Appendix 1

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

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

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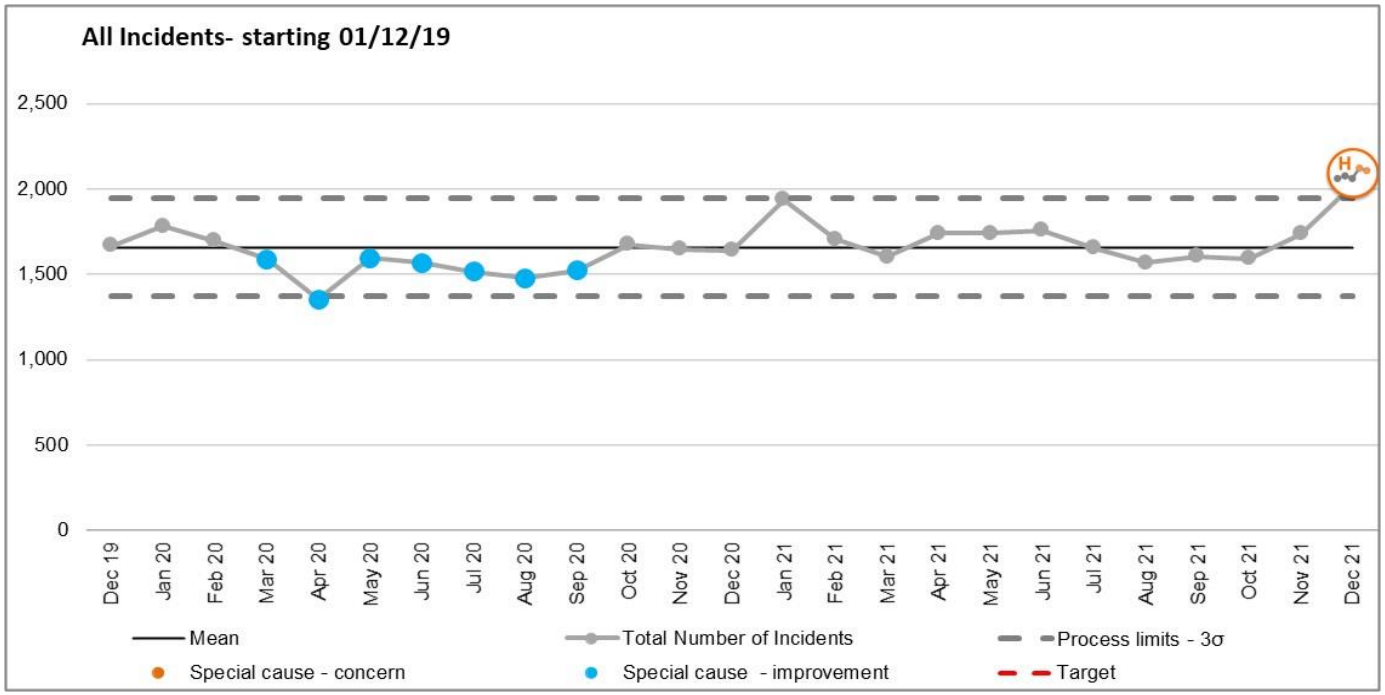
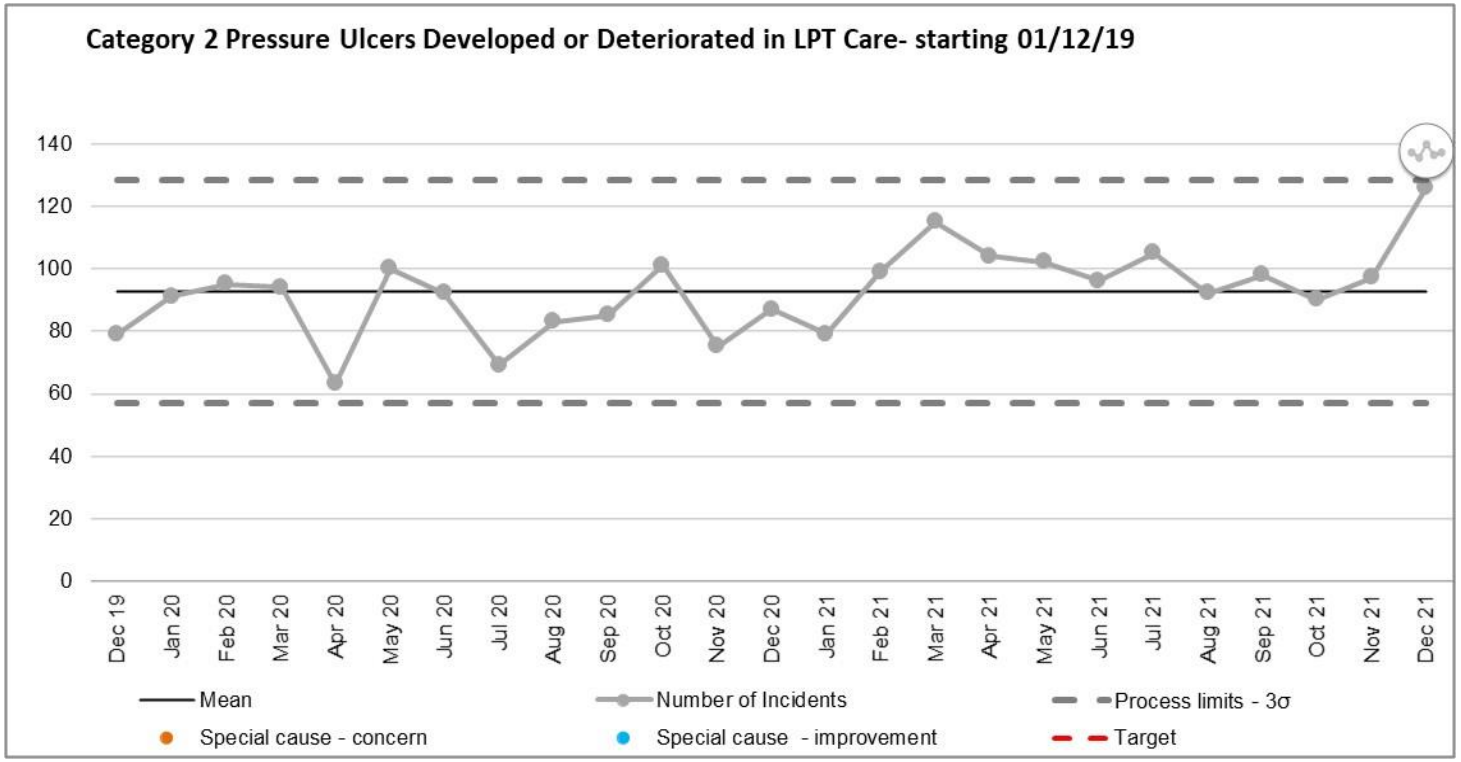
1. All incidents



