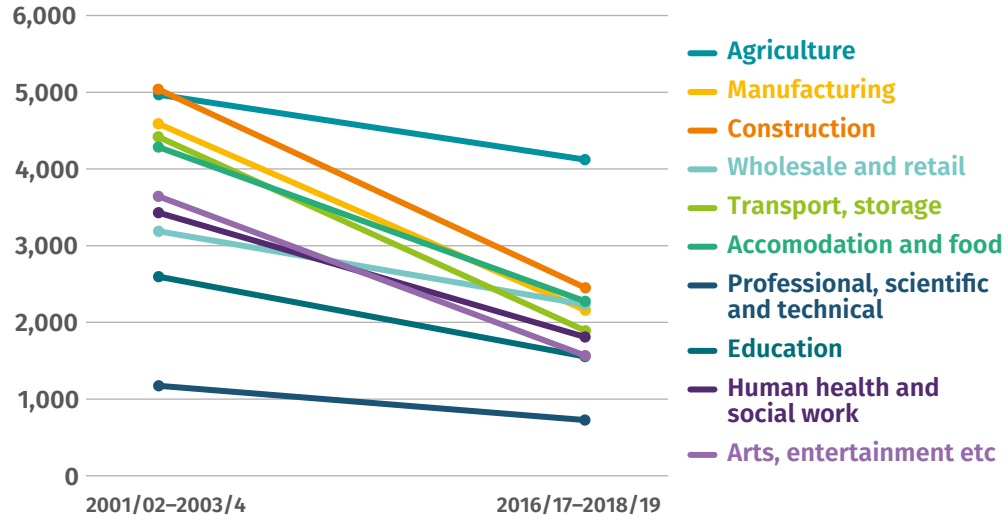
Source: IPPR analysis of HSE 2020a

Although this progress is welcome, such statistics do not fully capture the risk of death arising from the workplace. Thousands of people continue to die early from historic exposure to dangerous substances (such as asbestos) and poor working conditions (HSE 2019f). There is a significant lag: for example, working conditions 30 years ago affect deaths today. Further, an estimated 650 suicides a year are estimated to be work-related (Hazards Campaign 2020).

Focussing on morbidity, we are around half as likely today to experience a workplace injury than we were in 2000 (HSE 2019c) and there have been improvements across the board with good progress in some sectors such as construction, transport and manufacturing.

FIGURE 2.3: THE WORKPLACE INJURY RATE HAS FALLEN ACROSS DIFFERENT SECTORS, THOUGH CONSIDERABLE VARIATION REMAINS

Injury rate per 100,000 workers by occupational group



Source: IPPR analysis of HSE 2019b

Physical workplace illness rates are at their lowest ever recorded levels, in contrast to mental workplace illness rates which are at their highest ever recorded levels, impacting 600,000 workers and accounting for 54 per cent of all lost days due to ill health in 2018/19 (HSE 2019g). The government should closely monitor such trends and consider how it can reduce workplace stress particularly in the public sector where the issue appears most prevalent. Recent IPPR polling has found a rise in poor mental health amongst NHS workers during the Covid crisis (Thomas et al 2020).

Overall, however, these metrics suggest that the UK is doing well and has made considerable progress in the last 30 years.

THERE REMAINS ROOM FOR IMPROVEMENT AND THERE ARE FUNDAMENTAL ISSUES OF UNFAIRNESS

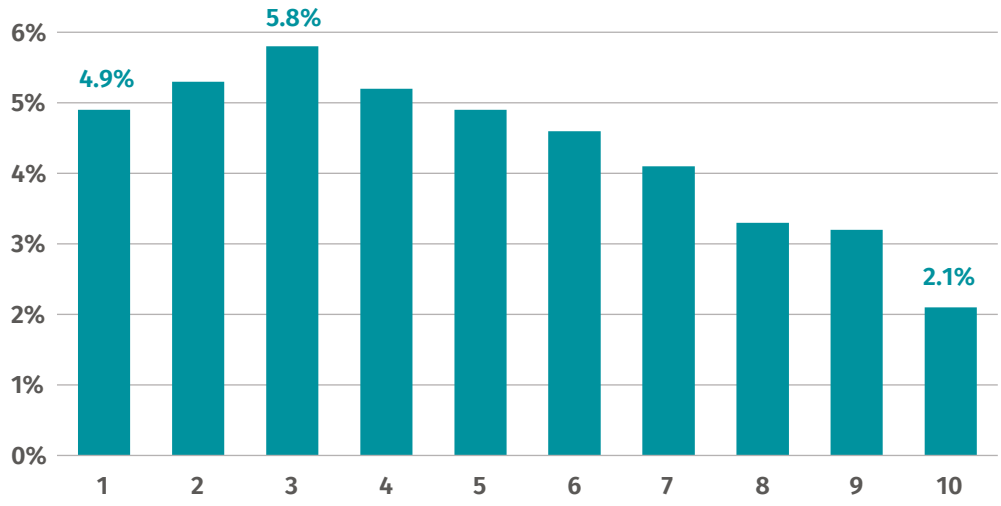
This is not to say that the situation is good enough. We remain a long way from a country where nobody experiences an avoidable workplace injury, illness, or death.

In the latest data, 581,000 workers sustained a workplace injury in the UK, with around one-quarter of those resulting in an absence of seven days or more (HSE 2019c). An estimated 1.3 million workers had an illness caused or made worse by work over the same period (ibid 2019h). Many of these conditions are very serious, with an estimated 19,000 people withdrawing from the labour market altogether every year as a direct result of workplace illness or injury (HSE 2011). And, of course, every workplace death is a death too many and a human tragedy; in 2019/20, 111 people died at work while on the job in totaL, and another 92 people were killed who were third parties (HSE 2020).

Our analysis show that workplace injuries and physical illness are more prevalent among lower earning groups, with **rates of physical injury and illness over twice as high in lower earning groups than higher earning ones.**

FIGURE 2.4: WORKERS ON LOWER RATES OF PAY ARE MORE LIKELY TO EXPERIENCE WORKPLACE INJURY OR ILLNESS

Physical injury and illness rate by hourly pay decile for people in work



Source: IPPR analysis of ONS 2020d, ONS 2019c, ONS 2018, with earnings in earlier periods adjusted by average wage growth to ensure comparability.

