Appendix 1

The following slides show Statistical Process Charts of incidents that have been reported by our staff during August and September 2021

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

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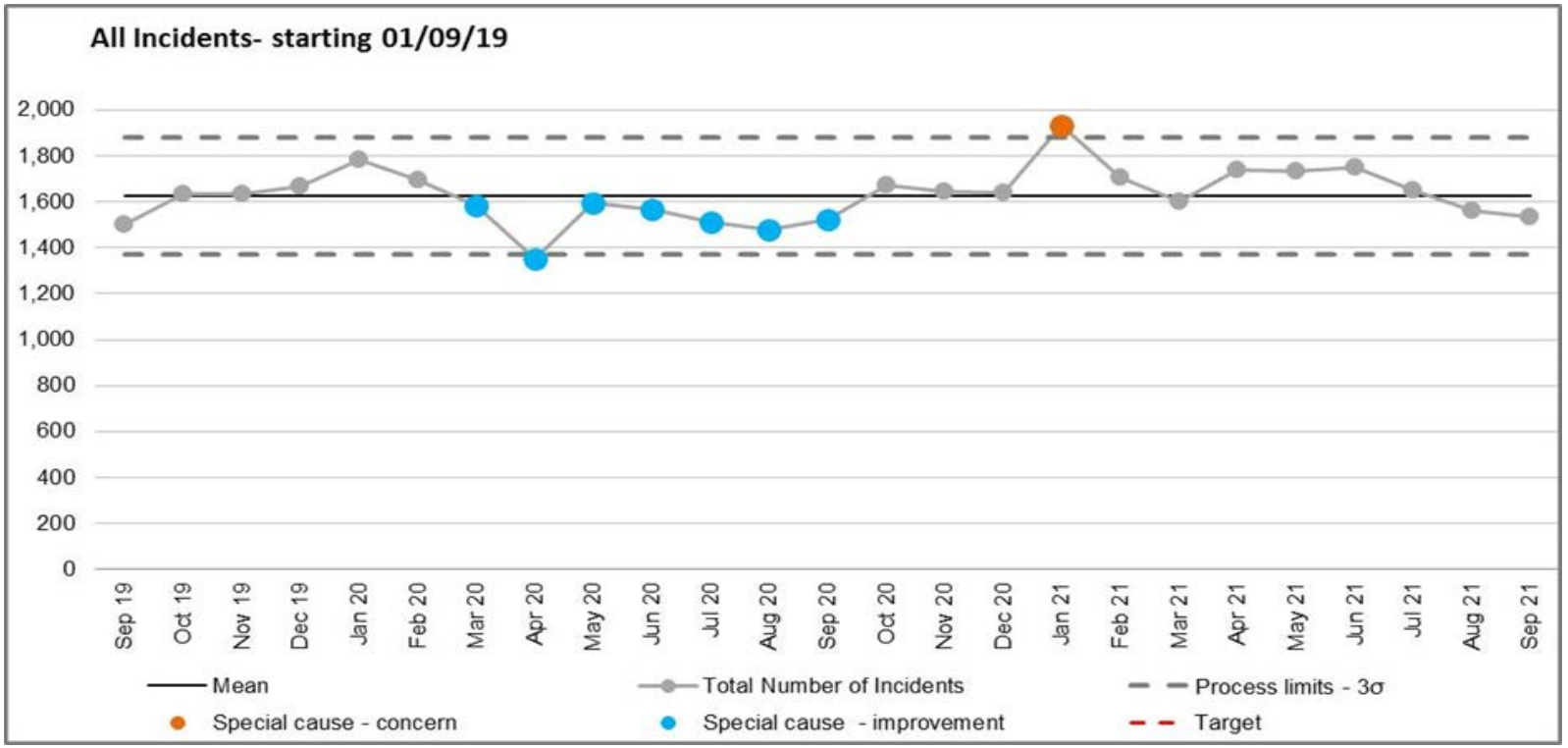
1. All incidents



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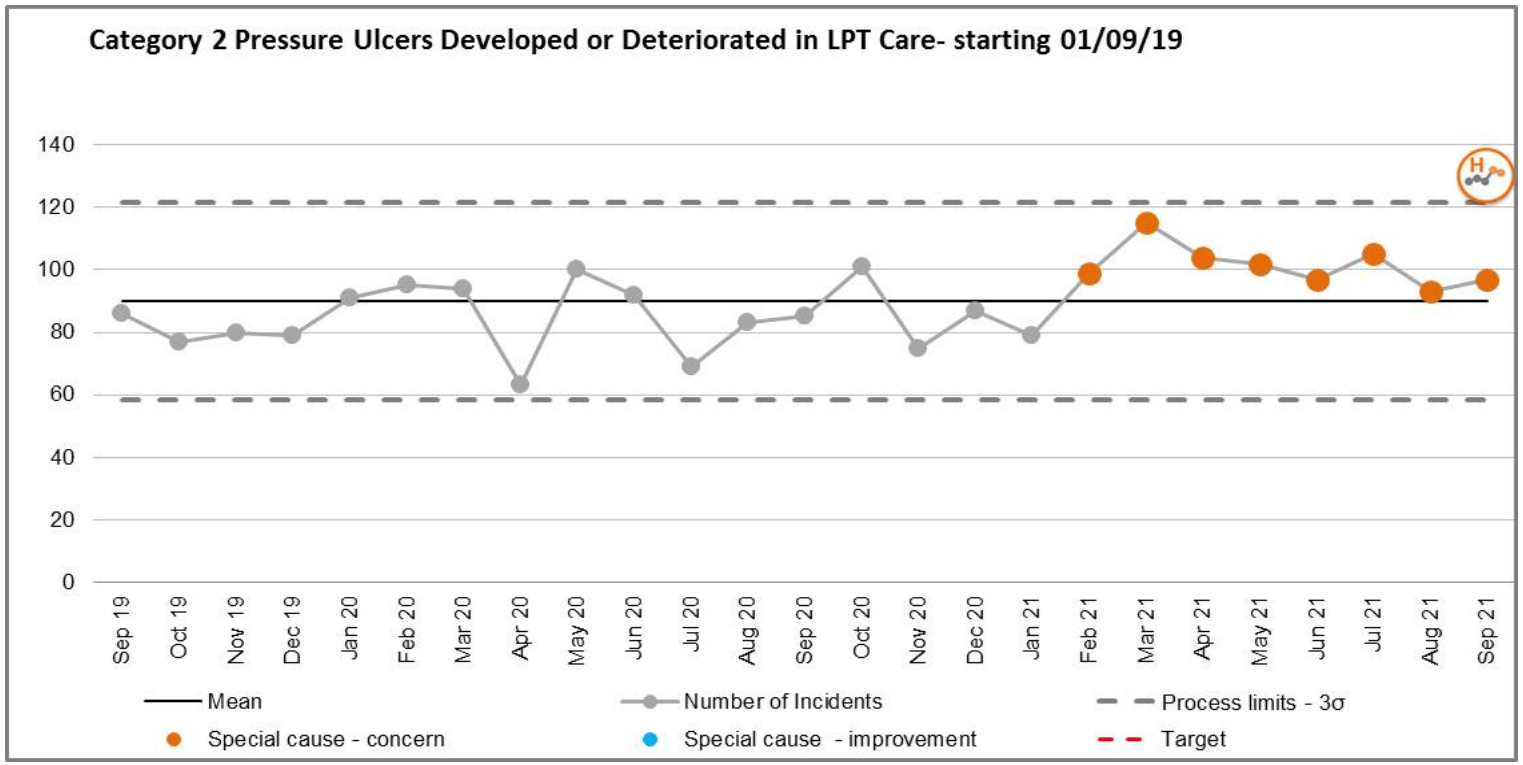
2. Category 2 Pressure Ulcers developed or deteriorated in LPT Care



