Front Sheet: Public Board of Directors
Item number: 11
Date: 29 January 2025

Private/ public paper:	Public
Report Title:	**Patient Safety and Learning Report – Quarter 2 2024/25**
Author(s) Accountable Director:	Ciara Perera – Patient Safety Specialist Caroline Johnson – Executive Director of Nursing, Professions and Quality
Presented by:	Caroline Johnson – Executive Director of Nursing, Professions and Quality
Vision and values:	The report is in line with our vision to improve the mental, physical and social wellbeing of the people in our communities. In working together to improve quality through continuous improvement we will continue to improve safety and make a positive difference to the lives of our patients, carers and communities.
Purpose and key actions:	The purpose of this report is to provide the Board of Directors with assurance of the processes in place to ensure learning from the review of incidents, complaints, safeguarding, freedom to speak up concerns, CQC enquiries and how this is being addressed through quality improvement initiatives.
Executive summary:	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 2085 incidents reported over the last 4 quarter. **88% of all incidents reported were in the no harm (near-miss, negligible) or low harm (minor) categories of actual impact**, and this is in line with the previous quarter's figures. This is an indication that SHSC staff have a positive reporting culture. Notably, there was a **slight increase in self-harm incidents** although the impact of these incidents did not significantly increase, suggesting that self-harm, in the main, remains low harm. While generally, the demographic group that was most likely to self-harm in SHSC services remained as white women, there was one month where there was a noted rise in Iack/British/Caribbean/African women self-harming. This appeared to be due to a small number of individuals with high self-harming behaviour. The important work being undertaken to improve demographic recording will support further analysis of this in future reports. Over the course of **quarter 2 patients in our inpatient settings incident themes have been similar to previous quarters**, such as 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 been reflected in incident reporting.

	In response to these patient safety risks there are **several quality improvement projects underway, such as reducing restrictive interventions and Culture of Care**. Alongside these quality improvement projects the **narrative data available clearly indicates that overall, there continues to be 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.** Both incident reports, and managers reviews of incident reports, are clear that dignity, reducing restrictive practice and considering creative ways of managing risk continue to be a focus for wards, and will need to continue being a focus of QI workstreams. **In Q4 2024/25 a Learning and Improvement group will be established** as a sub-group of the Clinical Quality and Safety Group, to ensure that improvement programmes are aligned with themes emerging from incidents, complaints, freedom to speak up and safeguarding processes.

Which strategic objective does the item primarily contribute to:					
Effective Use of Resources	*Yes*		*No*	**x**	
Deliver Outstanding Care	***Yes***	**X**	*No*		
Great Place to Work	***Yes***	**X**	*No*		
Ensuring our services are inclusive	***Yes***	**x**	*No*		

What is the contribution to the delivery of standards, legal obligations and/or wider system and partnership working.	
Standards relates to Care Quality Commission (CQC) regulations under Health and Social Care Act, Equalities Act, Use of Force Act, Human Rights Act and the Patient safety Incident Response Framework.	
BAF and corporate risk/s:	BAF RISK 0024 – Risk of failing to meet fundamental standards of care with the regulatory body caused by lack of appropriate systems and auditing of compliance with standards, resulting in avoidable harm and negative impact on service user outcomes and experience staff wellbeing, development of closed cultures, reputation, future sustainability of services which could result in potential for regulatory action.
Any background papers/ items previously considered:	Board of Directors receive this report on a quarterly basis.
Recommendation:	Board of Directors are asked to: • Take **assurance** form the update provided in this report • Note the planned development of a learning and improvement sub-group of the clinical quality and safety group • Note the learning and quality improvement initiatives

Patient Safety Learning Report: Quarter Two 2024/25

Foreword

In November 2023 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. Alongside a new policy SHSC developed a Patient Safety Incident Response Plan (PSIRP). This plan has since been reviewed and brought for Quality Assurance Committee Approval in November 2024.

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.

This report format will be reviewed by the new Patient Safety Specialist following submission of this report, to ensure it continues to deliver the assurance, understanding of patient safety, and understanding of organisation risks, that is required.

Section 1: Q2 Patient Safety Specialist: Learning and Safety Report

1.1 Executive Summary

The Daily Incident Safety Huddle (DISH) reviewed 100% of all incidents reported within 24-hours (72-hours at weekend) 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 a continuing theme of issues with communication in quarter 2. 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. From this identified learning, a thematic review of communication with families, significant others and carers has been agreed to be undertaken.

Learning has also highlighted some issues with the transformation of crisis services, which have been acted on quickly following these issues being identified to ensure the identified gaps are no longer present.

It is essential that SHSC has robust management plans in place and immediate risk reduction and improvement plans to address the above key themes 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.

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 The number of incidents reported and reviewed in the previous 4 financial years and previous 4 quarters is shown in table 1. The numbers remain relatively static with a slight reduction in Q2 2024.

Table 1: Number of incidents 2021-2024 and last 4 Quarters

Financial year	**2021/22**	**2022/23**	**2023/24**	**2024/25**	**Total**
No. Reported	8440	8521	8876	4016	**31920**
4 Quarters	**Q3 2023/24**	**Q4 2023/24**	**Q1 2024/25**	**Q2 2024/25**	**Total**
No. Reported	2258	2067	2067	1949	**8341**

3.2 The number of learning Responses actioned in Q2 2024/25 are shown in table 2. This highlights that all incidents are reviewed through the daily incident huddle and then further levels of investigation are commissioned through this process, ranging from 48-hour reports to full PSIIs.

Table 2: Learning responses

Type of Response	2023/24 Q3	2023/24 Q4	2024/25 Q1	July 24	Aug. 24	Sept. 24	2024/25 Q2
48hr Reports Requested	49	18	23	13	9	16	38
48hr Reports - Patient Death Reportable to HM Coroner Requested	8	3	22	3	2	5	10
Local Learning Reviews (LLR) Declared	0	5	6	3	1	0	3
Coordinated Learning Review (CLR) Declared	1	2	4	0	0	0	0
After Action Review (AAR) Declared	0	3	9	3	0	0	3
Structured Judgement Reviews (SJR) Declared	0	1	3	0	1	1	2
Patient Safety Incident Investigations (PSII) Declared	0	1	0	1	0	0	1
Manager Incidents Reviews Completed	2035	1920	2023	663	615	492	1770
Incidents followed up by the Daily Incidents Safety Huddle (DISH)	700	608	659	257	176	171	604
Blue Light Alerts	4	2	1	1	0	0	1

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 2085 incidents reported over the last 4 quarter.
- 1 Patient Safety Incident Investigation (PSII) was declared in quarter 2. This is in line with the expectation that this type of learning activity will significantly reduce post PSIRF implementation.