We also found that people in work with depression and/or anxiety were roughly **twice as likely** to report a workplace injury or develop a physical illness from past work, and workers with a learning disability were **over three times as likely.**

Rates of physical injury and illness are over **twice as high** in lower earning groups than higher earning ones

The Covid-19 pandemic has exacerbated existing structural and health inequalities among key workers. One in five of the NHS's nursing and support staff are BAME, but they comprise two-thirds of coronavirus deaths among such workers (Cook et al 2020). 64 per cent of all health and social care staff who have died with Covid-19 were BAME (ibid).

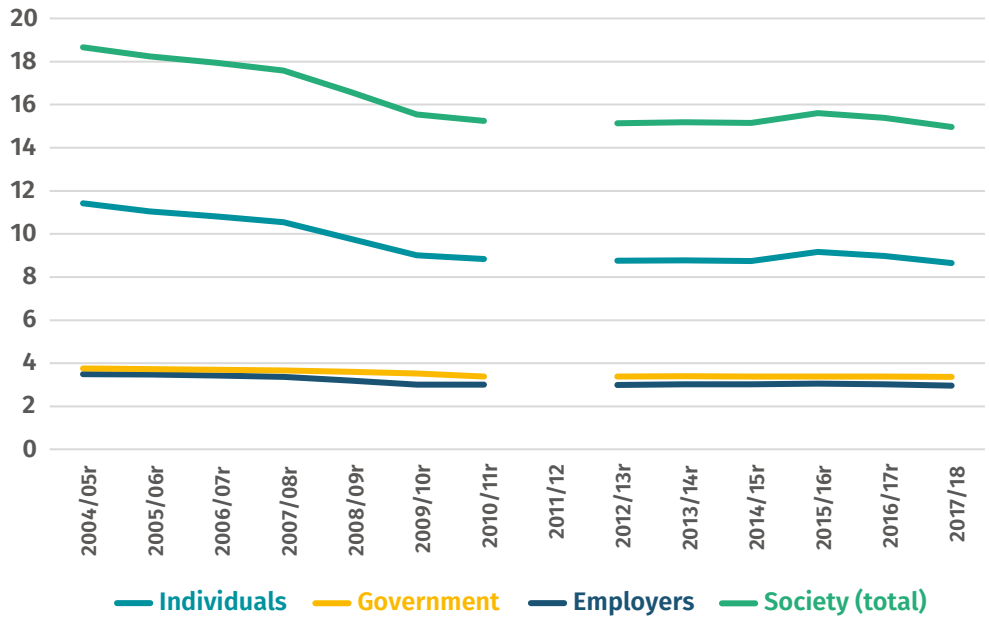
These statistics demonstrate how workplace injuries and illness disproportionately impact on some disadvantaged groups and so reducing them is a basic issue of fairness.

PROGRESS HAS STALLED AND COVID-19 PRESENTS AN IMMEDIATE THREAT TO WORKPLACE SAFETY

Progress on workplace injury prevention have stalled in recent years. Although the costs of workplace injury clearly go beyond the financial, the Health and Safety Executive has sought to quantify costs to employers, employees and taxpayers. In 2017/18, the societal costs of workplace injury were £15 billion, 57 per cent of which are borne by individuals – and although this has fallen from over £18 billion in 2004/05, this has been broadly flat since around 2010 (HSE 2019d).

FIG 2.5: WORKPLACE INJURY AND ILLNESS IS ESTIMATED TO COST SOCIETY £15 BILLION PER ANNUM

Estimated societal cost of workplace injury and illness over time (£m)



Source: HSE (2019e)
Notes: Figures are in 2017 prices. Data unavailable in 2011/12 due to a discrepancy in the data collection in that year.

These are substantial sums, which reflect the ongoing societal burden of workplace injuries incurred by workers, employers, and the government. It is therefore in everyone's interest to reduce these costs.

TABLE 2.1: THE COSTS OF WORKPLACE INJURIES TO SOCIETY

Individuals (£8.6 billion)	Employers (£3.0 billion)	Government (£3.4 billion)
Loss of gross family earnings (-)	Sick pay payments net of reimbursements (-)	State benefit payments (-)
Sick pay (+)	National insurance paid on sick pay (-)	Net income tax and national insurance reduction (-)
State benefits (+)	Work reorganisation (-)	NHS treatment and rehabilitation costs (-)
Income tax and national insurance savings	Recruitment and induction costs (-)	Treatment covered by private insurance (+)
Lump sum payments to individuals made from claims against employers' liability insurance cover	Employers' liability insurance premiums (-)	Administration of statutory sick pay and benefit payments
Out of pocket expenses (-)	Corporate private health insurance (-)	HSE operating costs for inspection/enforcement
Monetary value of loss of life and reduced quality of life (-)	Administration costs of sick pay, insurance, and compensation claims	Fines received by government (+)
Premiums for private medical insurance (-)	Costs to management of handling HSE or local authority investigation/prosecution costs (-)	
Administration of insurance, compensation, and benefit claims (-)	Fines paid (-)	
Insurance company profit margins (-)		

Source: HSE 2019d

Viral infection has become a key risk in occupational safety and injury prevention. Covid-19 presents many risks to the workplace injury picture both directly and indirectly.

- In the short term, if individuals cannot socially distance adequately at work, or are not provided with adequate protective equipment, then they may be more vulnerable to catching coronavirus from working.
- If businesses are under pressure to cut costs to stay afloat, this could lead to compromising workplace safety. This could be sanctioned by the government by a new de-regulation agenda under the guise of supporting the economic recovery.
- If workers feel less secure in their jobs in the recession, this may have a 'chilling' effect whereby they are less likely to raise issues with their managers for fear of negative consequences. Those whose work was already precarious may be particularly exposed.
- If workers are told to self-isolate, but this would result in loss of income they cannot afford, then people may ignore these instructions and then risk infecting other workers.
- If enforcement bodies are compelled to inspect more workplaces, then with no commensurate uptick in resource this could see the further watering down of the ability for workplaces to be inspected adequately.

All of the above could see progress reverse on workplace health and safety, and so we make recommendations on that basis.

PANDEMIC WORKPLACE SAFETY

The government should enable enforcement bodies to act with an appropriate increase in resource.

Both the HSE and local government (responsible for health and safety in 'lower risk' workplaces) have sustained large funding cuts since 2010 which make them poorly equipped for the current crisis. Inspection and enforcement were already at levels considerably lower than 2010 (Unchecked 2019) and the pandemic creates new demands on regulators to ensure that workplaces are Covid-secure across the UK in a wide range of settings. Workplaces which previously would have been considered 'low risk', such as retail, hospitality, call centres and offices, may now have a higher risk of infection (O'Connor 2020).

