Appendix 1

The following slides show Statistical Process Charts of incidents that have been reported by our staff during January/February 2023

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

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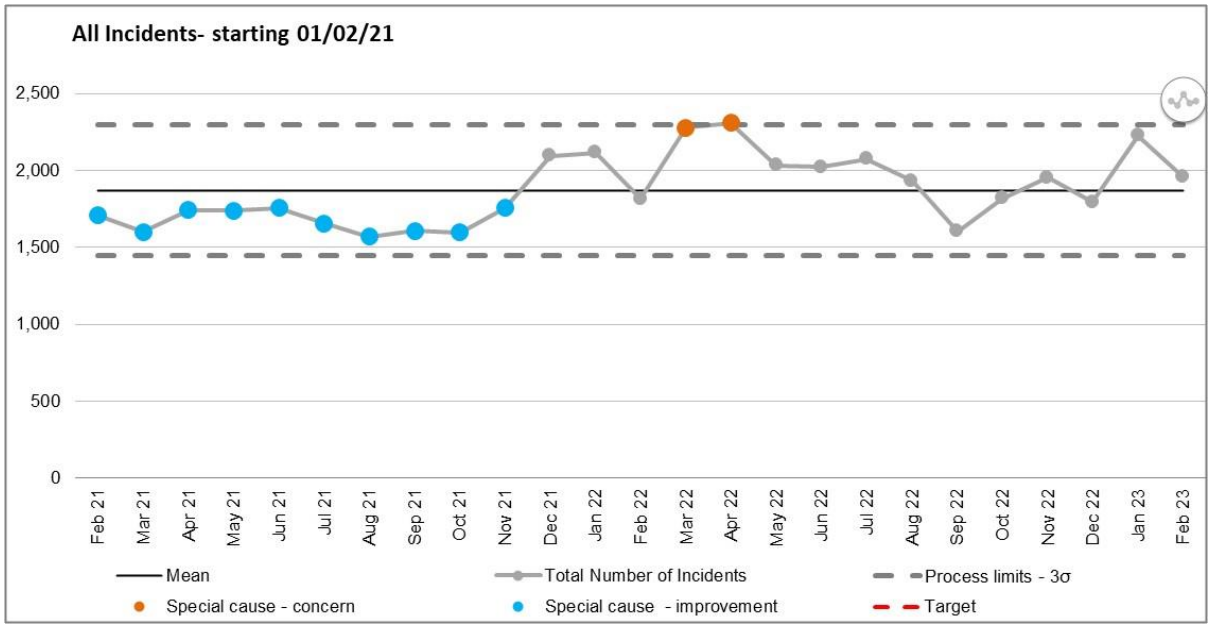
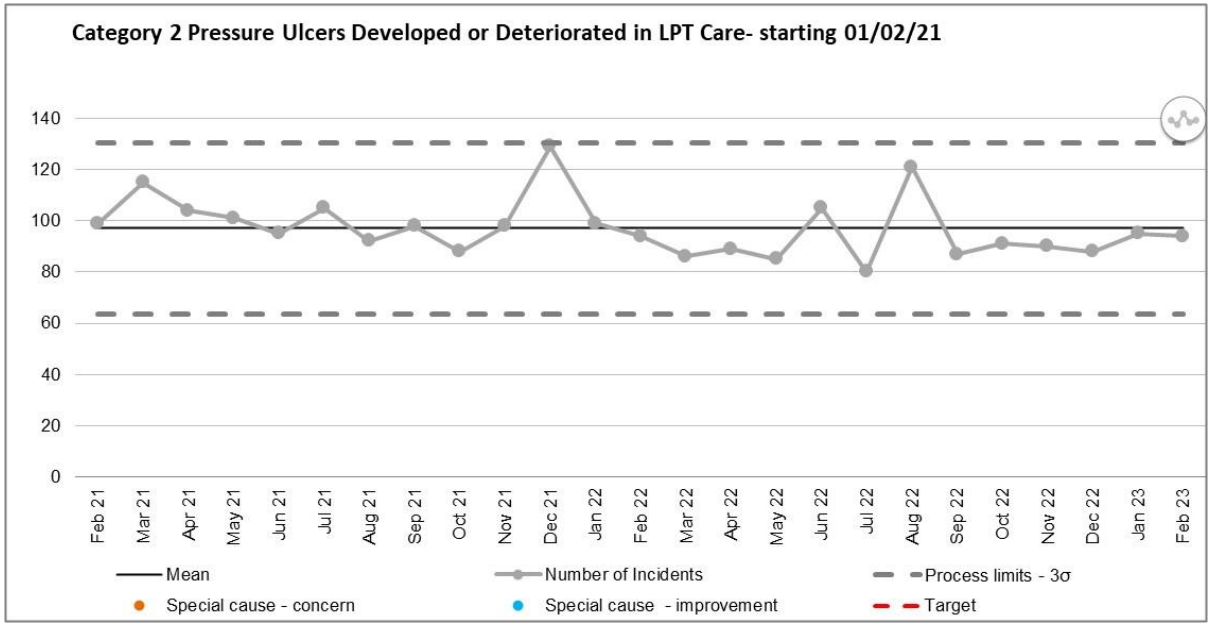
1. All incidents



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



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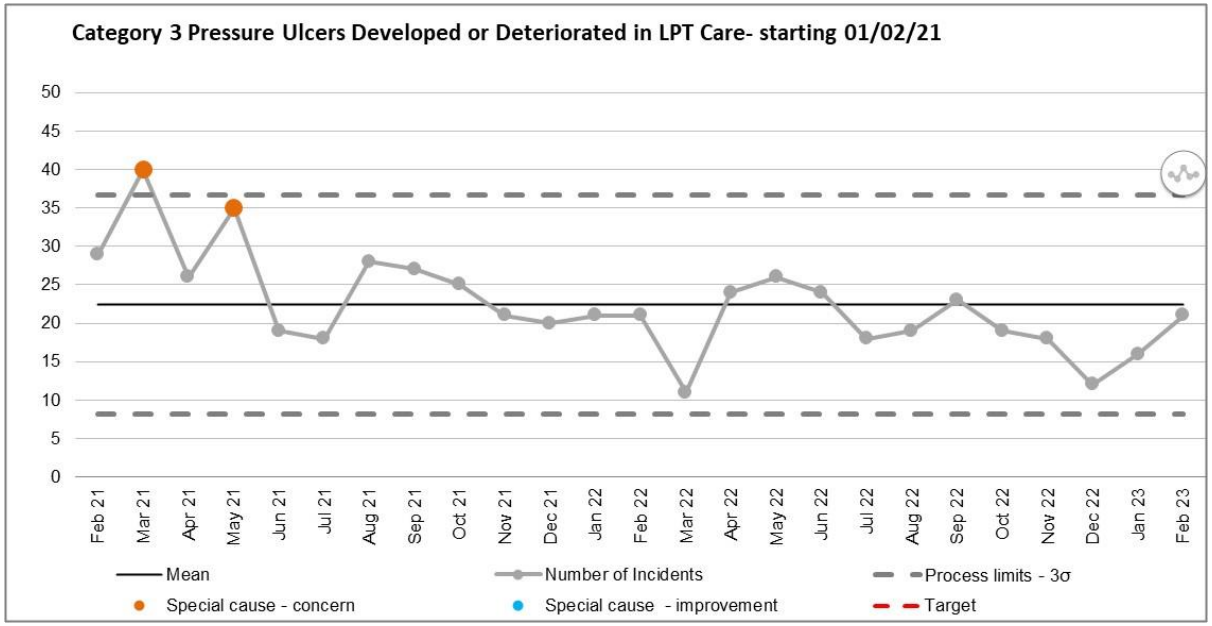
3. Category 3 Pressure Ulcers developed or deteriorated in LPT Care