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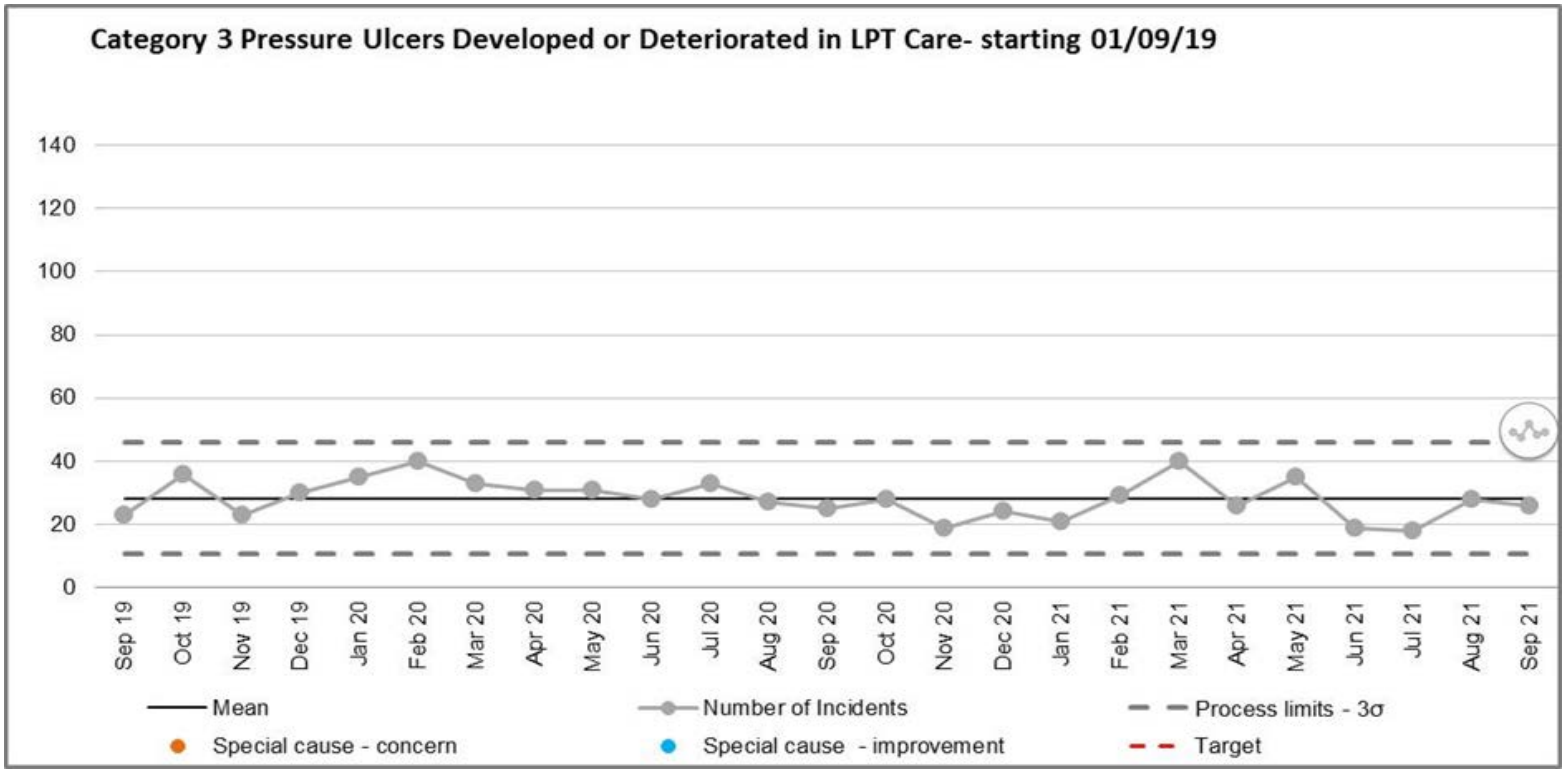
3. Category 3 Pressure Ulcers developed or deteriorated in LPT Care



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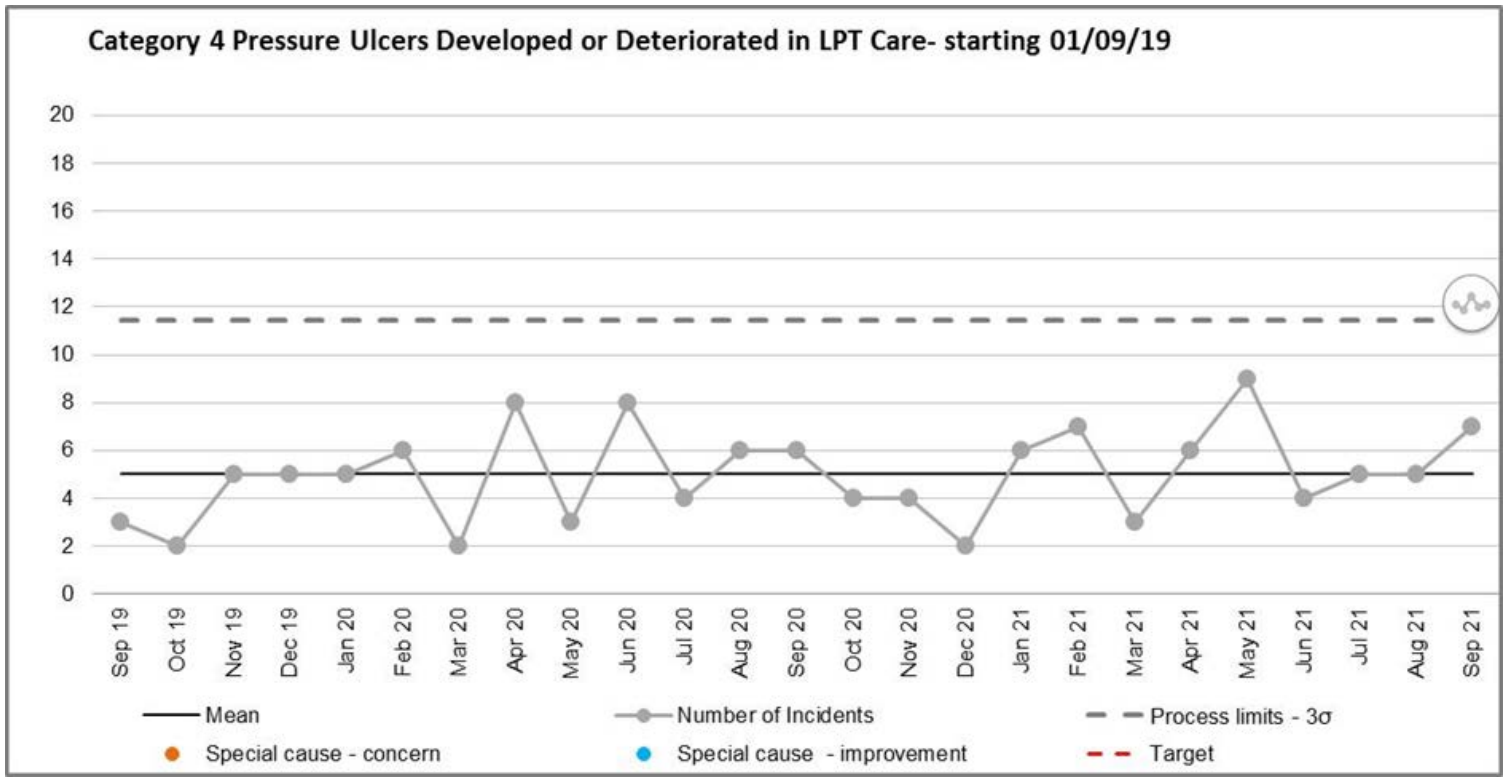
4. Category 4 Pressure Ulcers Developed or deteriorated in LPT Care



