Board of Directors - Public

SUMMARY REPORT	Meeting Date:	24 July 2024
	Agenda Item:	13

Report Title:	**Learning and Safety Report (Q4)**	
Author(s):	Vin Lewin, Patient Safety Specialist	
Accountable Director:	Salli Midgley, Director of Nursing, Professions and Quality	
Other meetings this paper has been presented to or previously agreed at:	**Committee/Tier 2 Group/Tier 3 Group**	Quality Assurance Committee (QAC)
	Date:	12 June 2024
Key points/ recommendations from those meetings	The QAC was assured that learning across patient safety incidents, complaints and safeguarding adults is being identified, triangulated and acted on to improve the quality and experience of patients and staff. The QAC recommended that there continues to be a focus on reducing self-harm incidents.	

Summary of Key Points in Report

Key points for this quarter:

- Formal governance systems related to the transition to Patient Safety Incident Response Framework (PSIRF) have oversight of all patient safety incidents.
- The number of formal 'Serious' Incident Investigations, now called Patient Safety Incident Investigation (PSII) are decreasing whilst broader spectrum learning via Local Learning Reviews (LLR) and Local Learning Responses (LLR) are increasing.
- Low threshold reporting remains at a consistent level.
- Physical assaults and sexual safety incidences remain static in number whilst incidences of self-harm continue to increase.
- Patient falls have increased in quarter 4, however, this is in the context of an overall decrease in falls over the last 12 months.

Recommendation for the Committee to consider:

Consider for Action		Approval		Assurance	X	Information	

It is recommended by the authors of this paper that the Board of Directors is assured that:

- Learning across patient safety incidents, complaints and safeguarding adults is being identified, triangulated and acted on to improve the quality and experience of patients and staff.
- Quality improvement plans, developments and quality improvement projects are being undertaken to demonstrate robust improvement for patient safety and experience.

Please identify which strategic priorities will be impacted by this report:

Effective Use of Resources	*Yes*	***X***	*No*	
Deliver Outstanding Care	*Yes*	***X***	*No*	
Great Place to Work	*Yes*	***X***	*No*	

Ensuring our services are inclusive	*Yes*	***X***	*No*	

Is this report relevant to compliance with any key standards?					**State specific standard**
Care Quality Commission Fundamental Standards	*Yes*	***X***	*No*		CQC fundamental standards
Data Security and Protection Toolkit	*Yes*		*No*	***X***	
Any other specific standard?	*Yes*	***X***	*No*		Serious Incident Framework 2015

Have these areas been considered? YES/NO					If yes, what are the implications or the impact? If no, please explain why
Service User and Carer Safety, Engagement and Experience	*Yes*	***X***	*No*		This report and the learning lessons report focus on patient safety and improving experience
Financial (revenue &capital)	*Yes*	***X***	*No*		There are financial implications of delivering the strategies aligned to this workplan. Currently no additional resource has been identified as required
Organisational Development /Workforce	*Yes*	***X***	*No*		There are training and development implications for the workplans aligned to both the Quality Strategy and Patient Safety Strategy. These will be articulated via individual implementation plans
Equality, Diversity & Inclusion	*Yes*	***X***	*No*		Work has already identified the potential for racialised care delivery to impact on outcomes for both staff and servicer users, Clinical Quality and Safety Group consider the EDI implications within their workplan
Legal	*Yes*	***X***	*No*		Failing to implement and embed quality improvement and assurance within SHSC will lead to regulatory issues, The patient safety framework is a contractual requirement and will be monitored via ICB/NHSEI
Environmental sustainability	*Yes*	***X***	*No*		Our aim is to innovate and transform to provide high quality care and support as early as possible in order to improve physical, mental and social wellbeing

Learning and Safety Report: Quarter Four 2023/24

Foreword

In November SHSC successfully transitioned to the new NHS framework; the Patient Safety Incident Response Framework (PSIRF). This marks a significant shift in how SHSC will respond to patient safety incidents.

Key PSIRF aims include:

- Having a broader range of responses to incidents, not just formal 'Serious Incident' investigations.
- Developing a proactive strategy for learning from patient safety incidents.
- Engaging meaningfully with staff, patients and their family when patient safety incidents happen.

- Acknowledging system failings rather than casting blame on individuals.
- Making better use of data, especially looking at what works well.
- Supporting appropriate and adequate patient safety training where it is needed.
- Applying focused work into areas in which the most impact may be achieved.

Section 1: Q4 Patient Safety Specialist: Learning and Safety Report

1.1 Executive Summary

- The Daily Incident Safety Huddle (DISH) reviewed 100% of all incidents reported within 24hrs of the incident being submitted. From this, where required, immediate actions were taken to mitigate the risk of further harm, support individuals and teams, address short falls in the quality of reporting and instigate a learning process.

- As outlined in more detail in this report; there continue to be several key themes across a range of patient safety monitoring and assurance mechanisms that tell us we continue to have risks to quality and safety and areas for improvement and learning which include:

  - Racial and Cultural Abuse.
  - Fall prevention.
  - Violence and Aggression.
  - Sexual Safety.
  - Self-harm.
  - Medication errors.

- Learning from patient safety incidents highlights that there is a continued need for focus on improving communication with patients and their family, between SHSC teams and with external partner agencies. There is an overarching theme of issues with communication in quarter 4. These are primarily verbal communication issues with patients and significant others. Whilst it is safe to assume that overall SHSC communicates well with the vast majority of those that use services and their significant others, learning from incidents highlights that in some cases poor communication causes additional distress and dissatisfaction with services provided.

- It is essential that SHSC has robust management plans in place and immediate risk reduction and improvement plans to address the issues in the medium term. We have clear evidence of learning that indicates where these situations continue (increased levels of self-harm, falls, violence and aggression and sexual safety issues) that the morale of staff is impacted, and cultural norms, values and behaviour can also be impacted leading to an increased risk to the safety of patients.

This quarter 4 report contains an additional section on incidents related to information governance breaches in order to offer a broader range of learning related to patient safety.

Section 2: Introduction

2.1 Purpose of Report

This report seeks to offer assurance that:

- Actual harm caused or contributed to by SHSC and experienced by patients and their family is very low in regard to the severity of harm experienced.

- Where incidents of patient harm do occur learning is extracted, acted upon and shared in line with local and national guidance.

- Improvement actions are being undertaken that enable us to maintain and promote a patient safety culture in line with the quality strategy and our ambition to deliver outstanding care.