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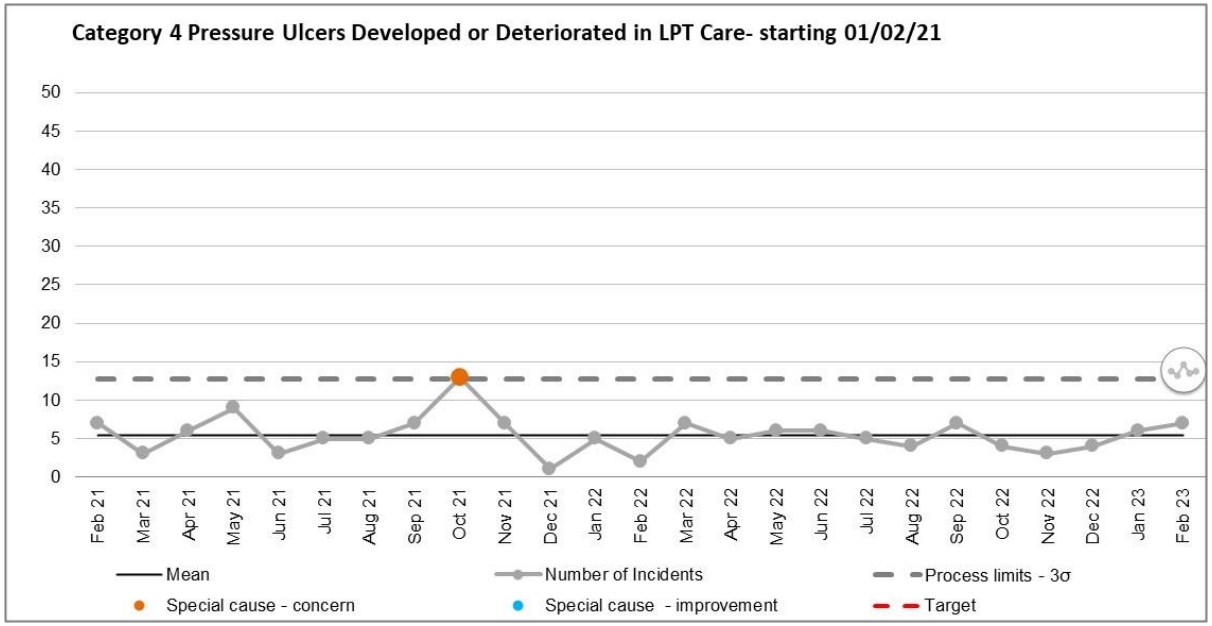
4. Category 4 Pressure Ulcers Developed or deteriorated in LPT Care



