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Front sheet: **Public Board of Directors**
Item number**: 11**
Date: **26 March 2025**

Private/ public paper:	Public
Report Title:	**Patient Safety and Learning Report for Quarter 3**
Author(s) Accountable Director:	Caroline Johnson, Executive Director of Nursing, Professions and Quality
Presented by:	Ciara Perera, Patient Safety Specialist
Vision and values:	This supports the Trust's vision regarding **continuous improvement of services** and **ensuring excellent services**. This report addresses **working together for our service users** and a **commitment to quality** in understanding patient safety issues and learning from these. The report emphasises that **everyone counts**.
Purpose and key actions:	The purpose of the report is to provide **assurance** that learning across patient safety incidents, complaints, safeguarding adults and freedom to speak up is being identified, triangulated and acted on to improve the quality and experience of patients and staff and that quality improvement plans, developments and quality improvement projects are being undertaken to demonstrate robust improvement for patient safety and experience.

Executive summary:	This iteration of the patient safety and learning report aims to streamline information previously included to address patient safety priorities. A number of areas have been reduced as they are reported in other areas as they are priority areas for the Trust, eg racial and cultural abuse is reported on via the People Directorate, the violence and aggression group and racial and equality groups. Sexual safety incidents are addressed through the sexual safety group and violence and aggression group workstreams, which report separately into the clinical quality and safety group and Quality Assurance Committee.
	The **highlights** from this report are:
	• The **Daily Incident Safety Huddle (DISH)** reviewed 100% of all incidents reported within 24hrs of the incident being submitted. Immediate actions were taken to mitigate the risk of further harm, support individuals and teams, address shortfalls in the quality of reporting and instigate a learning process
	• There continues 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:
	  o Falls prevention.
	  o Reducing Restrictive Practice and within this violence and aggression
	  o Self-harm.
	  o Medication errors.
	  o Unexpected deaths
	• **Learning from patient safety incidents** highlights that there is a need for consistent person-centred and needs-based care and risk

	management plans. Trauma informed care has also been reflected on as a learning need and is being progressed through ongoing improvement work. • Learning has also highlighted some issues with **physical health care**, both to reduce and prevent infections, and following self-harm incidents in bed-based services. • The report details the **improvement work** that is ongoing regarding the **5 key patient safety priorities** for the Trust, and there is a need to monitor this improvement work and the impact it is having in areas such as incident reporting, harm levels and patient and carer experience.

Which strategic objective does the item primarily contribute to:					
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		

What is the contribution to the delivery of standards, legal obligations and/or wider system and partnership working.	
Progress against the Patient Safety Incident Response Framework, a requirement from NHS England for all NHS Trusts in England. Requirement under CQC to learn from patient safety incidents, and this report analyses what learning is being taken and the impact this is having to improve services.	
BAF and corporate risk/s:	**BAF 0024** Risk of failing to meet fundamental standards of care caused by lack of appropriate systems and auditing of compliance with standards, **BAF 0029** There is a risk of a delay in people accessing core mental health services **BAF 0031** There is a risk we fail to deliver on national inequalities priorities and our strategic aim to deliver inclusive services, **Further**: Responses to patient safety incidents, aim to address risks to the Trust that may arise if learning is not taken from incidents, particularly where these incidents align with top internal patient safety risks. There is a risk that, where collaborative learning responses are identified following a serious incident, staff are not being released to engage with these learning responses, and this is causing delays to meaningful learning and changes to systems and processes. There is a risk around resourcing for the top identified patient safety priorities, as in some areas there is still a great degree of change and improvement work that needs to be put in place, which is not matched by the resources able to be released to make these changes.
Any background papers/ items previously considered:	The Patient Safety and Learning Report Quarter 3 was presented to the **Quality Assurance Committee in January 2025**. Further information about improvement work for self-harm has been addressed in this quarter's report. The Quality Assurance Committee (QAC), requested that the mortality review and learning report, better aligns with this report as there is some overlap between the two. QAC raised concern regarding the focus of smoking breaches in the report and how they are recorded on the same level as the

	lack of beds. It was noted that whilst important from a health promotion lens it could be problematic as a potential diversion of attention. It was agreed whilst duty and morally bound to offer smoking interventions to individuals it will be summarised in future reporting to avoid distraction from other reporting.
Recommendation:	The Board of Directors is asked to: • **Note for assurance** that actual harm caused, or contributed to, by SHSC and experienced by patients and their families is very low, in regard to the severity of harm experienced • **Note for assurance** that where incidents of patient harm do occur, learning is extracted, acted upon and shared in line with local and national guidance • **Note for assurance** that improvement actions are being undertaken, particularly in relation to the main identified priorities across the Trust. These actions enable us to maintain and promote a patient safety culture in line with our Quality Strategy and our ambition to deliver outstanding care.

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Patient Safety and Learning Report Quarter 3 2024/25

1. Purpose of the report

The purpose of the report is to provide assurance that learning across patient safety incidents, complaints, safeguarding adults and freedom to speak up is being identified, triangulated and acted on to improve the quality and experience of patients and staff and that quality improvement plans, developments and quality improvement projects are being undertaken to demonstrate robust improvement for patient safety and experience.

2. Background

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 responds to patient safety incidents. Alongside a new policy, SHSC developed a Patient Safety Incident Response Plan (PSIRP). This plan has since been reviewed, which was approved by the Quality Assurance Committee 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 families 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.

The format of this report has been revised to reflect the move to the Patient Safety Incident Response Plans Priorities – these priorities have been developed utilising a range of data, including incident data. The report has also been strengthened to provide assurance in relation to the improvement work being undertaken in response to the Trust's identified patient safety priorities. The learning and actions taken from serious incidents prior to the move to PSIRF will also be linked into this improvement work.

3. Learning and Safety Report

3.1 Patient Safety Incident Response Framework Learning Responses

Table1: Learning Responses actioned in Q3

Type of Response	2023/24 Q4	2024/25 Q1	2024/25 Q2	Oct 24	Nov 24	Dec 24	2024/25 Q3 Total
48hr Reports Requested	18	23	38	6	2	2	10
48hr Reports - Patient Death Reportable to HM Coroner Requested	3	22	10	7	6	8	21
Local Learning Reviews (LLR) Declared	5	6	4	1	1	5	7
Coordinated Learning Review (CLR) Declared	2	4	0	1	1	0	2
After Action Review (AAR) Declared	3	9	2	1	0	0	1
Structured Judgement Reviews (SJR) Declared	1	3	2	1	0	1	2
Patient Safety Incident Investigations (PSII) Declared	1	0	1	1	0	0	1

Type of Response	2023/24 Q4	2024/25 Q1	2024/25 Q2	Oct 24	Nov 24	Dec 24	2024/25 Q3 Total
Manager Incidents Reviews Completed	1920	2023	1770	749	688	701	2,138
Incidents followed up by the Daily Incidents Safety Huddle (DISH)	608	659	604	300	189	226	715
Blue Light Alerts	2	1	1	0	0	2	2

Key points to consider from the learning response data provided:

- 1 Patient Safety Incident Investigation (PSII) was declared in quarter 3. This is in line with the expectation that this type of learning activity will significantly reduce post PSIRF implementation. Local learning responses, led by the team, should increase in line with a reduction in PSII's.
- 46% of all reported incidents can be traced to working age adult bed-based services, which is an increase from the 39% seen in quarter 2. This has been interrogated further in the report and appears related to reported smoking breaches on hospital sites. When these incidents are removed, 33% of incidents can be traced to working age adult bed-based services which is more in line with normal variation. 15% of all incidents were reported by crisis and community services. Older adult services accounted for 18% of all incidents reported, the same as last quarter.
- Rehabilitation and Specialist services accounted for 24% of all incidents reported, when older adult services were removed from the count. 3% of incidents were reported by non-clinical services, including pharmacy services and facilities services.
- 78% of all incidents reported were in the no harm (near-miss, negligible) or low harm (minor) categories of actual impact, and this is a variation from the previous quarter's figures.
  This has been explored within the report, and the variation is due to "smoking breaches" being more routinely reported and classified as a "moderate" incident. There is no indication that the variation in impact is a result of patient safety issues or reflects a reduction in reporting low harm incidents. There continues to be a positive indication that SHSC staff have a low threshold for reporting incidents.
- This is likely being supported by the levels of staff undertaking mandatory Patient Safety training, which in quarter 3 reached levels of 95%.

- All patient safety incidents reported as having a catastrophic impact were in relation to death and 69% of patient deaths were either suspected or known to be due to natural causes, which is very similar to previous quarters. During quarter 3, there were no unexpected deaths in bed-based services. Care homes (Birch Avenue and Woodland View) reported 7 expected deaths, for patients on an end-of-life pathway of care.
- All deaths from suspected suicide (8%) were subject to individual due diligence and where required, a 48hr report was completed. The noted themes from subsequent 48-hour reports have been addressed in this report.

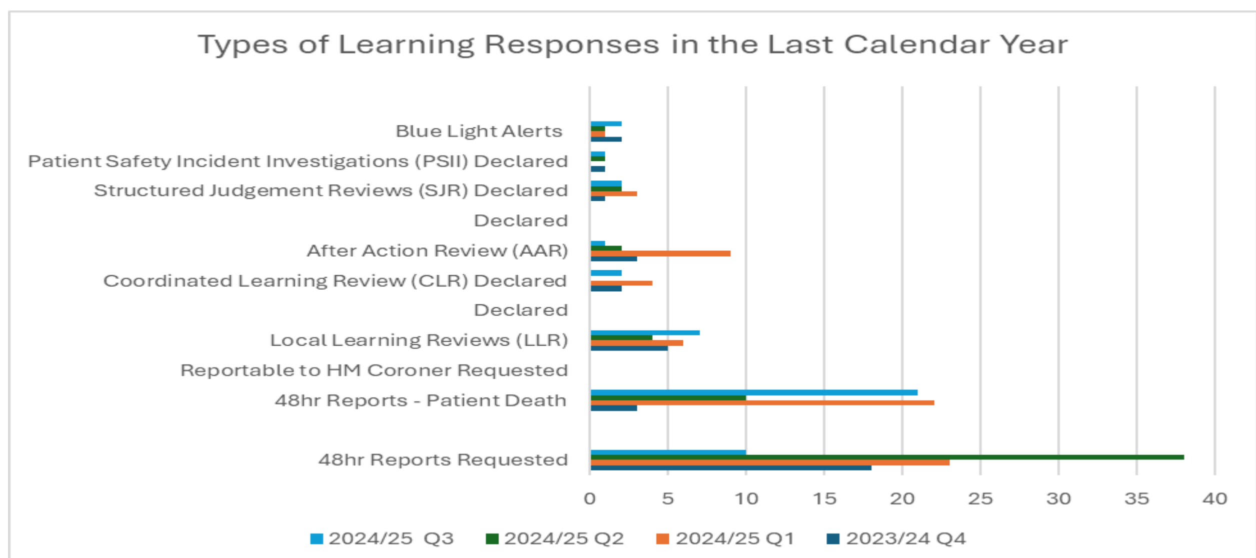
Of the 3 Local Learning Reviews (LLR) requested in quarter 3:

- 1 was related to an infection and isolation measures on inpatient wards
- One was related to self-harm on an inpatient ward
- Three were related to falls
- Two were related to self-harm (overdoses) in the community

In addition to more formalised learning responses, incidents may be followed up by members of the Daily Incident Safety Huddle (DISH), to provide expertise on areas of difficulty teams may be facing and identify if there is any local informal learning that members can support with.