Section 3: Key Performance Indicators - Daily Incident Safety Huddle and Serious Incident Investigations

3.1 Number of incidents reported and reviewed in the previous 4 financial years and previous 4 quarters.

Financial year	**2020/21**	**2021/22**	**2022/23**	**2023/24**	**Total**
No. Reported	8222	8440	8521	8876	**34059**
4 Quarters	**Q1 2023/24**	**Q2 2023/24**	**Q3 2023/24**	**Q4 2023/24**	**Total**
No. Reported	2262	2289	2258	2067	**8876**

3.2 Learning Responses actioned in Q4.

Type of Response	**2023/24 Q1**	**2023/24 Q2**	**2023/24 Q3**	**Jan 24**	**Feb 24**	**Mar 24**	**2023/24 Q4**
48hr Reports Requested	49	58	49	6	4	8	18
***Significant Analysia Reviews (SEA) Declared**	18	11	8	3	0	0	3
Local Learning Reviews (LLR) Declared	N/A	N/A	0	0	4	1	5
Coordinated Learning Review (CLR) Declared	N/A	N/A	1	2	0	0	2
After Action Review (AAR) Declared	N/A	N/A	0	2	0	1	3
Structured Judgement Reviews (SJR) Declared	N/A	N/A	0	0	0	0	1
Patient Safety Incident Investigations (PSII) Declared	10	7	0	0	0	1	1
Manager Incidents Reviews Completed.	2215	210	2035	635	611	674	1920
Incidents followed up by the Daily Incidents Safety Huddle (DISH)	695	739	700	217	166	225	608

Blue Light Alerts	6	3	4	0	1	1	2

* The SEA process was replaced by the LLR process in January 2024

3.3 Key points to consider from the data provided:

- The overall number of incidents reported over the last 4 financial years and the last 4 quarters has **remained stable** with no significant variation and with a mean number of 2219 incidents reported each quarter.
- One Patient Safety Incident Investigation (PSII) was declared in quarter 4. This is in line with the expectation that this type of learning activity will significantly reduce post PSIRF implementation. The findings from the PSII will be outlined in the 2024/25 quarter 1 report.
- All patient safety incidents reported as having a catastrophic impact were in relation to death and 80% of these were either suspected or known to be due to natural causes. All deaths were reported by community-based services. During quarter 4 there were no deaths reported by bed-based services (including the two nursing homes). All deaths from suspected suicide (8%) were subject to individual due diligence and where required a 48hr report was completed. 2% of reported deaths were in relation to substance misuse clients. These services are no longer commissioned from SHSC, accounting for the reduction in the number of reported deaths overall. However, SHSC continues to monitor coronial processes associated with substance misuse patients that previously had open episodes of care.
- 77% of all reported incidents can be traced to bed-based services. 53% of all incidents were reported by acute and community services. Rehabilitation and specialist services accounted for 45% of all incidents reported. 2% of incidents were reported by non-clinical services, including pharmacy services.
- 87% of all incidents reported were in the no harm (near-miss, negligible) or low harm (minor) categories of actual impact.

Tables 1 - Types of Patient Safety Incident Investigations since April 2021 by year

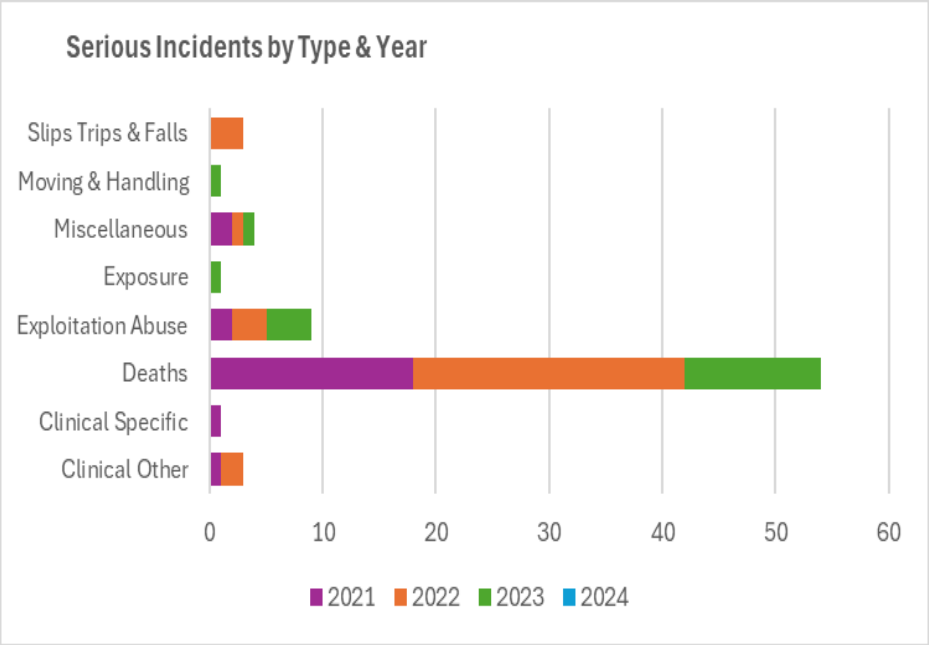
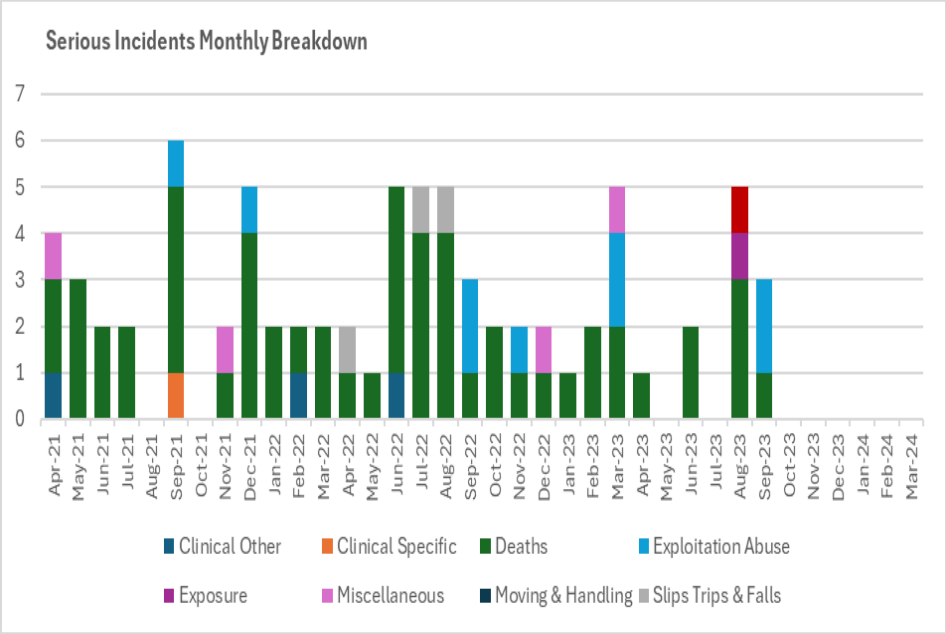


Table 2 - Types of Patient Safety Incident Investigations since April 2021 by month



Section 4: Incident reporting and Learning from Incidents

4.1 Incident reporting in NHS organisations is widely recognised as an important method for improving safety in healthcare settings. Organisations with a low threshold for reporting are indicative of an open and transparent learning culture. SHSC incident reporting remains consistent, and this is indicative of a low reporting threshold organisation.

This is supported below in the following 2 tables which indicate that there has been no significant variation in reporting since quarter 1, 2021 and that 87% of SHSC incidents in Q4 are in the low patient harm (minor) or no patient harm (negligible) category.

