S

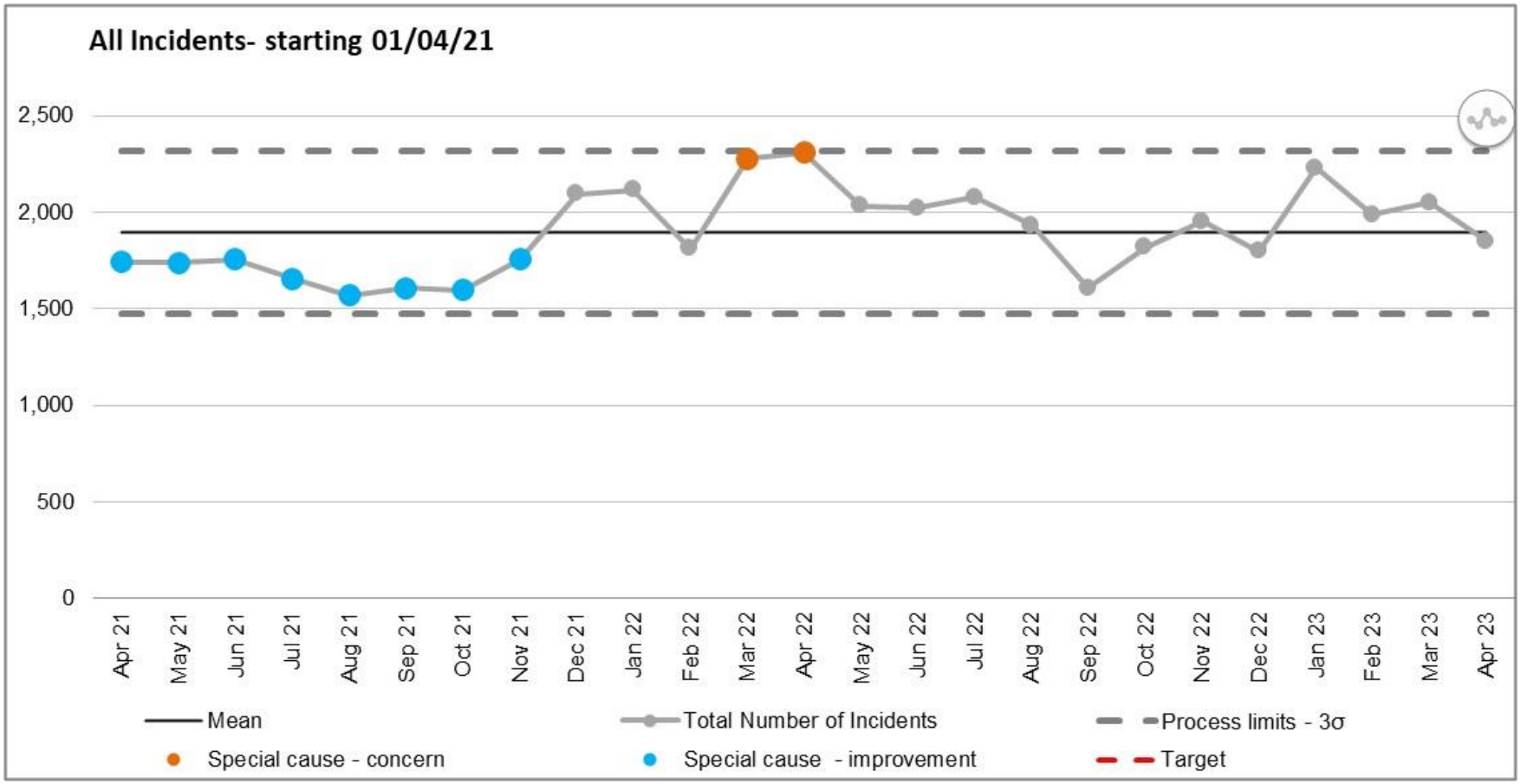
Appendix 1

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

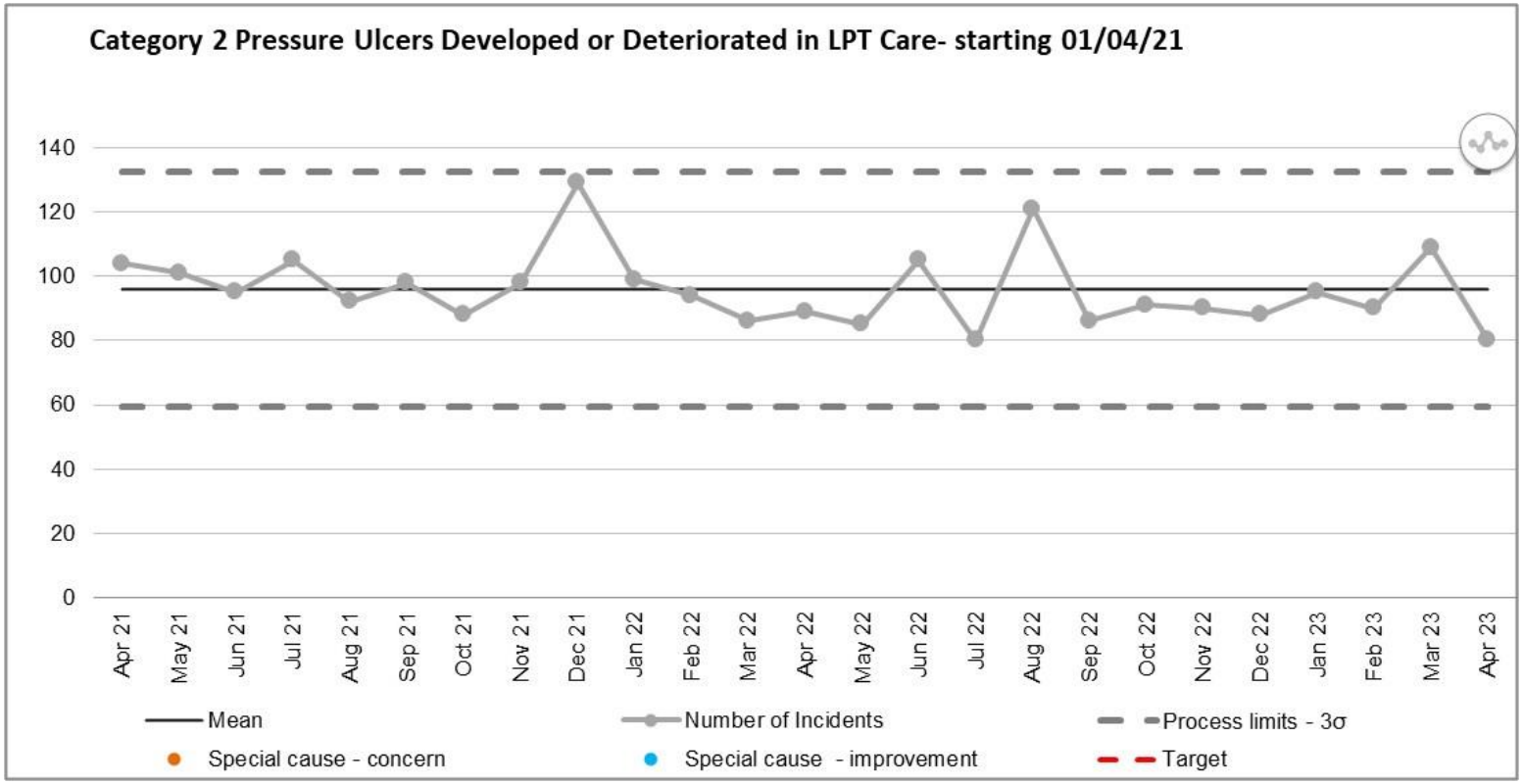
Any detail that requires further clarity please contact the Corporate Patient Safety Team