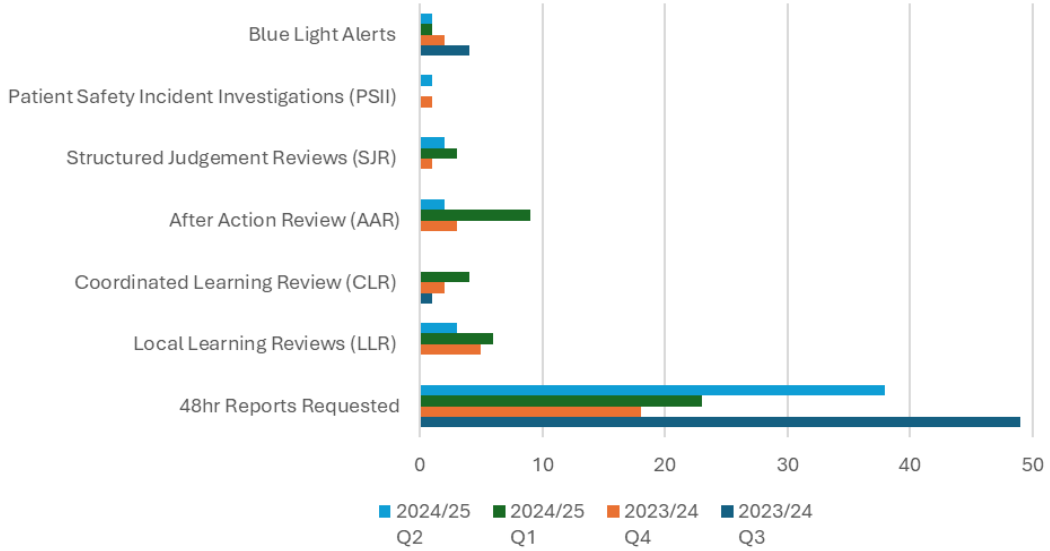
- All patient safety incidents reported as having a catastrophic impact were in relation to death and 68% of these were either suspected or known to be due to natural causes. During quarter 2 there was 1 death reported by bed-based services. This was a patient on an older person ward, who had been admitted to Northern General critical care unit 1 week before his death following a physical health deterioration. The patient had been detained at the time of his death and due diligence was completed, including requesting a 48-hour report and liaison with the coroner.
- All deaths from suspected suicide (10%) were subject to individual due diligence and where required a 48hr report was completed. This is a noted slight increase from the previous quarter's figure of 7%. The noted themes from subsequent 48-hour reports have been addressed in this report.
- 2 of the 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.
- 39% of all reported incidents can be traced to working age adult bed-based services. Older adult services accounted for 18% of all incidents reported
- 52% of all incidents were reported by acute and community services. Rehabilitation and specialist services accounted for 45% of all incidents reported. 3% of incidents were reported by non-clinical services, including pharmacy services and facilities services.
- 88% of all incidents reported were in the no harm (near-miss, negligible) or low harm (minor) categories of actual impact, and this is in line with the previous quarter's figures. This is an indication that SHSC staff have a positive reporting culture.

3.4 Of the 3 LLR's requested in quarter 2:

- 1 was related to self-harm
- One was related to an inpatient who did not return from unescorted leave, and was found to have seriously self-injured themselves by staff and police
- One was related to a service user in the community who physically assaulted their wife causing life changing injuries.

3.5 There was an increase in 48-hour reports (figure 1) and a reduction in other local learning responses available to SHSC under the PSIRF framework.

Figure 1 - Types of Patient Safety Incident Learning Responses since the organization moved to PSIRF in November 2023:



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 figures 2 and 3 which indicate that there has been no significant variation in reporting since quarter 1, 2021 and that 88% of SHSC incidents in Q2 are in the low patient harm (minor) or no patient harm (negligible) category.

Figure 2 - All incidents reported since Sept 2020:

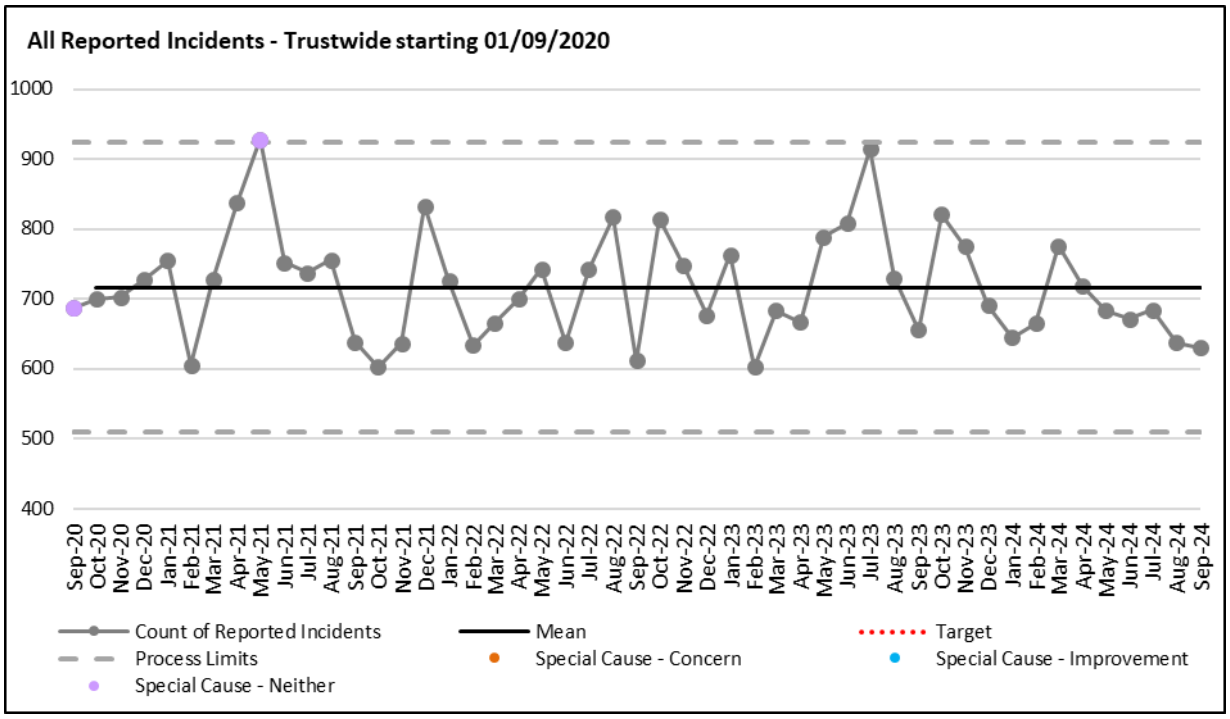
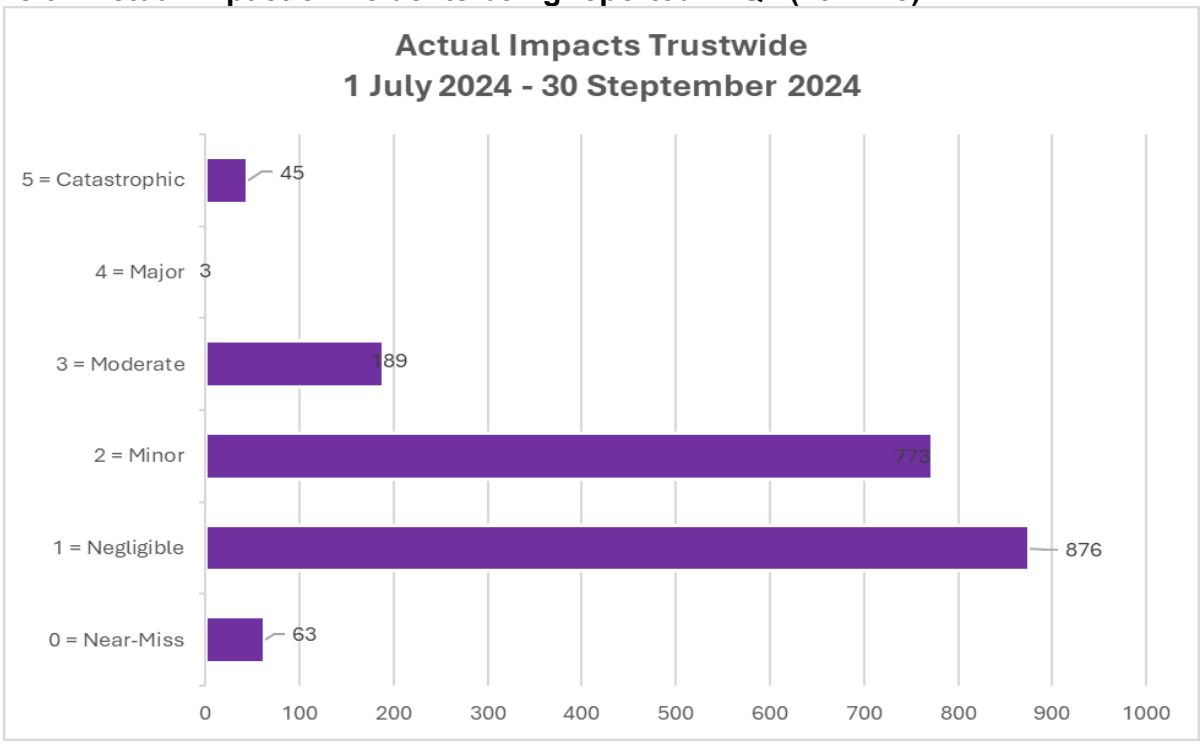