Urgent increases in funding are needed to enable the HSE and local authorities to carry out this crucial role, geared towards rapidly increasing the number of inspectors. Recruitment should be fast-tracked, with specific training frontloaded on ensuring workplaces are 'Covid-secure' so that new inspectors can enter the field as soon as possible. After the pandemic passes, resourcing should be reviewed to ensure that workplaces are as safe as necessary, with appropriate levels of inspections and compliance support for employers. Although the government has announced extra funding for the HSE of £14 million for the pandemic, this still leaves spending £84 million lower than in 2010/11. It also offers nothing to already cash-strapped local authorities who may be unlikely to find resources to increase their enforcement capacity.

We recommend that the HSE should, working with local authorities, establish the likely additional workload arising from Covid-19 from 'first principals', and that the government provides the level of funding necessary to handle this workload adequately while not compromising on other operating requirements. More broadly, the upcoming Comprehensive Spending Review should be taken as an opportunity for government to fundamentally review whether the HSE and local authorities have sufficient resource to carry out their role effectively.

There should be an increase statutory sick pay so that workers can self-isolate

In order to contain the virus, individuals will continue to need to self-isolate if they or anyone in their household develop even minor symptoms (PHE 2020). This compliance is costly to individual workers if their income is not be covered by employers. Those who are eligible for Statutory Sick Pay (SSP) will face a large drop in income given SSP is just £95.85 a week, two-thirds less than somebody working full-time at minimum wage. A further 2 million workers have no legal entitlement to SSP at all leaving them without income in the case of needing to self-isolate. This could lead to workers attending work when they should stay home, which risks spreading the virus. In a recent Unite survey of meat processing factory workers, 65 per cent said that they had attended work whilst unwell, with 69 per cent of those saying they did so because they could do afford to lose pay (Unite 2020).

To make workplaces safer, individuals cannot face a choice between compliance with the rules and financial insecurity. Current low rates and the incomplete coverage are not conducive to containing the virus and we recommend that the government should extend SSP to all workers and increase its generosity to avoid large reductions in income.

Government should promote and empower trade unions

More than ever workers' collective voice must be heard to ensure safe workplaces.

Safety measures have been advocated by trade unions in the UK since the 19th century (Litwin 2000). There is overwhelming evidence that unions in the workplace have a positive effect on injury and ill health prevention. One study found that found that employers who had trade union health and safety committees had half the injury rate of those employers who managed safety without unions or joint arrangements (Reilly et al 1995).

In this crisis, too, trade unions have played a key role in some sectors, enabling workers to resume operations safely in a way which was mutually beneficial to employers and employees (Jung et al 2020). This model and its benefits could be replicated more widely in the economy, but requires that employers are actively encouraged to engage with trade unions as a constructive partner in making workplaces safer. For workplaces without union representation, we support the Scottish Trade Union Congress's recommendation, developed in collaboration with the HSE, local authorities, and the Scottish government, that union health and safety representatives should be available upon request to support the development of workplace risk assessments (STUC 2020).

Businesses should be compelled to publish their Covid risk assessments

All businesses have a legal duty to conduct a risk assessment under regulation 3 of the Management of Health and Safety at Work Regulations 1999. In particular with respect to coronavirus the HSE advises that employers should:

- identify what work activity or situations might cause transmission of the virus
- think about who could be at risk
- decide how likely it is that someone could be exposed
- act to remove the activity or situation, or if this isn't possible, control the risk (HSE 2020b).

Although businesses are encouraged to publish these assessments, they are not compelled to do so, and we recommend that this should become mandatory for organisations with 50 employees or more. This will ensure that businesses take the process seriously and will open them up to public scrutiny.

The government should support small businesses to make workplaces Covid-secure

It should be made as easy as possible for businesses to comply with requirements to ensure their premises are Covid-secure, and so we recommend a grant scheme, operated by local authorities, in order to provide funds to support adaptation of workplaces as necessary where there could be large upfront costs. Initially we suggest £1.5 billion is set aside for this purpose.

SAFE WORKPLACES LONG-TERM

Even prior to Covid-19, there were several issues which risked undermining workplace health and safety in the UK.

Whistleblower policy is weak and should be strengthened

Workplace health and safety is compromised if individuals do not feel they are able to speak out against their employer if health and safety is not taken seriously. The all-party parliamentary group (APPG) on whistleblowing found last year that the system of whistleblower protection was "complicated, overly legalistic, cumbersome, obsolete and fragmented" (APPG 2019).

We recommend a 'whistleblowers' guarantee', which would include:

- access to legal aid to enable workers to fight unfair dismissal cases
- emergency access to financial support if someone has to leave a job as a result of whistleblowing
- banning non-disclosure agreements in whistleblower cases to ensure people are not silenced
- access to high-quality workplace counselling and wellbeing services.

Post-Brexit departures in health and safety legislation should be monitored and the government should held accountable

If the government is serious about a future trading relationship with the European Union, it is unlikely that the government will seek to immediately downgrade health and safety legislation as it could undermine the likelihood of achieving a comprehensive trade deal (Morris 2020). However, even in this best case scenario, it is likely that post-Brexit the EU will continue to develop health and safety legislation, which, assuming the UK does not agree to full regulatory alignment, the UK will no longer be compelled to implement. Over time, this could lead to a gulf developing between the UK and the EU law, leaving UK workers less safe than they would have been otherwise. Even more concerningly, if the UK government opts for a 'clean break' with the EU then changes could be much more sweeping should the government wish to pursue a deregulation agenda. For example, members of the current government, including the current prime minister, have previously taken issue with the EU working time directive.

In either scenario, we recommend that any departures from EU legislation be independently monitored. This role could be carried out by the House of Lords, for example, and would enable an informed discussion about the impacts of Brexit on worker protections and put pressure on the government, where appropriate, to retain or introduce legislation to avoid 'falling behind' on best practice.

A social partnership model could help heal the fractured relationship between HSE and employers

We found that, as funding has been reduced over the last decade, the relationship between the HSE and employers has become fractured. The HSE is increasingly viewed merely as an 'enforcer' as opposed to having a multi-faceted role – for example, providing advice and guidance in addition to enforcement. The revenue-raising measure of 'fee for intervention', which passes the costs of enforcement and inspection on to offending workplace along with any fines, has exacerbated this breakdown, with businesses less likely to engage constructively with the HSE. This was identified as early as the 2014 HSE Triennial Review (DWP 2014).