WeAreLPT
compassion respect
integrity trust

1. All incidents

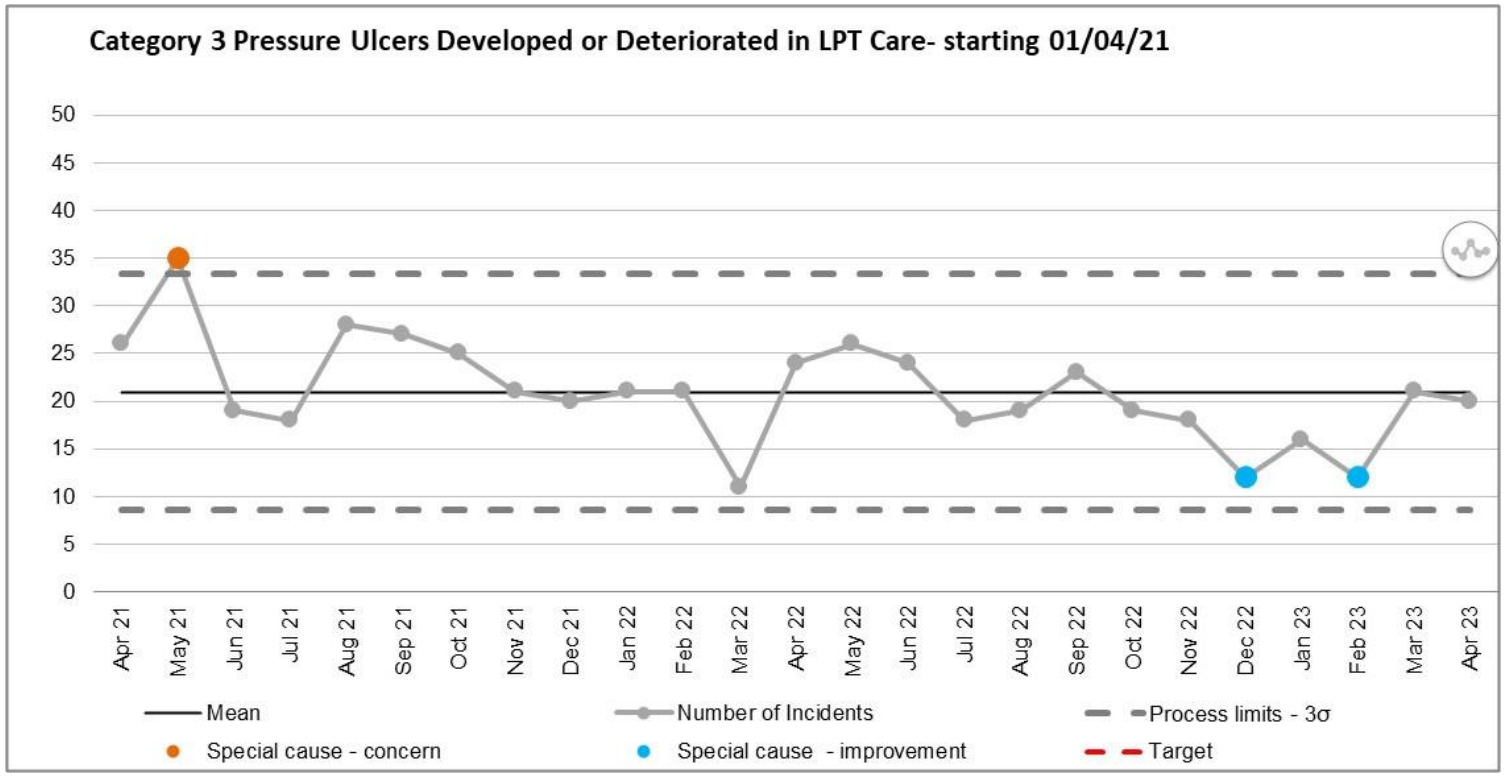


2. Category 2 Pressure Ulcers developed or deteriorated in LPT Care



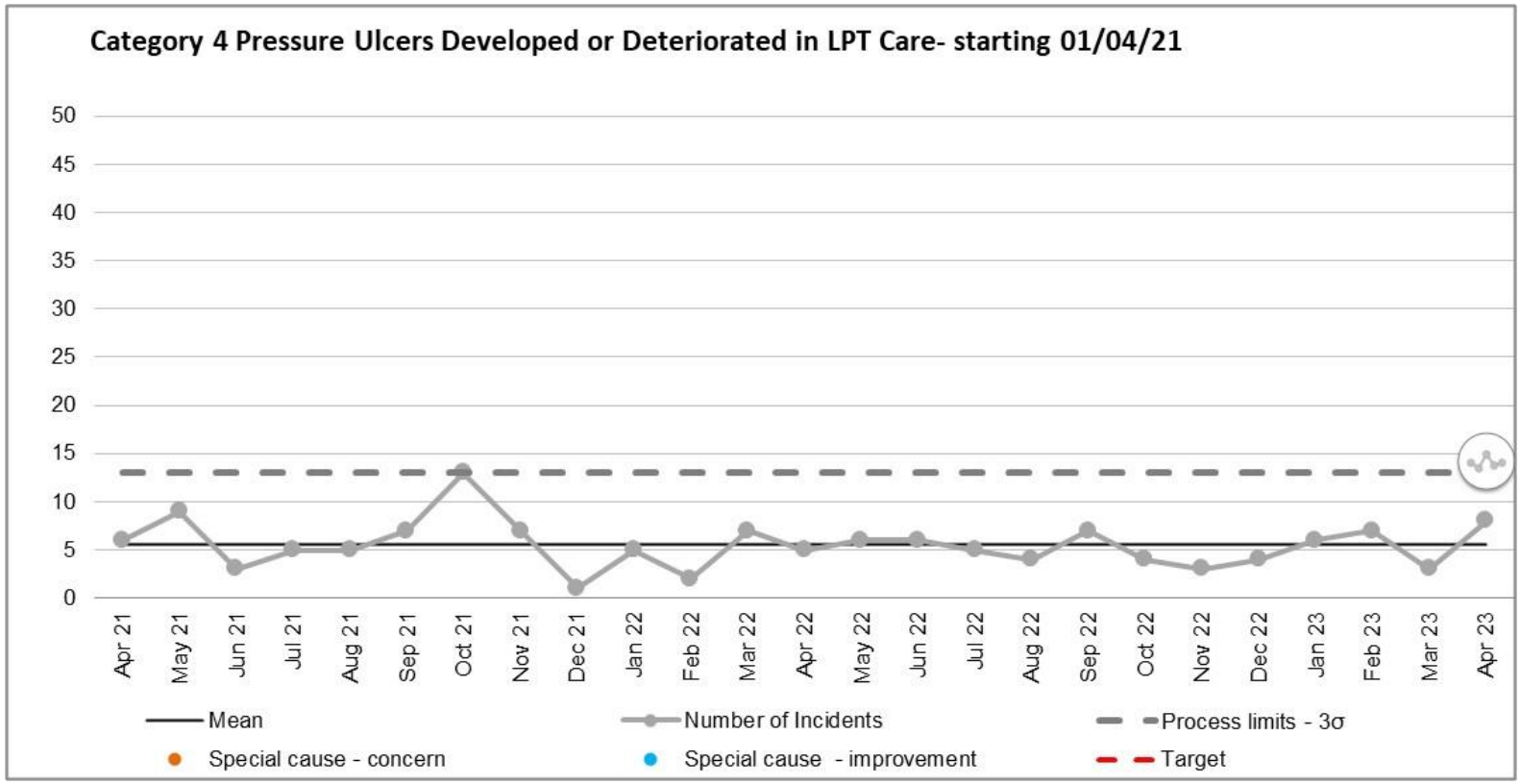
WeAreLPT
compassion respect
integrity trust

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



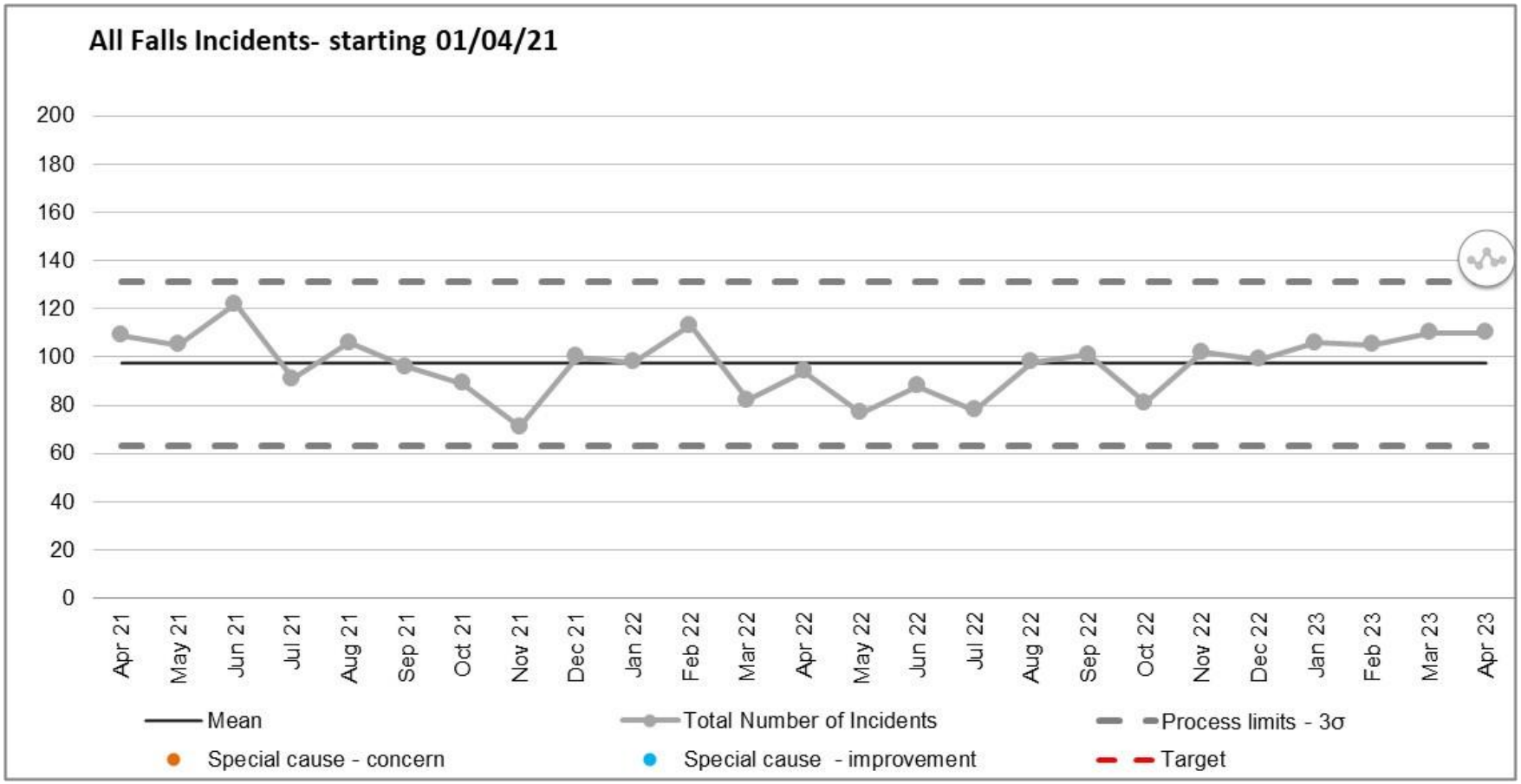
WeAreLPT
compassion respect
integrity trust

