Item: 10

Policy and Resources Committee: 28 November 2023.

**Evaluation of Service Health and Safety Performance.** 

Report by Corporate Director for Neighbourhood Services and Infrastructure.

# 1. Purpose of Report

To present the evaluation of service health and safety performance for 2022/23.

### 2. Recommendations

The Committee is invited to scrutinise:

### 2.1.

The Evaluation of Service Health and Safety Performance for 2022/23, attached as Appendix 1 to this report, in order to obtain assurance.

# 3. Evaluation of Service Health and Safety Performance

### 3.1.

In accordance with the Health and Safety Policy, an annual report, evaluating the health and safety performance of each Service, should be prepared.

### 3.2.

The Evaluation of Service Health and Safety Performance report, attached as Appendix 1 to this report, has been prepared for the year ending 31 March 2023 and is based on accident reports received by the Safety and Resilience Service covering the period 1 April 2022 to 31 March 2023.

### 3.3.

The report is presented in alignment to the new Council structure.

### 3.4.

The report follows a similar format to previous years and is specific to work-related accidents and ill health in relation to Council employees. Accidents to school pupils, service users in care establishments and members of the public in general are not included in this evaluation although all such accident reports are recorded and, where necessary, investigated.

### 3.5.

The total number of accidents/incidents occurring during the period decreased from 108 for the previous reporting year to 72 this year.

### 3.6.

The total number of reportable accidents under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (over seven days lost time and specified injuries) was six, which is a reduction from the previous report, when 32 accidents were reported. This reduction is due to the removal of the requirement by HSE to report COVID work-based outbreaks.

### 3.7.

In accordance with the existing Health and Safety Policy, all accidents and work-related ill health conditions will continue to be recorded and a copy of the adverse event report forwarded to the Council's Safety and Resilience service.

# 4. Corporate Governance

This report relates to the Council complying with its duties as an employer and therefore does not directly support and contribute to improved outcomes for communities as outlined in the Council Plan and the Local Outcomes Improvement Plan.

# 5. Financial Aspects

There are no financial implications arising directly from this report.

# 6. Legal Aspects

### 6.1.

Section 2 of the Health and Safety at Work etc Act 1974 states among other matters that it shall be the duty of every employer to prepare a written statement of its general policy with respect to the health and safety at work of its employees and the organisation and arrangements for carrying out that policy.

### 6.2.

Annual evaluation of the Council's health and safety performance is a requirement in terms of the Council's Health and Safety Policy.

### 7. Contact Officers

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# 8. Appendix

Appendix 1: Evaluation of Service Health and Safety Performance.



# **Evaluation of Service Health and Safety Performance** 2022/23

# 1. Purpose of the Report

- 1.1. In accordance with Orkney Islands Council's (the Council) Health and Safety Policy, an annual report, evaluating the health and safety performance of each Service, should be prepared.
- 1.2. This report has been prepared for the year ending 31 March 2023 and is based on the Council's adverse event reports received by the Safety and Resilience Service covering the period 1 April 2022 to 31 March 2023.
- 1.3. The report is specific to work related accidents and ill health in relation to the Council's employees. Adverse events affecting school pupils, service users in care establishments and members of the public in general are not included in this evaluation although any such reports are recorded and, where necessary, investigated.
- 1.4. Further to this it details changes and developments made during this period regarding the management of health and safety since the last annual report in accordance with the Council's Health and Safety Policy.

# 2. Legislative Background

- 2.1. In terms of Section 2(1) of the Health and Safety at Work etc. Act 1974, the Council has a duty to ensure, so far as is reasonably practicable, the health, safety and welfare of all its employees.
- 2.2. In terms of Section 2(2) of the Health and Safety at Work etc. Act 1974, the Council has a duty to prepare a written statement of its general policy with respect to the health and safety at work of its employees and the organisation and arrangements for carrying out that policy.
- 2.3. In terms of The Management of Health and Safety at Work Regulations 1999, Regulation 5, the Council shall make and give effect to such arrangements as are appropriate, having regard to the nature of its activities and the size of its undertaking, for the effective planning, organisation, control, monitoring and review of preventative and protective measures.
- 2.4. This evaluation of performance is a requirement of the Council's Health and Safety duties and Policy.