The DISH group consists of key individuals including the Patient Safety Specialist (chair), consultant nurse for Restrictive Practice, a Safeguarding team representative, a Health and Safety team representative, Physical Health leads and a Pharmacy representative. The DISH reviewed 100% of incidents reported within 24 working hours in Q3. All incidents are individually reviewed, and quality checked in line with existing policy and standards. During Q3, the DISH group directly followed up on 28% (659) of all incidents reported to offer support or request further information.

Figure 1 - Types of Patient Safety Incident Learning Responses in the Last Calendar Year



3.2 Incident Reporting Data

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. The overall number of incidents reported in SHSC over the last 4 years has **remained stable**, with the exception of quarter 3 which saw a slight increase.

Figure 2: Patient Safety Incidents reported Jan 2021 – Dec 2024

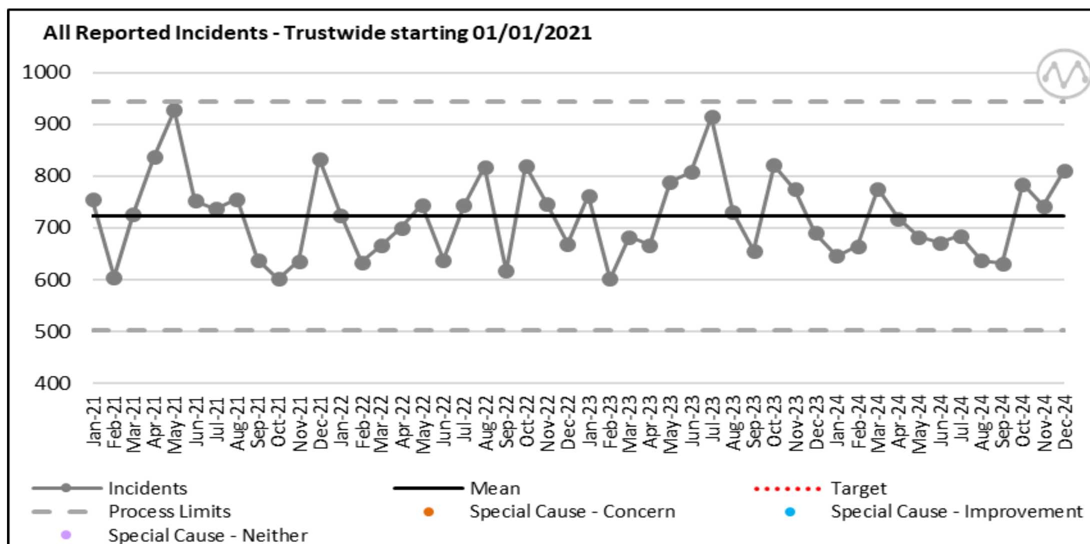
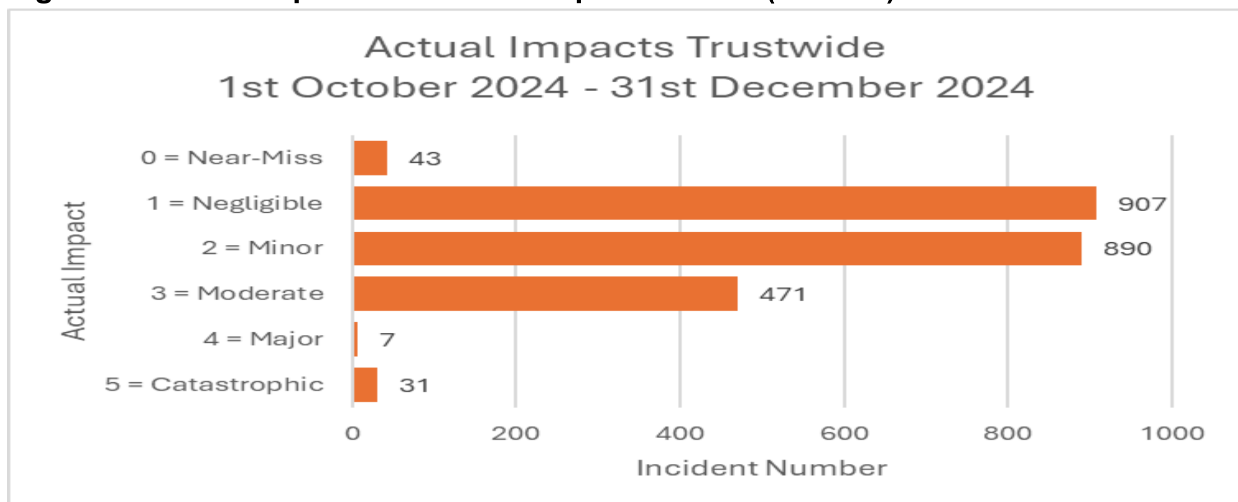


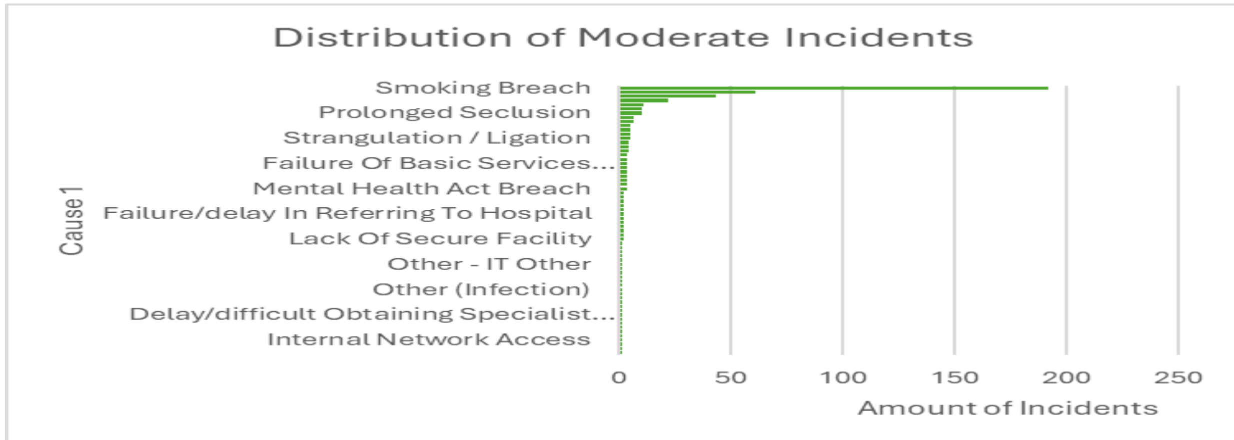
Figure 3 below shows that 77% of SHSC's incidents reported in Q3 are in the low patient harm (minor) or no patient harm (negligible) category.

Figure 3 - Actual impact of incidents reported in Q3 (2024/25):



These figures show that the amount of moderate impact incidents has significantly increased, from 189 in Quarter 2, to 471 in Quarter 3. The number of incidents reported over the quarter increased to 2350. However, this is a slight variation, which would not account for a variation in the moderate incidents.

Figure 4 – Q3 Moderate incidents by category



A deep dive into the incident data reveals that there were a large number of smoking breaches reported (192 overall). Trust policy has recently been re-reviewed, and a decision taken that all smoking breaches should be reported as "moderate" to reflect a breach in smoking policy. Prior to this, there were significant variations on both whether these incidents were reported, and the impact rating given when they were reported. As such, quarter 3 is the first quarter to see the results of the decision for consistent rating of moderate. The increase in these incidents being reported should be seen as positive, as it has increased visibility and transparency of an issue that could have a long-term effect on both patient and staff health.

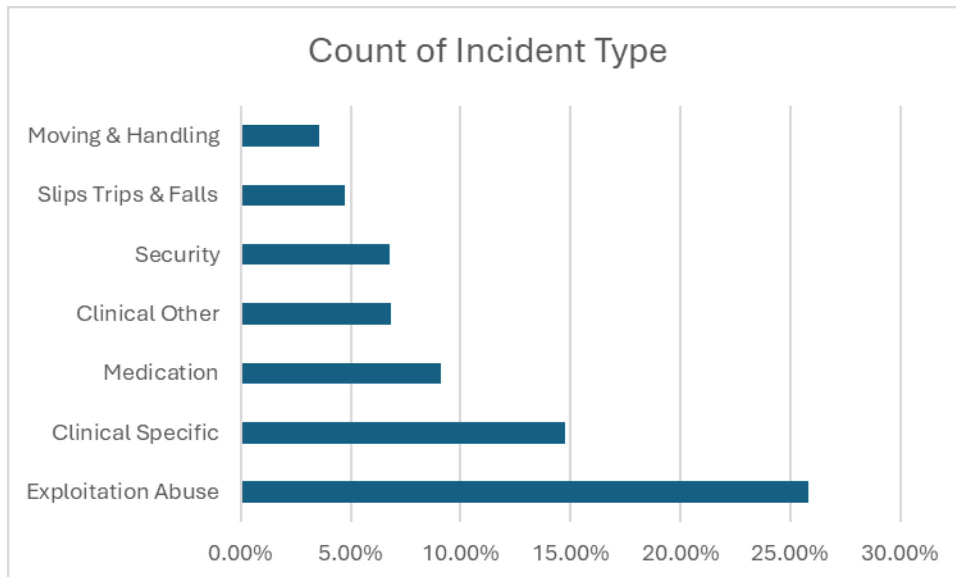
The majority of reported smoking breaches occurred at one base, the Michael Carlisle Centre, and referred to patients smoking on hospital grounds (outside the premises). SHSC is a smoke free site, therefore, this is against policy. It also has the potential to impact the health of both the patients smoking and those around the patient (such as escorting staff) and may be subject to further regulations and legislation in the coming years.

