Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

Quality and Standards Committee	Date:	

Agenda item	Title	Executive Director lead and presenter	Report author
BD/15/137	**APPENDIX C Supplementary Report to Annual Incident Report**	**Director of Nursing and Quality**	**Head of Patient Safety Systems**

This report is for:	
Decision	
Discussion	
To Note	X

History
Critical Incident Overview Group

The following impacts have been identified and assessed within this report	
Equality	
Quality	
Privacy	

Executive summary of key issues

This is a supplementary report written to address issues arising out of the Annual Incident Report that was received by the Committee in June.

This report addresses these strategic priorities:	
We will deliver the best care	X
We will support and develop our staff	X
We will continually improve what we do	X
We will use our resources wisely	X
We will be future focussed	X

1 Introduction

The purpose of this report is to provide additional commentary to issues raised by the Quality and Standards Committee following its consideration of the Annual Incident report. The Committee required further information to explore:

- Why the Trust reports more incidents of disruptive, aggressive behaviour than other mental health trusts;
- Why the Trust's level of near miss reporting is low compared to other mental health trusts;

and whether further Trust action is required in relation to either of these issues.

2 Disruptive Aggressive Behaviour

2.1 Background

The annual incident report shows that 'violence, aggression and harassment' remain the most commonly reported type of incident within the Trust, with 34% of incidents reported falling into this category. The report also shows that AWP's reporting of incident types to the National Reporting and Learning Service (NRLS) remains broadly in line with other trusts with the exception of 'disruptive, aggressive behaviour', which form 45% of incidents reported to the NRLS by AWP compared to a mean of 17% for mental health trusts overall.

2.2 Understanding the NRLS Reporting Process

The NRLS is concerned exclusively with patient safety incidents and not with all of the incidents that may be reported within an organisation.

Each Trust develops its own individual incident codes and then 'maps' these to the NRLS incident categories. There is significant variation in the incident coding systems devised by Trusts and it is possible that there is significant variation in how these codes are 'mapped' to the NRLS categories. Consequently any benchmarking of incident reporting to the NRLS by Trusts is not based on an exact like for like comparison.

It is only possible to 'map' an incident code to an NRLS incident category if the NRLS recognises that the wording relates to a patient safety incident. An incident code such as 'assault on staff' cannot be mapped (as the NRLS system does not recognise this as having an impact on a patient), whereas an incident code such as 'disruptive behaviour' can be mapped (as the NRLS system recognises this as a patient issue). Only those incidents that are 'mapped' to an NRLS incident category can be reported to the NRLS and its system rejects incidents reported using a code which is not 'mapped'. Essentially this means that the NRLS system will reject incidents if the Trust's incident coding does not indicate that there is an impact on a service user and if the incident details do not identify which service user is affected.

Incidents of 'disruptive, aggressive behaviour' are often complex, involving both 'patient' and 'non-patient' elements. For example, a service user may become agitated and aggressive, assault a member of staff and be restrained. Such an incident has an impact on the individual patient, other patients on the ward and the staff concerned, even when any harm that results is primarily to a member of staff and not the patient who instigated the assault. The AWP incident codes allow staff to record this incident as both:

a) An assault on staff and
b) An incident of 'disruptive behaviour'.

Reporting in this way recognises the impact on both staff and the service user and ensures that the incident is not rejected by the NRLS system as it recognises 'disruptive behaviour' as a patient safety issue, which is 'mapped' to the NRLS category 'disruptive, aggressive behaviour'.

The same incident would be rejected by the NRLS and would not appear in their data if the Trust did not have an incident code for 'disruptive behaviour'. If staff conceptualise an incident as primarily being an assault on a member of their team and are not enabled to report the parallel impact on the service user (through the availability of an appropriate code), then the incident cannot be reported to the NRLS. When the Trust's incident reporting system has been independently audited, the feedback from the auditors has suggested that the availability of a code for 'disruptive behaviour' may be enabling AWP to report this type of incident more robustly than other Trusts are able to do, if they do not have such a code in their internal incident classifications.

The proportion of 'disruptive, aggressive behaviour' incidents reported to the NRLS increased significantly in the period October 2008 to March 2009 and has remained at this new higher level ever since. This coincided with the introduction of targeted efforts to improve the reporting of the patient safety elements of those incidents which are also staff safety incidents. The introduction of the AWP code for 'disruptive behaviour', which is 'mapped' to the NRLS category of 'disruptive, aggressive behaviour', occurred at this time.

2.3 Proportion of 'Disruptive, Aggressive Behaviour' Incidents Reported to the NRLS from 2007 to Date.

The table below shows the increase in the proportion of such incidents reported from the period October 08 to March 09 onwards. The proportion of disruptive, aggressive behaviour incidents reported before this period was less than 20%. Since this period the mean proportion of such incidents reported has been 44.4% with a range of between 39% and 53%. The proportion of such incidents reported has, therefore, consistently been more than twice what it was before the 'disruptive behaviour' code was introduced.