Along with increased levels of funding, the HSE should seek to restore a social partnership model with employees and trade unions. This could be achieved in practice by more regular contact between safety reps and HSE inspectors, by running regional outreach events (which were held prior to 2010), and re-opening advisory hotlines – all of which are only possible with a more robust funding framework as outlined above. We also recommend that the government should evaluate whether the 'costs' of fee for intervention exceed the benefits in terms of revenue raised.

We expect that implementing all the recommendations above would enable UK workplaces to become safer, reducing needless injuries and the accompanying large societal costs of workplace injury and illness.

3. MEDICAL INJURIES

PATIENT SAFETY IS KEY TO THE PURPOSE OF THE NHS, BUT IT NEEDS IMPROVEMENT

The National Health Service was founded to provide healthcare to all, free at the point of need. This aim is undermined if patients are at risk while under the care of the NHS. Patient safety, then, is foundational to the mission of the NHS, and 'commitment to quality of care' is one of the key NHS values (PSL 2019, DHSC 2015). The 2008 NHS Next Stage Review set out high-quality care for all as a clear vision for the health service. It cited patient safety as a key aspect of high-quality care, with 'do no harm' meaning ensuring the environment is safe and clean, reducing avoidable harm such as excessive drug errors or rates of healthcare associated infections (DoH 2008). Healthcare UK, a joint initiative of the Department of Health and Social Care and Department for International Trade, promotes UK patient safety internationally (Healthcare UK 2016).

Patient safety is in need of improvement, however.[9] The NHS Patient Safety Strategy estimates 11,000 deaths per year resulting from patient safety incidents, with 33,000 patient safety-related disabilities and 110,000 patient safety-related treatment episodes (NHS England 2019). From October 2018 to September 2019, over 4,000 safety incident reports resulting in death and nearly 60,000 moderate to severe incidents were reported in England (NHS England 2020). Health inequalities are seen in patient outcomes, with the rate of maternal death in pregnancy much higher among black and Asian women (15 and 40 in 100,000, respectively) than among white women (eight in 100,000) (Anekwe 2020).

From October 2018 to September 2019, over **4,000 safety incident reports resulting in death** and nearly **60,000 moderate to severe incidents** were reported in England

Commonplace day-to-day failings sit alongside well-known and particularly egregious cases, such as the Mid-Staffordshire hospital scandal and the case of the disgraced surgeon Ian Paterson. And lessons from the maternity care failings of recent years have not been learned, despite a series of scandals. In 2015, the Morecambe Bay report revealed multi-level failings that led to the unnecessary deaths of one mother and 11 babies in the maternity unit of Furness General Hospital (Kirkup 2015). Factors included a culture of denial and collusion, poor levels of clinical competence, poor working relationships, and a drive to achieve normal childbirth "whatever the cost" (ibid). An investigation into maternity care at Shrewsbury and Telford Hospital NHS Trust is looking at over 1,000 cases spanning 40 years, with findings expected by the end of 2020 ('Shropshire baby deaths' 2020). East Kent Hospitals University Trust, also currently under investigation for poor maternity care after it emerged more than 130 babies suffered brain damage during their birth over a four-year period, still had an above average number of babies dying as recently as last year (Lintern 2020a).

The Covid-19 pandemic has presented challenges for patient safety and raised the issue's political profile. The lack of personal protective equipment (PPE) for health and social care workers, which can help prevent the transmission of infection between staff and patients, has caused a national scandal (RCN 2020, Foster and

9 Patient safety estimates vary, as avoidable harm is difficult to quantify.

Neville 2020). 43 per cent of healthcare workers responding to an April 2020 poll agreed that their ability to ensure patient or service-user safety had deteriorated as a result of the Covid-19 crisis (Thomas and Quilter-Pinner 2020).

And the pandemic has had broader health impacts beyond the virus. In an April 2020 survey, almost two-thirds of people with common life-threatening conditions (such as cancer, heart disease, and diabetes) had been unable to access care (Understanding Society 2020). Research suggests the crisis could lead to 18,000 additional cancer deaths (UCL IHI 2020), and the rollout of pre-exposure prophylaxis (PrEP), the life-saving HIV prevention drug, to be routinely available on the NHS in England has been delayed (Wareham 2020). As lockdown restrictions start to lift and routine services start to resume, the NHS will be under huge pressure to deal with backlogs while continuing to minimise the risk of Covid-19 infections (Lintern 2020b), which may endanger patient safety.

NHS England's Patient Safety Strategy appears to lack ambition, conservatively estimating its proposed measures could save only 1,000 lives per year by 2023–2024, of the estimated 11,000 total patient-safety related deaths. A 'vision zero' approach (aiming to prevent *all* deaths and serious injuries by looking at the system as a whole), by comparison, as used in road and occupational safety internationally (TfL no date, Vison Zero no date), would aim to eliminate deaths and serious injuries altogether.

POOR PATIENT SAFETY IS DRIVEN BY A RANGE OF FACTORS

Lack of learning is an important area for improvement. The 2019 Patient Safety Strategy recognises the need to improve how data is collected and to better involve patients and the public (NHS England 2019). Several stakeholders interviewed for this research felt that lessons from previous safety failings are not learned or shared, but that the same mistakes are being made again and again, with the chief inspector of hospitals at the Care Quality Commission (CQC) commenting in 2019: "it is very frustrating how little progress we have made" (Roberts and Bodkin 2019). East Kent Hospitals University Trust, under investigation for poor maternity care, acted on only two out of 23 recommendations made by an earlier 2016 review (Moore 2020).

The most recent in a line of patient safety investigations is the Independent Medicines and Medical Devices Safety Review, which documents the serious suffering caused by three treatments, and the chair of which describes the healthcare system as "disjointed, siloed, unresponsive and defensive" (IMMDS Review 2020). The review finds that women's concerns are not being heard, citing a "tone for a patient-clinician consultation that is far from equal and precludes any form of shared decision-making around future care and treatment" (ibid). Indeed, disregard for the voice of the patient is a common factor in many patient safety scandals over the last 20 years (PSL 2019). When a serious incident of patient harm is investigated, patients are often not invited to contribute to the investigation, are ignored, or have their views discounted, despite evidence suggesting that when patients are left out from investigations, the quality of the investigation is compromised (ibid).

The recommendations of the review include establishing better ways of allowing the patient's voice to be heard, improved informed consent procedures and the implementation of remedies to help those who have suffered harm, with a patient safety commissioner – modelled on the children's commissioner role – able to investigate patient complaints where appropriate and hold organisations to account (ibid).