Due to the increased awareness about this issue, there are ongoing quality improvement projects to both understand the reasons why patients feel the need to smoke on Trust grounds, re-visit approved leave arrangements for patients detained under the Mental Health Act and empower staff regarding their own health.

A lack of beds, or delayed availability of beds, was the second highest cause of moderate incidents, at 61 incidents. In the main, these were reporting breaches of the Health Based Place of Safety (HBPoS), where patients were placed in the HBPoS while on a section 2 or 3 of the Mental Health Act, awaiting admission to an acute bed. 23 of the incidents reported breaches of 3 days and 16 incidents reported breaches of 7 days or more. There is an understanding that breaches of the HBPoS create an environment for patients which is not therapeutic and does not meet their needs, particularly when breaches extend beyond a day. There is ongoing work to reduce the number of breaches and the time that people are breached. This is being monitored via the Directorate Integrated Performance and Quality Report and addressed through the Home First programme.

3.3 Top 5 Patient Safety Incidents Reported

Figure 5 - Top Incidents Reported in Quarter 3



There has been a variation in the top patient safety incidents for quarter 3. Unlike in previous quarters, "Clinical other" is within the top 5 reported incidents that relate to patient safety. In the main, "clinical other" relates to closure of the section 136 HBPoS, which had 43 incidents. Closure in this instance means being breached by a patient admitted under a section 2 or 3 of the mental health act, or informally. Seclusion also falls within "clinical other" (with 21 incidents), and the ongoing work is being addressed further in Section 5 of this report.

Security incidents have also risen throughout the financial year – however the largest amount of these incidents is damaged Trust property which, for the purposes of this report, is not a patient safety concern. Missing patients are also reported under the Security category. On a more in-depth review of the data, there does not appear to be a significant amount of these incidents in comparison with other incident types. Missing patient data is reported in the Integrated Performance and Quality dashboard (IPQR), which does not show any increase in the number of reported incidents.

4 Patient Safety Incident Response Plan Priorities

The patient safety priorities identified in the SHSC Patient Safety Incident Response Plan, are shown in table 2 below:

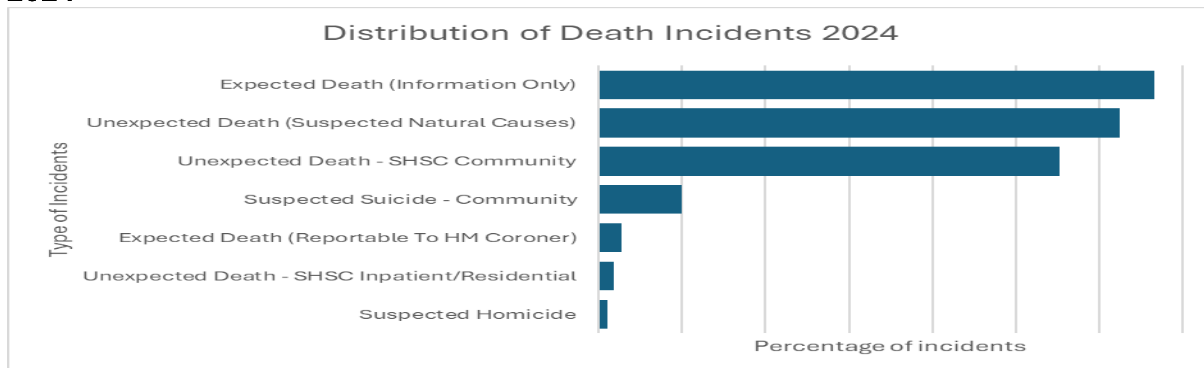
Table 2: Patient Safety Incident Response Plan Priorities

	Incident Type	Description	Specialty
1	Unexpected Deaths	Incidents where a patient death is thought more likely than not to be due to problems in care delivery, or unnatural inpatient deaths	All
2	Slips, Trips and Falls	Patient falls that lead to injury	All
3	Self-Harm	Patients that seriously self-harm during their treatment	All
4	Restrictive practice	Incidents where harm is caused by seclusion, restraint or chemical restraint	Inpatient Services
5	Medication Errors	Harm caused to patients by medication administration errors	All

In identifying these priorities, SHSC can work towards improvement in the 5 identified areas, and ensure learning is being taken from high risk, or outlying, incidents that fall into the above categories. This report highlights the main areas of learning and improvement under these 5 priorities and what the Trust is doing to address these, with supplemental information from the data to evidence the need for improvement.

4.2 Unexpected Deaths

Figure 6: Data regarding types of death incidents for the year Jan 2024 to Dec 2024



Death incidents accounted for 3% of all incidents reported across SHSC in 2024, and of these incidents, 29% were thought to be unexpected deaths, not due to natural

causes, and 5% were reported to be a suspected suicide. Unexpected deaths have been reducing across the Trust over the last 2 years. There were no inpatient or residential deaths thought to be a suspected suicide in 2024. All deaths are taken seriously within the Trust and are subject to in-depth follow up.

Older adult services, not unexpectedly, saw the highest level of death incidents at 42%. Crisis and community services reported 18% of deaths. Urgent and Crisis services reported the highest number of unexpected deaths, not thought to be natural causes. This should be expected, given that these services are the first line of contact with people in immediate crisis.

Unexpected deaths are one of the highest priorities for SHSC to ensure that learning is being taken. This is particularly true if the death is thought to be due to problems in care delivery.

In the main, learning from deaths highlights gaps and barriers in services do not appear to be a causative factor in a person's death, but should still be explored. This has been further discussed in section 5. Over the past two quarterly reports, it has been clear there is some learning for SHSC regarding communication with family and other professionals (GPs and Primary Care Mental Health Teams, for example), which, while this may not have contributed to a patient's unexpected death, does need exploring. Communication concerns with family or significant others in particular, could present a significant risk to a person's care. As such, thematically exploring these issues is one of the priorities to ensure there is learning from unexpected deaths. A thematic review regarding family and carer involvement is taking place to identify what learning can be taken from these incidents, any areas for further in-depth exploration and how to progress that learning.

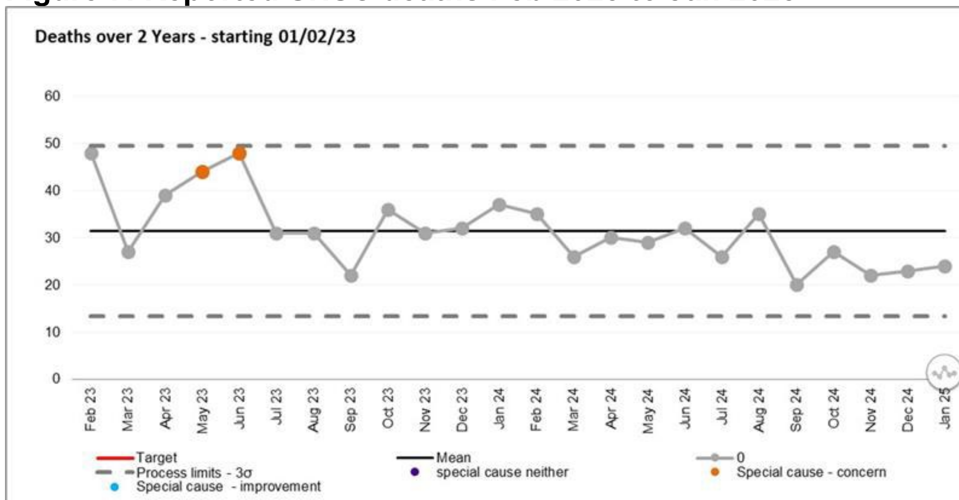
There are further workstreams to address barriers in communication with Primary Care Mental Health (PCMHT) services and, during Quarter 3, issues with PCMHTs does not appear as a theme within learning responses, which may be an early indication that some of the issues noted in Quarter 2 have been addressed.

The Trust is also underway with a programme to centralise recommendations that have been bought about as a result of learning from unexpected deaths and developing these recommendations with frontline teams to create meaningful change. Communication will form part of these actions. High profile external reviews of other Trusts will also be bought into this programme to ensure that SHSC has incorporated relevant learning from other Trusts. The centralised plan will develop robust actions that can lead to long term, Trustwide improvement, and be monitored through a central stream.

Taking learning from unexpected deaths, particularly suspected suicides, enables SHSC to work towards the Government's Suicide Prevention Strategy, which is one of the Trust priorities. The strategy has an overall aim of reducing suicides over the next five years, alongside aims to help achieve this.

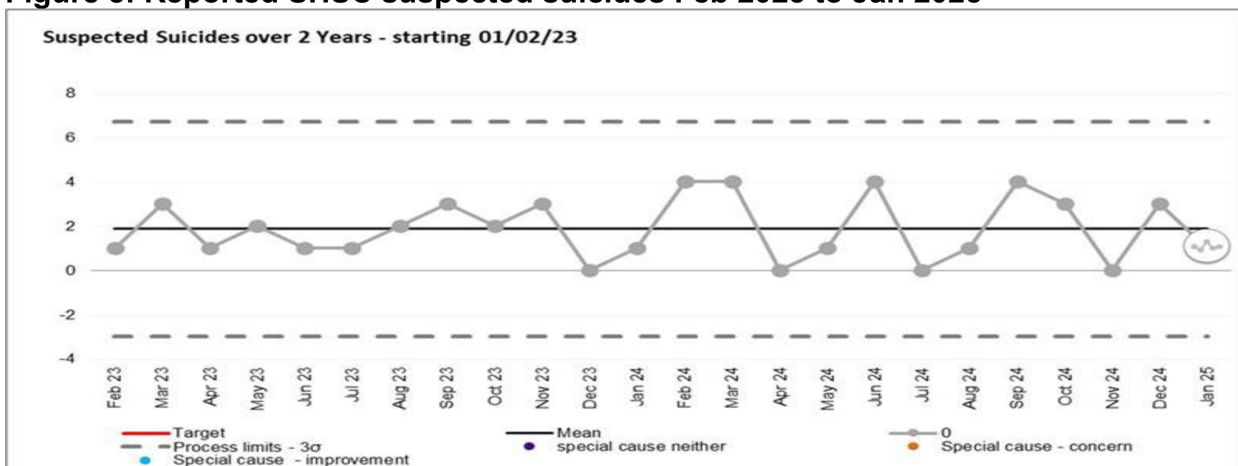
In line with SHSC's aim to reduce suicides, we have seen an ongoing downward trajectory in reported deaths in the last two years, which is positive to see. This trajectory is for both expected (for example, service users on end-of-life care) and unexpected deaths.

