Sheffield Health and Social Care NHS Foundation Trust

# Board of Directors - Public

| SUMMARY REPORT | Meeting Date: | 27 March 2024 |
|---|---|---|
| | Agenda Item: | 12 |

| | | |
|---|---|---|
| **Report Title:** | **Patient Safety Report - Learning and Safety Report (Q3)** | |
| **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** | Clinical Quality and Safety Group (CQSG)<br>Quality Assurance Committee (QAC) |
| | **Date:** | 27 February 2024 (CQSG)<br>13 March 2024 (QAC) |
| **Key points/ recommendations from those meetings** | The report was circulated to the Clinical Quality and Safety group membership following the meeting.<br>Discussion took place at Quality Assurance Committee in relation to how Patient Safety Incident Response Framework (PSIRF) was being received by families, patients and the coroner in relation to serious incidents. Assurance was received that no issues had been raised to date. The patient safety specialist meets with the coroner to discuss our approach to investigations when required. | |

**Summary of Key Points in Report**

**Key points for this quarter:**

- Formal governance systems related to the transition to PSIRF have oversight of all patient safety incidents.
- The number of formal 'Serious' Incident Investigations, now called Patient Safety Incident Investigation (PSII) are decreasing whilst broader spectrum learning via Local Learning Reviews (LLR) and Local Learning Responses (LLR) are increasing.
- Low threshold reporting remains at a consistent level.
- Falls and physical assaults and sexual safety incidences remain static in number whilst incidences of self-harm continue to increase.

**Recommendation for the Committee to consider:**

| Consider for Action | | Approval | | Assurance | X | Information | |
|---|---|---|---|---|---|---|---|

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

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

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

| | | | | |
|---|---|---|---|---|
| Effective Use of Resources | *Yes* | ***X*** | *No* | |
| Deliver Outstanding Care | *Yes* | ***X*** | *No* | |
| Great Place to Work | *Yes* | ***X*** | *No* | |
| Ensuring our services are inclusive | *Yes* | ***X*** | *No* | |

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

# Learning and Safety Report: Quarter Three 2023/24

**Foreword**

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

Key PSIRF aims include:

- Having a broader range of responses to incidents, not just formal 'Serious Incident' investigations.
- Developing a proactive strategy for learning from patient safety incidents.
- Engaging meaningfully with staff, patients and their family when patient safety incidents happen.
- Acknowledging system failings rather than casting blame on individuals.
- Making better use of data, especially looking at what works well.
- Supporting appropriate and adequate patient safety training where it is needed.
- Applying focused work into areas in which the most impact may be achieved.

Although initially, Trusts were informed they were no longer required to report 'serious' incidents via the national Strategic Executive Information System (StEIS), guidance has since changed and Trusts are still required to do this until new reporting mechanisms have been established.

Under the former serious incidents (SIs) regime, 37 actions relating to 9 SIs remain outstanding passed their due date as at 31 December 2023; the majority of these relate to three teams SPA/EWS, North Recovery Team and CRHTT. These actions are being actively progressed through the Governance Team, 4 of these relate to the roll-out of Rio.

# Section 1: Q3 Patient Safety Specialist: Learning and Safety Report

## 1.1 Executive Summary

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

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

    - Racial and Cultural Abuse
    - Fall prevention.
    - Violence and Aggression.
    - Sexual Safety

- Self-harm
- Medication errors

- Learning from patient safety incidents highlights that there is a continued need for focus on improving communication with patients and their family, between SHSC teams and with external partner agencies.

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

# Section 2: Introduction

2.1 **Purpose of Report**

This report seeks to offer assurance that:

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

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

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

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

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

| **Financial year** | **2020/21** | **2021/22** | **2022/23** | **2023/24** | **Total** |
|---|---|---|---|---|---|
| No. Reported | 8222 | 8440 | 8521 | 6809 | **31992** |
| **4 Quarters** | **Q4 2022/23** | **Q1 2023/24** | **Q2 2023/24** | **Q3 2023/24** | **Total** |
| No. Reported | 2036 | 2262 | 2289 | 2258 | **8845** |

3.2 Learning Responses actioned in Q3.

| **Type of Response** | **2023/24 Q1** | **2023/24 Q2** | **Oct 23** | **Nov 23** | **Dec 23** | **2023/24 Q3 Total** |
|---|---|---|---|---|---|---|
| **48hr Reports** | 49 | 58 | 17 | 18 | 14 | 49 |
| ***LLR's** | 18 | 11 | 5 | 1 | 3 | 8 |
| **Patient Safety Incident Investigations (PSII) Declared** | 10 | 7 | 0 | 0 | 0 | 0 |
| **Manager Incidents reviews completed.** | 2215 | 2108 | 757 | 730 | 548 | 2035 |
| **Incidents** | 695 | 739 | 224 | 247 | 229 | 700 |

| | | | | | | |
|---|---|---|---|---|---|---|
| **followed up by the Daily Incidents Safety Huddle (DISH)** | | | | | | |
| **Blue Light Alerts** | 6 | 3 | 0 | 1 | 3 | 4 |

*Local Learning Review (LLR). This process is used for team/service level learning investigations/reviews/responses.

3.3 Key points to consider from the data provided:

- The overall number of incidents reported over the last 3 financial years and the last 4 quarters has **remained stable** with no significant variation and with a mean number of 2211 incidents reported each quarter.
- No Patient Safety Incident Investigations (PSII's) were declared in quarter 3. This is in line with the expectation that this type of learning response will significantly reduce post PSIRF implementation.
- All patient safety incidents reported as having a catastrophic impact were in relation to death and 73% of these were either suspected or known to be due to natural causes. All deaths were reported by community-based services (including nursing home deaths (N6)). All deaths from suspected suicide (5%) were subject to individual due diligence and where required a 48hr report was completed. 5% of reported deaths were in relation to substance misuse clients. These services are no longer commissioned from SHSC, accounting for the reduction in the number of reported deaths overall. However, SHSC continues to monitor coronial processes associated with substance misuse patients that previously had open episodes of care.
- 77% of all reported incidents can be traced to bed-based services. 72% of all incidents were reported by acute and community services. Rehabilitation and specialist services accounted for 25% of all incidents reported. 3% of incidents were reported by non-clinical services, including pharmacy services.
- 88% of all incidents reported were in the no harm (near-miss, negligible) or low harm (minor) categories of actual impact.

