Appendix 1

The following slides show Statistical Process Charts of incidents that have been reported by our staff during August & September 2020

Any detail that requires further clarity please contact the Corporate Patient Safety Team

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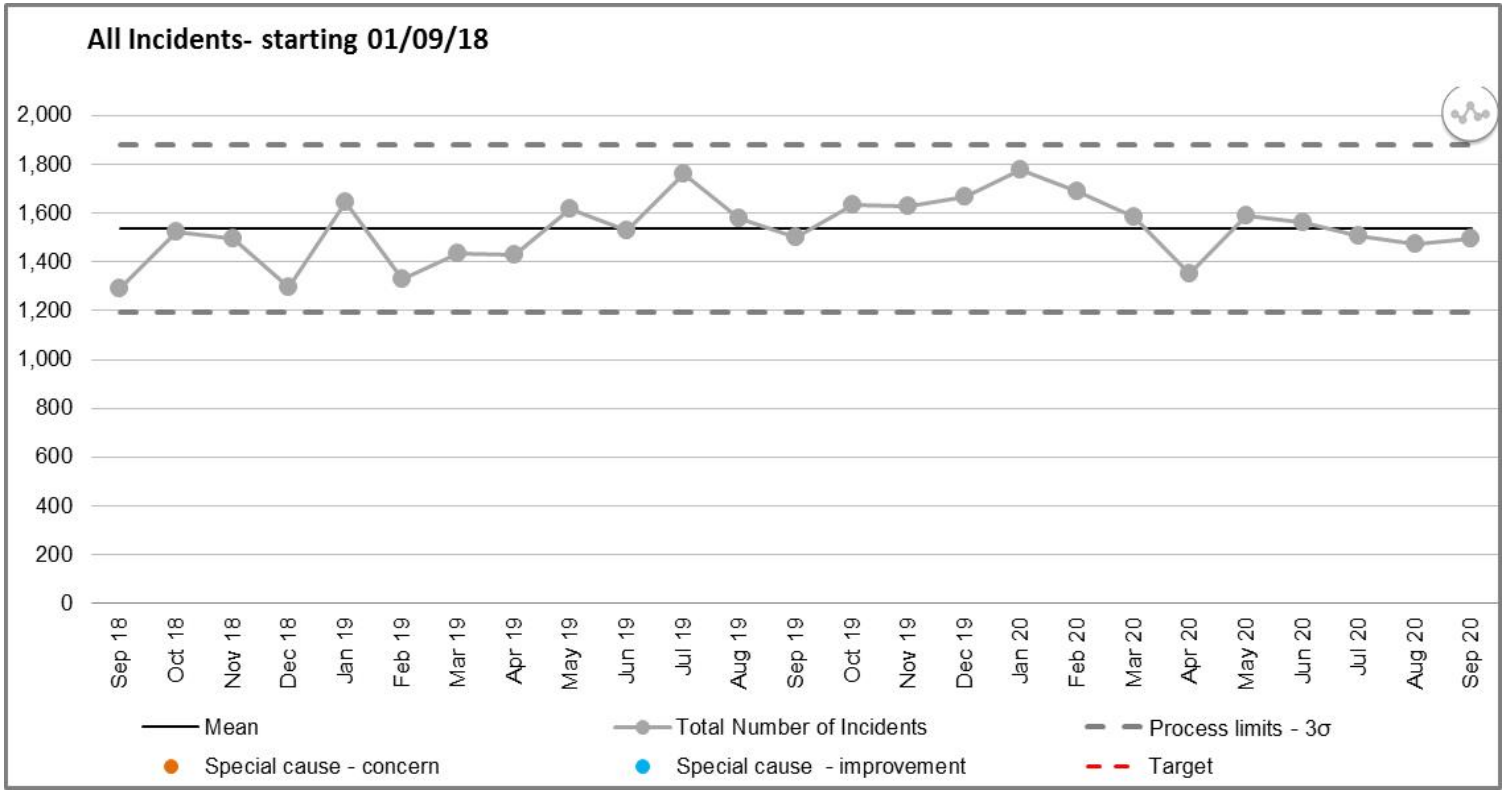
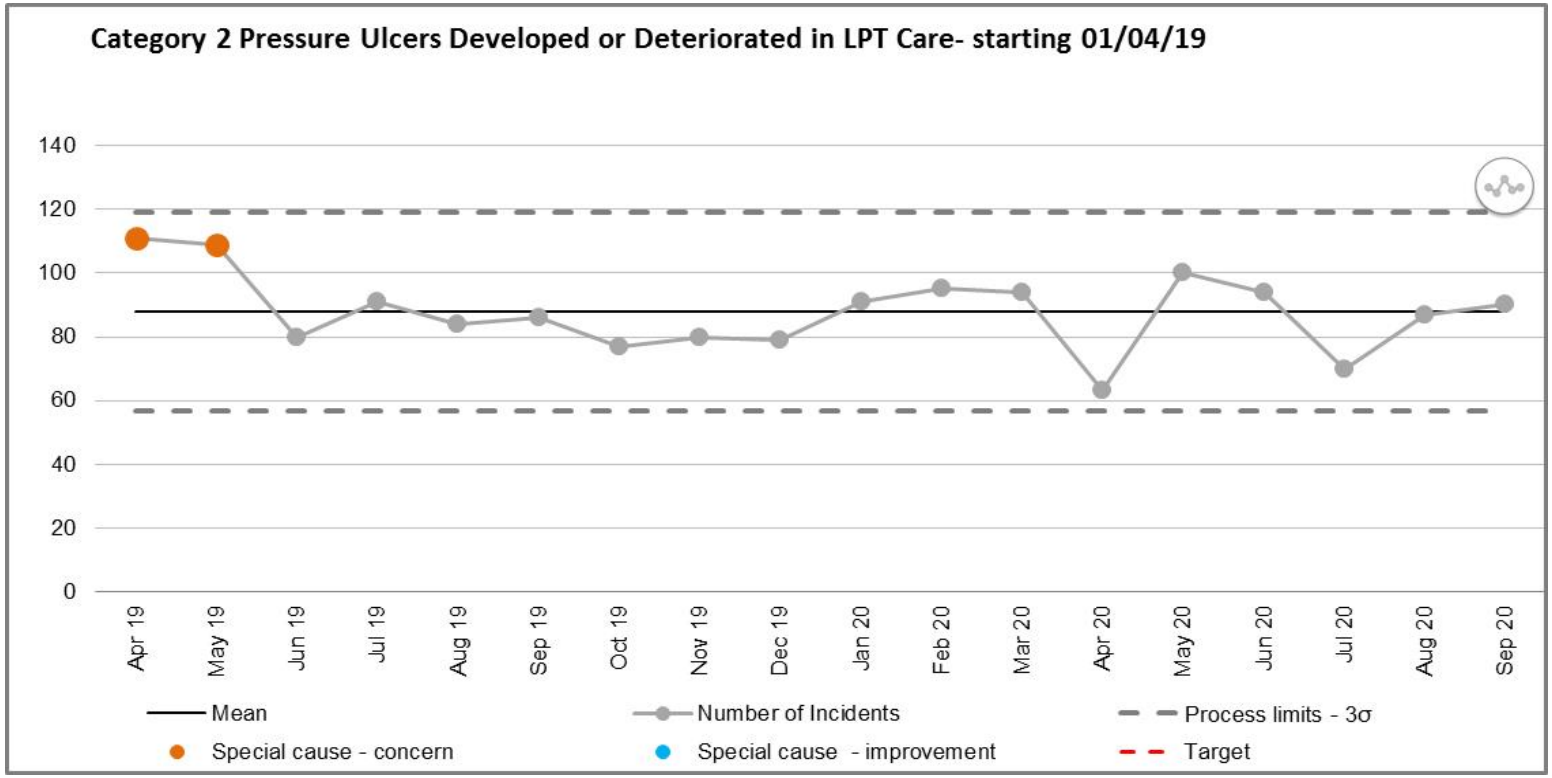
1. All incidents