Figure 3 - Actual impact of incidents being reported in Q2 (2024/25):



Section 5: Daily Incident Safety Huddle (DISH) Learning Themes Q2

Table 3 - Top 5 patient safety incidents since April 2022

Incident Type	April 2022 to March 2023	April 2023 to March 2024	Quarter 1 (April to June-2024)	Quarter 2 (July to Sept-24)
Exploitation Abuse	2357	2409	586	463
Medication	994	921	291	269
Clinical Specific	1044	1036	180	235
Moving & Handling	650	572	77	80
Slips Trips & Falls	696	608	169	152

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 Q2. All incidents are individually reviewed, and quality checked in line with existing policy and standards. During Q2 the DISH group directly followed up on 30% (604) 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 (79% which is slightly reduced from Q1). 18% of incidents reported in bed-based services were patient to patient racial and cultural abuses.

In Q2 90% of incidents were of a minor impact. In line with internal policies, all Racial and Cultural abuse incidents must have an actual impact of at least minor. Overall, the 90% percentage suggests they were primarily hate incidents rather than hate crimes. 3 incidents of racial and cultural abuse were reported as having a moderate impact of harm. All of these were in relation to extremely offensive verbal abuse. In all of the incidents, the incident was reported to the police. In 2 of the incidents, post incident support to staff was evidenced as offered. In 1 of the incidents, there is no mention in the incident report of post incident support.

There was an increase in Racial and Cultural abuse incidents, patient to other. From a review of the incidents, in all incidents the patient was making racist remarks not directed at any particular person.

A thematic review of all of the racial and cultural abuse incidents revealed that action was taken to challenge the perpetrators of abuse in all but one of the incidents. 44% of the victims of racial and cultural abuse were offered support to report the incident to the police which is a reduction from Q1's 63%. 70% of incident reports highlighted that the victims were offered post incident support which is a noted reduction from Q1's figures of 95% and 28% highlighted that the hate incident flow chart had been followed, which is an increase from 17% in Q1.

Regarding the reduction in post incident support, it is difficult to tell from this review if the reduction reflects quality of the manager's reviews recorded in the incident report forms, or a reduction in post incident reviews with staff. Work is underway to support a more robust management review of incidents with a focus on post incident support.

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 In quarter 2 2024/25 slips, trips and falls remained at 8%, which is the same as Quarter 1. This remains a slight percentage rise within the context of an overall reduction in the number of falls over the last 18 months. 95% of all reported falls in quarter 1 had a no harm or low harm impact. Of those that had a moderate impact, they have been thematically reviewed. In all cases, the moderate rating was given because the patient had been transferred to hospital following the fall. In the majority of incidents, the patient was transferred to hospital due to being on blood thinners, or receiving a wound which needed emergency attention, however upon further examination they were able to be returned to the unit or ward with limited treatment. In all cases, appropriate post falls checks and assessments had been carried out with the patient, and an ECP or paramedics then called.

84% of the reported falls were from older people's services, with 67% of these being reported by the two older people's nursing homes. The highest reporting service for falls continues to be Birch Avenue Nursing Home which reported 42% of all falls.

Woodland View Nursing Home reported one fracture following a fall. Post falls assessments were carried out on the person including physical observations and a pain assessment, in a timely manner. It was not identified the person had received an injury requiring treatment until later that day, as the person mobilised and presented as usual following the fall.

During quarter 1 G1 reported a 16% increase in falls from the previous quarter. In quarter 2, G1's reported falls have decreased to usual levels.

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 3% of all reported incidents in quarter 2 2024/25, however reassuringly 100% of these incidents were reported as low of no harm incidents that were de-escalated by staff intervention, and the good work of staff should be acknowledged. 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.

Actual physical assaults on staff accounted for 5% of all incidents. 88% of these incidents were reported as having a no harm or low harm impact. In this quarter, staff debriefs were recorded as offered in 90% of all incidents reported which is a noted decrease from the previous quarter's figure of 97%. More work needs to be done to understand if this is reflective of a lack of completion of post incident manager reviews or if this is reflective of post incident support being less available, and if so, what are the barriers.

Any type of abuse toward patients and staff can have a negative impact on patient safety and psychological harm cannot be underestimated, however, 95% of the exploitation and abuse incidents that were reported were given an actual impact rating of no or low harm which is the same as Quarter 1's figures.

In quarter 2, one incident was reported as having a major impact. This related to a physical assault from a patient to a staff member on an inpatient ward. Further details of this incident have not been provided as detail could identify the persons involved. Appropriate fact finding, support and follow up has been completed.

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 is working with teams such as Workplace Wellbeing around the post-incident manager reviews with the aim of ensuring the effectiveness of interventions that have been put in place to support staff victims of violent and aggressive behaviour.

The Violence and Aggression workstream has also been reviewed and is now led by the Deputy Director of Nursing with a view to ensuring a greater understanding of violence and aggression faced by staff and patients, bringing together the work across the Trust to reduce violence and reviewing support given post-incidents.

5.5 2% of all reported incidents were sexual safety incidents, of which 10 incidents involved actual physical contact with the victims. 8 of the victims were staff and 2 were patients. This is an increase from the previous quarter's figures of 2 incidents overall involving physical contact. From a review this appears to in the main relate to a small number of patients perpetrating the incidents, and mutual expectations were addressed with the patients in all cases. It is noted majority reviews of the incident make clear that the victims were supported.

73% of incidents were patient to staff sexual safety reports. 100% of these were categorised as no harm of low harm incidents with the highest proportion being verbal sexual abuse and/or intimidation. 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 and has continued into 2024/2025. In quarter 2 of 2024/25 71% of all the Clinical Specific category of incidents were reported as self-harm. Self-harm accounted for 9% of all reported incidents, an increase of 3% from last quarter. As a part of the Patient Safety Incident Response Plan (PSIRP) an in-depth thematic review is being undertaken into self-harm incidents. This review has been completed and will be presented to the Quality Assurance Committee in January 2025.