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



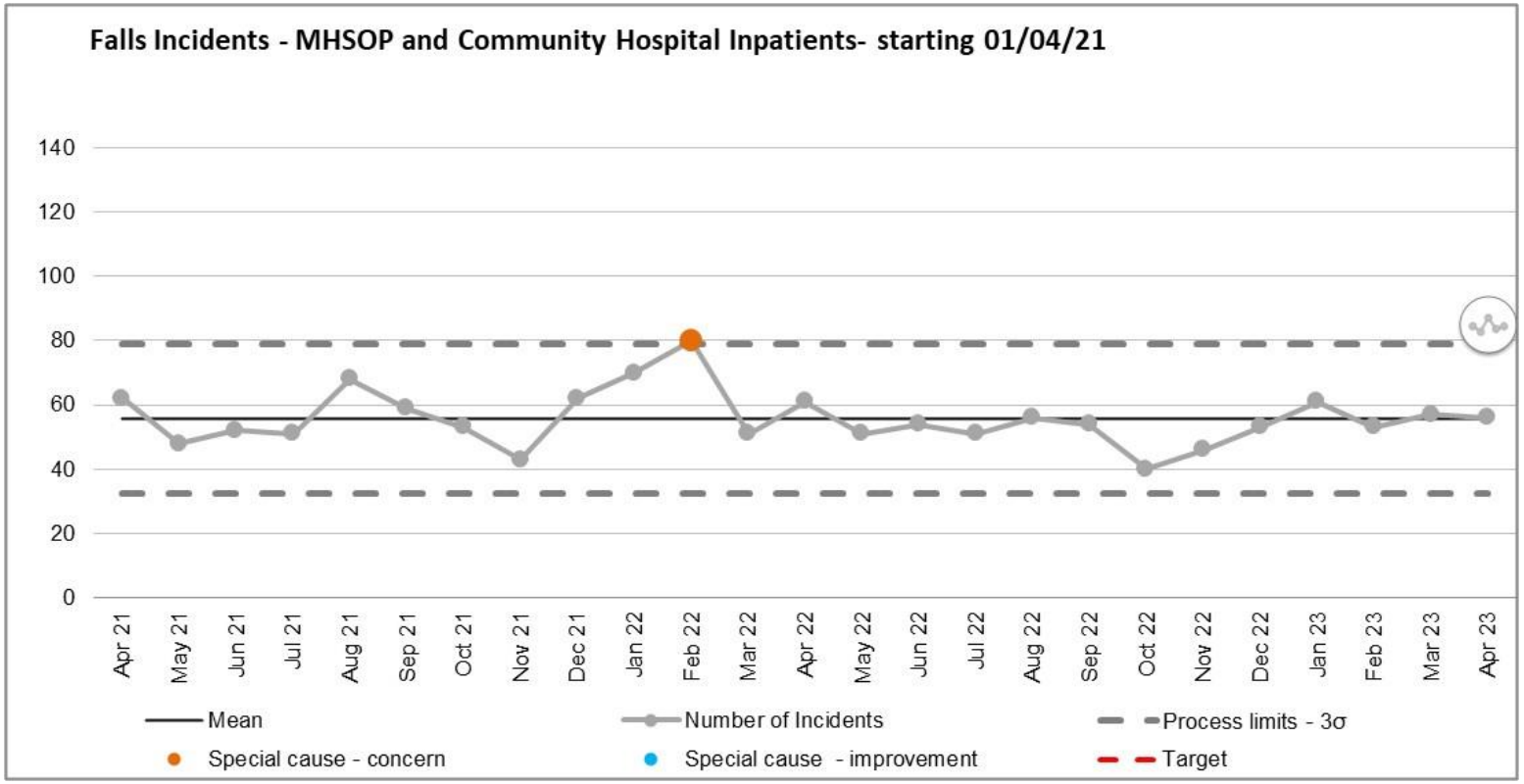
WeAreLPT
compassion respect
integrity trust

5. All falls incidents reported



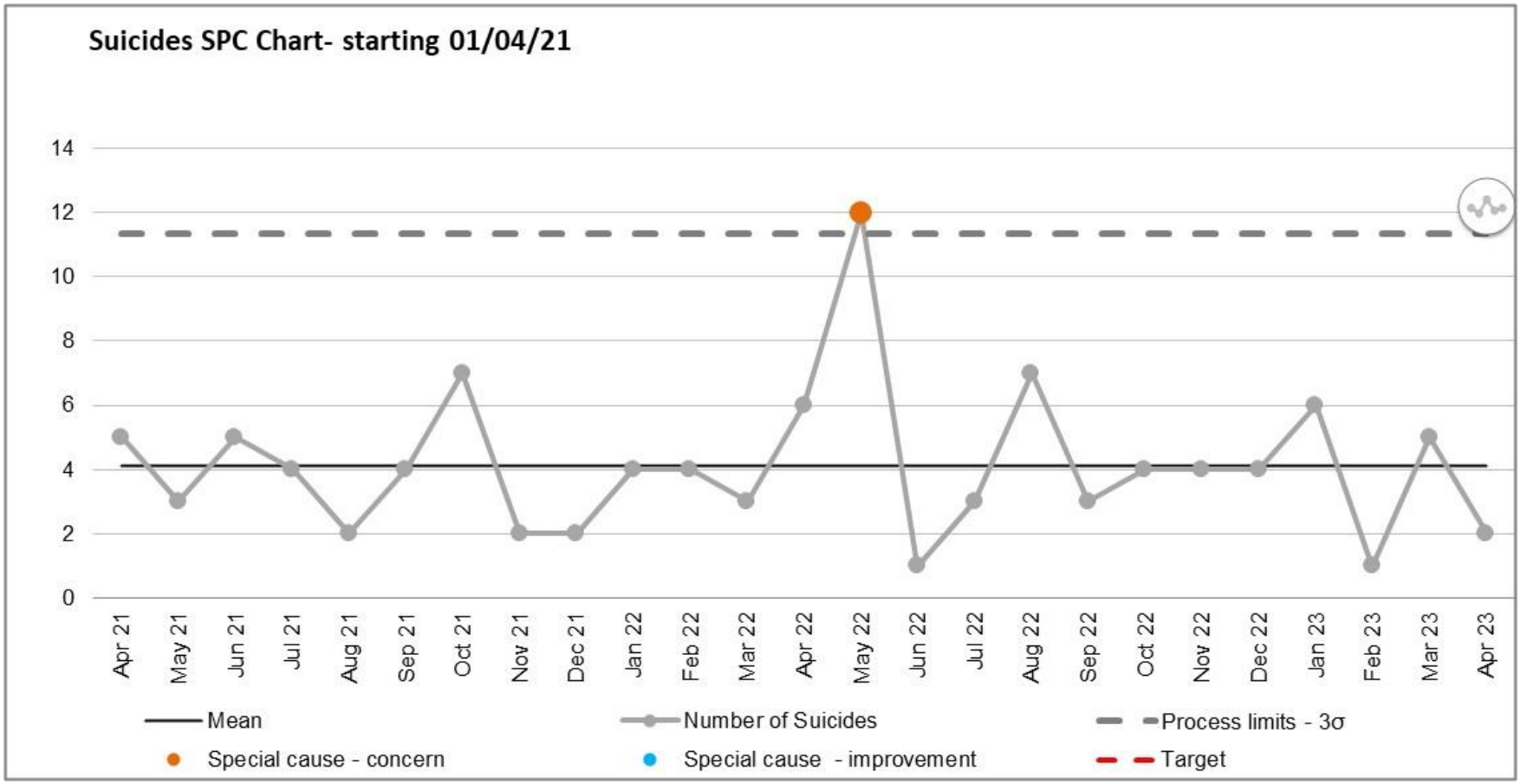
WeAreLPT
compassion respect
integrity trust