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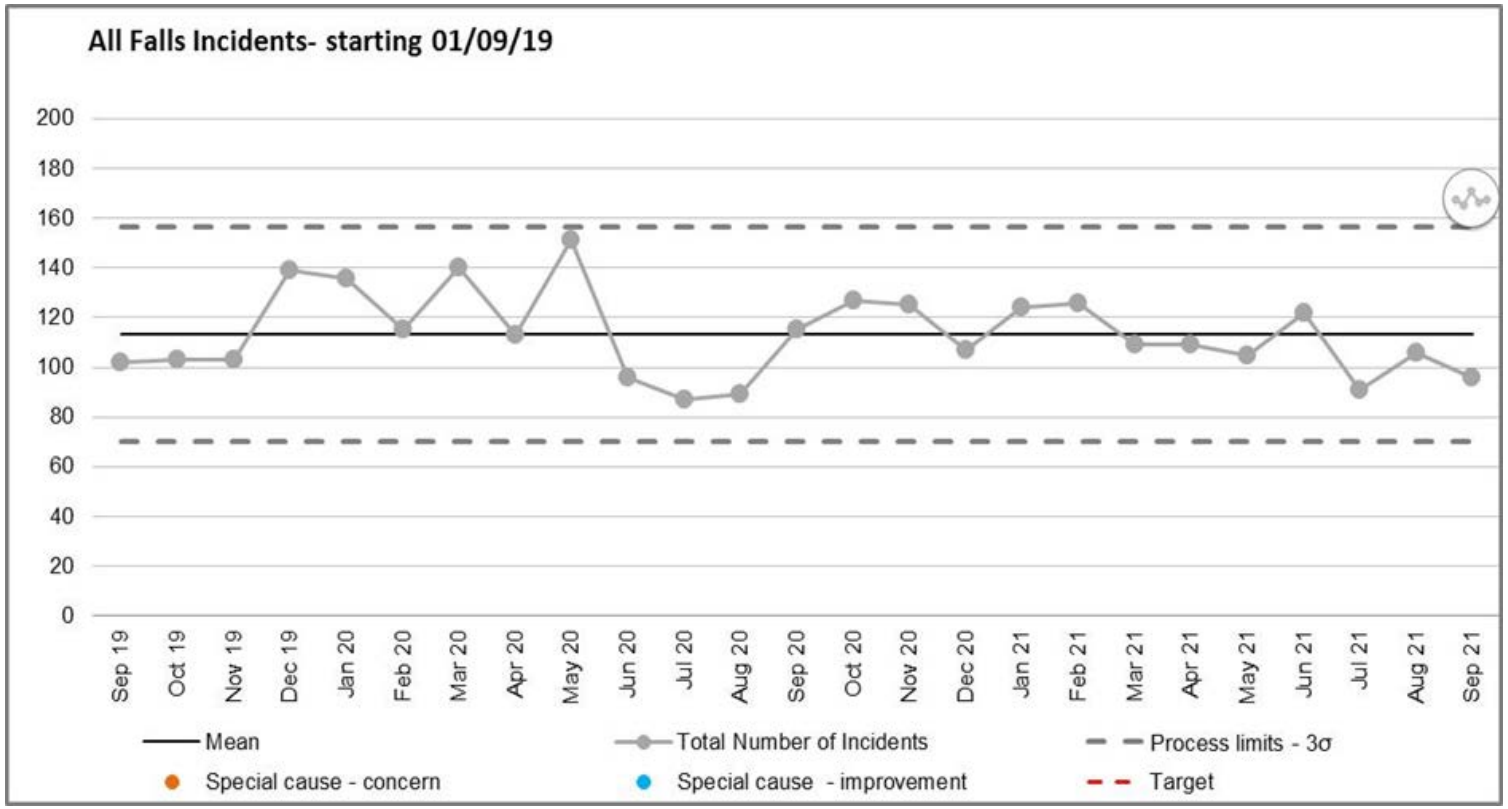
5. All falls incidents reported



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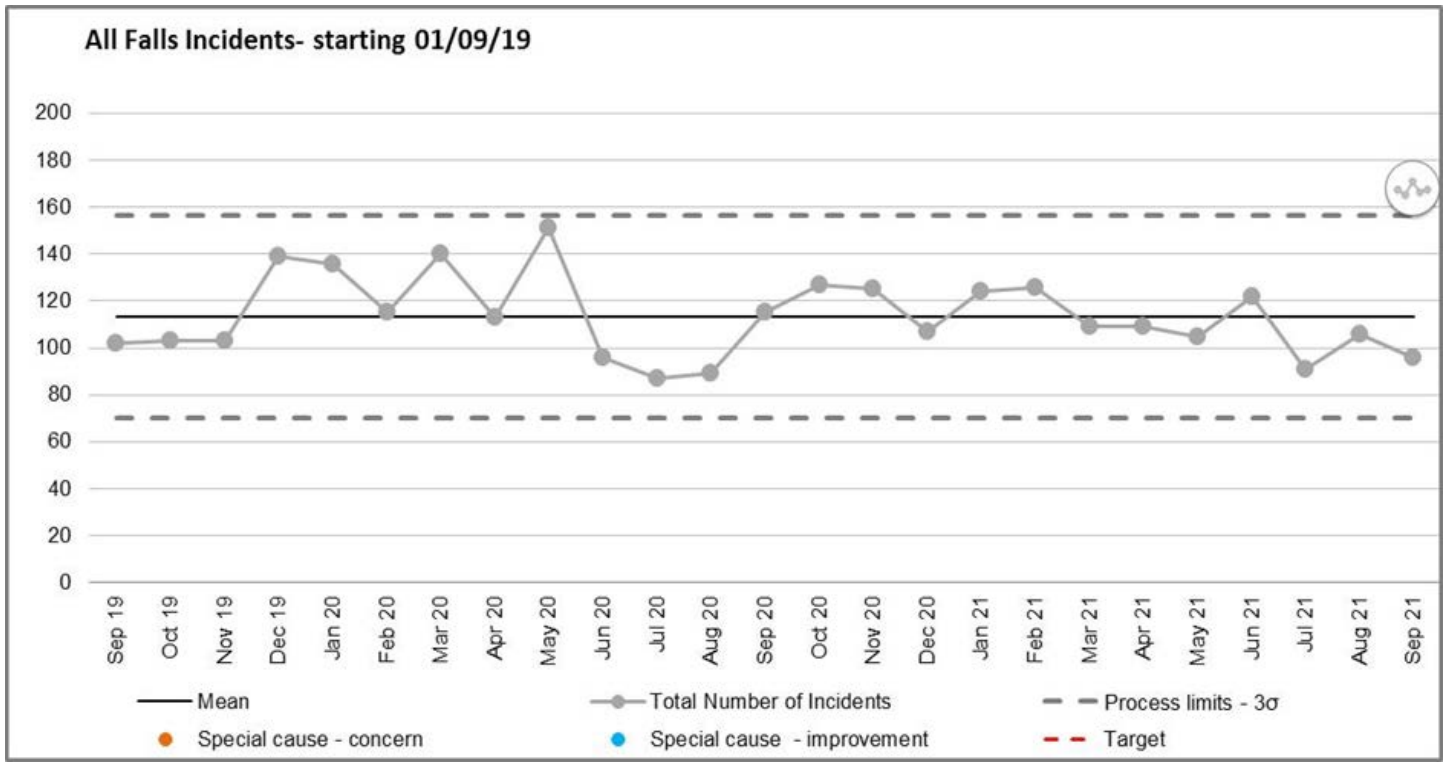
6. Falls incidents reported – MHSOP and Community Inpatients