Figure 4 - Self-harm by gender since Sept 2022

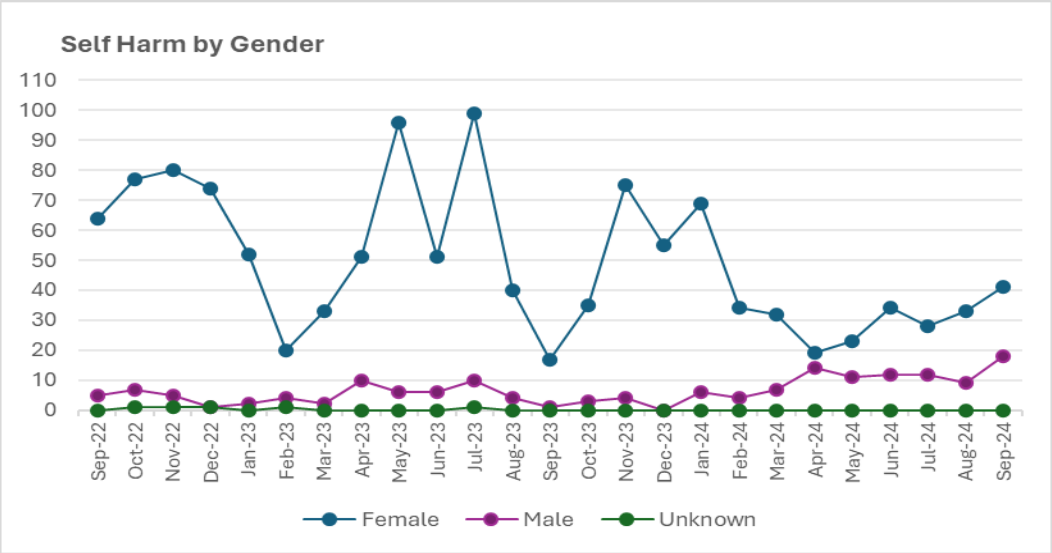


Figure 5 – Self-harm by ethnicity since September 2022

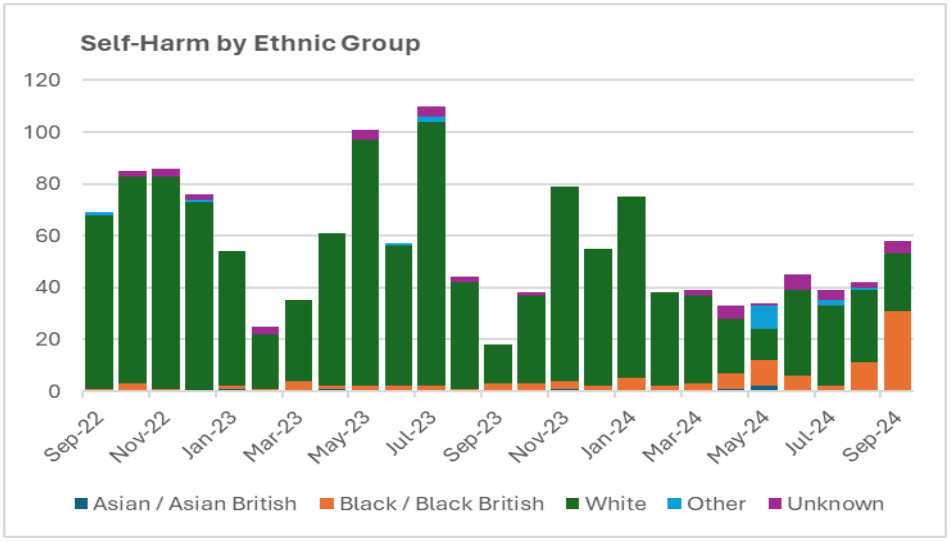


Figure 6 – Types of self-harm since Sept 2022

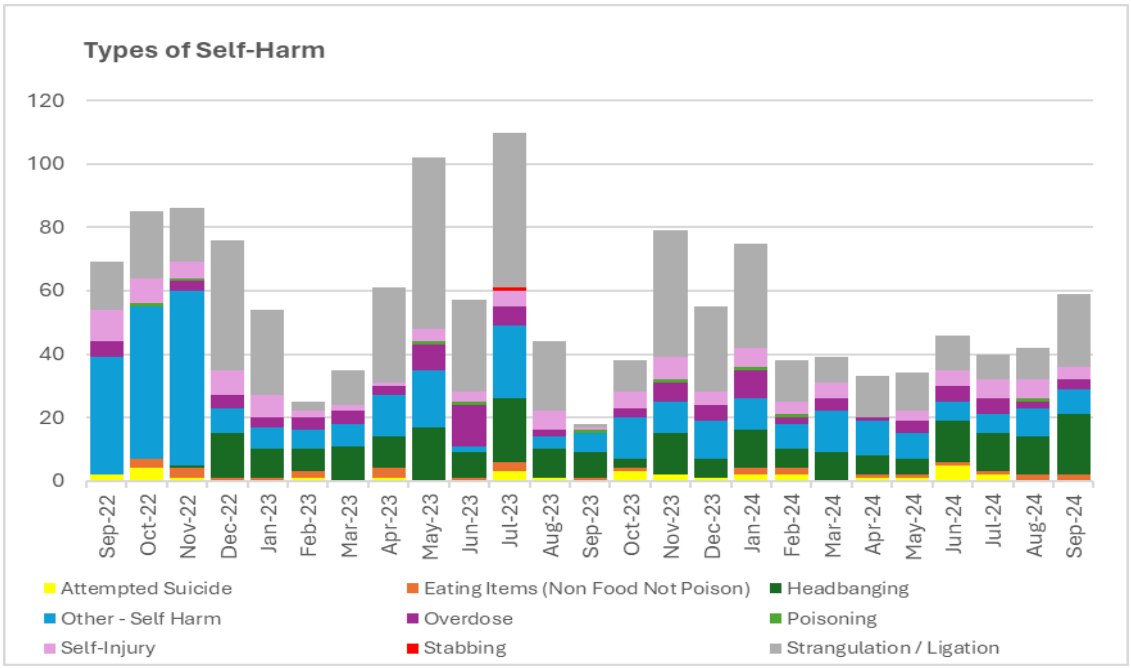
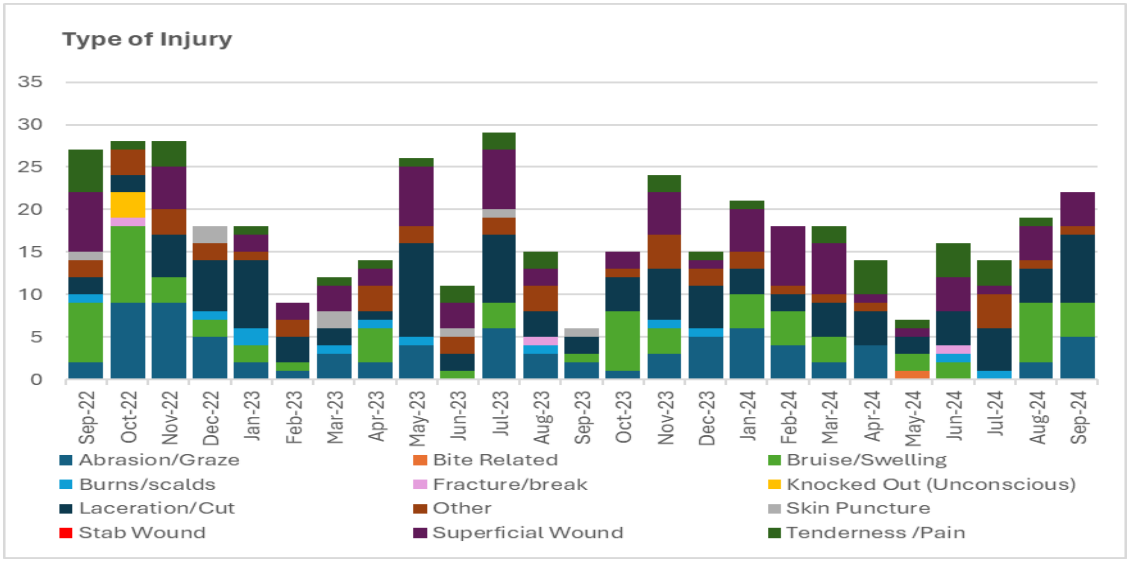