### 3. Introduction

- 3.1. The details and analysis presented within this report covers the period from 1 April 2022 to 31 March 2023 and is based on the Council's adverse event reports that are submitted to the Safety and Resilience Service.
- 3.2. The report is specific to work related accidents and ill health in relation to the Council's employees. Adverse events affecting school pupils, service users in care establishments and members of the public in general are not included in this

- evaluation although any such reports are recorded and, where necessary, investigated.
- 3.3. This report has been updated to reflect the current service structure as this was in place for all the period being reported.
- 3.4. During the period covered, the Safety and Resilience Service has been through a significant transition period. Due to staff changes, the Service now has a new Service Manager and two Safety and Resilience Officers. The Council's recruitment process has ensured the employment of three skilled, knowledgeable and experienced safety and resilience practitioners.
- 3.5. The Safety and Resilience Service continues to ensure the delivery of a competent, robust and high-quality service for both the strategic and operational needs of the Council, regarding both its responsibilities to employees, but also the communities of Orkney. During this reporting period, the Safety and Resilience Service has undertaken a systematic assessment of all current health and safety approaches delivered by the Council. Further details on the findings of this review will be presented later in this report.

# 4. Executive Summary

- 4.1. This health and safety evaluation highlights an improvement in accident rates within the reporting period. There has been a notable reduction in accidents, with accidents dropping from 108 to 72. This 33% decrease is attributed to a combination of factors including the removal of the requirement for in work COVID transmission reporting, service training programmes, such as positive behaviours, and a strong culture of safety awareness among staff.
- 4.2. The report details further the specific factors that contribute to this improvement and outlines key areas for further focus to sustain and build upon this positive trend.
- 4.3. The findings support the Council's commitment to foster a safe and secure work environment for all employees. Continued strengthening of our health and safety systems is required to ensure a positive reduction trend is maintained.

# 5. Adverse Data Reporting

- 5.1. The total number of accidents/incidents occurring during the period of 1 April 2022 to 31 March 2023 was 72 reports as shown in Figure 1. As per standard health and safety reporting, the Council uses the Health and Safety Executive (HSE) categorisations of accidents and a full breakdown for this period is shown in Figure 2. As shown, there is a significant decrease in accidents reported however as discussed later this is predominantly down to the removal of the requirement for in work COVID transmission reporting.
- 5.2. At the beginning of the pandemic in 2020, the HSE confirmed that a person at work (a worker) that has been diagnosed as having COVID-19 attributed to an occupational exposure to coronavirus should be reported as a case of occupational disease. Cases of COVID-19 were only to be reported where the likelihood was the virus had been contracted in the workplace, if there was any doubt in this, then the case should not be reported. This requirement lasted until April/May 2022 when the changes to the legislation relating to COVID-19 controls meant that it would be extremely challenging for employers to ascertain the source of any transmission.
- 5.3. Data handling in the Council has been in a transitional pathway since 2020. This is due to several factors including the interim COVID recording as requested by HSE, the subsequent inclusion of the AIRIS Roads and Environmental Services reports since

2021/22 and the significant change in working patterns of staff during lock down in 2020/21. Therefore, comparative data is presently not as informative as with previous years. The Safety and Resilience Service is working to strengthen this area and aims to establish a cohesive data handling and reporting system. This development will ensure that in future years comparisons on emerging trends and our ability to action safety interventions based on the data will be increased.



Figure 1: Total number of accidents Year on Year.

 2021/22 and 2022/23 Includes COVID reporting and Accidents reported in AIRIS (Roads and Environmental Services). As discussed in section 6.3.

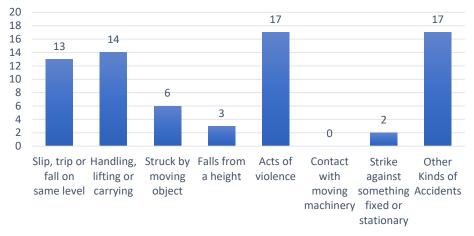


Figure 2: Breakdown of accident data for the period of April 2022 to March 2023

- 5.4. Under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) there is a requirement on employers, and other people in control of work premises, to report and keep records of:
  - · work-related accidents which cause death;
  - work-related accidents which cause certain serious injuries (reportable injuries);
  - diagnosed cases of certain industrial diseases; and
  - certain 'dangerous occurrences' (incidents with the potential to cause harm) as all employers are required to report certain accidents and incidents to the HSE.
- 5.5. The RIDDOR definition of an accident is "a separate, identifiable, unintended incident that causes physical injury. This specifically includes acts of non-consensual violence to people at work". As per the Council's Health and Safety Policy all accidents are recorded. However, there are threshold criteria for reporting certain accidents to the HSE which are: the accident is work-related; and it results in an injury of a type which is reportable (as listed under 'Types of reportable injuries').

