Public Board of Directors
Item number: 11
30 July 2025

Confidential/ public paper:	Public paper
Report Title:	**Patient Safety and Learning Report for Quarter 4**
Author(s):	Caroline Johnson, executive director of nursing, professions and quality
Accountable Director:	Caroline Johnson, executive director of nursing, professions and quality
Presented by:	Caroline Johnson, executive director of nursing, professions and quality
Vision and values:	This supports the Trust's vision **to improve the mental, physical and social wellbeing of the people in our communities**. This report reflects the values **we work together,** and **we keep improving** in understanding patient safety issues and learning from these. The report emphasises that everyone counts.
Purpose and key actions:	The purpose of the report is to provide assurance that learning across patient safety incidents, complaints, safeguarding adults and freedom to speak up is being identified and acted on to improve the quality and experience of patients and staff. Quality improvement plans are being undertaken to demonstrate robust improvement for patient safety and experience.
Executive summary:	This report provides assurance to the Board of Directors of the Trust's continued progress in embedding the Patient Safety Incident Response Framework (PSIRF) and strengthening its learning and improvement culture. It presents key themes, learning, and improvement actions arising from patient safety incidents, complaints, safeguarding, and freedom to speak up activity during Quarter 4 (January–March 2025). **Key highlights include:** • **High levels of incident reporting** have been maintained and the majority of incidents are low or no harm • The **Daily Incident Safety Huddle (DISH)** continues to provide real-time oversight and rapid learning, reviewing 100% of incidents within 24 hours. • The Trust has launched a **Learning and Improvement Group** to oversee delivery of improvement initiatives aligned to patient safety priorities and ensure learning is systematically reviewed and acted upon. • A governance review by the **Good Governance Institute** is underway to strengthen learning dissemination. **Progress on the five patient safety priorities includes:** 1. **Unexpected Deaths**: A thematic review is underway, supported by the rollout of the Personalised Assessment of Risk (PAR) tool and a new care planning format. Improvements in risk assessment and prioritisation processes are already being implemented. 2. **Self-Harm**: A reduction in incidents has been observed, supported by improved post-incident reviews, and targeted staff training. Work is ongoing to embed trauma-informed care and improve understanding of self-harm triggers. 3. **Medication Errors**: Improvement initiatives include the EDMET programme to explore systemic causes of error, strengthened protocols for controlled drugs, and environmental changes to

	support safer medication administration. 4. **Restrictive Practice**: A sustained reduction in seclusion and rapid tranquilisation has been achieved, particularly on Burbage Ward and psychiatric intensive care unit (PICU), supported by cultural change, leadership stability, and revised Respect training. 5. **Falls**: A 44% reduction in falls has been achieved in older adult services through the implementation of HUSH huddles and the introduction of falls champions. Environmental learning and safe transfer practices are being reinforced. These developments reflect a proactive and structured approach to learning and improvement, with a clear focus on translating insights into measurable safety outcomes

Which strategic objective does the item primarily contribute to:					
Effective Use of Resources	*Yes*	**x**	*No*		
Deliver Outstanding Care	*Yes*	**x**	*No*		
Great Place to Work	*Yes*	**x**	*No*		
Reduce inequalities	*Yes*	**x**	*No*		

What is the contribution to the delivery of standards, legal obligations and/or wider system and partnership working.	
This report provides assurance on the Trust's progress in meeting its statutory obligations under the **Patient Safety Incident Response Framework (PSIRF)**, a national requirement from NHS England for all NHS Trusts. It also supports compliance with **Care Quality Commission (CQC)** expectations to demonstrate that learning from patient safety incidents is being systematically identified, acted upon, and used to improve the quality and safety of services	
Board Assurance Framework (BAF) and corporate risk/s:	**BAF 0024** Risk of failing to meet fundamental standards of care caused by lack of appropriate systems and auditing of compliance with standards, **BAF 0029** There is a risk of a delay in people accessing core mental health services **BAF 0031** There is a risk we fail to deliver on national inequalities priorities and our strategic aim to deliver inclusive services, **Further**: Responses to patient safety incidents, aim to address risks to the Trust that may arise if learning is not taken from incidents, particularly where these incidents align with top internal patient safety risks.
Any background papers/ items previously considered:	The Patient Safety and Learning Report Quarter 3 was presented to the **Quality Assurance Committee and the Board of Directors in March 2025**. The Quality Assurance Committee (QAC), requested that the mortality review and learning report, better aligns with this report as there is some overlap between the two. It was requested for more concise narrative around moderate incidents particularly smoking breaches. There was a request for more assurance around the impact of learning and the processes in place.
Recommendation:	The Board of Directors are asked to: • **Receive assurance** that the Trust has a positive incident reporting culture evidenced through the high number of near-miss, negligible and minor harm incidents reported. • **Support the establishment** of the new **Learning and Improvement Group**, which will oversee the delivery of improvement initiatives aligned to the Trust's patient safety priorities and ensure systematic review and implementation of learning from all sources. • **Note the progress** made in embedding PSIRF principles, including