3.4 Of the 8 LLR's requested in quarter 3:

- 1 was related to the incorrect dose of medication being administered to a patient.
- 1 was related to an external breach of patient confidentiality.
- 1 was related to a lack of appropriate equipment on an inpatient ward.
- 1 was related to the delayed availability of an inpatient bed.
- 1 was related to self-harm.
- 2 were in relation to patient falls.
- 1 was related to an unsafe patient environment.

Learning themes from 3 outstanding local investigations will be presented in the Q4 2023/24 learning and safety report.

**Tables 1 - Types of Patient Safety Incident Investigations since July 2020 by year**

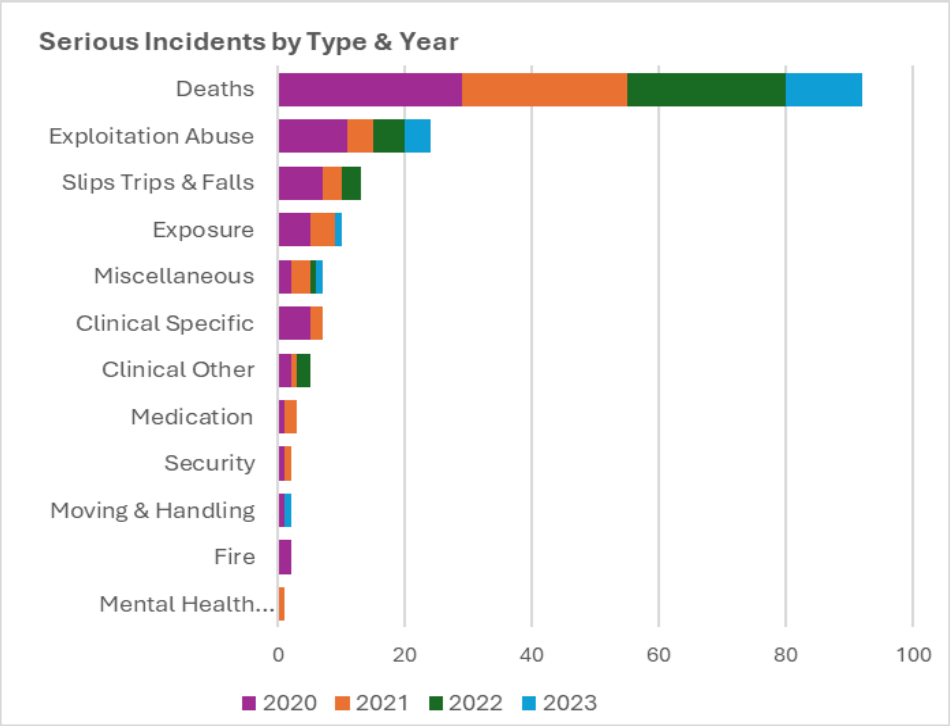
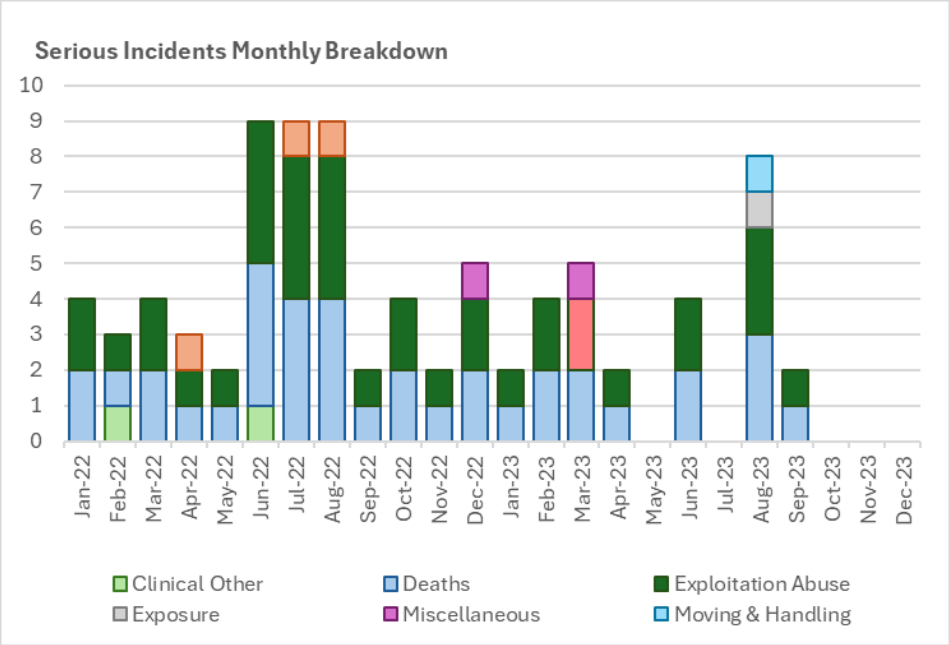



**Table 2 - Types of Patient Safety Incident Investigations since January 2022 by month**



# Section 4: Incident reporting and Learning from Incidents

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

This is supported below in the following 2 tables which indicate that there has been no significant variation in reporting since quarter 1, 2021 and that 90% of SHSC incidents in Q3 are in the low patient harm (minor) or no patient harm (negligible) category.