Time period	Proportion of AWP incidents reported to the NRLS as 'disruptive, aggressive behaviour'
Oct 07 to March 08	17.8%
April 08 to Sept 08	16.5%
Oct 08 to March 09	40.0%
April 09 to Sept 09	47.4%
Oct 09 to March 10	53.0%
April 10 to Sept 10	52.9%
Oct 10 to March 11	39.3%
April 11 to Sept 11	40.3%
Oct 11 to March 12	42.7%
April 12 to Sept 12	42.1%
Oct 12 to March 13	46.7%
April 13 to Sept 13	45.0%
Oct 13 to March 14	44.1%
April 14 to Sept 14	38.7%

2.4 Other Sources of Information on Incidents of Violence and Aggression

Other agencies collect information on reports of violence and aggression, but they all use slightly different definitions and sample or obtain information in different ways. For example, we would not expect the information generated by self-reports of violence via the staff survey to directly replicate the incidents reported via SIRS reporting; the incident system; HSE data or the NRLS data.

2.5 AWP's Internal Incident Data on Incidents of Violence, Abuse and Harrassment

AWP's annual incident reports (based on all incidents reported, rather than on the incidents uploaded to the NRLS as per the table above) show that the proportion of incidents of violence, abuse and harassment has been stable or has been gradually decreasing over the same time period:

Incident type	07/08 %	08/09 %	09/10 %	10/11 %	11/12 %	12/13 %	13/14 %	14/15 %
Violence, Abuse, Harassment	40	44	46	41	42	39	38	34

2.5.1 Staff survey results

The AWP staff survey results show the proportion of staff reporting physical violence and harassment, bullying or abuse from patients, relatives or the public as follows:

Year	Proportion of staff reporting physical violence from patients, relatives or the public in last 12 months %	Proportion of staff reporting harassment, bullying or abuse from patients, relatives or the public in last 12 months %
2007	20	37
2008	21	36
2009	20	33
2010	17	25
2011	14	24
2012	24	41
2013	21	40
2014	19	34

The 2014 staff survey results confirm that:

- The level of physical violence experienced by AWP staff from patients, relatives and the public is broadly in line with other mental health trusts (mean = 18%).
- The level of verbal abuse is higher than other mental health trusts (mean = 29%).

2.6 SIRS Data

The following data on assaults on staff has been obtained from SIRS, the system which provides the information required by NHS Protect, or its predecessor reporting system. All data is checked prior to uploading to the SIRS system for accuracy.

Physical Assaults	07-08	08-09	09-10	10-11	11-12	12-13	13-14	14-15
Reported to SMS / NHS Protect	1055	636	507	768	609	606	905	960
Reported to Police	1	34	21	30	28	26	78	46

2.7 HSE Data

The following table shows the incidents reported as RIDDOR incidents by AWP to the HSE between 2007 and 2014. The RIDDOR process requires some incidents of violence to staff to be reported, but this data also includes a range of other incident types.

	07/08	08/09	09/10	10/11	11/12	12/13	13/14
Riddor Reportable Incidents	2	29	34	38	39	30	35

2.8 Analysis

The different sources of information on incidents of violence and aggression show no significant increase in the number of incidents reported over the period in question with the exception of the RIDDOR data from the HSE and the data on the number of incidents reported to the police. The RIDDOR data is not directly comparable (because not all the incidents reported are the result of violence and aggression). Furthermore both the RIDDOR process and the process for reporting incidents to the police have been very actively and successfully promoted over the period in question. Indeed our internal incident data shows a downward trend in the proportion of such incidents reported.

It is likely, therefore, that this increase in the proportion of disruptive, aggressive behaviour incidents uploaded to the NRLS is largely due to the approach we have taken to reporting these, rather than a higher level of this type of incident per se. This may demonstrate that we are not in line with other mental health trusts in terms of our reporting processes to the NRLS, but any change to our process now would be unwise, given that the NRLS is considering how to maximise reporting of restrictive interventions and our current process underpins the reporting of incidents involving these interventions to the NRLS. Restrictive interventions are currently reported as an intervention that is implemented in response to another incident, such as violence or aggression. Any change to our processes that could result in a decrease in the number of such primary incidents (i.e. the violence and aggression) being reported to the NRLS may unintentionally reduce our NRLS reporting of restrictive interventions at a time when there is an increasing focus on these locally and nationally and a drive to ensure full and open reporting.

CIOG has reviewed the above data and had the opportunity to discuss it in detail. It is satisfied with the narrative provided and recommends that the Trust continues to capture data, map data and upload data to the NRLS in the same way as present, keeping a watching brief on benchmark information.

