Board of Directors - Public

SUMMARY REPORT	Meeting Date:	27 September 2023
	Agenda Item:	10

Report Title:	**Patient Safety Specialist: Learning and Safety Report Q1**	
Author(s):	Vin Lewin Patient Safety Specialist	
Accountable Director:	Salli Midgley: Director of Nursing, Professions and Quality	
Other meetings this paper has been presented to or previously agreed at:	**Committee/Tier 2 Group/Tier 3 Group**	Quality Assurance Committee
	Date:	13 September 2023
Key points/ recommendations from those meetings	The Quality Assurance Committee approved the report and were significantly assured that improvement action is being undertaken as a result of learning from patient safety incidents. The actual impact of harm in relation to racial and cultural abuse was raised as a point of clarification by a member of the committee. It was acknowledged that the current national grading matrix does not estimate the level of psychological harm experienced by an individual abused in this way. Further work is underway, and will be outlined in the quarter 2 report, in relation to understanding harm from a psychological perspective.	

Summary of key points in report

Key points for this quarter:

- SHSC continues to have a low threshold for reporting patient safety incidents with the majority of the incidents reported being low or no-harm incidents.
- In this quarter there are 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:
  - Self-harm, falls prevention and sexually safety.
  - Communication systems and processes.
  - Risk assessment and documentation.

Recommendation for the Board to consider:

Consider for Action		**Approval**		**Assurance**	**X**	**Information**	

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

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

Please identify which strategic priorities will be impacted by this report:				
Recover services and improve efficiency	Yes		No	X
Continuous quality improvement	Yes	X	No	
Transformation – Changing things that will make a difference	Yes	X	No	
Partnerships – working together to make a bigger impact	Yes	X	No	

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

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

Name of Report: Patient Safety Specialist: Learning and Safety Report

Section 1: Executive Summary

1.1 **Executive Summary**

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

- In this quarter there are 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:

    - **Self-harm** is currently the highest single reported incident type and there has been a significant increase in the number reported over the preceding 12 months to date. Whilst the act of self-harm is frequently an individual experience, often linked to mental well-being and previous trauma, there is a psychological impact on others and the act itself can often lead to physical interventions such as restraint and rapid tranquilisation, which in many cases also has a significant negative impact on everyone involved. The inpatient wards are currently undertaking a Quality Improvement project in the form of a feasibility trial of a Just in Time Adaptive Intervention (JITAI) to prevent self-harm events in an inpatient care setting.

    - **Fall prevention**, whilst there is excellent work underway to reduce the number of falls and this is bearing fruit in older adult inpatient areas, falls in the two residential nursing homes continue to be frequently reported. Overall, there has been a steady downward trend in incidents of falls since January 2023. Safety Huddle implementation is well underway in these areas and senior staff are also working collaboratively with the University of Bradford in a sharing of best practice capacity.

    - **Sexual safety** continued to be a key area of focus in quarter 1 and there is an improvement plan underway in order to ensure that staff have to appropriate knowledge and training to mitigate sexual safety risks and implement preventative measures in accordance with the sexual safety policy. Sexual safety has been added as a standing agenda item at the Clinical Quality and safety Group for monthly reporting and quarterly reporting to the Quality Assurance Committee is underway.

- Learning from serious incidents highlights that there is a need for continued focus on improving communication with patients and their family, between SHSC teams and with external partner agencies. The Detailed Risk Assessment and management plan DRAM is not fit for purpose and work is underway to replace this. Extensive work is also underway to improve the experience of patients waiting for services and for patients being cared for out of the city.

- It is essential that SHSC has robust management plans in place and immediate risk reduction and improvement plans to address the issues in the medium term. We have clear evidence of learning that indicates where these situations continue (increased levels of self-harm, falls 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.

- In quarter 1 there is evidence that Quality Improvement continues to have a positive impact on learning across teams. We can summarise therefore that risks and learning are identified within this quarter but there is a need for continual improvement plans, developments and quality improvement projects to fully demonstrate robust improvement for patient safety and experience.

Section 2: Introduction

Purpose of Report

2.1 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 serious 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: Reporting: Key Performance Indicators

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

Financial year	**2020/21**	**2021/22**	**2022/23**	**2023/24**	**Total**
No. Reported	8222	8440	8521	2262	27445
4 Quarters	**Q2 2022/23**	**Q3 2022/23**	**Q4 2022/23**	**Q1 2023/24**	**Total**
No. Reported	2170	2235	2036	2262	8703

3.2 48hr reports, *StEIS and **SEAs identified in Q1

	April 2023	**May 2023**	**June 2023**	**Total**
48hr Reports	13	16	20	49
StEIS Reports	5	1	1	7
SEA's	6	7	5	18

*Strategic Executive Information System (StEIS). This is the national database where Serious Incidents are reported and monitored.
**Significant Event Analysis (SEA). This document is used for team/service level learning investigations.

3.3 Key points to consider from the data provided:

- The 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 8394 incidents each financial year.
- All incidents reported as having a catastrophic impact were in relation to death and 74% of these were either suspected or known to be due to natural causes. 1 expected death was reported by one the two nursing homes, all other reported deaths were reported by community-based services. All deaths from suspected suicide (2%) were subject to individual due diligence and where required a 48hr report was completed. One homicide was reported in Q1 in relation to the death of a service user. The perpetrator was not known to SHSC and further investigation will be considered by the Local Authority Safeguarding team. 19% of reported deaths originated from substance misuse services. These services are no longer commissioned from SHSC and it is anticipated that this will lead to a reduction in the number of reported deaths overall.
- 67% of all reported incidents can be traced to bed-based services. 77% of all incidents were reported by acute and community services. Rehabilitation and

specialist services accounted for 21% of all incidents reported. 3% of incidents were reported by non-clinical services, including pharmacy services.

