Health and Safety Related Incidents Summary: Annual RIDDOR Reportable Incidents

Reporting Period: 01 April 2023 - 31 March 2024
Date Report Generated: 30 April 2024

1. Introduction

1.1 The Reporting of Injuries, Diseases and Dangerous Occurrences Regulation 2013 (RIDDOR) requires the Trust to report deaths, certain types of injury, some occupational diseases, and dangerous occurrences that 'arise out of or in connection with work'.

1.2 Whilst the RIDDOR regulation predominantly relates to employees, it also includes the requirement to report certain injuries and ill health involving people not at work including patients and visitors. The HSE and the Care Quality Commission (CQC) as regulators are required to ensure effective health and safety for patients, service users and members of the public visiting our premises.

1.3 All RIDDORs are fully investigated as per the Trust Incident Investigation process and monitored by the Trust's Health and Safety Committee.

1.4 The purpose of the report is to provide the Health and Safety Committee with a summary of reported RIDDORS and emerging trends from both the Ulysses and RADAR incident reporting systems between 01 April 2023 and 31 March 2024.

2. Executive Summary

2.1 This report offers 2023 / 2024 overarching data and narrative of all reportable RIDDORs, within a wider context to provide assurance that as an organisation we are complying with regulatory requirements.

2.2 The report has been generated utilising combined incident data from Ulysses and Radar. The scope of this report includes incidents occurring across Somerset NHS Foundation Trust, including the subsidiary organisation Simply Serve Limited.

2.3 The report does not include RIDDOR reportable incidents reported by Symphony Healthcare Services, an additional subsidiary of the Trust. They currently report their own RIDDOR incidents to the Health and Safety Executive (HSE).

2.4 There was an ongoing programme of work to align health and safety incidents from both the historic data from the two former legacy organisations, Somerset NHS Foundation Trust (SFT) and Yeovil District Hospital NHS Foundation Trust (YDH). The current incident data is applicable as of the date of integration between the two organisations on the 1 April 2023.

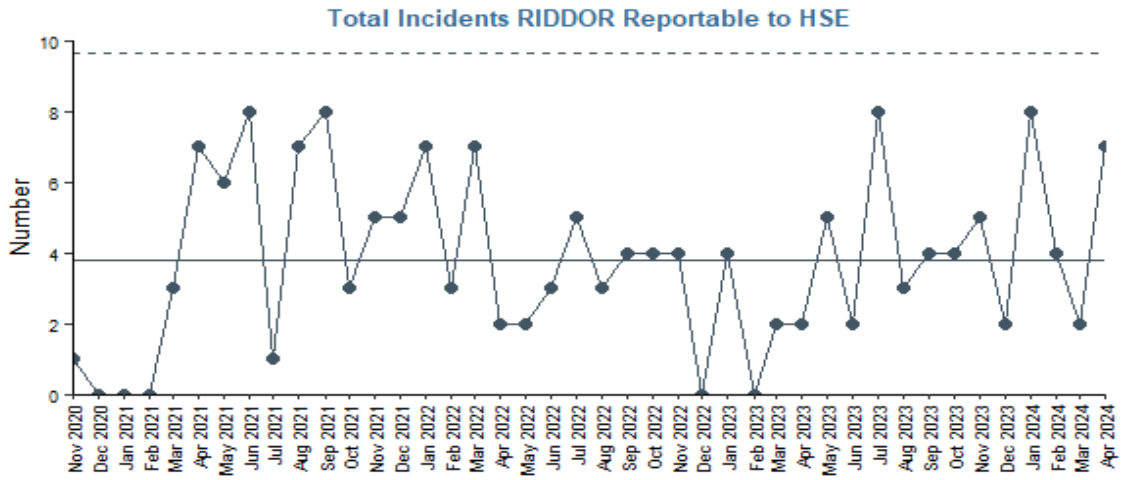
2.5 From the 1 May 2024 following consultation with the Board of Directors, Radar have been allocated the contract for all incident reporting for the next 3 years. The Trust will also on 1

May 2024 implement NHS England (NHSE) Learning from Patient Safety Events (LfPSE) as the new Trustwide incident reporting system. A training programme to facilitate LfPSE's implementation for colleagues is planned.