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



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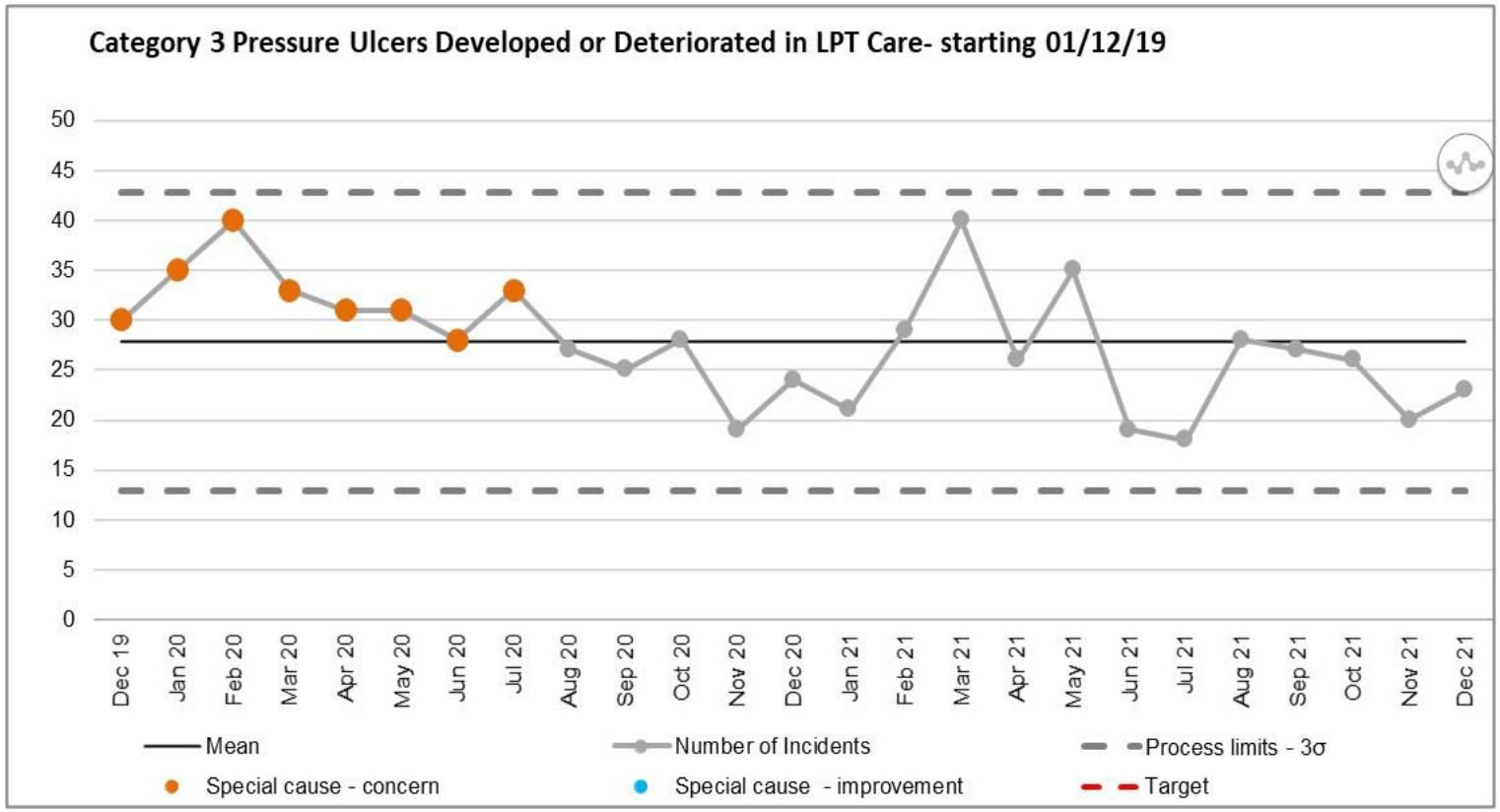
3. Category 3 Pressure Ulcers developed or deteriorated in LPT Care



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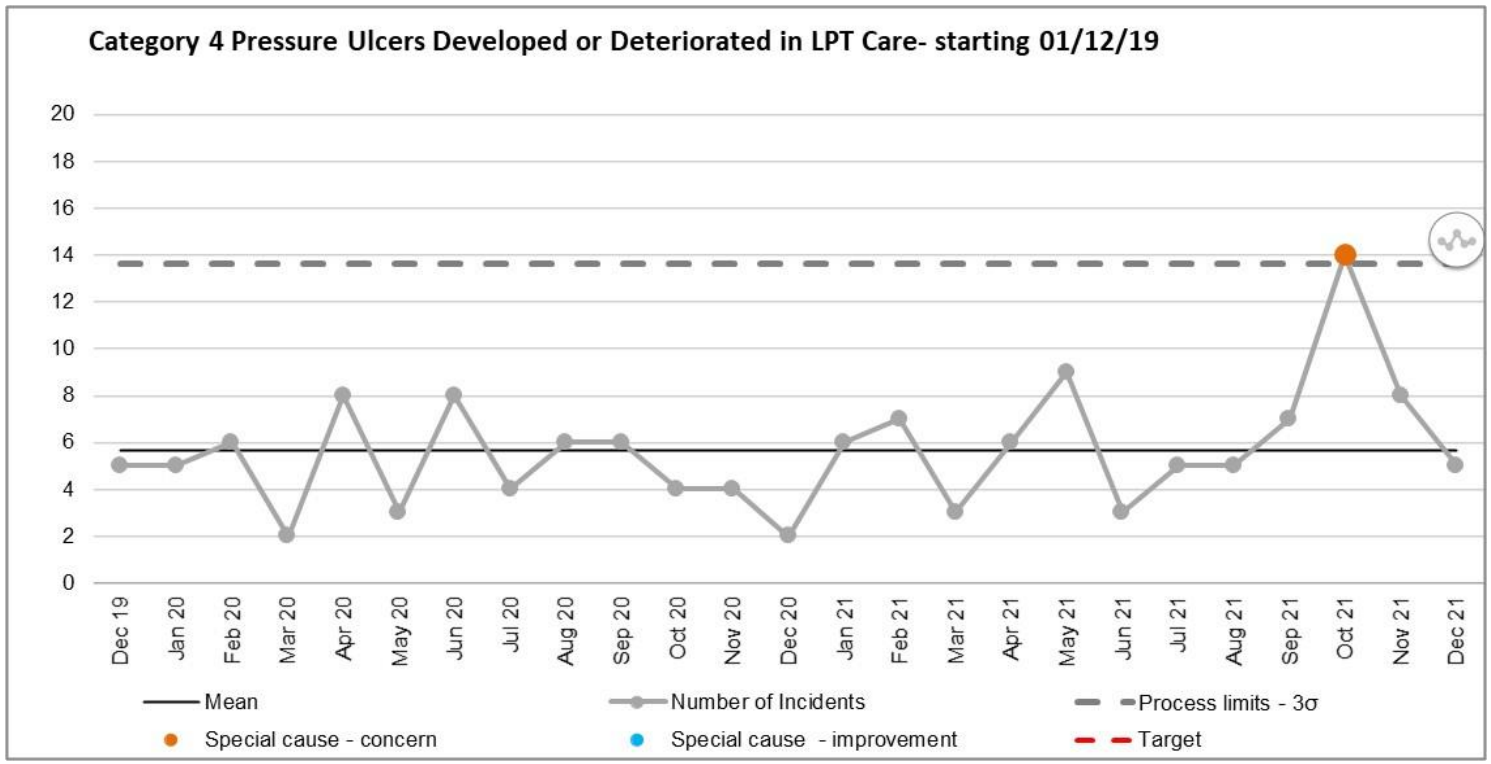
4. Category 4 Pressure Ulcers Developed or deteriorated in LPT Care