5.6. The total number of RIDDOR reportable accidents for this reporting period was six. The breakdown categorisations of these RIDDOR reportable accident are presented in Figure 3. Figure 4 shows the number of RIDDOR reportable accidents per year over the last nine years. It is important to note that comparisons at this time should not be drawn with previous years due to the points previously discussed in section 5.3. There were no RIDDOR reportable work-related ill health or dangerous occurrences incidents recorded for the period.

20 18 16 14 12 10 8 6 4 1 1 1 1 2  $\cap$ Slip, trip or Handling, Other Kinds Struck by Falls from a Acts of Contact Strike fall on same lifting or moving height violence with against of carrying level object moving something Accidents machinery fixed or stationary

Figure 3: RIDDOR Reportable Accidents for 2022/23





- 2021/22\*Includes COVID Reporting and part of the reporting period in 2022/23 also includes COVID Reporting.
- 5.7. Since August 2019, all RIDDOR reportable accidents have been investigated by the Safety and Resilience Service and a findings report is produced which details the causal factors and recommendations, where appropriate, for prevention of a recurrence. These reports are shared with the relevant Service and an Executive Summary is shared with the Safety Committee.
- 5.8 The Accident Incidence Rate (AIR) figure is widely used to compare health and safety performance. The AIR is based on the number of RIDDOR reportable accidents per 1,000 employees. This does not include dangerous occurrences. The AIR is calculated using the number of reportable accidents, multiplied by 1,000 then divided by the number of employees. The figure of 2,705 has been used as the average total number of employees. It should be noted that this number also includes part time staff but does not include relief staff the number is not FTE equivalent. These figures are provided by the Human Resources section.

5.9. For this reporting period the AIR figure is 2.22. Table 5 shows the AIR each year for the last nine years. For 2021/22 the COVID events have been removed to allow for a more comparative picture to be presented.

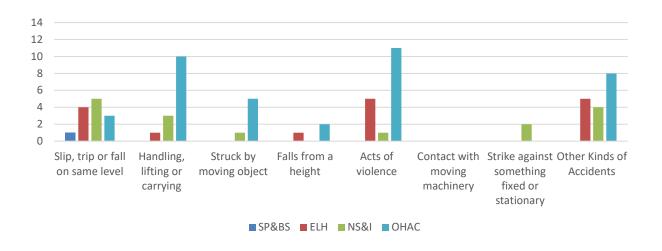
5 4.45 4.5 4 3.53 3.5 2.96 2.81 3 2.38 2 44 2.22 2.5 2.04 1.86 2 15 1 0.5 0 2014 to 2015 to 2016 to 2017 to 2018 to 2019 to 2020 to 2021 to 2022 to 2015 2016 2018 2019 2020 2021 2022 2023 2017

Figure 5: Accident Incident Rate year on year Comparison.

### 6. Statistical Evaluation

- 6.1. With the introduction of the realigned Council directorates, the Safety and Resilience Team undertook a three-year review of all adverse events and have presented comparable data for all directorates over this three-year period.
- 6.2. Figure 6 presents the HSE categorisation breakdown across all service areas for this reporting period. This breakdown highlights that OHAC stands out with significant higher accidents in five of the eight HSE categories. This discrepancy can be attributed to the nature of the work conducted in this specific area, which involves certain unique risk factors.
- 6.3. This diagrammatic presentation of accidents across the different directorates supports the need for targeted safety measures and interventions in the identified high risk-areas. This information is crucial for implementing tailored safety protocols and allocation of resources effectively to mitigate risk and enhance overall workplace safety, which will be discussed further in the directorate breakdowns.

Figure 6 : Adverse event factors between the Council Directorates for April 2022 to March 2023.