2. Category 2 Pressure Ulcers developed or deteriorated in LPT Care



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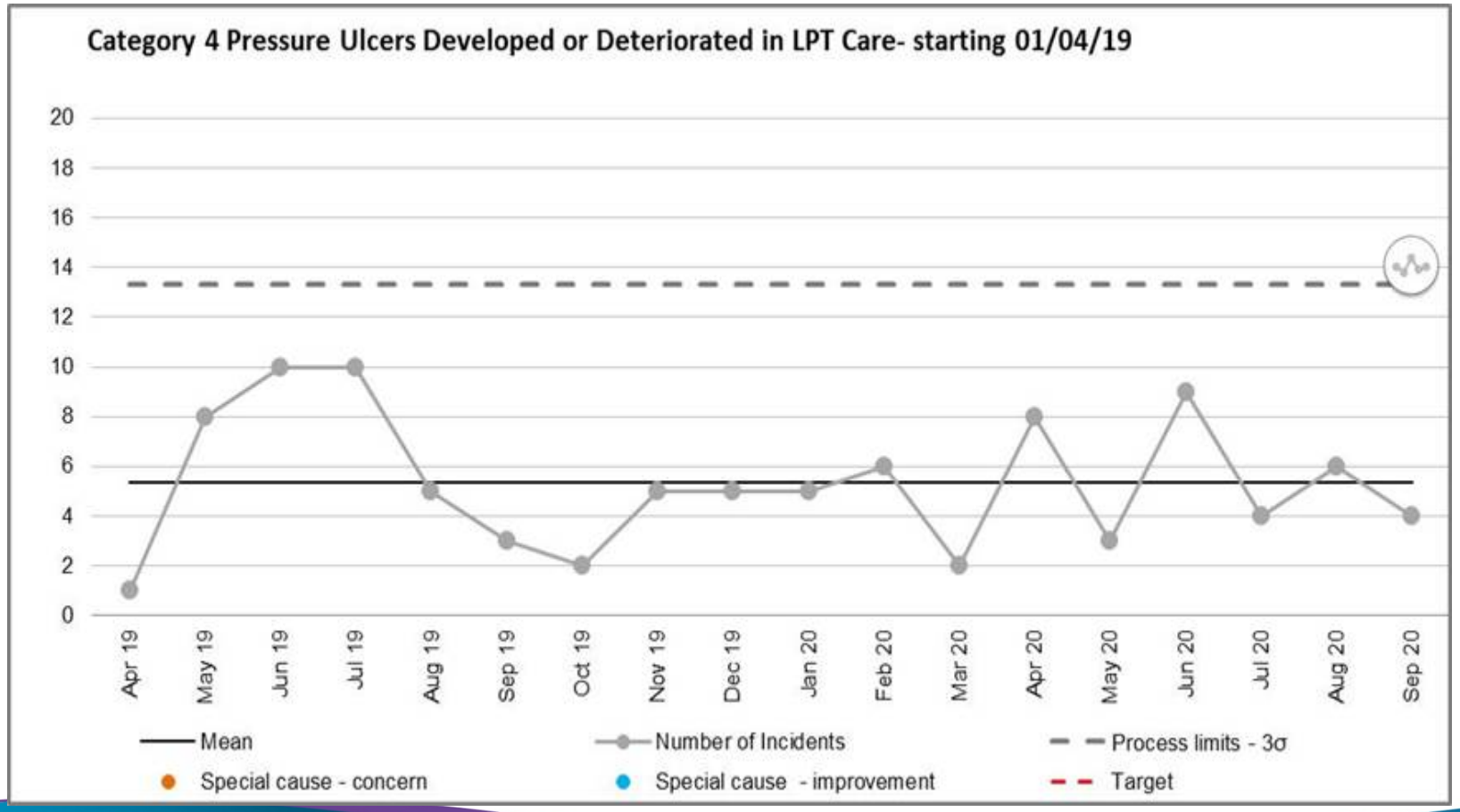
3. Category 4 Pressure Ulcers Developed or deteriorated in LPT Care