- 89% of all incidents reported were in the no harm (near-miss, negligible) or low harm (minor) categories of actual impact.
- 12% (6) of the 48hr reports requested were reported externally to the Strategic Executive Information System (StEIS)

3.4 Of the 7 Serious incidents where potential learning was identified were reported to StEIS:

- 1 was a suspected suicide in the community.
- 2 were unexpected deaths in the community, cause unknown.
- 1 was an expected death as a result of Covid-19.
- 1 was a suspected homicide, however, after due diligence this was requested to be delogged from StEIS as no learning investigation was required by SHSC.
- 1 was an incident related to a service user found with an injury (fractured arm) following transfer out of city.
- 1 was a sexual safety incident that occurred between two service users.

Learning themes from these investigations will be presented in the Q2 2023/24 learning and safety report.

Tables 1 - Types of Serious Incident Investigations since July 2020 by year

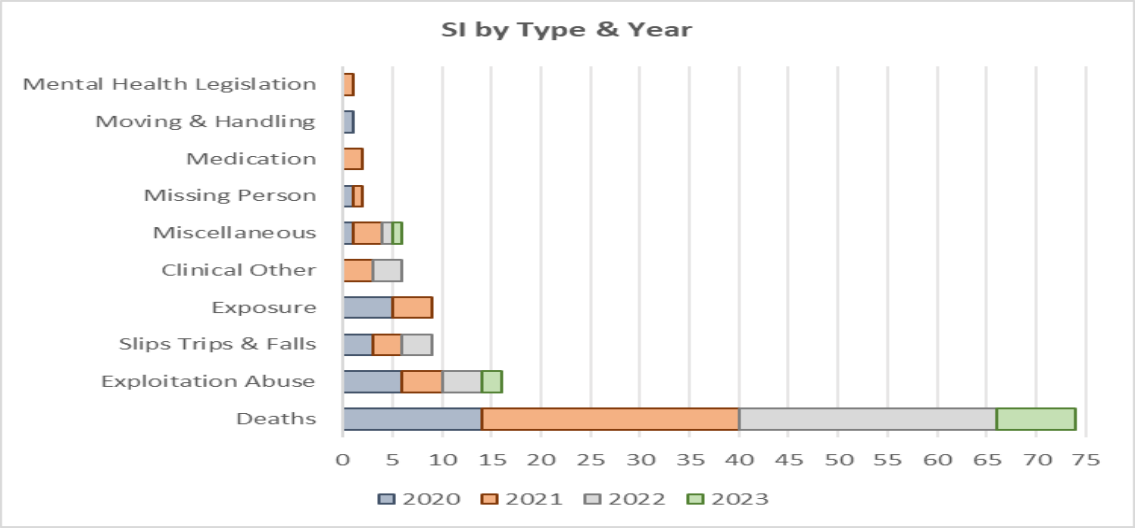
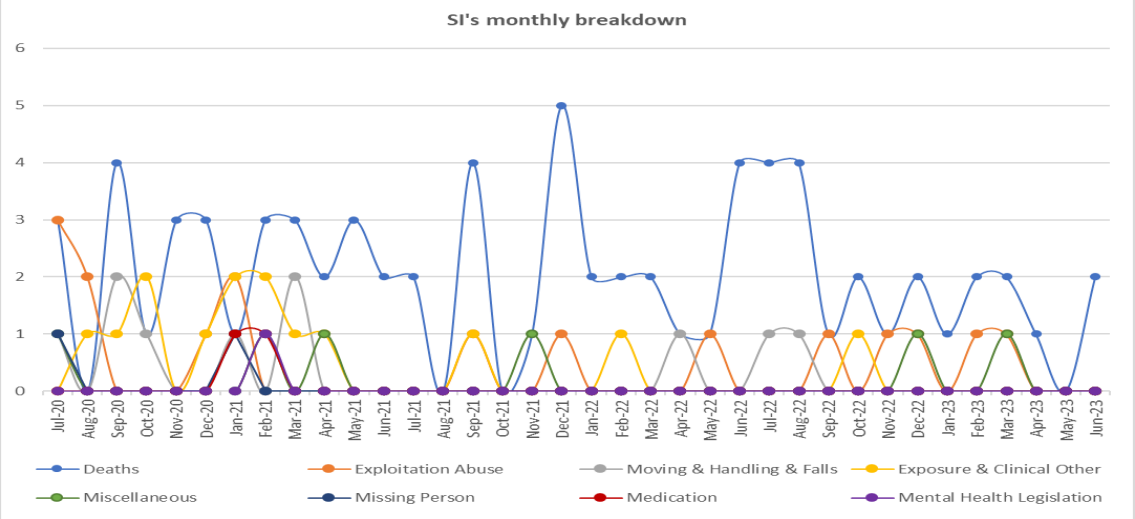


Table 2 - Types of of Serious Incident Investigations since July 2020 by month



Section 4: Incident reporting and Learning from Incidents

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

This is supported below in the following 2 tables which indicate that there has been no significant variation in reporting since quarter 1, 2021 and that 88% of SHSC incidents in Q1 are in the low patient harm (minor) or no patient harm (negligible) category.