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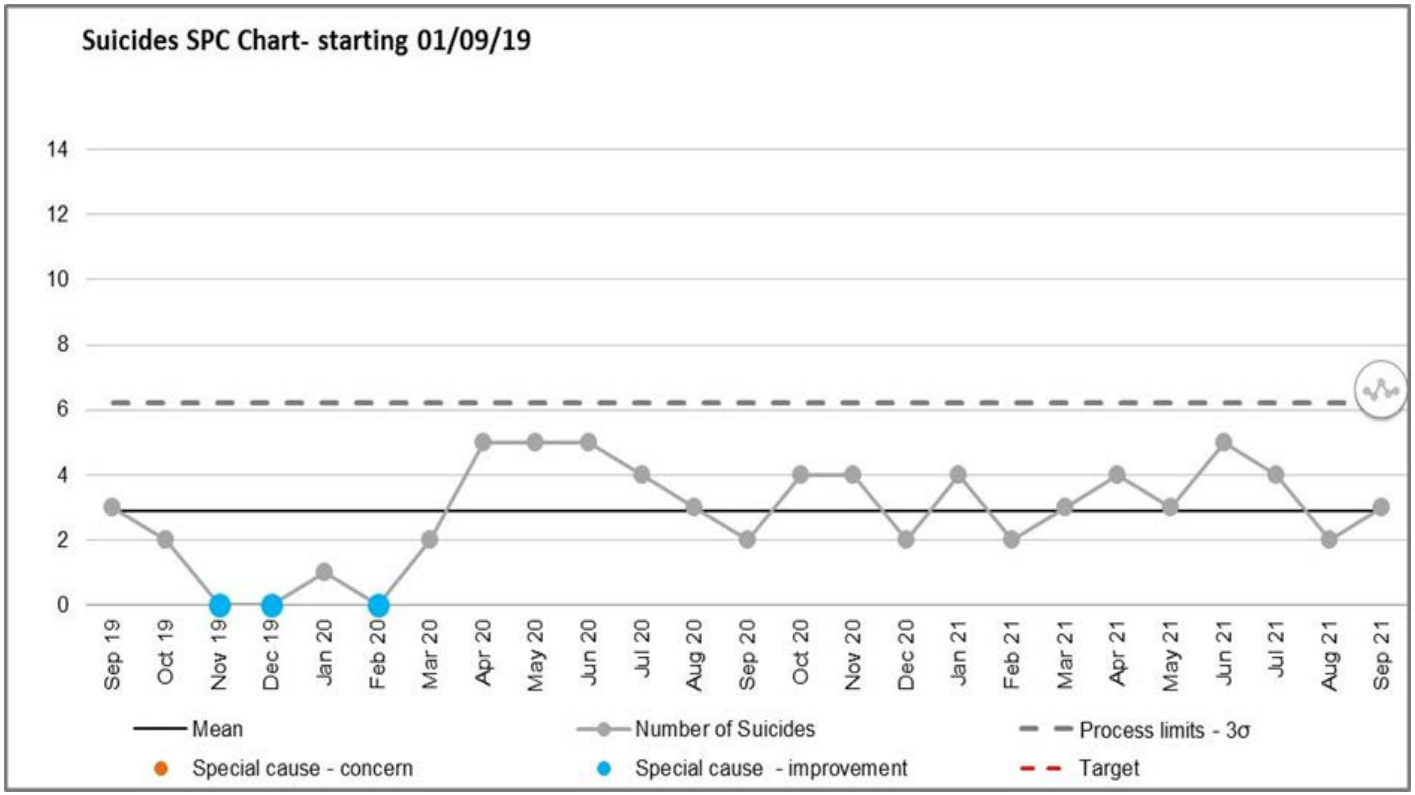
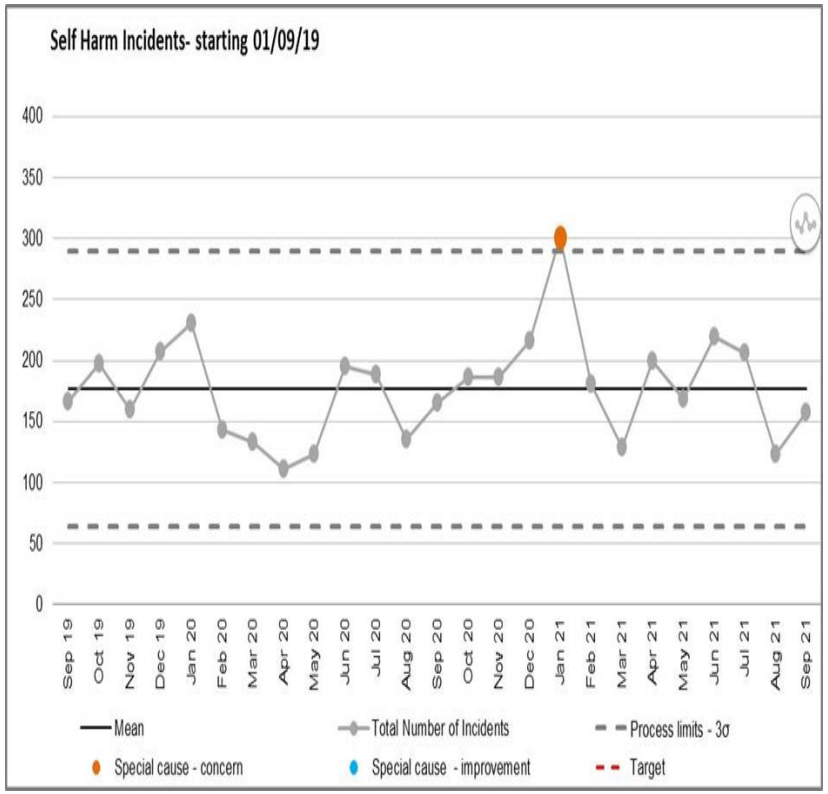
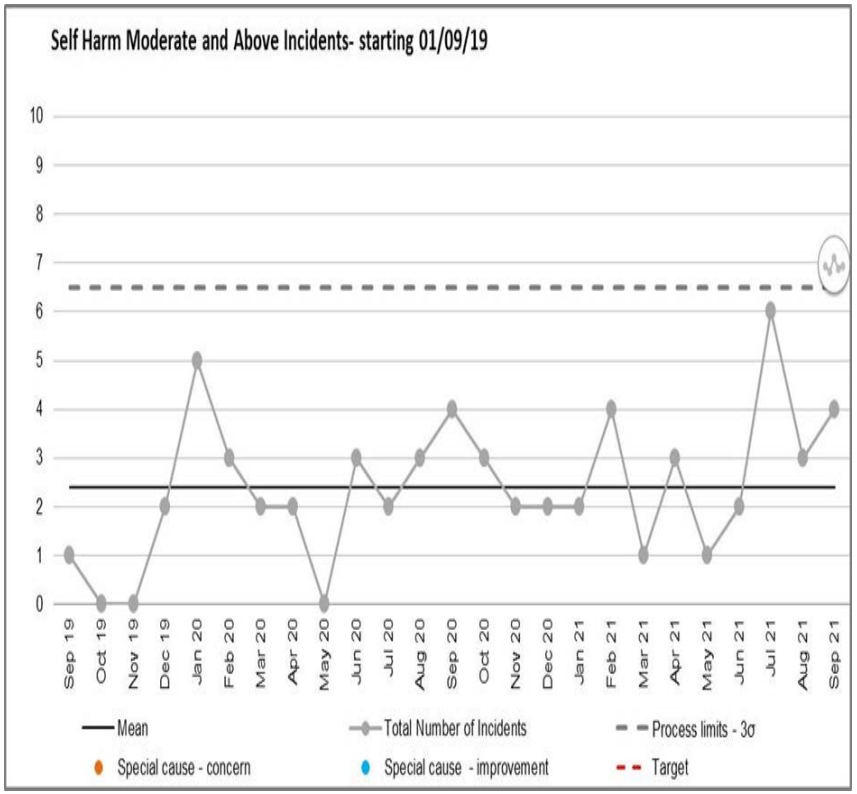
7. All reported Suicides