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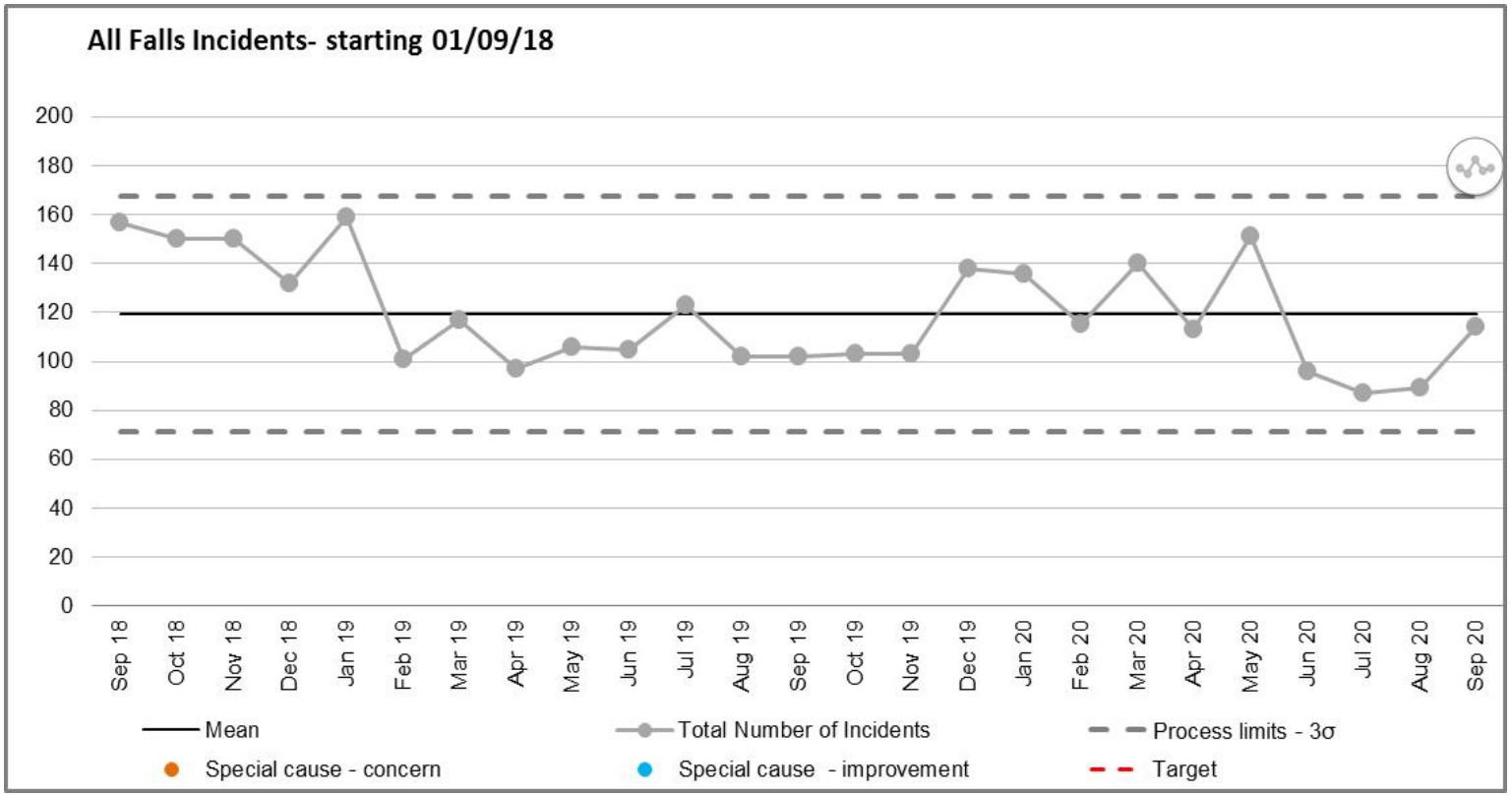
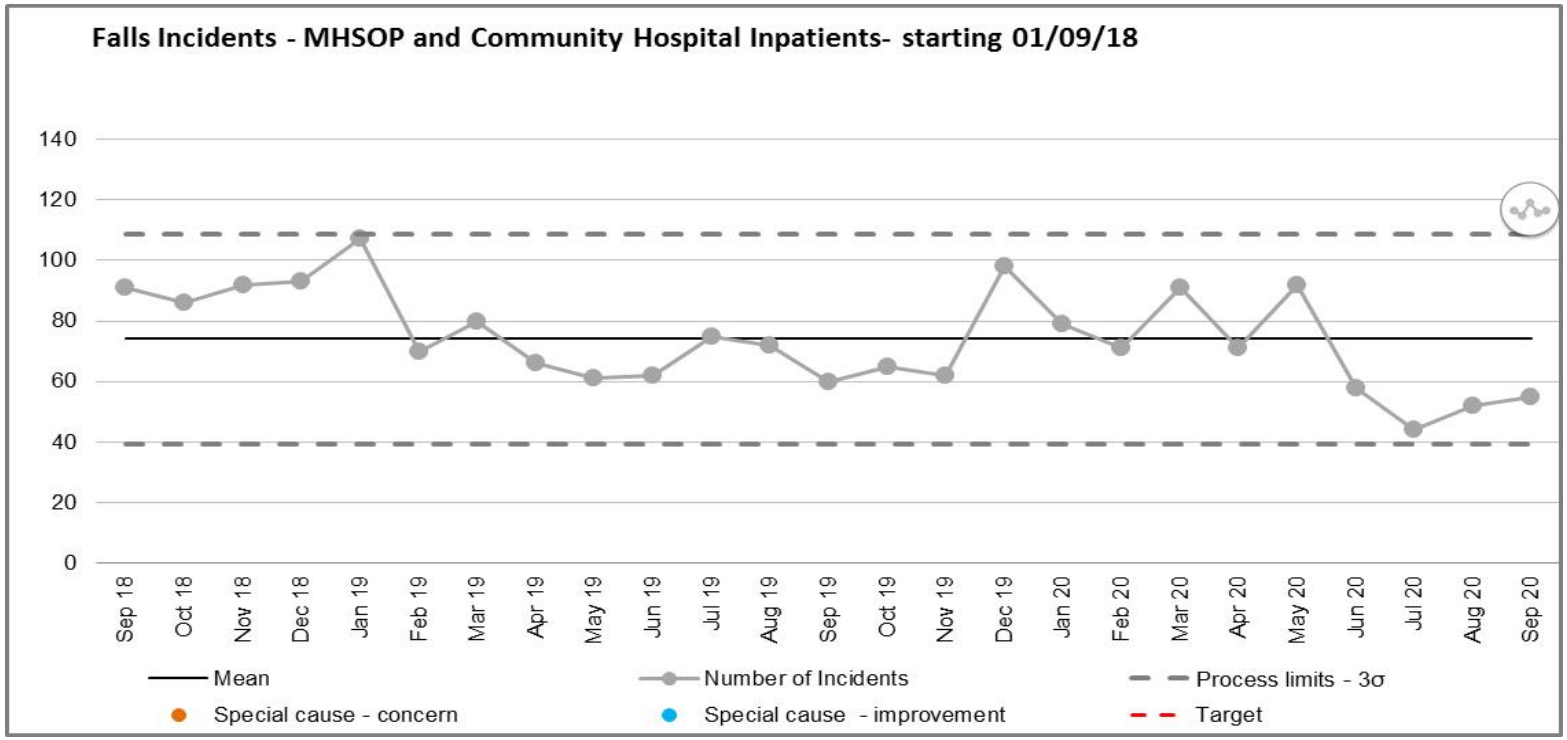
4. All falls incidents reported