Figure 7 – Types of self-harm injury since September 2022



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. It is however noted that this changed in September 2024, where Black British/African/Caribbean female patients were the most likely patients to self-harm. A review of the incidents suggests that this is in relation to a small subset of patients, who had significant self-harming behaviour while inpatients.

5.8 A thematic review of a sample of individual patients that self-harmed in quarter 2 continued to highlight that a common association across the demographic was previously reported early life trauma and a diagnosis of a personality disorder type. Regarding inpatient self-harm, a noted theme for quarter 2 was that the restrictive environment of inpatient wards was not conducive. A review of a sample of DRAMs suggests that these associations are not clearly recorded as contributing factors to the risk of self-harm and there is not consistent evidence of risk formulations regarding self-harm behaviours, although there is evidence of care planning around self-harm behaviours.

There was noted evidence that in some situations, mood charts were used to good effect, which the staff and patient engaged with daily to support the patient to communicate mood and assess the imminence of self-harm.

The most consistently reported incident themes related to self-harm continue to be ligation/strangulation and headbanging. By comparison, patients that self-harmed in a community setting most commonly reported self-injury and overdoses of medication as a means of self-harm.

It should be noted that under the categories of self-harm, self-mutilation is still the term used. This is outdated terminology and work is underway to change this category to be in line with current NICE guidelines.

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.

The narrative evidence provided through incident reports and managers reviews continues to highlight that to prevent serious self-harm, behavioural management plans, therapeutic engagement, increased observations, care plans and colour charts will continue to be utilised. Restrictive practices such as restraint, use of the safety pod and rapid tranquilisation are used as a preventative last resort and there were low levels of restrictive practice noted in the incident reports.

5.8 In terms of Medication incidents, medication management was the highest reported incident. 68% of medication incidents were reported as management of medication, and 17% were reported as administration incidents.

98% of all medication incidents were reported as no harm or low harm. As in quarter 1 of 2024/2025 the thematic trend in this quarter reflected errors in procedural systems with only 9% of medication incidents overall leading to the patient being given the wrong dose or type of medication. Of this 9% there was 1 recorded physical harm to the patient (which was reported as minor in nature) and in most but not all cases the basic requirements of the statutory duty of candour were implemented by way of an explanation and face-to-face apology. This is based on the data to hand, and it is likely that in all incidents the patient was provided with an explanation that has not been fully recorded in the incident report. The Duty of Candour policy is being reviewed and from this review, will be disseminated to teams with a plan for further work to be done with teams around re-launching the duty of candour policy.

From a thematic review of the incidents, there appear to be several points within the medication dispensing and administration system that have led to errors reaching patients, and reviews from pharmacy and team management address ongoing work to resolve these systems. In addition, the running of medication was noted to be a causal factor in 3 incidents (10%) of incorrect medications or doses being given.

The most frequently reported incidents were related to storage fridge and room temperature fluctuations (21% of medication incidents) and Controlled Drug stock discrepancies (10%). In the majority of cases these discrepancies were linked to 1 or 2 missing tablets, which were later identified as documentation errors. In one reported incident, it was identified that rather than utilising syringes and supplied bungs for liquid Clonazepam, a team had been measuring the medication using medication pots and this led to a discrepancy in the medication accounted for. Since then, work has been done with wards to ensure they are aware of where bungs can be found, and stock check for these.

Section 6: Learning from Further Investigation

6.1 Local Learning Reviews in quarter 2 (LLR)

Three Local Learning Reviews were approved by the Patient Safety Oversight Panel in quarter 2 – one of these LLR's was linked to two incidents.

LLR 1: Self-Harm Ligation: A patient self-harmed via ligation on an inpatient ward and, when the ligature was cut using ligature cutters, the patient had a non-epileptic seizure. When that seizure finished, the patient had a second seizure. It was identified staff following the care plans for distress management and seizures, however there was no IM (intramuscular) medication prescribed at the time, and this is part of the patient's care plan. This has been reinstated. The patient fed back that she would like staff to be more insistent on physical observations when they decline, and it seems the Neurological Observations were not recorded. This has been discussed and acted on with staff, along with actions to ensure staff are competent with Neurological observations.

LLR 2: It was reported that a patient had been arrested for attempted domestic homicide. The patient was under SHSC for a short period of time prior due to acute anxiety. It was noted that the initial assessment of risk was clear and led to a broad understanding of risks including to the wife. However, the risk management plan process and reporting of historic risk in subsequent risk assessments required improvement. This LLR was incorporated into a further independent thematic review, and an action plan was created through that process.

LLR 3: This was an LLR in relation to two incidents which occurred for the same patient at a similar time, leading to the same outcome. An inpatient took unescorted leave to their mother's home and did not return. Staff attended the property with the police and discovered that the person had seriously self-harmed and was transferred to hospital. The patient was well supported at the time and was safeguarded. For learning, the lines of communication between staff and the ward, along with crisis plans, will be strengthened. In addition, a section 135 warrant, while not needed this time, would have supported to remove the patient from the property. There have been appropriate meetings with police services to review response.

6.2 **48hr Reporting**

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

Theme 1: Patients absconding from wards:

- Two patients absconded from inside PICU, due to some previous damage to the doors that had appeared minor at the time, and the patients having a working knowledge of electrical/magnetic doors from work experience. The risk regarding the doors was put on the risk register, as it was noted most doors had some form of minor damage compromising security, and temporary work was carried out on the doors to improve functionality while awaiting agreement for doors to be replaced.

- There were also incidents of patients absconding from acute inpatient units, and learning from those incidents relates to ensuring good communication with service users to alleviate stress they may be feeling, and also ensuring this communication takes into account people's needs particularly for reasonable adjustments. It was also noted there was a need to ensure that procedures around leave are followed and documented.

- There have been continued themes around the Right Care Right Person protocol in relation to incidents of absconding, and a need to balance the risk and clinical resources when staff are expected to attend patient homes to find and bring patients back

Theme 2: Seclusion reviews: Regarding an incident where there was a breach in seclusion reviews, it was noted that staff, both medical and nursing, did not always understand the importance of seclusion reviews and that reviews would need to be escalated if there were no medical staff available. Work has been undertaken to support the team, who had several new staff, to understand the seclusion process.