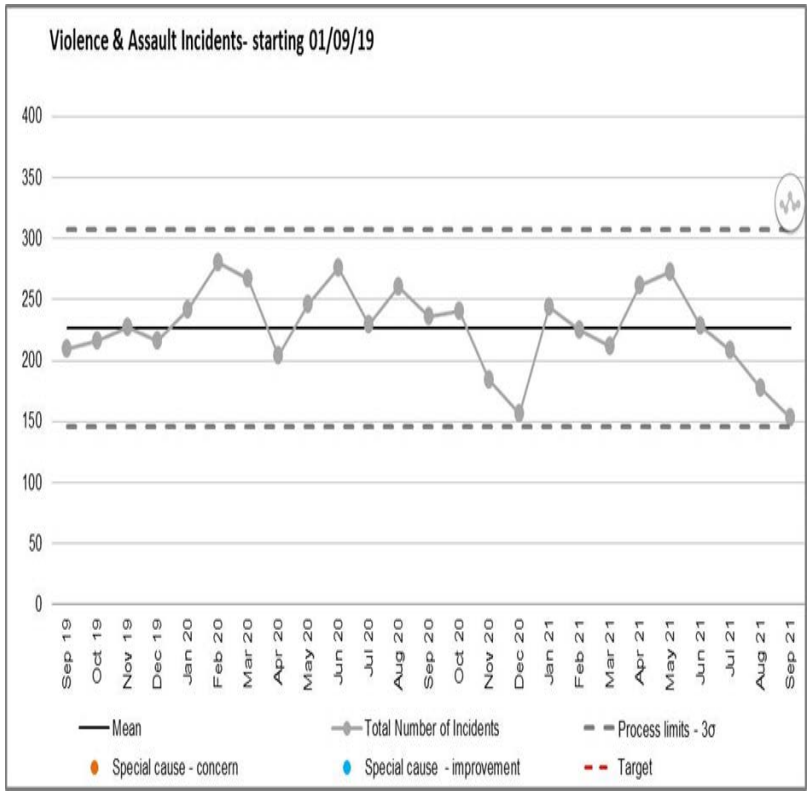


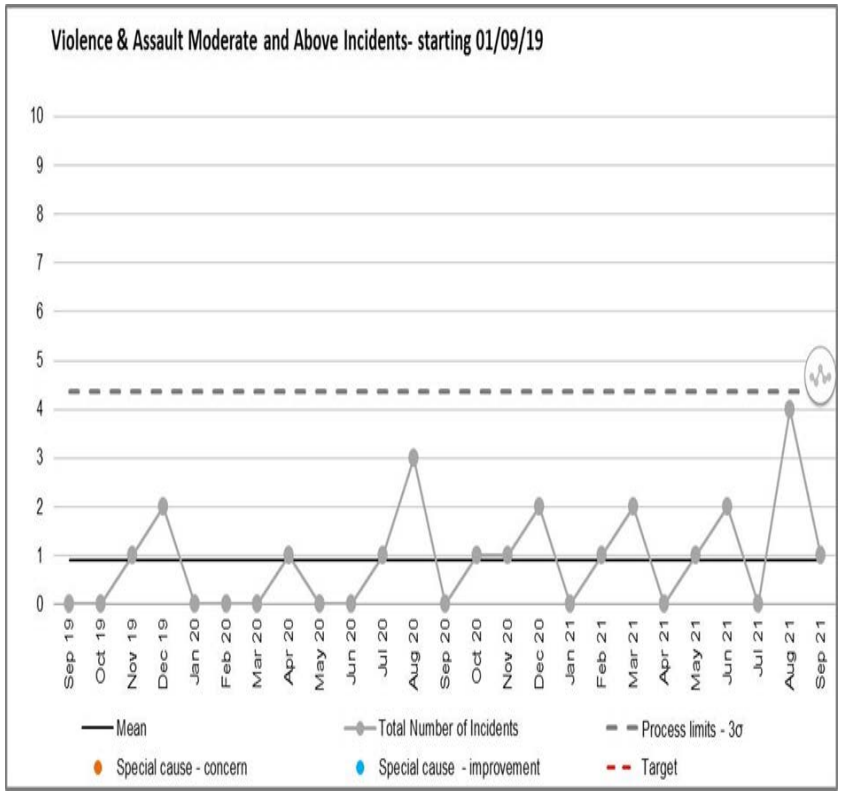
8. Self Harm reported Incidents



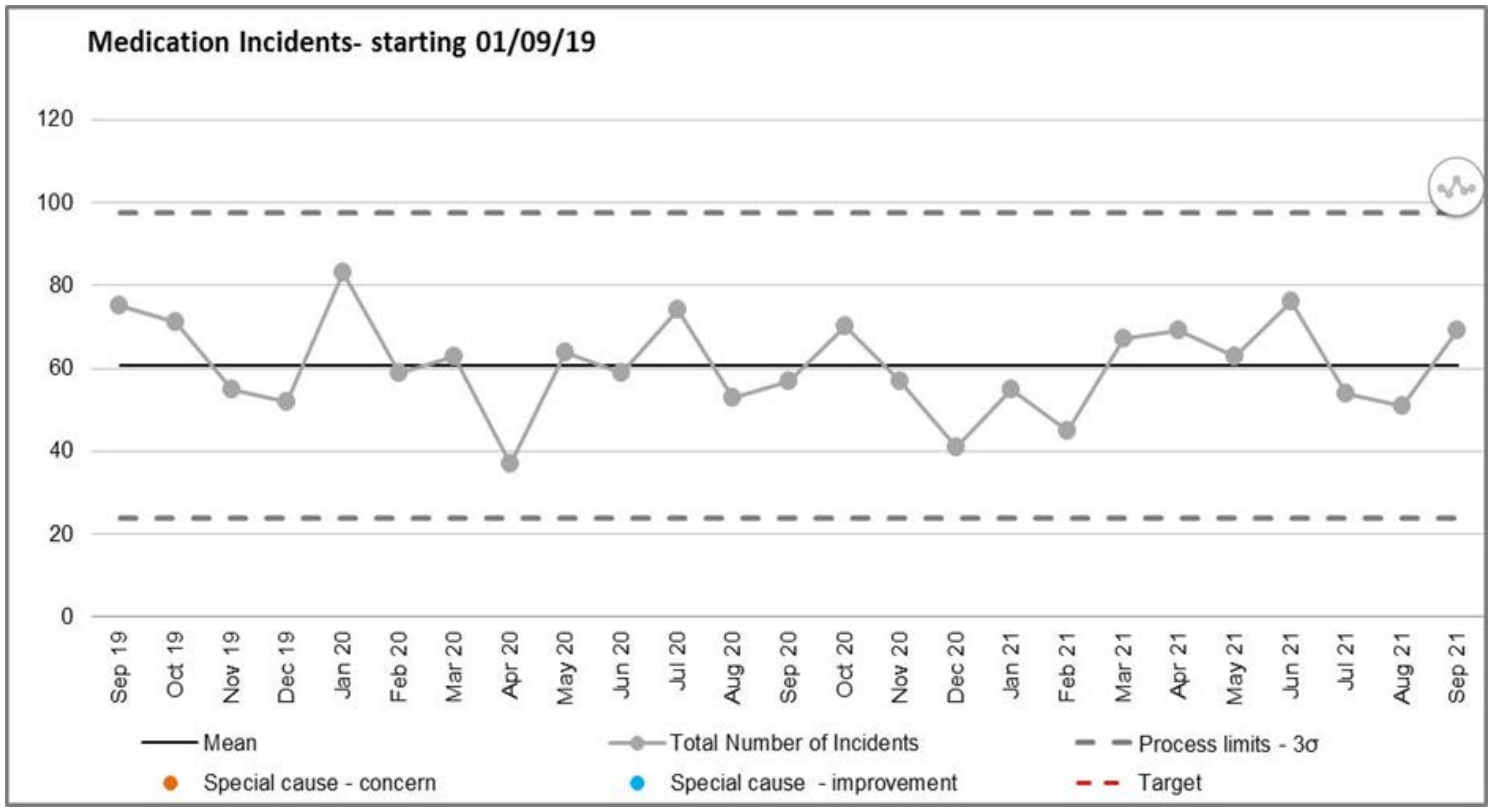


9. All Violence & Assaults reported Incidents





10. All Medication Incidents reported



11. Directorate Specialities describing Top 5 Incidents

Table 1: Mental Health: Inpatients

Mental Health Non MHSOP Inpatient - August	
Cause Group	**Total**
Violence/Assault	108
Patient Falls, Slips, And Trips	28
Self Harm	26
Security	22
Staffing	12

Mental Health Non MHSOP Inpatient - September	
Cause Group	**Total**
Violence/Assault	84
Self Harm	28
Clinical Condition	24
Patient Falls, Slips, And Trips	24
Security	20

Table 2: Mental Health Community

Mental Health Non MHSOP Community - August	
Cause Group	**Total**
Violence/Assault	42
Self Harm	34
Infection Control	23
Safeguarding (Adults)	13
Patient Death	12

Mental Health Non MHSOP Community - September	
Cause Group	**Total**
Self Harm	52
Violence/Assault	31
Infection Control	18
Patient Death	13
Safeguarding (Adults)	12

Directorate Specialities describing Top 5 Incidents

Table 3: MHSOP – Inpatients

MHSOP Inpatient - August	
Cause Group	**Total**
Patient Falls, Slips, And Trips	35
Clinical Condition	13
Violence/Assault	12
Tissue Viability	3
Accident	2

MHSOP Inpatient - September	
Cause Group	**Total**
Patient Falls, Slips, And Trips	32
Violence/Assault	12
Clinical Condition	7
Infection Control	4
Allegations Against Staff	2

Table 4: MHSOP – Community

MHSOP Community - August	
Cause Group	**Total**
Patient Death	8
Self Harm	4
Infection Control	2
Safeguarding (Adults)	2
Medication	1

MHSOP Community - September	
Cause Group	**Total**
Self Harm	7
Patient Death	5
Infection Control	3
Medication	2
Communication	1

Directorate Specialities describing Top 5 Incidents

Table 5: Learning Disability – In-Patient

LD Agnes Unit - August	
Cause Group	**Total**
Violence/Assault	15
Accident	1
Allegations Against Staff	1
Clinical Condition	1
Communication	1

LD Agnes Unit - September	
Cause Group	**Total**
Violence/Assault	14
Hate/PREVENT Incident	2
Clinical Condition	1
Communication	1
Infection Control	1

Table 6: Learning Disability - Community

LD Community - August	
Cause Group	**Total**
Self Harm	9
Safeguarding (Adults)	8
Infection Control	7
Violence/Assault	6
Patient Death	4

LD Community - September	
Cause Group	**Total**
Self Harm	6
Violence/Assault	4
Infection Control	3
Safeguarding (Adults)	3
Case Notes & Records	2

Directorate Specialities describing Top 5 Incidents

Table 7: FYPC Inpatient CAMHS

FYPC CAMHS Inpatient - August	
Cause Group	**Total**
Self Harm	51
Clinical Condition	3
Infection Control	3
Staffing	3
Case Notes & Records	2
Patient Falls, Slips, And Trips	2

FYPC CAMHS Inpatient - September	
Cause Group	**Total**
Self Harm	70
Mental Health Act	25
Staffing	5
Violence/Assault	3
Patient Falls, Slips, And Trips	2

Table 8: FYPC non LD Non CAMHS

FYPC Non LD Non CAMHS - August	
Cause Group	**Total**
Case Notes & Records	5
Violence/Assault	5
Infection Control	3
Security	3
Communication	2

FYPC Non LD Non CAMHS - September	
Cause Group	**Total**
Communication	4
Case Notes & Records	3
Confidentiality	1
IT Equipment / Systems	1
Medication	1

Directorate Specialities describing Top 5 Incidents

Table 10: CHS In-Patient

CHS Inpatient - August	
Cause Group	**Total**
Tissue Viability	31
Patient Falls, Slips, And Trips	29
Patient Death	8
Access, Admission, Appts, Xfer, Discharge	5

