Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

HEALTH & SAFETY COMMITTEE
PWYLLGOR IECHYD A DIOGELWCH

DYDDIAD Y CYFARFOD: DATE OF MEETING:	09 May 2022
TEITL YR ADRODDIAD: TITLE OF REPORT:	Health and Safety Regulations – Reporting of Injuries, Diseases and Dangerous Occurrence Regulations 2013 (RIDDOR) Overview and End or Year Statistics
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Mandy Rayani, Director of Nursing, Quality and Patient Experience
SWYDDOG ADRODD: REPORTING OFFICER:	Adam Springthorpe, Health and Safety Manager

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report to the Health and Safety Committee provides an update regarding Hywel Dda University Health Board's (HDdUHB) compliance with RIDDOR and presents the end of year RIDDOR reporting figures for the 2021-22 financial year.

Cefndir / Background

RIDDOR places a duty on employers and people in control of work premises to report certain serious workplace accidents, occupational diseases and specified dangerous occurrences to the Health and Safety Executive (HSE).

Regulations 1-3 cover citation, interpretation, and the role of the Responsible Person.

Regulations 4-6 require deaths and injuries to be reported only when:

- there has been an **accident** which caused the injury; and
- the accident was **work-related;** and
- the injury is of a type which is **reportable.**

What is an 'accident'?

In relation to RIDDOR, an accident is a separate, identifiable, unintended incident, which causes physical injury. This specifically includes acts of non-consensual violence to people at work. Injuries themselves, e.g. 'feeling a sharp twinge', are not accidents. There must be an identifiable external event that causes the injury, e.g. a falling object striking someone. Cumulative exposures to hazards, which eventually cause injury (e.g. repetitive lifting), are not classed as 'accidents' under RIDDOR.

What is meant by 'work-related'?

RIDDOR only requires accidents to be reported if they arise 'out of or in connection with work'. The fact that there is an accident on work premises does not, in itself, mean that the accident is work-related, the work activity itself must contribute to the accident. An accident is 'work-related' if any of the following played a significant role:

- the way the work was carried out
- any machinery, plant, substances, or equipment used for the work

- the condition of the site or premises where the accident happened.

What are 'reportable' injuries?
The following injuries are reportable when they result from a work-related accident:

- The death of any person (Reg. 6).
- Specified injuries to workers (Reg. 4).
- Injuries to workers that result in their incapacitation for more than seven days (Reg. 4).
- Injuries to non-workers that result in them being taken directly to hospital for treatment, or specified injuries to non-workers that occur on hospital premises. (Reg. 5).

Regulation 7 covers dangerous occurrences, which are certain, specified near-miss events with a high potential to cause death or serious injury. They are listed in Schedule 2 of RIDDOR and include events related to lifting equipment, pressure systems, overhead electric lines, electrical incidents causing explosion or fire, explosions, biological agents, radiation generators and radiography, collapse of scaffolding etc.

Regulation 8 requires employers to report cases of certain diagnosed reportable diseases which are linked with occupational exposure to specified hazards i.e. where these are likely to have been caused or made worse by their work. A reportable disease must be diagnosed by a doctor. Diagnosis includes identifying any new symptoms, or any significant worsening of existing symptoms. For employees, they need to provide the diagnosis in writing to their employer. Reportable occupational diseases include, carpal tunnel syndrome, cramp of the hand or forearm, occupational dermatitis, hand arm vibration syndrome, occupational asthma and tendonitis or tenosynovitis.

Regulation 9 covers reporting incidents where, in relation to a person at work, the responsible person receives a diagnosis of:

- any cancer attributed to an occupational exposure to a known human carcinogen or mutagen (including ionising radiation); or
- any disease attributed to an occupational exposure to a biological agent.

RIDDOR also sets timeframes within which the HSE should be notified of certain work-related incidents. For most types of incidents including accidents resulting in the death of any person, specified injuries to workers, non-fatal accidents requiring hospital treatment to non-workers and dangerous occurrences, the responsible person must notify the HSE without delay, and a report submitted within 10 days of the incident. For accidents resulting in the over-seven-day incapacitation of a worker, the HSE must be notified within 15 days of the incident.