5. Falls incidents reported – MHSOP and Community Inpatients



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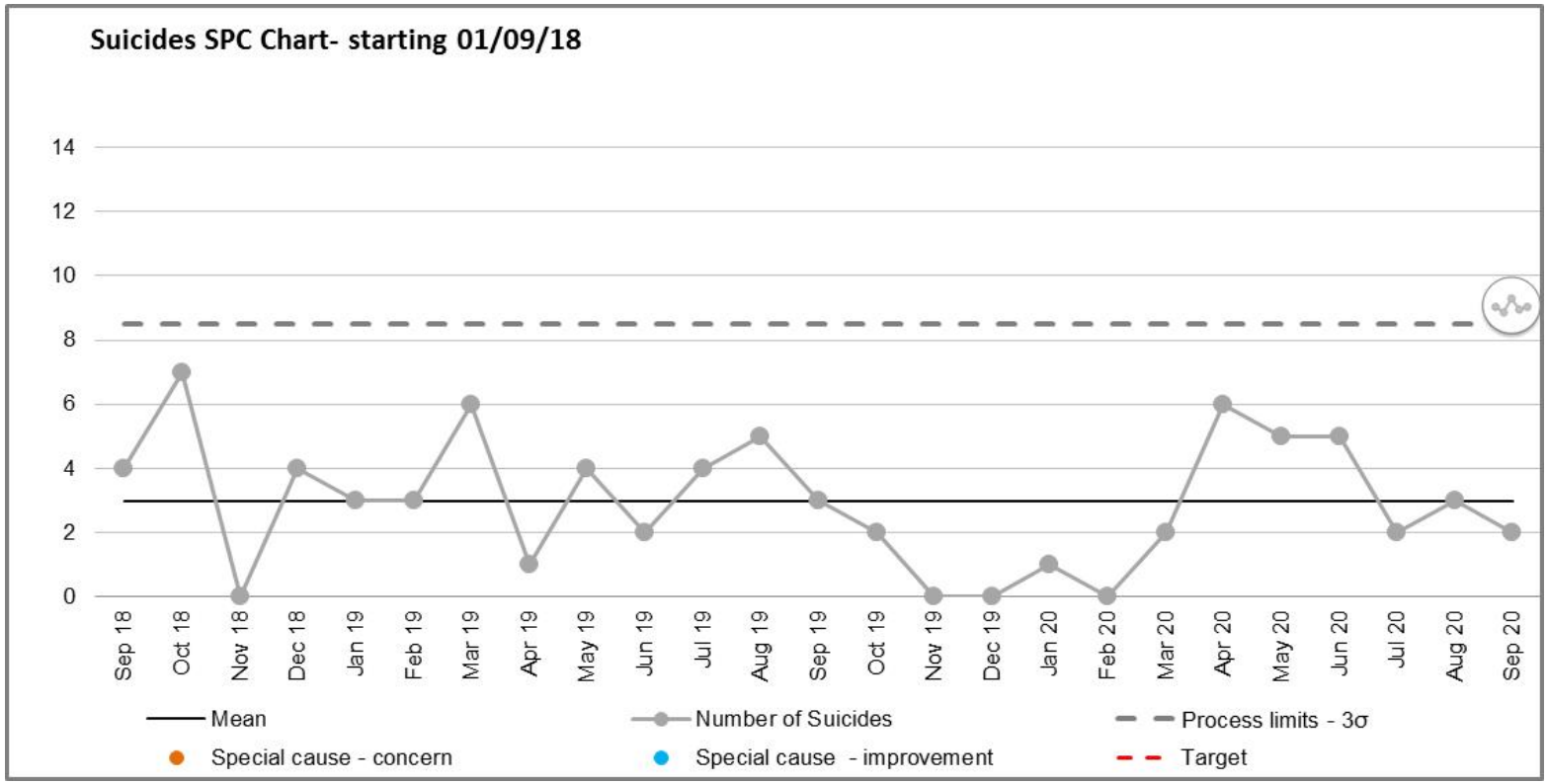
6. All reported Suicides