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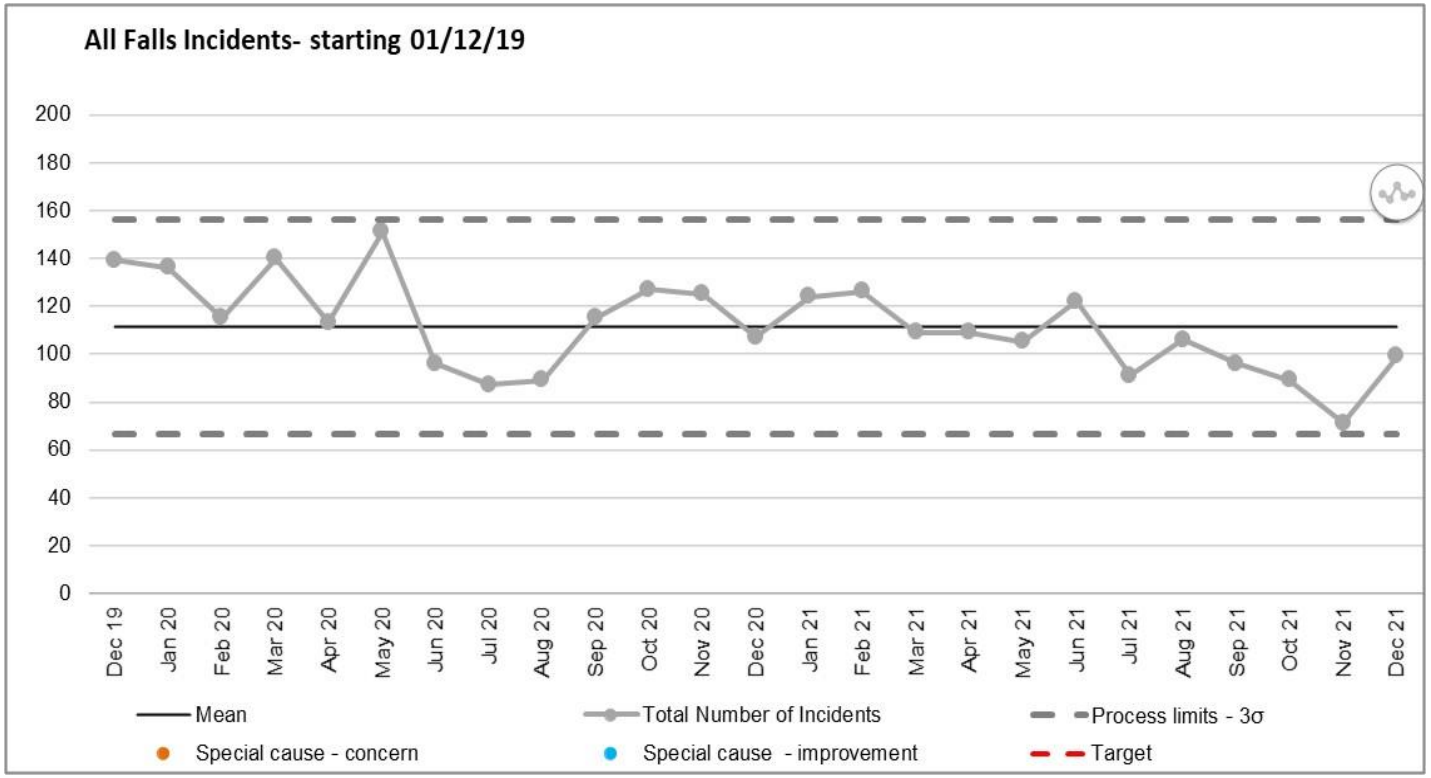
5. All falls incidents reported



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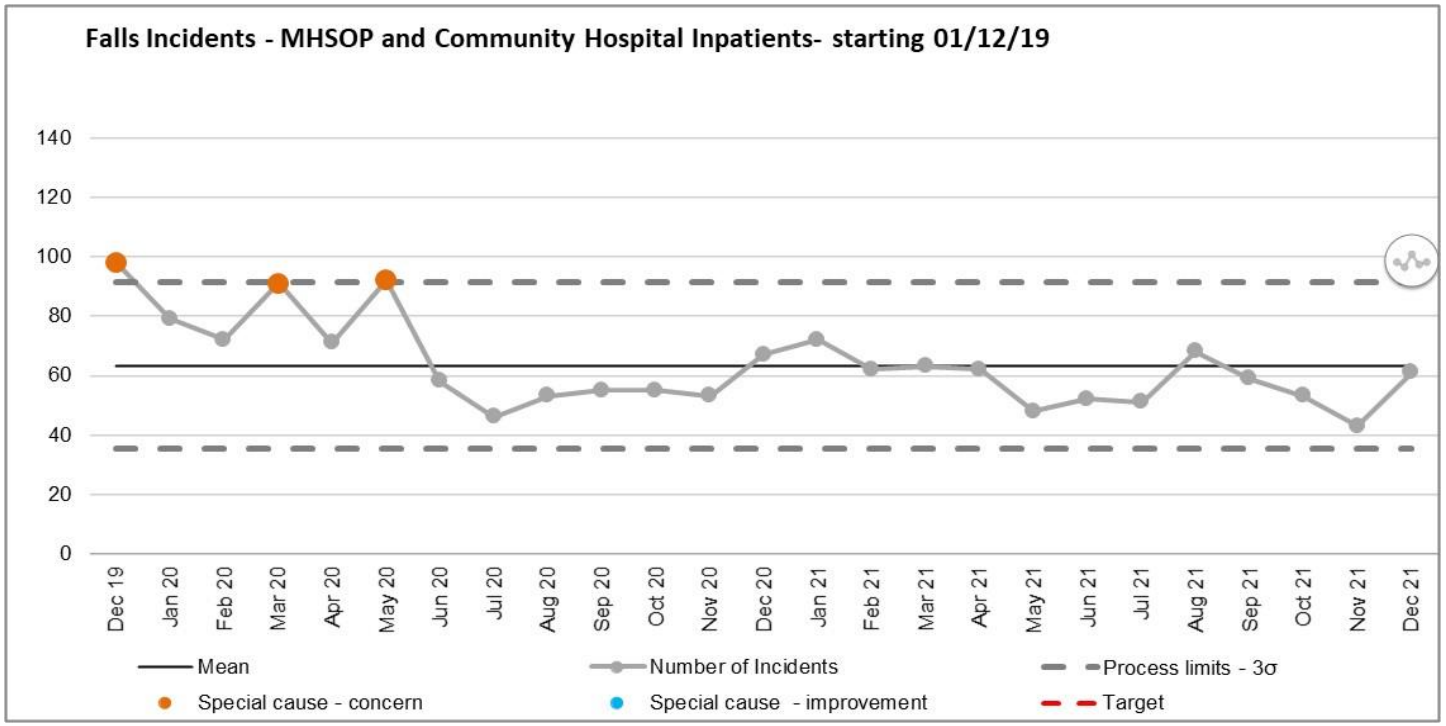
6. Falls incidents reported – MHSOP and Community Inpatients