6. Falls incidents reported – MHSOP and Community Inpatients

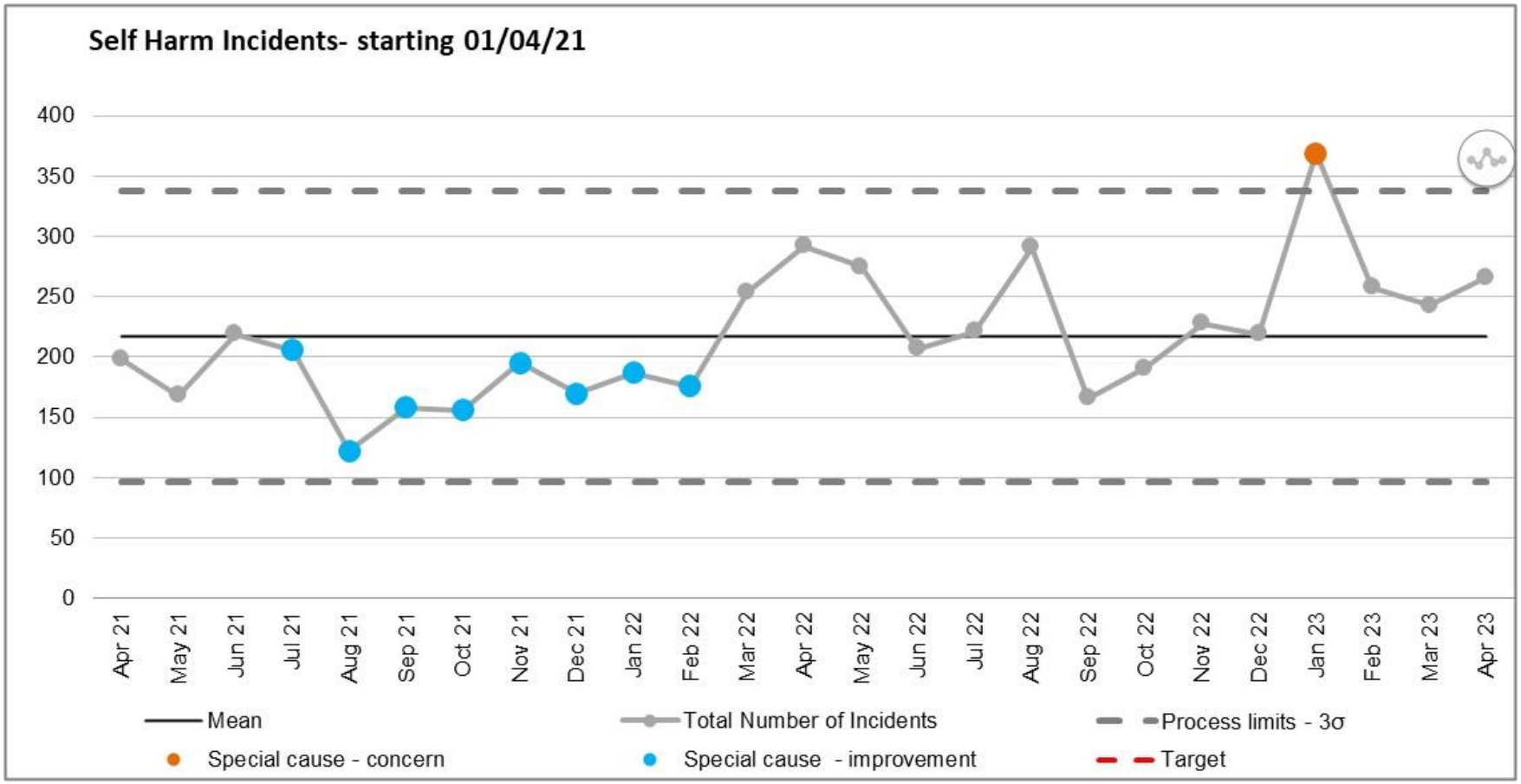


WeAreLPT
compassion respect
integrity trust

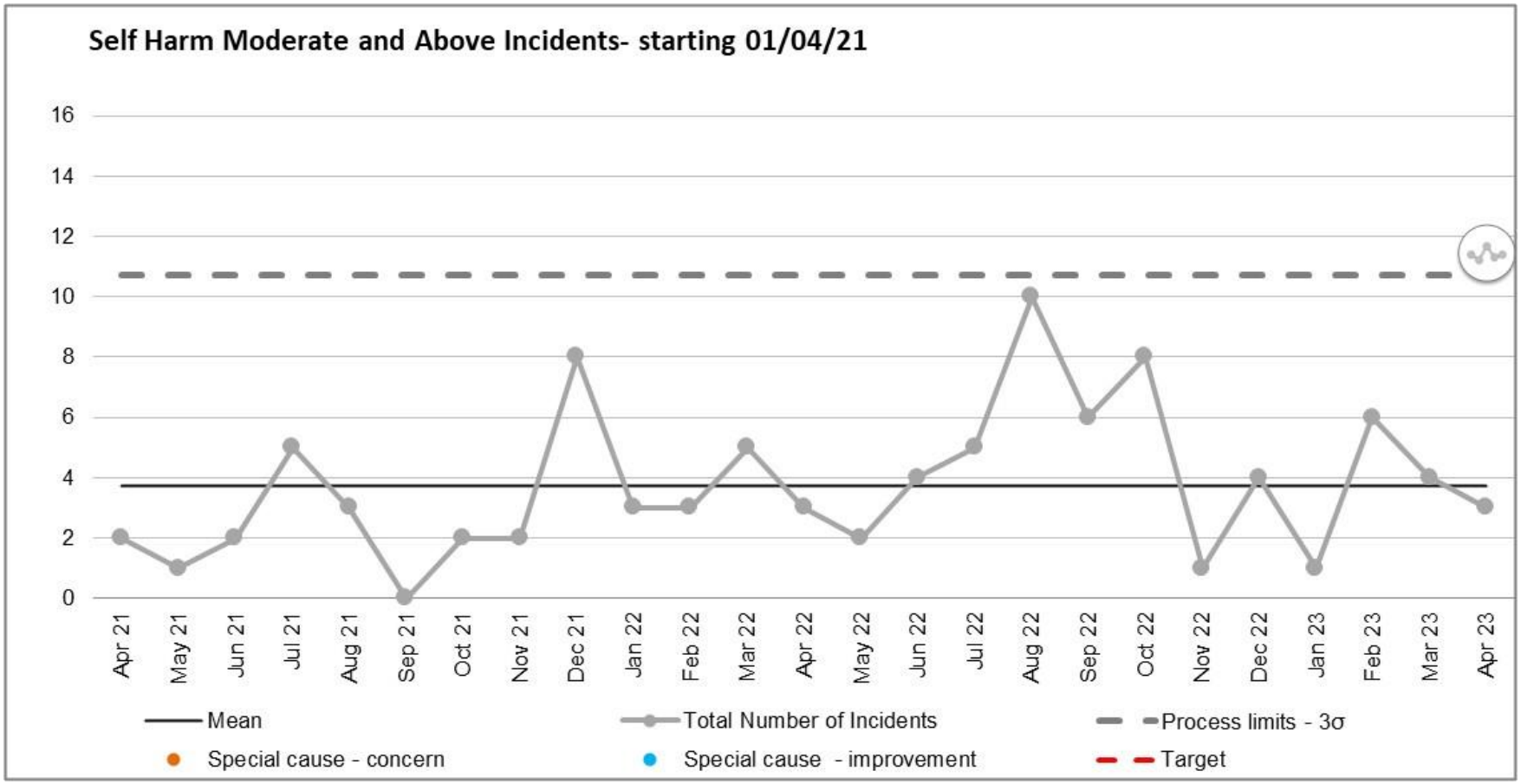
7. All reported Suicides