Table 3 - All incidents reported since January 2020:

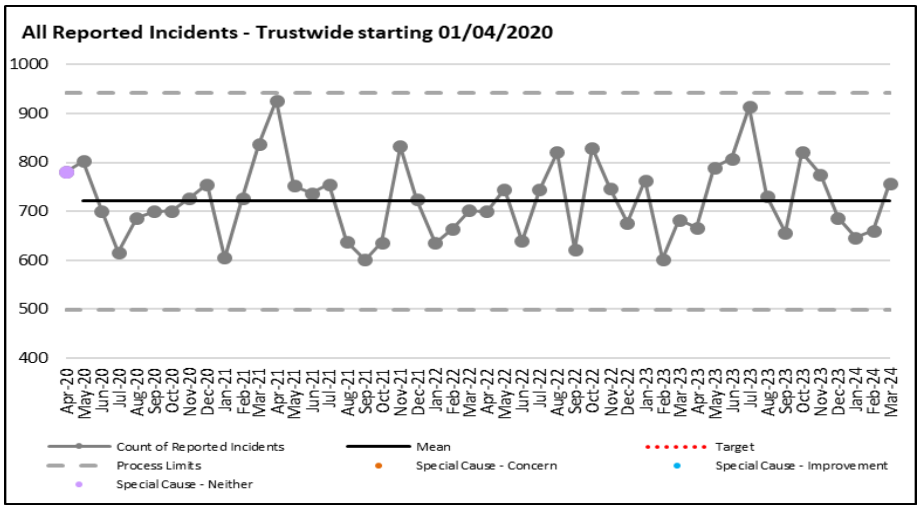
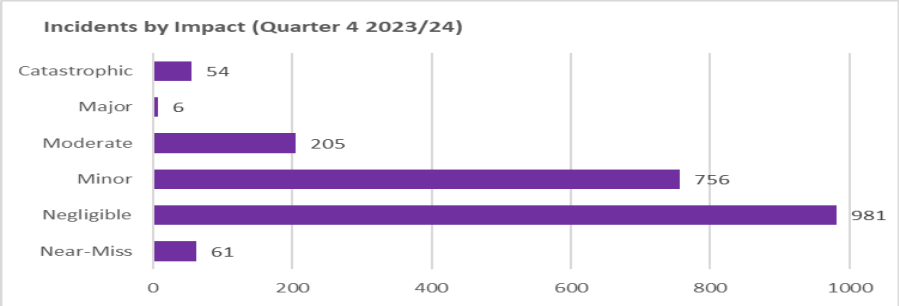


Table 4 - Actual impact of incidents being reported in Q4:



Section 5: Daily Incident Safety Huddle (DISH) Learning Themes Q4

Table 5 - Top 5 incidents since April 2021

Incident Type	April 2021 to March 2022	April 2022 to March 2023	Quarters 1, 2, 3 & 4 (April to December-2023)
Exploitation Abuse	2963	2357	2409
Medication	1234	994	921
Clinical Specific	902	1044	1036
Moving & Handling	905	650	572
Slips Trips & Falls	810	696	608

5.1 The DISH group, consisting of key individuals including the Patient Safety Specialist (Chair), Consultant Nurse for Restrictive Practice, the Safeguarding team, the Health and Safety team, Physical Health leads and Pharmacy, reviewed 100% of incidents reported within 24 working hours in Q4. All incidents are individually reviewed, and quality checked in line with existing policy and standards. During Q4 the DISH group directly followed up on 29% (608) of all incidents reported to offer support or request further information.

5.2 Racial and Cultural Abuse incidents were primarily reported as patient to staff incidents in bed-based services (53%). Nine racial abuse incidents were experienced by the Community Enhancing Recovery Team (CERT), these were all via the telephone and the telephone answering machine and they were all attributable to one patient. CERT is in regular contact with the police regarding this. 15% of incidents reported were patient to patient racial and cultural abuses. The huddle noted a continued trend toward offering staff and patients directly subjected to racial and cultural abuse, debrief support and support to contact the police. Reported incidents are categorised by the huddle as either a potential hate crime or as a hate incident.

In Q4 91% of incidents were considered to be of a negligible or minor impact, suggesting they were primarily hate incidents rather than hate crimes. Three incidents of racial and cultural abuse toward staff were reported as having a moderate impact of harm. These were in relation to extremely offensive verbal abuse and staff support was provided in the form of a post incident debrief.

There were three incidents of racially motivated attempted physical assaults reported in Q4. There were no physical injuries as a result of these incidents and all 3 were considered to be triggered by acute mental health deterioration requiring medical intervention.

A thematic review of all of the racial and cultural abuse incidents revealed that action was taken to challenge the perpetrators of abuse in 100% of the incidents. 80% of the victims of racial and cultural abuse were offered support to report the incident to the police. 95%

incidents highlighted that the victims were offered post incident support and 17% highlighted that the hate incident flow chart had been followed.

All incidents of this nature are reported directly to the inclusion equality and engagement lead for individual review and, where required individual follow up.

5.3 Slips, trips and falls accounted for 7% of all incidents reported in quarter 1 of 2023/24, this reduced to 6% in quarter 2 of 2023/24 and remained static at 6% in quarter 3 of 2023/24. In quarter 4 there was an increase to 8%. However, this is a small percentage rise within the context of an overall reduction in the number of falls over the last 12 months. Despite this, the falls reduction group have undertaken a deep dive into the falls data to ensure further increases can be avoided wherever possible.
86% of the reported falls were from older people's services, with 66% of these being reported by the two older people's nursing homes. The hotspot for falls continues to be Birch Avenue Nursing Home which reported 51% of all falls. There was one fracture following a fall reported by Birch Avenue nursing home in quarter 4. The Local Learning Review (LLR) identified that all appropriate falls risk assessments were in place prior to the fall and that all post fall actions were undertaken in a timely manner. The review did identify that the resident's daughter, living in Australia, felt she was not being communicated with effectively by other family members, therefore a communication plan was put in place by the team at Birch Avenue to address this.

The Older People's services continue to engage in a quality improvement project aimed at reducing preventable falls by using the Huddling Up for Safer Healthcare (HUSH) methodology. This methodology appears to be having a positive impact in all older adult bed-based services, where the numbers of reported falls have reduced overall.

5.4 Actual Physical Assaults on patients by other patients, in bed-based environments accounted for 5% of all reported incidents in quarter 4 of 2023/24 and this number has remained static since quarter 3 of 2023/24. Actual physical assaults on staff accounted for 5% of all reported incidents in quarter 4. In all cases, where a patient was subject to physical assault the Safeguarding Adults team in SHSC were notified and external safeguarding referrals were made where required.