CHS Inpatient - September	
Cause Group	**Total**
Tissue Viability	43
Patient Falls, Slips, And Trips	25
Patient Death	14
Medication	11
Staffing	11

Table 11: CHS Community

CHS Community - August	
Cause Group	**Total**
Tissue Viability	411
Infection Control	28
Medication	20
Case Notes & Records	8
Patient Falls, Slips, And Trips	8

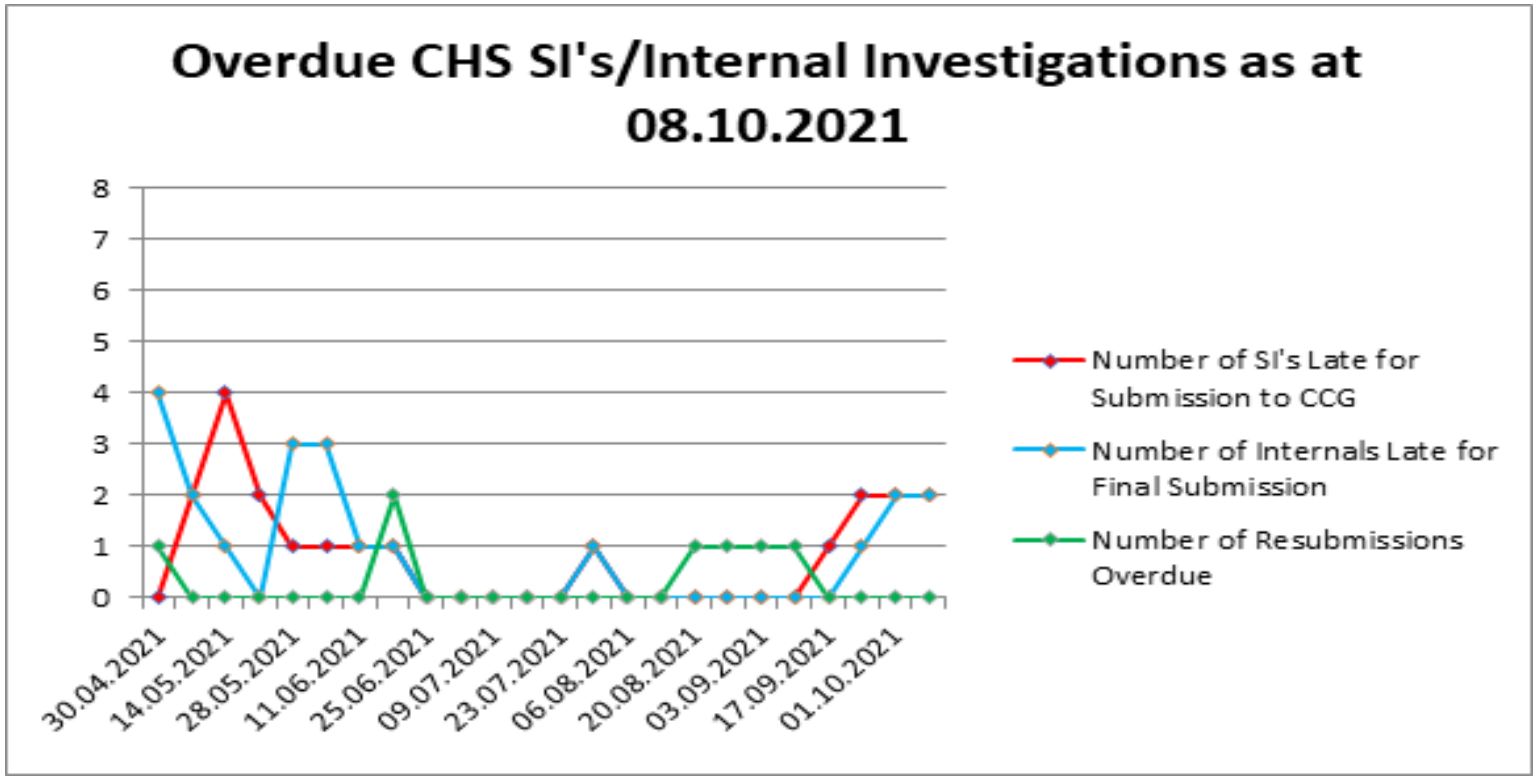
CHS Community - September	
Cause Group	**Total**
Tissue Viability	389
Medication	26
Infection Control	24
Medical Equipment	9
Patient Falls, Slips, And Trips	8

12. Ongoing - StEIS Notifications for Serious Incidents

2021/2022 StEIS Notifications

		StEIS Notification			SI Investigations			Internal Investigations		
		Down-grade/ removal	SI's declared DMH	SI's declared FYPC-LD	SI's declared CHS	Signed off in month	Comment	DMH	FYPC-LD	CHS
2021/22 - Q1	April	0	11	2	2	5		4	2	6
	May	0	4	0	1	4		2	1	3
	June	0	11	5	2	6		2	2	6
2021/22 - Q2	July	0	5	2	1	8		4	2	1
	Aug	0	3	3	2	14		1	1	7
	Sept	0	5	0	0	11		6	2	3
2021/22 - Q3	Oct									
	Nov									
	Dec									
2021/22 - Q4	Jan									
	Feb									
	Mar									

12a. Overdue Serious Incidents/Internal Investigation & CCG resubmissions(includes totals) - CHS