8. Self Harm reported Incidents

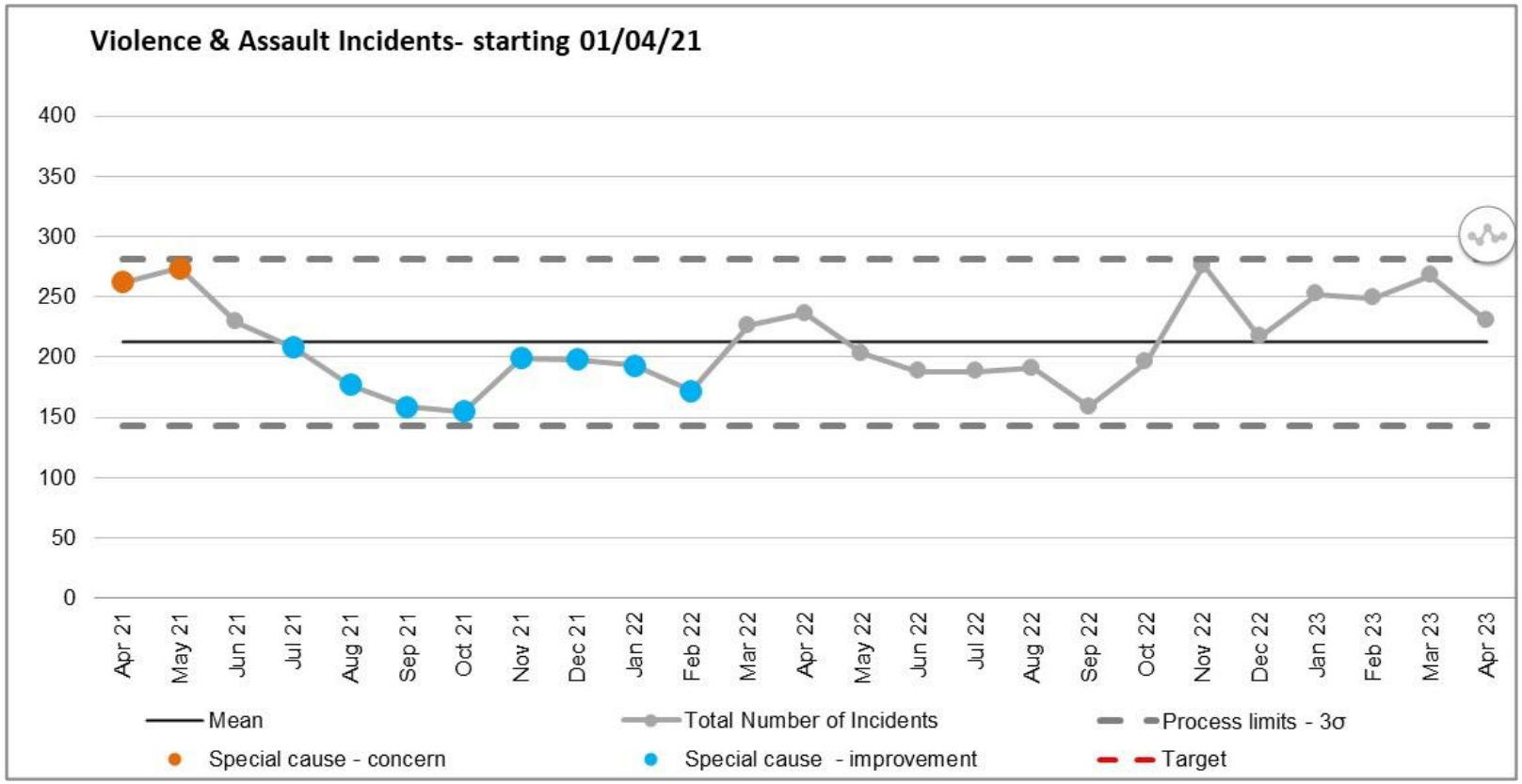


8a. Self Harm reported Incidents



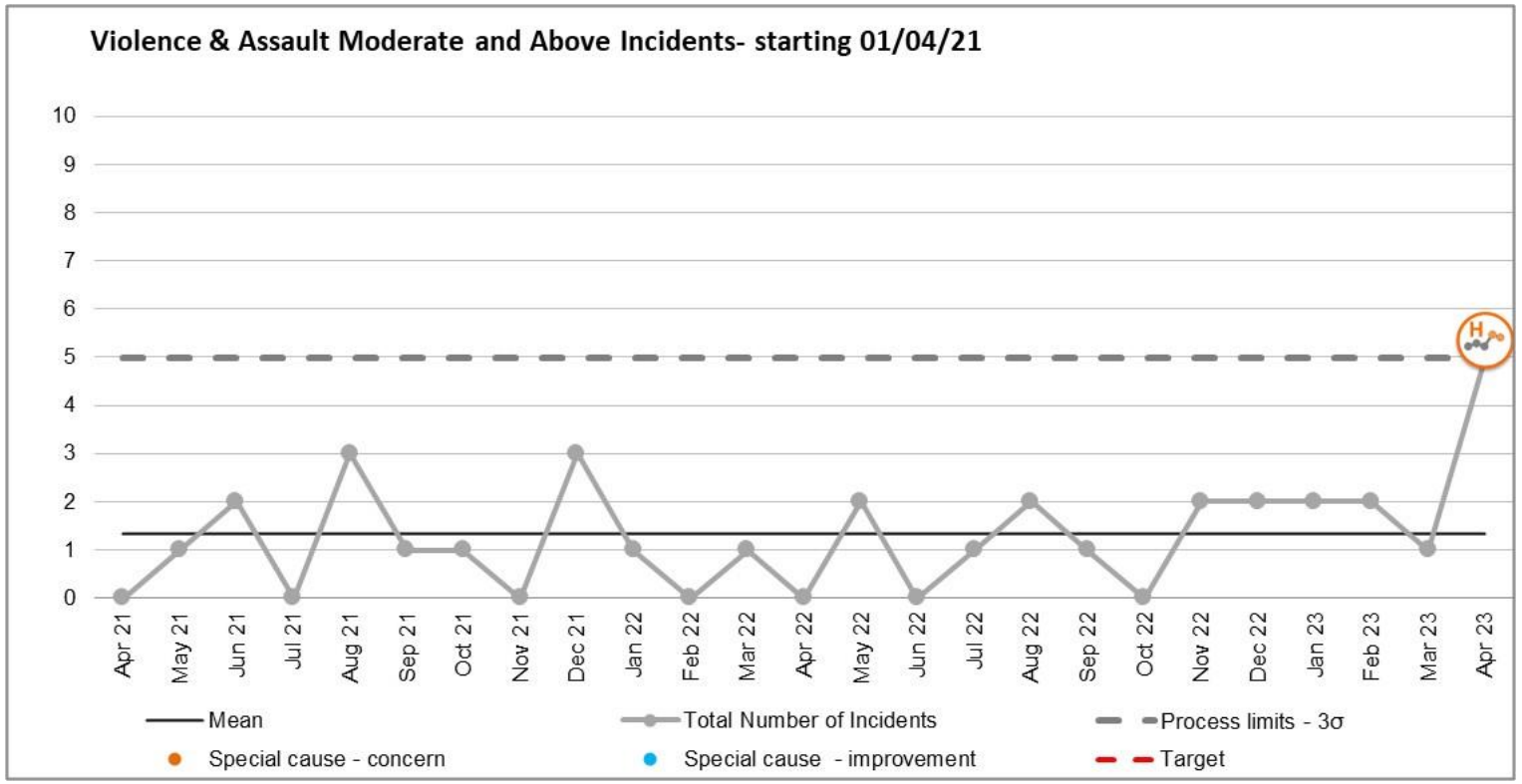
WeAreLPT
compassion respect
integrity trust