3. Incidents Reported Over Time

3.1 There were 9093 Health and Safety related incidents reported between 01 April 2023 and 31 March 2024, reported on both the former SFT reporting system Radar and the former YDH reporting system Ulysses. 49 incidents were noted to be RIDDOR Reportable. See Figure 1.

Figure 1



3.2 Of the incidents reported during this period, 46 involved a colleague, 2 involved patients, and 1 involved a visitor to Somerset NHS Foundation Trust premises.

3.3 During this period the 46 colleague reportable incidents comprised of 6 major incidents due to the nature of the injuries sustained (e.g. bone fracture). One incident reported as an occupational disease (specifically, contact dermatitis). A further two reported as dangerous occurrence (specifically, sharps injury involving a blood borne virus patient), and finally thirty-seven were reported as 'over 7 day' incident. Please refer to Figure 2.

3.4 The patient and visitor reportable incidents were all reported as major incidents due to the nature of the injuries sustained i.e. bone fractures.

Figure 2

RIDDOR Incidents Reported by HSE Reporting Categories

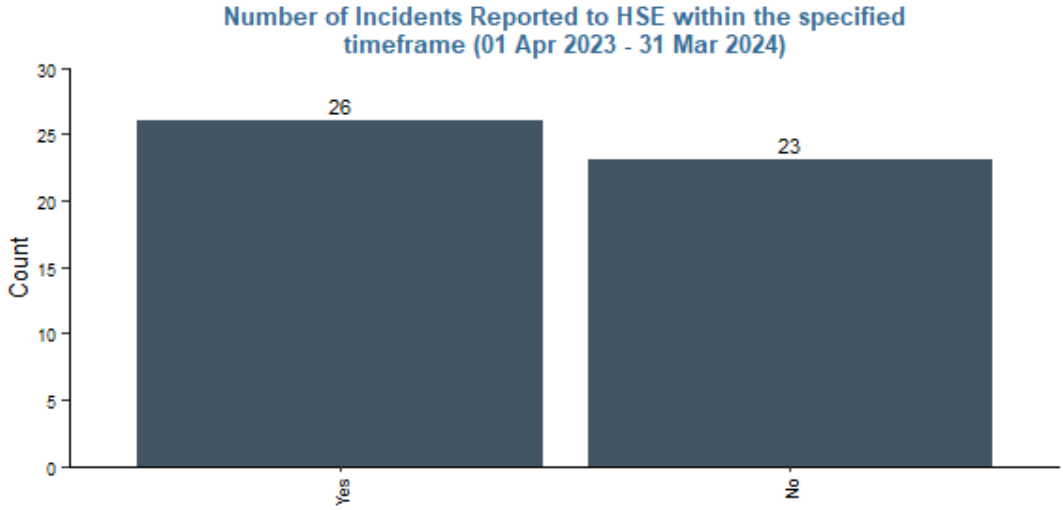
HSE Reporting Category	RIDDOR Incidents (01 Apr 2023 - 31 Mar 2024)	RIDDOR Incidents (01 Apr 2022 - 31 Mar 2023)
Over 7 Day	37	22
Major	9	9
Dangerous Occurrences	2	1
Disease	1	0
Total	**49**	**32**

4. Reporting of RIDDOR Reportable Incidents to the HSE

4.1 The HSE have mandatory requirements for the reporting of RIDDOR reportable incidents; these are 15 days for over 7-day injuries and 10 days for all other incidents. Figure 3 shows the number of RIDDOR incidents reported within the specified time frames.