Any type of abuse toward patients and staff can have a negative impact on patient safety and psychological harm cannot be underestimated, however, 90% of the incidents that were reported were given an actual impact rating of no or low harm. Only 10% of incidents were rated at a moderate or major level and a thematic review of these revealed that this grading was primarily related to the use of seclusion (54%) to maintain the safety of patients and staff.
In quarter 4, one incident was reported as having a major impact. A community team identified a risk of violence toward a patient's partner and reported this appropriately. The patient was later remanded into police custody.
Violence can cause physical injuries but can also have psychological consequences on staff victims which include anger, fear, anxiety post-traumatic disorder symptoms, guilt, self-blame, decreased job satisfaction and increased intent to leave the organisation, among others. To this end, the DISH closely monitors post-incident manager reviews with the aim of checking the effectiveness of interventions that have been put in place to support staff victims of violent and aggressive behaviour.

5.5 2% of all reported incidents were sexual safety incidents, of which only three incidents involved actual physical contact between patients. Two of the incidents were reported about the same patient touching another patient in an unwanted way (touching and rubbing the other patient's arm in a sexualised way). Appropriate action was taken to safeguard both of the vulnerable adults involved in these two incidents. One reported incident in quarter 4 was a patient-to-patient sexual safety incident that involved intimate sexual contact. Due diligence, fact finding and safeguarding processes were undertaken to ensure the safety of the individual patients. A 48hr report and a safeguarding investigation have been undertaken. The 48hr report identified learning in regard to the use of corridor observations and these are being reviewed.

60% of incidents were patient to staff sexual safety reports. 100% of these were categorised as no harm or low harm incidents with the highest proportion being verbal sexual abuse and/or intimidation. Appropriate support was given to staff in each case and the alleged perpetrator was informed that their behaviour was inappropriate directly.

5.6 Self-harming behaviour by patients in bed-based services was a consistent theme over all 4 quarters of 2023/24. In quarter 1 of 2023/24 76% of all the Clinical Specific category of incidents were reported as self-harm, rising to 79% in quarter 2 and 85% in quarter 3 and reducing to 72% in quarter 4. 42% of all self-harm incidents were reported by Dovedale 2 ward.

