Appendix 1

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

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

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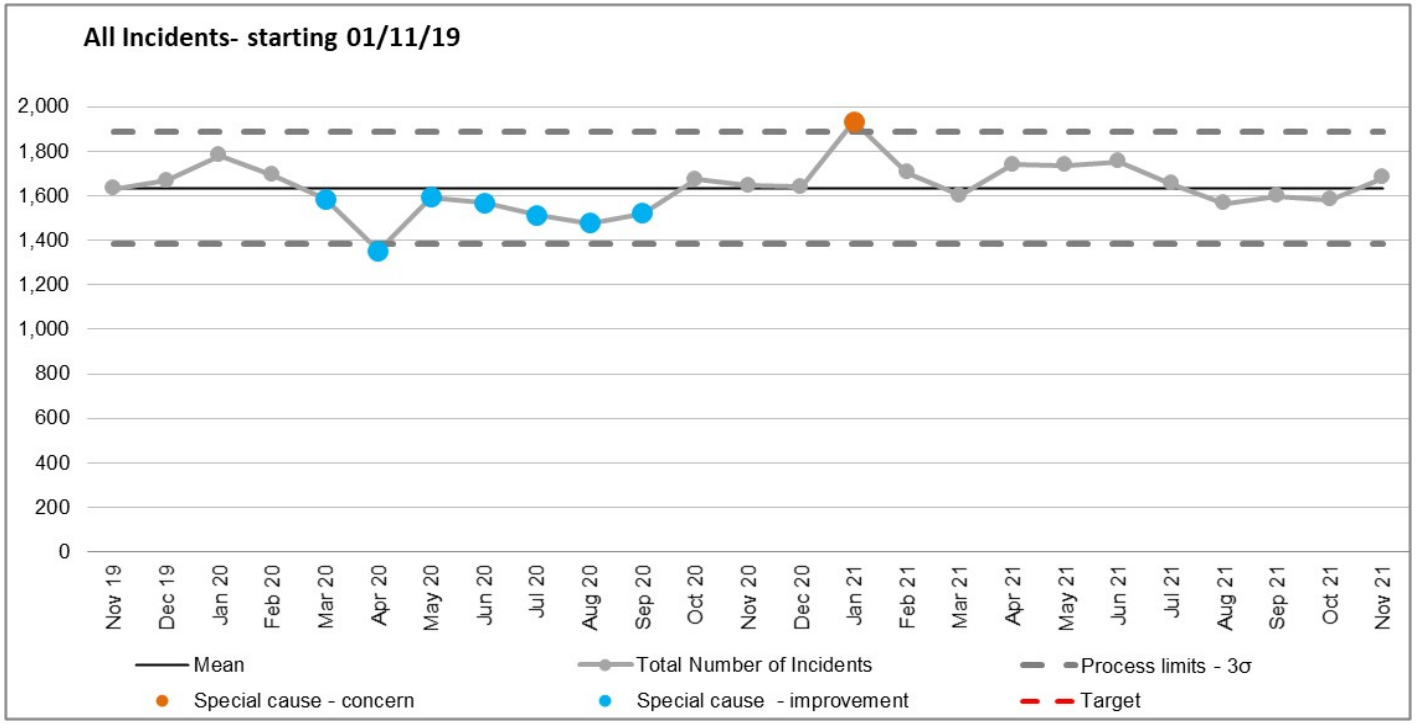
1. All incidents



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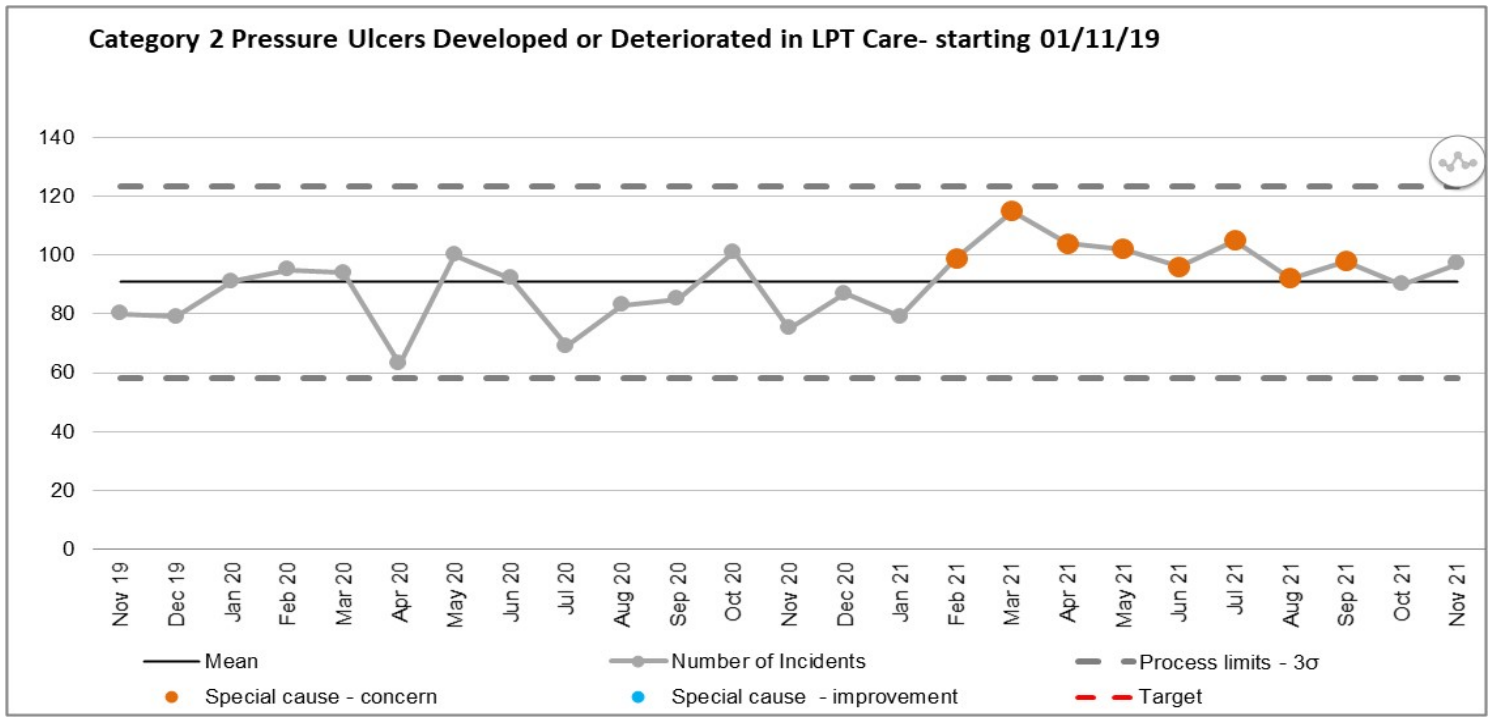
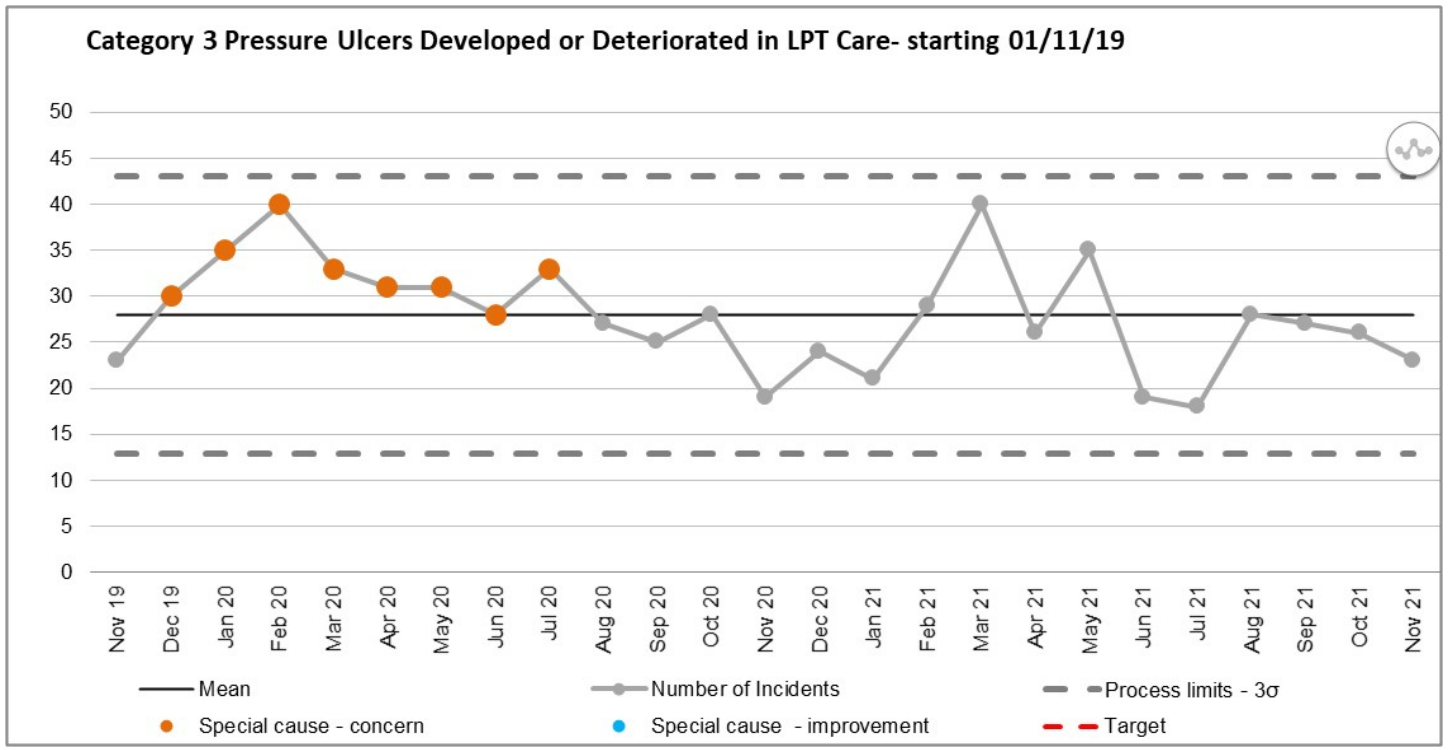
2. Category 2 Pressure Ulcers developed or deteriorated in LPT Care