### Strategy, Performance and Business Solutions

- 6.4. During the 2022/23 period, there was one reported accident that was RIDDOR reportable. In the previous two years there were no reported accidents in any categorisation.
- 6.5. When considering the directorate variance with such a small, reported accident rate from previous years, any increase will have a notable result. Further investigation into the accident was able to identify that it was not indicative of a systemic issue of safety and solely a result of normal variances in adverse events.

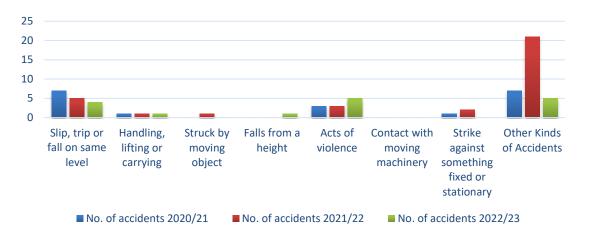
### **Enterprise and Sustainable Regeneration**

6.6. It is important to note that this directorate includes services such as Marine Services which do not currently report incidents into the Safety and Resilience service. Their accident figures are reported separately to the Council.

### **Education, Leisure and Housing (ELH)**

6.7. Overall, there has been a reduction in most categories across ELH reported figures. There has for the first time in four years been an incident involving fall from height which was RIDDOR reportable. Acts of violence have also seen an increase between this year and the previous two years, whilst the large drop in other kinds of accidents is due to the changes in reporting for COVID-19.

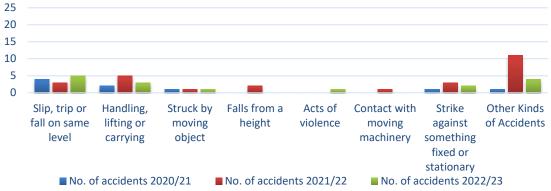
Figure 7: Adverse event factors between 2020 and 2023 for Education, Leisure and Housing.



### Neighbourhood Services and Infrastructure (NSI)

- 6.8. The is an observable increase in adverse events for the NSI directorate. This can specifically be attributed to the inclusion of AIRIS data and last year's full reporting on COVID work-based transmission.
- 6.9. The adverse events predominately centre on the HSE categories of Other Kinds of Accidents and slips, trips and falls for NSI. No causal linkages could be found between the adverse events. For the first time in three years an Act of Violence against a staff member by a member of the public was reported.
- 6.10. Two RIDDOR reportable adverse incidents occurred in this reporting period. Each incident was investigated, and relevant mitigation measures were identified and implemented. No causal linkages between the adverse events were identified.

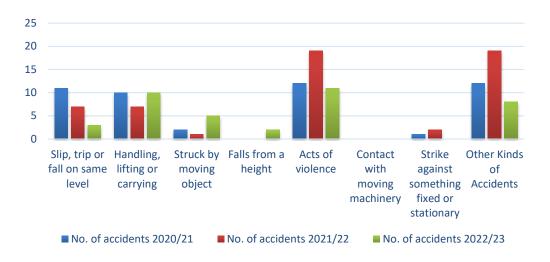
Figure 8: Adverse event factors between 2020 and 2023 Neighbourhood Services and Infrastructure.



### Orkney Health and Care (OHAC)

- 6.11. Working within any Health and Care setting involves certain unique risk factors such as dealing with challenging behaviour or the greater risk of violence. To address such risks, Orkney Health and Care employees implement multi approaches to these challenges such as personal risk assessments, training and ongoing staff support.
- 6.12. The adverse events for OHAC predominately centre on the HSE categories of acts of violence; handling, lifting or carrying and struck by moving object. It should also be noted that for this year two falls from height were reported whereas in previous years there were none.
- 6.13. There has been a significant drop in reported "other kinds of accidents" which can be attributed to the change in COVID reporting.
- 6.14. The service continues to proactively review risk assessments and provides further training to staff specifically around promoting the Positive Behaviour Programme. There has been a significant decrease in Acts of Violence, and this can be attributed to the positive impact the training has had and the reduction of pressures from the application of restriction on visitors due to COVID.
- 6.15. Two RIDDOR reportable accidents occurred in this reporting period one Falls from height and the second categorised under struck by moving object. Each incident was investigated, and relevant mitigation measures were identified and implemented. No causal linkages between the adverse events were identified.