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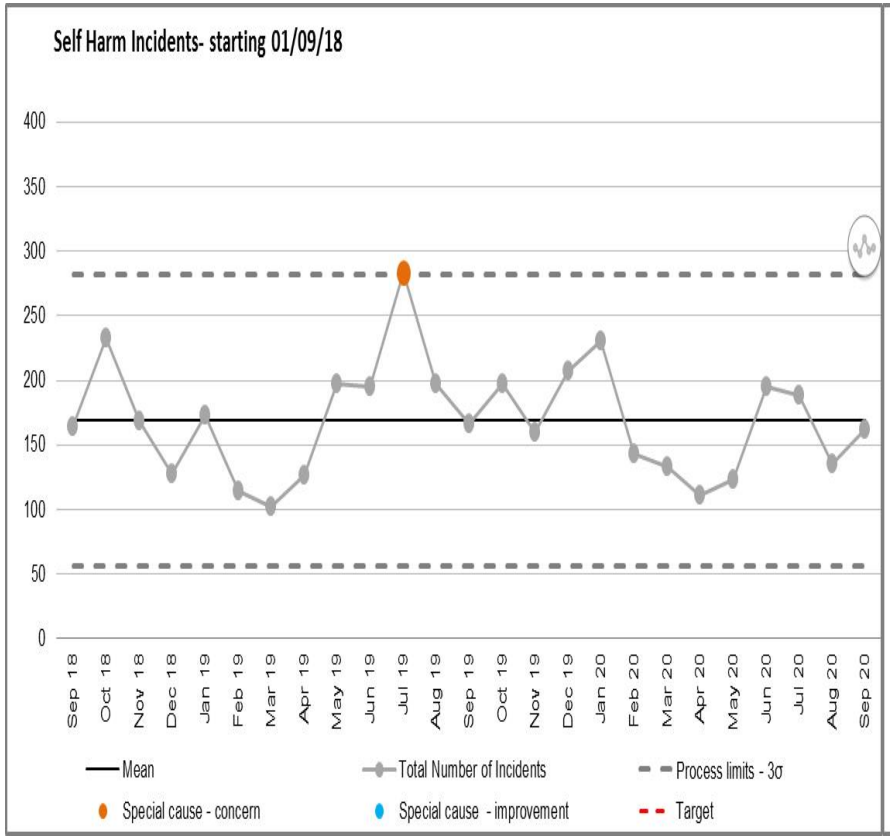
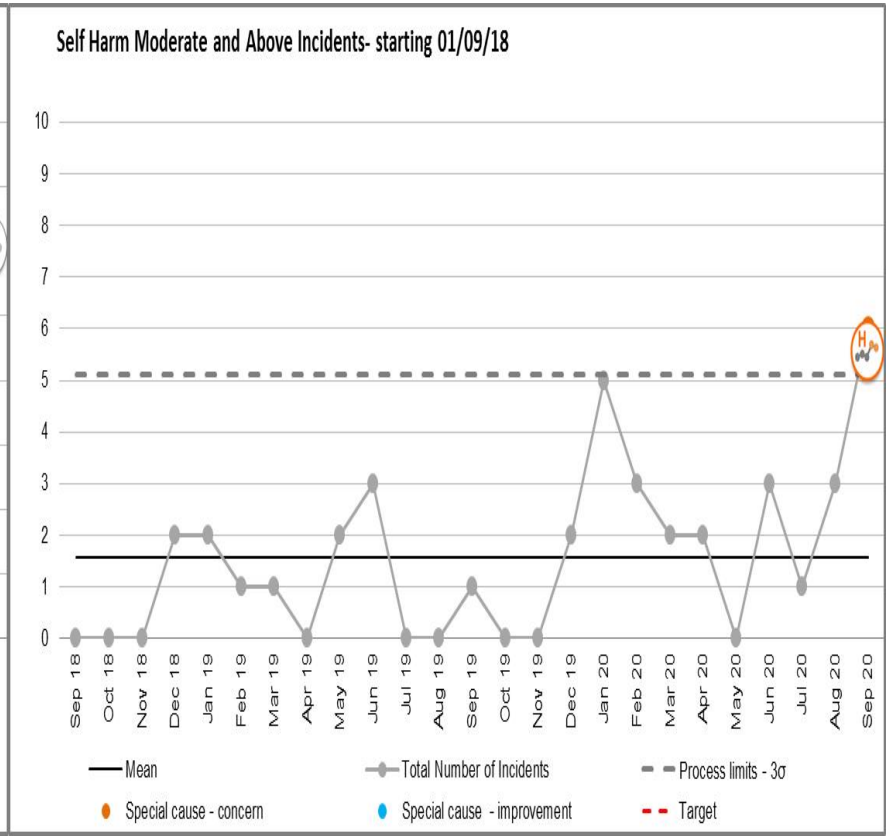
7. Self Harm reported Incidents