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



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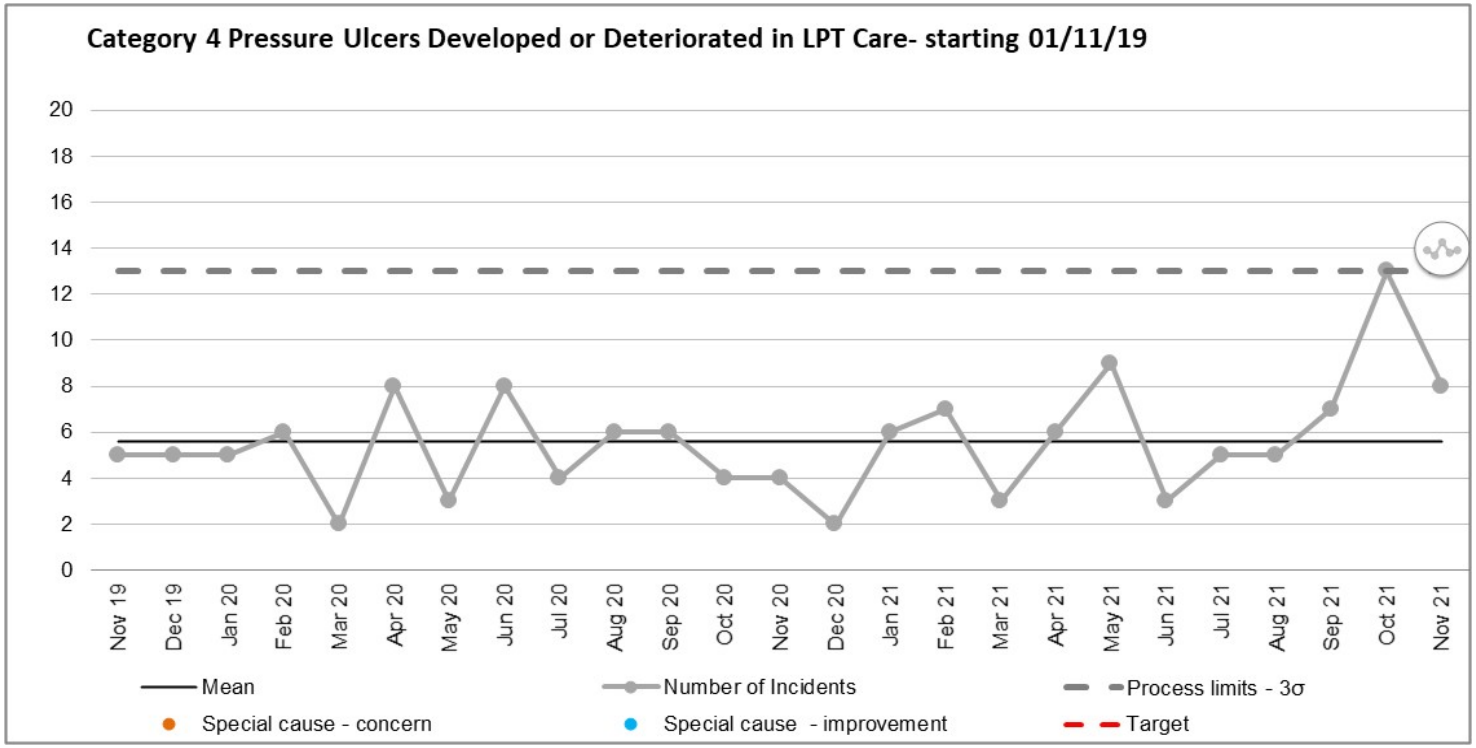
4. Category 4 Pressure Ulcers Developed or deteriorated in LPT Care