Insufficient funding and staffing are also key factors. IPPR analysis shows that 3.5 per cent growth per annum in health spending is the bare minimum requirement to maintain provision, whereas the 3.4 per cent announced in 2018 excludes crucial

areas of spending including workforce training (Quilter-Pinner 2018). The Royal College of Nursing has called for an additional £1 billion annual investment in nurse higher education to ensure safe and effective care (RCN 2019).

Staffing gaps are frequently a threat to quality of care (CQC 2014). In England there is a staffing shortfall of 100,000, at risk of increasing to 250,000 over the coming decade (King's Fund et al 2018). Understaffing in nursing in particular is an issue, with nearly 40,000 vacancies in 2018/19 Q4 (NHS Improvement 2019). Despite the government confirming a nursing grant of at least £5,000 from September 2020, applications to study nursing were still down by 25 per cent compared to 2016, when funding for nursing students was initially withdrawn (DHSC 2019, Mitchell 2020).

Poor morale among staff is also a risk in terms of providing high-quality and safe care (Pinder 2008). Some 92 per cent of staff think low morale is a cause of high staff turnover and vacancies (Wilmington Healthcare 2017). Half a million now feel ill through stress (Thomas 2020). Social inequalities are mirrored in NHS working conditions, with doctors from ethnic minorities twice as likely to face disciplinary action as white doctors (GMC 2019).

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It's clear that the culture in the NHS is not optimised for patient safety; it is perceived as hierarchical, not open to learning, and with an atmosphere of fear (NHS England 2019, Carding 2019). Research into NHS England's culture and behaviour shows that barriers to high-quality care include unclear goals, overlapping priorities that distract attention, and compliance-oriented bureaucratised management (Dixon-Woods et al 2013). Dame Professor Donna Kinnair, director of nursing policy and practice at the Royal College of Nursing, finds that most healthcare settings have a 'retributive' workplace justice culture, which looks for who is responsible and what the consequences should be, rather than a 'restorative' justice culture, which looks at the conditions that led to the incident and the needs of those involved (Kinnair 2017, Dekker 2016). Whistleblowing, a key function in preventing grave patient safety failings, has long been taboo in the NHS, and whistleblowers have often been ignored or faced with disciplinary proceedings (Morrow et al 2016). The Freedom To Speak Up review by Robert Francis in 2015, which intended to improve whistleblowing practice in the NHS, was criticised for not going far enough (Francis 2015, Campbell 2015). In the annual NHS staff survey, those responding 'agree' or 'strongly agree' to the statement "I would feel secure raising concerns about unsafe clinical practice" rose only slightly from 68.3 per cent in 2015 when the report was released to 71.7 per cent in 2019 (NHS Staff Survey 2019).

The barriers to learning from, about, and for patient safety include:

- staff may not be trained in effective safety investigations
- introducing new ways of working is challenging
- patient safety skills may not be highly valued in pay and progression or even mentioned in job remits
- metrics of success may be oriented towards targets such as waiting times rather than safety outcomes
- budgets may be siloed and not include resources for long term patient safety measures (PSL 2020).

Finally, although they have an unparalleled insight into the entire treatment journey, patients' voices are not heard enough. Complaints made to the NHS remain a largely untapped resource for patient safety improvements (PSL 2020). The importance of the role of patients, their families and carers, and other lay

people in improving the quality of NHS care is recognised in the 2019 Patient Safety Strategy, but it in practice it is not drawn upon consistently.

SOME PROGRESS HAS BEEN MADE, AND THERE IS RENEWED COMMITMENT TO PATIENT SAFETY

The importance of patient safety was recognised in the wake of a number of high profile patient safety controversies in recent years – from Mid-Staffs to Winterbourne View to Morecambe Bay – and the then health secretary Jeremy Hunt MP prioritised the issue. This push included the introduction of a 'duty of candour' in all hospital trusts to ensure incidents are reported, the inclusion of patient safety in the CQC inspection regime, and the creation of a fully independent investigations body. A new Patient Safety Strategy for England was launched last year (NHS England 2019).

There has been significant progress over the last decade on patient safety in the NHS. The percentage of patients receiving harm-free care has increased by approximately 2 percentage points since 2012, stabilising at just over 94 per cent of patients (Quilter-Pinner 2018). There has also been a reduction in the number of pressure ulcers (6 per cent to 4 per cent) (ibid). Likewise, MRSA and Clostridium Difficile Infection (CDI) rates are down, though other forms of healthcare associated infections such as MSSA have been increasing (ibid).

The 2020 Covid-19 pandemic has brought patient safety to the fore of public consciousness. In a recent index ranking of OECD countries' response to the pandemic, the UK scored in the bottom four of 21 countries, with possible reasons for the high excess deaths cited as: an insufficiently fast and co-ordinated response, an initial lack of testing capacity, and a decision to suspend track and trace in early March (EIU 2020). The pandemic response simulation 'Exercise Cygnus', carried out by NHS England in 2016, showed that a flu pandemic would cause the country's health system to collapse from a lack of resources (Pegg et al 2020).

The public health and healthcare picture into the 2020s – changing demographics, the rise of chronic disease, growing patient expectations, and ever-developing science and technology – will present new challenges for, and increase the importance of, patient safety.

For every increase of **one nurse**, patients have a **14 per cent decrease in risk** for in-hospital mortality

The government should commit to long-term safe staffing

Staff shortages over the last decade have significantly impacted their ability to provide a quality service. Furthermore, it has meant that services rely too frequently on existing staff's goodwill and unpaid labour. Recognising their effort in this crisis means guaranteeing steps will be taken to reinforce them in the future.

Healthcare in this country does not currently have adequately safe staffing levels. For example, international evidence suggests a GP should see no more than 23 patients a day. Yet, the average seen in practice is 41.5 (Thomas and Quilter-Pinner 2020). A stronger approach to safe staffing levels has proven effective elsewhere. For example, California prescribes a nurse to patient ratio that must be followed at all times: for example, one nurse for every two ICU patients, which has been shown to reduce patient deaths and allow nurses to give more attention to patients (Aiken et al 2010). Other research found that for every increase of one nurse, patients have a 14 per cent decrease in risk for in-hospital mortality (Driscoll et al 2018).