Figure 7: Reported SHSC deaths Feb 2023 to Jan 2025



However, it should be noted that suspected suicide deaths have not shown much variation in terms of an overall trajectory, and it remains an area of focus for the Trust. Along with learning responses from suspected suicided (such as patient safety incident investigations and coordinated learning reviews), a thematic review of suspected suicides since November 2023 will be triggered in Quarter 4 to understand if there were any thematic learning that would support the Trust to work towards a reduction in suspected suicides. The SHSC Clinical and Social Care Strategy identifies suicide prevention as a central high-level objective. The fundamental principles of the Strategy are highly relevant to suicide prevention: Person-Centred and Trauma□Informed, Strengths-Based and Evidence-Led. Examples of this a self-harm suicide intervention workbook is being trialled on inpatient wards; a research programme is underway with liaison staff delivering harm reduction programmes and compassion focussed therapy for people who self-harm. The ROOTs and trauma informed training and emotional needs pathway have been taken forward across a number of services.

Figure 8: Reported SHSC suspected suicides Feb 2023 to Jan 2025



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4.2 Falls

In quarter 3 2024/25 “slips, trips and falls” incidents fell to 5%, down from Quarter 2’s figure of 8%. The Trust has been seeing an overall reduction in the number of falls over the last 18 months, however both Q1 and Q2 had shown a slight rise, contrary to the expected reduction in numbers. As such, it is positive to see the reduction of incidents this quarter, which suggests that the ongoing workstreams are continuing to take effect and reduce incidents. In addition, 97% of all reported falls in quarter 3 had a no harm or low harm impact.

One incident had a moderate impact and resulted in the patient being significantly bruised and transferred to hospital, however, the patient received limited treatment and was able to return to their unit.

This incident was also reviewed by the Safeguarding team at the time of reporting, who deemed that positive action had been taken by the team. The professional duty of candour applied to this incident.

Two incidents were reported as having a major impact – one related to a staff member who tripped over damaged flooring at a Trust site, resulting in a fracture. The staff member was given support and appropriate actions were taken regarding the flooring including making repairs and assessing the environment for further risks. The other incident related to a patient who was found on the floor, following a reported fall. Following tests and x-rays, it was discovered this patient had sustained a pubic ramus bone fracture. Duty of candour was followed, and an apology was provided to the affected patient. A local learning review has been requested to identify how the team and organisation can learn from this incident.

78% of the reported falls were from older people’s services, with 54% 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 29% of all falls.

This does represent a percentage increase in falls in non-older adult services. This may partly reflect the overall reduction in falls in older adults’ services. A thematic review indicated a slight increase in falls at Forest Close, relating to one patient with epilepsy who is also prescribed clozapine. The team is working with Neurology services to support the patient’s care. The physical health team has also supported the unit around post-falls care.

There was also a slight increase in falls in acute inpatient services. From a review of reported incidents, this appears to show no underlying cause, having only happened for that patient once, or related to underlying physical health conditions which staff were aware of and monitoring.

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.

The Trust’s priorities for falls are two-fold – to reduce falls and to also reduce the impact of falls. The data reflects that this is occurring. The falls group has, however, identified that further education and awareness is needed for staff in relation to multi-

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factorial falls risk assessments and around post-falls care, to reduce the impact of falls.

The falls group is taking this work forward as part of quality improvement workstreams. There is also a need to review and improve upon technology used within older adults' services to better monitor patients and reduce falls. This work would sit within the remit of a falls lead.

4.3 Self Harm

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 and as such, is one of the priorities identified by the Trust in the PSIRP. In quarter 3 of 2024/25, self-harm accounted for 13% of reported incidents across the Trust, and this has increased by around 3% every quarter of 2024/2025.

Figure 9 - Self-harm by gender since January 2023

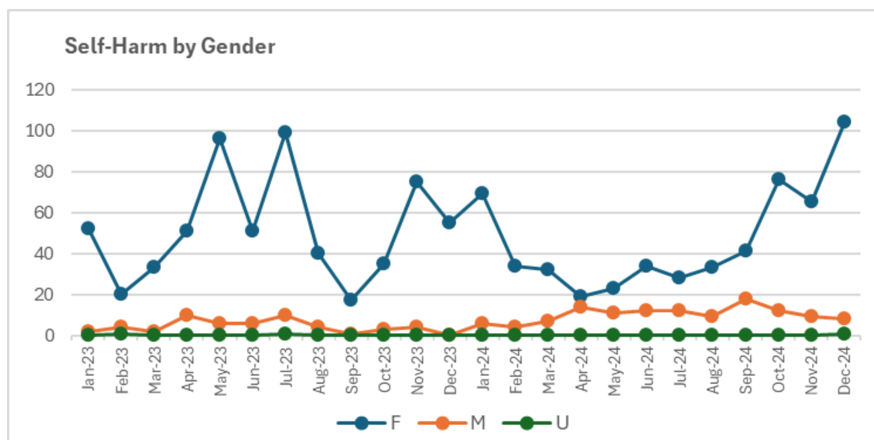
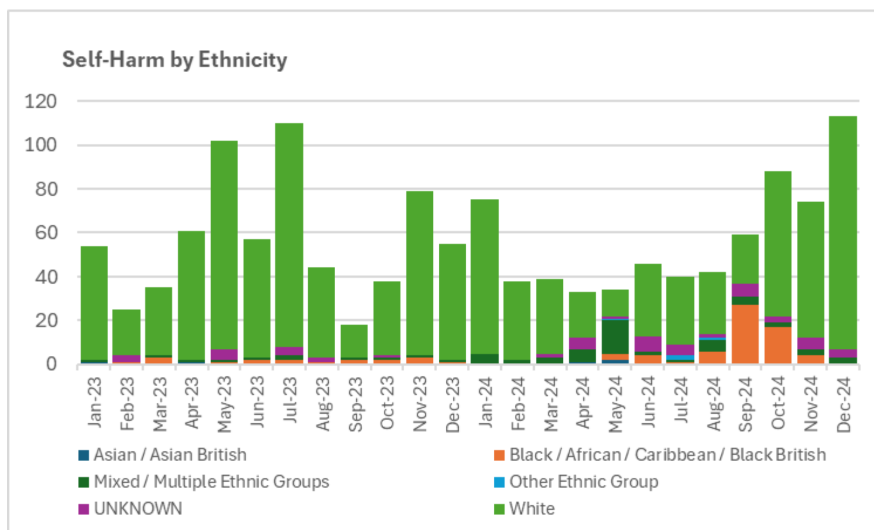


Figure 10 – Self-harm by ethnicity since January 2023



In the previous quarter, there was a rise in people of Black/African/Caribbean/Black British origin self-harming. A review suggested that this was related to a small number of inpatients on acute wards and did not seem to be in relation to diverse needs – although this was only based on incident data and a limited thematic review. It was identified any continuation of this trend would need further review to understand if there is an increase in needs being unmet, and if this is in relation to ethnicity. In quarter 3, the number of Black/African/Caribbean/Black British patients self-harming has reduced to within the usual variation that has been seen over the last 2 years.

Figure 11 – Types of self-harm since January 2023

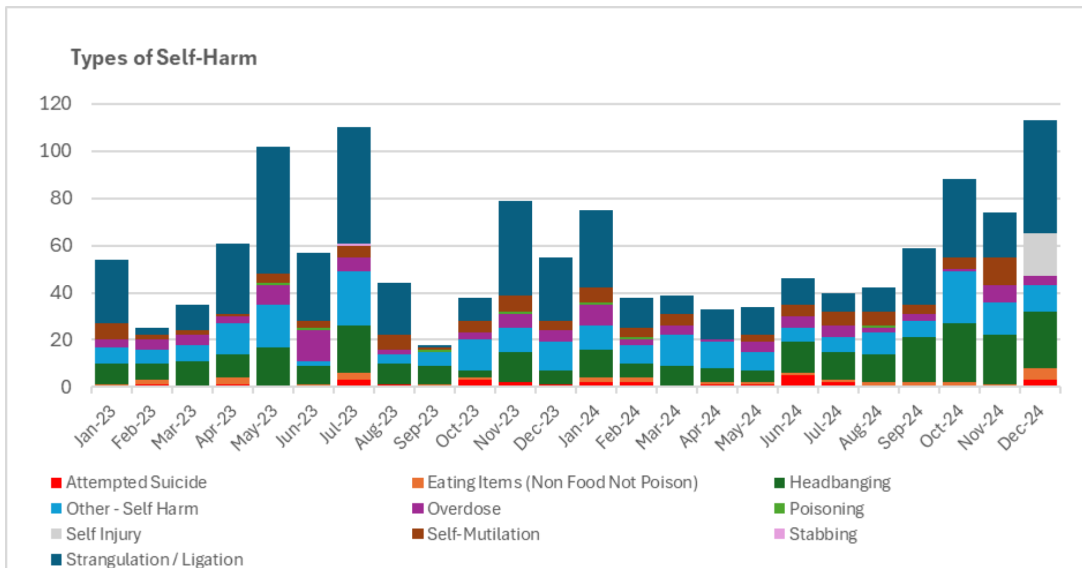
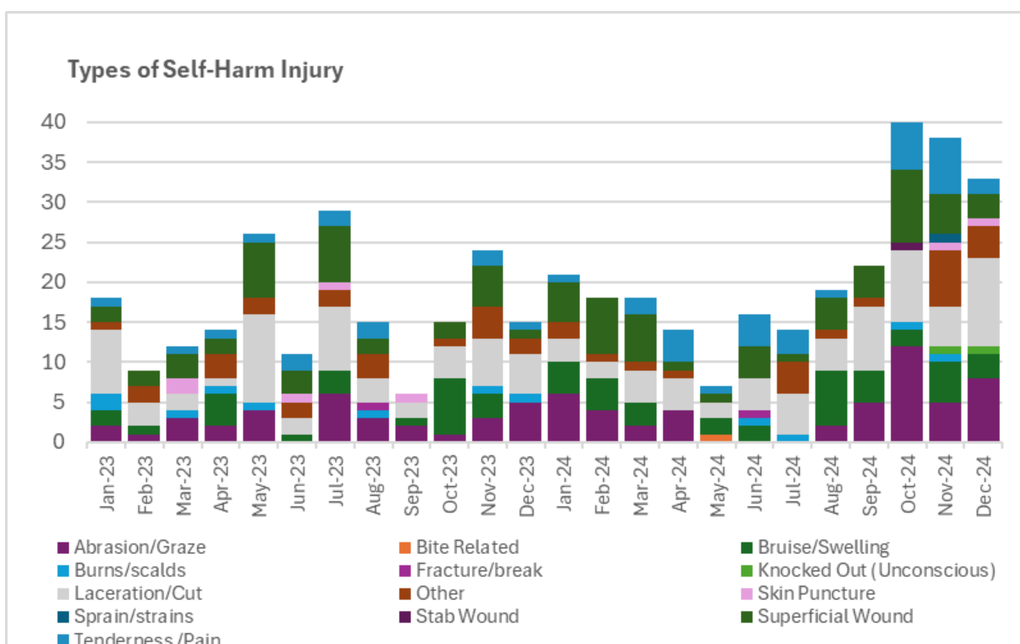


Figure 12 – Injuries caused through self-harm since January 2023



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. The injuries sustained, in general, do not show a significant variation, although it is noted that "other" seems to have risen in quarter 3.