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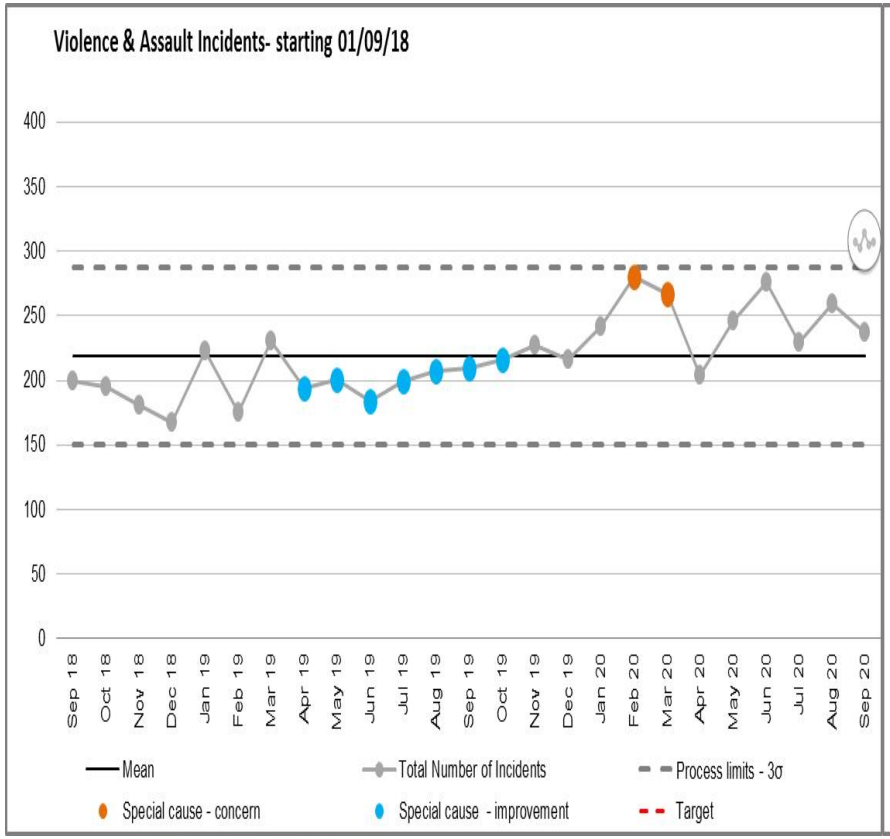
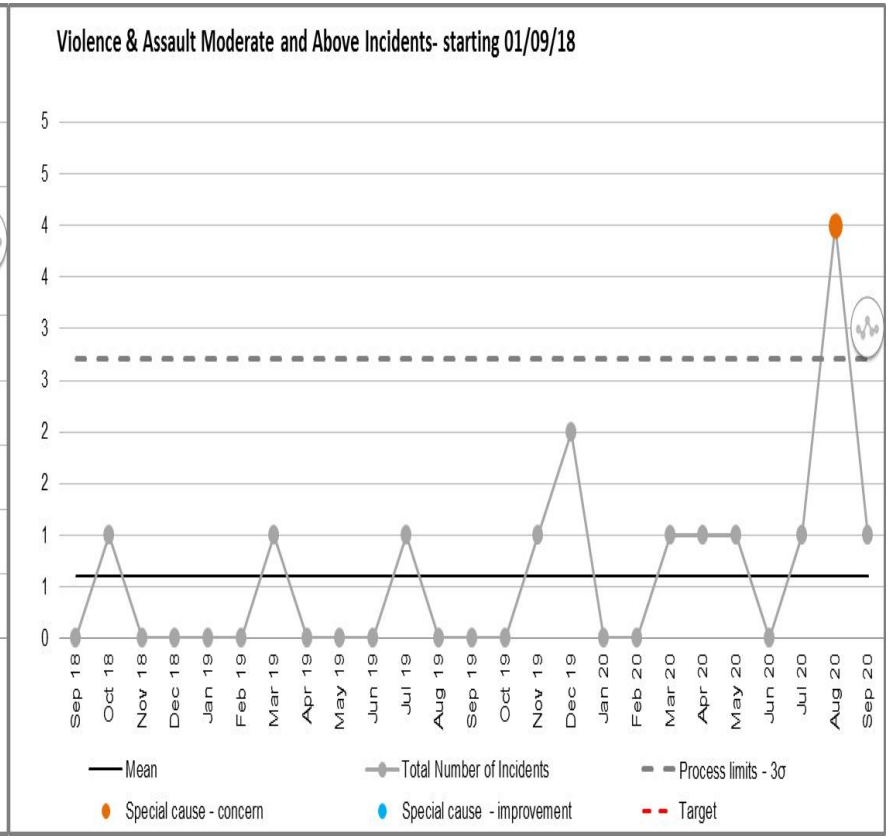
8. All Violence & Assaults reported Incidents