In the UK, Covid-19 has exposed the need to do significantly better. **A legal duty to account for safe staffing levels should be placed on the secretary of state for health and social care** – to help build political capital for a long-term and sustainable approach. It would need to be supported by guidelines and regular reporting. NICE

had begun a process of establishing safe staffing levels. That should continue. A report could be made in the annual Department of Health and Social Care reporting cycle – as is currently the case with the legal duty on health inequality.

Regulation is also important. The CQC considers safe staffing, to some extent, but **it should have the power to open legal proceedings against the secretary of state** – similar to powers given to the Equality and Human Right Commission (EHRC) – where it identifies funding or political will as a barrier to achieving staff staffing levels. This will ensure accountability is not transferred to trusts when politically expedient.

The NHS should use patient safety networks to share best practice

Increased resourcing should be complemented by improved ways of working in order to reduce danger to patients. The NHS comprises a vast ecosystem of organisations and departments and can be thought of as comprising multiple subcultures (Mannion and Davies 2018). Best practice for patient safety is therefore often 'trapped' within smaller areas of the NHS (Macrae 2018). The ability of a system to navigate complexity comes down to the number and efficacy of designated networks, collaborations, and peer support within the system (The Bayswater Institute 2019, Marjanovic et al 2017). It is important that local NHS organisations have networks around them to identify best practice, provide peer support,t and provide a conduit to share learning and champion successes.[10]

Uptake of best practice could be disseminated more widely and more quickly through the launch of a **patient safety network**, which would see those performing best on patient safety designated as **'anchor institutions', partnered with a range of providers** within their footprint, and given a lead role in raising performance. The focus within the networks should be tackling clearly defined problems through shared learning, training, and peer support.

10 The Patient Safety Learning Hub is an example of this principle. A free online patient safety knowledge platform with resources and opportunities to share knowledge with practitioners, patients and policy experts, it has had over 40,000 visitors from over 30 countries since it launched in October 2019.

DUTY OF CANDOUR

The 'duty of candour' standard was introduced as law in November 2014 following the Mid-Staffordshire NHS Foundation Trust public inquiry. It charges healthcare staff with an overriding obligation to be open and transparent, coupled with clear requirements to notify patients where there is a 'reportable patient safety incident' (one which could have or did result in moderate or severe harm or death). The notification must be prompt, and while the requirements are dependent upon the level of harm sustained, the focus is on ensuring that patients are kept properly informed and that errors and other unintended consequences are not 'brushed under the carpet'.

The CQC is responsible for monitoring compliance with the duty of candour. However, the CQC has so far been slow to prosecute, and since its introduction there has been only two fines issued by the CQC for failure to comply. A 2018 report by the charity Action Against Medical Accidents (AvMA) found several causes for concern around monitoring and compliance, including: a continuing absence of a central compliance recording system, an inability at the CQC to gather reports on all regulatory action, and varying levels of knowledge and awareness among staff and patients (Negri 2018). It made a number of recommendations for improvement, including:

1. a more robust framework for inspections to assist with assessing compliance
2. improved handling of reports alleging breaches
3. consistent reporting on the duty of candour in inspection reports
4. more proactive publicity for the CQC's regulatory action with regard to the duty of candour
5. collaboration with other statutory bodies and stakeholders to ensure consistently high-quality training on Duty of Candour across England.

To provide an incentive, **anchor institutions could have access to a small amount of funding, with which to pilot and test new evidence-based safety interventions within their area.** Successful pilots could then feed into future iterations of patient safety strategies and NICE guidelines.

4.
TRAVEL INJURIES

DESPITE SIGNIFICANT ROAD DANGER REDUCTION, CASUALTY LEVELS ARE STILL TOO HIGH AND PROGRESS HAS STALLED

The UK is viewed as having safe roads. Measured by number of road deaths per million inhabitants, the UK is the third safest country in Europe (DfT 2019a). The past 30 years show significant progress, and 2006 to 2010 saw a substantial reduction in fatalities (ibid).

Progress has slowed in recent years, however. In 2018 in Great Britain, there were 1,784 reported road deaths, or nearly five deaths per day on average, a figure which has not changed significantly since 2012 (DfT 2019b). Like fatalities, serious injuries are declining, but more gradually than pre-2010 (adjusting for changes in reporting). There were an estimated 27,811 serious injuries in 2018 (DfT 2019b). Because non-fatal injuries are underreported to police, however, this is likely to be an underestimate. Overall, road deaths and injuries are estimated to cost society over £35 billion a year (DfT 2019c).

In the 21st century, we have become desensitised to road deaths because they are so commonplace. The human cost of road collisions, and the continuing need for road danger reduction, is clear when listening to victims' experiences (see Roadpeace 2020, for example). The arrival of motor vehicles has been described as a violent revolution rather than benign evolution, protested in the US in the 1920s by anti-automobile campaigns, where cities erected memorials to the car dead as well as to the war dead (Norton 2008).

As with most public services, road maintenance has suffered from funding cuts. From 2010/11 to 2017/18, Highways England's spend on maintaining major roads fell by 43 per cent and spend on road maintenance by English local authorities fell by 29 per cent (Unchecked 2019). Evidence suggests that a reduction in road maintenance – leading to potholes, faint road markings, and lower street lighting, for example – negatively impacts road safety (Gould et al 2013).

Resourcing for enforcement has also fallen. There was a 22 per cent reduction in the number of dedicated roads policing officers between 2010 and 2014, and a further reduction of 18 per cent since 2015 (Norbury 2020). In 2019, dedicated roads-policing officers made up only around 4 per cent of total force strength, of which many are often 'double-hatted' – meaning they are responsible for carrying out more than one function (ibid).

Changes in road policing and enforcement has had a noticeable effect on road casualties. Research shows that, broadly speaking, when enforcement increases, compliance improves and casualties reduce; but where cutbacks affect enforcement, there is little or no improvement (ibid). In 2015, a transport select committee inquiry found that, as the number of traffic police fell, so too did the number of road traffic offences detected. However, the number of 'causing death' offences, which will always be recorded where they occur, did not fall, suggesting that the reduction in overall offences recorded did not represent a reduction in offences actually being committed (Transport Committee 2016). The consultation is currently running for the Department for Transport (DfT)'s roads policing review into road danger and casualty reduction (DfT 2020a).

The UK lacks a coordinated approach to learning from traffic collisions, with fragmented investigations – there is no road equivalent to the Health and Safety Executive. A 'Highways Accident Investigation Branch' has been proposed, following the model seen in other methods of transport including rail, maritime and aviation (Jackson et al 2018). This approach would see dedicated teams carrying out in-depth research in selected cases to better understand the causes of collisions. Among the benefits of the Rail Accident Investigation Branch is improved communication with victims and their families (ibid).