4.2 Within this reporting period we have been monitoring the time taken from the date of incident to the time taken to report to the HSE. As well as monitoring the date of the incident against the time taken to notify the Health & Safety Team.

Figure 3



4.3 For incidents reported within this period, on average (Median) it took 4 days from the date the Health & Safety Team becoming aware of the incident occurring, to report to the HSE. *(Range: 3 days - 9 days)*.

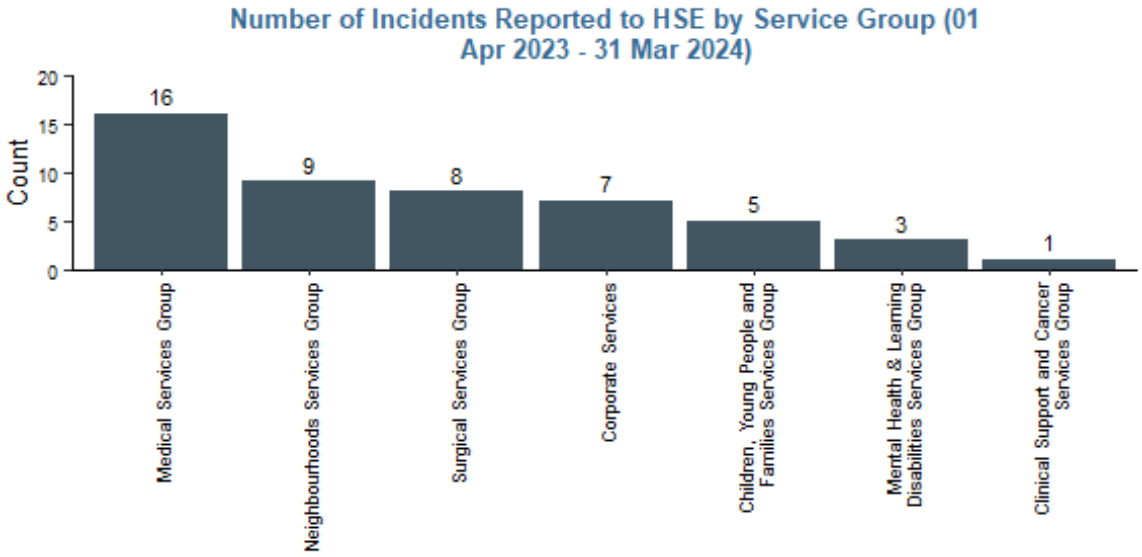
4.4 For incidents reported within this period, on average (Median) it took 20 days from the incident occurring for managers to report the incident to the Health & Safety Team. *(Range: 8 days - 73 days)*.

5. Incidents by Service Group

5.1 For incidents reported between 01 April 2023 and 31 March 2024 details of the Service Group where the originating incident for the RIDDOR took place, is shown in Figure 4.

5.2 As of the 1 April 2023, Directorates were re-aligned to Service Groups. This saw movement of Community Hospitals and Estates from their former Integrated and Urgent Care and Estates and Facilities Management Directorates to their current Neighborhoods and Corporate Service Groups. This has identified noticeable changes in the data for the current reporting period of this report. Despite these changes for the last 4 years the Medical related Service Group / Directorate remains the highest originator of incidents reported to Radar/Ulysses, that on investigation meet the criteria to be reported as RIDDORs to our regulator the HSE.