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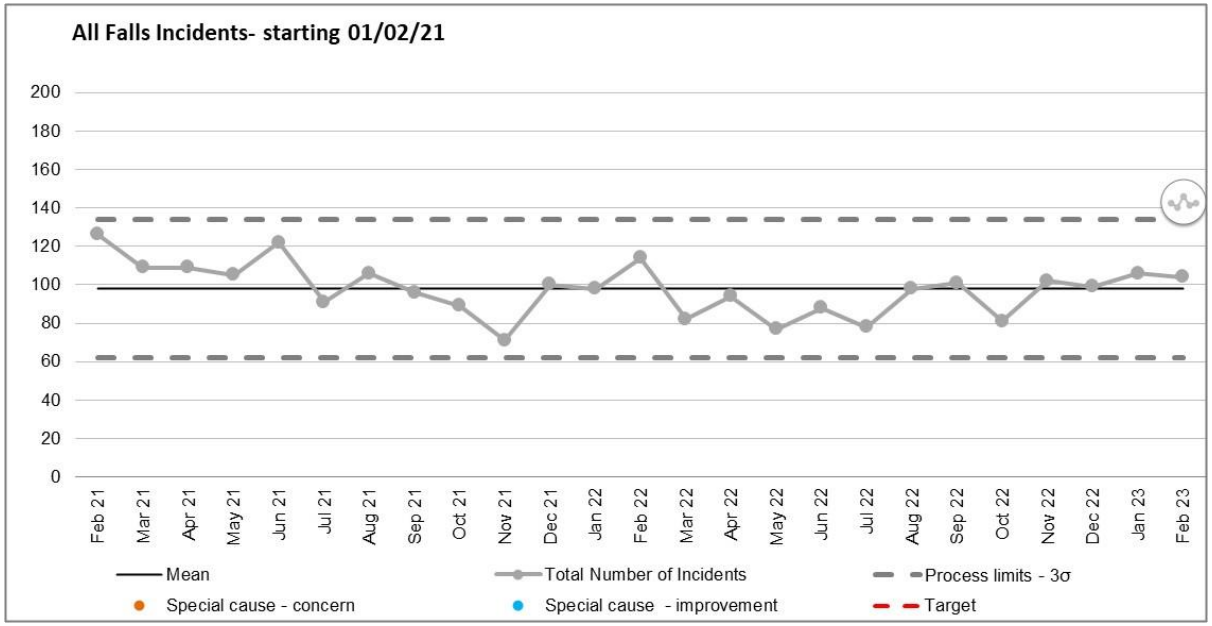
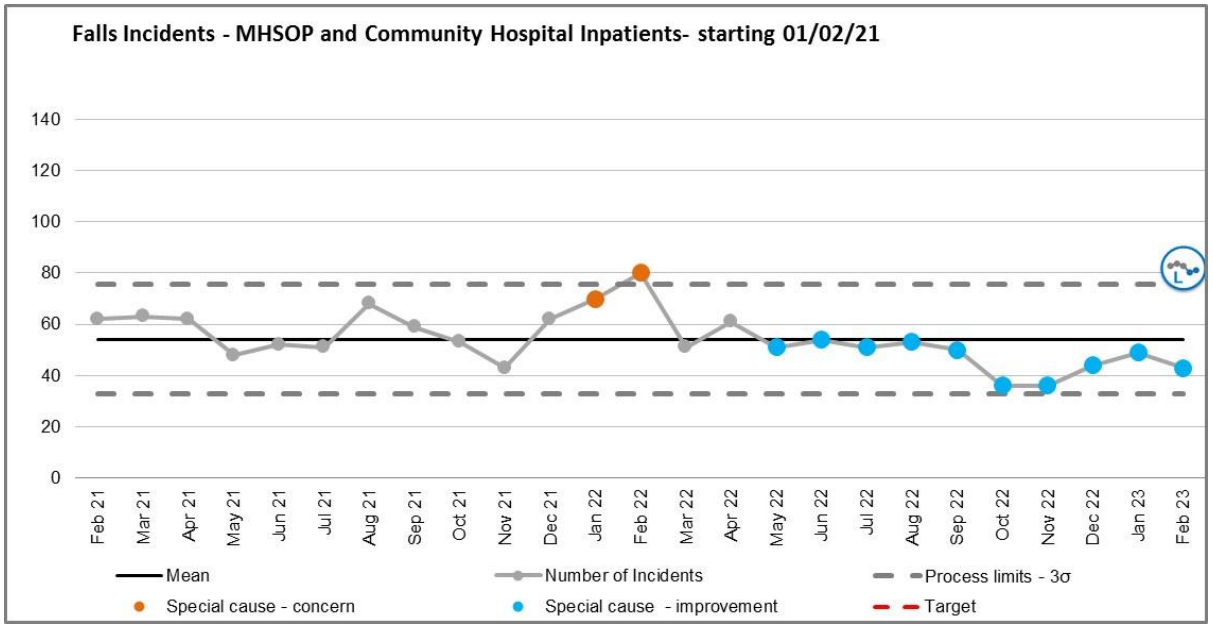
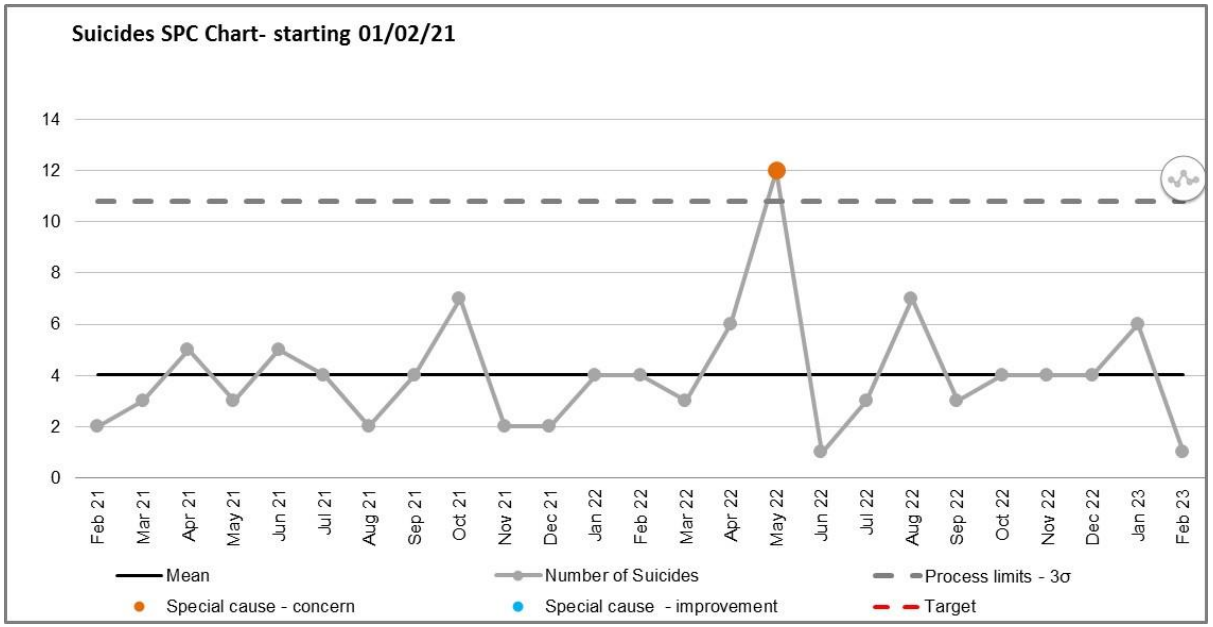
5. All falls incidents reported



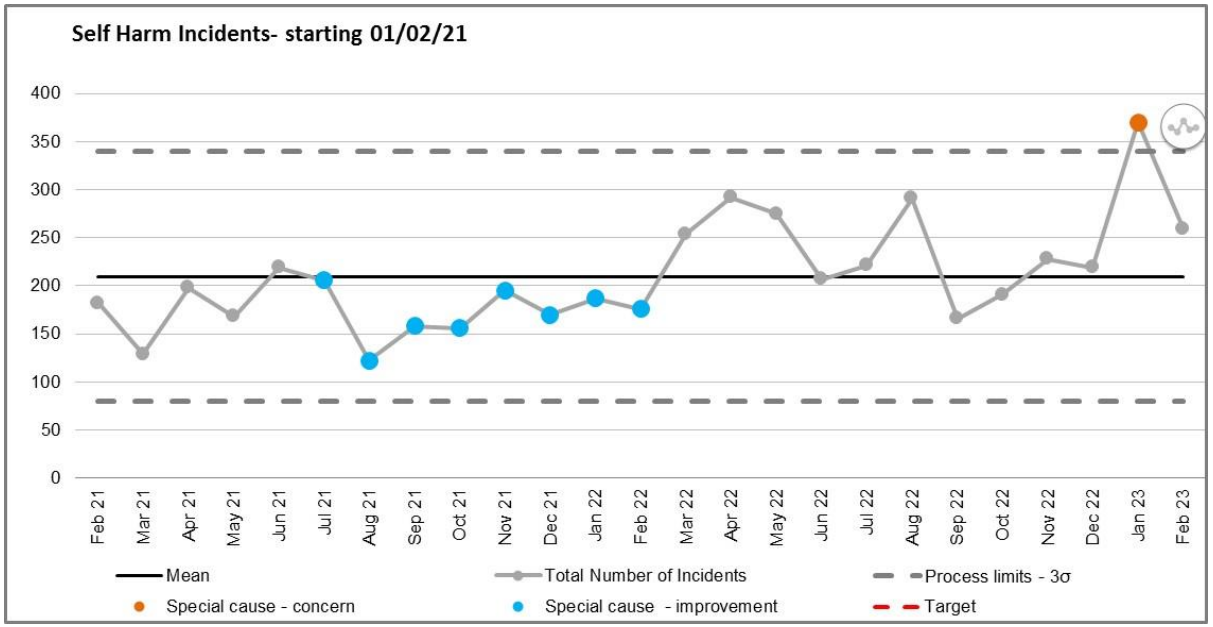
6. Falls incidents reported – MHSOP and Community Inpatients