OUR TRANSPORT SYSTEM PRESENTS ENVIRONMENTAL AS WELL AS SAFETY CHALLENGES

Transport presents broader safety risks beyond injury. Along with agriculture and buildings, transport is a key sector that is holding the UK back from meeting its decarbonisation targets. Although showing signs of improvement, surface transport is still the largest-emitting sector in the UK, accounting for 23 per cent of UK emissions (CCC 2019). Road traffic is responsible for significant pollution as well as greenhouse gases – 31 per cent of emissions of NOx (which includes NO2) and 80 per cent of NOx concentrations at roadside (NAEI no date, Defra 2017). Research suggests that air pollution leads to around one in five childhood asthma cases and 28,000 to 36,000 early deaths per year (COMEAP 2018). Overall, annual air pollution-related health costs add up to £20 billion or more (RCP 2016). Air pollution also exacerbates existing inequalities: primary and secondary schools in more deprived areas are disproportionately affected, for example (Brooke et al 2017). The disproportionate impact of Covid-19 felt by ethnic minorities has been linked to air pollution (Carrington 2020). The Committee on Climate Change has called for DfT to do more to drive down emissions, including an earlier and more detailed phase-out of petrol and diesel (CCC 2019). To comply with the Paris Agreement, the UK must reduce traffic between 20–60 per cent (depending on take up of electric vehicles) by 2030 (Hopkinson and Sloman 2019). 69 per cent of those surveyed in UK cities did not want to return to pre-lockdown levels of air pollution (YouGov 2020).

A PUBLIC-FOCUSSED, MULTI-MODAL, AND ZERO CARBON TRANSPORT SYSTEM WOULD REDUCE BOTH ROAD DANGER AND ENVIRONMENTAL DAMAGE[11]

Transport, and especially the convenience of transport links and the cost of travel, is a significant determinant of opportunity, poverty, and broader measurements of wellbeing. Poor public transport is a key barrier to realising the latent economic potential of the north of England, for example – for the last 10 years London has received 2.4 times more public spending per person on transport than the North (Raikes 2019a and 2019b). A public-focussed, multi-modal, and zero carbon transport system[12] is one that prioritises public transport, cycling and walking, reduces private vehicle use and ensures all remaining vehicles are zero emission. It is a fairer, healthier and safer transport system, in step with people's lifestyle preferences. Nearly one-quarter of households (and nearly half of low-income households) don't have access to a car, and over half of motorists would like to reduce their car use (DfT 2018a, Dudleston et al 2005).

Such a system would have the following features.

A complete re-design of urban transport and a reduction in private car use

Road traffic in Great Britain increased by 29 per cent from 1990–2018 (ONS 2019b). Almost two-thirds of UK road transport emissions are from cars (DfT 2018b), and in Great Britain car occupants accounted for 44 per cent of road deaths in 2018 (DfT

11 See forthcoming IPPR report from the Environmental Justice Commission

12 Phrase from https://www.common-wealth.co.uk/reports/away-with-all-cars-redux

2019b). Cars are also dangerous to pedestrians and cyclists, with most pedestrian and cyclist casualties involving a motor vehicle (Allan 2019). Around three quarters of pedestrians killed or seriously injured on the road in 2018 were hit by cars (DfT 2020d, DfT 2020e). However, the DfT's *Road to Zero* strategy for decarbonising transport did not focus on reducing traffic growth (DfT 2018c) (although a transport decarbonisation plan is planned for later in 2020 (DfT 2020c)). Those using roads for business journeys would also benefit from reduced private car congestion. It is estimated that about one-third of road collisions involve someone who is driving for work, so non-essential work journeys, as well as personal journeys, should also be reduced (RoSPA 2018). Businesses may also be able to reduce their use of traditional vehicles – electric vehicles and non-vehicle delivery options such as e-cargo bikes provide alternatives to traditional vans (Sloman and Hopkinson 2019). There will need to be an accelerated transition to electric vehicles more broadly, although a like-for-like replacement of all traditional vehicles is not desirable socially or environmentally, as they have significant embodied environmental impacts. They also present road danger concerns similar to traditional vehicles, and are not a solution to congestion, transport inequality, and urban planning issues (Ricardo 2011).

The benefits of reduced car use during the pandemic lockdown are clear. In May 2020 there were an estimated 1,750 fewer deaths from road traffic and industrial emissions in the UK, as well as 1.3 million fewer days of work absence, 6,000 fewer children developing asthma, 1,900 avoided emergency room visits and 600 fewer preterm births across Europe (CREA 2020). Post-lockdown, some fear a spike in car use (due to limited public transport) combined with increased numbers of active travellers could result in increased road danger, although a majority of motorists plan to make fewer unnecessary journeys after lockdown, and over one-third plan to be more cautious with car maintenance and safety (Press Association 2020).

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1.3 million fewer days of work absence

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1,900 avoided emergency room visits

600 fewer preterm births across Europe

An increase in active travel

A timely policy response is important here to avoid a sharp increase in car use as people seek alternatives to public transport while social distancing is in place. Some change is already underway, and government and local authorities have been stepping up cycling and walking provision to promote 'active travel', which also promotes the health benefits of an active lifestyle. The government has announced a £2 billion package for active travel in England – the largest boost ever for walking and cycling, and a new watchdog, Active Travel England, will give residents power to banish through-traffic from local streets, and prevent councils from building substandard cycle lanes (DfT 2020b, DfT 2020f). In July 2020, rental e-scooters were legalised in a 12-month trial. To make this viable long-term, safety concerns around their power and storage should be addressed (BBC News 2020). New active travel measures should be embedded to become permanent changes to infrastructure.

An expansion and electrification of affordable public transport

Bus and rail travel is safer than car travel, and shifting to public transport would reduce casualties (DfT 2020d). Greater investment in low-carbon public transport links could reduce incentives to drive, and significantly reduce inequalities and provide greater access to jobs, learning and local support services for the poorest

while also improving quality of life for everyone (GOS 2019). An RAC survey found three fifths of drivers would swap to public transport if the services were better (RAC 2018). A civil society coalition has highlighted the importance of public, community and shared transport connections to a sustainable recovery from the pandemic (CBT 2020). Following social distancing measures, the UK's rail franchising system has changed significantly to a model which is already used by Merseyrail, London Overground and TfL Rail (Dennis 2020).