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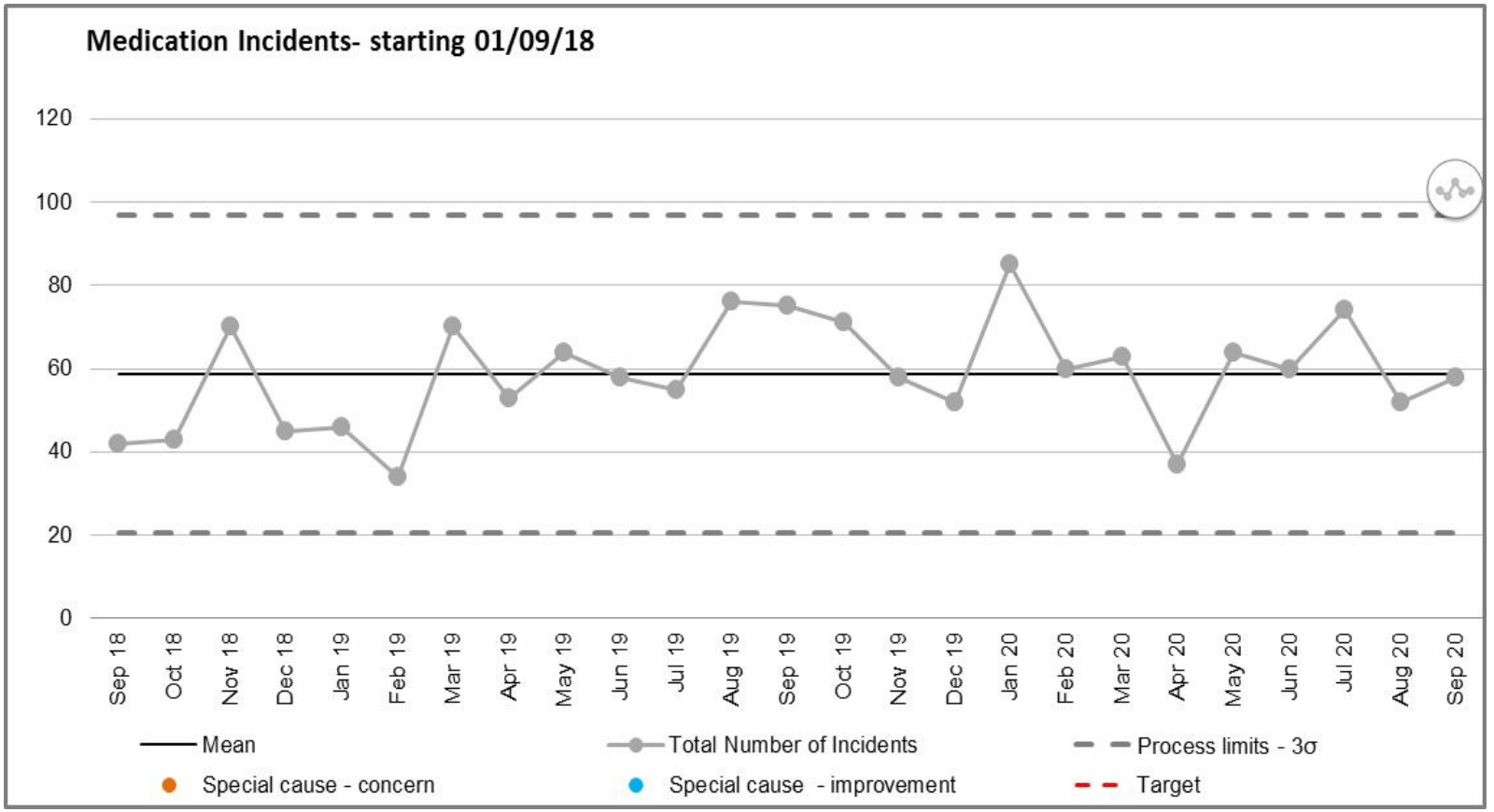
9. All Medication Incidents reported



10. Directorate Specialities describing Top 5 Incidents

Table 1: Mental Health: Inpatients

August 2020 Themes	Number of Incidents	Sept 2020 Themes	Number of Incidents
Violence/ Assault	148	Violence/ Assault	131
Self-Harm	32	Patient Slips, Trips & Falls	46
Patient Slips, Trips & Falls	23	Self Harm	21
Security	17	Medication	20
Clinical Condition & Missing Patient	16 16	security	19

Table 2: Mental Health Community

August 2020 Themes	Number of Incidents	Sept 2020 Themes	Number of Incidents
Self-Harm	39	Self-Harm	34
Violence/ Assault	24	Violence/ Assault	21
Patient Death	7	Patient Death	10
Communication	6	Safeguarding	6
Clinical Condition	5	Security	6

Directorate Specialities describing Top 5 Incidents

Table 3: Learning Disability – In-Patient

Aug 2020 Themes	Number of Incidents	Sept 2020 Themes	Number of Incidents
Violence /Assault	52	Violence / Assault	67
Staffing	6	Self-Harm	15
Patient, Slips, Trips, Falls	4	Hate/PREVENT	6
Access, Admission, Transfer, Discharge	3	Allegations against staff	4
Unsafe Environment	3	Patient, Slips, Trips, Falls & Staffing	4 4

Table 4: Learning Disability - Community

Aug 2020 Themes	Number of incidents	Sept 2020 Themes	Number of Incidents
Violence/ Assault	6	Self-harm	12
Safeguarding	4	Safeguarding	6
Confidentiality	3	Violence/ Assault	3
Self-harm	3	Infection Control	2
Allegations against staff	2	Security	2

Directorate Specialities describing Top 5 Incidents

Table 5: FYPC CAMHS

Aug 2020 Themes	Number of Incidents	Sept 2020 Themes	Number of Incidents
Self-Harm	48	Self-Harm	72
Violence/ Assault	16	Violence/ Assault	8
Missing Patient	6	Confidentiality	3
Staffing	4	Access, Admission, Transfer, Discharge	2
Unsafe Environment	3	Case notes & records	2