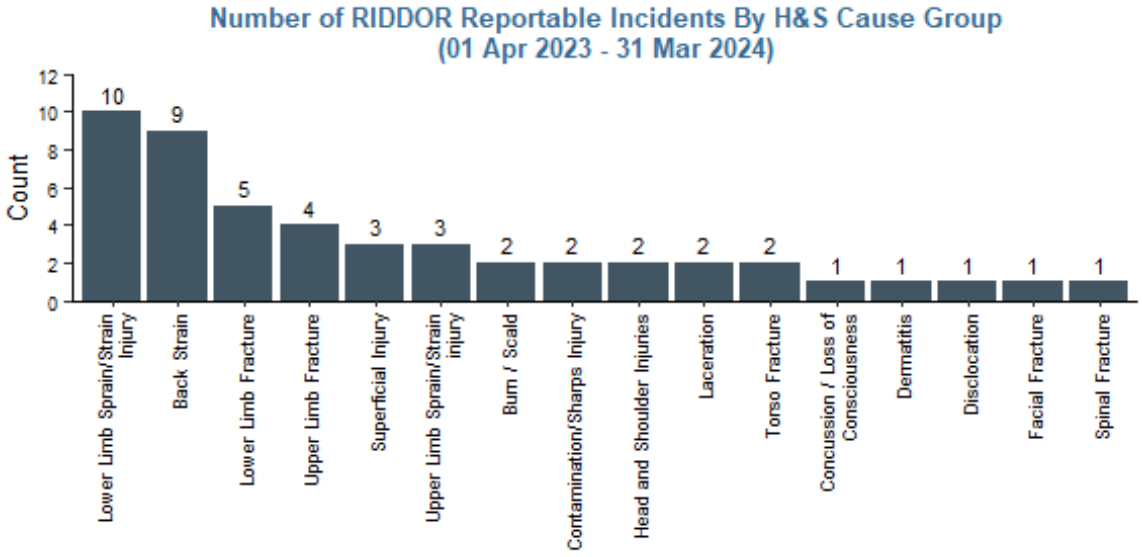
Figure 4



6. Harm Resulting from RIDDOR Reportable Incidents

6.1 Injuries from RIDDOR Reportable incidents are detailed in Figure 5 below. These have been standardised to aid confidentiality. It is unusual to see an injury of concussion and spinal fracture as reportable incidents. We want to offer assurance that through our collaborative investigation process the incident highlighted a software systems failure in regular checking of bi-fold doors in the Duchess Building on the Musgrove Park Hospital (MPH) site being missed. The software system has been reviewed by EFM, and 6 monthly checks have been re-instated. The second incident (spinal fracture) was a patient related incident, it identified that a bed rail risk assessment was completed requiring the need for bed rail use but at the time of the incident was not in place.

Figure 5



7. RIDDOR Reportable Incidents by Cause Group

7.1 Each health and safety related incident have been assigned a high-level cause group. Incidents resulting in RIDDOR reports between 01 April 2023 and 31 March 2024 corresponding to these cause groups are detailed below in Figure 6, against those reported over the previous 12-month period.

Figure 6

Health and Safety Cause Group	RIDDOR Incidents (01 Apr 2023 - 31 Mar 2024)	RIDDOR Incidents (01 Apr 2022 - 31 Mar 2023)
Slips, Trips and Falls	19	14
Accidental Injury	10	6
Violence and Aggression	8	3
Moving & Handling	7	7
Environmental Issue	2	0
Not HS Related Cause	2	1
Sharps	1	1
Total	**49**	**32**

8. RIDDOR Reporting Assurance

8.1 To provide the Trust with assurance that RIDDOR injuries are being reported as appropriate, several validation methods are in place as outlined below.

Colleague and Visitor Incidents

8.2 During the reporting period 49 RIDDOR incidents were assessed and investigated. However, an additional 88 incidents were reviewed and investigated with local managers to determine whether they would meet RIDDOR reporting requirements.

8.3 To promote a positive health and safety culture and prevent recurrences those 88 incidents that were reviewed and investigated by the Health & Safety Team that did not meet the RIDDOR reportable criteria; the manager responsible for the investigation is advised in high-risk incidents and where possible and capacity allows to consider and communicate any learning outcomes of the incident to their colleagues prior to the investigation being closed. In addition, where appropriate Service Groups were also advised of the health and safety review, and investigation for any learning outcomes.