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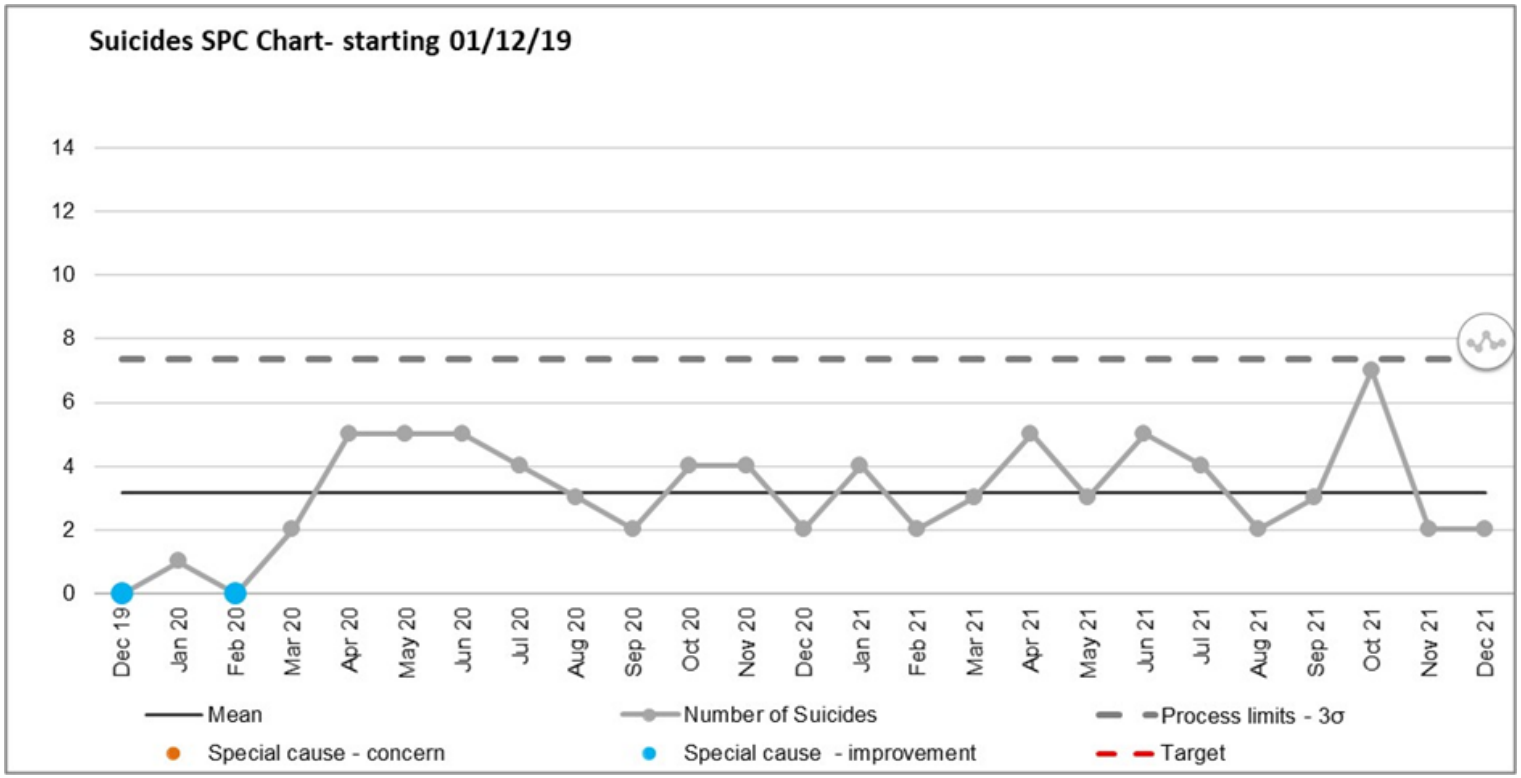
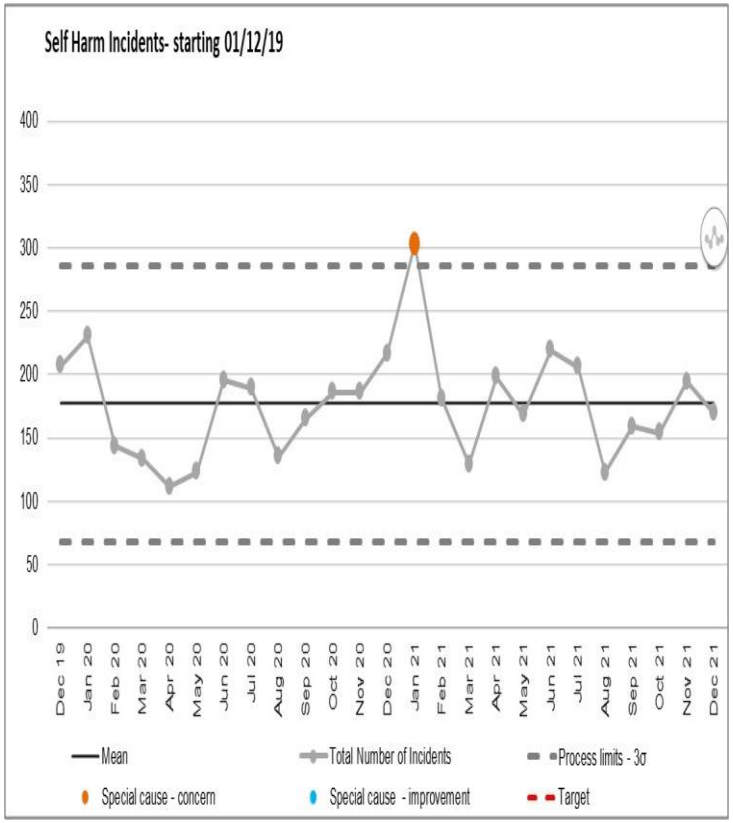
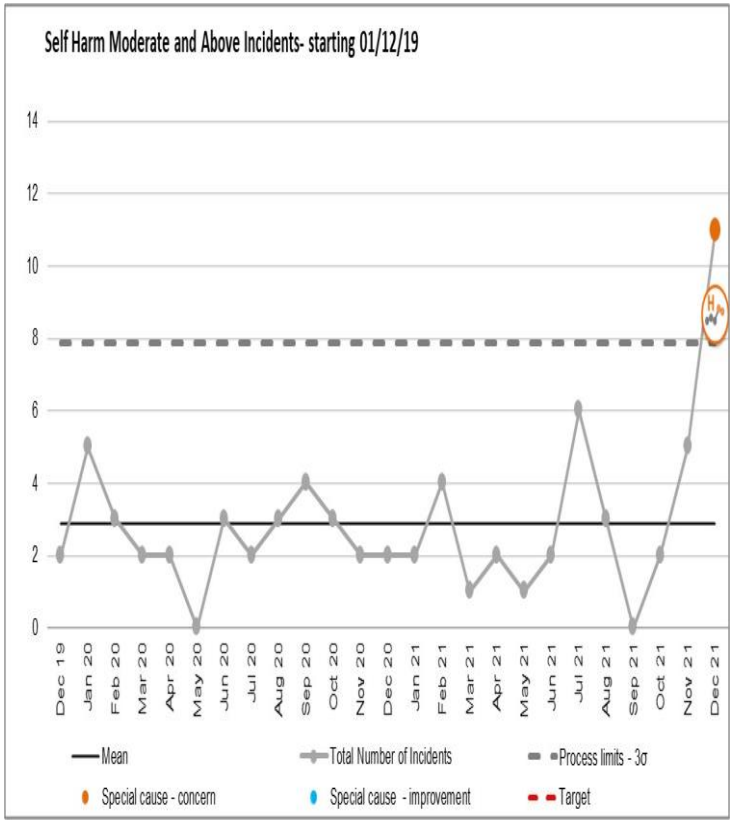
7. All reported Suicides



8. Self Harm reported Incidents





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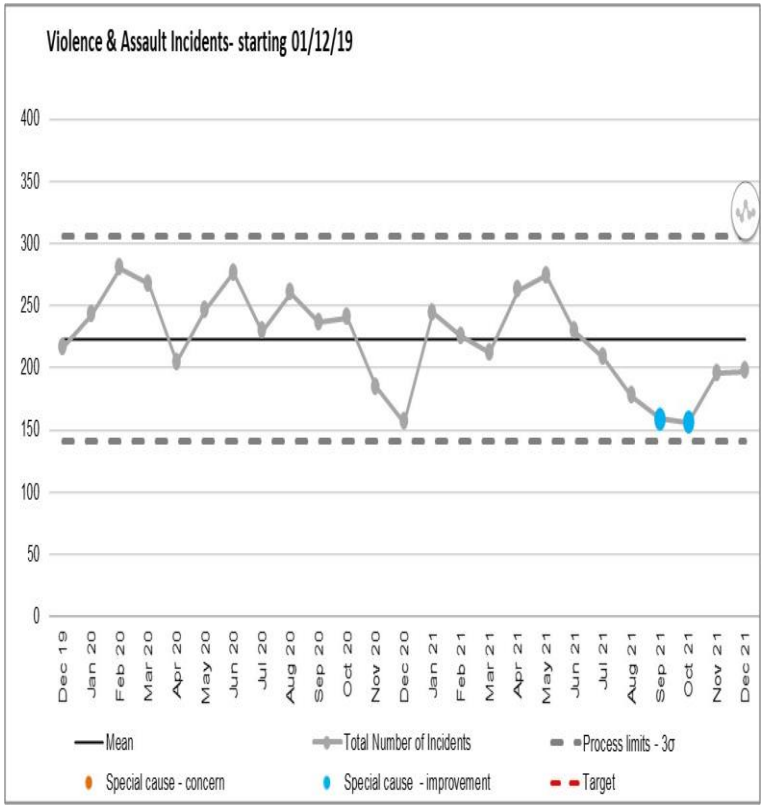
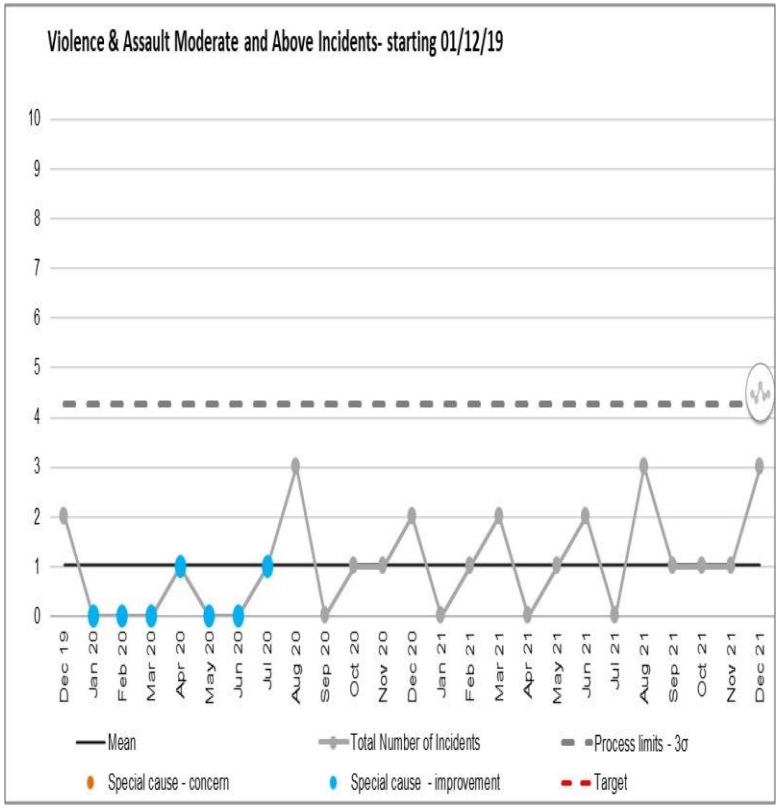
9. All Violence & Assaults reported Incidents