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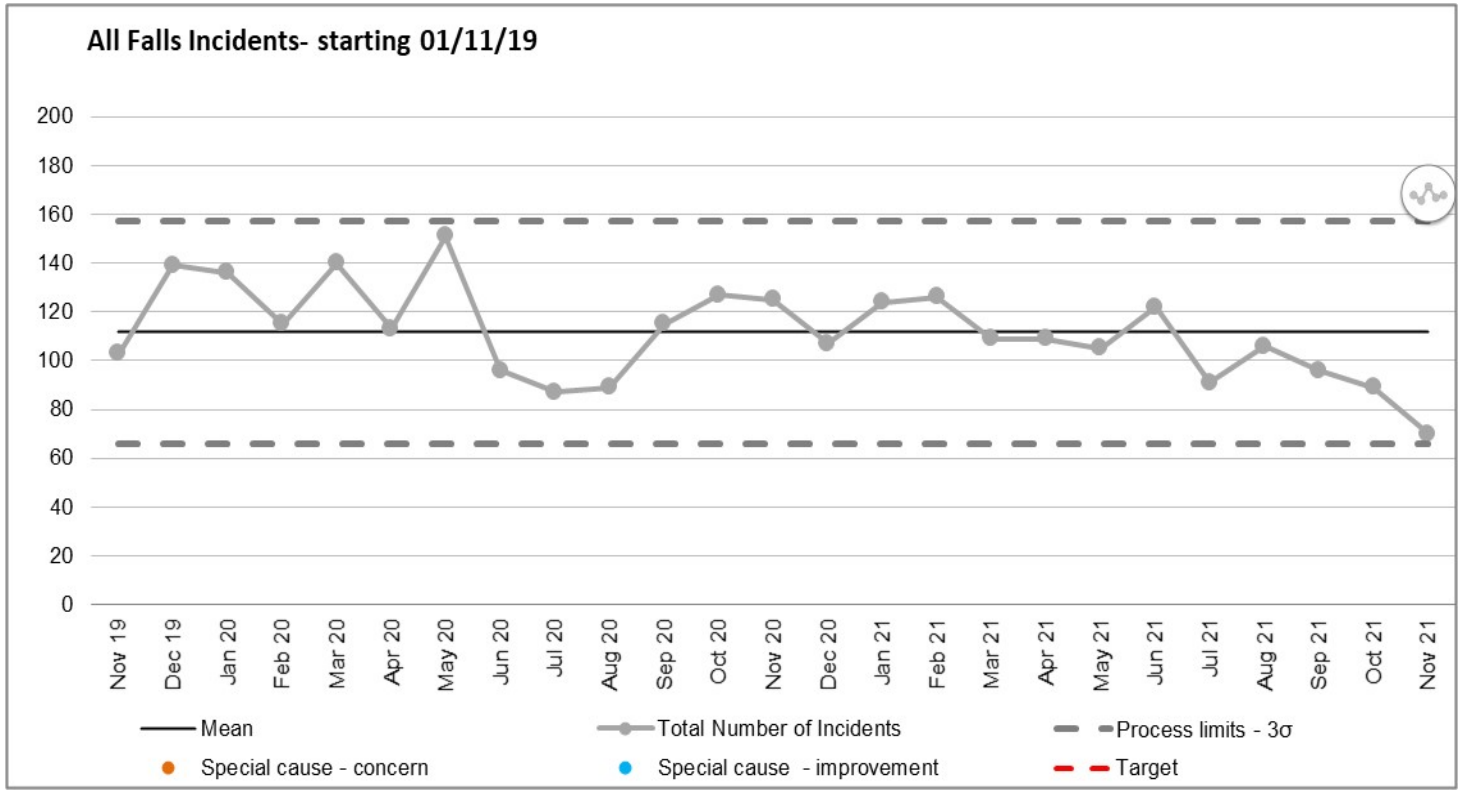
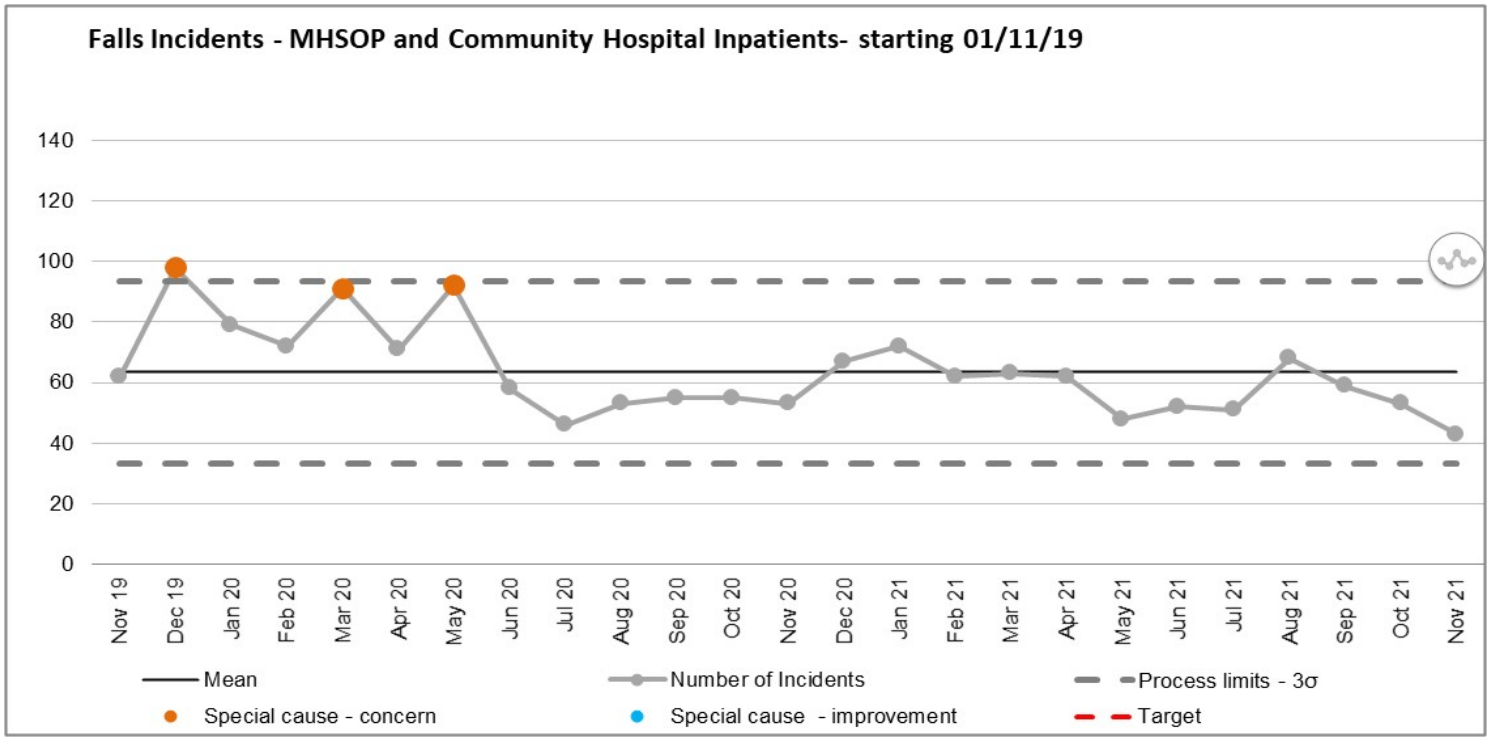
5. All falls incidents reported