**Table 3 - All incidents reported since January 2020:**

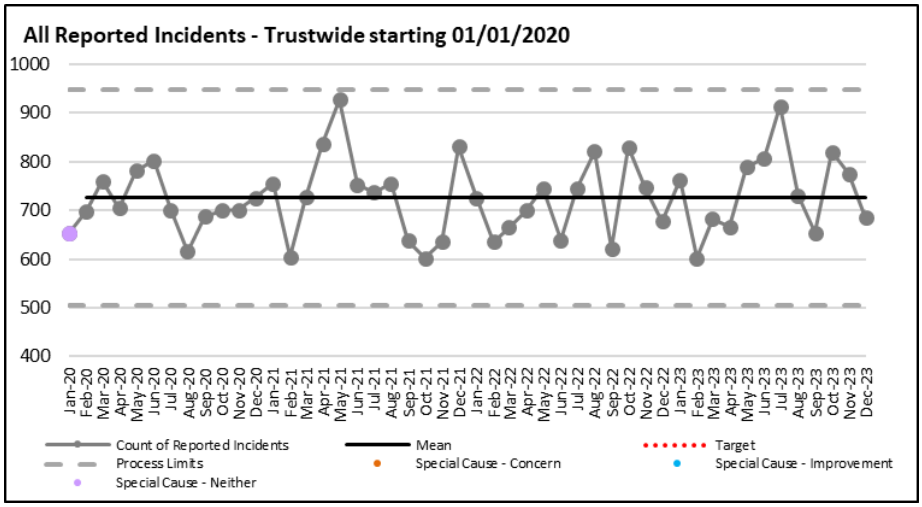


**Table 4 - Actual impact of incidents being reported in Q3:**


# Section 5: Daily Incident Safety Huddle (DISH) Learning Themes Q3

**Table 5 - Top 5 incidents since April 2021**

| Incident Type | April 2021 to March 2022 | April 2022 to March 2023 | Quarters 1, 2 & 3 (April to December-2023) |
|---|---|---|---|
| **Exploitation Abuse** | 2963 | 2357 | 1865 |
| **Medication** | 1234 | 994 | 705 |
| **Clinical Specific** | 902 | 1044 | 803 |
| **Moving & Handling** | 905 | 650 | 507 |
| **Slips Trips & Falls** | 810 | 696 | 449 |

5.1 The DISH group, consisting of key individuals including the Patient Safety Specialist (chair), consultant nurse for Restrictive Practice, the Safeguarding team, the Health and Safety team, Physical Health leads and Pharmacy, reviewed 100% of incidents reported within 24 working hours in Q2. All incidents are individually reviewed, and quality checked in line with existing policy and standards. During Q3 the DISH group directly followed up on 31% (700) of all incidents reported.

5.2 Racial and Cultural Abuse incidents were primarily reported as patient to staff incidents in bed-based services (80%). The huddle noted a continued trend toward offering staff and patients directly subjected to racial and cultural abuse debrief support and support to contact the police. Reported incidents are categorised by the huddle as either a potential hate crime or as a hate incident.

In Q3 96% of incidents were considered to be of a minor impact, suggesting they were primarily hate incidents rather than hate crimes. 2 incidents of racial and cultural abuse toward staff were reported as having a moderate impact of harm. One of these incidents was a repeated incident of racial abuse received on a staff member's mobile telephone. The member of staff was given support following this. The second incident was reported racial abuse toward a staff member by another staff member. Support was given to the victim and action is being taken, aligned to the disciplinary policy, to address this with the alleged perpetrator of the abuse.

There were five incidents of racially motivated physical assaults reported in Q3. 4 of these were patient to staff assaults and 1 was a patient-to-patient assault. There were no physical injuries as a result of these incidents and all five were considered to be triggered by acute mental health deterioration requiring medical intervention. In total there were 6 incidents of racial and cultural abuse that were patient-to-patient incidents. In each case the victim was supported by staff and provided with the opportunity to report the abuse to the police. A thematic review of all of the racial and cultural abuse incidents revealed that action was taken to challenge the perpetrators of abuse in 100% of the incidents. 76% of the victims of racial and cultural abuse were offered support to report the incident to the police. 93% incidents highlighted that the victims were offered post incident support and 10% highlighted that the hate incident flow chart had been followed.

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

5.3 Slips, trips and falls accounted for 7% of all incidents reported in quarter 1 2023/24, this reduced to 6% in quarter 2 2023/24 and has remained static at 6% in quarter 3 2023/24. 87% of the reported falls were from older people's services, with 73% 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 49% of all falls, however, overall, there continues to be a downward trend in falls at Birch Avenue in quarter 3. There were no fractures following a fall reported by any services in quarter 3.

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

5.4 Actual Physical Assaults on patients in bed-based environments accounted for 3% of all reported incidents in quarter 3 2023/24 and this number has remained static since a decrease from the 5% reported in quarter 3 2022/23. Actual physical assaults on staff accounted for 7% of all reported incidents in quarter 3. In all cases, where a patient was subject to physical assault the Safeguarding Adults team in SHSC were notified and external safeguarding referrals were made where required.

Any type of abuse toward patients and staff can have a negative impact on patient safety and psychological harm cannot be underestimated, however, 91% of the incidents that were reported were given an actual impact rating of no or low harm. Only 8% 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 (80%) to maintain the safety of patients and staff.

In quarter 3 one incident was reported as having a major impact. During a clinical procedure the demeanor of the patient changed rapidly and as a result a staff nurse was harmed when the patient plunged their injection needle 4 times into the stomach of the administering nurse. Immediate medical attention was sought, and the injured member of staff was admitted for hospital treatment. Whilst the staff member currently remains off work ongoing supportive contact has been provided and the incident has been reported directly to the police. Violence can cause physical injuries but can also have psychological consequences on staff victims which include anger, fear, anxiety post-traumatic disorder symptoms, guilt, self-blame, decreased job satisfaction and increased intent to leave the organisation among others. To this end, the DISH closely monitors post-incident manager reviews with the aim of checking the effectiveness of interventions that have been put in place to support staff victims of violent and aggressive behaviour.

5.5 2% of all reported incidents were Sexual Safety incidents, of which only three incidents involved actual physical contact between patients. One was reported as a patient holding onto the arm of another, the second was in regard to two patients holding hands and the third was in regard to one patient touching the covered bottom of another patient and making suggestive remarks. Appropriate action was taken to safeguard all of the vulnerable adults involved in these incidents. One reported incident in quarter 3 was a staff to patient

sexual safety incident. Due diligence, fact finding and safeguarding processes were undertaken to ensure the safety of the individual patient.