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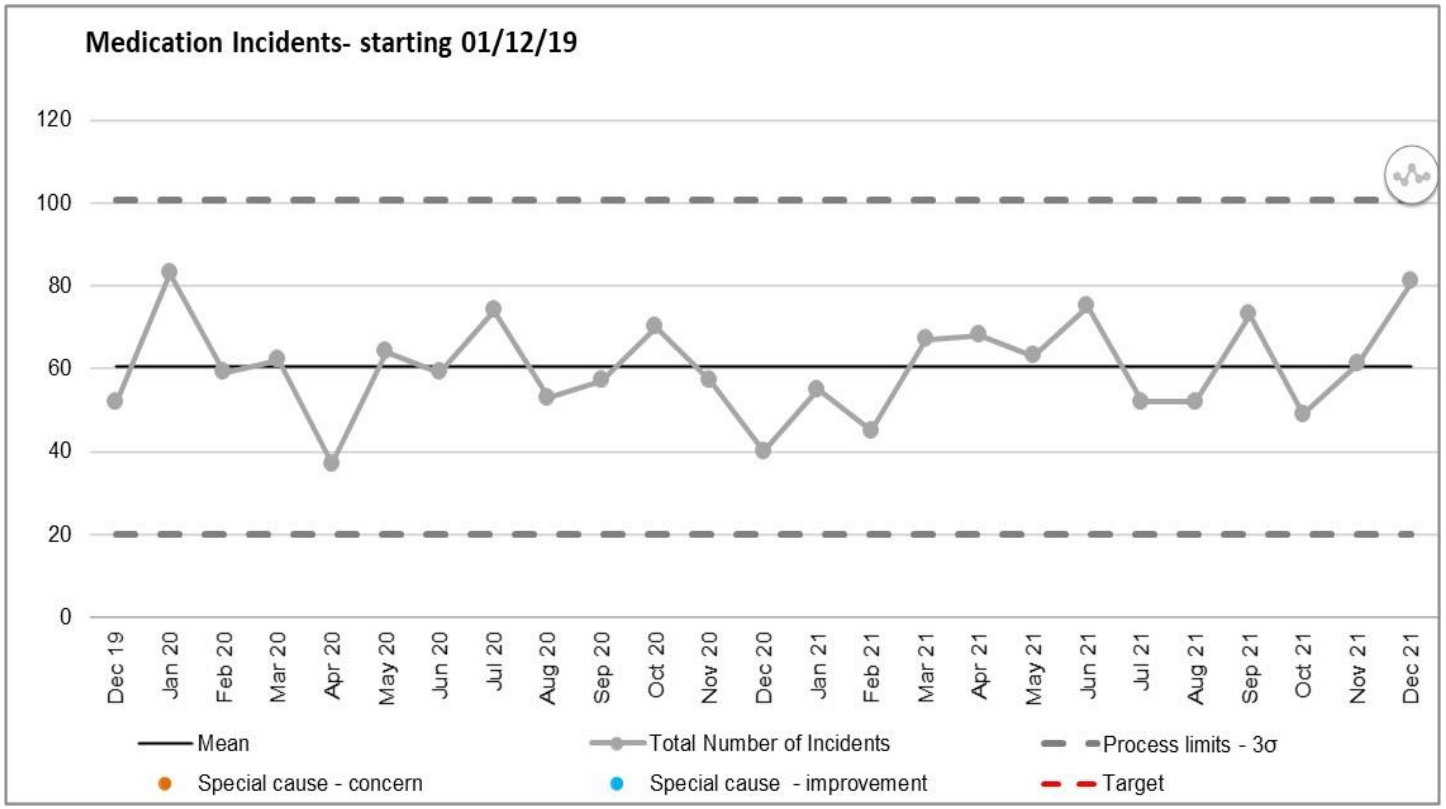
10. All Medication Incidents reported



11. Directorate Specialities describing Top 5 Incidents

Table 1: Mental Health: Community

Mental Health Non MHSOP Community - December	
Cause Group	Total
Self Harm	55
Infection Control	49
Violence/Assault	32
Safeguarding (Adults)	16
Staffing	13

Table 2: Mental Health: Inpatients

Mental Health Non MHSOP Inpatient - December	
Cause Group	**Total**
Violence/Assault	89
Self Harm	34
Infection Control	27
Security	19
Clinical Condition	18

Directorate Specialities describing Top 5 Incidents

Table 3: MHSOP – Inpatients

MHSOP Inpatient - December	
Cause Group	**Total**
Violence/Assault	23
Patient Falls, Slips, And Trips	21
Clinical Condition	8
Infection Control	7
Medication	5

Table 4: MHSOP – Community

MHSOP Community - December	
Cause Group	**Total**
Infection Control	7
Patient Death	6
Self Harm	4
Patient Falls, Slips, And Trips	3
Safeguarding (Adults)	3

Directorate Specialities describing Top 5 Incidents

Table 5: Learning Disability – In-Patient

LD Agnes Unit - December	
Cause Group	**Total**
Violence/Assault	28
Self Harm	6
Allegations Against Staff	2
Clinical Condition	2
Infection Control	2
Missing Patient	2

Table 6: Learning Disability - Community

LD Community - December	
Cause Group	**Total**
Violence/Assault	14
Infection Control	13
Patient Falls, Slips, And Trips	6
Self Harm	5
Case Notes & Records	4
Safeguarding (Adults)	4

Directorate Specialities describing Top 5 Incidents

Table 7: FYPC Inpatient CAMHS

FYPC CAMHS Inpatient - December	
Cause Group	**Total**
Self Harm	61
Mental Health Act	28
Infection Control	13
Violence/Assault	11
Clinical Condition	4

Table 8: FYPC non LD Non CAMHS

FYPC Non LD Non CAMHS - December	
Cause Group	**Total**
Infection Control	49
Case Notes & Records	11
Communication	10
Safeguarding (Children)	10
Medication	9

Directorate Specialities describing Top 5 Incidents

Table 10: CHS In-Patient

CHS Inpatient - December	
Cause Group	**Total**
Infection Control	68
Tissue Viability	60
Patient Falls, Slips, And Trips	40
Medication	17
Patient Death	16

Table 11: CHS Community

CHS Community - December	
Cause Group	**Total**
Tissue Viability	471
Infection Control	59
Medication	21
Case Notes & Records	11
Safeguarding (Adults)	11