6. Falls incidents reported – MHSOP and Community Inpatients



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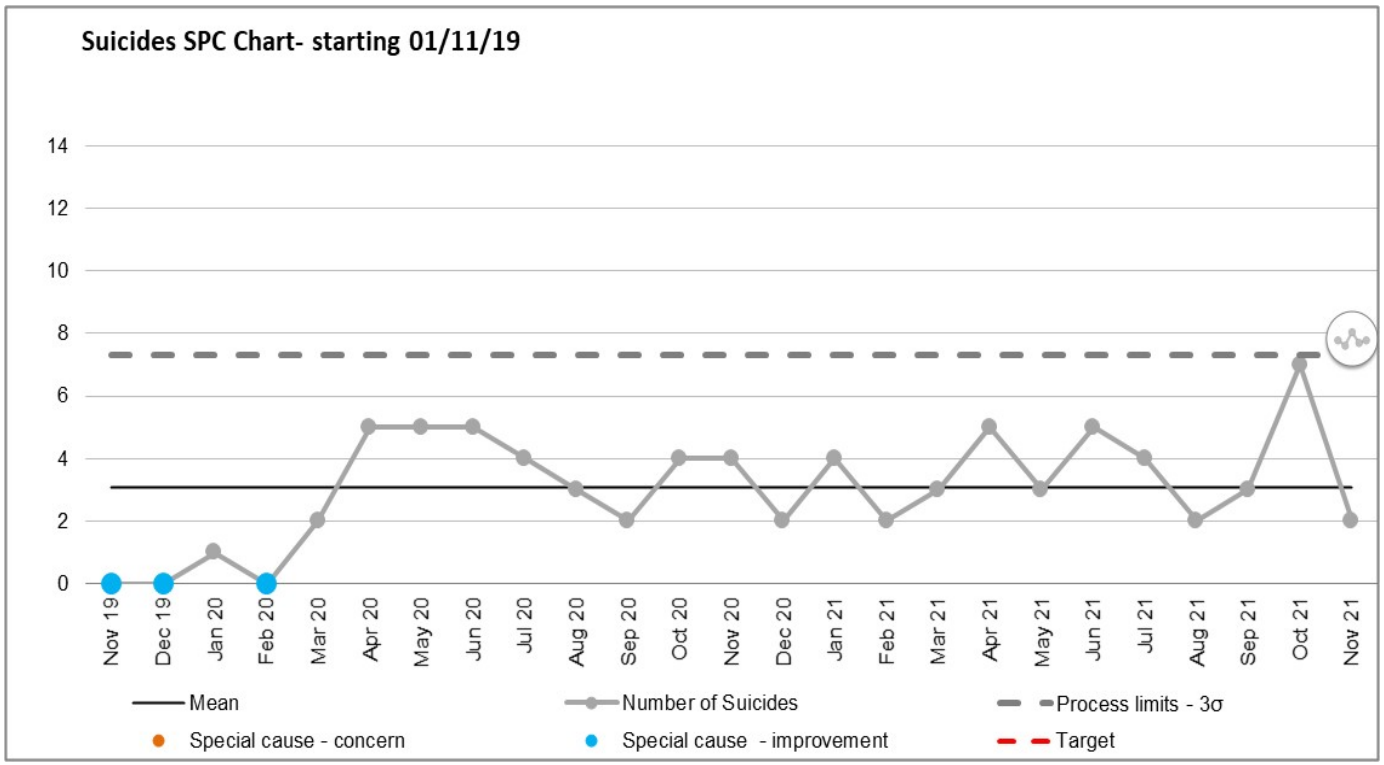
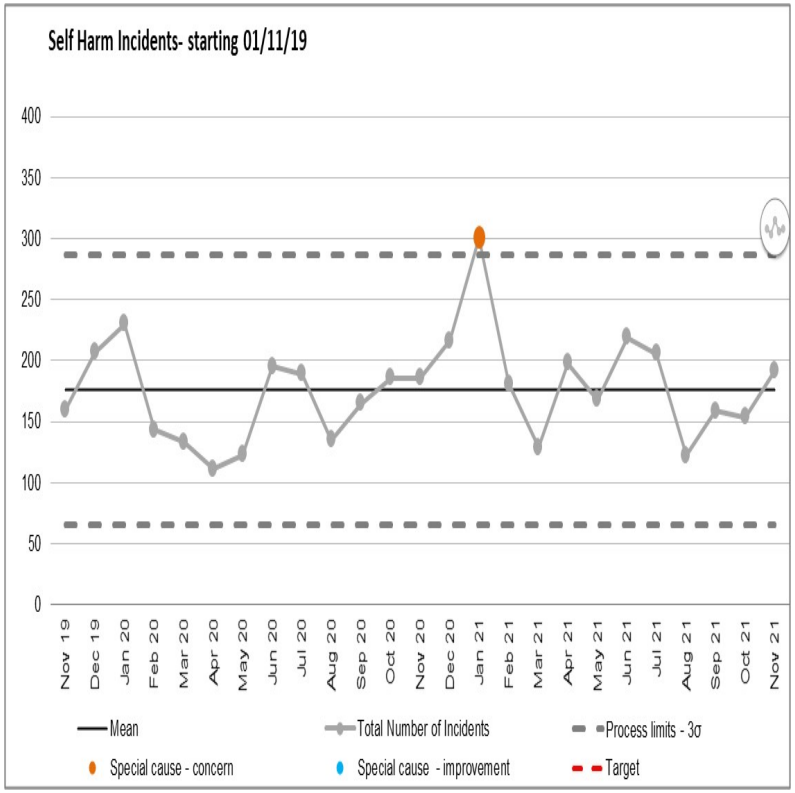
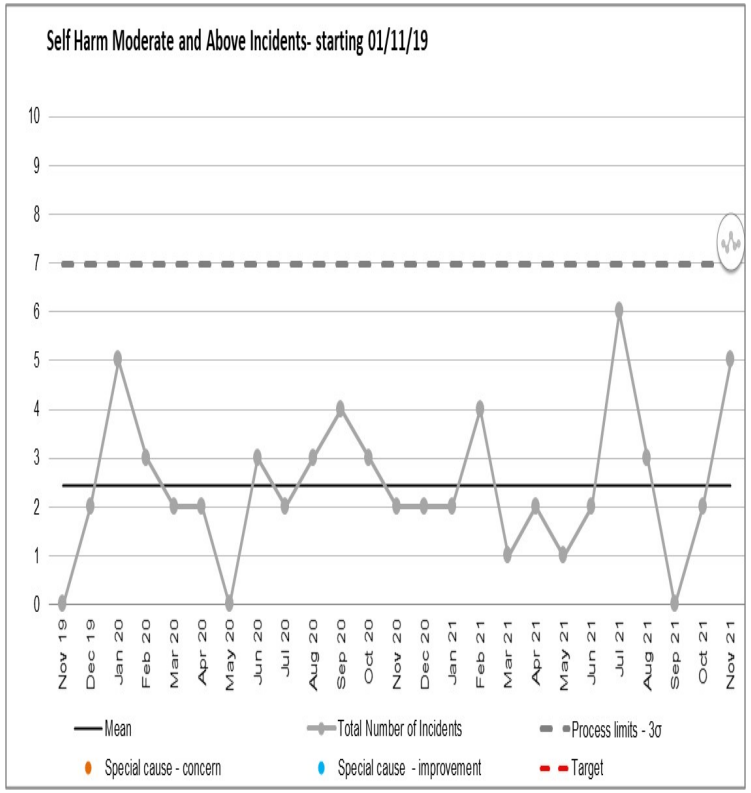
7. All reported Suicides