68% of incidents were patient to staff sexual safety reports. 100% of these were categorised as no harm of low harm incidents with the highest proportion being verbal sexual abuse and/or intimidation. Appropriate support was given to staff in each case and the alleged perpetrator was informed that their behaviour was inappropriate directly. 95% (53) of the incidents were reported by bed-based services.

5.6 Self-harming behaviour by patients in bed-based services was 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, rising to 79% in quarter 2 and 85% in quarter 3. 60% of all self-harm incidents were reported by Dovedale 2 ward.

**Table 6 - Self-harm by gender since January 2022**

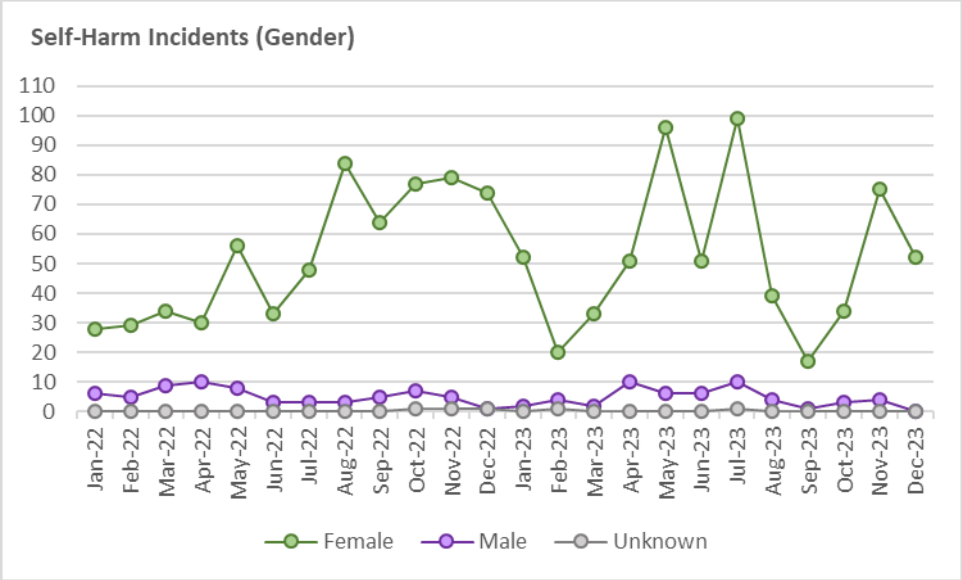



**Table 7 – Self-harm by ethnicity since January 2022**

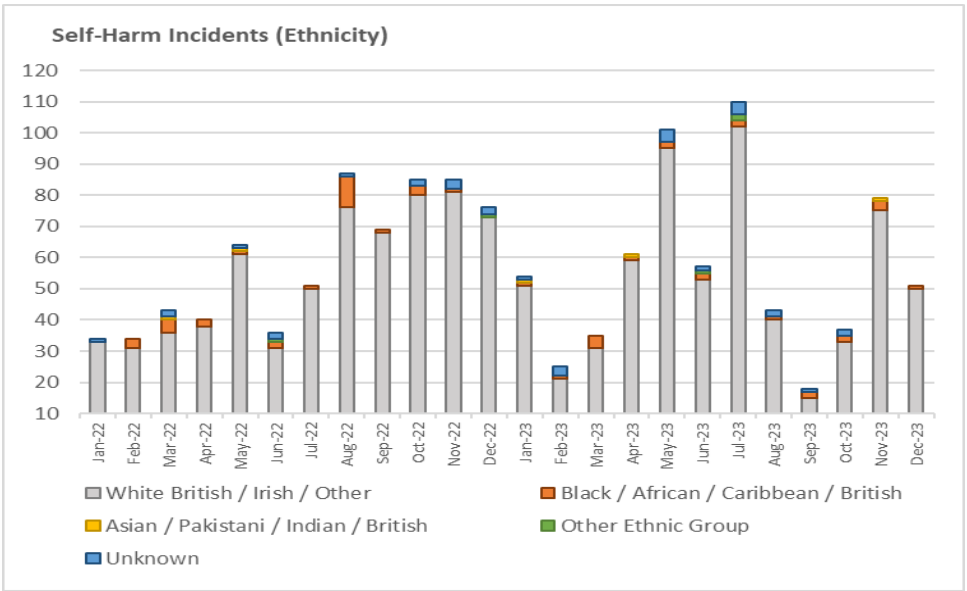


**Table 8 – Types of self-harm in quarter 3**

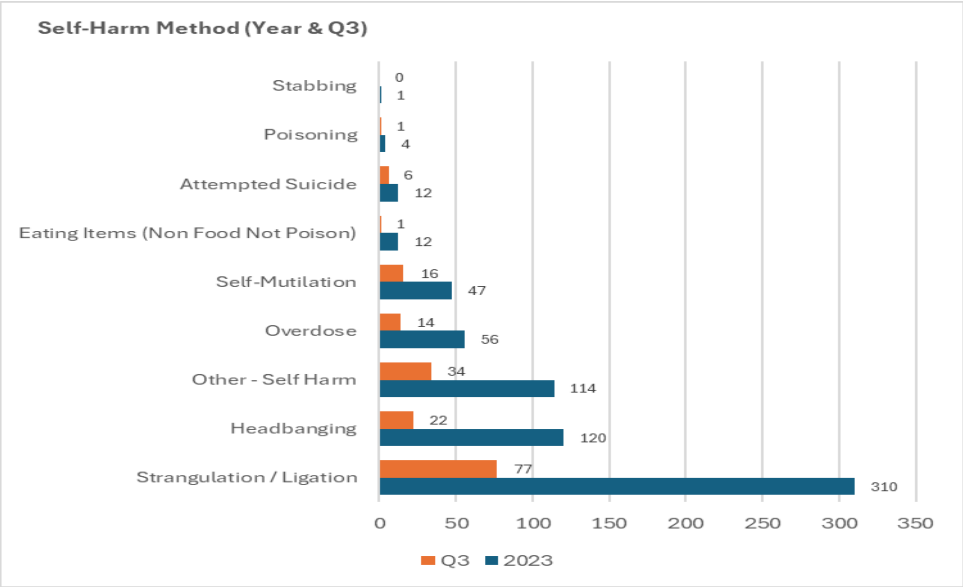
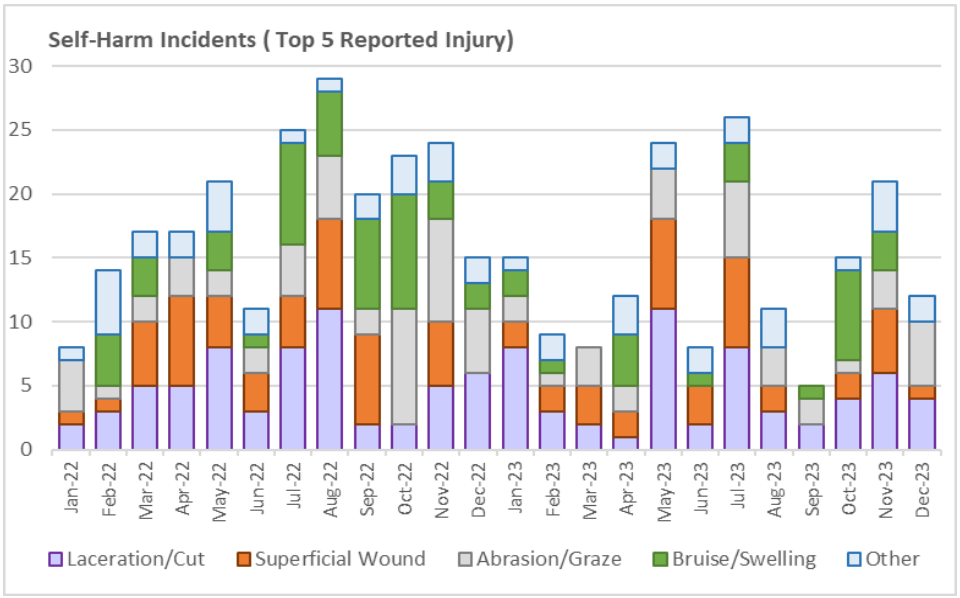



**Table 9 – Types of self-harm injury since January 2022**




5.7 Female patients with a White/ British/Irish/ Other ethnicity are the demographic with the highest reported self-harming behaviour, leading to a range of injuries. A thematic review of individual patients that self-harmed in quarter 3 revealed that a common association across the demographic was previously reported early life trauma and a diagnosis of a personality disorder type. The most consistently reported incident themes related to self-harm are ligation/strangulation and headbanging. The thematic review also revealed that in a high number of cases, where one type of potential self-harm is mitigated or removed by staff an alternative form of self-harm is utilised by the patient. It is an SHSC policy requirement that nursing staff undertake neuro observations as part the ward-based post incident interventions for ligation and headbanging incidents. Staff will complete a NEWS2 or Non-contact NEWS2 every time a patient uses a ligature or headbangs. The Physical Health team works collaboratively with the Clinical Risk Advisor and the respective team leaderships to support the nursing staff and to monitor compliance with this requirement. They also attend the wards regularly to provide ad hoc neuro-observation and self-harm risk management coaching.

The narrative evidence provided through incident reports and managers reviews continues to highlight that to prevent serious self-harm, restrictive practices such as restraint, use of the safety pod and rapid tranquilisation are frequently used as a preventative last resort.

The thematic review continued to note an increase in the use of behavioral management plans, positive use of de-escalation through therapeutic engagement, safe spaces and distraction techniques.