	the increased use of proportionate learning responses (e.g., Local Learning Reviews, After Action Reviews) and the reduction in formal investigations. • **Endorse the continued focus** on the five patient safety priorities: unexpected deaths, self-harm, medication errors, restrictive practice, and falls and the improvement initiatives underway to address these areas. • **Acknowledge the impact** of initiatives such as the Daily Incident Safety Huddle (DISH), HUSH huddles, and the RESPECT training programme in promoting a proactive safety culture and reducing harm. • **Support the governance review** being undertaken by the Good Governance Institute and the associated work to strengthen learning dissemination and accountability across all levels of the organisation.

Board of Directors
Patient Safety and Learning Report Quarter 4 2024/25
30 July 2025

1. Introduction

In November 2023, SHSC successfully transitioned to the new NHS framework; the Patient Safety Incident Response Framework (PSIRF). This marks a significant shift in how SHSC responds to patient safety incidents. Alongside a new policy, SHSC developed a Patient Safety Incident Response Plan (PSIRP). This plan has since been reviewed, which was approved by the Quality Assurance Committee in November 2024.

Key PSIRF aims include:

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

The format of this report has been revised to reflect the move to the Patient Safety Incident Response Plan's Priorities – these priorities have been developed utilising a range of data, including incident data.

This report provides assurance that learning from patient safety incidents, complaints, adult safeguarding concerns, and Freedom to Speak Up activity is being identified and triangulated to inform improvement. While the Trust is continuing to strengthen its approach to translating learning into systematic quality improvement, progress is being made. The report outlines several quality improvement initiatives designed to address key safety themes and the governance processes that have been established to ensure learning is translated into action.

2. Learning and Safety Report

2.1 Patient Safety Incident Response Framework Learning Responses

This section provides an overview of the learning responses undertaken by the Trust during Quarter 4 (Q4) of 2024/25, in line with the Patient Safety Incident Response Framework (PSIRF). The table below presents a comparison with the previous three quarters to highlight trends and areas of focus.

Figure 1: Learning Responses actioned in Q4

Type of Response	Jan 25	Feb 25	Mar 25	2024/25 Q4	2024/25 Q3	2024/25 Q2	2024/25 Q1
PSIRF 48hr Reports Requested	4	10	2	16	10	38	23
48hr Reports - Patient Death Reportable to HM Coroner	7	7	1	15	21	10	22

Local Learning Reviews (LLR) Declared	5	0	1	6	7	4	6
Coordinated Learning Review (CLR) Declared	0	1	0	1	2	0	4
After Action Review (AAR) Declared	1	1	0	2	1	2	9
Structured Judgement Reviews (SJR) Declared	1	0	1	2	2	2	3
Patient Safety Incident Investigations (PSII) Declared	1	0	0	1	1	1	0
Manager Incident Reviews Completed	818	613	393	1824	2138	1770	2023
Incidents followed up by the Daily Incidents Safety Huddle (DISH)	261	181	158	600	715	604	659
Blue Light Alerts issued	0	0	2	2	2	1	1

Key Insights and Developments

- **Patient Safety Incident Investigations (PSII):** One PSII was declared in Q4, consistent with expectations under PSIRF, which promotes a reduction in formal investigations in favour of more proportionate learning responses. This case involved the death of a service user awaiting recall to hospital.

- **Local Learning Reviews (LLRs):** Six LLRs were declared in Q4, reflecting a gradual increase in local learning activity. This aligns with PSIRF's emphasis on enabling learning closer to the point of care. However, further work is required to embed this approach consistently, including the use of trained facilitators within teams. Of the six LLRs, three remain in progress at the time of reporting. Topics included self-harm, unsafe discharge, inappropriate admission to the Decisions Unit, and falls in older adult services.

- **Innovative Practice – Immediate Learning Huddles:** A pilot of immediate learning huddles is underway in one service area. These huddles aim to facilitate rapid, team-based learning following non-fatal incidents, potentially reducing the need for 48-hour reports. The pilot will be evaluated to assess its effectiveness, scalability, and any barriers to wider implementation.