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	0	6	1	6	6	7	2	7
2021/22 Q4	January								
	February								
	March								
YTD			65	15	22	75	41	16	42

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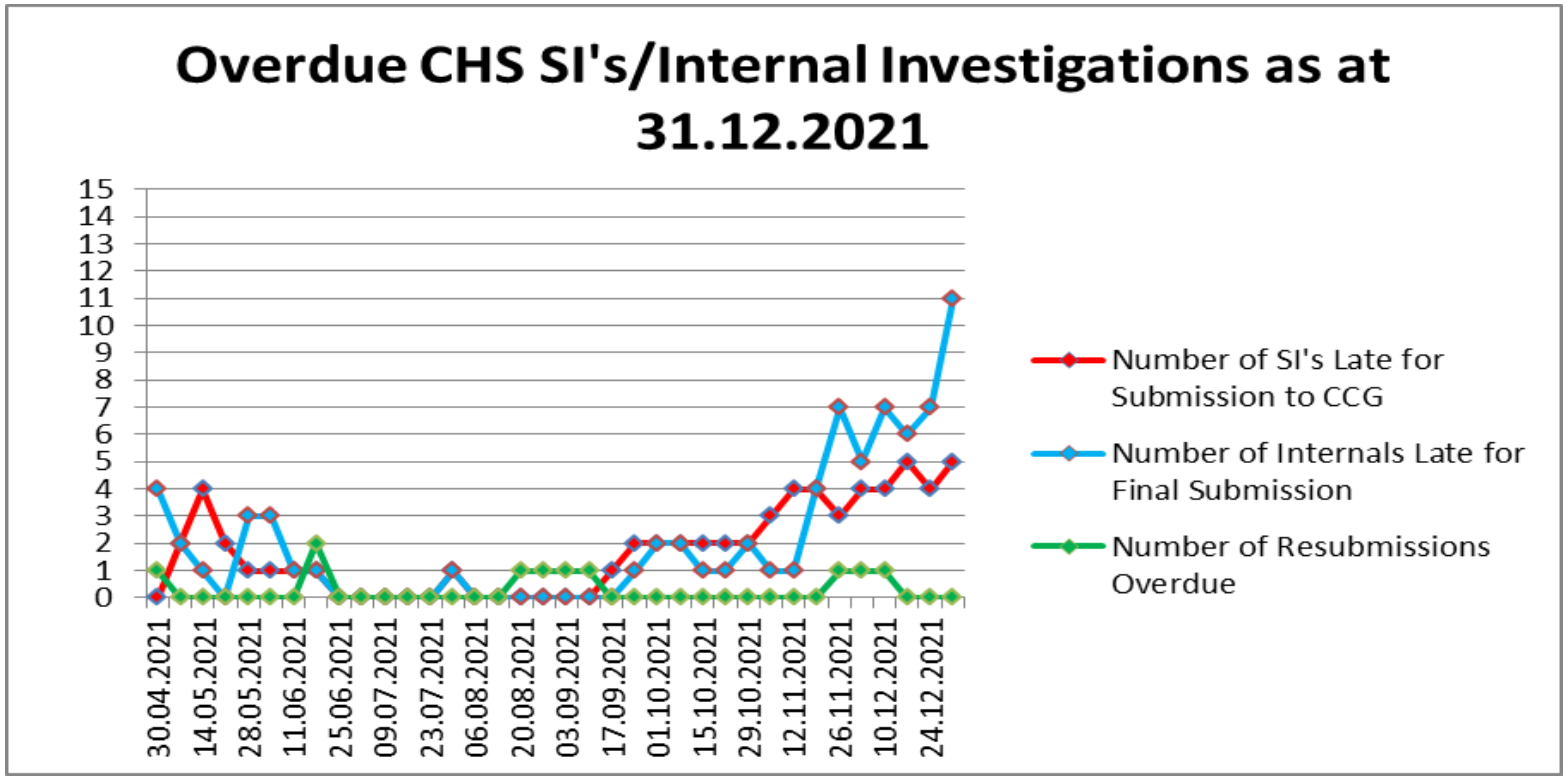
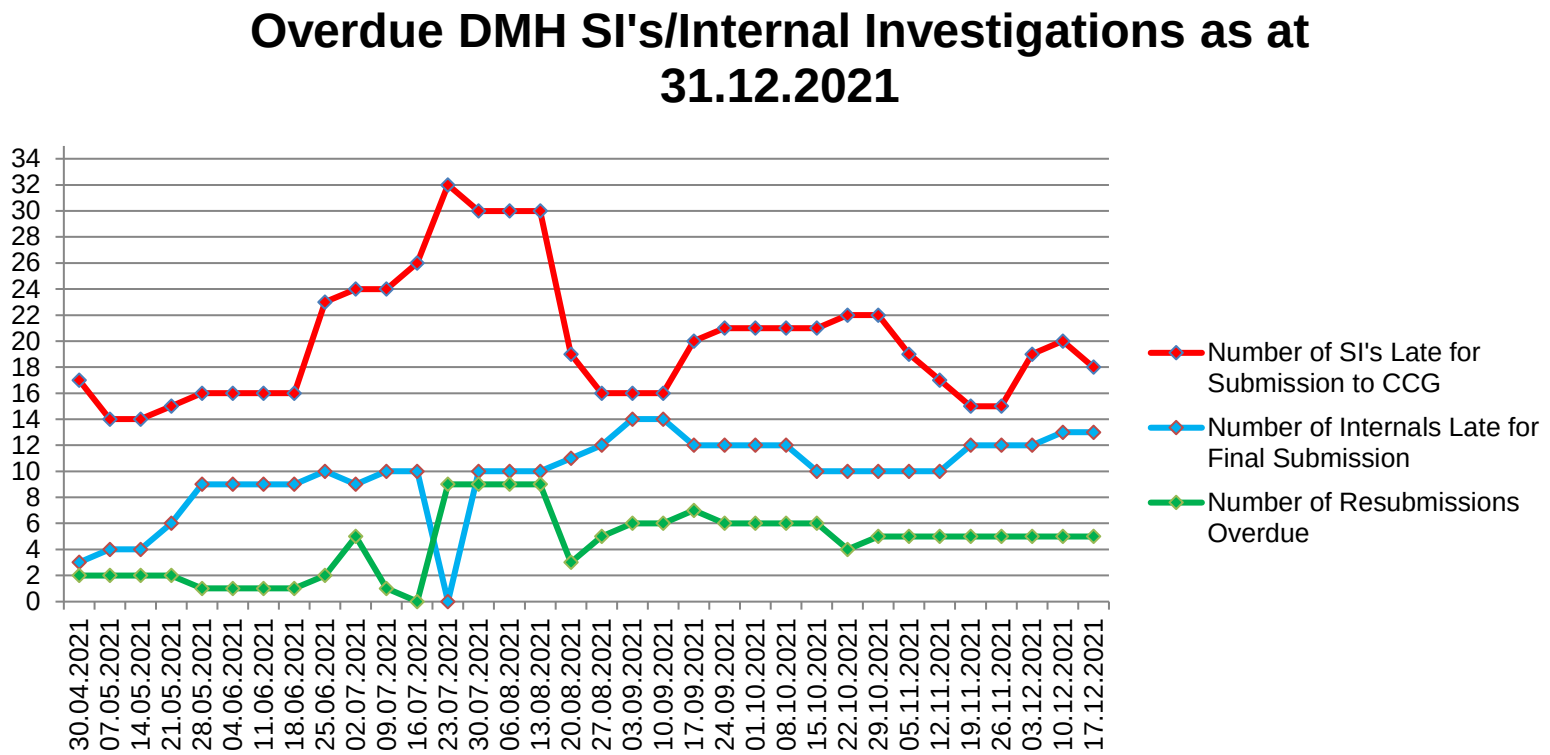
12a. Overdue Serious Incidents/Internal Investigation & CCG resubmissions(includes totals) - CHS