3 Near Misses

3.1 Near Miss Definition

There is little consensus on how 'near misses' are defined.

The Department of Health Definition (2000)[i] for a Health care near miss is:

"A situation in which an event or omission, or a sequence of events or omissions, arising during clinical care fails to develop further, whether or not as the result of compensating action, thus preventing injury to a patient".

This forms the basis for the National Reporting and Learning Service definition, which has been adopted by AWP and is contained in the Trust's Incident Policy:

A near miss is "an unplanned or unexpected event, clinical or non clinical, which has the potential to result in injury, damage, etc., but which does not realise its full potential for harm. There are two types of near miss:

***Prevented incidents** – which are those incidents where something goes wrong, but it does not cause any harm because an individual or system acts to prevent this:*

e.g. a service user is given a prescription for the wrong dose of a medication, but the error is noticed and corrected by the pharmacist.

***No harm incidents** – which are those incidents where something goes wrong, but by chance it does not cause any harm:*

e.g. a pharmacist supplies a service user with the wrong medication, but the service user suffers no ill-effects from this."

This is, therefore, the definition that the Trust aspires to operationalize.

3.2 Incident or Near Miss?

This definition is not, however, an intuitive definition which makes it difficult to operationalize consistently. If, for example, the pharmacist supplies the service user with the wrong medication, this is an actual medication error. As such, it is reportable as an incident. If no harm to the service user resulted, the NRLS definition would deem this a near miss incident. Most clinical staff would, however, not define this instinctively as a near miss incident because the error actually occurred and it was pure luck that no actual harm occurred. The incident system instructs staff to categorise an incident in one of the following three ways (no more than one category can be selected):

- A near miss
- A patient incident
- A non-patient incident

Most staff would consider the dispensing error described above to be a patient incident (and not a near miss) because an actual error occurred and the error impacted on (or reached) the patient. Indeed most staff would select the 'patient incident' category for any incident that had an actual or potential impact on a patient, in preference to using the 'near miss' category, given that it is not possible for them to report an incident as both a 'near miss' and a 'patient incident'. Their first question in conceptualising the incident category is 'did this or could this have affected a patient?' If so, they tick the 'patient incident' box. They cannot then tick the 'near miss' box as well and, if they try to do so, then the 'patient incident' box is un-ticked automatically. This feels uncomfortable if there was a real or potential impact on a patient and they then revert to ticking

the 'patient incident' box instead. Having done this they would then grade the incident as causing 'no harm' if no actual harm resulted. It is clear that staff are reporting this type of incident regularly, even if they are not categorising it as a 'near miss', because of our higher than average reporting of 'no harm' incidents demonstrated by the NRLS mental health trust comparison reports. This very high level of reporting for 'no harm' incidents would not be possible if staff were not actively reporting 'near miss' incidents.

The problem with this type of definition has been articulated clearly by the Institute of Safe Medication Practices in the United States[ii], which articulate the problem with a similar definition of near misses commonly used in the USA as follows:

"1) It does not clarify whether the harmless error that resulted in the "event" or "situation" reached the patient; and

2) It fails to foster ongoing evaluation of system controls that can help capture errors or prevent patient harm once an error has reached the patient. Instead, it implies that patient harm was avoided purely by chance, giving little credence to capture and recovery opportunities that may be working well or in need of improvement."

3.3 Review of AWP Processes

The Patient Safety Systems Team have undertaken an audit of near miss reporting using a sample of incidents reported as near misses and a sample of incidents reported as low grade (i.e. no harm) patient incidents. The intention was to explore whether these incidents had been correctly reported by staff, both in terms of distinguishing between patient incidents and no harm incidents and in terms of the appropriateness of the incident grading. The process of undertaking the audit, however, showed how difficult it is to make a distinction between 'no harm patient incidents' and 'near misses' in many cases. Different reviewers came to different conclusions in a number of cases, despite directly referencing the AWP definition when reviewing each incident

3.4 Analysis

The feedback presented to CIOG was as follows:

- It is difficult for staff to distinguish 'no harm patient incidents' and 'near misses'
- Directly referencing the definition enabled reviewers to come to a common agreed decision in some, but not all cases
- Further attempts to ensure that staff can operationalise a commonly understood and shared definition of near misses are unlikely to be successful in this context
- The Trust is reporting significantly higher levels of 'no harm patient incidents' than its peers (90% compared to 61%)
- Staff are, therefore, clearly reporting high levels of incidents where there was no actual harm to a patient

As high reporting levels for no harm incidents are a marker of a strong reporting culture, CIOG concluded that no further action was needed.

4 Conclusion

The Board is asked to **note** CIOG's deliberations and conclusions.

[i] Department of Health: An Organisation with a Memory (2000)
[ii] https://www.ismp.org/newsletters/acutecare/articles/20090924.asp