Patient Injuries

8.4 Where a patient has sustained a major injury (e.g. fracture) there is a process in place within the Governance Support Team for an initial review to ascertain if there are any immediate environmental or care management concerns directly relating to the injury, which may lead to RIDDOR reporting. Patient incidents are reviewed collaboratively, on a weekly basis, with the Health and Safety Team and the Incident and Learning Leads (ILLs) to determine whether the incidents meet RIDDOR reporting criteria.

8.5 During the reporting period, 126 patient incidents have been investigated and reviewed by the Health and Safety Team in conjunction with the ILLs which identified 2 in-patient incidents as being RIDDOR reportable. This is the same number of patient RIDDORS reported during 2022/2023.

8.6 For this reporting period any patient incidents identified as RIDDOR reportable were reported to the Serious Incident Review Group for awareness and to drive learning.

Diseases and Dangerous Occurrences

8.7 This reporting criteria is reliant upon local managers advising the Health & Safety Team of a disease or dangerous occurrence to a colleague either following an occupational health referral via the content of the report, or a specific incident that is then subsequently identified and confirmed by the Health & Safety Team as a RIDDOR reportable disease or dangerous occurrence.

8.8 The Health & Safety Team, receive a fortnightly report from the Trusts Occupational Health provider to identify possible RIDDOR reportable incidents. These are followed up with the local manager and investigated to determine if they are RIDDOR reportable or if not to determine any actions or interventions are required e.g. learning or support signposting. This process was sporadic and included poor quality data throughout the early reporting period of 2023 but has improved during the latter half of 2023 with a significant improvement in quality of data and consistency of reports being provided by the Occupational Health provider towards the end of the reporting period.

8.9 Following the HSE sharps inspection in October 2022 and subsequent enforcement all sharps' incidents are reviewed specifically for any blood borne virus contamination.

9 HSE / CQC Investigation Activity

9.1 Under the HSE/CQC memorandum of understanding, there are statutory requirements for the notification of incidents including RIDDORs. Under this arrangement both agencies will work collaboratively by notifying the other party as appropriate and as soon as possible about information they receive on incidents and sharing of relevant intelligence and enforcement data.

HSE

9.2 There have been no investigations or inspections during this reporting period.

CQC

9.3 An inspection was conducted on the 20 & 21 November 2023, in the Maternity Units both at MPH and YDH. Concerns were raised regarding various topics and a notice issued. As a result, Stephen Thomson, Director of Integrated Governance in conjunction with other members of GST have supported Maternity with a programme of work which is ongoing to respond to the concerns raised.

10. Conclusion

10.1 Work was ongoing during this reporting period to align historic and current data from SFTs two RIDDOR reporting incident systems (Ulysses and Radar). It is worth noting that from May 2024, SFT will have one RIDDOR reporting incident system after a rigous pre-market engagement. It is anticipated that there may be an initial drop in incidents being reported but it is hoped that with implementation of training and the support of the wider Governance

Support Team and key stakeholders that RIDDOR reportable incidents will remain consistent.

10.2 Incident data will continue to be monitored weekly by Heath and Safety and Incident Leads for any patient RIDDOR reporting inconsistencies.

10.3 Following the introduction of Patient Safety Incident Response Framework (PSIRF), colleague RIDDOR reportable incidents will be locally investigated by Line Managers following the same PSIRF systems model of investigation. It is hoped this will reinforce learnings and outcomes from RIDDOR reportable incidents to strengthen Line Manager investigatory skills.

10.4 Where a RIDDOR incident is deemed to require additional support, either due to severity or risk to the Trust, the Health & Safety Team will provide competent advice, guidance and support to resolve and enable a thorough investigation.

10.5 All RIDDOR reportable incidents for the Trust (including those of its subsidary organisation SSL) will continue to be reported to the HSE by the Health and Safety Team.

11. Recommendation

11.1 The Quality Governance Assurance Group are asked to receive the annual Health & Safety RIDDOR Summary and Trends Report for this reporting period as a supplementary report to the Trust's Annual Health & Safety Report.