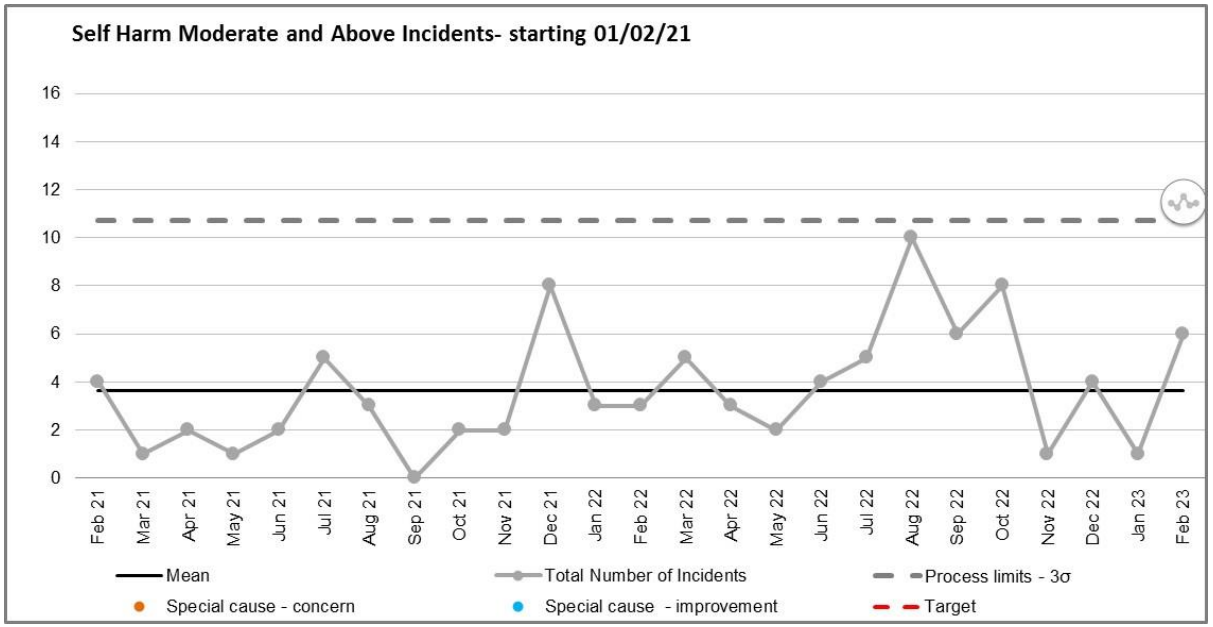
7. All reported Suicides



8. Self Harm reported Incidents



8a. Self Harm reported Incidents



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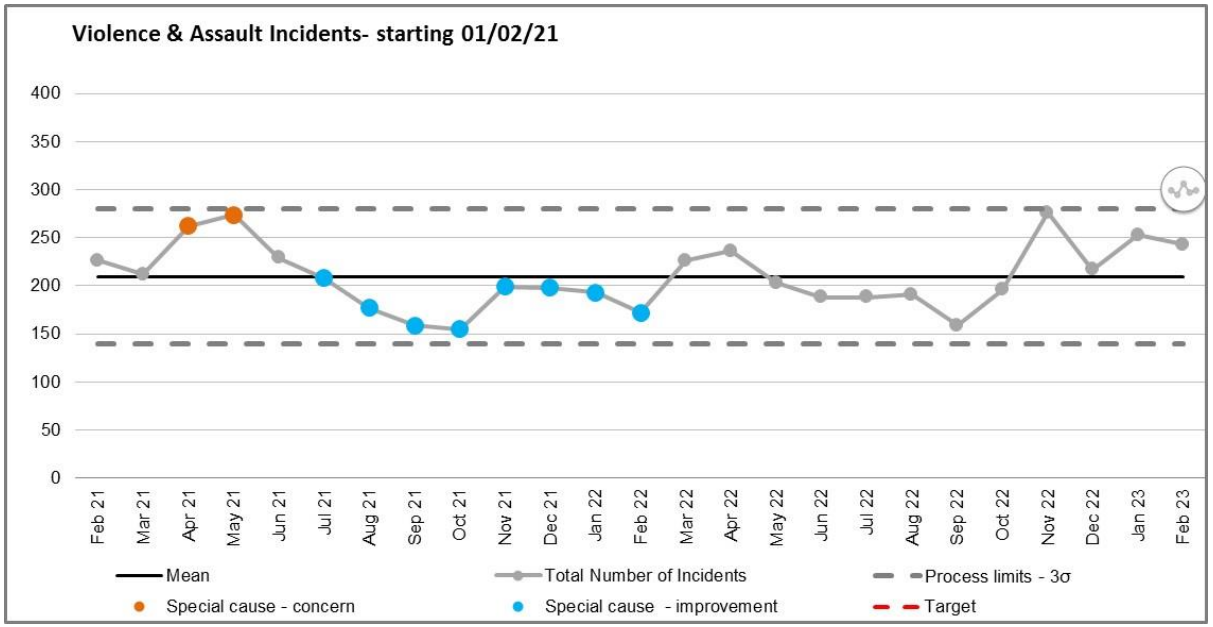
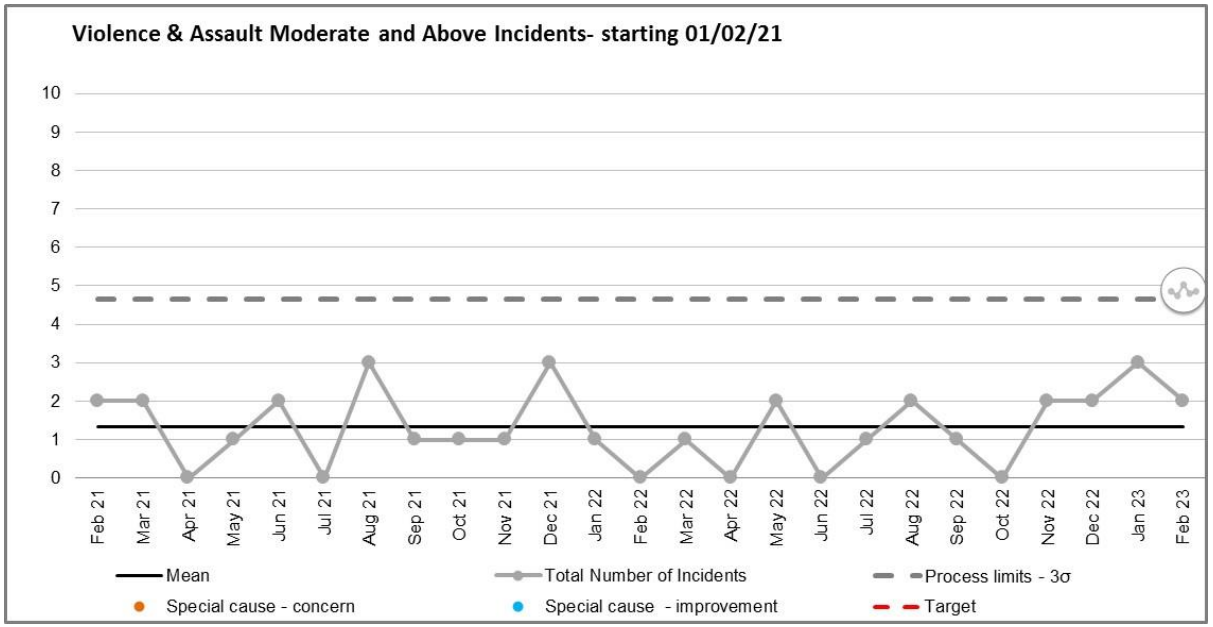
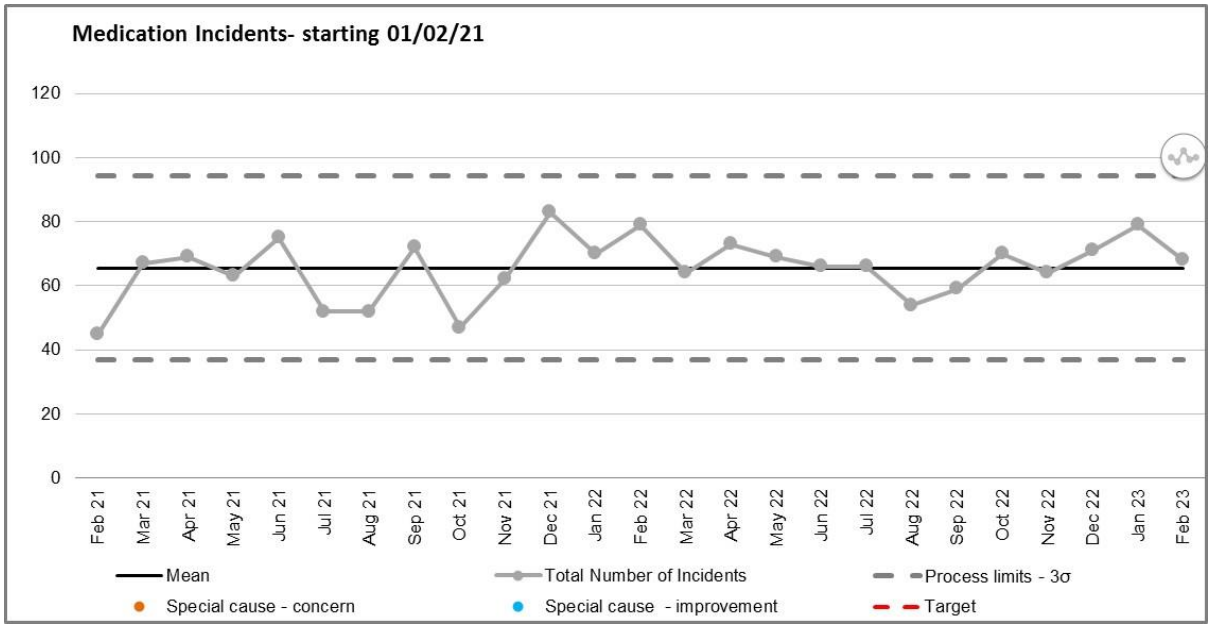
9. All Violence & Assaults reported Incidents