In quarter 3 the thematic review revealed a number of patient safety issues related to patients attempting to self-harm whilst on escorted leave, either in the community or at Sheffield Teaching Hospital sites. These incidents can be extremely challenging for escorting staff as in some instances there has been a need to restrain the patient to protect them from harm. In one reported incident a patient climbed an external fire escape with the intention of jumping off and as a result was restrained by a member of staff and a passing member of the public until assistance arrived. In another example a member of staff was injured whilst trying to safely remove a patient from a busy main road before they could be struck by traffic. As a result of these incidents learning responses have been planned and support and guidance has been provided to teams in regard to the use of the Mental Health Act outside of SHSC premises. Each reported restraining incident, including any restraint involving Secure Transport Conveyances, is reviewed by the Lead for Restrictive Practice to ensure that appropriate support is offered to the teams, staff and patients involved.

5.8 Medication management incidents: as opposed to medication administration continued to be reported on a regular basis. 99% of all medication incidents were reported as no harm or low harm. As in quarter's 1 and 2 the thematic trend reflected errors in procedural systems with only 5% of medication incidents overall leading to the patient being given the wrong dose or type of medication. Of this 5% there was no recorded physical harm to the patient and in all cases the basic requirements of the statutory duty of candour were implemented by way of an explanation and face-to-face apology. The most frequently reported incidents were related to storage fridge and room temperature fluctuations and missing second signatures for controlled drugs (25%).

Only three medication incidents accrued actual impacts of moderate harm. All three were related to prescribing errors. One titration error led to a patient being given more medication than originally prescribed and this incident was subject to a formal learning review in collaboration with pharmacy. The patient was not harmed, and medical monitoring was undertaken appropriately.

# Section 6: Learning from Further Investigation

6.1 **Local Learning Reviews in quarter 3 (LLR)**

LLR 1: Prescription - Wrong Medication Prescribed. A patient on an acute ward was incorrectly administered variable doses of medication. The subsequent learning undertaken identified a need for further training on the difference between specific medication preparations, the need for clearer documentation and a requirement to avoid titrating medication at a weekend when there is decreased specialist support. Human error on the part of the pharmacy and medical team was identified as a contributing factor in this incident, this was addressed by specific supervision.

LLR 2: External Breach of Patient Confidentiality. Patient information was sent to the wrong address on eight occasions. Measures have now been put in place by the team to ensure that due diligence is undertaken before any correspondence is sent.

LLR 3: Suspected/Reported Fall. A patient with a diagnosis of dementia was admitted on a section: 136 to the Health Based Place of Safety. During their time there the patient became physically unwell and experienced a fall. The learning being undertaken identified gaps in staff knowledge around physical health monitoring. Unplanned changes to staffing levels due to clinical need were also found to have impacted on the delay in responsiveness in this situation.