Most reported self-harm incidents occur in acute inpatient settings and, as per previous quarters, relate in the main to headbanging, self-injury and ligation. "Other" also features heavily in the data for acute inpatient settings. From a thematic review of the available data, this seems to relate to incidents where more than one self-harm type was used, and, in some limited cases, where the type of self-harm used is not possible to capture in the existing categories (for example, hair pulling).

By contrast, as with previous quarter, the most common self-harm reported in the community relates to overdoses.

A review of a sample of inpatients that self-harmed in quarter 3 revealed a theme regarding prolonged admission and discharge delays, mainly due to patients awaiting social care provision. It appears both the delays and uncertainty about discharge plans had, at times, triggered self-harming behaviour. This theme is being addressed through the Home First Programme.

There was evidence that in some situations, traffic light systems 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. In one case, "target setting" was used with a patient who had shown continuous self-harm behaviour, leading to a direct decrease in incidents. This highlights some of the positive work being done in inpatient services to meet people's needs. This positive practice will be shared through the Patient Safety Brief produced from the key highlights of this report. Similar positive practice from previous quarters data has also been explored in the Self-Harm Thematic Review, and this review will be shared collaboratively with teams to support learning from good practice, and also exploring where practice, particularly the systems around self-harm, can improve.

As part of the Patient Safety Incident Response Plan (PSIRP), an in-depth thematic review has been undertaken into self-harm incidents reported over a 12-month period. Findings from this highlighted that in some cases, care planning and risk management identified individual needs and early warning signs, however this was not consistent. Recommendations from this review will be taken forward and an improvement plan is being developed.

Within the priorities for self-harming incidents, physical health has also been identified as an area for improvement, which is also reflected in the in-depth thematic review of self-harm mentioned above. It is a policy requirement that inpatient nursing staff undertake neurological observations as part of the post incident interventions for ligation and headbanging incidents. Staff must also complete a NEWS2 or non-contact NEWS2 every time a patient uses a ligature or headbangs. The Physical Health team supports ongoing work to improve physical observations, particularly neurological observations following head banging incidents. The team follow up incidents of self-harm where there is not mention of physical observations, to ensure the observations have been undertaken and, if not, work with the involved team to learn. They also attend the wards regularly to provide ad hoc neuro-observation and self-harm risk management coaching. The use of NEWS2 is subject to audit as part

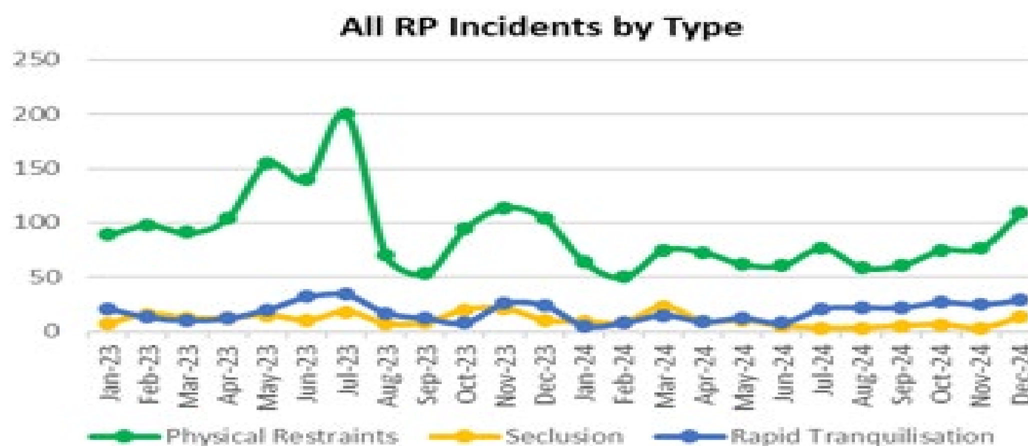
of the physical health delivery and restrictive practice audits that are undertaken. The results from this are reported through the respective groups. Incident reports suggest an improved use of NEWS2 and neurological observations.

There is other improvement work ongoing within the Trust regarding self-harm, through the trauma informed workstream (part of the Clinical and Social Care Strategy). The ROOTs method is being rolled out to measure trauma-informed practice, and this is being supported by the Quality Improvement Team. This work has identified that training for staff regarding trauma informed care, but more specifically regarding self-harming, is an essential requirement.

Overall, the outcome from the workstreams will look to address the quarter-on-quarter increase of self-harm incidents, improve staff confidence in providing therapeutic interventions and reduce the impact from self-harm incidents.

4.4 Restrictive Practice Incidents

Figure 13 – Trajectory of restrictive practice incidents January 2023-December 2024



In general, over the last 2 years, restrictive practice has been reducing across the Trust, particularly the use of seclusion. However, the level of restrictive practice is still a concern, as restrictive practice to prevent harm needs to be balanced with a patient's human rights.

The top 5 themes across restrictive practice appear to be:

- Physical restraint
- Rapid tranquilisation
- Seclusion
- Use of the Safety Pod
- Personal searches

Physical restraint has increased in quarter 3, and rapid tranquilisation has shown a slight increase across the last 2 quarters. This could be related to a rise in exploitation/abuse incidents and as a response to avoid harm in those incidents. However, it may be linked to increased admissions of new patients who, due to being in a crisis state on admission and due to an undeveloped knowledge of the new patients and how to best manage their risks, may be subject to restraint while their immediate mental health crises are managed.

There is quality improvement work ongoing to address all of the above five areas, which forms part of the Reducing Restrictive Practice Strategy. The Reducing Restrictive Practice workstreams focus on 7 areas:

- Knowledge and Skills
- Use of Data
- Learning and Leadership
- Capable Environments
- Involvement and Information
- Policies and Procedures
- Community

The overall aim of these areas is to affect cultural change in restrictive practice and align restrictive practice considerations with the Human Rights Act. The organisation aims to enable a culture of both reducing restrictive practice and learning. Monitoring of improvements will take several forms, including feedback from service users, staff experience and data showing a reduction in restrictive practice incidents, rapid tranquilisation and seclusion.

It is reflected that some of the areas that lead to restrictive practice (such as ward environments, delays in discharge and inappropriate use of units such as the Health Based Place of Safety), fall into several areas of improvement work across the Trust.

This learning is monitored through the Restrictive Practice Operational Group and Oversight Group, which reports directly to the Quality Assurance Committee.

4.5 Medication Incidents

Medication management was the highest reported category out of all medication incidents in Quarter 3. 73% of medication incidents were reported as management of medication, and 14% were reported as administration incidents.

99% of all medication incidents were reported as no harm or low harm. Only one incident was given an impact rating of moderate and related to issues with a pregnant community patient being prescribed Sertraline. The patient had an adverse reaction and was admitted to Hallamshire ITU. A local learning review is ongoing to explore systems around prescribing for pregnant community patients, and duty of candour was completed with the patient.

As in quarter 2 of 2024/2025, the thematic trend in this quarter reflected errors in procedural systems. Only 9% of medication incidents overall resulted in 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 because of problems with injecting a depot, leading to lumps in the patient's skin. The resulting impact was reported as minor. In every incident but one, the basic requirements of the professional duty of candour were implemented, by way of an explanation and face-to-face apology. There was one incident where it was not evidenced that this occurred – which is an improvement on last quarter. This analysis is based on the Ulysses record, which captures duty of candour, however, it is possible that the patient was provided with an explanation but that it was not fully recorded in the incident report. The importance of ensuring accurate recording of duty of candour has been fed back to the team. The Duty of

Candour policy has been reviewed during the quarter and a plan to relaunch this to teams and raise awareness of undertaking and recording duty of candour is underway and will be done by the end of April 2025.

From a thematic review of the incidents, it was found that several points within the medication dispensing and administration systems led to errors reaching patients. Pharmacy and team managers are working together to resolve these system errors/weaknesses. An example is implementing consistent use of bungs on wards in response to several medication administration incidents which would not have occurred if a bung had been used. There was a slight increase in incident reviews identifying learning for individual staff, rather than exploring the wider system issues that appears to have resulted in the incident. This presents a risk around taking meaningful learning from incidents to resolve barriers in the system.

The majority of medication errors occur in inpatient services, and it is noted that there have been several changes in the leadership team of inpatient services. These changes have impacted the consistency of the improvement work to embed a systems approach to incident reviews. A systems learning approach maximises the opportunity for learning when compared with the narrow root cause approach that has traditionally been used. The Patient Safety team are working closely with team managers to embed systems thinking.

The most frequently reported incidents were related to medication storage (fridge and room temperature fluctuations), accounting for 25% of all medication incidents. Incidents relating to the absence of second signatures for controlled drugs accounted for 11% of all medication incidents and this appears in line with previous quarters. There is a risk that second signatures on controlled drug administrations are not being recorded due to second checks not occurring. SHSC policy outlines that controlled drugs should be administered by one staff member, but with another staff member witnessing and confirming they have witnessed the administration. Systemic factors appear to include staffing resources, leadership changes and absence impacting on reviewing and learning from incidents and implementing changes needed to support second signature uses such as training and auditing. The pharmacy team are working with wards to further embed training and ensure consistent auditing. The nursing leadership have created and are actioning an action plan accounting for missing signatures.