Theme 3: Attempted Suicide: Some significant learning came from one incident that links to learning, addressed further down, regarding unexpected deaths in the community. The Urgent and Crisis service is a newly transformed service within SHSC, it is a 24-hour response to crisis contacts, to triage and decide if further crisis assessments, or onward referrals, are required. The ways of working are undergoing continuing review and improvement, and in relation to an incident of attempted suicide, the following learning was acted on:

- Triaging within 1 hour and explaining that response, and the timeframes, to any referrers
- Training staff on the Triage rating scale and risk management
- Ensuring consistency of practice across the day and night service, and addressing concerns about divides between day and night staff
- Team to be more specific in documentation regarding decision making on the timeframes to respond to people and what the response will be
- When informing referrer of any plans, being specific and checking if the referrer and service user is accepting

Theme 4: Regarding an incident of nakedness/exposure of an inpatient, where rapid tranquilisation was utilised while the person was in the garden, it was identified that the patient had been escalating throughout the day, however a plan from the care team to administer PRN medication was stopped by a deputy ward manager, and the learning from this was to ensure discussions and collaboration decision making occurred for patients, and everyone is aware of their roles and duties.

Theme 5: There was an incident of a Decisions Unit patient gaining access to the Longley Centre Roof. At the time there was an immediate response, the police attended and were able to support the person from the roof. This has triggered a review of all the access points to the roof. These have been documented, the issue is on the risk register and estates are undergoing work to resolve the access points where possible. This is also monitored through the Health and Safety Committee. There was also noted learning around ensuring the criteria for Decisions Units admissions was applied, as on the face of the risk information about the patient they were likely not suitable to be on the Decisions Unit, as an informal service user.

Theme 6: the pathway for PICU referrals from acute wards was raised in several 48-hour reports, the exclusion criteria was said to be unclear and felt to be a barrier to patients receiving the appropriate care.

Theme 7: Self-Harm: in two 48-hour reports, the need for staff to be supported and trained regarding risk assessment, formulation and suicide prevent training were highlighted as learning points. In one report, this was also linked to the need to ensure contemporaneous information is received from services who know the patients, such as when there is a handover from CAMHS to adult services, to support understandings of risk.

6.4 **Learning identified from unexpected death:**

Theme 1: Suspected Suicide in the community: The review found issues regarding arranging follow up appointments. In one situation a service user had an appointment cancelled due to clinician's annual leave and this was not followed up.

Theme 2: Suspected suicides in the community and unexpected deaths: documentation was a noted theme throughout several 48-hour reports from several community services. In some cases, collaborative care plans and DRAMs (risk assessments) have not been updated. In other cases, Triage documentation had not been appropriately completed and concluded on the electronic patient record, and there were times that decision making about next steps (such as whether to offer further assessments or refer on to other services) was not clear in patient records. It was also noted that in some reviews, episodes of care had not been closed appropriately after a person had been discharged from services.

Theme 3: Unexpected Death: PCMHT (Primary Care Mental Health Team) was a theme throughout several 48-hour reports. The main issue appeared to be that SHSC services are having issues with refering directly into the PCMHT, and access to PCMHT assessments sits with the GP booking into their allocated assessment slots. Access is also given through the huddle that GP services attend with the Community Mental Health Teams. In some cases, this huddle had not been used as would be expected, to plan a route for a person's care. In other cases, issues arose from SHSC services not having access to PCMHT electronic record system, and vice versa, causing issues with continuity of care. Learning is being undertaken with the PCMHT around these issues, and changes are being made to be able to access PCMHT records.

Theme 4: Unexpected Deaths: Consent and contact was a theme in relation to crisis services, in that when referrals were made by family or others known to the service user, and consent was unclear or had explicitly not been given to the family, there would not be a follow up for the service user unless they were open to other SHSC services. Following this theme being raised, the Urgent and Crisis team enacted changes to their referrals process to make contact with all service users wherever practicable in order to ensure that risks are appropriately identified and assessed or referred to more appropriate services.

Theme 5: Contact/communication with other services. This was noted in relation to substance misuse services. A learning point has been ensuring joint working and strong relationships continue despite the separation of substance misuse from SHSC. This theme was also noted in relation to ensuring communication with the GP to understand any physical health needs a person has. However, there were also noted pockets of good practice, where SHSC teams had communicated well with each other to understand and manage risk.

6.5 **Coordinated Learning Reviews from Q2 2024/25**

After Action Review (AAR)1: The Patient Safety Team undertook a review with the Urgent and Crisis service, following an incident where during a crisis assessment at a service user's home, the service user grabbed a knife with intent to cut their own neck. The staff members at the assessment restrained the service user and called the police. The police advised they would not attend, and an ambulance was called. Several staff from the Out of Hours section of the Urgent and Crisis team attended along with the senior practitioner. Learning involved reflections on when is best to leave a situation and also how these sorts of considerations are captured in the Respect training so that staff understand the best response in difficult community situations, especially when a weapon is present. The team had an open conversation regarding concerns about the police response which they feel is reflective of the relationships between SHSC and the police. These concerns will be fed back through appropriate joint working meetings.

After Action Review 2: This AAR was undertaken with Stanage Ward, following an incident of a difficult restraint period with a patient, who was assaultive to staff throughout. In addition, there were issues with the Secure Transport team's response while they were attempting to transport the patient to seclusion. The review was supported by a Patient Safety Partner and had excellent attendance by team members with a multidisciplinary background.

Space was given for individuals involved to talk through their experience and reflect on what could have been done to manage the situation differently.

There was a learning discussion about leadership in these situations as those involved reflected that during the incident there had been confusion about who was leading.

After Action Review 3: This review was completed with Maple (Dovedale 2) ward and related to an incident of sexual contact between two service users while they were in a lounge that was not often used or observed, as it was considered an "empty" female only area. The team met to complete a formal AAR and to consider what could be done differently. The majority of the team felt that the recent move to single sex accommodation had left a gap in their consideration of the overall risks. In particular the empty previously female-only areas were not observed in the same way as they were when they were occupied- they have resolved this by increasing observations in this area.

Section 7: Learning from Safeguarding Processes

7.1 In Q2 a total of 8 Section 42 (2) Enquiries were caused to SHSC by the Local Authority. Overarching themes this quarter were of concerns about care and treatment, neglect and physical harm. The S42 Enquiries and tracker continue to be reviewed at the weekly Patient Safety Overview Panel for assurance and approval. 4 enquires resulted from internal safeguarding concerns. 2 were from family and 2 from the CQC. 2 Enquiries relate to 1 person.

15 Allegations Against Staff have been raised in Q2. Themes of allegations related to physical harm during restraint, verbal abuse, financial abuse and staff conduct. 3 cases progressed to a HR investigation, 1 case progressed to both a HR investigation and a Section 42 Enquiry. The remaining 11 cases were deemed following fact find to require no further action (NFA) under the Allegations Against Staff Policy.

All cases that are recorded as NFA will have been through a fact-finding process and an initial huddle held with appropriate senior managers for that directorate. We make every effort to get further detail from the person making the allegation, review records to identify any possible

incident of concern and speak to and support staff members. Some cases will have multiple huddles to review fact finding before deciding an outcome.

Some acutely unwell persons in our inpatient services, may make allegations that can be initially alarming and can be linked to deterioration in their mental health. However, we take all allegations seriously at the time they are made and by holding initial concerns meetings we can quickly identify if an allegation is likely to have occurred. We have not provided further detail of the allegations that led to further investigation as detail could identify the persons involved. If further information is required, this can be sought from the safeguarding team.