Asesiad / Assessment

Numbers of Incidents Reported
A benchmarking exercise, reported to the then Health, Safety and Emergency Planning Sub-Committee in November 2016, indicated that HDdUHB may have been under-reporting RIDDOR incidents at that time. The benchmarking exercise compared the RIDDOR submissions made by HDdUHB to those made by Betsi Cadwaladr University Health Board (BCUHB) over comparable 12-month periods. The results were:

- BCUHB: 14264 Employees – 107 Incidents reported
- HDdUHB: 10000 Employees – 17 Incidents reported

In an attempt to tackle the possible under-reporting of incidents in HDdUHB there have been several RIDDOR initiatives led by Health, Safety and Security (HS&S) since 2017, the main of which has been the development of the RIDDOR Decision Making Flowchart, created by HS&S, which has been widely distributed and is now well embedded within HDdUHB. The

RIDDOR Decision Making Flowchart clarifies that the only requirement on staff management in terms of RIDDOR is to recognise the trigger points for RIDDOR reporting and to contact HS&S to make them aware when a reportable incident occurs.

Year	Reported Incidents
2017-18	43
2018-19	55
2019-20	42
2020-21	42
2021-22	58

In HDdUHB, all RIDDOR notifications are submitted to the HSE by members of the HS&S team to ensure consistency and quality of reports and to allow the centralised recording of information. As a result of raising this awareness, the number of reported incidents have grown significantly compared to the figures from 2016, to what is now more likely to be a more representative figure.

Timeliness of Reporting

The 2016 benchmarking exercise also looked at the number of incidents that were submitted on time by HDdUHB, which at the time was only 41% (with BCUHB reportedly achieving 72%). The primary focus of the HS&S Team during the initial awareness raising was to increase awareness of RIDDOR and to educate managers on the triggers for reporting, rather than the timeframes within which reports need to be made to the HSE. Therefore, although compliance grew slightly, only 51% were submitted on time in 2017 and 49% in 2018.

In response, HS&S undertook a Critical Path Analysis in early 2019 to identify the main causes for late submissions under RIDDOR, allowing the development of a targeted strategy for the next phase of the RIDDOR awareness raising initiative. In order to understand the main causes for the late submissions it was necessary to interrogate each incident individually. This was completed for all late submissions by the Reporting Officer between 01/01/2017-06/06/2019. The top 4 reasons found in the Critical Path Analysis are outlined below:

	%
RIDDOR mandatory reporting timeframe already missed at the point that the Datix is submitted.	39.5
Datix submitted within RIDDOR timeframe. Outside timeframe once HS&S Team informed or requested information supplied.	18.6
Datix originally Level 1 or 2 (i.e. Not automatically seen by HS&S Team).	11.6
Severity of incident not immediately apparent.	9.3

The Critical Path Analysis indicated a widespread lack of understanding by management of the RIDDOR reporting timeframes. It was therefore decided to update the RIDDOR Reporting Decision Flowchart to include the mandatory reporting timeframes and a definition of ‘arisen out of or in connection with the work’ to aid the decision-making process.

HS&S now scrutinise all health and safety related Datix incidents, rather than specific levels as before, therefore less potential RIDDORs now bypass HS&S through incorrect ratings.

It was identified that most of the incidents reported late due to a late Datix submission were because the Datix was not submitted until the injured party had returned to work. It was therefore decided that the next phase of the RIDDOR awareness raising initiative would be the development of a Datix and RIDDOR guidance sheet for managers to use for all staff incidents. The guidance sheets had three elements:

- When to report incidents, emphasising timeliness.
- Expectations of managers when investigating staff incidents on Datix.
- A reminder of RIDDOR requirements and a link to the Flowchart.

This guidance sheet was rolled out via face-to-face visits to all key areas and presentations at key meetings throughout the Health Board. This was supplemented by a Global e-mail campaign. In response to HSE scrutiny the guidance sheet was updated again in 2021 to include investigation techniques and establishing immediate, underlying and root causes.