Table 3 - All incidents reported since April 2021:

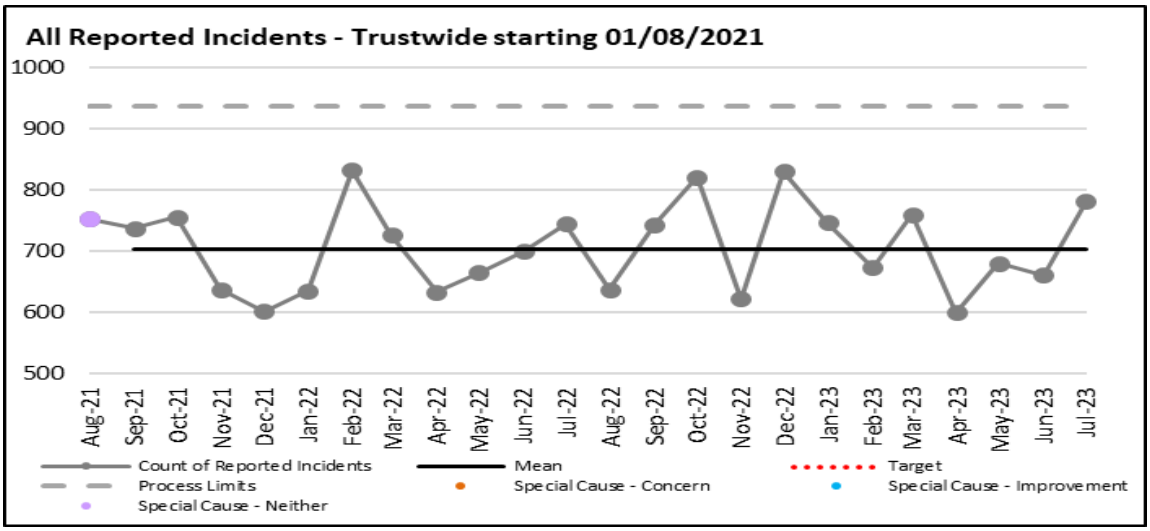


Table 4 - Actual impact of incidents being reported in Q1:

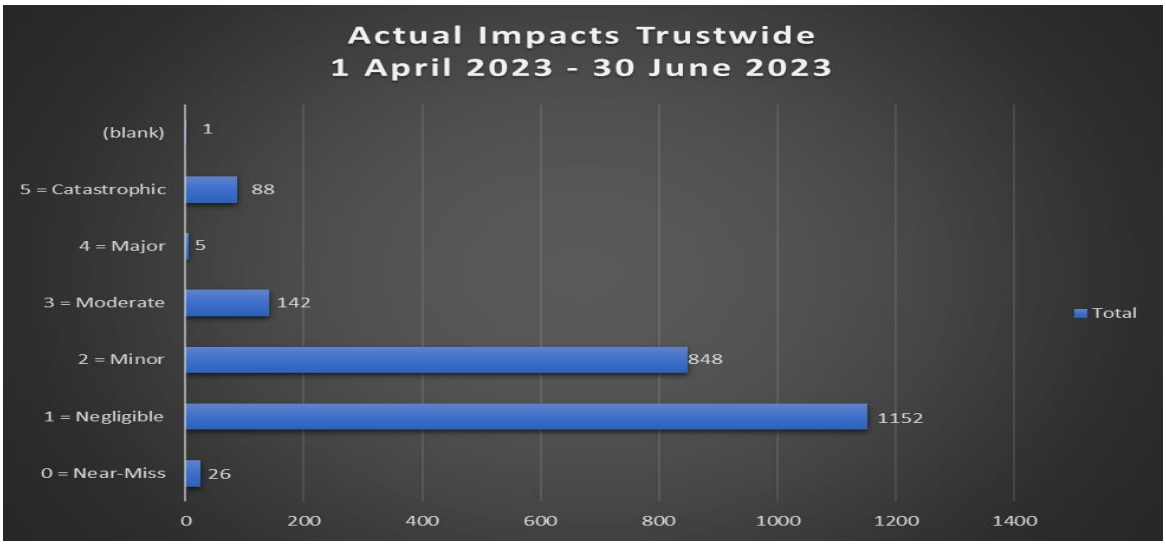


Table 5 - Top 5 incidents since April 2021

Incident Type	April 2021 to March 2022	April 2022 to March 2023	Quarter 1 (April to June-2023)
Exploitation Abuse	2963	2357	538
Medication	1234	994	229
Clinical Specific	902	1044	309

Moving & Handling	905	650	222
Slips Trips & Falls	810	696	165

4.2 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 Q1. All incidents are individually reviewed, and quality checked in line with existing policy and standards. During Q1 the DISH group directly followed up on 31% (695) of all incidents reported.

4.3 Racial and Cultural Abuse incidents were primarily reported as patient to staff incidents in bed-based services (87%). The huddle continues to note an increasing trend toward offering staff and patients directly subjected to racial and cultural abuse debrief support and support to contact the police. Reported incidents are categorised by the huddle as either a potential hate crime or as a hate incident.

All racial and cultural abuse is graded at minor (low harm) or above.The current system for grading the level of harm experienced is based on a physical harm rating therefore racial and/or cultural abuse is not appropriately graded aligned to potential psychological harm. The grading is currently under review by NHSE at a national level in order to ensure psychological harm is considered and SHSC are closely involved in this work.

In Q1 94% of incidents were considered to be of a minor impact, suggesting they were primarily hate incidents rather than hate crimes. 3 incidents of racial and cultural abuse toward staff were reported as having a moderate impact of harm and in each case the hate crime flow chart was followed, and subsequently reported to the police. There was one incident of a racially motivated physical assault on staff reported in Q1. There were no physical injuries as a result of this incident which was considered to be triggered by acute mental health deterioration requiring medical intervention.

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

4.4 Slips, trips and Falls accounted for 7% of all incidents reported in quarter 1, this reduced from 9% in quarter 4. 86% of the reported falls were from older people's services, with 66% of these being reported by the two older people's nursing homes. The hotspot for falls continues to be Birch Avenue Nursing Home which reported 50% of all falls. 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 has had a positive impact at Woodland View, G1 and Dovedale 1 where the numbers of reported falls have reduced overall.

4.5 Actual Physical Assaults on patients in bed-based environments accounted for 3% of all reported incidents in quarter 1 which has remained static since quarter 4, following a decrease from the 5% reported in quarter 3. Actual physical assaults on staff remained at 6% of all reported incidents in quarter 1.