There is a theme of medication administration errors being linked to there being no secondary witness. On reviewing incidents and engaging with teams, the Pharmacy team have noted this might be related to gaps in the education staff have received on medication administration, and SHSC policies around second checks. As such, this is a key patient safety issue and there is ongoing improvement work between the pharmacy and ward leadership teams to educate staff on medication administration.

Last quarter, incidents regarding Controlled Drug stock discrepancies were noticeably high at 10%, however this quarter they have reduced to 7%, which is more in line with expected numbers. It does not appear this is specifically related to improvement work.

There are ongoing projects to address some of the key issues that this data highlights. In particular, the pharmacy team is working with bed-based services to improve second signature recording. There is also ongoing work to embed the

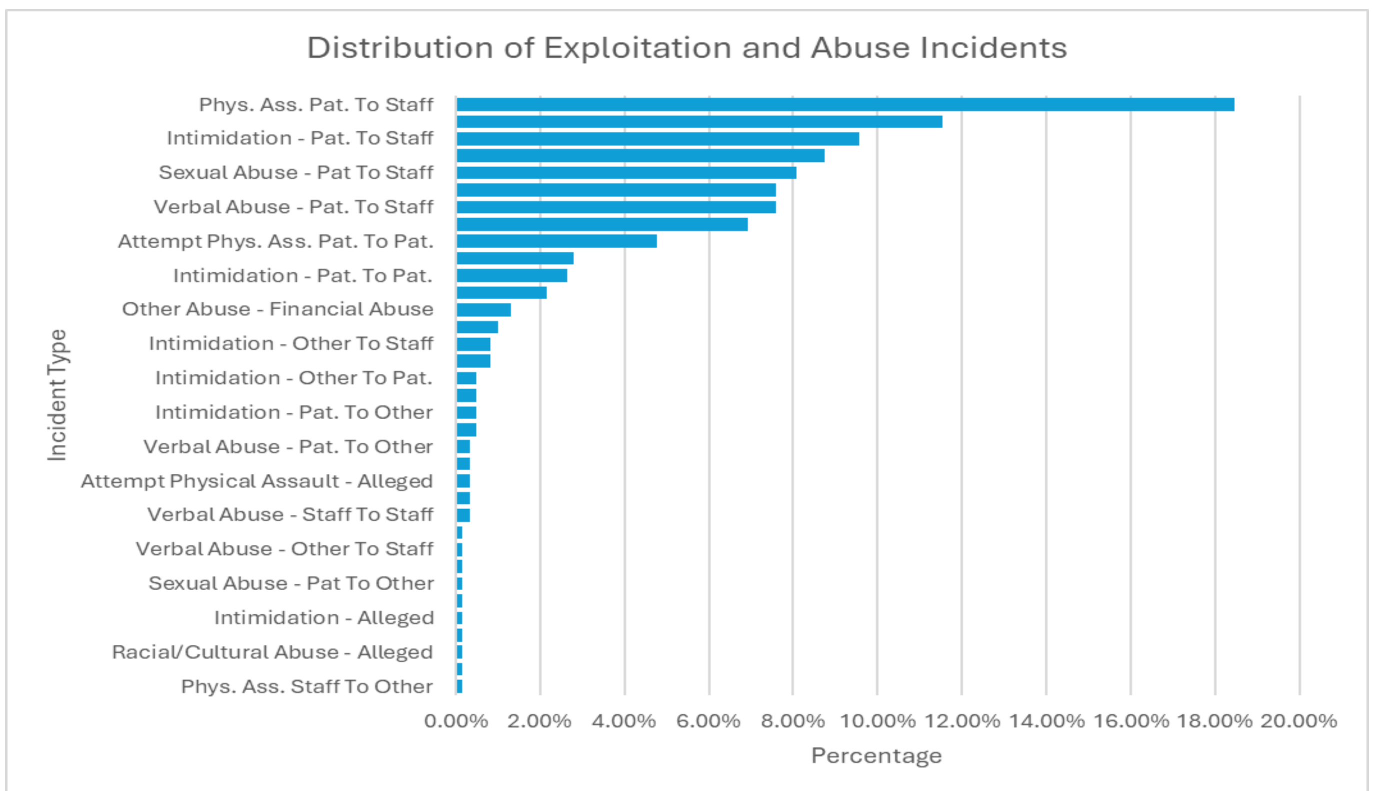
EdMet system following medication incidents, which will support teams to standardise administration and learn from dispensing incidents.

By implementing these enhancements, we aim to achieve a more comprehensive understanding of the systemic factors leading to medication incidents, ultimately leading to a reduction in both medication administration and prescribing errors. Our targeted improvement efforts on second signatures and verification checks are expected to minimise the occurrence of missing second signatures in inpatient wards'-controlled drugs records.

4.6 Other Patient Safety Incidents

The highest reported incident across the Trust is exploitation/abuse, and this has been a consistent picture for several years. In the main, these are primarily reported as patient to staff incidents in bed-based services.

Figure 14 – Exploitation and Abuse Incidents



95% of incidents were reported as having no or minor impact on victims. Of those that had a moderate impact, and where the victim was a patient, two led to injuries. One incident related to an adult protection issue, wherein a patient was in an acute hospital setting awaiting a mental health support package, including an informal inpatient bed, for over a month. Their mental health deteriorated during this time and the patient self-harmed several times. A coordinated learning review is underway regarding this incident, and the learning will be included in the next quarterly report. A duty of candour response has been provided by the Patient Safety Specialist.

In the other moderate incident, a patient detained in an out of area bed, reported being assaulted by a staff member during restraint. The police were notified of this, duty of candour has been completed with the patient and an investigation is underway.

In all moderate incidents where a patient was the victim, the Safeguarding team reviews and supports teams with any follow-on actions. Reassuringly, all patient-to-patient abuse was reported as having low impact and, again, reviewed by the SHSC safeguarding team.

Actual physical assaults on staff accounted for 5% of all incidents, as was the case in quarter 2. However, in general the Trust is seeing a downward trajectory for abuse to staff. 91% of these incidents were reported as having a no harm or low harm impact which, positively, is a slight increase from last quarter. As per last quarter, 2% of all reported incidents were sexual safety incidents, and the majority of these were patient to staff incidents in bed-based services. Around 0.1% were patient to patient incidents.

Any type of abuse towards patients and staff can have a negative impact on patient and staff safety and psychological harm cannot be underestimated. Violence can cause physical injuries but can also have psychological consequences on staff victims, including 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. These reviews will also aim to ensure that post incident support and reviews are embedded for patient victims.

The violence and aggression and the sexual safety workstreams have been reviewed and a comprehensive action plan has been developed, including policy reviews, strengthening of risk assessments to safeguard staff and revised risk assessments are launching in March 2025. The plan also includes strengthening communications with staff particularly around the zero-tolerance policy in place.

SHSC is prioritising exploitation and abuse and working towards embedding the zero-tolerance policy in every level of service. There are workstreams for reducing violence and aggression, with a focus on reducing this towards staff and challenging this behaviour where it is seen in day-to-day work. Where abuse has occurred to a patient, the safeguarding team responds to these incidents and supports teams to ensure patients are supported in the right way, ensuring appropriate alerts are made to the police and local authorities. Where there are outlying incidents where there is learning that clearly needs to be taken, this learning will be and has been done through the PSIRF framework in requesting the appropriate learning response.

5 Learning from Further Investigation

5.1 Learning Identified from Local Learning Reviews

Five Local Learning Reviews (LLRs) were approved by the Patient Safety Oversight Panel in quarter 3. Two of the LLRs requested had not yet been returned by the end of the quarter.

LLR 1: for an **Infection Prevention Control** (IPC) Incident.

A patient on an older adult ward had a confirmed Clostridium Difficile (c. diff) positive test result returned to the ward, and IPC measures were not implemented. These should have been implemented when the sample was obtained, per SHSC policies. Advice was, however, sought from the IPC team and isolation measures were then commenced. This was a healthcare associated infection, likely obtained outside SHSC, and was an isolated case.

Good practice was identified around staff quickly identifying the need for a sample, reviews were completed immediately when a c. diff infection was confirmed, and the infection did not spread to any other patients.

It was identified there are training needs for the team who were not experienced in infection prevention, particularly in regard to c.diff (Clostridium difficile). It was also acknowledged that there is a wider Trust training need which the IPC team will take forwards.

LLR 2: following a **fall**

A patient was found on the floor, having likely rolled out of bed. Due to being on anti-coagulants, and having banged their head, an ambulance was called who conveyed the patient to hospital. The patient was returned to the ward with no further treatment needed. The learning from this was that the nursing response was quick and well managed, and good communication was had with the patient and between staff. Section 17 leave was a noted learning point, in that this needs to be promptly checked and granted, while awaiting an ambulance. It did not, however, affect the incident response at the time. This learning is also being addressed through improvement programmes regarding both section 17 leave and older adults' improvement work.

LLR 3: regarding **self-harm** incidents

Following a patient on an acute ward, ligating numerous times in one day (and following high risk ligating behaviour throughout the week), a local learning review took place to assess the care and systems in place for ligation. Learning identified a need for staff understanding and confidence regarding physical health implications, and actions to support, following ligation. The physical health team is supporting this. It was identified that there had been a large amount of racial abuse from the patient to staff, that had not been incident reported. As such, staff support given could have been impacted and led to feelings of fear and uncertainty in caring for this patient. The learning from this links to the reducing violence and aggression to staff action plan addressed in section 4.6 of this report, which will support to safeguard staff being abused. Positive risk taking was another learning area identified, and leadership were working with the team to explore how to do this in the context of high self-harming behaviour. This will link in with the improvement work from the self-harm thematic review around patient-centred and needs-based care planning.

There was also a local learning review following an overdose by a patient in the community. The LLR identified good, person-centred care was given to the patient and the LLR author collaborated with the patient to seek their feedback and views on

any learning. The patient supported the analysis that good care, and a supportive response to their overdose, had taken place.

Following an older adult overdosing, the older adult community mental health team undertook a local learning review. It was identified that, overall, good care was provided to the patient. It was noted there were some difficulties engaging the patient close to the overdose incident, and while it seems staff took appropriate actions to engage the patient, there was not clear documentation regarding this, and this learning will be actioned by the team. The Trust wide record keeping training will also support with this.

In the main, the local learning reviews for Quarter 3 are linked to the identified PSIRP priorities, however the data shows that as a Trust we are identifying and taking learning from non-priority incidents where there are identified patient safety concerns.