As a result of this second phase of awareness raising, compliance figures have risen further from their initial level of 42%, peaking at 66.6% in 2019-20, as shown in the adjacent table. Figures have dipped in the last two years however it is hoped that this is, at least in part, due to the impact of COVID-19 on manager's time.

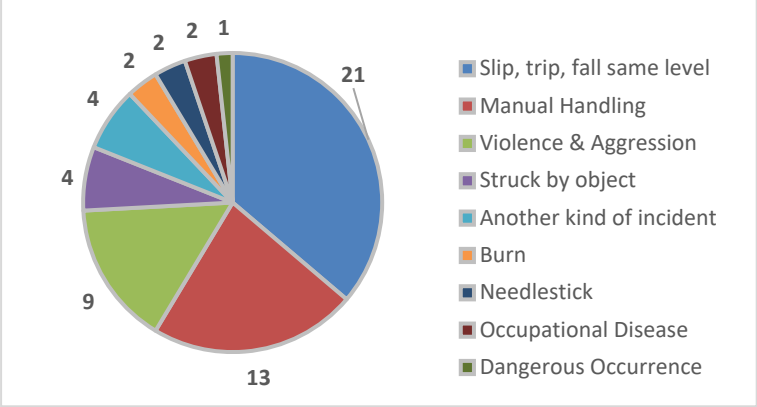
Year	% Reported in Time
2018-19	54.5%
2019-20	66.6%
2020-21	61.9%
2021-22	56.9%

HS&S continue to promote the RIDDOR reporting requirements and timeframes, having included an update in the 2021-22 Q4 HS&S 7 Minute Briefing that was circulated in March 2022 and discussed at the Quality and Safety Groups across the Health Board.

It is very unlikely that the Health Board will achieve 100% compliance, however, specific Directorates have now been identified for targeted awareness raising so that submission to the HSE can be improved during 2022/23.

2021-22 End of Year Statistics
The table and chart below breakdown the 2021-22 RIDDORs by the main cause of the incident:

Breakdown by Cause	No.
Slip, trip, fall same level	21
Manual Handling	13
Violence & Aggression	9
Struck by object	4
Another kind of incident	4
Burn	2
Needlestick	2
Occupational Disease	2
Dangerous Occurrence	1

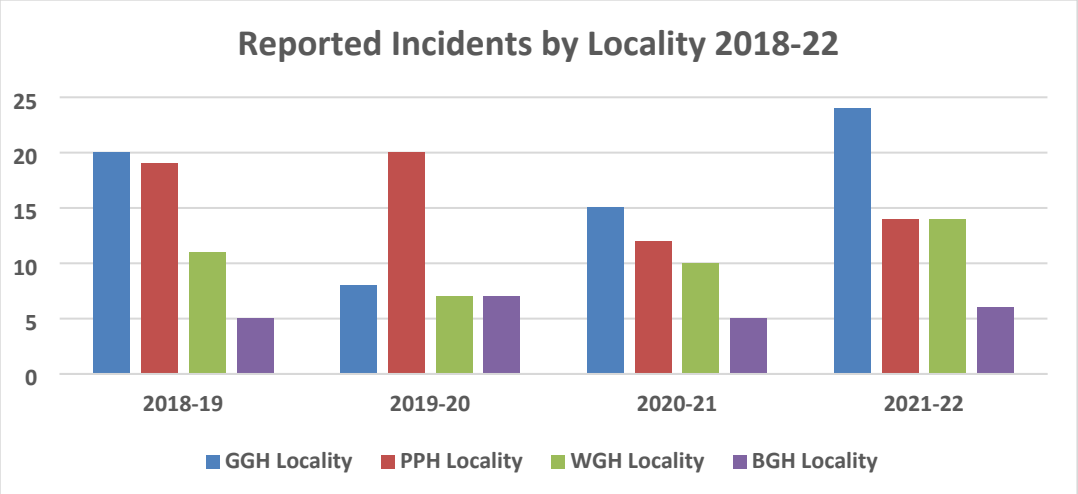


From the table and chart above it can clearly be seen that the greatest cause of incident in 2020-21 was slips, trips and falls on the same level, by a clear margin. This is of no surprise as slips, trips and falls have been the leading cause of RIDDOR reportable incidents in HDdUHB for the last 4 years.