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



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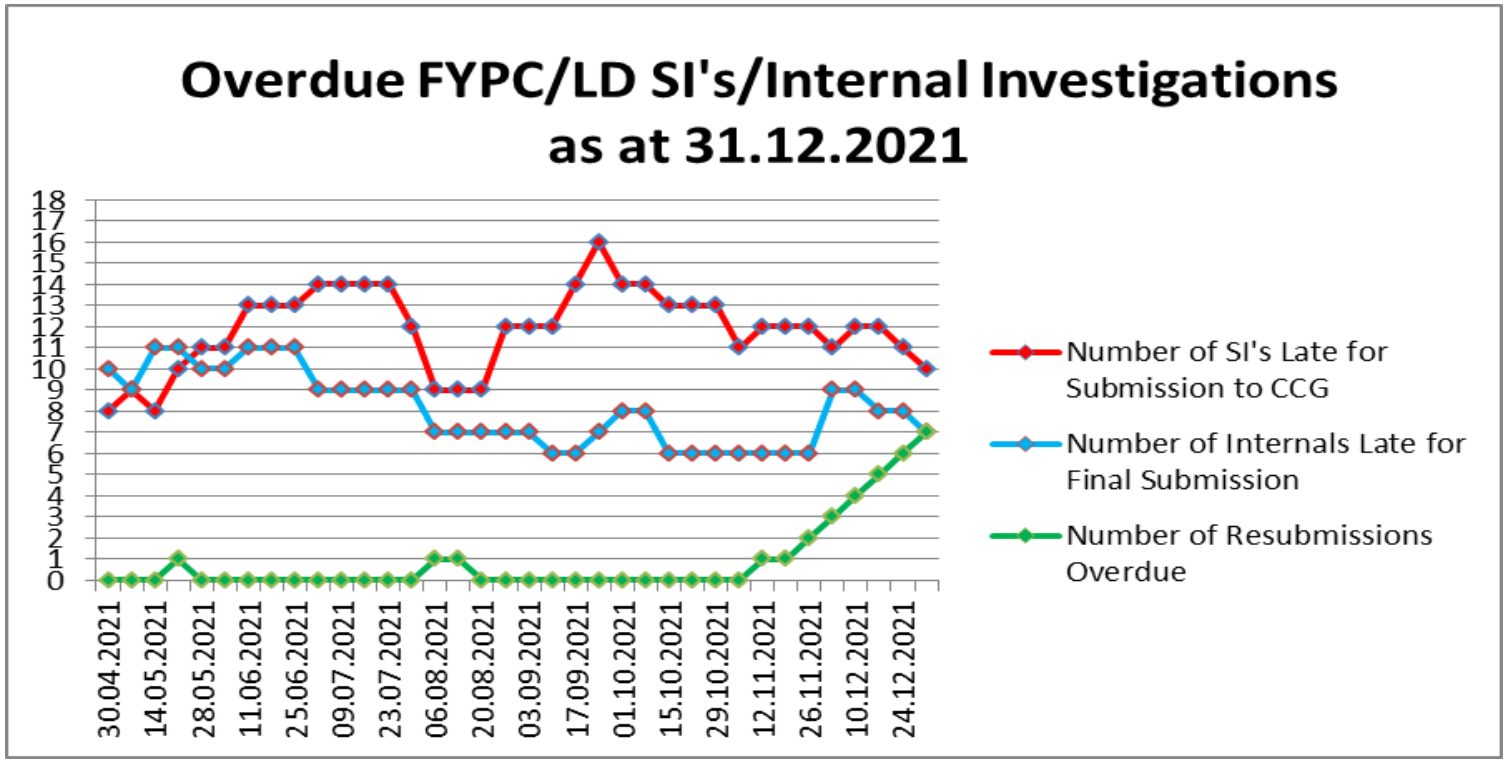
12a. Overdue Serious Incidents/Internal Investigations & CCG resubmissions (includes totals) - FYPCLD



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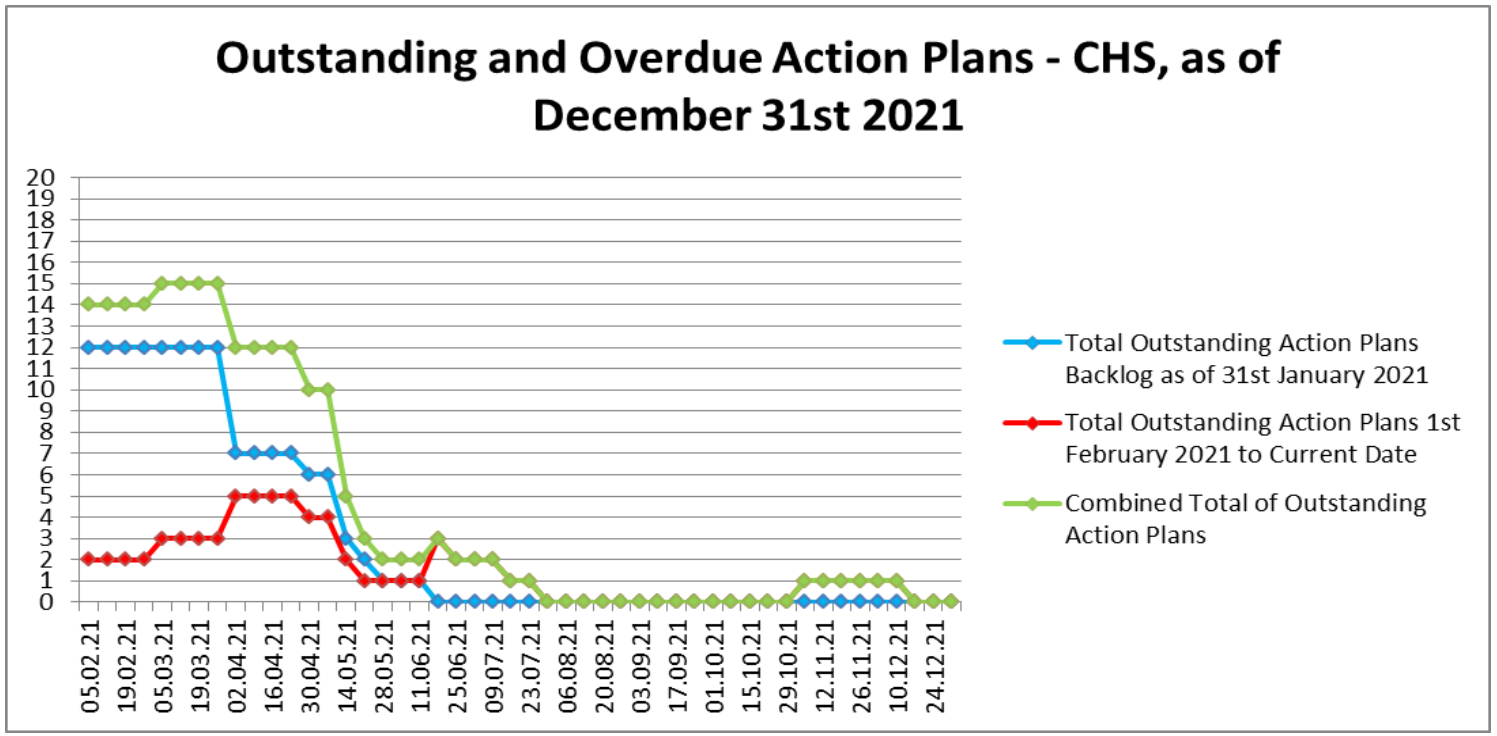
12.b Directorate SI Action Plan Compliance Status 2020/21 to date - CHS