LLR 4: Beds Lack of /delayed Availability. A patient with a community treatment order requiring a bed was reported to have deteriorated in the community.

Whilst the Local Learning Review was able to establish that the patient wasn't significantly harmed by the delay, action was undertaken to review flow meetings and the clinical standards for those awaiting admission.

LLR 5: Self -Harm -Poisoning. A patient that had been recently discharged drank anti-freeze and was admitted to intensive care. The learning identified related to pre-discharged communication and planning between the inpatient and community services. A focused After Action Review (AAR) is planned for March 2024 with the Directorate Leadership Team and services involved.

6.2 **48hr Reporting**

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

Theme 1: Mental Health Act Legislation: Four 48hr reports were requested during Q3. Key learning themes included a need for more effective communication and improved documentation. Failure to follow procedure was found to have led to the delay in an application of legal powers and lack of understanding of the Nearest Relative Order.

Theme 2: Seclusion Review Breach: A range of learning actions were undertaken to ensure that the correct procedure for seclusion review is undertaken, including specific reference to this in individual clinical supervision. The Duty of Candour guidance was implemented for the individual being secluded at the time of the incident.

Theme 3: Clinical Other: There were three 48hr reports that highlighted learning in regard to communication, procedural guidance, physical health monitoring and clinical record keeping. A range of learning actions were undertaken with induvial teams to address these issues including specific input from the physical health team.

Theme 4: Medication Management: Two 48hr reports highlighted a need for staff training in regard to implementing contingency plans for sourcing medication out of hours. Support is being offered to staff around the procedure for accepting medication deliveries and the secure transport guidance is being reviewed in relation to the safe delivery of medication.

Theme 5: Self-harm: Eight 48hr reports found several common learning points including a need for improved communication and documentation. The Ligature Achor Point Assessment process is being reviewed in order that our processes reflect those recently published by the CQC. Planning is being undertaken by the Health and Safety team to develop simulation learning sessions in relation to emergency responses. Attendance at daily safety huddles has been reviewed to ensure all members of the team attend the huddles. The transfer checklist used when patients move between wards has been reviewed to ensure they clearly reflect all medication that is being transferred.

Theme 6: Physical Assaults: Work has been undertaken with the safeguarding team to ensure that appropriate management plans are in place when two service users have the potential to come into conflict. Teams are ensuring that where patients and/or staff are assaulted supportive debriefs are offered in a timely way.

Theme 7: Seclusion 'guesting': Endcliffe ward have undertaken a review of their procedures and are developing a Standard Operational Policy (SOP) around what actions can be undertaken when their seclusion facilities are full. A RAG rating process is to be included in the PICU pathway escalation process to ensure effective communication when the demand for seclusion, due to acuity, is high.

Theme 8: Physical Restraining / use of reasonable force in a public place. Further training and coaching is being given to the nursing team around S17 leave risk assessments, including providing feedback from incidents occurring on previous leaves rather than just including the patients presentation during time of assessment. Further training is being planned for maintaining patient safety when physical interventions are needed for a patient in the community.

6.4 **Learning from Serious Incident Investigations for Q2 2023/24**

6.5 Two Serious Incident investigations were marked as completed and sent to the ICB from July 2023 to August 2023.

6.6 **Notable Practice**

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

- There was evidence of clear communication between the GP, the family and the Community Mental Health Team in regard to the patient's needs.
- Good documentation of the reasons for discharge back to the Community Mental Health Team

6.8 **Lessons Learned and Actions**

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

- Investigation 1: Following the suicide of a community patient the team are undertaking audit reviews to ensure that the recently ratified Standard Operating Procedure for clinical record keeping, currently being rolled, out is embedded effectively within the Recovery Team. Safety planning documentation requirements are also being reinforced within the team.
- Investigation 2: Following the suicide of a patient recently discharged from Sheffield Teaching Hospitals the team identified a missed opportunity for effective communication regarding the proposed discharge. It was felt that an earlier specialist metal health assessment of the patient may have identified their intention not to comply with physical health treatment.

## Section 7: Learning from Safeguarding Processes

7.1 The Domestic Homicide Review for 'Leah' has been completed and returned from the Home Office. This DHR will not be published or shared with the DHR repository due to the sensitivities of the case and the perpetrator being at large in the community. However, the learning brief is available on our Jarvis links to the DACT and can be found here DHR-S-Leah-Learning-Brief-Final.pdf (sheffielddact.org.uk).

In summer 2020 'Leah', a mother and a victim of domestic abuse, died by suicide following an overdose of prescription drugs and alcohol. Her partner had breached a 14-day Domestic Abuse Violence Protection Order (DVPO) and he was with 'Leah' leading up to her death. The breach of the DVPO had not been reported to police by 'Leah' or by professionals. 'Leah' and the perpetrator had both been through a number of adverse experiences (ACE's) from early on in their lives. Missed opportunities were identified in relation to these past adverse experiences and professionals understanding how this affected their ability engage in healthy relationship and what opportunities they had to engage as young people and offer them early interventions.

Agencies did not fully address the risk of suicide as a possible outcome of the domestic abuse she was experiencing and there was an overemphasis that her children were a protective factor. 6 weeks prior to her death, 'Leah' had retaliated, and the incident was assessed as high risk which led to her being referred to MARAC as a perpetrator. This was despite numerous previous incidents where she had been the victim. The learning brief and our L3 safeguarding training encourages professionals to consider self-defense/violent resistance when women apparently perpetrate domestic abuse.

7.2 The Domestic Abuse Coordination Team (DACT) have completed a Best Practice Guidance tool on Mental Capacity and Coercive Control. This has been reviewed by SHSC Head of Safeguarding and Head of Mental Health Legislation. Assessing capacity where there are concerns about coercive control can be difficult and the guidance will support staff to understand undue influence. The final version can be shared in the next quarter.