5.2 Learning Identified from 48 Hour Reports

Theme 1: Self-harm on inpatient wards:

There were several 48-hour reports in relation to inpatients overdosing as a method of self-harm:

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- An inpatient gained access to the clinic treatment room while there were no staff present and reported taking drugs from the drug disposal bin. There were clear environmental issues regarding this patient gaining access to controlled drugs, due to problems with the treatment room door design and issues with the drug disposal bin design, and processes on how it is used. Learning was identified to address the environmental factors that made it possible for the patient to gain access to the medication and actions such as reviewing door designs and the functionality of medication disposal bins was taken forward by the directorate leadership team. Although immediate actions were taken to prevent recurrence of this incident, such as the waste medication disposal bins being locked away, the service user later informed staff that the medication he had taken was not obtained through this route.
- A patient absconded from the ward and took a serious overdose of an illicit substance. Following the 48-hour report, a patient safety incident investigation was declared, to ensure that learning is optimised to inform actions to reduce the likelihood of future incidents of a similar nature. An initial review of the learning identified good practice in the immediate response from staff following the overdose, contributing to a positive outcome for the patient, despite being seriously unwell as a result of the overdose.
- A patient managed to seek medication from external sources, and it is not clear how this happened. The patient did not have leave or abscond, so drugs may have been bought in by a visitor. There was no indication the incident would occur. There was some learning identified in relation to the need for staff to use therapeutic relationships to debrief the patient, and issues with the patient remaining in an unsuitable inpatient environment with no discharge pathway due to their complex needs. This will be further expanded on in the above identified patient safety incident investigation regarding action needed.

Overall, the learning was a mixture of environmental changes and learning in relation to better engaging with patients, particularly where their complex needs create additional

pressures in engagement. The learning regarding engagement also ties in with learning highlighted by the self-harm thematic review undertaken, suggesting a wider organisational need. This is being progressed through an improvement project lead by the Head of Psychological Professions.

Theme 2: A patient to staff physical assault was discussed through a 48-hour report, due to the significant consequences of the assault. While the full details cannot be disclosed, to avoid identification of any parties involved, learning included reviewing pregnancy risk assessment processes, how staff are placed on acute inpatient wards, exploring how staff are supported following violent and aggressive behaviours and ensuring staff are equipped with the full knowledge and confidence to manage aggressive behaviour in patients. The Executive Team are leading several improvements in relation to this incident.

Theme 3: Adult protection issues have been noted in two 48-hour reports, regarding assaults to patients. Noted themes were around ensuring the incidents were reported to the police, and the impact in one of the incidents of the police taking no further action, although the Trust has initiated HR processes. This provides further evidence for a need to maintain lines of communication with the police to review such incidents and what further support can be given. This will be taken forward though strengthening senior communication forums with the police.

Theme 4: Identification of an infection in an older adult bed-based service was noted in one 48-hour report, and there does appear to be similar learning identified in the LLR regarding infection prevention control, around early identification of a potential infection, early barrier nursing and when and how to escalate concerns. It was noted that systems around intentional rounding were not helpful in this patient's situation and may have led to escalation points being missed. In the 48-hour report, there were also difficulties within the system for microbiology sampling. Actions taken forward by the IPC and Physical Health Teams included reviewing intentional rounding charts, developing clearer documentation and training staff in sepsis identification and management to include microbiology sampling.

5.3 Learning Identified from Unexpected Deaths (48 Hour Reports)

Theme 1: Following a suspected suicide, a theme identified in one 48-hour report was ensuring a **risk assessment** is carried out, when teams are referring into the Urgent and Crisis service for concerns that a patient is expressing suicidal thoughts. Risk assessment is essential to ensure good risk management and a clear understanding of risk from the assessing staff member. This is contained in relevant Standard Operating Procedures and the action is to explore with the team any barriers to undertaking risk assessments. It is important to not that risk assessment is a repeat theme across incidents. This is being addressed through two workstreams – Culture of Care in the inpatient wards and currently focussed training in the CMHTs.

Theme 2: **waitlists for specialist services** was raised in two 48-hour reports related to suspected suicides and unexpected deaths. It was acknowledged that there are long waiting lists in certain specialist services. Improvement work is being undertaken in services to review care pathways and reduce waiting lists and to ensure those on waiting lists are up to date. Some positive improvements are noted in some services through the IPQR. For the 48-hour reports, there was learning identified to ensure that waiting well strategies are communicated, the details we hold for people are up to date, and that people are aware of expectations, including information about how long waiting lists are predicted to be.

Theme 3: One 48-hour report following an unexpected death identified particularly **good practice** regarding a patient being fully involved in their care and enjoying a good relationship with their named worker.

Theme 4**: delays in assessment** due to problems with waiting list referrals have been identified through two 48-hour reports for a service who receive referrals via SystmOne. The two 48-hour reports both relate to the same patient and were separately reporting the delay in assessment and the person's unexpected death. While it does not appear that the delay in assessment affected the patient's sad outcome, there was some clear learning regarding SystmOne's referral process. The referral system is built in a way that human error could occur, if not processed correctly by administrators and enquiries have been made about fail safes, but this is not possible to build in. However, regular auditing will take place of referrals which will then identify if referrals have not been processed in the right way and used to inform learning and supervision within the teams.

Theme 6: **information sharing** with relevant carers and professionals was identified and has been an identified theme in the previous quarter's 48-hour reports. In one 48-hour report, following an unexpected death, it was noted that a patient had understood advice that staff gave around their choking risks, declined to follow the risk management plan and had capacity to understand that doing so could put her themself at risk. This was documented clearly; however, care home staff were not informed of the risks so they could support management of the risks where possible. The service is producing a standard operating procedure to assist where patients choose not to follow advice, to include the sharing of information with relevant people (where there is consent). In a second 48-hour report following an unexpected death, information around a patient's risks was posted to their GP when the patient did not attend an assessment session. However, the risks were identified as significant, and the learning was that a conversation with the GP to ensure those risks were understood would have been supportive. This will be conveyed to the staff and adjusted in the team's usual procedures.

Theme 7: **follow-up of patients** when a staff member is unexpectedly on leave was raised in one 48-hour report, and this links to a noted theme from last quarter of follow up for patients when appointments are cancelled due to annual leave. Learning was identified around ensuring there is oversight for workload of staff who are unexpectedly absent long term. Positively, the service manager attended the Patient Safety Oversight Panel to update on the work that the team has done to build these oversight processes into standard practice.

5.4 Learning Identified from Coordinated Learning Reviews

After Action Review 1: The Patient Safety Team undertook a review with the Early Intervention Service, following an incident where a patient in the community took an overdose and presented at A&E, however declined to see Liaison Psychiatry. The patient was discharged home, and there was a delay of 3 days in the patient being followed up by staff. From this review, there were several system issues highlighted, and much of this seems to be due to the change in model that EIS operates under. As the service continues to progress under the new model, learning and changes will be identified. This was a good

opportunity to understand what parts of the new system were supporting staff and what parts of the system were creating barriers. Staff engaged well with the review and took actions away that were meaningful to them. Actions included:

- Reviewing the role of the "shift coordinator" and providing more clarity on their daily focus
- Reviewing the use of the shared inbox that the team utilises to distribute tasks to both the shift coordinator and other staff
- Making changes to supportive structures like daily huddles and multi-disciplinary team meetings, to address risk.
- Reviewing how senior practitioners support teams when other senior practitioners are absent, and for all EIS teams to ensure they consider escalating risk issues to other senior practitioners where needed

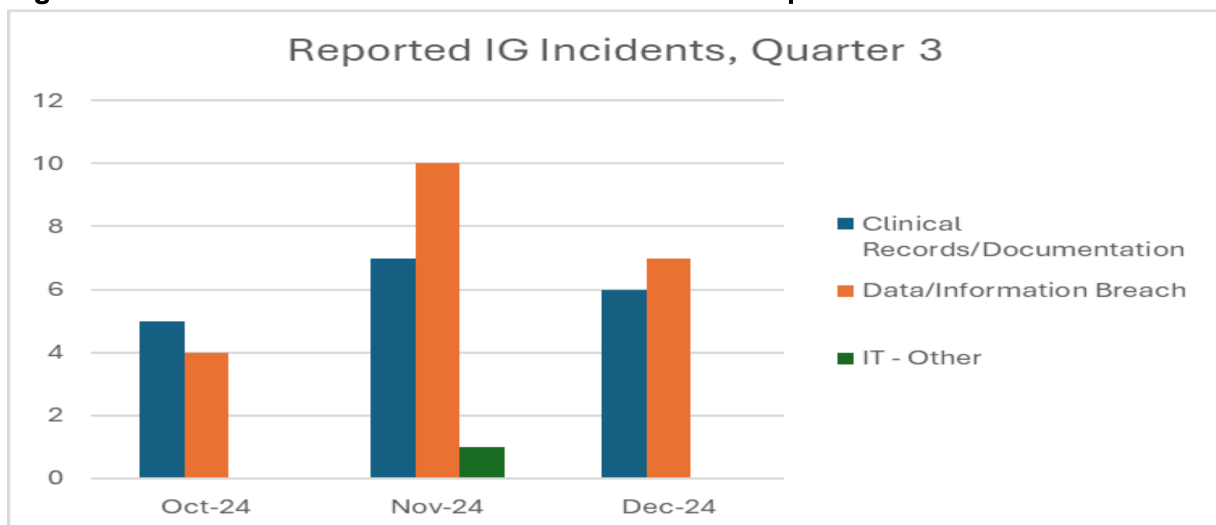
6 Learning From Other Avenues Across the Trust

As well as the incident response framework and subsequent actions detailed within this report, there are a variety of other avenues across the Trust, where learning is taken from incidents, and feedback from staff, service users and families.
It is important that this learning is captured within existing learning frameworks, so that it is meaningful and can contribute to organisational memory and learning.

6.1 Information Governance Incidents in Quarter 3

One incident was reported to the Information Commissioner's Office (ICO) during the quarter and involved a service user claiming on admission that staff within another service routinely viewed Insight notes of people not referred to their service and discussed their cases.
An audit trail for the specific service user did not reveal unauthorised access, so the ICO decided not to take further action but a more comprehensive review of access within the other service is being undertaken.
The investigation into a previously reported incident where a member of staff was said to have accessed service user records and shared details inappropriately is still ongoing.

Figure 15 - Information Governance Incidents raised in quarter 3



The Trust suffered a phishing attack in November, the attacker managed to gain the login details of a member of staff then used their account to send out further mailings. Security for e-mail logins was increased as a result.
Nine of the reported incidents concerned incomplete records.
There were a further three incidents where information was sent to the wrong e-mail address in error and one where the wrong record was sent to a service user.