9. All Violence & Assaults reported Incidents



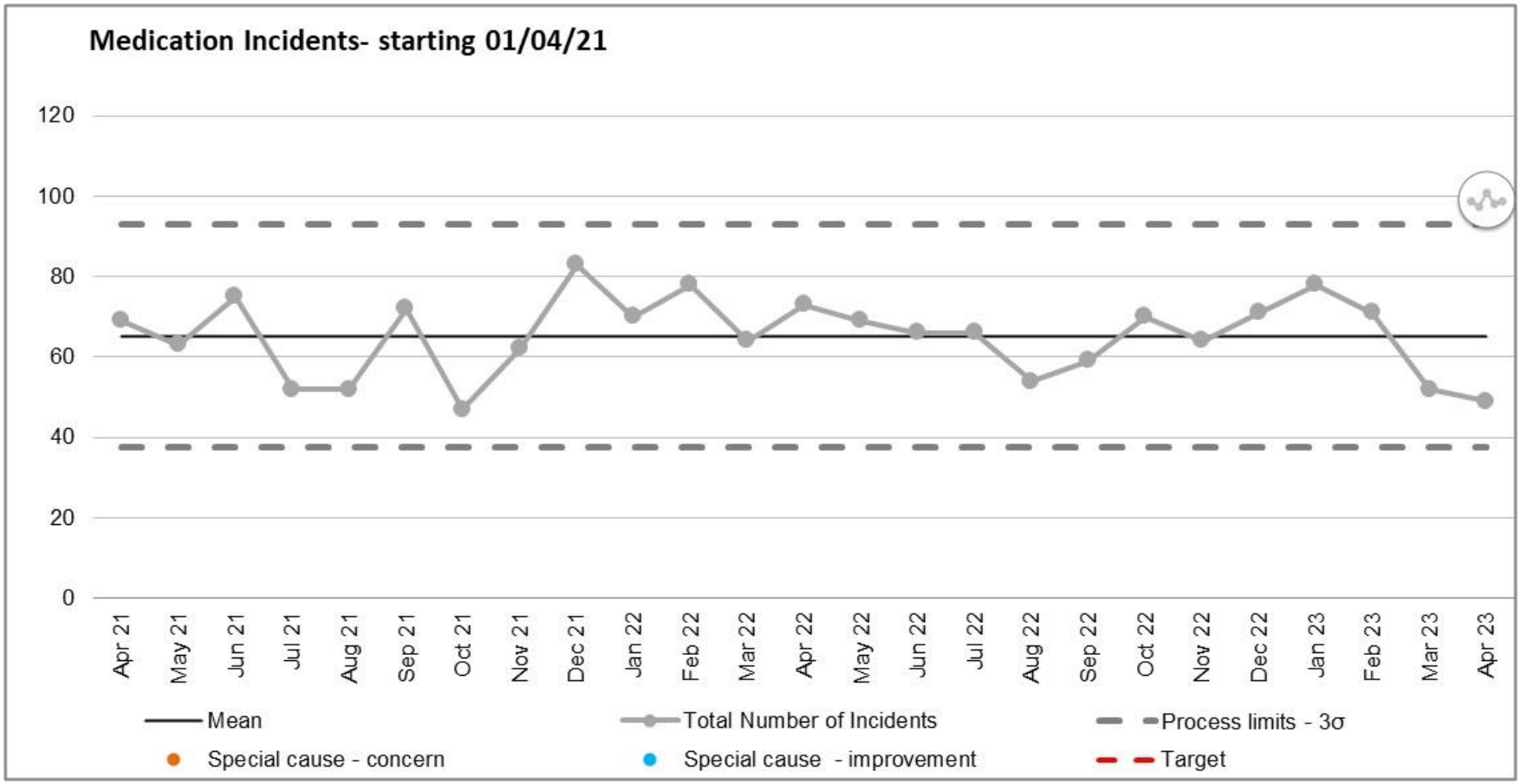
WeAreLPT
compassion respect
integrity trust

9a. Violence & Assaults moderate harm reported Incidents



WeAreLPT
compassion respect
integrity trust

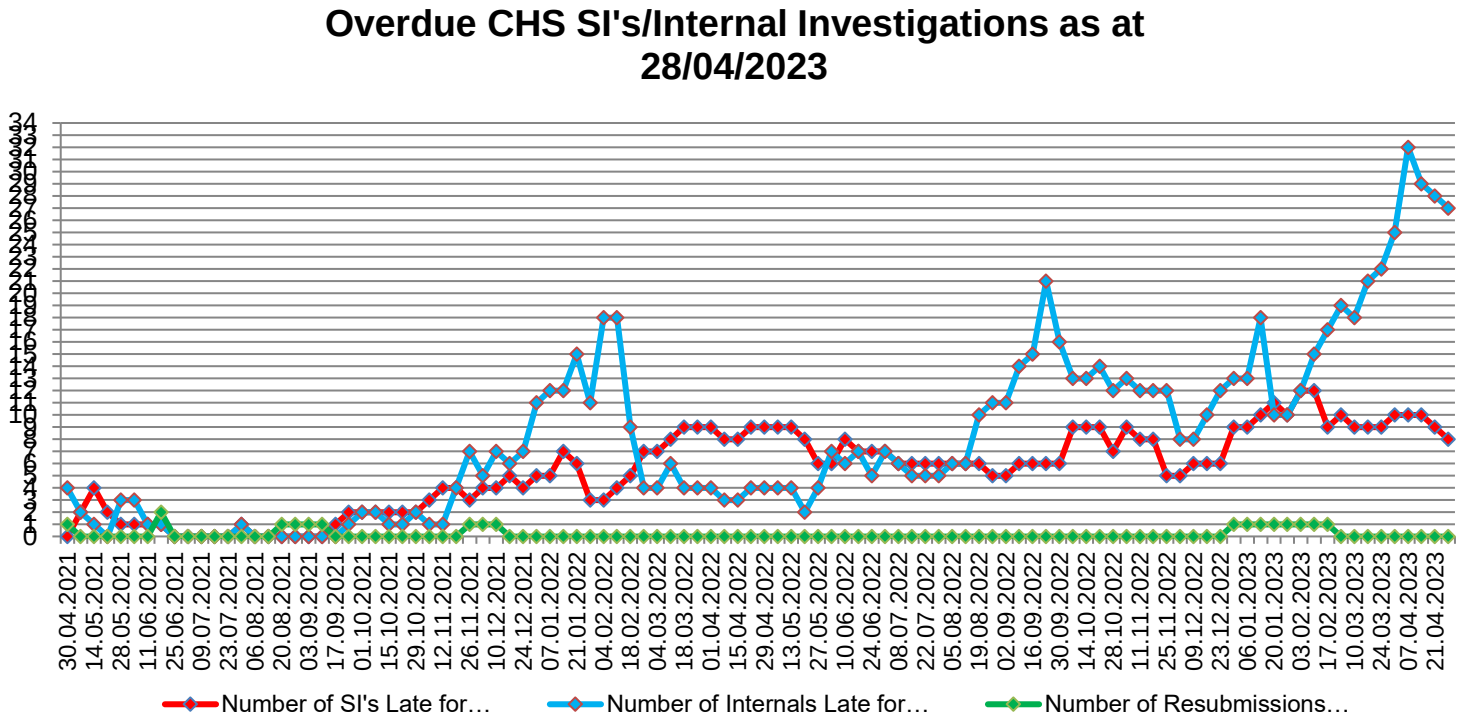
10. All Medication Incidents reported



11. Ongoing - StEIS Notifications for Serious Incidents

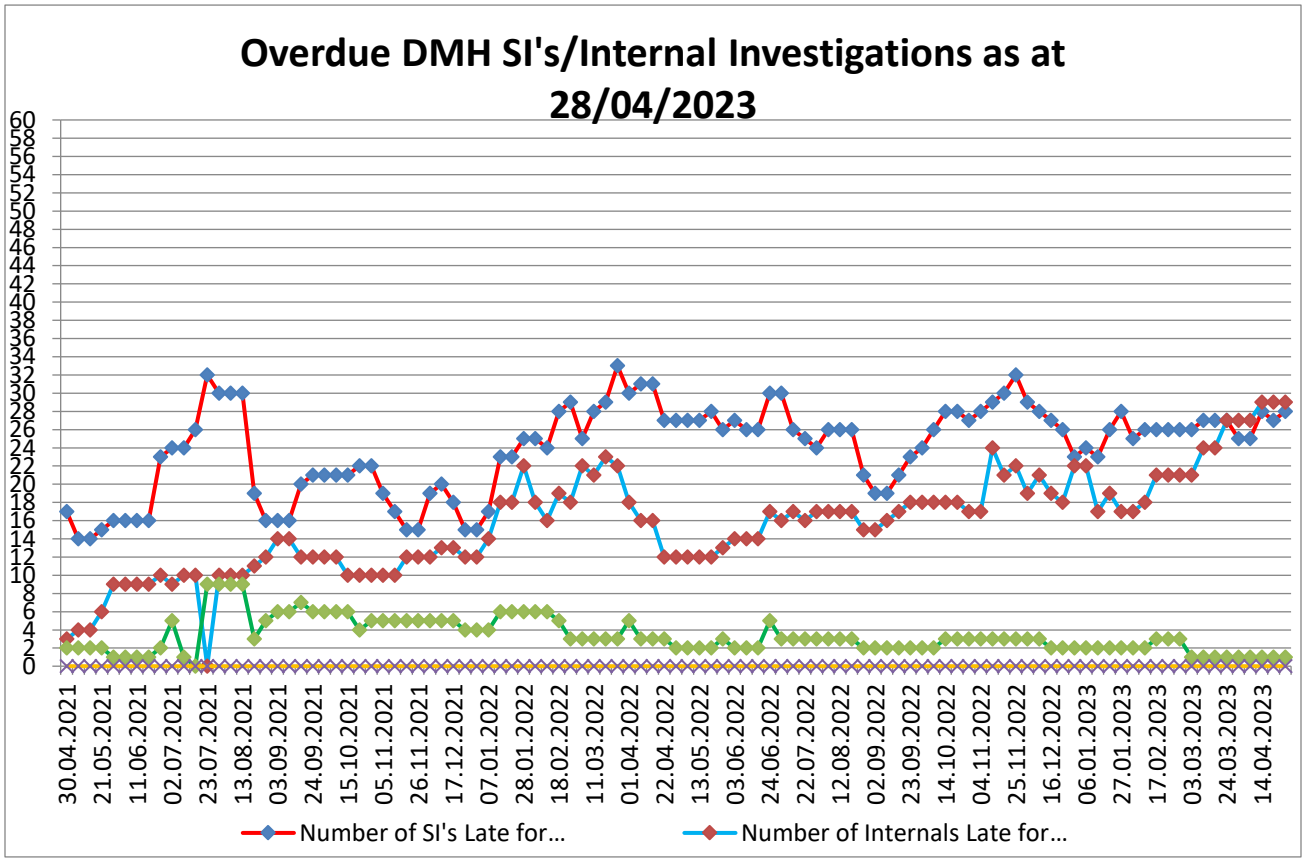
2022-2023 StEIS Notifications and Internal Investigations								
	StEIS Notifications	SI INVESTIGATIONS				Internal Investigations		
	Downgrade & removal requests	SIs declared DMH	SIs declared FYPC/LD	SIs declared CHS	Signed off in month	DMH	FYPC/LD	CHS
2022-2023								
April	0	2	0	2	10	3	3	3
May	0	3	0	0	12	5	0	4
June	0	4	1	2	7	2	1	3
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
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
January	0	2	0	1	9	3	0	10
February	0	4	1	1	9	7	2	6
March	0	1	0	0	11	9	1	5
2023-2024								
April	0	3	1	1	4	8	2	2
Total	0	50	7	21	99	70	20	79