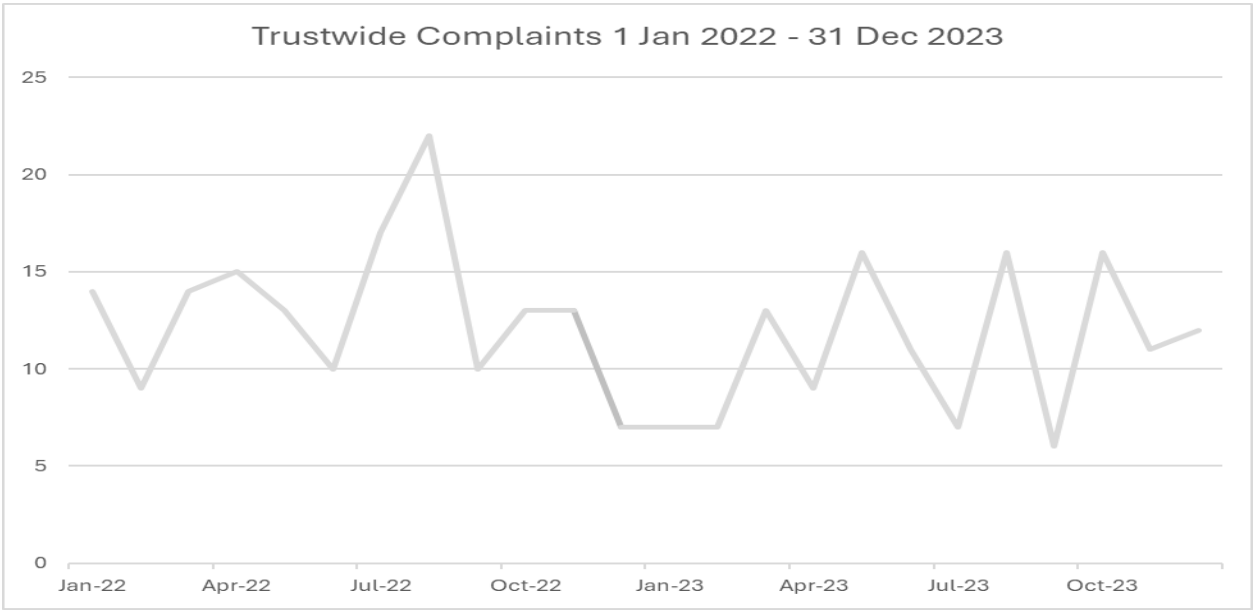
7.3 In Q3 a total of 14 Section 42 (2) Enquiries were caused to SHSC by the Local Authority. 2 enquiries were in relation to Allegations Against Staff and following fact finding were closed and returned to the LA.

Overarching themes this quarter were around physical harm (allegations of abuse by staff or peers and service users coming to physical harm due to poor care) and concerns regarding care and treatment (medication, inappropriate setting). 5 enquiries were caused from external referrals (2 Family member via the LA, 1 Family member via Complaint, 2 x STH).

- Previous Organisational Safeguarding investigation for Woodland View has now been closed.
- An Organisational Safeguarding was considered in relation to Birch Avenue due to concerns being raised about staff conduct. A meeting was held with LA and ICB colleagues and agreed to close following assurances of actions already taken through HR processes.

## Section 8: Learning from Complaints

**Table 9 - Formal complaints since January 2022**




39 formal complaints were received during quarter three (1 October 2023 to 31 December 2023). This is an increase on the previous quarter (29 complaints received). The top complaint themes for quarter three were "Access to Treatment or Drugs" (15 complaints), "Patient Care" (6 complaints) and "Values and Behaviours" (5 complaints).

32 cases were closed in quarter three, 7 of these were complaints that were withdrawn by the complainant. This is a slight decrease over the quarter two closure rate (36). Out of the 25 complaints that were closed during quarter three 21 (84%) were closed within agreed timescales, with 4 (16%)

closed after agreed deadlines. 10 complaints were not upheld (40%), 9 complaints were partially upheld (36%) and 6 complaints (24%) were fully upheld.

**Table 10 – Complaints Themes**

| Complaint category | Q2 2023/24 | Q3 2023/24 | |
|---|---|---|---|
| Access to Treatment or Drugs | 5 | 15 | ↑ |
| Admissions and Discharges | 4 | 3 | ↓ |
| Clinical Treatment | 3 | 2 | ↓ |
| Communications | 11 | 4 | ↓ |
| Other | 0 | 1 | ↑ |
| Patient Care | 0 | 6 | ↑ |
| Prescribing | 0 | 2 | ↑ |
| Trust Policies | 1 | 0 | ↓ |
| Values and Behaviours | 4 | 5 | ↑ |
| Waiting Times | 1 | 1 | - |
| Total | 29 | 39 | ↑ |

8 out of the 15 complaints received during the quarter (relating to 'access to treatment or drugs'), were received in December 2023 and were attributed to mainly the Sheffield Adult Autism and Neurodevelopmental Service (SAANS), SPA/EWS and the Mental Health Recovery Teams.

**Table 11 - Complaints by team/service from 2021/22**

| | Number of complaints recorded | | | |
|---|---|---|---|---|
| **Team/Service** (In order of 2023/24 Year to Date total) | 2023/24 (Q3) | 2023/24 (YTD) | 2022/23 (Total) | 2021/22 (Total) |
| SPA / EWS | 5 | 14 | 21 | 22 |
| Mental Health Recovery Team (South) | 3 | 12 | 30 | 22 |
| Mental Health Recovery Team (North) | 2 | 8 | 5 | 17 |
| Memory Service | 2 | 5 | 1 | 2 |
| Eating Disorders Service | 2 | 5 | 1 | 2 |
| Liaison Psychiatry | 5 | 5 | 4 | 3 |
| Psychotherapy Services | 1 | 4 | 3 | 3 |
| Maple Ward | 2 | 4 | 11 | 6 |
| Burbage Ward | 2 | 4 | - | 3 |
| CRHTT | 1 | 4 | 2 | 7 |
| Early Intervention Service | - | 4 | 4 | 2 |
| Flow Coordinators | 1 | 4 | 3 | 5 |
| Decisions Unit | 1 | 3 | 1 | 1 |
| Endcliffe Ward | 1 | 3 | 3 | 3 |
| Autism & Neurodevelopmental Service | 3 | 3 | 12 | 10 |
| OACMHT | - | 3 | 1 | - |
| Dovedale 2 | 2 | 2 | 2 | - |