9. Violence & Assaults moderate harm reported Incidents



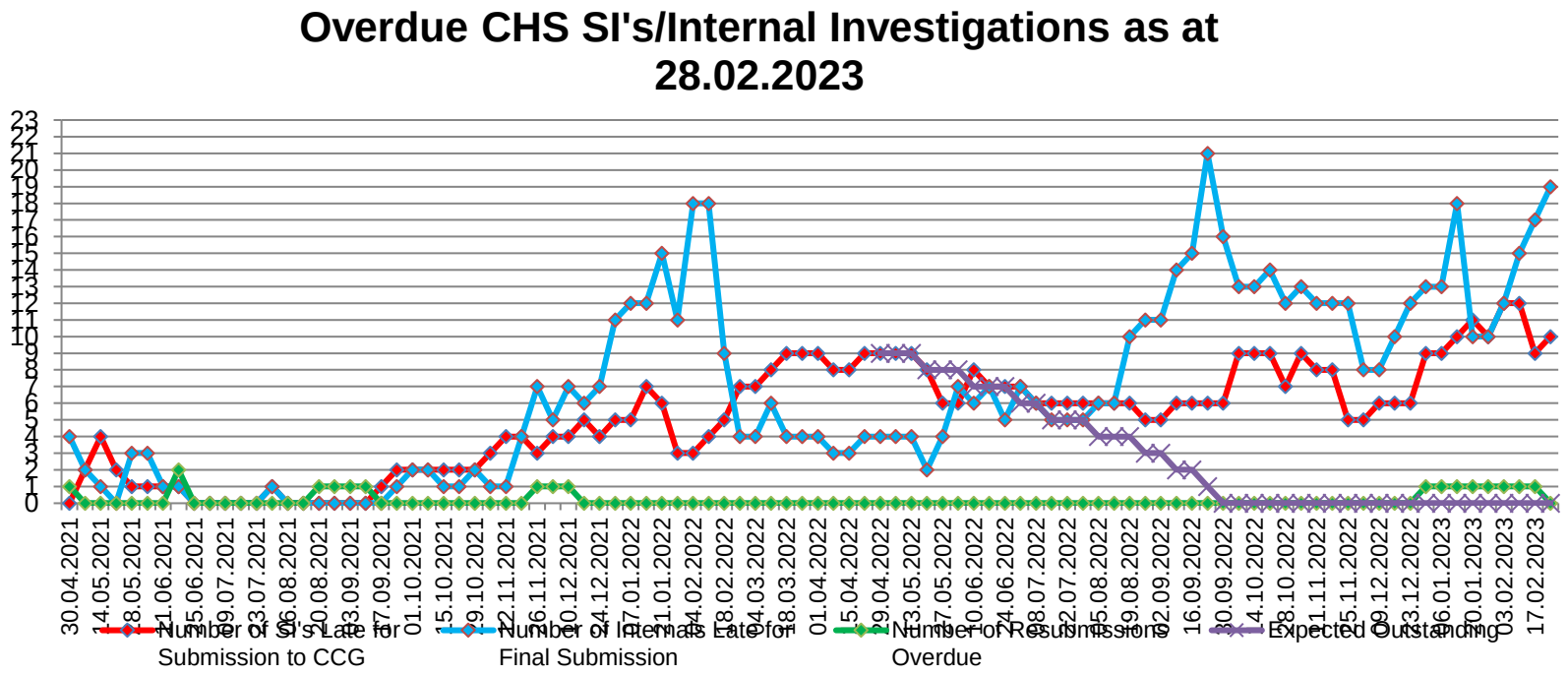
10. All Medication Incidents reported



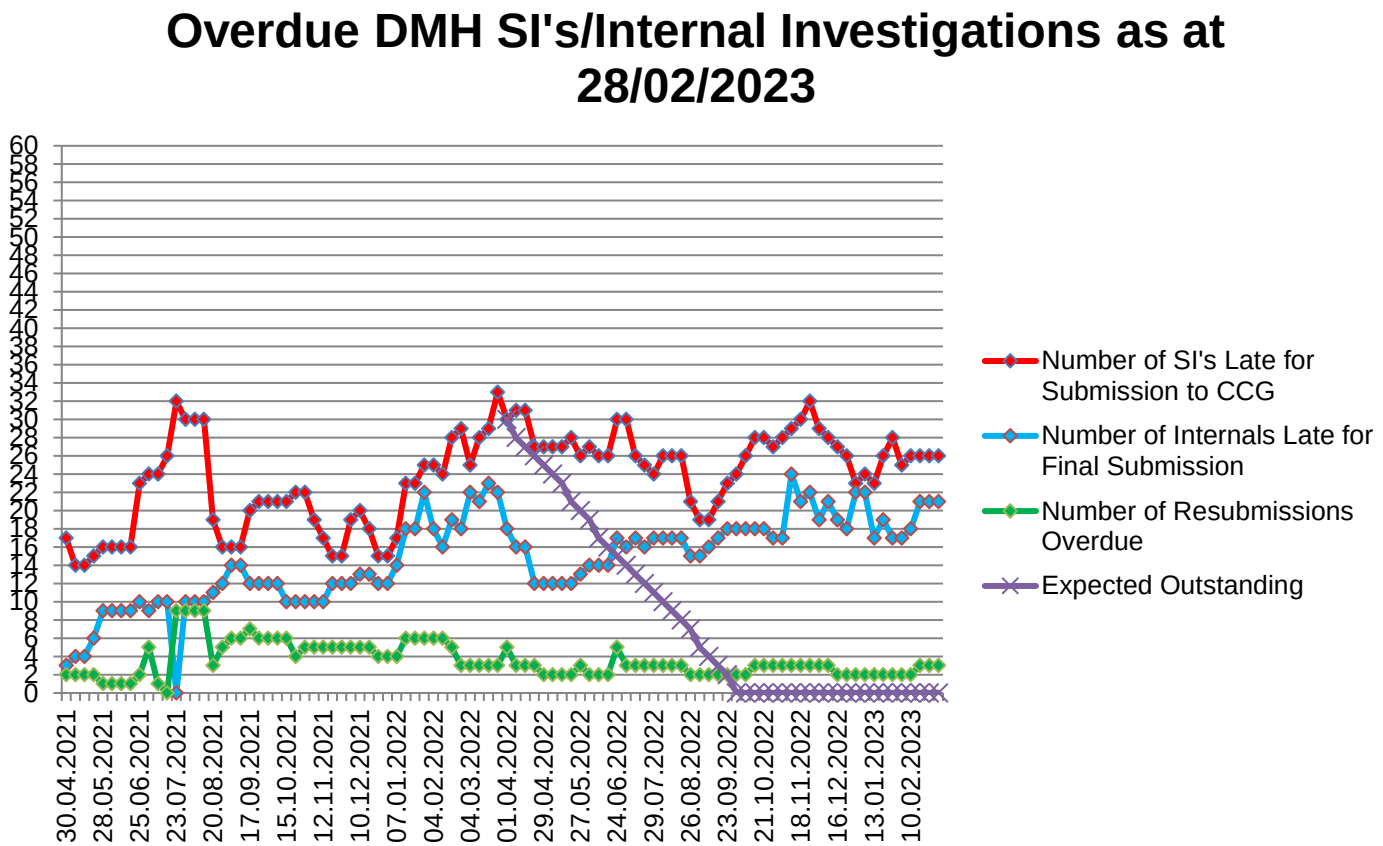
11. Ongoing - StEIS Notifications for Serious Incidents

2022/2023 - StEIS Notifications and Internal Investigations									
		StEIS Notifications	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
2022/23 Q1	April	0	2	0	2	10	3	3	3
	May	0	3	0	0	12	5	0	4
	June	0	4	1	2	7	2	1	3