The huddle continues to note significant increases in the use of the Brøset Violence Checklist (BVC) and subsequent use of the Pyschiatric Intensive Care pathway, de-escalation techniques and staff and patient debriefs following these types of incidents. In addition, a Quality Improvement project is underway which is seeking to improve the process for debrief and formalise the reporting arrangements so that data can be more easily captured and monitored.

Any type of abuse toward patients and staff can have a negative impact on patient safety and psychological harm cannot be underestimated, however,

92% of the incidents that were reported were given an actual impact rating of no or low harm. Only 4% of incidents were rated at a moderate level and a thematic review of these revealed that this grading was primarily related to the use of seclusion to maintain the safety of patients and staff.

4.6 1% of all reported incidents were Sexual Safety incidents which is a slight reduction from 2% in the previous quarter. 81% (22) of the incidents were reported by bed-based services. Where required sexual safety incidents resulted in a safeguarding concern being raised. All of the incidents related to patient safety were categorised as negligible in their impact. A thematic review of these incidents found that the most commonly reported incidents were related to sexualised comments, followed by disinhibited behaviour which required intervention to maintain the patient's dignity.

In quarter 1 the incident reporting system has been updated to reflect the CQC detailed reporting categories and these have been retrospectively applied to reported sexual incidents over the past year August 2022 to July 2023. This provides a more detailed baseline level of data to work with as a benchmark to note levels of reporting and improvements in quality interventions related to sexual safety. The summary findings from this indicate that the most common reasons stated for sexual behaviour is related to the mental state of the perpetrator.

4.7 Self-harming behaviour by patients in bed-based services has remained a consistent theme over all 4 quarters of 2022/23. In quarter 1 of 2023/24 76% of all the Clinical Specific category of incidents were reported as self-harm. 45% of all self-harm incidents were reported by Dovedale 2 ward. However, self-harm incidents dramatically increased in quarter 1 on both Dovedale 2 and Maple Ward. In the previous quarter Dovedale 2 reported 70 incidents of self-harm whilst Maple ward reported 18 incidents. In quarter 1 Dovedale 2 reported 107 incidents and Maple ward reported 57 incidents. Across all reporting services there was a 30% increase in self-harm incidents.

Table 6 - Self-harm by gender since January 2023

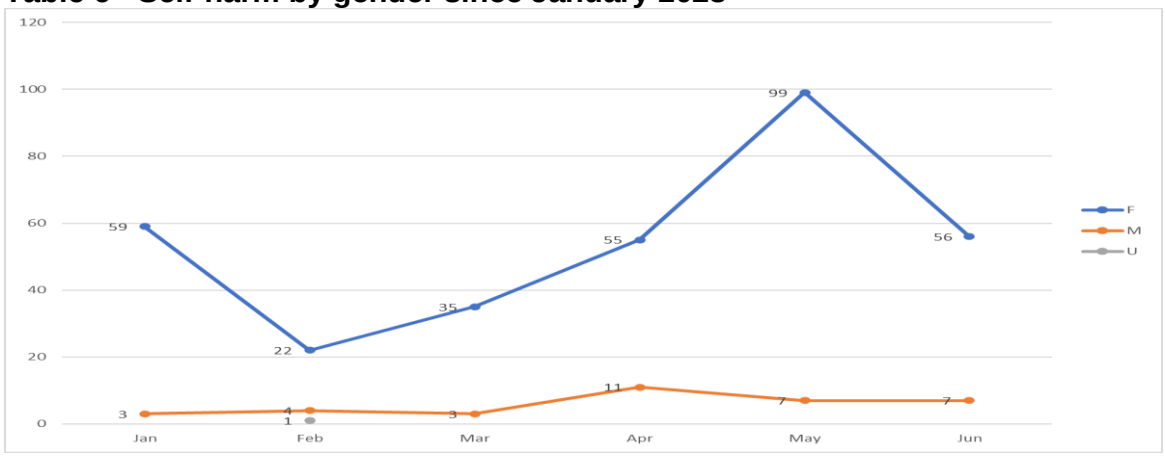
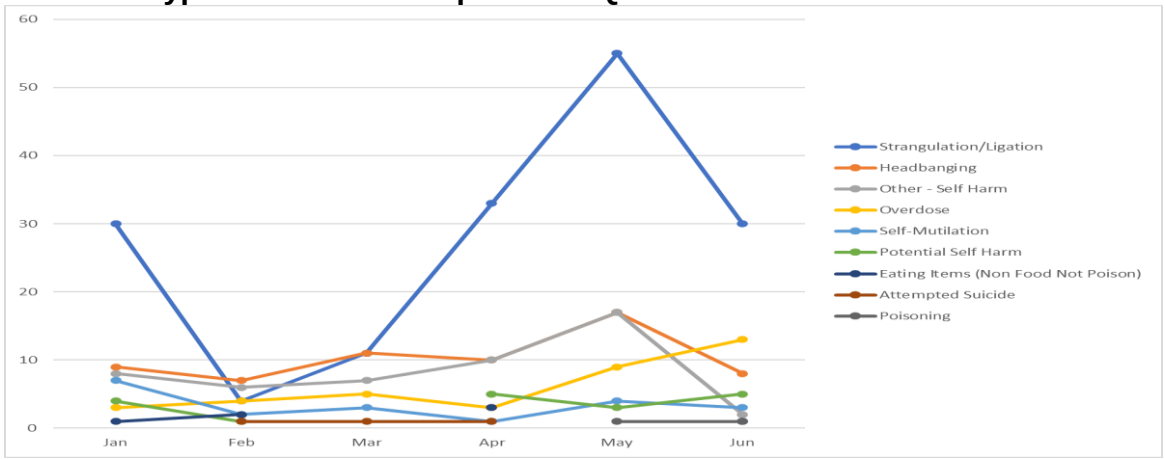


Table 7 – Types of self-harm reported in Q1



The most consistently reported incident themes related to self-harm are ligation/strangulation and headbanging often by multiple different patients on the same day. Self-harm by its very nature is a complex patient safety concern and management issue and in the majority of cases, even for those patients where close constant observations were in place, the self-harming behaviour occurred before the staff could therapeutically intervene. The narrative evidence provided through incident reports also highlights that in an effort to prevent serious self-harm restrictive practice such as restraint and rapid tranquilisation increased. However, the huddle continued to note an increase in the use of behavioral management plans, positive use of de-escalation through therapeutic engagement, safe spaces and distraction techniques.