7.2 In Q2 the Safeguarding Team received 9 requests for information for consideration for SAR's (Safeguarding Adults Reviews) and DHR's (Domestic Homicide Reviews). We continue to see a sharp rise in the number of SAR and DHR considerations in comparison to Q1 and Q2 2023/24, where we received 4 and 3 requests respectively. Of note, one SAR has been delayed due to change in the independent author. This Learning Review is nearing completion by a new author and should be available by the Q3 report. The Adults Y DHR now known as Howard and Margaret, is nearing completion for submission to the Home Office. The coroner's inquest is now completed and SHSC were given a notification of Prevention of Future Deaths. This homicide was also part of the independent review, and a meeting was held with the DHR Author to ensure any recommendations were cohesive with the independent review.

The Learning brief for Adult SJC known as 'Sam' has been completed and published. Sam was known to SHSC Single Points of Access and Alcohol Liaison Team. Sam was a 51-year-old male who died in June 2022. Sam's flat is believed to have been used by close associates of people engaged in antisocial and criminal activity (Cuckooing). Sam had become socially withdrawn, depressed, had poor health and had developed an alcohol dependency over several years. Whilst health professionals encouraged Sam to accept support, there was a lack of focus on a trauma informed approach and understanding what lay behind the struggles that Sam was facing and why he was unable to protect himself from people that were abusing and exploiting him. This review highlighted that although a person may retain the mental capacity and have the right to make unwise decisions, the duty of care still requires professionals to explore why unwise decisions are being made. Professionals need to build trusting relationships and consider how they can support a person who may appear reluctant to engage with support.

The SAR and DHR Newsletter can be found here.

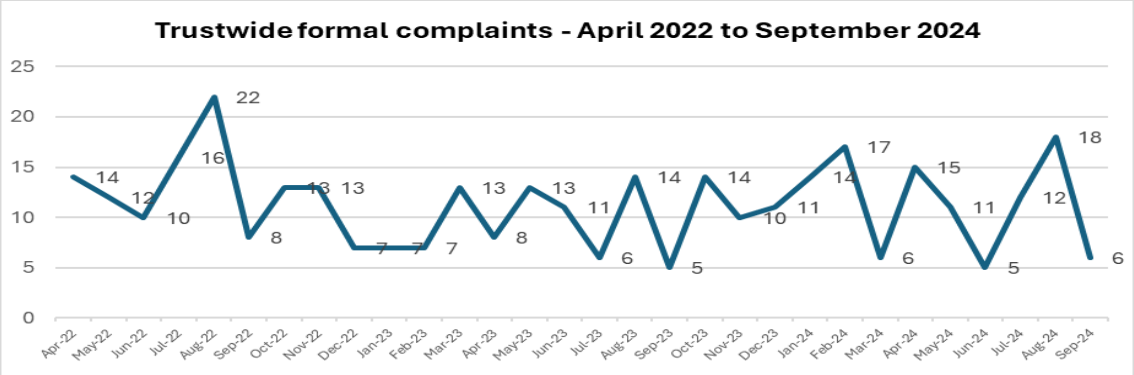
7.3 Cuckooing, anti-social behaviour and self-neglect have been identified as concerns in Adult SHW and Adult PM and these 2 SAR referrals have been amalgamated and a Learning Review will be completed. SHSC has provided lengthy chronologies for both of these cases who were known to our Single Point of Access, Crisis Services, Crisis Resolution and Home Treatment Team, and the Community Mental Health Team North.

.

Section 8: Learning from Complaints

Formal complaints

Figure 8: Formal complaints April 2022 – September 2024



36 formal complaints were received during quarter two (1 July 2024 to 30 September 2024). This is an increase on the previous quarter (31 complaints).

The top complaint themes for quarter two were “Access to Treatment or Drugs” (10 complaints), “Clinical Treatment” (8 complaints) and “Communication” (6 complaints).

28 cases were responded to in quarter two. Out of these 28 complaints closed, 21 (75%) were closed within agreed timescales.

The outcomes of complaints is shown in table 4.

Table 4: Complaint outcomes

Outcome	Number	%
Not upheld	7	25%
Partially Upheld	19	68%
Upheld	2	7%

The complaint themes are shown in table 5 with the highest 3 complaint categories being access to treatment/drugs, clinical treatment and communication.

Table 5: Complaint themes

Complaint category	Q2 2024/25		Q1 2024/25
Access to Treatment or Drugs	10	↑	9
Clinical Treatment	8	↑	0
Communications	6	↑	3
Patient Care	5	↑	2
Values and Behaviours	3	↓	7
Admissions and Discharges	2	↓	5
Prescribing	1	↑	0

Complaint category	Q2 2024/25		Q1 2024/25
Waiting times	1	⬇	3
Trust policies	0	⬇	1
Privacy and Dignity	0	⬇	1
Appointments	0	-	0
Access to Records	0		0
Total	36		31

Table 6 below shows the areas with the complaints by service/team. As can be seen the highest areas for complaints are CMHTs, SAANS and Burbage ward.

Table 6: Complaints by team/service from 2021/22

Team/Service	2024/5	2023/24	2022/23	2021/22
(In order of 2024/5 Year to Date total)	To date	(Total)	(Total)	(Total)
CMHT (North)	8	10	5	17
CMHT (South)	8	13	30	22
SAANS	8	6	12	10
Burbage Ward	7	5	-	3
SPA / EWS	5	18	21	22
Endcliffe Ward	4	5	3	3
Liaison Psychiatry	3	7	4	3
OACMHT	3	3	1	-
Flow Coordinators	2	4	3	5
CRHTT	2	6	2	7
Early Intervention Service	2	5	4	2
Stanage Ward	2	-	5	7
Urgent and Crisis Services	2	-	-	-
Eating Disorders Service	1	6	1	2
Gender Identity Service	1	6	10	9
Maple Ward	1	5	11	6
Decisions Unit	1	3	1	1
G1 Ward	1	1	2	2
Perinatal Mental Health	1	1	-	1
Birch Avenue	1	1		
Psychotherapy Services	1	5	3	3
Forest Close	1	-	1	-
Forest Lodge	0	3	2	5
Memory Service	0	6	1	2
Dovedale 2	0	2	2	-
CLDT	0	3	2	1
IAPT	0	2	4	7
CERT	0	1	-	1
Safeguarding Team	0	1	-	-
Central AMHP Team	0	1	-	-
OAHTT	0	1	-	-
CISS (LDS)	0	1	-	-

Team/Service	2024/5	2023/24	2022/23	2021/22
(In order of 2024/5 Year to Date total)	To date	(Total)	(Total)	(Total)
OT services	0	1	-	-
Complaints	0	1	-	-
HBPOS (136 suite)	0	1	-	-
Dovedale	0	2	2	1
ECT Suite	0	-	-	1
HAST	0	-	1	-
Neuro Enablement Service	0	1	1	-
Out Of Hours Team	0	-	-	1
START Services	0	-	3	3
STEP	0	-	1	-
Woodland View	0	-	-	1
Other	0	1	-	-

For assurance the only atypical spike identified was in relation to Burbage ward, which (unusually) received seven complaints in the quarter. There is an awareness within the service of a number of pressures on the ward during this period and the increase in complaints may be reflective of that. An improvement programme is in place chaired by the Executive Director of Nursing.

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 2 one Blue Light Alerts was cascaded to staff and services.