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



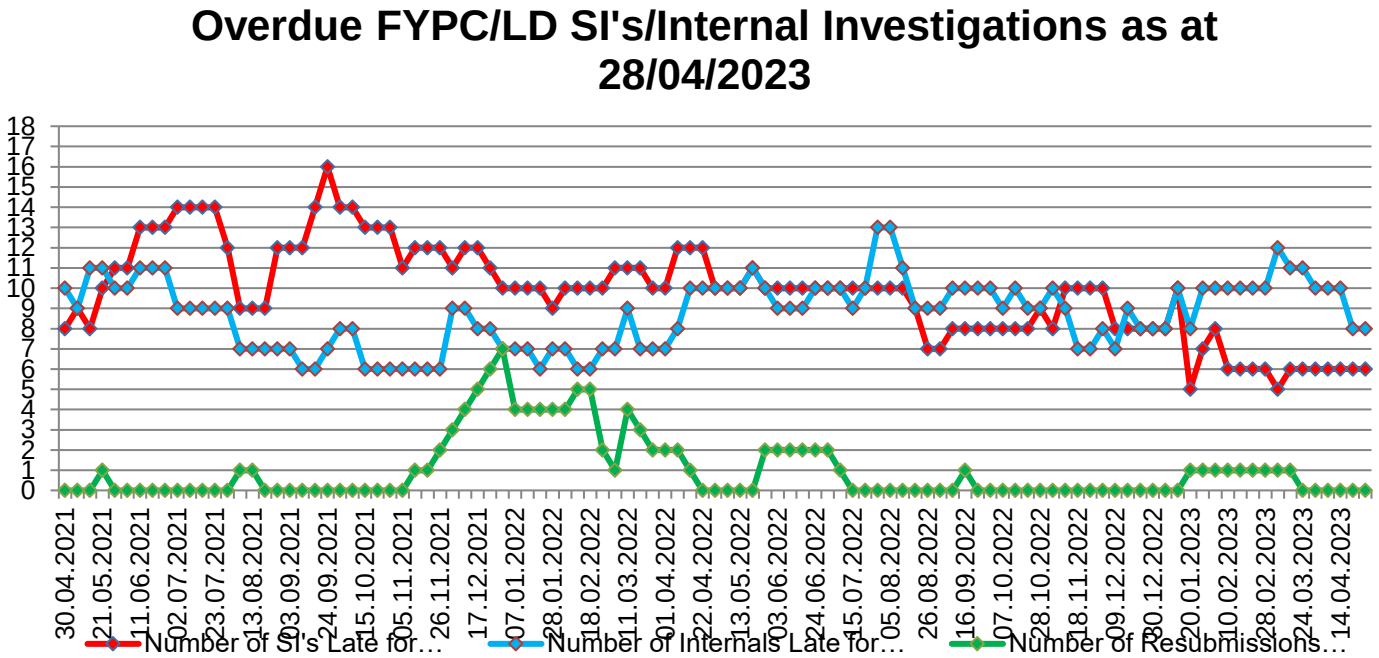
WeAreLPT
compassion respect
integrity trust

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



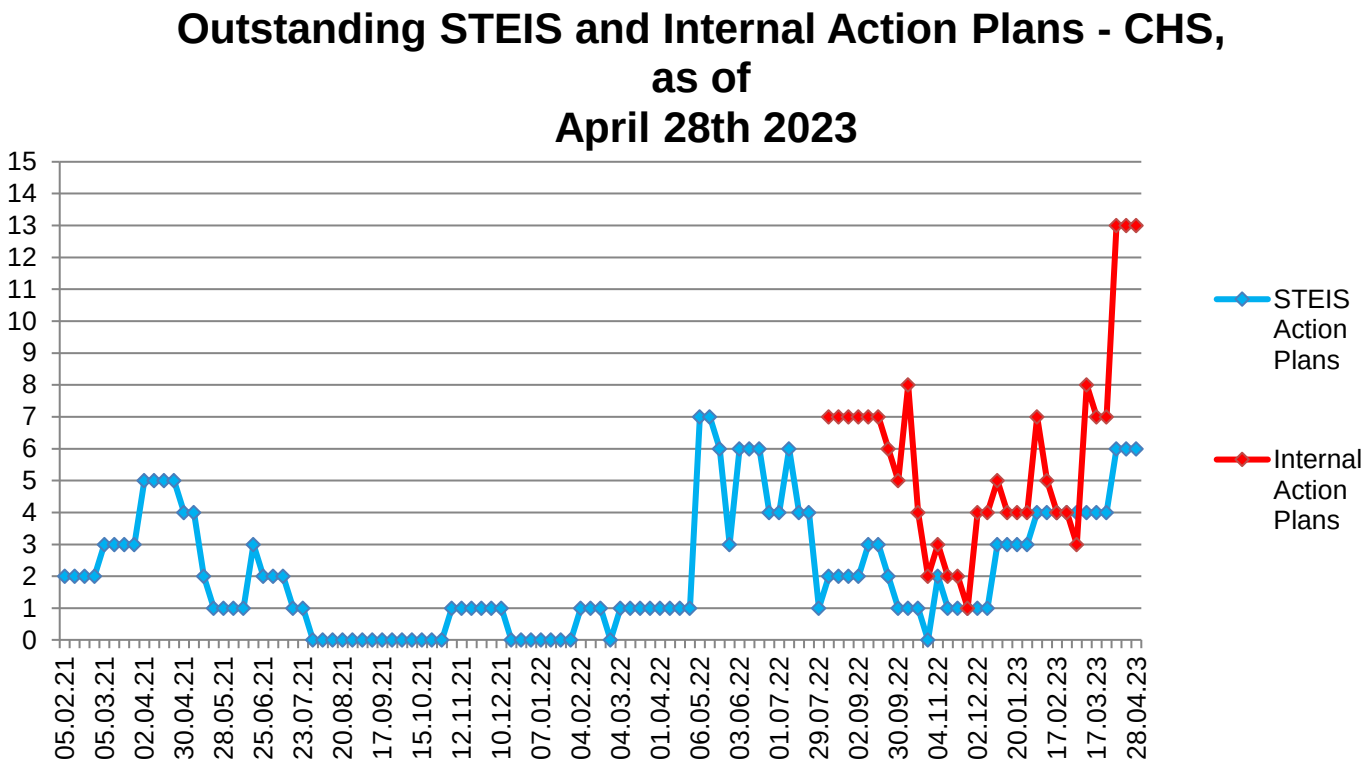
WeAreLPT
compassion respect
integrity trust