The inpatient wards are undertaking a Quality Improvement project in the form of a feasibility trial of a Just in Time Adaptive Intervention (JITAI) to prevent self-harm events in an inpatient care setting.

4.8 Medication management incidents: as opposed to medication administration continued to be reported on a regular basis. As in quarters 2, 3 and 4 the thematic trend reflects errors in procedural systems with only 6% of medication incidents overall leading to the patient being given the wrong dose or type of medication. Of this 6% there was no recorded physical harm to the patient and in all cases the basic requirements of the statutory duty of candour were implemented by way of an explanation and face-to-face apology.
Only two medication incidents accrued actual impacts of moderate harm, and both were in relation to deliveries of medications to the nursing homes by external providers. SHSC's pharmacy team liaised with the external provider in order to resolve the issues as quickly as possible.

4.9 Drug and alcohol misuse at the Forest Close site was frequently reported in quarter 1. The incidents were primarily in relation to alcohol misuse and cannabis use on the grounds and within the buildings. As a result, the management team have liaised with the police community team, and they have agreed to come to community meetings to talk with our patients and to do a shadow shift on the wards. They have also advised that staff can report all these incidents through 101 where the criminal justice route is indicated.

Section 5: Learning from Further Investigation

5.1 **Significant Event Analysis (SEA)**

SEA 1: The Community Learning Disability Team (CLDT) reported an increased number of patients not being seen within the 18-week waiting time. On review the team identified a waiting list of 49 patients with 24% breeching the wait time. The CLDT have developed a project mandate for dysphagia assessment and introduced a high-risk category at the point of screening. The team continue to follow risk review protocols for those on the waiting list.

SEA 2: A resident at Woodland View had a significant fall. The team have developed hard copies of their daily huddle highlights, which identifies those at high risk of falling, to ensure key information is readily available to supporting staff.

SEA 3: A acutely unwell patient attempted to assault staff on G1 ward. On review the staff identified specific challenges since the removal of seclusion facilities. Whilst the staff in this case used their de-escalation skills effectively further work was identified and undertaken to develop plans for future collaborative working with external services and to consider the use of a second de-escalation space on the ward.

SEA 4: During a seclusion review on Endcliffe ward a patient reported that they had used Class A drugs and that these had been supplied by a fellow patient. Further review indicated that restricted items may have been brought to the service by visitors. As a result, the team implemented post-visit searches for restricted items, are improving their guidance of restrictive items for visitors and improved the documentation of next of kin details to ensure contact with relatives is timely.

SEA 5: A regulation breach of Use of Force policy whilst off SHSC premises was identified when it was reported that staff had used restrictive practice to prevent a patient absconding from general hospital. The team established that there is a difference in the use of restraining to convey someone to hospital and the use of restraint to prevent them leaving after arrival. The team undertook several improvement actions to prevent this happening in the future.

SEA 6: A medical emergency occurred on Maple Ward which required use of the suction machine. Tubing and mouthpiece on suction machines are single use. There was no replacement tubing or mouthpiece in stock on Maple ward. Stock checks across all areas was undertaken and where required stock was replenished. The stock checking system on the ward was found to be unclear and this was amended and shared with all staff.

5.2 **48hr Reporting**

5.3 Learning identified from the 48hr reports not taken forward for further investigation can be themed:

Theme 1: A patient was inappropriately restrained by the police on SHSC premises. Work is ongoing to improve communication with the police in regard to 136 patients and it was highlighted that staff are empowered to take control of any situation involving a potential patient safety incident for patients in their care.

Theme 2: Four periods of leave were taken by a patient without the appropriate authorization. Human error due to staffing factors was identified as the primary cause of this incident. A locum consultant has been recruited in order to support the clinical workload.

Theme 3: The level of Respect trained staff on duty fell below the approved level. The service involved was experiencing high levels of activity and this was the case across all clinical inpatient areas. The learning highlighted a need for increased due diligence by those involved in managing staff shortfalls across all services.

Theme 4: It was noted that a patient had extremely high blood pressure. Further review found that there had been missed opportunities to effectively manage the patient's physical health and non-compliance with medication. Teaching sessions by the ward medical team were provided with further planned training support from the physical health team.

Theme 5: A patient was discharged from A&E back to an SHSC acute ward. The patient was identified as having the same precipitating physical health issue. On further review learning highlighted that there had been a sub-optimal response to the physical health issue prior to transfer to A&E and then a breakdown in communication between the ward and A&E. As a result, improvements to communication and documentation were identified and addressed by the team, including a reflective practice learning session focused on decision making in emergency situations.

Theme 6: A patient broke the conditions of overnight leave by not returning to the ward as agreed and had not been in contact with his community team for 2 days. A review identified a need for improved communication with South Yorkshire Police when a patient is reported to be missing.

Theme 7: Due to the change in demeanor of 3 patients it was suspected and later confirmed that they had consumed alcohol brought onto the ward by a returning leave patient. As a result, the ward team have reviewed their process for reducing the risk of patients concealing contraband and the practice of risk assessing individual patients prior to leave. Further search training is being provided to staff.

Theme 8: A acutely unwell patient was admitted after assaulting a member of the public. The review identified a need for improved communication between community teams and flow coordinators. Going forward individual risk profiles will be discussed in all crisis meetings where decisions are made in relation to those awaiting admission.