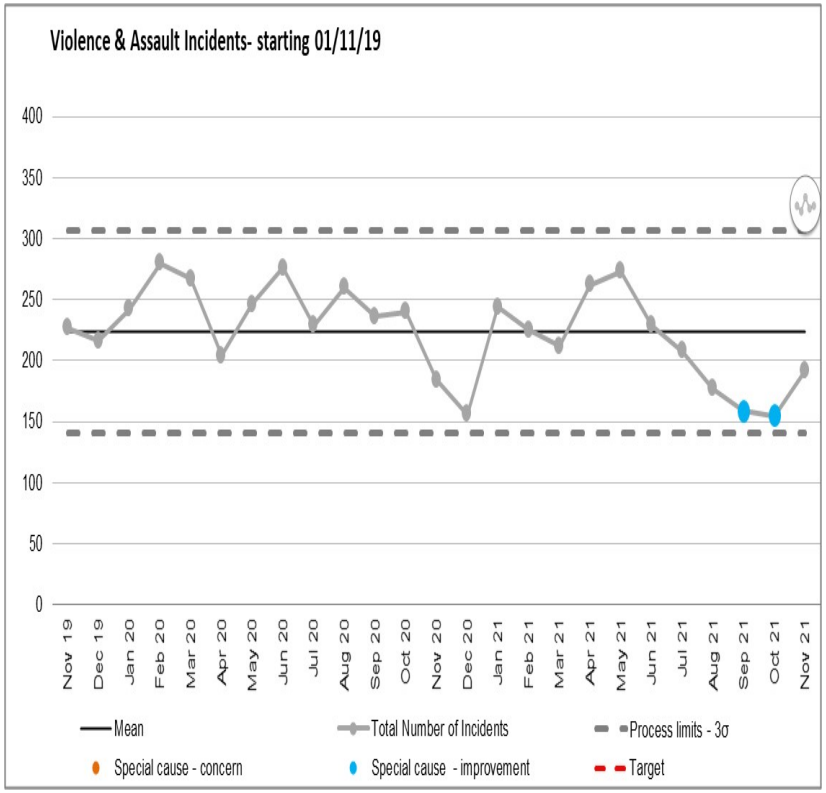


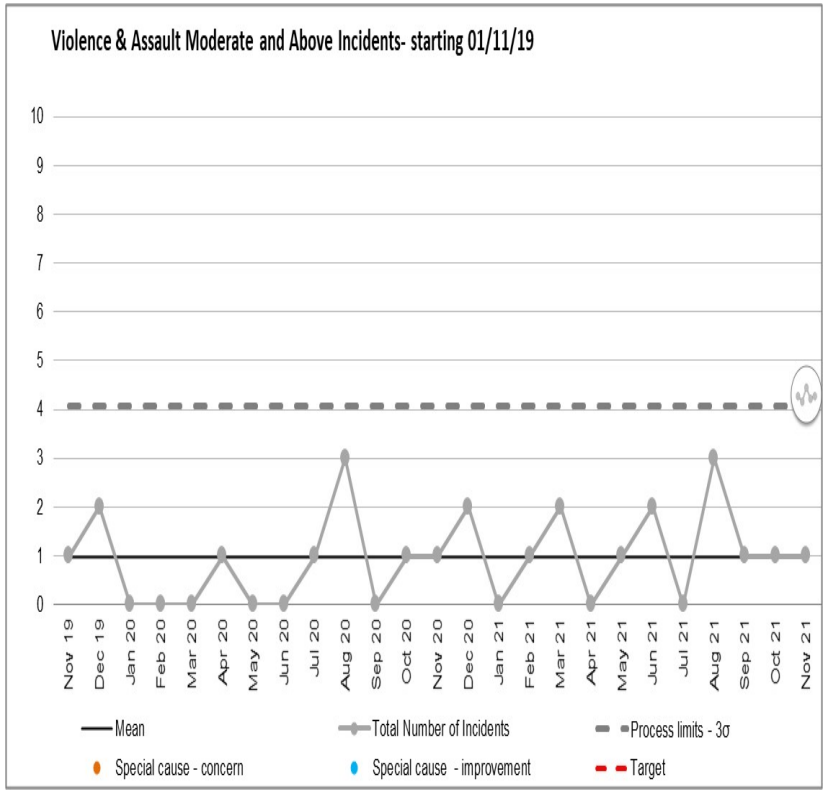
8. Self Harm reported Incidents





9. All Violence & Assaults reported Incidents





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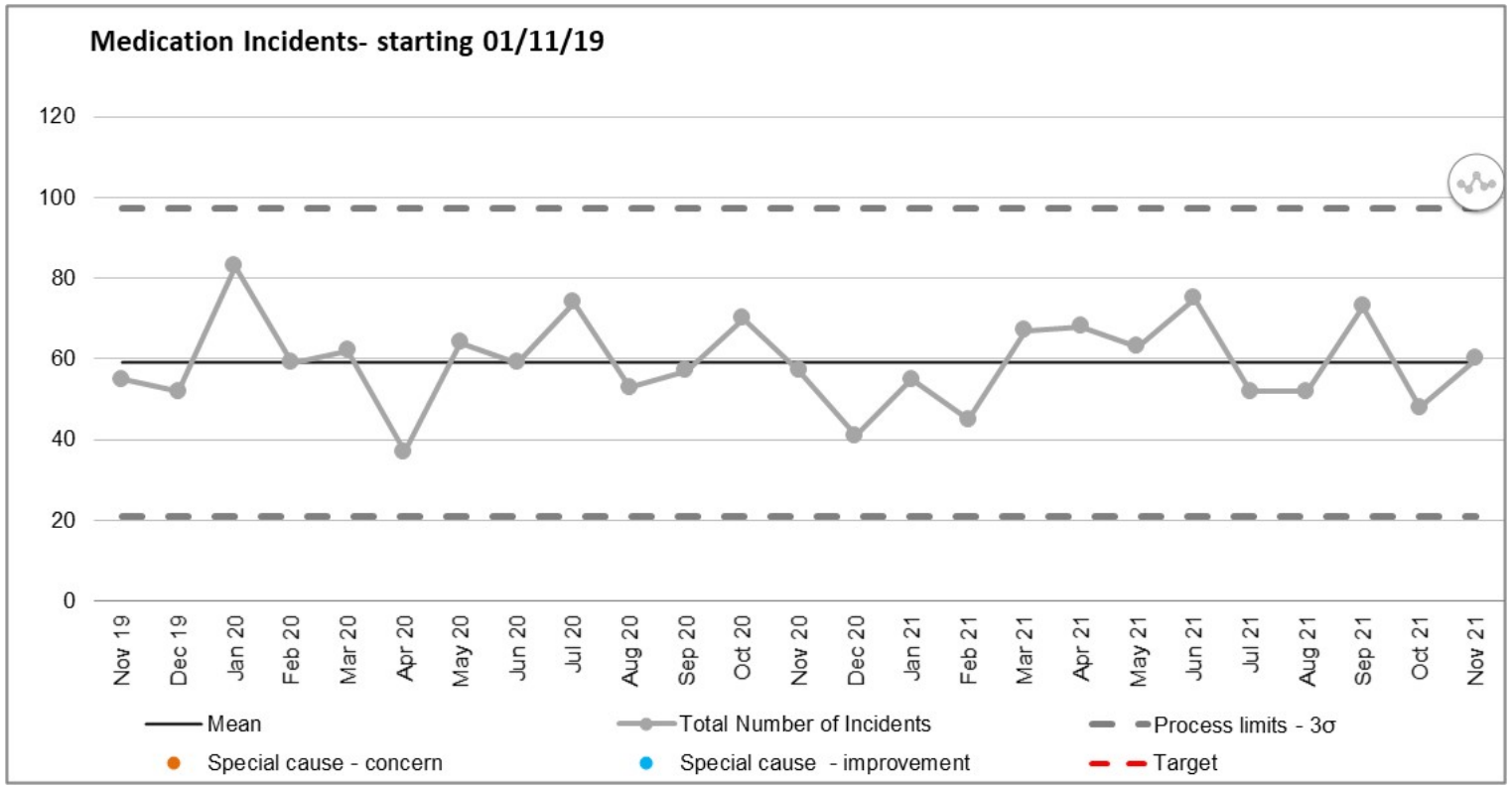
10. All Medication Incidents reported



11. Directorate Specialities describing Top 5 Incidents

Table 1: Mental Health: Community

Mental Health Non MHSOP Community - October	
Cause Group	**Total**
Self Harm	55
Violence/Assault	30
Patient Death	16
Safeguarding (Adults)	13
Infection Control	11

Mental Health Non MHSOP Community - November	
Cause Group	**Total**
Self Harm	61
Violence/Assault	32
Patient Death	16
Safeguarding (Adults)	15
Clinical Condition	11

Table 2: Mental Health: Inpatients

Mental Health Non MHSOP Inpatient - October	
Cause Group	**Total**
Violence/Assault	101
Self Harm	26
Staffing	26
Patient Falls, Slips, And Trips	25
Infection Control	18

Mental Health Non MHSOP Inpatient - November	
Cause Group	**Total**
Violence/Assault	102
Patient Falls, Slips, And Trips	23
Clinical Condition	22
Self Harm	21
Staffing	17

Directorate Specialities describing Top 5 Incidents

Table 3: MHSOP – Inpatients

MHSOP Inpatient - October	
Cause Group	**Total**
Patient Falls, Slips, And Trips	21
Clinical Condition	11
Violence/Assault	9
Medication	4
Security	3

MHSOP Inpatient - November	
Cause Group	**Total**
Patient Falls, Slips, And Trips	17
Clinical Condition	11
Violence/Assault	10
Infection Control	2
Non-Medical Equipment	2

Table 4: MHSOP – Community

MHSOP Community - October	
Cause Group	**Total**
Patient Death	7
Self Harm	3
Infection Control	2
Safeguarding (Adults)	2
Confidentiality	1

MHSOP Community - November	
Cause Group	**Total**
Patient Death	7
Safeguarding (Adults)	4
Case Notes & Records	3
Missing Patient	3
Infection Control	2

Directorate Specialities describing Top 5 Incidents

Table 5: Learning Disability – In-Patient

LD Agnes Unit - October	
Cause Group	**Total**
Violence/Assault	16
Fire	5
Staffing	2
Accident	1
Allegations Against Staff	1