Table 6 - Self-harm by gender since April 2022

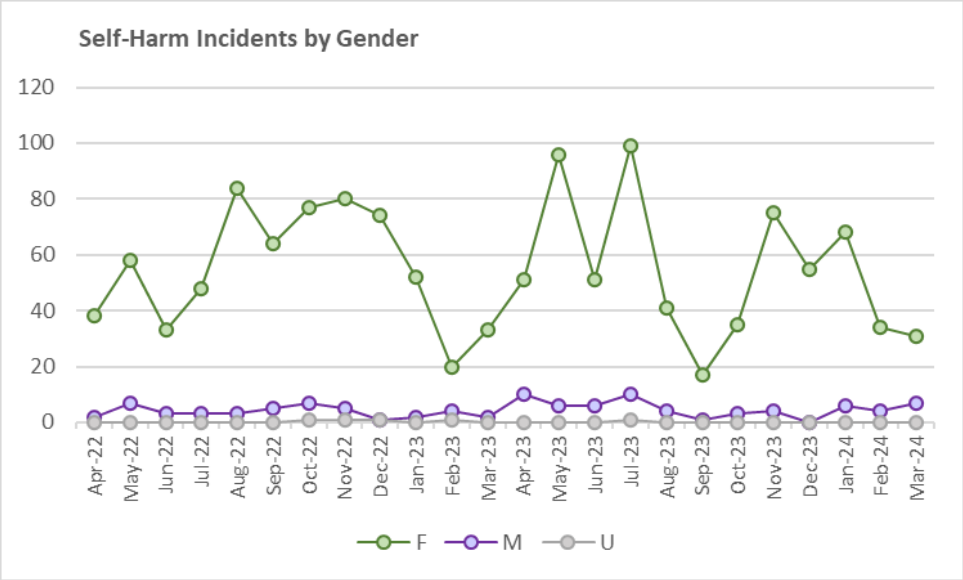


Table 7 – Self-harm by ethnicity since April 2022

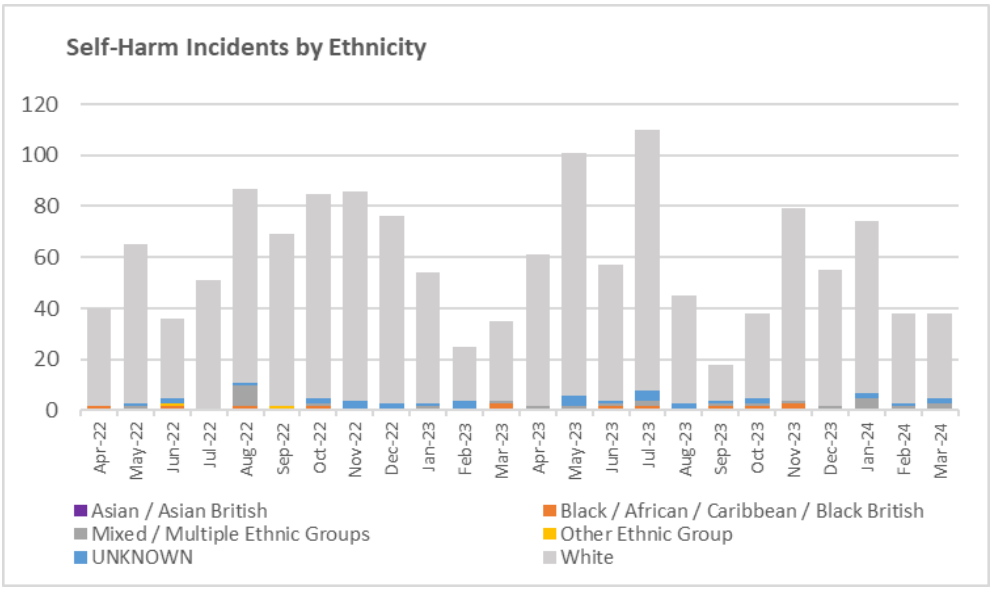


Table 8 – Types of self-harm in quarter 4

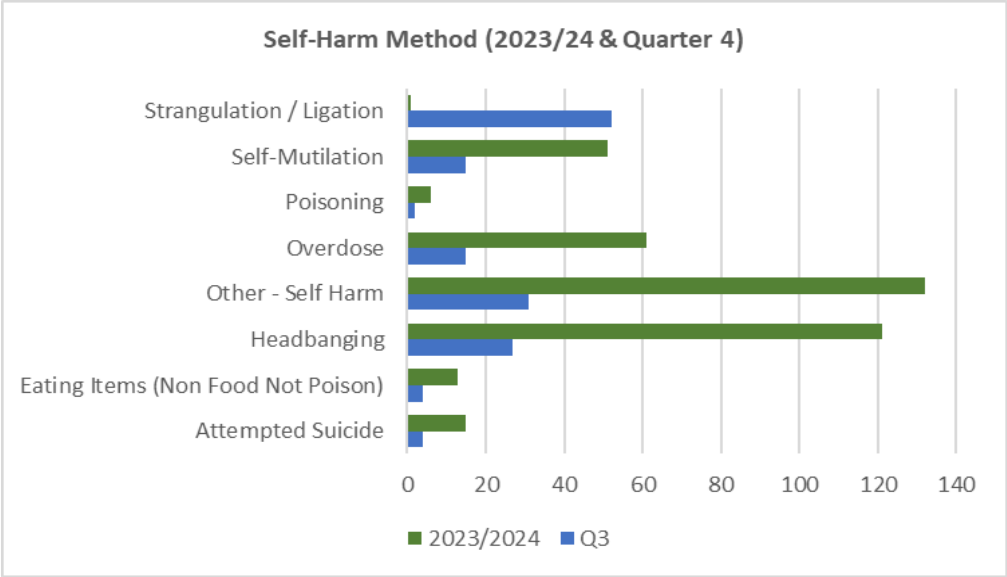
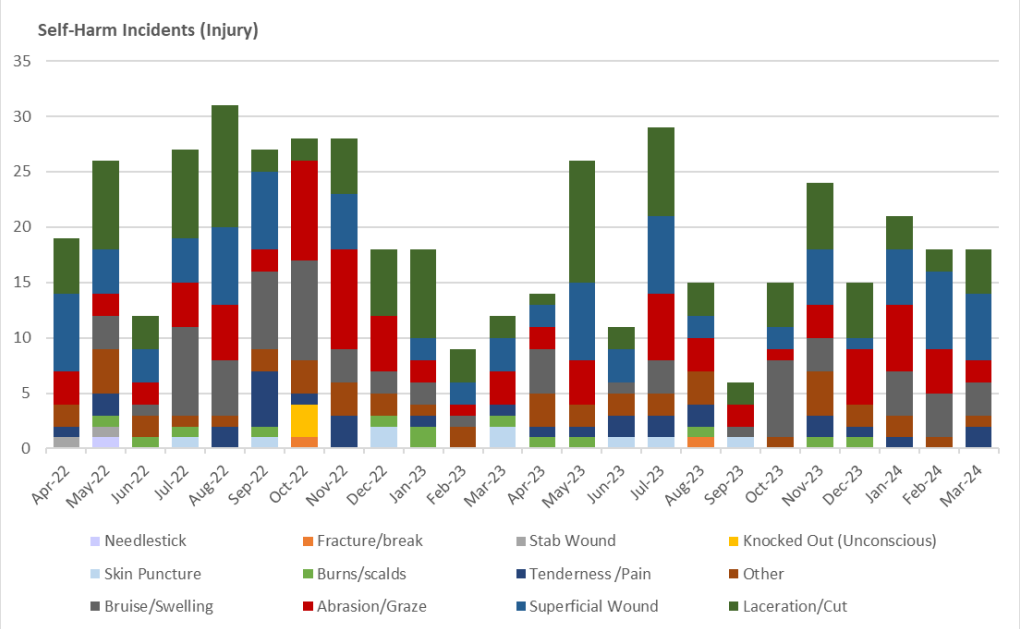


Table 9 – Types of self-harm injury since April 2022



5.7 Female patients with a White/ British/Irish/ Other ethnicity are the demographic with the highest reported self-harming behaviour, leading to a range of injuries. A thematic review of individual patients that self-harmed in quarter 4 revealed that a common association across the demographic was previously reported early life trauma and a diagnosis of a personality disorder type. The most consistently reported incident themes related to self-harm are ligation/strangulation and headbanging. By comparison, patients that self-harmed in a community setting reported taking overdoses of medication as a means of self-harm.

It is an SHSC policy requirement that nursing staff undertake neuro observations as part the ward-based post incident interventions for ligation and headbanging incidents. Staff will complete a NEWS2 or Non- contact NEWS2 every time a patient uses a ligature or headbangs. The Physical Health team works collaboratively with the Clinical Risk Advisor and the respective team leaderships to support the nursing staff and to monitor compliance with this requirement. They also attend the wards regularly to provide ad hoc neuro-observation and self-harm risk management coaching.

During quarter 4 there was a noted increase in one inpatient being able to access paracetamol in order to take overdoses. During checks of food that the patient had ordered to be delivered staff found packets of paracetamol hidden amongst the food. Action was taken to alert others to this and to highlight concerns to the specific food delivery company.

The narrative evidence provided through incident reports and managers reviews continues to highlight that to prevent serious self-harm, restrictive practices such as restraint, use of the safety pod and rapid tranquilisation are frequently used as a preventative last resort. The thematic review continued to note an increase in the use of behavioral management plans, positive use of de-escalation through therapeutic engagement, safe spaces and distraction techniques.

5.8 Medication management incidents: as opposed to medication administration continued to be reported on a regular basis. 99% of all medication incidents were reported as no harm or low harm. As in quarters 1, 2 and 3 the thematic trend reflected errors in procedural systems with only 6% of medication incidents overall leading to the patient being given the wrong dose or type of medication. Of this 5% there was no recorded physical harm to the patient and in all cases the basic requirements of the statutory duty of candour were implemented by way of an explanation and face-to-face apology. The most frequently reported incidents were related to storage fridge and room temperature fluctuations and missing second signatures for controlled drugs (25%).
Only three medication incidents accrued actual impacts of moderate harm. Two were related to prescribing errors. One error, during a power cut, led to a patient being given more medication than originally prescribed and this incident was subject to a formal learning review in collaboration with pharmacy. The patient was not harmed, and medical monitoring was undertaken appropriately.

Section 6: Learning from Further Investigation

6.1 **Local Learning Reviews in quarter 4 (LLR)**

LLR 1: Adult Protection / Child Protection Issues: The LLR identified potential learning in relation to the care and treatment pathway for people who are pregnant and require secondary mental health support. In this case there was found to be a lack of clarity between SHSC ward/STH staff around responsibilities when a patient is being cared for at the general hospital. In this case immediate action was instigated by the Deputy Director of Nursing and Quality to bring together all relevant professionals in a complex case forum. Further joint learning is planned to take place across both services in the shape of an after action review scheduled for June 2024.

LLR 2: Intimidation – Patient to Staff: During a home visit two members of the community mental health team were prevented from leaving the patients property and the patient made serious threats to harm them both. The police attended the property and the staff were able to leave unharmed. The LLR identified learning related to the lone worker policy and a working group has been set up, consisting of staff from North and South Community Mental Health Team, options are being considered and improved practices implemented, including recommendation to the trust if investment is required.

LLR 3: Slips, Trips & Falls: Found on the floor injured: Whilst the LLR found that all of the correct pre and post falls actions had been undertaken it did reveal that the residents daughter, who lives in Australia, did not feel like her family in England were effectively communicating with her. The service have developed a communication plan to ensure she receives regular updates on her mothers wellbeing. The Duty of Candour process was followed appropriately in relation to this incident.

LLR 4: Clinical Other: Diagnosis/Treatment – Delay / failure to follow up: During a seclusion review, a review of the patients' records was undertaken to establish the frequency of contact with the community prior to admission. The LLR found:

- Record keeping standards need improving to ensure accurate comprehensive records are maintained in line with SHSC policy and national guidance and ensure that all significant contact with or attempts to contact a service user are recorded in the clinical record.