Theme 9: A situation in the 136 suite required an emergency response, however, the emergency alarm fobs were found to be missing leading to a potential delay in response. Action was taken to mitigate this risk going forward including, scheduling checks to ensure the fobs remain in place, a review of the anti-ligature doors and a review of the system for summoning emergency assistance in that area.

5.4 **Learning from Serious Incident Investigations for Q3 2022/23**

5.5 Six Serious Incident investigations were marked as completed and sent to the ICB from January 2023 to March 2023.

5.6 **Notable Practice**

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

- Good documentation of legitimate reasons for not involving family members in specific decision making was noted.
- The care the patient received from NHS Talking Therapies (Previously known as IAPT) was of a high standard and met all of the relevant guidelines.
- Staff interviewed demonstrated that they were considering the impact of stress associated with recent circumstances, age, redundancy, separation, shame associated with recent criminal charge and a forthcoming court date.
- It is unusual for a medically unfit person to be referred to the SPA team. The medical emergency was identified and properly prioritised with appropriate action taken. The SPA team acted on previous advice to facilitate the patient getting to the Minor Injuries department rather than A&E and provided him with transport.
- It is noted that the Service User had a difficult and traumatic upbringing which affected him throughout his life. However, the care, communication and attempts to engage proactively and sympathetically with the Service User, despite his risk history, was of notable practice, particularly by the Forensic Social Worker involved.

5.8 **Lessons Learned and Actions**

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

- Investigation 1: Follow the suspected suicide of a community patient the investigation identified a need for improved communication and information sharing with neighboring mental health service providers and Service Users' GP practice. The following actions were undertaken:

- A review of procedures relating to the sharing of Mental Health Act assessments with GPs, and the robustness of these procedures.
- A review of the current Standard Operating Procedure (SOP) to ensure clarity on information sharing with neighbouring providers, in the event of an out of area Health Based Place of Safety (HBPoS) bed being utilised for a Sheffield resident.
- A review of the training provided to Approved Mental Health Practitioners (AMHPs) and s12 doctors in relation to alcohol misuse and mental health.

- Investigation 2: Following the suspected suicide of a liaison psychiatry client an investigation established that a significant factor in the client leaving the emergency department before assessment was a prolonged assessment waiting time. Work is underway to formulate contingency plans and protocols that can be enacted when the standard waiting time cannot be met. This will allow for positive engagement with those facing longer waits prior to assessment taking place and may mitigate the risk of the client leaving the department as a result of frustration.

- Investigation 3: Following the suspected suicide of a patient whilst out on unescorted Section 17 leave it was established that the Detailed Risk Assessment and Management plan (DRAM) design and format does not provide the functionality required to support clinicians in building and maintaining a structured clinical risk assessment. There is also a planned review of SHSC's Leave Policy, specifically the arrangements for informal leave processes, to simplify and agree a standard method for recording/monitoring and responding to those who do not return in line with their plan.

- Investigation 4: Following the suspected suicide of a patient in contact with the Single Point of Access (SPA) team, Substance Misuse Services and the Crisis Resolution and Home Treatment Team (CRHTT), SPA have updated their team awareness of NICE guidelines around self-harm. Work is underway to ensure that all staff are aware of which services outside of SHSC can refer to the Liaison Psychiatry team. The interface and clinical pathways between Minor Injuries at Sheffield Teaching Hospitals and SHSC are being reviewed to ensure there is clarity of communication between services.

- Investigation 5: Following a fall where a patient fractured their hip the subsequent investigation identified a need for theFalls Policy to be effectively embedded through all inpatient areas in SHSC. A number of actions are being undertaken by the Falls Reduction and Oversight Group.

- Investigation 6: Following the suspected suicide of a community patient receiving support from the CRHTT and the South Recovery team a number of actions are being undertaken as a result of the learning identified by the investigation these include:

    - The CRHTT and the Recovery teams are reviewing and formalising joint working processes and adequate handovers between the teams.
    - The allocation system in the Recovery teams is being documented as part of a SOP in order to establish assurance mechanisms that identify those that are not seen within time scales.
    - The South Recovery team are developing a system that flags a lack of contact with care coordinators in order to prevent excessive gaps between contacts. A clear system is being developed for contacts when allocated care coordinators are away from work.
    - SHSC are auditing the recent improvement work related to record keeping standards.

- The South Recovery Team are undertaking a training needs analysis.
- The CRHTT and Recovery services are reviewing processes surrounding prioritising return calls/responses to non-answered calls and non-engagement.
- The CRHTT are developing a family/carer engagement plan aligned to SHSC carers strategy managed through Directorate Integrated Performance & Quality Report (IPQR).
- The interface working with specialist services is to be identified in the community mental health transformation project.
- The model for structured clinical management (SCM) is being shared across teams including the training provided to staff and the delivery system and allocation process.

5.9.1 **Learning from S42 Enquiries:** (A section 42 enquiry relates to the duty of the Local Authority to make enquiries, or have others do so, if an adult may be at risk of abuse or neglect)

- Enquiry 1: Key learning points were identified for action following the inappropriate discharge of a patient from an out of area bed these included:

    - The SHSC safeguarding team have highlighted to the out of city provider the missed opportunity to report a suspected forced marriage and to put supportive processes in place prior to discharge.
    - The SHSC safeguarding team have retrospectively reported the suspected forced marriage to adult safeguarding authorities and to South Yorkshire Police.
    - SHSC are reviewing the current process for monitoring the progress of our service users admitted to an external provider and will make appropriate recommendations to improve current practice. This will include ensuring consideration has been given to appropriate follow up requirements and referrals made **before** discharge.

- Enquiry 2: A number of learning points were identified following an enquiry into suspected inappropriate sexual contact between two patients on Maple Ward these included:

    - The development of a record keeping SOP to ensure there are clear records regarding events, risk and changes to observation levels.