LD Agnes Unit - November	
Cause Group	**Total**
Violence/Assault	40
Self Harm	13
Clinical Condition	2
Confidentiality	2
Fire	2

Table 6: Learning Disability - Community

LD Community - October	
Cause Group	**Total**
Case Notes & Records	4
Self Harm	4
Infection Control	3
Patient Falls, Slips, And Trips	3
Safeguarding (Adults)	3
Safeguarding (Children)	3

LD Community - November	
Cause Group	**Total**
Infection Control	6
Self Harm	5
Violence/Assault	5
Safeguarding (Adults)	4
Communication	3
Fire	3

Directorate Specialities describing Top 5 Incidents

Table 7: FYPC Inpatient CAMHS

FYPC CAMHS Inpatient - October	
Cause Group	**Total**
Self Harm	75
Mental Health Act	41
Infection Control	7
Staffing	7
Medication	3

FYPC CAMHS Inpatient - November	
Cause Group	**Total**
Self Harm	89
Mental Health Act	31
Staffing	11
Violence/Assault	8
Staff Falls, Slips, And Trips	2

Table 8: FYPC non LD Non CAMHS

FYPC Non LD Non CAMHS - October	
Cause Group	**Total**
Infection Control	24
Communication	14
Case Notes & Records	8
Safeguarding (Children)	8
Staffing	6

FYPC Non LD Non CAMHS - November	
Cause Group	**Total**
Infection Control	18
Case Notes & Records	9
Communication	9
Medication	9
Confidentiality	8

Directorate Specialities describing Top 5 Incidents

Table 10: CHS In-Patient

CHS Inpatient - October	
Cause Group	**Total**
Tissue Viability	34
Patient Falls, Slips, And Trips	32
Patient Death	11
Infection Control	10
Medication	7
Staffing	7

CHS Inpatient - November	
Cause Group	**Total**
Tissue Viability	45
Patient Falls, Slips, And Trips	26
Staffing	17
Medication	15
Patient Death	13

Table 11: CHS Community

CHS Community - October	
Cause Group	**Total**
Tissue Viability	397
Infection Control	16
Medication	14
Safeguarding (Adults)	9
Communication	5
Patient Falls, Slips, And Trips	5

CHS Community - November	
Cause Group	**Total**
Tissue Viability	465
Medication	22
Infection Control	19
Safeguarding (Adults)	12
Access, Admission, Appts, Xfer, Discharge	8

12. Ongoing - StEIS Notifications for Serious Incidents

2021/2022 - STEIS Notifications and Internal Investigations

		StEIS Notification	SI INVESTIGATIONS				Internal Investigations		
		Downgrade & removal requests	SIs declared DMH	SIs declared FYPC/LD	SIs declared CHS	Signed off in month	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
	August	0	3	3	2	14	1	1	7
	September	0	5	0	0	11	6	2	3
2021/22 Q3	October	0	11	1	2	15	6	3	3
	November	0	9	1	6	6	9	1	6
	December								
2021/22 Q4	January								
	February								
	March								
YTD			39	12	8	48	19	10	26