2022/23 Q2	July	0	4	1	4	8	4	1	6
	August	0	7	1	1	7	5	2	2
	September	0	3	1	3	10	8	2	9
2022/23 Q3	October	0	4	0	3	4	4	4	11
	November	0	6	0	1	4	6	0	8
	December	0	7	1	2	4	6	2	10
2022/23 Q4	January	0	2	0	1	9	3	0	10
	February	0	4	1	1	9	7	2	6
	March								
YTD			46	6	20	84	53	17	72

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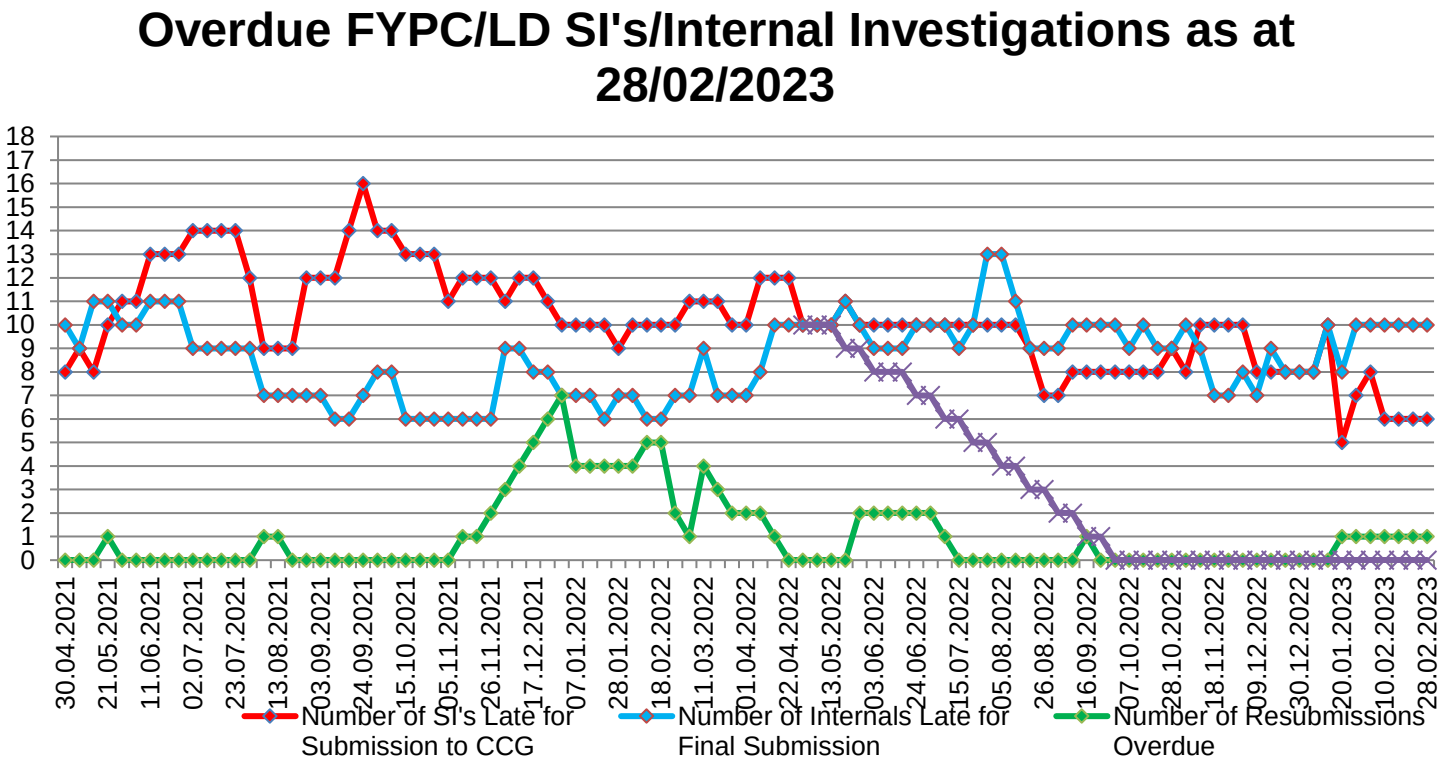
12a. Overdue Serious Incidents/Internal Investigations & CCG resubmissions (includes totals) - FYPCLD