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



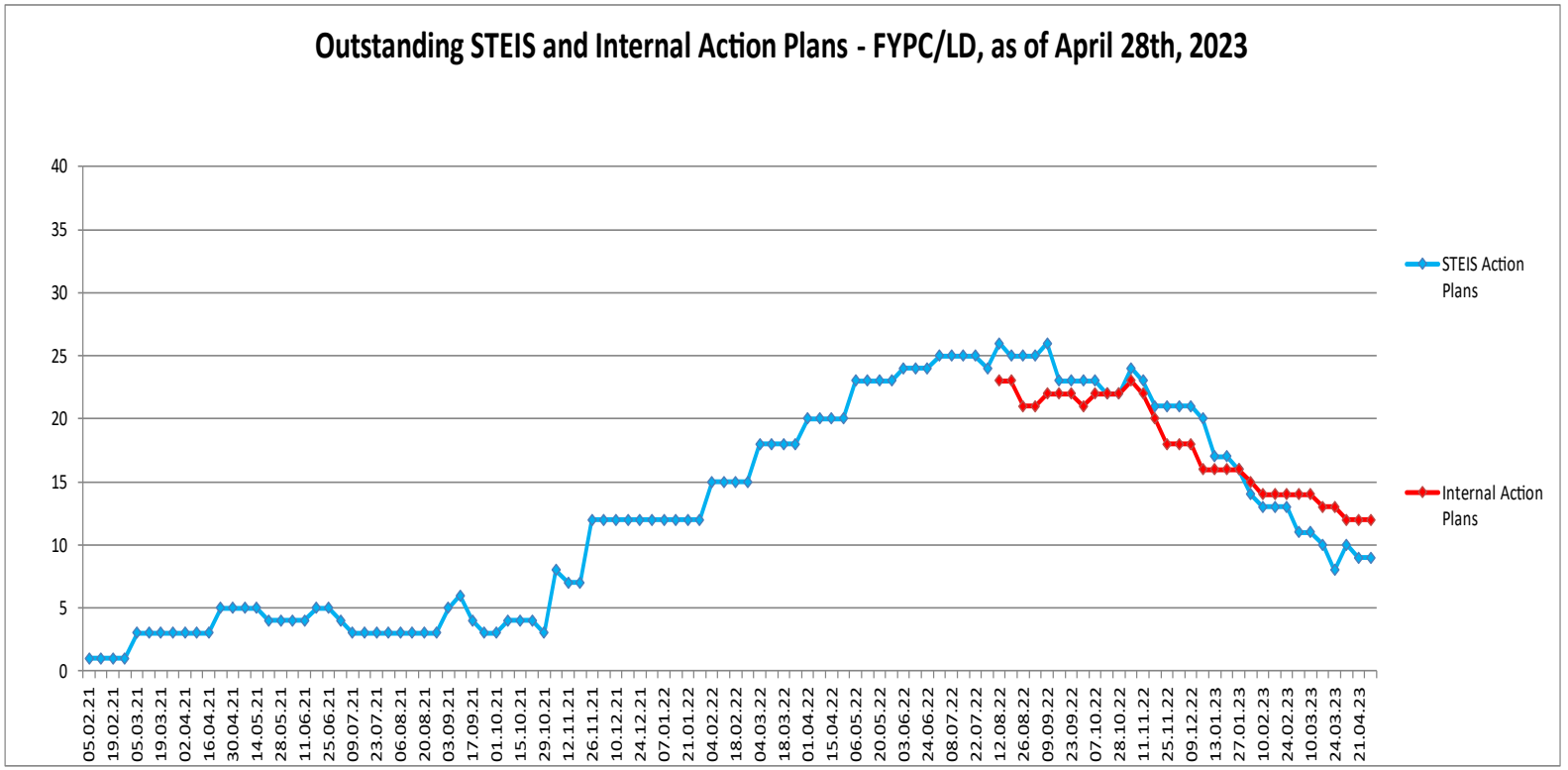
WeAreLPT
compassion respect
integrity trust

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



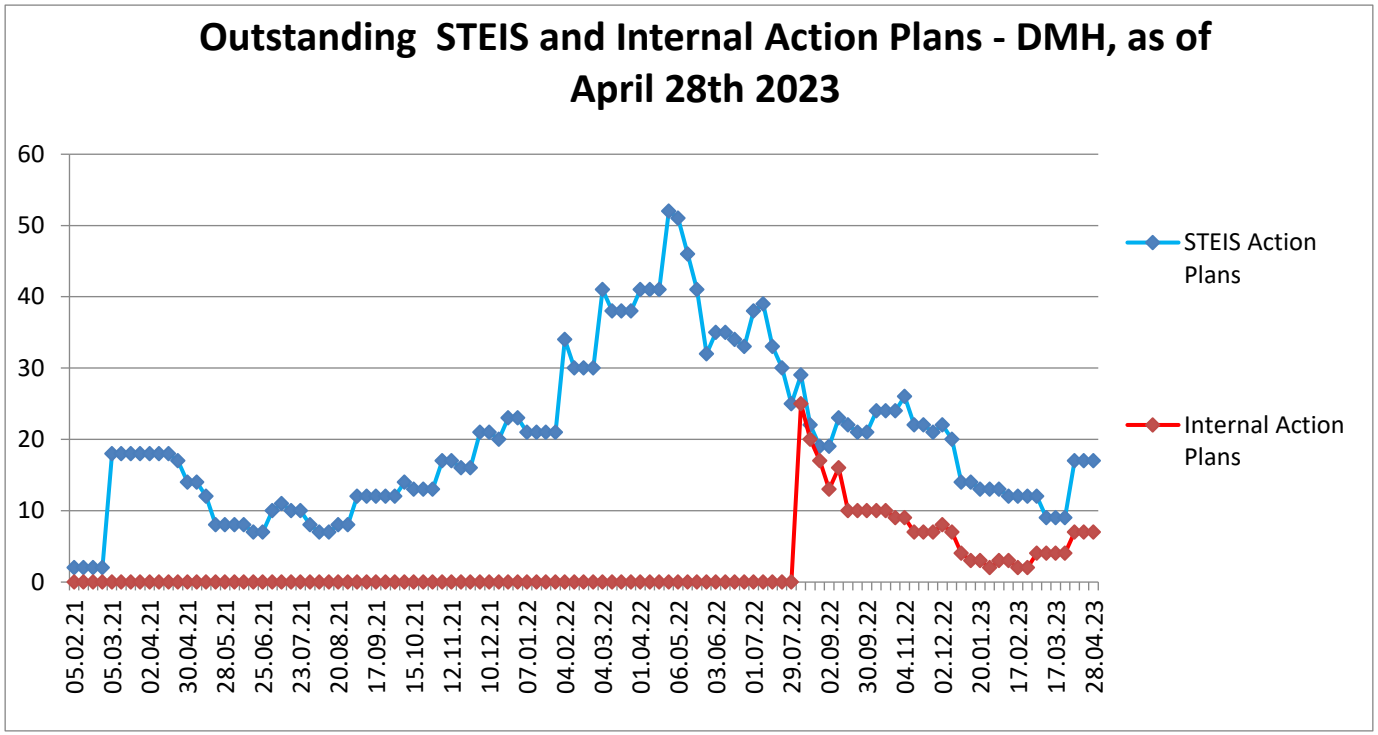
WeAreLPT
compassion respect
integrity trust

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



WeAreLPT
compassion respect
integrity trust

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



WeAreLPT
compassion respect
integrity trust

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.

A further development discussed with trust board is that where actions are recommended but not possible for reasons not in LPT control etc these will be held for organisational memory and shared with the ICB as appropriate

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 was trialled in safeguarding committee and is now extended to all appropriate governance groups
- Compliance with these will be overseen by the trust Incident Oversight Group (IOG) and reported to the Quality Forum
- Patient safety team to initially hold the areas for future development and reporting and oversight of these to be agreed

14. Learning March/April2023

Serious & Internal Incidents/Complaints Emerging & Recurring Themes

- There is a theme around decisions made regarding patients who need to be transferred out of the organisation around their mode of transport and the requirement for escort. Previous work has taken place to support staff who are escorting patients and has been successful- this included ‘grab packs’ containing phones with numbers already saved and paperwork to document patients progress and vouchers for staff refreshment
- Incidents have identified that better support and guidance is required to help staff to make decisions around the method of transport ie Ambulance, secure transport, police, Taxi
- This is a challenge for staff for example when the patients condition is considered to be urgent and the possible delays in waiting for secure transport or for example the police offer to transport.

Recommendation

The escorting and the transport policies should be reviewed to consider if combining these two would better support staff to both make decisions and to easily document their decision making to include who should make the decisions and how to mitigate risk if for example secure transport is not available.

Action

The two policies are being reviewed with the learning from incidents in mind

15. Learning March/April 2023 continued

Serious & Internal Incidents/Complaints Emerging & Recurring Themes

Incident investigations have highlighted that some seating in community hospitals was quite old and it was not always clear to staff what pressure relieving was included in the seats.

Also identified a need for more advice and support for staff with seating and time spent sitting

Actions taken

- Review of all patient seating including pressure relieving cushions and integrated specialist pressure relieving systems on the stroke units.
- Involving LPT staff in the decision making for new equipment at a designated event at the NSPCC.
- CHS and joint working with the TVN team to produce pictorial guidance to support patients with individual risks for sitting out of bed and a process identified to ensure that is embedded at ward level
- Review if the photography oversight care plan on SystmOne that was used as part of the pilot on the Life QI pressure ulcer prevention project to establish if this can be instigated across CHS for community RN oversight
- A process put in place to check the functioning of pressure relieving mattresses.
- (CHS Community) a process put in place to ensure RN oversight of Simple wound care plans is consistent and that these reviews are not consistently deferred