- Service or teams should review previous significant notes particularly written by colleagues in other teams to develop a picture of the service user needs and ability to engage to inform plans for future support and intervention.

LLR 5: Missing persons high: A vulnerable older person was able to leave the ward into the community. He was located by staff and brought back to the ward by secure transport. The review identified this to be one of a cluster of incidents related to the fence in the garden of DD1. Due to previous incidents work had been scheduled and since completed to replace the original fence with one that prevents people climbing it.

6.2 **48hr Reporting**

6.3 Learning identified from non-death potential patient safety incidents:

Theme 1: Exploitation Abuse: Sexual Abuse - Pat to Pat: Two patients on Maple Ward were observed to be displaying sexually disinhibited behaviour and were later discovered to be engaged in a sexual act. Both patients were supported psychologically, and safeguarding adult concerns were raised for both. On medical review both patients were deemed to have capacity, in the context of neither patient was the decision to engage in a sexual act, however, both patients were vulnerable due to their mental well-being. The 48hr report found that corridor observations may not have been sufficient in this situation. A further section 42 enquiry is currently underway.

Theme 2: Exploitation Abuse – Physical Assault Pat-Staff / Self Harm: Following the suspension of a patients leave, due to personal safety concerns, he repeatedly kicked and punched the office door. An Xray identified damaged tissue in the patient's hand. The 48hr report identified that the situation had been contributed to by planned changes to his medication leading to relapse and therefore suspension of leave. The team formulated a plan to provide short-term escorted leave in an attempt to minimise the patient's frustration during the period on medication titration.

Theme 3: Self-Harm: Attempted Suicide: During a period of escorted leave the patient received a distressing telephone call that triggered a negative emotional response. After initial de-escalation assisted in helping prevent the patient from jumping off a bridge, she made her way to the railway station and attempted to get onto the railway line. The patient was restrained by British Transport police and returned to the ward in secure transport. The 48hr report identified good team working across a number of services and commended the escorting staff for their action to keep the patient safe. However, there were concerns about how the incident was documented on both the Insight record and the incident report form and this was addressed directly with the team.

Theme 4: Clinical Specific – Self Harm: Eating Items: A patient disclosed that she had swallowed 2 razor blades that she had brought to the ward following a period of home leave. The patient was treated in the Accident & Emergency department. The 48hr report found that the search policy had not been followed when the patient had returned from leave. Individual supervision was undertaken to reinforce the requirement for adherence to the search policy and search requirements were added to the ward safety huddle and the section 17 leave risk assessment for returning patients.

Theme 5: Clinical Specific: Self-Harm – Self Mutilation: The patient absconded from escorted leave and was later reported to be engaging in self-harm in the street, by a member of the public. The patient was treated in the Accident & Emergency department. The 48hr report highlighted that all appropriate action was taken once the patient had absconded and that preventing the patient from absconding would not have been possible at that specific point in time. The team have reviewed whether there was a need for a Best Interest meeting prior to leave being granted and have engaged with the Respect team in regard to the management of patients absconding in the community.

Theme 6: Intimidation – Patient to Staff: During a home visit two members of staff were prevented from leaving the patient's property and threatened with violence. The team have set up a working group to review their approach to lone working. Both staff were offered psychological and emotional support.

Theme 7: Lack of Clinical or Risk Assessment: Following a delay in the Mental Health Act assessment it was established that the patient had been found unconscious and transferred to Intensive Care. The 48hr report established that there was a lack of contingency planning for this patient and that the documentation of risks was not sufficient. A further, more detailed learning response is currently being undertaken to address the learning identified in the 48hr report.

Theme 8: Sexual abuse – patient to staff: During a home visit to administer a depot injection the patient was sexually inappropriate with the member of staff. Psychological and emotional support was provided to the member of staff. It was noted that there were evident signs of relapse in the patient's mental health and a referral was made for a Mental Health Act assessment, however the patient was arrested for an unrelated matter before this was completed.

Theme 9: Security – Missing Patient: Attempted / failed Absconsion: A Dovedale 2 patient was able to abscond from Sheffield Teaching Hospitals where she was receiving medical treatment. Security staff safely returned the patient to the ward. Actions were undertaken to ensure Sheffield Teaching Hospital staff were aware of the care plan and of the leave restrictions placed on the patient.

Theme 10: Lack of S17 Leave Risk Assessment: A patient was reported to be absent without leave from the ward, despite being documented on the observation chart as being on leave, it was verbally handed over that he was on the ward. The 48hr report identified that there was a lack of pre-leave risk assessment, poor communication and documentation in regard to the whereabouts of the patient. The patient was safely returned back to the ward. The ward has since implemented a white board system to ensure all patient leave status is clearly recorded and completed improvement actions in conjunction with Safewards initiative regarding the handover procedure.

6.4 Learning identified from unexpected death:

Theme 1: Suspected Suicide: Information was received through the Realtime Surveillance network that the person had died, suspected to be suicide. Further due diligence revealed that the individual had had previous contact with the Gender Identity services but that the last contact had been in 2019.

Theme 2: Unexpected Patient Death – Suspected Suicide (SHSC Community): The team were informed that the patient had died following an overdose of medication. The 48hr report revealed that the team were providing a robust service, she was being seen on a weekly basis in the hearing voices group, led by psychologists, she was also seen by registered nurses for her depot medication to be administered and additionally she did have a named worker, although this had recently changed due to the original worker having a prolonged sickness absence. The patient would also receive regular calls from our duty team. Staff had identified a persistence to her low mood and highlighted this accordingly in the notes putting in place an appropriate response. The team contacted the family to give their condolences and they were provided with a further opportunity to meet with the patient safety specialist.

Theme 3: Unexpected Patient Death (SHSC Community): following concerns about a lack of recent contact with services the team rang the patient's father who informed them his son had died. The 48hr report revealed that the team was responsive to the fact that he had not been seen for some time and were flexible in their approach to him not answering the numerous telephone calls. The team carried out a total of 3x cold call visits to his property. The patient's father was offered the opportunity to meet with the patient safety specialist.

Theme 4: Unexpected Patient Death -SHSC Community: The social care team informed SHSC that the patient had been discovered deceased in her home address. The 48hr report revealed that actions, with regard to capacity and best interest decision making were effective in commissioning additional support within a multi-agency approach to enable the patient to live independently. She remained living in her home, for which she had emotional attachment and was safeguarded from future potential financial abuse.

Theme 5: Unexpected Patient Death – SHSC Community: The coroners service informed SHSC that an individual had been discovered deceased at the Salvation Army. Due diligence revealed that the individual had had a brief contact with Sheffield Talking Therapies and that the correct protocols for this individual had been followed.