Five of the incidents were the result of actions by external organisations – a partner organisation gave inaccurate information about a service user, information was shared via a personal e-mail address rather than to a Trust address, a check was made on the wrong person who had a similar name to our service user, and in two cases another Trust did not follow appropriate procedures where people should have been referred to SHSC.
Four cases concerned service user information not being stored securely – two of these were files being stored on electronically on a drive where they could be accessed by others and two were paper records which were accessible to others.
There were also three instances of service user information being shared inappropriately, including one where a service user had been approached by someone in the community who said they knew about their recent treatment.
There were two misfiled records found as a result of subject access requests, and one case where service users had been confused with each other and records made on the wrong service user's file.

6.2 Learning from Safeguarding Incidents for Quarter 3
In Q3 there were a total of 8 Section 42 (2) Enquiries caused to SHSC by the Local Authority. Overarching themes this quarter were around concerns about care and treatment, neglect and physical harm. The S42 Enquiries tracker continues to be reviewed at the weekly Patient Safety Overview Panel for assurance and approval. Four enquires resulted from internal safeguarding concerns, two were from family and two from the CQC. Two Enquiries related to one person.
There were 20 Allegations Against staff (AAS) raised in Q3 (previous numbers reported were 15 in Q2 and 21 in Q1). Themes of these allegations related to physical harm during restraint, sexual safety, verbal abuse, and staff conduct. 4 cases progressed to HR investigation, 1 case progressed to HR investigation & Safeguarding referral made out of area, 2 police referrals, 2 Local learning responses and 9 cases were no further action (NFA) under the AAS Policy. 2 cases were withdrawn by the Service User.
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 seek 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.
Some cases that are NFA under the AAS Policy will have had other local learning outcomes such as supervision and reflection with staff involved.
In Q3 the Safeguarding Team received 6 requests for information for consideration for Safeguarding Adult Reviews (SAR) and Domestic Homicide Reviews (DHR). We continue to see a sharp rise in the number of SAR and DHR considerations. So far in Q4 we have received 11 requests for information. 2023/24 saw a 100% increase in volume compared with 2022/23 and based on figures so far, we have seen a 94% increase in 2024/25 compared with the previous year.
Of note, we have contributed to final amendments to the DHR for Adults Y known as Howard and Margaret and a Prevention of Future Deaths Action plan has been shared with the author. The learning from this action plan is mainly themed around communication with other services such as Neurology, and this links to other learning identified in Quarter 3's 48-hour reports regarding communication with services such as GP's. The action plan will aim to create clearer processes for communicating and sharing important information with other services, within the boundaries of service user consent and data protection legislation.
There have been no new Learning Briefs for SAR's or DHR's published this quarter.
All SAR and DHR Learning Briefs and the newsletter can be found here
https://www.sheffieldasp.org.uk/assets/1/version_for_sharing_october_2024_sar-dhr_quarterly_update.pdf
We shared in our Q2 update that cuckooing, ASB and self-neglect had been identified as concerns in 2 SAR's and these have been amalgamated, and a Learning Review will be completed. We have continued to see Self-Neglect as a feature in SAR referrals accounting for 50% of the referrals in Q3. The issue has been discussed at the SASP Performance and Quality Sub-group, and a separate working group is to be led by the Designated Professional Safeguarding Adults (ICB) to better understand and plan how we can improve our response to persons who self-neglect.

6.3 Freedom to Speak Up Data in Quarter 3
Freedom to Speak Up is an alternative route for raising any concern. Here are some examples of the learning from FTSU concerns raised or closed in Q3.
Concerns were raised across both community and inpatient areas. The Director of Nursing, the Director of Quality and Strategy, and the Deputy Director ensured these issues were followed up. Actions taken included meetings, increased leadership support, a review of service user care, support and training from the physical health team, increased contact over the festive period, and the reallocation of staff.
Several concerns were raised regarding workplace relationships, particularly around fairness and a perceived lack of understanding and accountability when issues arise. There were specific concerns about microaggressions, disability, and ethnicity, highlighting potential bias, a lack of awareness, and, in one case, a lack of compassion. These issues significantly impact staff wellbeing, motivation, and retention. Staff may feel vulnerable, particularly when raising concerns about microaggressions, discrimination, or workplace relationships, especially when there is a power imbalance. The FTSU Guardian provides additional support, offering a confidential space for staff to raise concerns safely.

A concern was raised about how clinical managers and nurse specialists are supported in ward areas. Supporting new managers has been a priority for some time, and a new managers' training program has been launched, covering a wide range of topics, including practical information, leadership, discrimination, and workplace culture. The new Director of Nursing has taken steps to understand current challenges, and in addition to governance, she has focused on supervision, meaningful support, and role modelling in response to the concern raised. Prioritising staff wellbeing and support, particularly for new clinical leaders, remains an ongoing effort given the challenges they face. FTSU continues to offer a confidential space for all staff and managers, which can be especially valuable for those in junior leadership roles or who are new to the trust and may not yet have built trusted relationships with colleagues.

6.4 Learning from CQC Data in Quarter 3

- 22 CQC enquiries were received by Care Standards during Q3.
- All 22 enquiries were acknowledged within 2 working days of receipt.
- 12 of these enquiries are now closed with CQC.
- 2 enquiries have had responses submitted to CQC and we are awaiting formal notification of closure from CQC.
- Of the remaining 8 open enquiries, 3 are repeated previous enquiries and pending a meeting with CQC to discuss closure and relate to multiple whistleblowing enquiries received about one service. An improvement plan has been implemented and is underway in response to the concerns raised.
- 5 of the open enquiries are ongoing investigations.

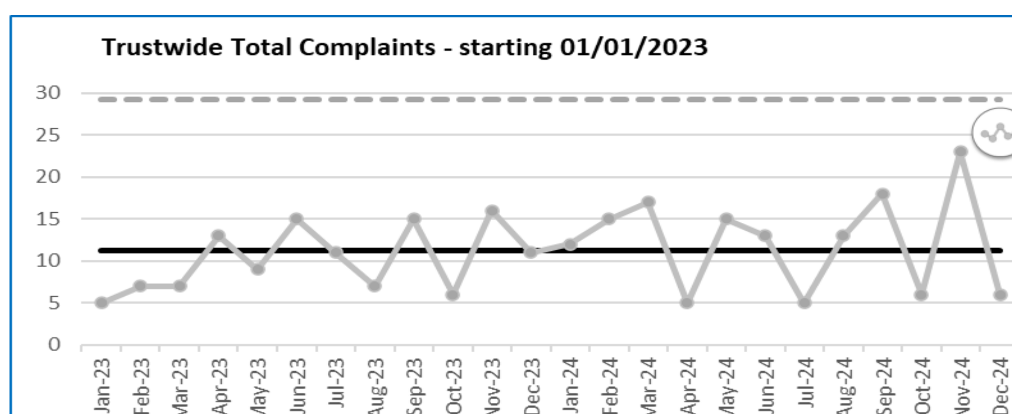
In the main, the enquiries from the CQC in Q3 related to incidents that a learning response had already been requested or taken place for and has been discussed above. Examples include:

- A request around a patient absconding on escorted leave and taking an overdose of medication (from which, a Patient Safety Incident Investigation was declared in Q3 and will be available in future quarters).
- An incident of a fall where a person had fractured their pelvic bone. This incident triggered a local learning review and is discussed in section 5.3 of this report.
- An incident of abuse to a patient where a 48-hour report was requested, and learning discussed in section 5.2 of this report.
-

6.5 Complaints Data in Quarter 3

New Complaint Themes

Figure 16 - Number of formal complaints recorded 1/1/23 – 31/12/24



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It can be seen from the graph above that there was an increase in the number of complaints received in November 2024, however, this was not deemed to be 'special cause variation' as it did not breach the upper control limit.
40 formal complaints were received during Q3. The categories of these are broken down as follows:

Table 3 – Complaints broken down by Category for the last 3 quarter 2024/25

Complaint category	**Q3**		**Q2**	**Q1 2024/25**
Access to Treatment or Drugs	8	↓	10	9
Clinical Treatment	5	↓	8	0
Communications	10	↑	6	3
Patient Care	4	↓	5	2
Values and Behaviours	6	↑	3	7
Admissions and Discharges	4	↑	2	5
Prescribing	1	-	1	0
Waiting times	-	↓	1	3
Trust policies	1	↑	0	1
Privacy and Dignity	1	↑	0	1
Appointments	-	-	0	0
Access to Records	-	-	0	0
Total	40		36	31

- Communications was the highest category of complaint, accounting for 25% of new complaints. 7 out of the 10 complaints received in this category highlighted communication with the patient being the concern. The remaining 3 raised communication with family/carers being poor.

  Communication is a theme that spans across incidents and complaints, as can be seen within this report.

- 20% of complaints within the quarter related to access to treatment and/or drugs. Access to services and service provision were the areas highlighted in this category.
- Values and behaviours accounted for 15% of the complaints received in the quarter. These were split across 5 different categories, with no overarching theme.
- 12.5% of complaints in the quarter related to clinical treatment – lack of clinical assessment being the biggest area of concern raised.

- Admissions and discharges and patient care accounted for 10% each of the new complaints recorded. Transfer against the patient's wishes was the biggest concern highlighted in this category.

Closed Complaint Themes

- 43 complaints were closed during Q3.
- 36 complaints were closed within agreed timescales, 6 were closed outside of agreed timescales and 2 complaints were withdrawn.
- 17% of the closed complaints were fully upheld (ie the concerns raised were validated)
- 59% of the closed complaints were partially upheld
- 22% of the closed complaints were not upheld (ie there was no evidence to support the concerns raised)
- 23% of the complaints closed related to access to treatment and/or drugs. A further 17% related to communications and values and behaviours. These 3 categories accounted for 56% of complaints closed during Q3.

7 Recommendations

The Trust Board is asked to:

- Note for assurance that actual harm caused, or contributed to, by SHSC and experienced by patients and their families is very low, in regard to the severity of harm experienced
- Note for assurance that where incidents of patient harm do occur, learning is extracted, acted upon and shared in line with local and national guidance
- Note for assurance that improvement actions are being undertaken, particularly in relation to the main identified priorities across the Trust. These actions enable us to maintain and promote a patient safety culture in line with our Quality Strategy and our ambition to deliver outstanding care