Table 6: FYPC Service (non CAMHS/LD)

Aug 2020 Themes	Number of Incidents	Sept 2020 Themes	Number of Incidents
Communication	12	Case Notes & Records	14
Self-Harm	8	Self-Harm	6
Safeguarding	7	Communication	5
Confidentiality	6	IT Equipment/ Systems	5
Medication	6		4

Directorate Specialities describing Top 5 Incidents

Table 7: CHS In-Patient

Aug 2020 Themes	Number of Incidents	Sept 2020	Number of Incidents
Tissue Viability	27	Tissue Viability	25
Patient, Falls, Slips & Trips	25	Patient, Falls, Slips & Trips	23
Case Note & Records	21	Staffing	13
Patient Death	11	Medication	12
Medication	9	Communication Death	8 8

Table 8: CHS Community

Aug 2020 Themes	Number of Incidents	Sept 2020	Number of Incidents
Tissue Viability	390	Tissue Viability	356
Medication	14	Medication	14
Communication	11	Communication	11
Case Note & Records	10	Access, Admission, Appts. Transfer, Discharge	8
Patient, Falls, Slips & Trips Safeguarding	7 7	Safeguarding	8

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11a. StEIS Reported Serious Incidents (SI's)

Appendix 3 - STEIS Notifications and Internal Root Cause Analysis Investigations

		StEIS Notificatio	SI INVESTIGATIONS							Internal Root Cause Analysis Investigations				
		Downgrade & removal requests	SIs declared AMH/LD	SIs declared FYPC	SIs declared CHS	Signed off within month	Within original deadline	SI Downgrade requests	Confirmed DoC breaches	AMH/LD	FYPC	CHS	Signed off within month	Withi origina deadli
2019/20 Q1	April	0	3	0	0	3	*	0	0	9	4	1	*	*
	May	0	7	2	4	3		0	0	2	4	0		
	June	0	3	1	10	3		0	0	4	2	0		
2019/20 Q2	July	0	6	0	11	2		0	0					
	August	0	2	0	4	7		0	0					
	September	0	3	1	22			2	0					
							31%							
2019/20 Q3	October	0	2	2	4	5		0	0	0	0	0		
	November	1	10	1	4	9		1	0	0	0	0		
	December	1	4	4	1	9		1	0	1	0	1		
							32%							
2019/20 Q4	January	0	3	2	10	8		0	0	2	2	1		
	February	0	5	2	10	2		0	0	0	1	1		
	March	6	3	0	5	27		0	0	2	0	2		
YTD		8	51	15	85	78		4	0	20	13	6	0	#DIV/
2020/21 Q1	April	7	6	3	0	0		0	0	6	0	2		
	May	0	8	3	9	7		0	0	3	1	2		
	June	1	5	4	4	2		0	0	9	0	2		
2020/21 Q2	July	0	5	2	16	9		1	0	9	3	0		
	August	0	4	0	3	13		0	2	2	2	0		
	September	1	8	2	2	17		1	14	0	0	0		
2020/21 Q3	October													
	November													
	December													
2020/21 Q4	January													
	February													
	March													
YTD		9	36	12	34	48	0.0%	0	16	29	6		0	#DIV/

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11b. Directorate SI Action Plan Compliance Status 2019/20 to date

	Total SI (Other) Action Plans due to be Implemented	Total SI (Other) Action Plans Implemented	Total SI (Pressure Ulcer) Action plans due to be Implemented	Total SI (Pressure Ulcer) Action plans Implemented	% Total SI Action Plans Implemented by Month	% Total SI Action Plans Implemented YTD	% Quarterly
Apr-20	7	1	0	0	14.29%	14.29%	
May-20	7	1	0	0	14.29%	14.29%	20.83%
Jun-20	10	3	0	0	30.00%	20.83%	
Jul-20	6	3	0	0	50.00%	26.67%	
Aug-20	2	1	0	0	50.00%	28.13%	39.47%
Sep-20	30	11	0	0	36.67%	32.26%	
Oct-20	0	0	0	0	-	32.26%	
Nov-20	0	0	0	0	-	32.26%	#DIV/0!
Dec-20	0	0	0	0	-	32.26%	
Jan-21	0	0	0	0	-	32.26%	
Feb-21	0	0	0	0	-	32.26%	#DIV/0!
Mar-21	0	0	0	0	-	32.26%	
Total YTD:	62	20	0	0	32.26%	32.26%	

12. Lessons Learned/Learning

Sepsis

- During September the CPST along with clinical colleagues supported the development of the information focus on a 360° Audit into how well we deliver timely and appropriate care to our patients who maybe showing signs of sepsis.

Deteriorating patients

- Early Spring we introduced a specific incident review tool for this group of patients. With support/clinical discussion & guidance with CPST Aug/Sept has seen proactive engagement from MHSOP Leaders; they regularly recognise the need to review a patients care without asking. In addition, they have high level information for incident reporting for these patients with many using the SBAR approach.
- National Early Warning Score (NEWS observation tool)

The approach to the NEWS in informing and timely escalations of a patients condition has featured in incidents recognising areas for improvement across all specialities

This work is being led through the deteriorating patient and resus group as well as the Sepsis standard.

12. continued – what we know……

Violence & aggression

- The level of Violence & Aggression across Mental Health, CAMHS & Learning Disability Inpatients continues to be of concern with a number of staff being injured leading to RIDDOR reporting and the safeguarding team reviewing patient on patient violence
- Concerns continue for support for bank/agency staff in the clinical areas for equipment and ensuring access to training