Theme 6: Unexpected Patient Death – Suspected Suicide (SHSC Community): The Realtime-Surveillance network informed SHSC that an individual was suspected to have died by suicide. Due diligence revealed that the person had had previous contact with Liaison Psychiatry and SPA. SPA attempted contact several times over 4 separate days, from the 15th -19th January. Brief contact was made on 18th January whereby the person reported he was visiting a family member in hospital and couldn't speak; a further time was agreed. Senior Recovery Worker contacted at the agreed time however, he stated he was unable to speak as he was on his way to the hospital and agreed a further time. A multi-disciplinary team attempted to respond to the presenting concerns and need. He had advised that social stressors were driving his distress and attempts were made to support him with this issue.

Theme 7: Unexpected Patient Death - Suspected suicide (SHSC Community): The coroners services informed SHSC that an individual had died, and suicide was suspected. Dur diligence revealed that the person had had brief previous contact with SHSC before being discharged. As per standard protocol for new service users, the Sheffield Talking Therapies clinician tried to engage him in a thorough risk assessment. He indicated that he had taken overdoses in the past therefore the clinician attempted to engage him in making a safety plan to support him keeping himself safe should things deteriorate but he declined. He did assure the clinician that he could keep himself safe on the day of the assessment and that he had no immediate plans to hurt himself or end his life. As he indicated that he would be happier speaking with his GP, the clinician sent a comprehensive letter to assist the GP. Feedback was provided to the clinician involved on this good practice.

6.5 **Learning from Serious Incident Investigations from Q3 2023/24**

6.6 Five Serious Incident investigations were marked as completed and sent to the ICB from 1 January 2024 to 31 March 2024.

6.7 **Notable Practice**

6.8 In regard to notable practices that have been identified during an investigation, investigators found the following:

- Assessments were all carried out appropriately and in a timely manner. The correct staff were involved with care and referrals were all deemed to be appropriate.
- Suicide and harm risks were reviewed on a regular basis and were documented within the medical notes. The DRAM (risk assessment document) was updated regularly and when any changes were noted with regards to Service User A.
- Good documentation of the reasons for discharge back to the Community Mental Health Team
- Throughout the care under SHSC, all professionals involved had the dedication to do the right thing for Service User. In particular nurse 2 showed dedication supporting the Service User and doing the right thing throughout his care. This was highlighted through wife's gratitude expressed to the service after the Service User died.

6.9 **Lessons Learned and Actions**

6.9.1 Regarding themes, lessons learned and actions, investigations found the following:

- Theme 1: Following the suspected suicide of a SPA patient investigators noted that it would be beneficial if professionals and family members could refer people into the Single Point of Access without gaining consent of the person, if there were concerns

about a person's imminent risk. This would potentially reduce the time for when contact is made.
SPA is currently going through a transformation programme and will be under the remit of primary care mental health, ensuring a more connected and integrated system going forwards. The transformation aims to dissolve barriers between primary and secondary care and stop individuals falling between gaps in local services.

- Theme 2: Following the suspected suicide of a South CMHT patient it was the investigators view that not making a safeguarding referral was correct in this instance, however, the investigator would have liked to have seen documented evidence of the rationale for not doing this,
SHSC are delivering a service-wide project to address wider issues with record keeping, both in contact notes and risk assessments. In addition, a new electronic patient record system is being rolled out to all teams which will provide practitioners with further tools to maintain a high standard of record keeping and a high standard of risk assessments.

- Theme 3: Following the suspected suicide of a liaison patient the investigator found that, although not related to the terms of reference, sending letters to a patient on the same day, one related to psychology appointment, one related to medic appointment, could have been confusing for the patient.
The OA CMHT are reviewing their processes around sending letters to patients to ensure patients are not receiving different letters regarding different elements of their care from the same service.

Section 7: Learning from Safeguarding Processes

7.1 The first multi-agency audit for "William" has been completed and the learning brief has been published by the Sheffield Adult Safeguarding Partnership (SASP) in March 2024. This can be found here: learning_brief_-_accessible.pdf (sheffieldasp.org.uk)

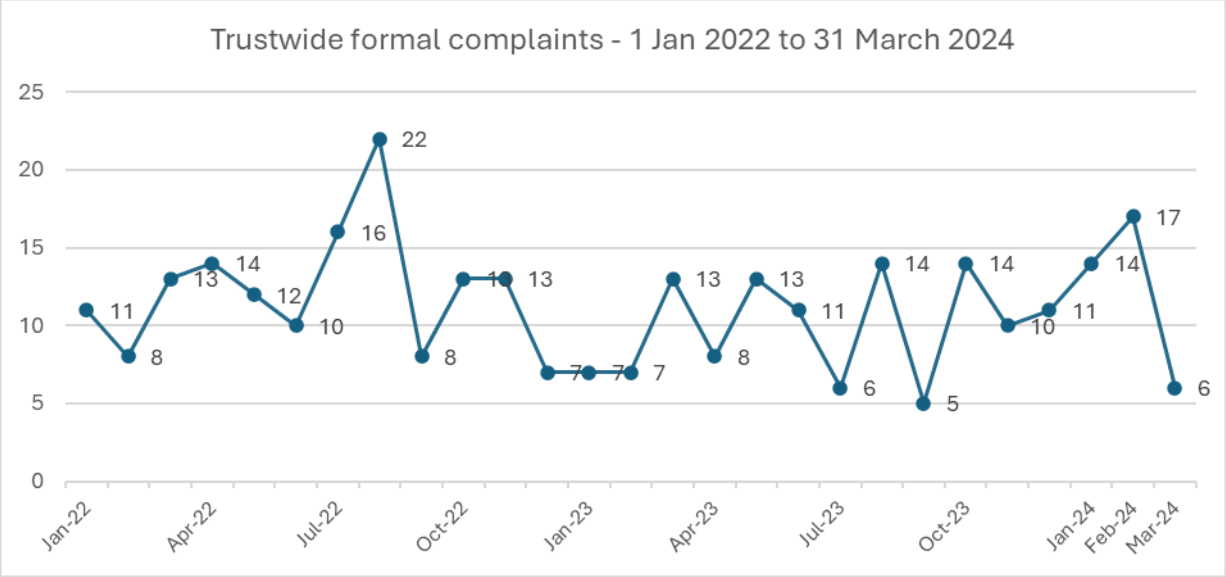
7.2 In Q4 a total of 10 Section 42 (2) Enquiries were caused to SHSC by the Local Authority. 2 enquiries were caused to SHSC but returned to the Local Authority as they related to other agencies such as transport services, AMHP Team and District Nursing Services.

Overarching themes this quarter were around neglect and sexual safety. 4 enquiries were caused from external referrals (1 x Family member and 3 x STH) and 3 Enquiries relate to 1 person.

The S42 Enquiries and tracker continues to be reviewed at the weekly Patient Safety Overview Panel for assurance and approval.

Section 8: Learning from Complaints

Table 9 - Formal complaints since January 2022



37 formal complaints were received during quarter four (1 January 2024 to 31 March 2024). This is a slight increase on the previous quarter (35 complaints received).

The top complaint themes for quarter three were “Access to Treatment or Drugs” (12 complaints), “Values and Behaviours” (9 complaints) and “Patient Care” (4 complaints). These were the same top three in quarter three.