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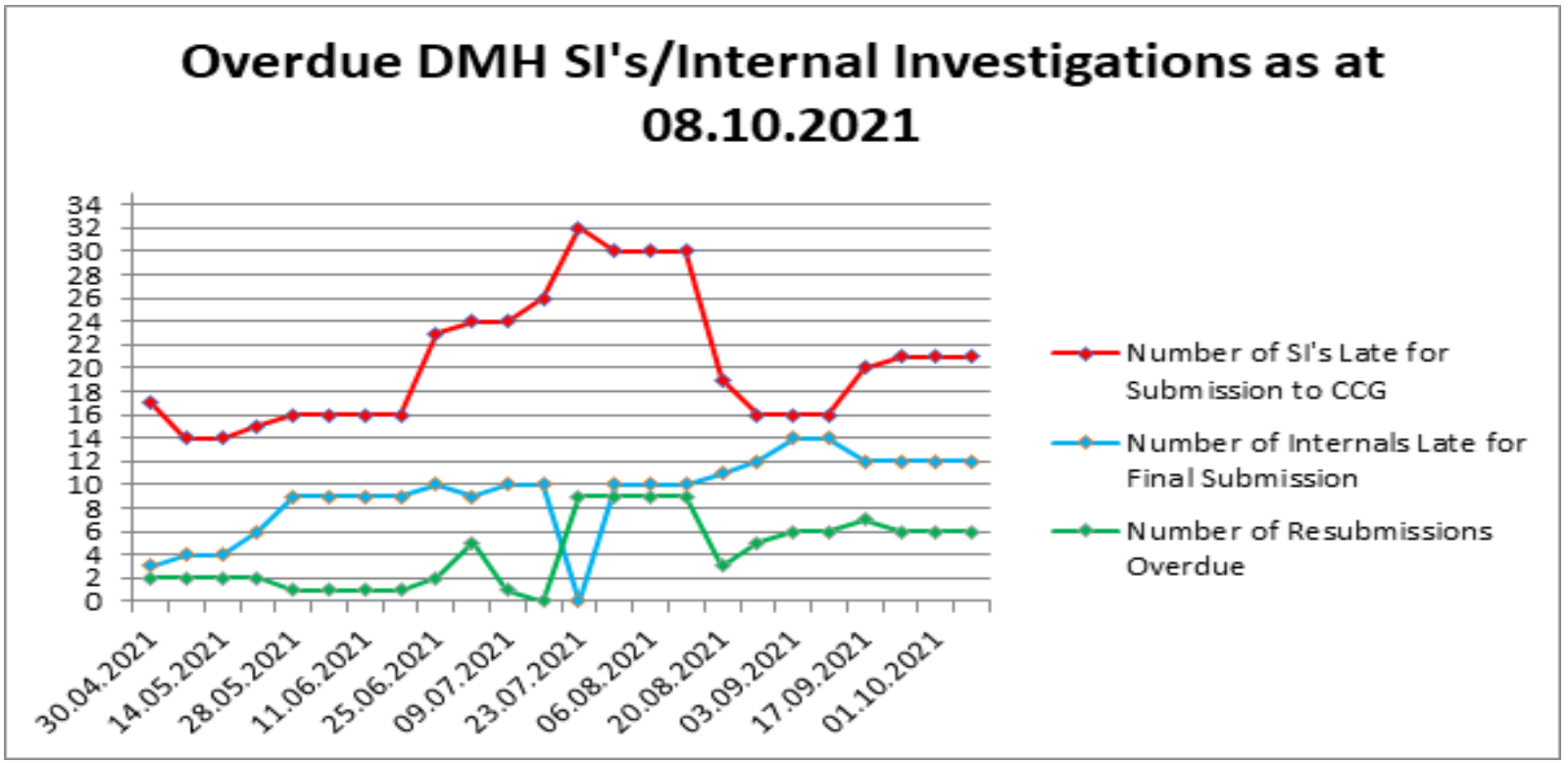
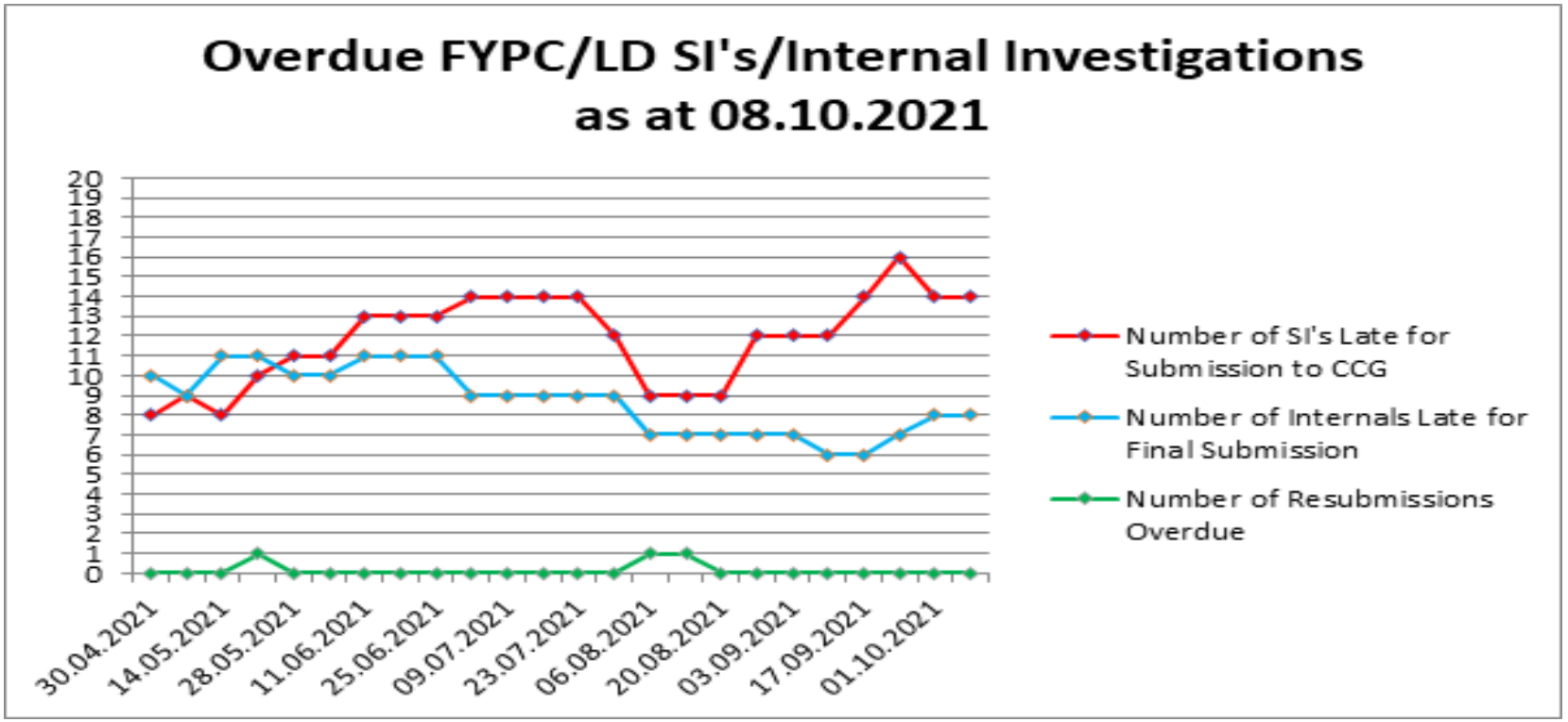
12a. Overdue Serious Incidents/Internal Investigation & CCG resubmissions (includes totals) - DMH



12a. Overdue Serious Incidents/Internal Investigations & CCG resubmissions (includes totals) - FYPCLD