Figure 9: Adverse event factors between 2020 and 2023 for Orkney Health and Care.



### 7. Near Misses

- 7.1. Near miss reporting is a crucial component of health and safety monitoring. Near misses are defined by the HSE as an event not causing harm but has the potential to cause injury or ill health and includes dangerous occurrences. The Safety and Resilience Service receives near miss reports that identify potential hazards and prevent future accidents.
- 7.2. The current steps of the near miss reporting include
  - Identification of Near Miss.
  - Report Submission.
  - Documentation and Analysis.
  - Root Case Analysis.
  - Corrective Actions.
  - Communication and Training.
- 7.3. The benefits of this approach to near miss reporting include
  - Prevention of Accidents.
  - Improved Safety Culture.
  - Data for Analysis.
  - Legal and Regulatory Compliance.
  - Cost Savings.
- 7.4. Whilst near miss reporting is a powerful tool for the enhancement of safe working culture, it is known that near misses are universally underreported.
- 7.5. All submitted near misses for this reporting period were investigated and control measures installed, where appropriate, to prevent future accidents.

# 8. Health and Safety Management System

- 8.1. In accordance with the Council's Performance Management System, Services monitor their Health and Safety performance, using the last six months' accident data, taken from the previous 12-monthly period in performance reports and in subsequent reports to service management teams and service committees.
- 8.2. Other measures implemented throughout the directorates include:
  - Health and Safety Committee.
  - Health and Safety Audits.
  - Engagement with Safety and Resilience Service.
  - Operational team meetings and toolbox briefs.
  - Works Representative Committee.
  - Quarterly Union engagement meetings, which include Health and Safety as standing item.
  - Quality Management System
  - Harbour Authority monthly meetings at which health and safety is a standard agenda item.
  - Operational team meetings and toolbox briefs.
  - Performance monitoring.
  - Service Manager meetings.
  - · Lead Professional meetings.
  - Team meetings.
  - Staff supervision processes.

- Positive Behaviours Training.
- Education Resource Meetings.
- Orkney Joint Negotiating Committee.
- Leisure Management meetings.
- Papdale Halls of Residence Management meetings.

### 9. Recommendations

- 9.1. The following recommendations aim to provide a holistic approach to enhancing health and safety in the Council.
  - Continuous Vigilance Encourage a culture where all employees take an active role in reporting hazards and near misses.
  - Training Ensure appropriate training is delivered with emphasis on high-risk tasks and newly introduced procedures.
  - Proactive Risk Assessments Conduct regular, thorough risk assessments across all directorate areas. Prioritise areas with historically higher incident rates and implement targeted interventions to reduce risks.
  - Adherence to Personal Protective Equipment (PPE) standards Emphasise the importance of wearing appropriate PPE for specific tasks and rigorously enforce compliance through regular checks and reminders.
  - Sustaining a Reporting Culture Sustain a robust reporting system, ensuring that all
    employees feel empowered to report actual and potential hazards.
  - Thorough Incident Investigations and Learning Conduct comprehensive investigations for all incidents. Use these findings to drive meaningful corrective actions and preventative measures.
  - Regular Review and Improvement Promote a culture of continuous improvement by routinely reviewing and updating safety policies and procedures based on lessons learned and industry best practices.

### 10. Conclusion

- 10.1. In conclusion, this evaluation report provides a comprehensive overview of the health and safety environment within the Council. Through the analysis of adverse event data, and current implemented safety protocols valuable insights into the Council's current performance has been presented.
- 10.2. The noted reduction in overall adverse events from 108 to 72 represents a collective commitment to raising a safer working environment. Targeted safety initiatives such as the Positive Behaviours training are having the affirmative benefit required to reduce adverse events.
- 10.3. However, it is imperative to acknowledge that there are areas warranting continued attention. The identification of a specific work area with higher adverse incidents underscores the need for tailored interventions to address unique risks associated within each directorate.
- 10.4. Moving forward, a proactive approach to health and safety remains paramount. This includes tailored training, regular safety audits and a vigilant focus on potential hazards. Additionally, ensuring a positive cross directorate communication culture will further strengthen health and safety throughout the Council.