34 cases were responded to in quarter four and 1 was withdrawn. Out of the 34 complaints closed during quarter four, 31 (91%) were closed within agreed timescales.

Table 10 – Complaint Themes

Complaint category	Q4 2023/24		Q3 2023/24
Access to Treatment or Drugs	12	↓	14
Values and Behaviours	9	↑	5
Patient Care	4	↓	6
Clinical Treatment	3	↑	2
Communications	3	↓	4
Admissions and Discharges	2	↑	1
Prescribing	1	↓	1
Privacy and Dignity	1	↑	0
Appointments	1	↑	0
Access to Records	1	↑	0
Total	37		35*

Of the 12 access to treatment complaints, 3 were relating to SAANS and the known issues with waiting times for ADHD assessments. There were no other clusters of complaints for this category

Section 9: Learning from Blue Light Alerts

9.1 Blue Light Alerts: This is a cascading system for issuing patient safety alerts, important safety messages and other safety critical information and guidance to staff and services across SHSC. During quarter 4 two Blue Light Alerts were cascaded to staff and services.

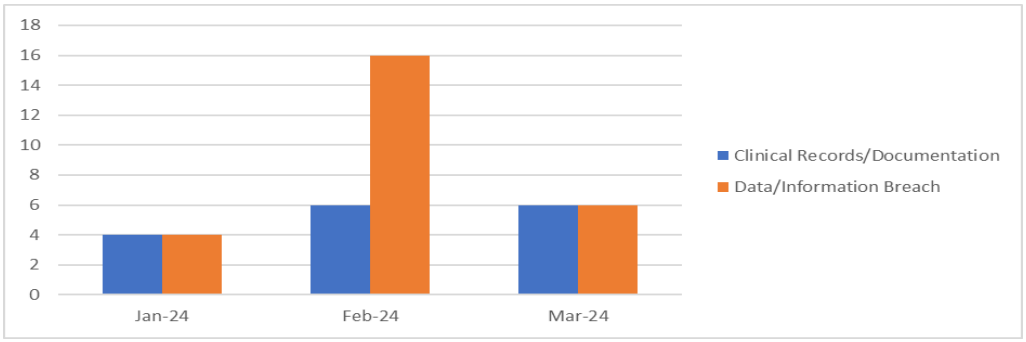
- Blue Light Alert 1: During a routine search of a takeaway food delivery, ordered by a service user, staff members discovered quantities of paracetamol subtly hidden amongst the food. The paracetamol had been removed from the blister packaging and was hidden amongst the service user's chips.
  This incident has been reported to South Yorkshire Police.

- Blue Light Alert 2: NHS England shared that curing powder is widely available on the internet to purchase and can be deadly if ingested in large amounts. The main ingredient is salt (Sodium Nitrite) and there are other substances contained within the product which may cause harm.
  Over the past few years, an increase in consumption of the substance has been linked with suicide in Canada and the United States of America. Norfolk and Suffolk NHS Foundation Trust (NSFT) have recently seen two cases where curing salt has been ordered with the intention of self-harm. It is understood from international sources that consuming high levels can lower the ability of red blood cells to move oxygen. Doctors refer to this harmful condition as methemoglobinemia. This can affect the ability to breathe, which can cause collapse.

Section 10: Information Governance Incidents in Q4

10.1 During the quarter, one incident was notified to the Information Commissioners Office. It was reported that a support worker on an inpatient ward had informed a patient's mother which ward the patient was on and what medication she was taking even though the patient did not want the mother to know where the patient was and did not want her to visit. The ICO decided to take no further action over this case although ultimately, the support worker was not identified.

Table 12- Data information breaches in Q4



Numbers of reported incidents varied between months with February seeing a large number of reported breaches.

- The most common type of incident was e-mails containing confidential information being sent to the wrong person (5 reported incidents). This can happen when Outlook suggests recipients and the wrong one is chosen so care is required to check recipients before sending e-mails. One report concerned sending information to a former member of a group because the membership had not been updated when that person left.

Breaches occasionally occur when e-mails or appointments are sent to groups of people without using the 'blind copy' (bcc) function so that all recipients are able to see all other recipients, potentially identifying service users or carers.

- Two incidents involved documents about one service user being given to a different person whilst they were both inpatients.
- There were two reported incidents of information about service users being given to the wrong person over the phone where we had out of date contact details recorded.
- Daily records have been recorded against the wrong service users on patient information systems (2 instances), and there were also several reports of notes or documents not being recorded on systems when they should have been.
- An inpatient was reported to be using their phone to video other service users on the ward.
- The reports also include two occasions when incorrect or inappropriate information was received by the Trust – a referral for the wrong person from a GP practice and a list of patients from another hospital which was not needed.
- The recurring incidents reinforce the need to staff to be careful to check recipients when e-mailing or posting confidential information, to make sure addresses and contact details are up to date, and to ensure that paper records are stored securely and that both paper records and computer systems are protected from inappropriate access.

Section 11: Summary

11.1 During quarter 4 2023/24 a range of governance and oversight processes ensured that SHSC successfully monitored and responded to patient safety concerns and patient safety incidents. The quantitative and qualitative data provided supports the assertion that we have a low threshold for reporting incidents and that when incidents do occur, they are primarily no harm or low harm incidents.

11.2 Notably, there were 69 Information Technology & information Governance related incidents which were reported by staff via the Ulysses Risk Management System. Data/information breach incidents accounted for 40% of these incidents, whilst RIO related challenges accounted for 16% of incidents.

11.3 Over the course of quarter 4 patients in our inpatient settings have faced similar risks to those that they have faced in previous quarters, for example falls and medication errors. In addition, some unsafe behaviours associated with serious mental health problems for example self-harm, and the measures taken to address these, such as restraint, have undoubtedly resulted in further risks to patient safety. In response to these patient safety risks there are a number of live quality improvement projects that aim to reduce any potential harm to the patient. Alongside these quality improvement projects the narrative data available clearly indicates that overall, there is an increasing trend toward reducing restrictive practices, offering trauma informed care, use of person-centred de-escalation techniques and safe spaces and patient and staff debriefs. Incident reports demonstrate that our inpatient settings pose unique challenges for patient safety, which require ongoing quality improvement support and translation into safety conscious clinical practice.

11.4 For Q4, missing patient related incidents accounted for 58 of the total reported incidents. 12 of these incidents are directly linked to the Right Care Right Care approach. Team SHSC continues to work collaboratively with local police services to implement the news ways of working and to build trusted relationships between the two stakeholders.

11.5 The data used to inform this report indicates that SHSC is taking patient safety very seriously; incidents continue to be reported consistently and at a low threshold, most incidents are no or

low harm, the Daily Incident Safety Huddle is increasing the numbers of follow up actions taken and the number of requests for 48hr reports, and Local Learning Reviews is increasing. This is set against a decreasing number of Patient Safety Incident Investigations (previously called Serious Incident Investigations) which have high resource implication and a narrow focus and do not take into account the breadth of learning available across all reported incidents.