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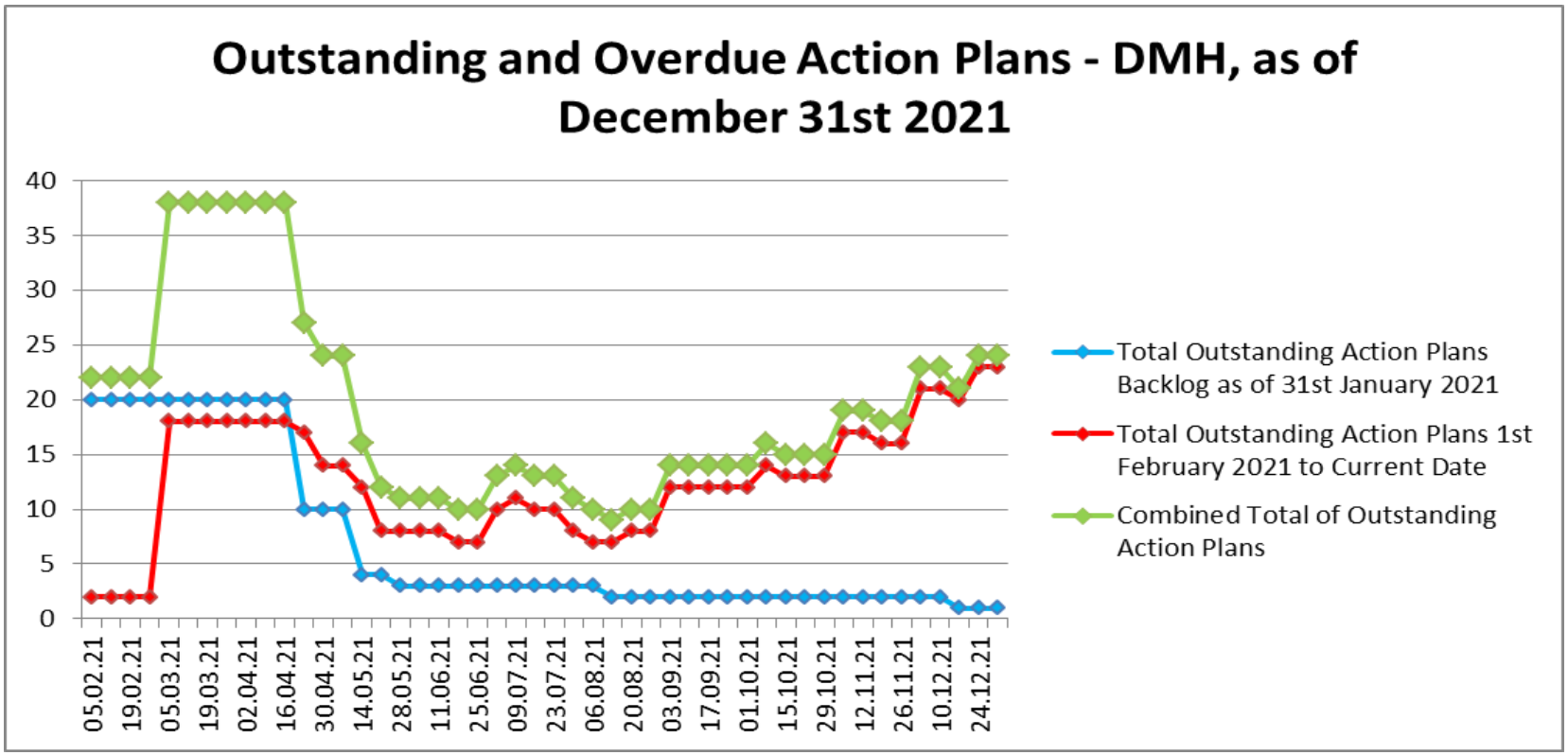
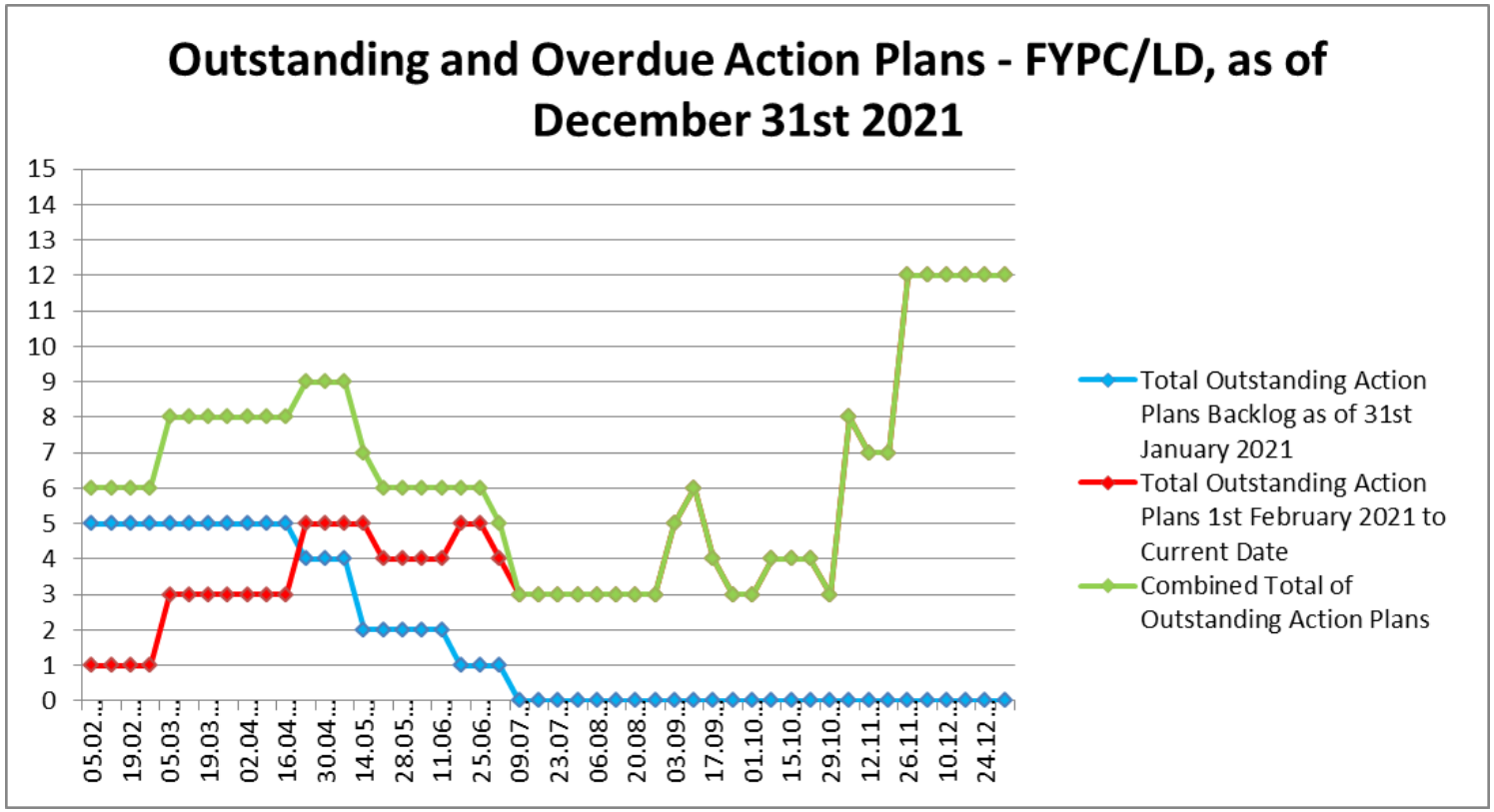
12.b Directorate SI Action Plan Compliance Status 2020/21 to date - DMH



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



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 a flow of knowledge
- Updated risk assessments and their application to clinical practice and from a MDT approach, emerging theme in outpatient mental health
- Mental Capacity and safeguarding knowledge
- Lying & standing blood pressure and medication reviews in falls with harm
- Feedback related to changes from face to face to virtual appointments has been feedback identified from patients/families as a challenge for some patients and also makes assessment more difficult
- Involving families in care decisions related to consent, confidentiality & information sharing in mental healthcare & suicide prevention which very topical following the publication of a national report form Zero Suicide Alliance in August 2021

12. Lessons Learned – Trust-wide process

- Continues to be increasing challenges with feedback from commissioners delaying closure of reports
- Continued promotion of 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 & supporting delayed/reallocated starting of investigations
- The continued promotion of 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 increasingly being reported by investigators as challenging to find their way the different modules/journals to gather and find information and inconsistent places/approach to recording patient contact