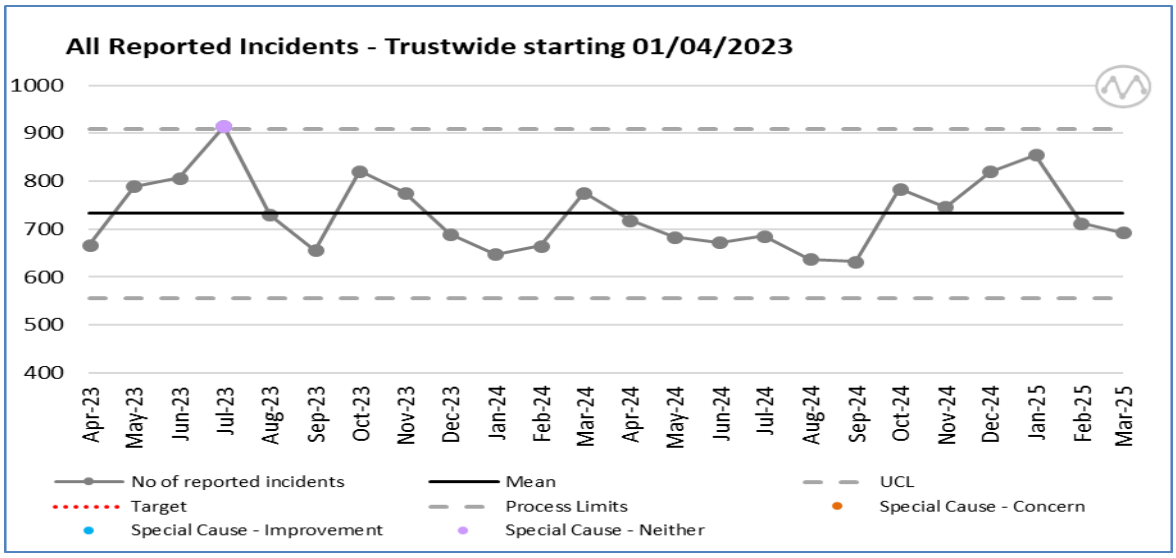
Daily Incident Safety Huddle (DISH)

The DISH continues to play a critical role in real-time incident oversight. The multidisciplinary group comprises of the Patient Safety Specialist (Chair), Consultant Nurse for Restrictive Practice, and representatives from Safeguarding, Health and Safety, Physical Health, and Pharmacy. The DISH reviewed 100% of reported incidents within 24 working hours during Q4.
Of the 600 incidents reviewed, 26% were followed up directly by the DISH team to provide support or request further information. This reflects a proactive approach to ensuring timely learning and appropriate escalation.

2.2 Incident Reporting Data

Incident reporting is a cornerstone of patient safety within NHS organisations. A consistently high level of reporting particularly of low or no-harm incidents is widely recognised as a marker of an open, transparent, and learning-focused culture. SHSC continues to demonstrate these characteristics, with incident reporting levels remaining stable over the past four years.

Figure 2: Patient Safety Incidents reported April 2023 – March 2025



Key Incident Insights – Q4 2024/25

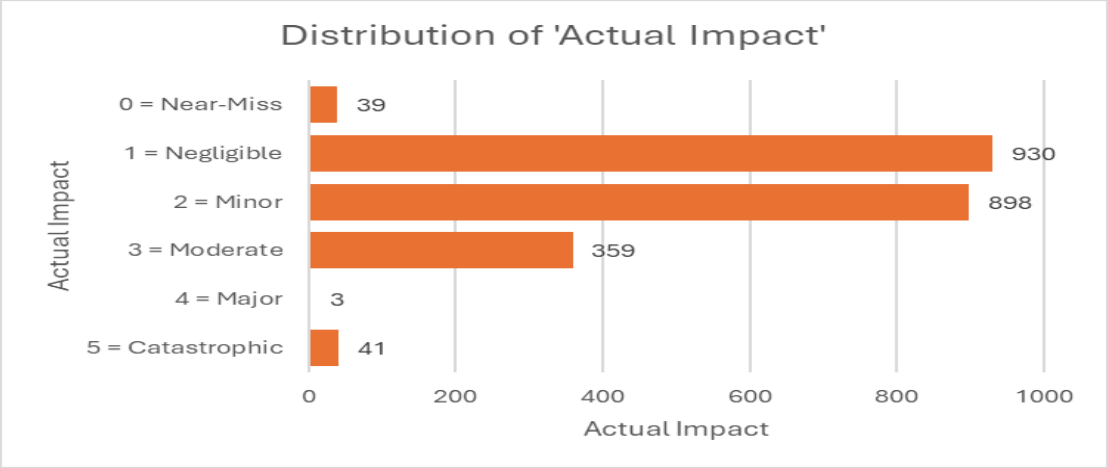
- **Working Age Adult Bed-Based Services** accounted for 43% of all reported incidents a slight decrease of 3% from Quarter 3.
- **Crisis and Community Services** contributed 15% of reported incidents.
- **Older Adult Services** represented 22% of all incidents.
- **Rehabilitation and Specialist Services** accounted for 20%.
- **Non-Clinical Services** reported 1% of incidents.