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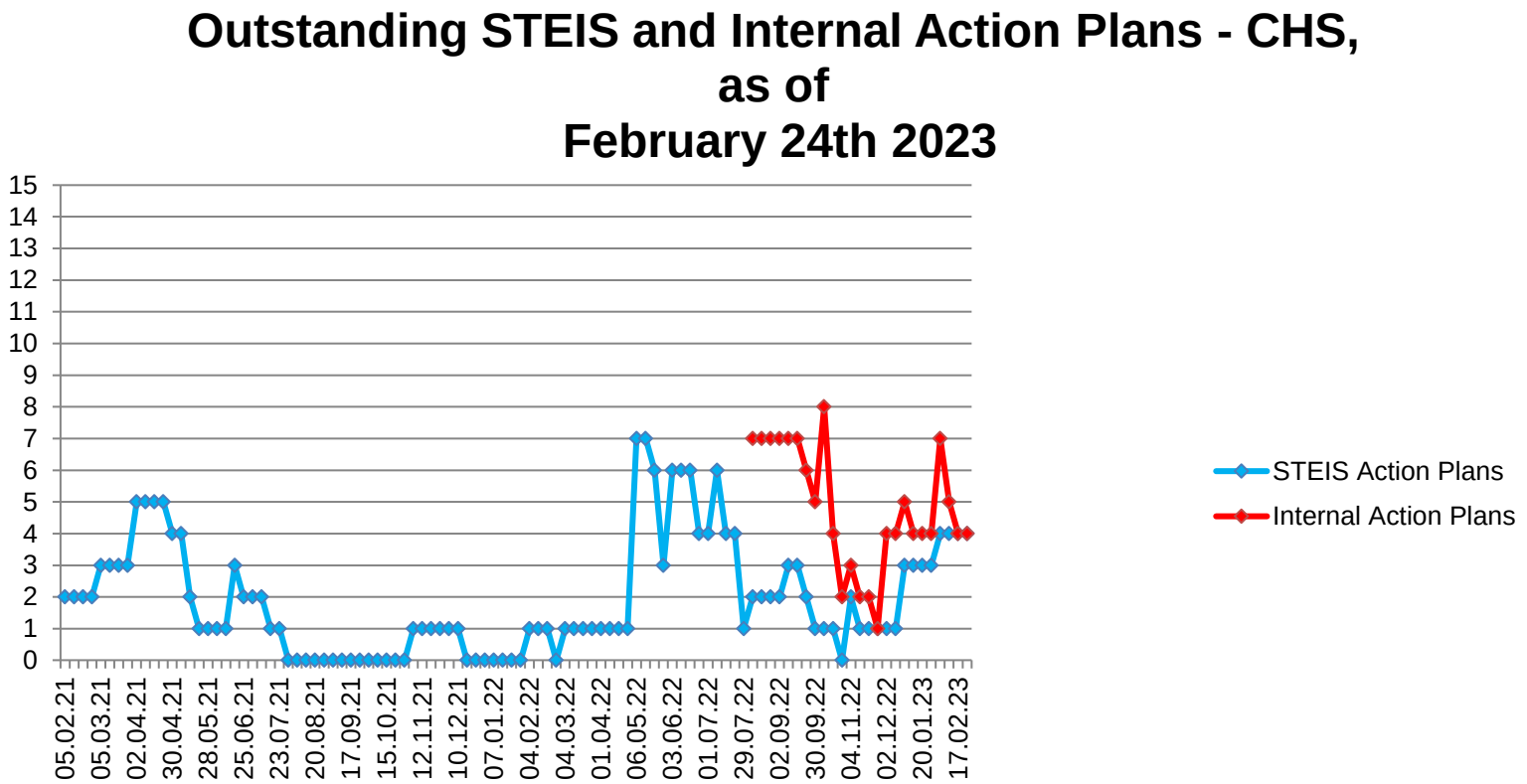
12b. Directorate SI Action Plan Compliance CHS Status 2021/22 to date