The movement towards transport-as-a-service (TaaS) models, such as car-sharing and car-hire from fleets, also presents opportunities. For example, one study in the US estimates that, by 2021, TaaS travel options could be four to 10 times cheaper per mile than buying a new car and two to four times cheaper than operating an existing vehicle (Arbib and Seba 2017).

Need for investment in public transport is uneven across the country. Over the past decade transport spending has increased by 2.5 times more per person in London than in the North of England – if the North had received the same transport spending per person as London over the last decade, it would have received £66 billion more than it did (Raikes and Lockwood 2019). Planned transport spending to 2033 is set to be almost three times as much per person in the capital as the North of England (ibid). As well as improved local transport, a 'whole journey' approach to subnational transport can provide seamless journeys across regions and economic areas (TfN 2019).

Investment is key as public transport services are currently under severe financial pressures from a fall in use and revenues due to social distancing measures, and numbers may remain low until confidence in safety in public spaces returns (Jolly and Walker 2020).

In the transition to a safe, sustainable transport system, it will be paramount that increased levels of active travel do not result in increased casualties among pedestrians and pedal cyclists. There are currently higher casualty and fatality rates per billion passenger miles among pedestrians and pedal cyclists than car users (34.4 pedestrian and 29.7 pedal cyclist fatalities compared to 1.8 car fatalities in Great Britain) (DfT 2019b). Pedestrians and cyclists are more vulnerable to the impact of a collision than those in an enclosed vehicle. In London, for example, fear of death or injury from collisions is the greatest deterrent to cycling more (TfL 2016).

A reduction in vehicle use would, on its own, reduce danger to vulnerable road users. Further measures include: increased provision of wide pavements; wide, segregated cycle lanes; traffic light signalling that prioritises pedestrians and cyclists; and redesigning junctions to minimise danger to pedestrians rather than prioritising traffic speed (C40 CCLG 2019). Oslo and Helsinki, which have both implemented similar measures, saw one and zero pedestrian deaths in 2019 respectively (Ng 2020, Smart Cities news team 2020). Again, there have been new measures in this area since the pandemic: in June 2020, local authorities in England gained new powers to keep cyclists safe, using CCTV to issue penalty charge notices to drivers who park or load illegally in mandatory cycle lanes.

Specific measures could include:

- further developing active travel lockdown measures, such as consistently prioritising cyclists and pedestrians over vehicles at junctions (Allan 2018)
- measures to embed behavioural changes seen during lockdown, such as a public campaign for fewer unnecessary car journeys alongside increased active travel

- regulating the number of new fossil fuel cars and vans that can be sold, so that by 2030 all new car and van sales will be ultra low emission vehicles (ULEVs), and nearly all will be zero emission battery electric vehicles (Hopkinson and Sloman 2019)
- reforming the grant scheme for electric cars to a trade-in rebate system, with grants only for trading in or scrapping an existing vehicle (ibid)
- offering similar or higher financial support for electric car clubs, public transport or e-bikes in exchange for scrappage of an old, high-emission car (ibid).

Transport changes require investment in our infrastructure and the green transition. A key method to reduce road traffic is by making travel less necessary, and providing alternative ways to connect people, such as by investing in high-speed broadband across the UK. To make sustainable travel methods viable, such as electric vehicles, the electricity grid, energy system, and electric vehicle (EV) infrastructure must be expanded, also requiring investment.

PARIS: '100 PER CENT BICYCLE'

A city without a tradition of cycling, Paris has undergone a transformation in recent years in favour of pedestrians and cyclists. As a share of total travel, driving within Paris city limits has dropped about 45 per cent since 1990, while cycling has increased tenfold and public transport by 30 per cent (Héran 2017). Socialist Party mayor Anne Hidalgo was re-elected in June 2020 for a second term promising far reaching measures to make Paris '100 per cent bicycle' (Hidalgo 2020):

- the removal of 72 per cent of on-street car parking spaces
- a cycle path on every street by 2024
- protected cycleways on every bridge in the city
- 100,000 additional bicycle parking spaces
- road camera surveillance to ensure safety for cyclists and pedestrians
- regulation of heavy goods vehicles without anti-blind spot equipment.

Milestones for the city already in place include a ban on diesel and tourist buses by 2024 and 100 per cent electric vehicles by 2030 (Samuel 2019, Love 2017). Her previous term saw 'Plan Vélo' ('Bicycle Plan') remove space for cars and boost space for cyclists and pedestrians, with 500,000 euro funding enabling over 1,000km of new cycle lanes, grants for electric vehicles and e-cargo bikes.

Hidalgo envisions a '15-minute city' ('une ville du quart d'heure'), where residents can access everything they need within 15 minutes from home. During lockdown, she banned most motor traffic from major central road Rue de Rivoli, and added 50km of additional protected cycle lanes on main roads. Her campaign was oriented towards residents of Paris proper, in contrast to the lower income 'banlieues' suburbs who may be more reliant on cars, but who are not enfranchised in the mayoral elections (Vock 2020). This may have enabled her to be more radical in her proposals.

5. CONCLUSION

A 15,000-year-old thigh bone with a healed fracture has been cited as the first sign of civilisation (Oak 2013). Other animals die from significant bone fractures, so we know that other people must have provided care to that individual over a significant period of time for the bone to heal. A further sign of civilisation is surely collective effort to prevent such an injury in the first place.

The UK in the 21st century faces new risks in various areas. Our vulnerability as individuals and the vulnerability of our social and economic systems have been thrown into sharp relief by the Covid-19 pandemic. The most efficient way of managing many large-scale risks is to pool risk collectively, but over the course of successive governments a 'great risk shift' has passed previously collective risks such as disability, parenthood, and unemployment, onto the individual (Quilter-Pinner et al 2020). Meanwhile, human impacts on the environment have reached a critical stage, potentially eroding the conditions upon which socioeconomic stability is possible and creating a new 'domain of risk' (Laybourn-Langton et al 2019). The policy response must focus on preparedness for the consequences of environmental breakdown on all socioeconomic and natural systems (Laybourn-Langton et al 2020).

There are inherent benefits in becoming more resilient as a society (ibid), and a new society-wide focus on resilience and preparedness for future shocks and challenges is paramount. An effective injury prevention strategy is a part of this, for its own sake and to free up planning and response resources for other challenges. The UK requires a renewed focus on injury prevention of all types, whether physical or mental illness or disability, and in every setting, and the Covid-19 pandemic may mark a turning point in attitudes and the policy landscape.

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