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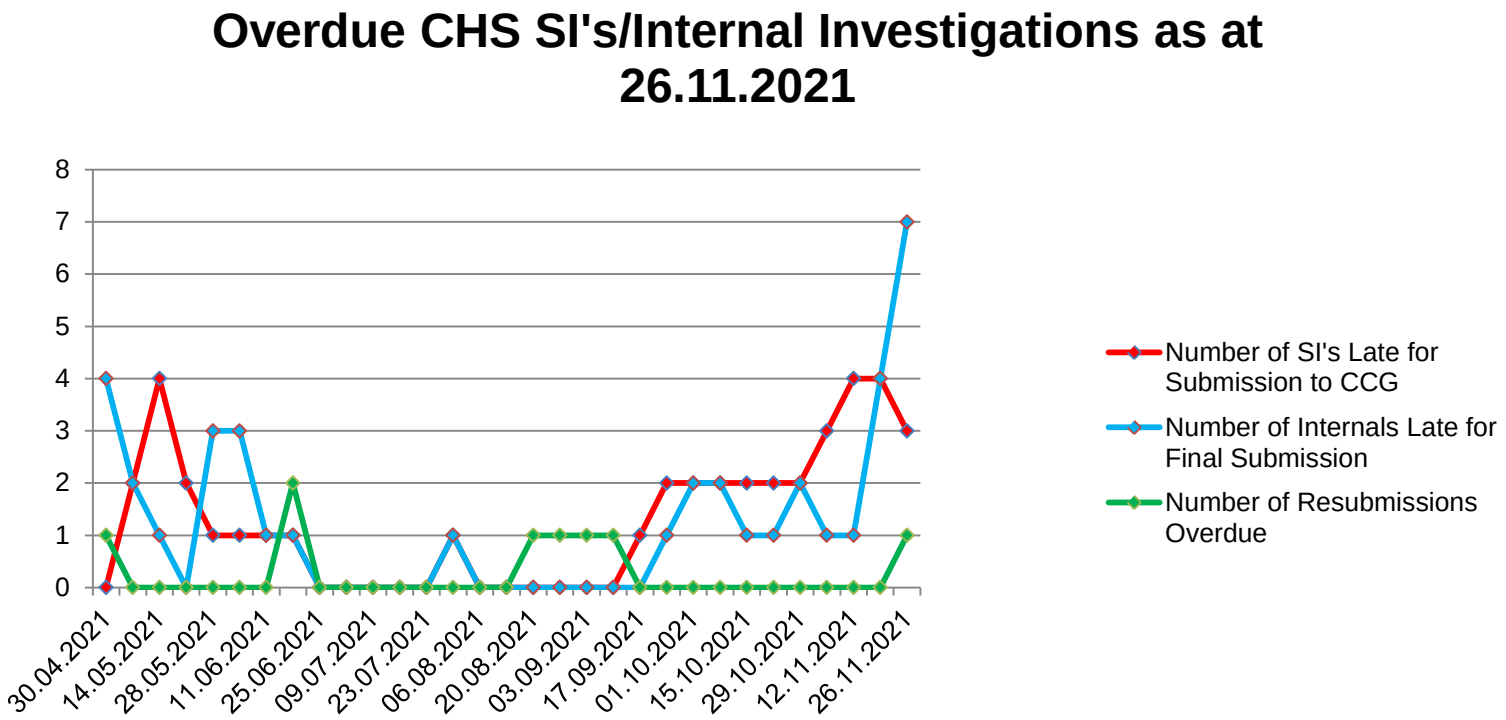
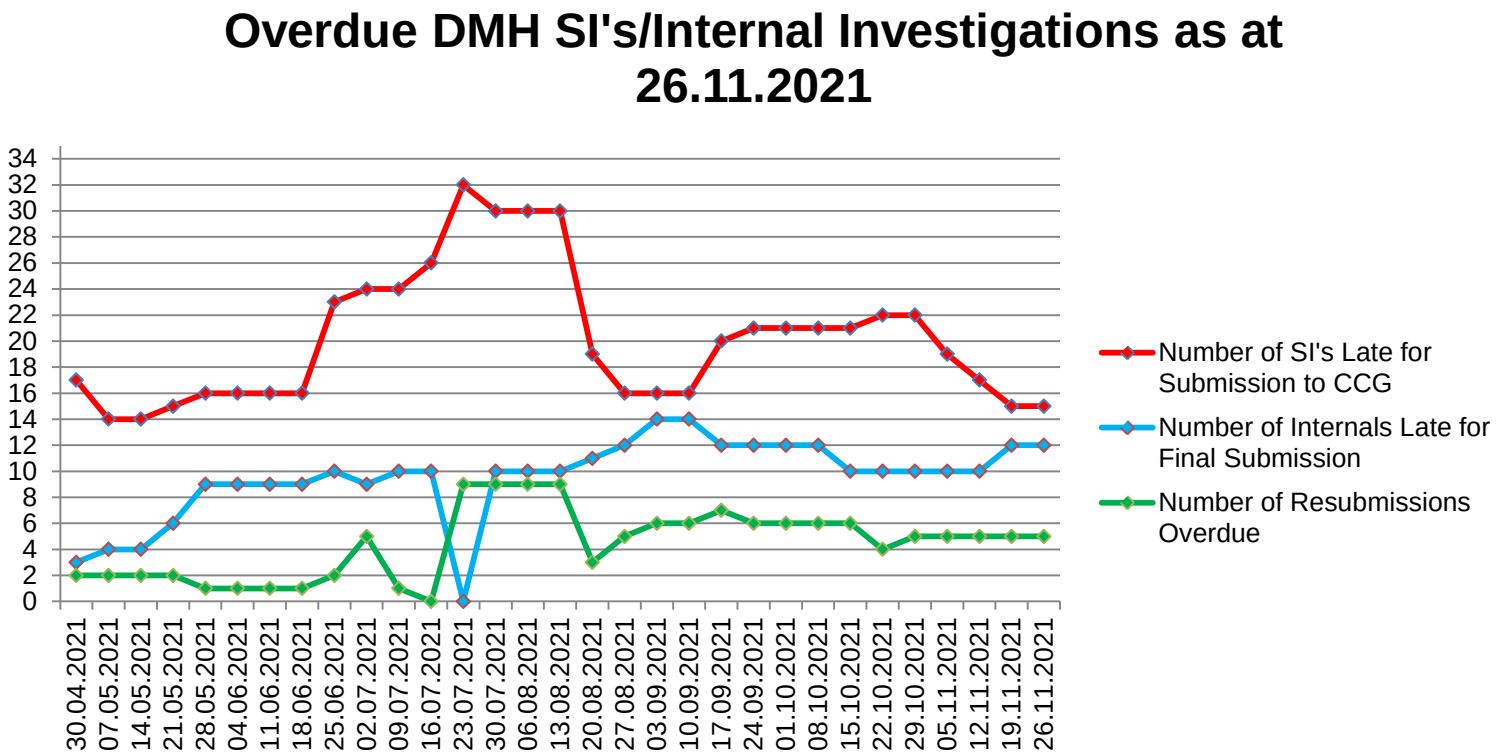
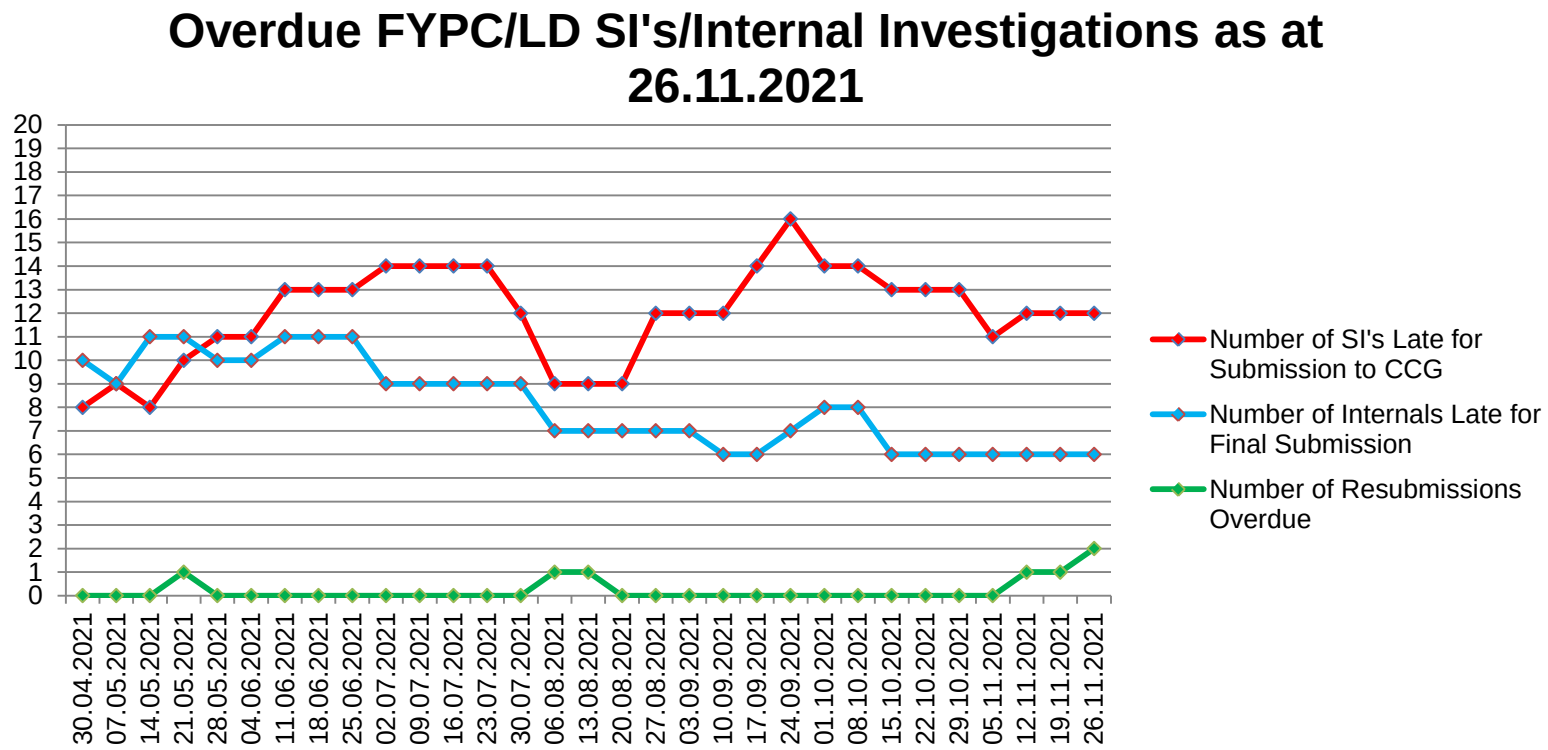
12a. Overdue Serious Incidents/Internal Investigation & CCG resubmissions(includes totals) - CHS



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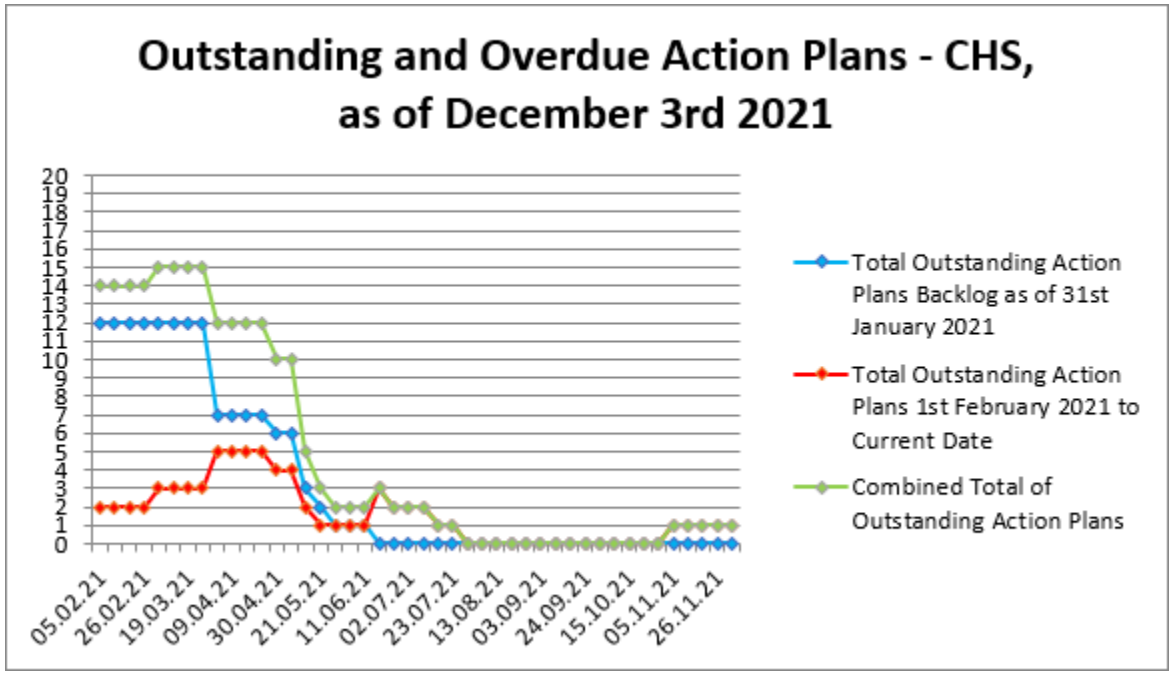
12.b Directorate SI Action Plan Compliance Status 2020/21 to date - CHS