| | | | | |
|---|---|---|---|---|
| CLDT | - | 2 | 2 | 1 |
| IAPT | - | 2 | 4 | 7 |
| Gender Identity Service | - | 2 | 10 | 9 |
| CERT | 1 | 1 | - | 1 |
| Safeguarding Team | 1 | 1 | - | - |
| Central AMHP Team | 1 | 1 | - | - |
| OAHTT | 1 | 1 | - | - |
| G1 Ward | 1 | 1 | 2 | 2 |
| Perinatal Mental Health | 1 | 1 | - | 1 |
| CISS (LDS) | - | 1 | - | - |
| OT services | - | 1 | - | - |
| Complaints | - | 1 | - | - |
| Forest Lodge | - | 1 | 2 | 5 |
| HBPOS (136 suite) | - | 1 | - | - |
| Stanage Ward | - | - | 5 | 7 |
| Dovedale | - | - | 2 | 1 |
| ECT Suite | - | - | - | 1 |
| Forest Close | - | - | 1 | - |
| Homeless & Assess Support Team (HAST) | - | - | 1 | - |
| Neuro Enablement Service | - | - | 1 | - |
| Out Of Hours Team | - | - | - | 1 |
| START Services | - | - | 3 | 3 |
| STEP | - | - | 1 | - |
| Woodland View | - | - | - | 1 |
| **Total** | 39 | 104 | 140 | 150 |

SAANS received their first complaints of the year in December 2023 (n3), all of which related to waiting times. Liaison Psychiatry also received their first complaints of the year during quarter three (n5). These relate to communication and service provision (bed availability). Dovedale 2 also received their first formal complaints (n2) since September 2022, both of which relate to clinical care and treatment.

## Section 9: Learning from Blue Light Alerts

9.1 Blue Light Alerts: This is a cascading system for issuing patient safety alerts, important safety messages and other safety critical information and guidance to staff and services across SHSC. During quarter 3 four Blue Light Alerts were cascaded to staff and services.

- Blue Light Alert 1: A standard vape which had been provided by the ward was damaged by a patient and subsequently used to self-harm. Staff were asked to carefully consider the needs of the patient against the potential risk posed and to consider nicotine replacement alternatives where unmitigated risks were identified.

- Blue Light Alert 2: It was discovered that some clinical records, for patients recently deceased had been updated after their death. Staff were reminded that clinical records must never be updated in this way and guidance was provided for taking the appropriate action.

- Blue Light Alert 3: Following the release of recent CQC safety guidance in relation to communal wheelchairs practice guidance was shared with teams that included guidance on training, maintenance and risk assessment.

- Blue Light Alert 4: A recent external safety notice highlighted a potential risk from concealed blades in keyrings and vapes. This information was shared with all staff for heightened awareness.

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

10.1 Freedom to Speak up is an alternative route to raise any concern. Here are some examples of the learning from FTSU concerns raised in Q3.

- A staff member was assaulted and was unhappy with the support offered afterwards. They contacted the FTSU Guardian who offered support and explored how to raise their concerns in their directorate with someone who they would feel supported by. This example illustrates the importance of staff being able to have an alternative person to talk to in times of stress and to ensure their concerns are raised and they receive support.

- A concern was raised about staff sleeping on nights. Local action was taken as well as the development of a new Standard Operating Procedure designed to address attentiveness at work. It is important to have different routes for staff to raise systemic issues.

- Several concerns were raised around the issue of sexual safety and staff. The issues were investigated, and staff were supported. However, the experience of the one of the staff members was that nothing had happened. This was reviewed and it was found that not all intended actions were taken. As soon as this was discovered prompt action was taken and the person was updated. This was also communicated to several stakeholders who are part of the present work around sexual safety to ensure we learn from this experience. This includes the importance of tracking actions, and making sure the experience of the people speaking up is at the heart of any actions taken. The FTSU Guardian will be invited to relevant sexual safety meetings to present direct feedback about any poor experiences of how sexual safety concerns have been dealt with.

- A Staff member raised a concern that they were getting e-mails intended for another member of staff with the same name. There wasn't a clear solution, and it took several attempts to be able to resolve the issue. It demonstrated that perseverance and team working enabled an adequate solution to be found.

- A Staff member informally raised concerns about how an incident was handled by a manager. The information helped to feed into wider concerns about unacceptable behaviour and it was addressed with the staff member. Feedback from the person who raised the concerns was that they had felt supported. This shows the importance of having a FTSU Guadian who is able to have confidential conversations, offer additional support and to raise issues where needed.

## Section 11: CQC Enquiries

11.1 7 enquiries were received during Q3.

All 7 enquires were acknowledged within the standard of 2 working days and 5 are now closed with CQC.

- 2 remain open.

  - 1 is related to a formal complaint from an inpatient at one of our acute wards (Endcliffe Ward). The findings of this complaint have been shared with the complainant and we are awaiting a response from the complainant to acknowledge this.

  - We are awaiting formal instruction from CQC to close this enquiry following submission to CQC of the information requested.

## Section 12: Summary

12.1 During quarter 3 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.

12.2 Over the course of quarter 3 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.

12.3 From a community mental health perspective quarter 3 highlight's that ongoing quality improvement projects related to issues such as communication and documentation.

12.4 The data used to inform this report indicates that SHSC is taking patient safety very seriously; incidents continue to be reported consistently and at a low threshold, most incidents are no or low harm, the Daily Incident Safety Huddle is increasing the numbers of follow up actions taken and the number of requests for 48hr reports, and Local Learning Reviews is increasing. This is set against a decreasing number of Patient Safety Incident Investigations (previously called Serious Incident Investigations) which have high resource implication and a narrow focus and do not take into account the breadth of learning available across all reported incidents.

At the same time the overall number of falls in reducing, medication errors remain primarily related to errors of medication management and therapeutic interventions such as de-escalation and use of post incident de-briefs is increasing.