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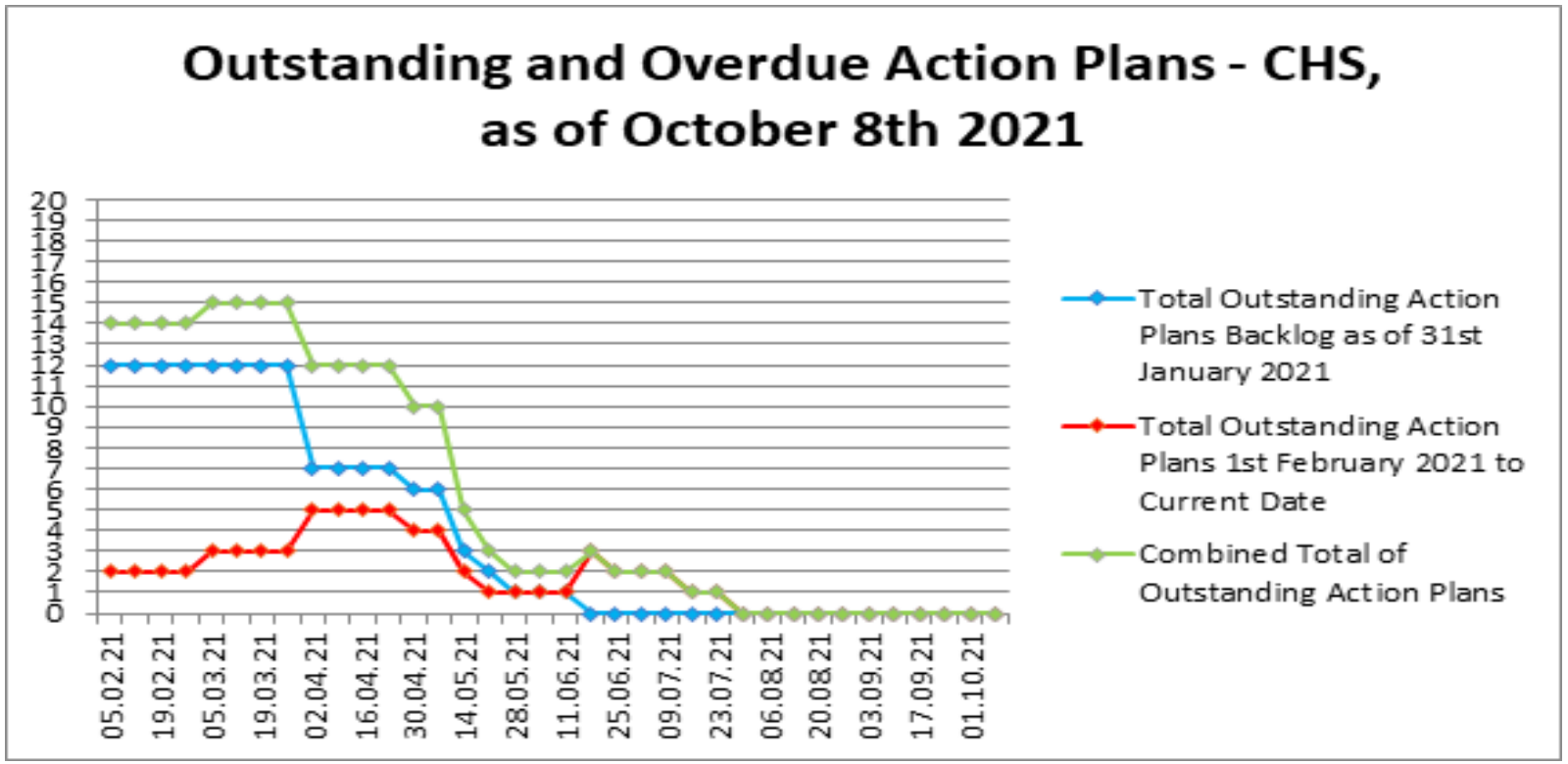
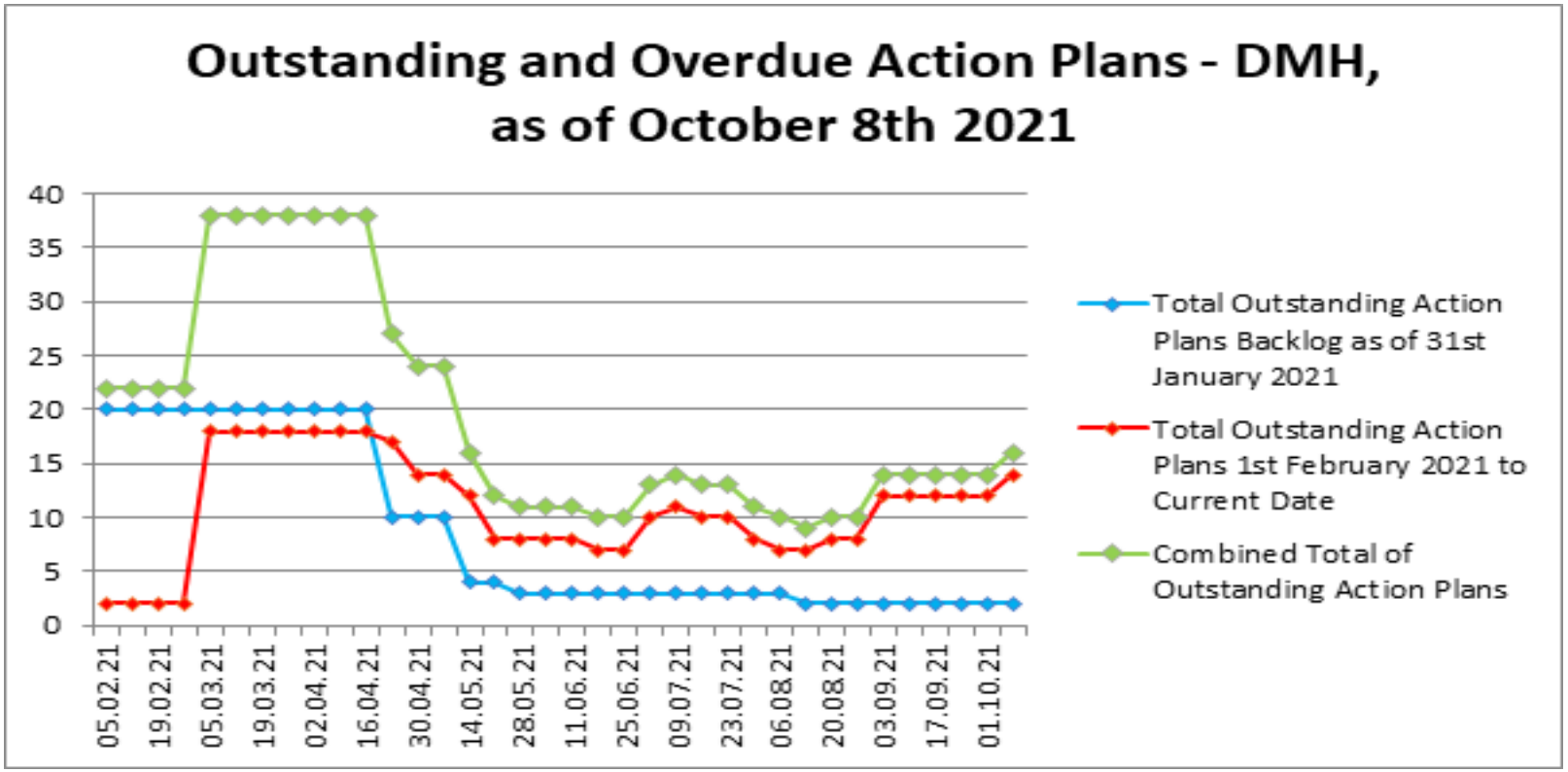
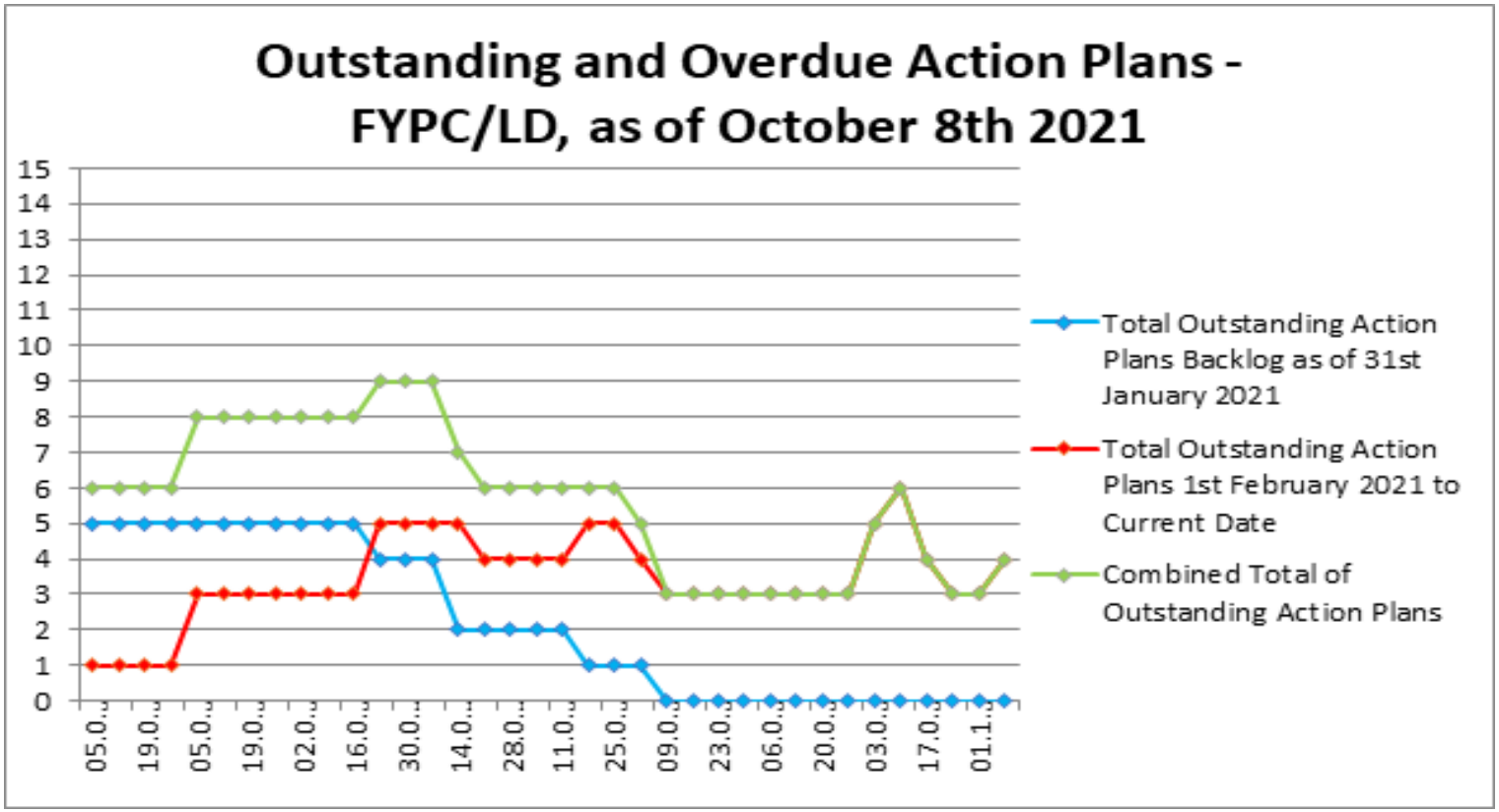
12.b Directorate SI Action Plan Compliance Status 2020/21 to date - CHS



12.b Directorate SI Action Plan Compliance Status 2020/21 to date - DMH



12b. Directorate SI Action Plan Compliance Status 2020/21 to date - FYPC-LD



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12. Learning

Serious and Internal Incidents Emerging Themes

There is a requirement to consider Human Factors and system thinking in relation to our processes. All areas are facing staff challenges which make it essential that our processes are efficient and consistently reliable to support staff to do their best work.

An example would be ensuring the right nurse with the right skills and the right equipment visits the patients home to improve efficiency.

Another example is the need to strengthen administrative processes in the management of clinics and the oversight so that improvements can be made where required

12. Lessons Learned – safeguarding focus

- Safeguarding thresholds for category 3 & 4 Pressure ulcers have not been consistently & accurately measured at LPT to inform practice or threshold of 'neglect' (according to the care act)
- Additional support put in to address the requirement to ensure compliance with the above to respond to individuals at risk of developing pressure ulcers, and preventing harm where they occur & for LPT to be compliant with https://www.gov.uk/government/publications/pressure-ulcers-safeguarding-adults-protocol (January 2018)
- Improvement to make safeguarding personal when undertaking patient safety incident investigations (PSII) – named safeguarding practitioner for each PSII

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