HS&S continue to raise awareness with managers with a dedicated section on the management of workplace slips, trips and falls on the Manager's Health and Safety Induction linked to the Policy. A separate piece of work is planned to interrogate the causes of RIDDOR reportable slip, trip and fall incidents to see if there are any patterns that can direct our future work on the topic.

In previous years it has been apparent that a large proportion of RIDDOR incidents were reported by the two Carmarthenshire localities, and it was felt that the other localities may have been underreporting. To address this, in 2018, HS&S undertook targeted awareness raising activities in Pembrokeshire and Ceredigion. Since then the year-end spread of incidents has

been much more representative of actual staffing levels, which can clearly be seen in the chart below (with the anomaly of Glangwili General Hospital (GGH) in 2019-20):



HS&S have never before split the RIDDOR reported incidents by Directorate to see where the incidents are occurring, so this has now been done to better provide information to the Directorates as part of their Quality and Safety / Governance meetings. This will continue to be done for all future reported incidents to facilitate reporting.

Directorate	Total	'On Time'
Scheduled Care	8	75.0%
Womens / Childrens	3	0.0%
Community	7	57.1%
Mental Health	10	50.0%
Estates / facilities	7	57.1%
Unscheduled Care	20	65.0%
Operations	2	50.0%
Therapies	1	0.0%

Please see adjacent all 2021-22 RIDDOR reportable incidents split by Directorate. These figures can also be split further to feedback to individual directorates i.e. incidents per locality per directorate.

HS&S have been able to use this information proactively, having for instance already raised the compliance level in the Women & Children's Directorate Quality, Safety & Experience meeting.

Argymhelliad / Recommendation

For the Health & Safety Committee to gain assurance from this report that the Health Board is operating in compliance with the RIDDOR regulations, with exception of reports being submitted more timely.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	5.8 Ensure there is a process of review of findings of safety management system audits and seek assurance that corrective actions are put in place.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	N/A
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2.1 Managing Risk and Promoting Health and Safety

Nodau Gwella Ansawdd: Quality Improvement Goal(s):	Focus On What Matters To Patients, Service users, Their Families and Carers, and Our Staff
Amcanion Strategol y BIP: UHB Strategic Objectives:	2. Living and working well.
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2018-2019	2. Develop a skilled and flexible workforce to meet the changing needs of the modern NHS

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	• The Health and Safety at Work etc. Act 1974; • All subordinate health and safety legislation; • Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR); • HSE Approved Codes of Practice; • HSE Guidance; • EU Directives.
Rhestr Termau: Glossary of Terms:	Contained within the body of the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd Iechyd a Diogelwch: Parties / Committees consulted prior to Health and Safety Assurance Committee:	Health and Safety Advisory Group whose membership includes: • Health, Safety & Security Department; • Moving & Handling Department; • Occupational Health; • HB Legal Team.
Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Not directly.
Ansawdd / Gofal Claf: Quality / Patient Care:	There are no impacts on quality or patient care.
Gweithlu: Workforce:	Not directly.
Risg: Risk:	No specific risk on the risk register.
Cyfreithiol: Legal:	It should be noted that a failure to report within the timescales set by RIDDOR is technically a contravention of the regulations and that it is therefore an offence under Section 33(1)(C) of the Health and Safety at Work etc. Act 1974. The Health and Safety Executive who receive these

	reports will on occasion be critical of the delays in reporting and could seek assurance from the Health Board that improvements will be made.
Enw Da: **Reputational:**	Potential for political or media interest if compliance or enforcement action is served.
Gyfrinachedd: **Privacy:**	N/A
Cydraddoldeb: **Equality:**	No evidence gathered to indicate a negative impact on any protected group(s).