- **Blue Light Alert 1:** Details of this incident were shared with SHSC by CAMHS:
  "We currently charge young people's mobile telephones in our nursing office and one of the young people who has an apple watch showed us that they can connect to their phone via their watch and listen to what is being said in the office using 'live listen'. This can also be done via Air Pods."
  Action Required: As an immediate measure staff should turn off any mobile telephones or Air Pods that are handed in to the office for safekeeping and/or charging.
  This shared intelligence should be shared widely with teams and services.

Section 10: Learning via Freedom to Speak Up (FTSU)

10.1 Freedom to Speak up is an alternative route to raise any concern and has a significant influence on patient and staff safety. Here are some examples of the learning from FTSU concerns raised in Q2.

- Several staff reported experiencing discrimination within one team. This prompted the Director of Operations and Transformation to ensure concerns were investigated and provide direct support to those affected. The concerns also influenced FTSU training, leading to the introduction of a new anti-racism module, which will be delivered by the FTSU Guardian and offered to all new managers.

- Repeated concerns in one clinical area led to additional measures and, later, a comprehensive care review to assess safety and support needed for the team. As there had been long-standing challenges, there was a keen focus on learning from past support offered to develop a sustainable and effective plan. This has led to new approaches being taken to support the team.

- Several staff approached the FTSU Guardian as they had concerns but were unsure who to approach, whether anything could be done, or what steps they could take. By providing a safe and supportive space, along with tailored advice, the FTSU Guardian enabled staff to feel heard, supported, and empowered to make informed decisions about the next steps. This highlights the importance of the role of the FTSU Guardian as it helps staff to raise concerns which is an important aspect of patient safety.

Section 11: CQC Enquiries

11.1 10 enquiries were received during quarter 2.

- All 10 enquires were acknowledged within the standard of 2 working days.
- 9 of these enquiries are now closed with CQC.
- 1 enquiry has had the final response submitted and we are awaiting confirmation of closure from the CQC.
- Where a response timescale was given by the CQC, the initial response was provided within that timescale for all 10 of the enquiries.

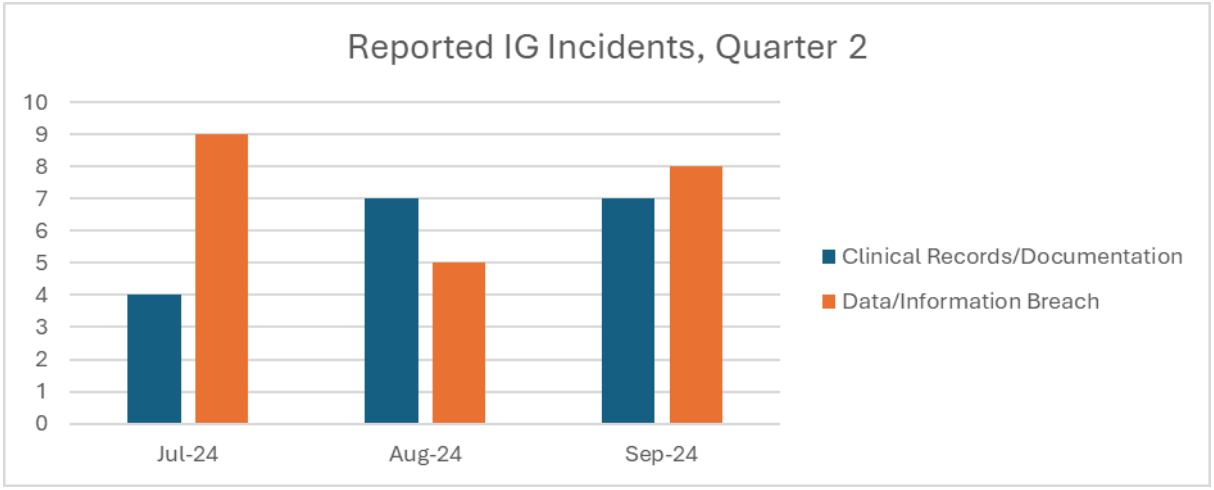
All CQC enquiries are fully responded to and overseen by the Executive Director of Nursing. Actions to address any improvements identified are overseen through the hotspot process which reports to EMT and QAC.

Section 12: Information Governance Incidents in Q2

12.1 Two incidents were reported to the Information Commissioner's Office (ICO) during Quarter 2. In one incident, sensitive information about a patient's partner was received as part of a referral and was mentioned to the patient but it transpired that the patient was previously unaware of the information. This was followed up internally to ensure appropriate safeguarding actions were taken. The ICO have not provided any decision.

In the other incident, a service user reported that their records had been accessed inappropriately by a member of staff and information shared without their consent. There has been no further action from the ICO.

Figure 9 - Data information breaches in Q2



12.2 During quarter 2, there were 5 reported incidences of e-mails sent to the wrong address and one of a confidential e-mail being sent to a non-secure shared e-mail address. There were also 4 occasions when letters were sent to the wrong postal address, either out of date or incorrectly recorded. There is ongoing training being rolled out across the Trust regarding Clinical Recording Keeping, and reminders regarding up-to-date demographic information for service users are part of this training.

12.3 There were 12 reports of appropriate records not being made. In 5 cases, confidential records were not stored appropriately and in another 3, records were found to have been discarded or inappropriately disposed of.

12.4 A laptop and notebook were lost on public transport but fortunately recovered later.

12.5 The Trust was notified of a potential data breach by an external system supplier which could have resulted in the disclosure of staff information, but it was later confirmed that SHSC data had not been compromised.

12.6 It was discovered that a number of electronic referrals had not been forwarded to an external service provider. Work is underway to understand how to resolve this issue, and ensure interim measures are in place.

Section 13: Summary

13.1 During quarter 2 2024/25 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 continue to have a low threshold for reporting incidents and that when incidents do occur, they are primarily no harm or low harm incidents.

13.2 Notably, there was a slight increase in self-harm incidents although the impact of these incidents did not significantly increase, suggesting that self-harm, in the main, remains low harm. While generally, the demographic group that was most likely to self-harm in SHSC services remained as white women, there was one month where there was a noted rise in lack/British/Caribbean/African women self-harming. This appeared to be due to a small number of individuals with high self-harming behaviour. The important work being undertaken to improve demographic recording will support further analysis of this in future reports.

13.3 During Q2, The DISH observed several incidents of patients absconding that appeared high risk, either due to the means of absconding (patients being able to abscond through secure doors) or the harm that occurred during the patient absconding. The police response and working relationships with the police (particularly around Right Care, Right Person) were a noted theme in incident responses and there is an action around strengthening the working groups SHSC has with the police service.

13.3 Over the course of quarter 2 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 continues to be 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. Both incident reports, and managers reviews of incident reports, are clear that dignity, reducing restrictive practice and considering creative ways of managing risk continue to be a focus for wards, and will need to continue being a focus of QI workstreams.

13.4 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 are increasing. It should be noted that in this quarter, more 48-hour reports were requested than the previous quarter, and less local learning reviews were requested, which is a balance that the DISH, and Patient Safety Oversight Panel, will seek to analyse and, if needed, correct to ensure there is meaningful and collaborative learning. 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 consider the breadth of learning available across all reported incidents. In triangulating the various narrative and numerical data contained in the various sections of this report it is evident that where serious concerns are raised or identified swift action is taken to ensure immediate safety and to develop improvement plans for the longer term.

13.5 In Q4 2024/25 a Learning and Improvement group will be establish as a sub-group of the Clinical Quality and Safety Group, to ensure that improvement programmes are aligned with themes emerging from incidents, complaints, freedom to speak up and safeguarding processes.