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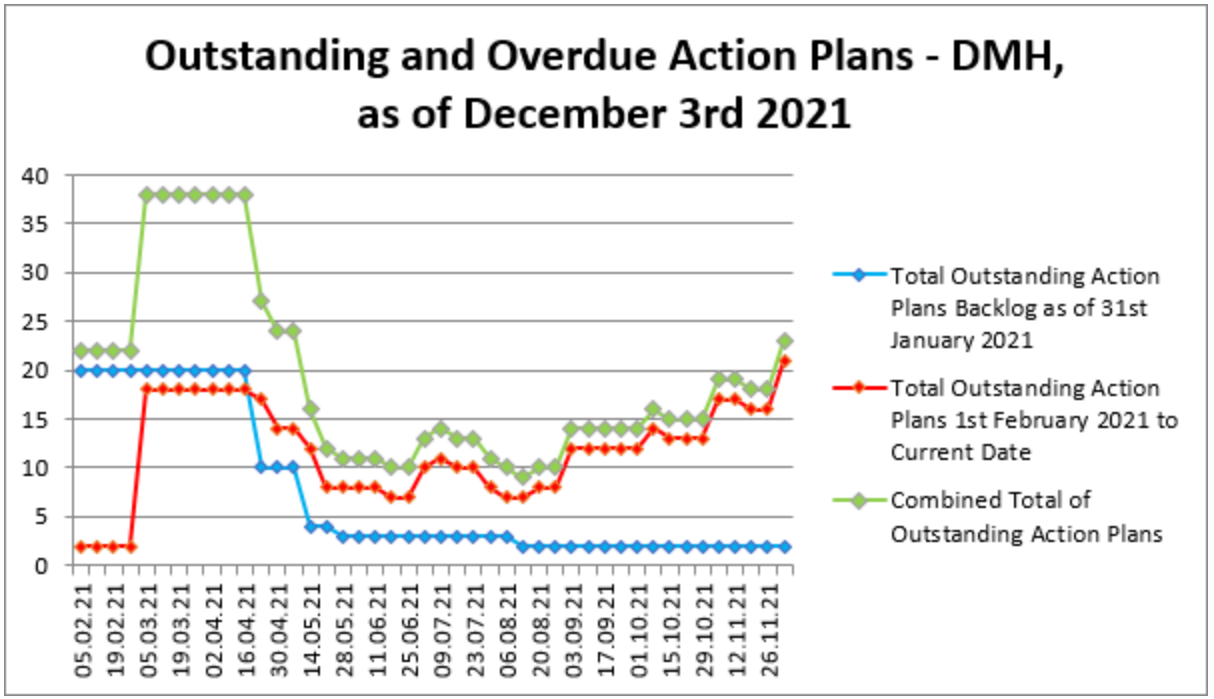
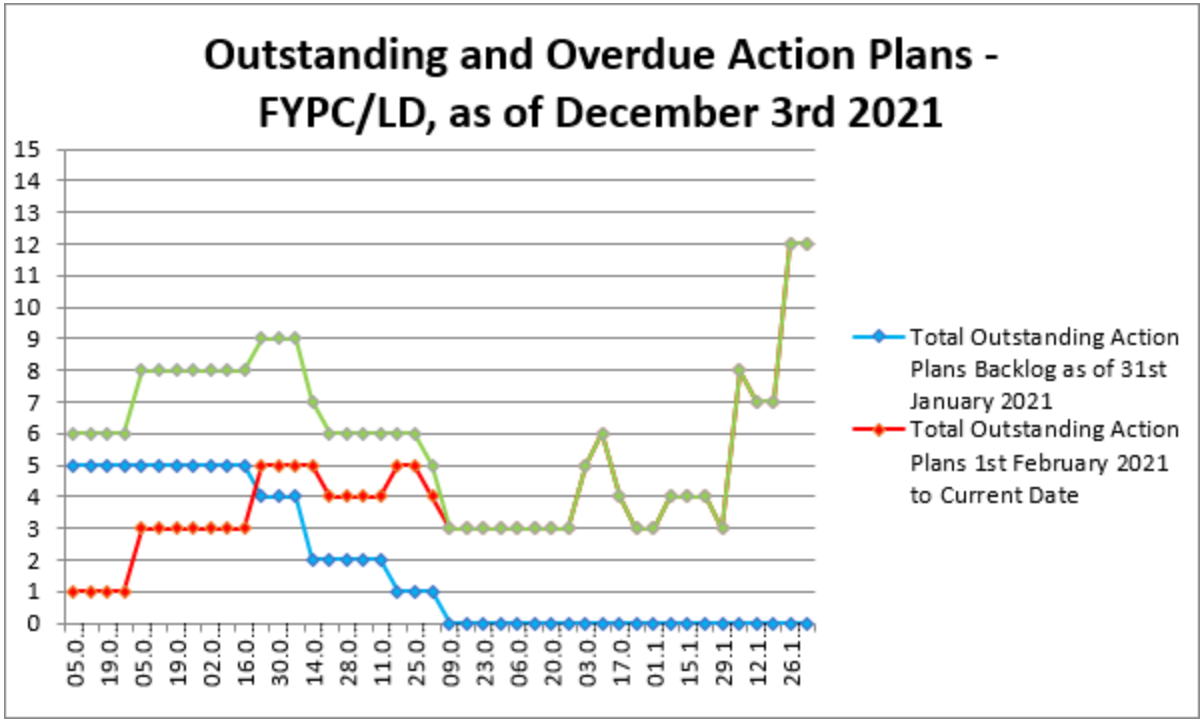
12.b Directorate SI Action Plan Compliance Status 2020/21 to date - DMH



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



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12. Learning

Serious & Internal Incidents Emerging & Recurring Themes

•Record keeping consistently highlighted across all directorates either due to timing of entries (i.e. not contemporaneous), standard of record to provide and flow of knowledge **Action**; teams considering how audit can support the QI work in relation to this

•CMHT's have identified challenges with the MDT approach to updating and **Action**; this is being considered as part of the transformation work

•Mental Capacity and safeguarding knowledge of staff across the organisation **Action**; safeguarding team responding to the identified gaps in knowledge and understanding

•Medication quantity for regular prescriptions linked to risk taking behaviour of self-harm behaviour, knowledge **Action**; working group looking at a model for safe dispensing

•Lying and standing blood pressure and medication reviews in falls with harm **Action**; ANP's to action by asking staff for results as part of their review

•Feedback related to changes from face to face to virtual appointments has been identified by staff patients/families as a challenge for some patients and also makes assessment more difficult **Action**; reports to ensure we are clear 'patient seen on' to be specific on the methodology. Senior Nursing Team for DMH considering this emerging theme

12. Lessons Learned – Trust-wide process

- Increasing challenges with feedback from commissioners delaying closure of reports
- Earlier sharing of final draft serious incidents with families/staff at point of sharing with commissioners
- The benefit of the corporate investigators becoming involved in investigations bringing objectivity
- The importance of recognising early actions as part of the investigation process and being able to offer assurance to commissioners of enactment before report completion
- SystmOne is being reported by investigators as challenging to find their way the different modules/journals to gather and find information