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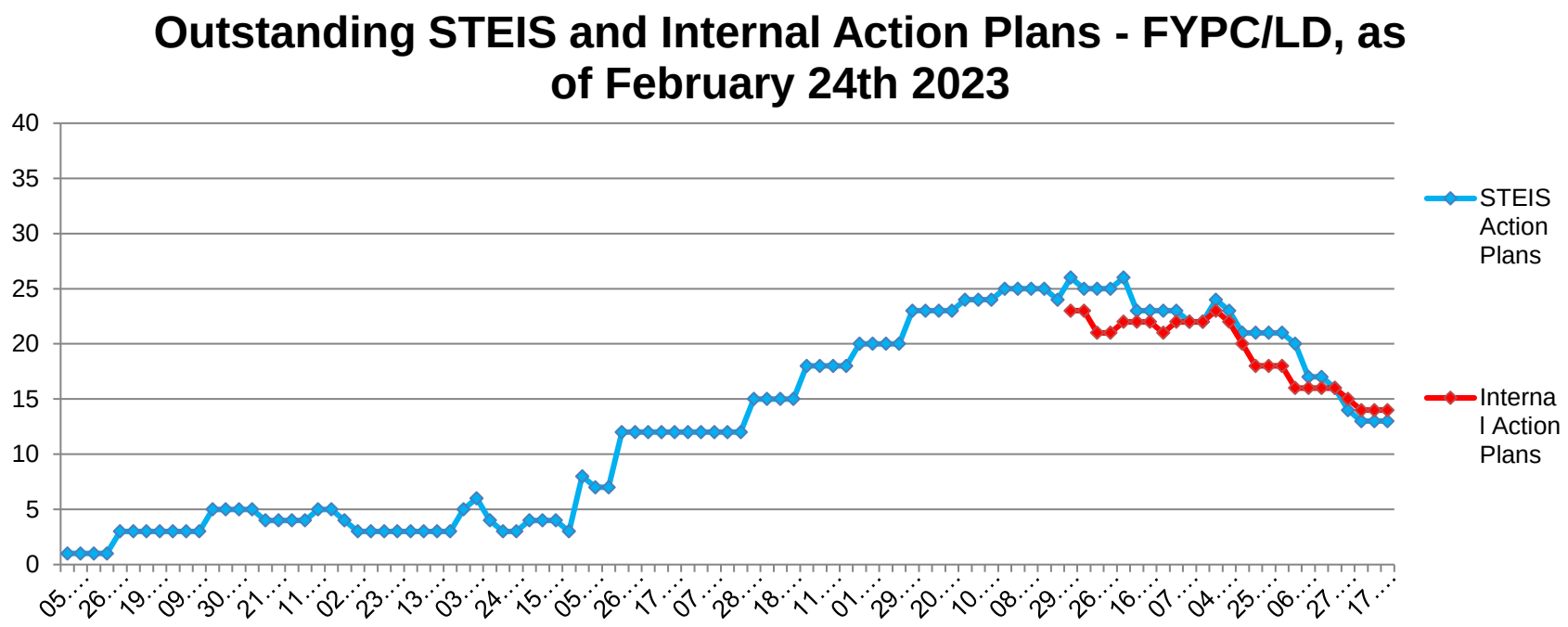
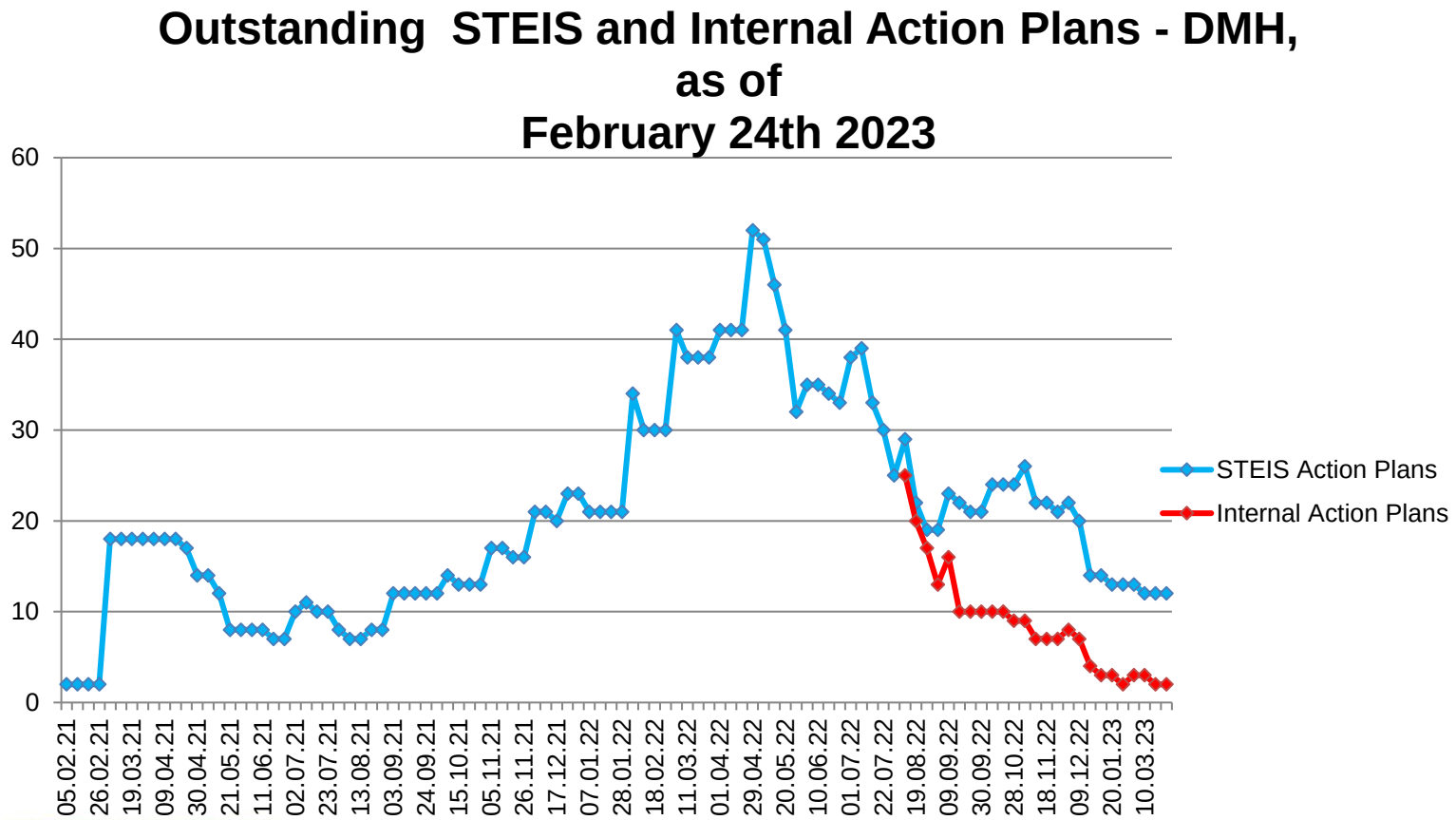
12b. Directorate SI Action Plan Compliance FYPC/LD Status 2021/22 to date



12b. Directorate SI Action Plan Compliance DMH Status 2021/22 to date



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13. Learning from the SI process

As we improve the quality of our investigations the resulting recommendations will be more robust and likely to focus on trust system or process improvements.

This has resulted in directorate teams struggling to oversee and manage these actions – sometimes delaying their action plan closure

Action

- The action plan will now be called an improvement plan
- This is split into two parts for directorate management and corporate oversight
- These corporate actions will be overseen by the most appropriate trust governance group – this is being trialled in safeguarding committee
- Compliance with these will be overseen by the trust Incident Oversight Group (IOG) and reported to the Quality Forum

14. Learning Jan/Feb 2023

Serious & Internal Incidents/Complaints Emerging & Recurring Themes

- There is a repeated theme across the organisation about our engagement with families

Including

- Engaging with families of adults who are inpatients in relation to their mental health care, treatment and recovery– the review identifies that staff are concerned about protecting patients confidentiality however this is described by families as not feeling involved/informed
- Not having next of kin details on file, particularly in Mental Health Services.
- Generally when talking to relatives and reviewing complaints across the directorates there is a theme that our communication is not always consistent and timely
- Families of patients in CHS in patient wards have expressed concern that they have not felt fully informed of their relatives clinical condition/ new diagnosis

Action- A trust wide piece of work to be commenced to ensure there are clear processes to identify formal NOK, significant contacts and agree the level of communication and ensure there is clear documentation for staff to see what has been communicated, when and with whom

15. Learning Nov/Dec 2022 continued

Serious & Internal Incidents/Complaints Emerging & Recurring Themes

There has been a theme identified of male patients in their 50/60's who have been found deceased at home who have not been identified as having taken their own life. There is evidence of self neglect or substance misuse. Although these deaths are considered as 'natural causes' it is important for us to understand if there was other action or learning we could take to better support these patients to access help and support.

Action

The DMH Learning from deaths group has been asked to consider these themes and we will triangulate with any learning from investigations undertaken