    - Continued zonal observations on the Maple ward corridor– zonal observations will continue in line with new Therapeutic Engagement policy.
    - Past risk history is to be considered at time of admission to identify if mixed ward is appropriate.
    - Handover is now online but Maple ward also use a handover book. Maple Ward are reviewing their handover process to ensure clarity and consistency.
    - The team will relaunch the Sexual Safety Policy and processes.
    - The leadership team are ensuring that staff understand and follow the incident management policy.
    - The leadership team are ensuring that the policy is reiterated during Multidisciplinary team (MDT) meetings and supervision.
    - Staff are ensuring that all safeguarding concerns are reported when disclosed and support and signposting is offered.
    - The leadership team are also ensuring that staff understand and follow the safeguarding policies, and these are reiterated to staff during MDT and supervision.
    - All sexual safety concerns are being highlighted within the DRAM to ensure safe and appropriate admission.

Section 6: Learning from Safeguarding Processes

6.1 There were no further Domestic Homicide Reviews, Safeguarding Adult Reviews or Serious Incident Reviews (DHR/SAR/SIRs) submitted to the Home Office or Sheffield Adult Safeguarding Partnership (SASP) this quarter, but 1 DHR is ready for submission to the Home Office by the Domestic Abuse Coordination Team (DACT). SHSC have completed an Individual Management Review (IMR) and chronology for 1 DHR relating to a service user who has been found guilty of the manslaughter of his parents by reason of diminished responsibility.

Professional Curiosity has been a focus of this quarter and further training tools such as 'Top Tips' and briefings for staff have been shared. Professional Curiosity is covered in Adult Safeguarding L3 training and will be included in our new L3 Safeguarding Children training. Other cross cutting themes from other areas also include transfer and sharing of information, 'Was not Brought' and hearing and listening to the voice of the person.

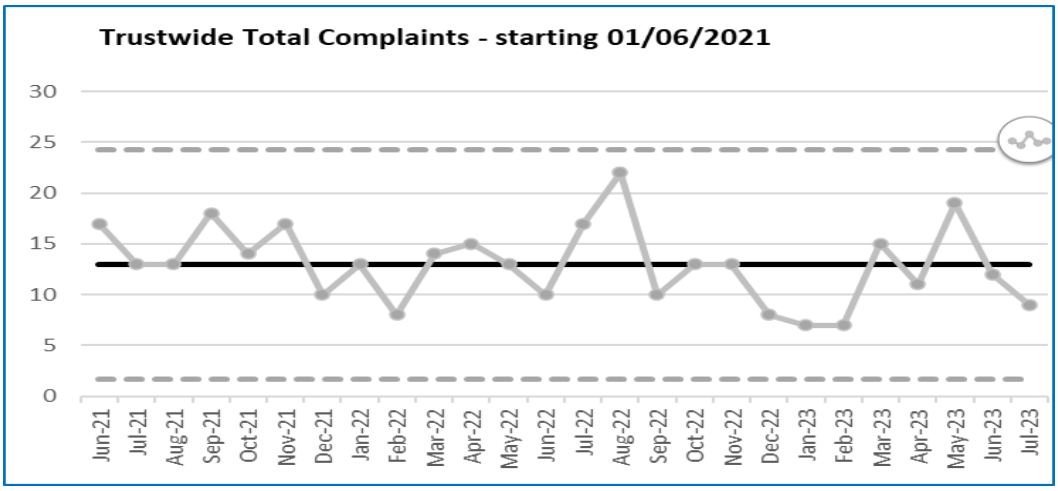
The safeguarding team have submitted 1 DHR and 2 SAR information requests for consideration in Q1.

In Q1 a total of 6 Section 42 (2) Enquiries were caused to SHSC by the Local Authority (LA). 2 enquiries were in relation to Allegations Against Staff and following fact finding were closed and returned to the LA. Following fact finding we were not able to find any information to substantiate the allegations, however, we took learning from the process. We had identified that submission of SA Concerns before fact finding had been completed had led to duplication in enquiries completed by SHSC and then requested by the LA. Following discussion with the LA we have agreed that incident forms will be completed as soon as the allegation is known, and a safeguarding concern will be completed following the initial concerns meeting and fact finding. This will ensure we are sharing accurate and detailed information with our Adult Social Care colleagues and avoid duplication of enquiries.

Overarching themes from enquiries were around neglect (either by family members or links to care and treatment) and physical harm. Themes around neglect and concerns about lack of care and treatment can often be linked to poor communication with relatives/carers. In a particular enquiry there was misunderstanding regarding Next of Kin and Nearest Relative, and frustrations arose due to lack of information being shared with whom the family thought was the correct person. There were also issues with consent to share information which were perceived as information being withheld and being kept in the dark. Early, open communication and explanation could have avoided escalation to formal enquiries.

Section 7: Learning from Complaints

Table 8 - Formal complaints since April 2021



7.1 Thirty-six formal complaints were received during quarter one (1 April 2023 to 30 June 2023), eight more compared to quarter four (1 January 2023 to 31 March 2023). Top three complaint themes for quarter one relates to 'Access To Treatment Or Drugs' (fifteen), 'Clinical Treatment' (five), and 'Communications' (five). This involves service users advising that they are unclear on what to expect from services, delays being transferred/referred to services, and lack of consistency in care treatment.

7.2 Twenty-nine complaints were closed in quarter one, which was the same volume compared to quarter four. The key lesson learnt in quarter one is that we need to improve our communication with our service user's and their families, keeping them in the loop wherever possible. A new Community Framework for Mental Health has been introduced nationally, replacing the Care Programme Approach. A major aspect of this new model is the replacing of the care co-ordinator post with a named worker. This will mean that our service users' will receive consistent care from a named worker in the future.

Table 9 – Complaints Themes

Complaint Categories	Q1 2023/24	Q4 2022/23
Access to Treatment or Drugs	15	6
Clinical Treatment	5	1
Communications	5	9
Patient Care	4	-
Values And Behaviours	4	2
Admissions and Discharges	1	2
Trust Policies	1	2
Waiting Times	1	-
Access to Records	-	1
Other	-	1
Prescribing	-	4
TOTAL	36	28

Table 10 - Complaints by team/service from 2021/22

Team/Service	No. of Complaints Recorded		
	2023/24 (Q1)	2022/23	2021/22
Mental Health Recovery Team (South)	7	30	22
SPA / EWS	6	21	22
Mental Health Recovery Team (North)	4	5	17
Eating Disorders Service	3	1	2
Endcliffe Ward	2	3	3
Gender Identity Service	2	10	9
Memory Service	2	1	2
OACMHT	2	1	-
Psychotherapy Services	2	3	3
Early Intervention Service	1	4	2
Forest Lodge	1	2	5
HBPOS (136 suite)	1	-	-
IAPT	1	4	7
Maple Ward	1	11	6
Stanage Ward	1	5	7
Autism And Neurodevelopmental Service	-	12	10
Burbage Ward	-	-	3
Central AMHP Team	-	2	2
CERT	-	-	1
CLDT	-	2	1
CRHTT	-	2	7
Decisions Unit	-	1	1
Dovedale	-	2	1
Dovedale 2	-	2	-
ECT Suite	-	-	1
Flow Coordinators	-	3	5
Forest Close	-	1	-
G1 Ward	-	2	2
Homeless & Assess Support Team (HAST)	-	1	0
Liaison Psychiatry	-	4	3
Neuro Enablement Service	-	1	-
Out Of Hours Team	-	-	1
Perinatal Mental Health	-	-	1
START Services	-	3	3

STEP	-	1	-
Woodland View	-	-	1
Total	**36**	**140**	**150**

Section 8: Learning from Blue Light Alerts

8.1 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 1 six Blue Light Alerts were cascaded to staff and services.

- Blue Light Alert 1: **Safe sharps devices**: Remedial action was undertaken after an incident involving the use of non-safe devices for the administration of Insulin highlighted that some services may still have supplies of non-safe devices within their storage areas.
- Blue Light Alert 2: **Blu tack:** A service user on an acute inpatient ward used blu tack to block/jam the bedroom door key lock, preventing staff from unlocking the bedroom door to gain entry. The blu tack was sourced from posters in the ward areas. While blu tack (and chewing gum) is a restricted item across some inpatient areas, this is not a restricted item across all units, therefore managers were asked to review their team's practice.
- Blue Light Alert 3: **Service user swallowing a door stop:** East of England Provider Collaborative shared an incident from their region of a service user swallowing a door stop. This was a wedge placed under a door to stop it from closing. Sadly, the doorstop could not be removed, and the service user died as a result. Following cascade managers and other staff were asked to ensure their clinical areas did not use these types of items.
- Blue Light Alert 4: **Knives disguised as pens:** Information was received from the Public Health lead for suicide prevention in Manchester that there have been TWO incidents where a knife, disguised as a pen have been used by patients in mental health wards to self-harm. The "pens" are purchased from a company called SHEIN for less than £1. Following cascade staff in all services were asked to familiarise themselves with the pictures of these items and follow correct sharps disposal process if any were discovered.
- Blue Light Alert 5: **En-suite tamper screw fixed ligature risk.** It was identified through an inpatient incident that a service user managed to ligate using what is termed an anti-ligature piece of equipment. The incident occurred in the Health Based Place of Safety 136 suite where the service user managed to access the tamper proof screws in the hinge housing of the en-suite anti-ligature toilet door and used this in an attempt to ligate. The exposed screws provided a weight bearing fixed ligature anchor point. Immediate action was taken to review all doors across the estate alongside a range of mitigating actions implemented across all services.
- Blue Light Alert 6: **Scoring of the DASH Risk Assessment:** A Domestic Homicide Review (DHR) has highlighted the need for improved scoring of the Domestic Abuse, Stalking, Harassment and Honor Based Violence Assessment (DASH) Risk Assessment Form. Following cascade all staff were provided with guidance in order to ensure we score the DASH appropriately.

Section 9: CQC Enquiries

9.1 Seventeen enquiries were received from the CQC between 1 April 2023 – 30 June 2023.
All seventeen enquires were acknowledged within the standard of 2 working days. 13 were closed and/or submitted but awaiting confirmation of closure from the CQC. 4 remain open – 2 of these are ongoing S42 enquiries that are highlighted in

this report, 1 is an ongoing DHR and 1 an ongoing Trust Serious Incident investigation this is related to the death of a staff during training.

Section 10: Summary

10.1 During quarter 1 2023/24 a range of governance and oversight processes ensured that SHSC successfully monitored and responded to patient safety concerns and patient safety incidents. The quantitative and qualitative data provided supports the assertion that we have a low threshold for reporting incidents and that when incidents do occur, they are primarily no harm or low harm incidents.

10.2 Over the course of quarter 1 patients in our inpatient settings have faced similar risks to those that they have faced in previous quarters, for example falls and medication errors. In addition, some unsafe behaviours associated with serious mental health problems for example self-harm, and the measures taken to address these, such as restraint, have undoubtedly resulted in further risks to patient safety. In response to these patient safety risks there are a number of live quality improvement projects that aim to reduce any potential harm to the patient. Alongside these quality improvement projects the narrative data available clearly indicates that overall, there is an increasing trend toward reducing restrictive practices, offering trauma informed care, use of person-centred de-escalation techniques and safe spaces and patient and staff debriefs. Incident reports demonstrate that our inpatient settings pose unique challenges for patient safety, which require ongoing quality improvement support and translation into safety conscious clinical practice.

10.3 From a community mental health perspective quarter 1 highlight's that ongoing quality improvement projects related to issues such as communication, waiting lists, allocation of care coordinators and engaging with families and carers are yet to fully have the desired impact.