Importantly, 82% of all reported incidents in Quarter 4 were categorised as no harm or low harm, reflecting a positive shift from the previous quarter. This is widely recognised as a marker of a healthy safety culture, as organisations with high levels of low-severity incident reporting are typically characterised by openness, transparency, and a proactive approach to learning. NHS England highlights that high levels of incident reporting particularly of low or no harm events are often seen in organisations with strong safety cultures (NHS England, 2023).

While the reduction in severity may reflect genuine improvements in safety, it is also likely influenced by more accurate severity grading, supported by increased staff engagement with patient safety training. In Quarter 4, compliance with mandatory Patient Safety training reached 85%, which is likely contributing to improved awareness, reporting accuracy, and early intervention.

Figure 3 below shows the breakdown of the actual impact of incidents reported during quarter 4.

Figure 3: Actual impact of incidents reported in Q4 (2024/25):

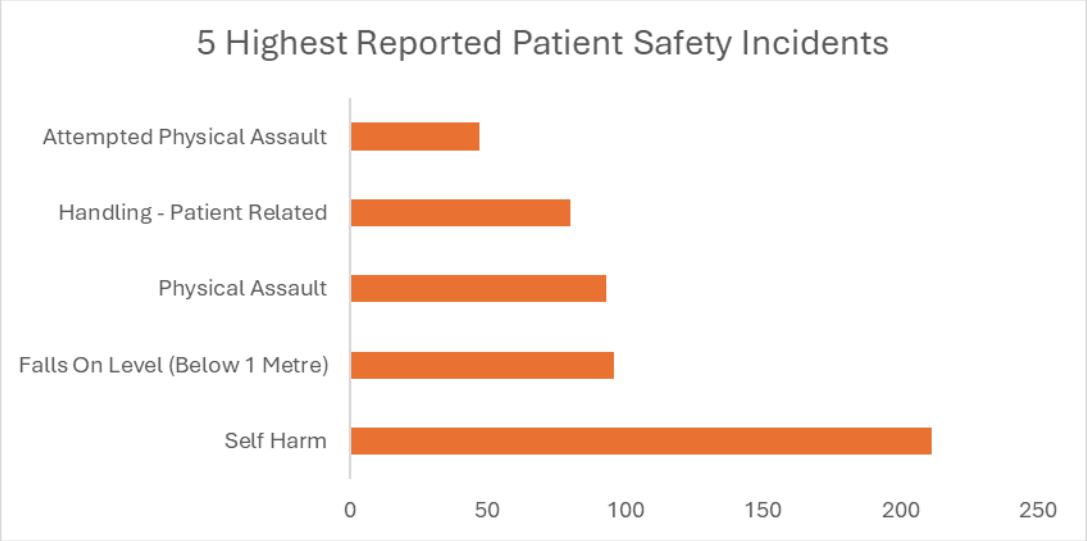


The proportion of incidents resulting in **moderate harm** has decreased compared to Quarter 3 and now falls within normal variation limits. This suggests a positive trend in the severity profile of reported incidents and may reflect the impact of ongoing safety initiatives and increased staff awareness through training.

2.3 Highest Patient Safety Incidents Reported

Figure 4 below shows the breakdown of the top 5 highest categories of incidents reported during quarter 4.

Figure 4: Highest Categories of Patient Safety Incidents Reported in Quarter 4



A slight increase was observed in the category “Handling – Patient Related.” On further analysis, this increase is primarily associated with incidents involving restraint. However, it is important to note that this does not reflect an increase in the use of physical restraint. As evidenced later in this report, the overall number of restraint incidents continues to decline.

Thematic analysis indicates that many of these incidents involved staff intervening to manage risks of harm to self or others, which led to the use of restraint. These incidents could have been alternatively categorised under self-harm (although only a small amount) or intimidating behaviour but were recorded under handling due to the nature of the intervention.

To support accurate and consistent incident categorisation, the Risk Department continues to deliver targeted training sessions for staff. These sessions aim to improve understanding of incident types and ensure alignment with reporting standards.

3. Patient Safety Incident Response Plan Priorities

The patient safety priorities identified in SHSC's Patient Safety Incident Response Plan, are shown in figure 5 below.

Figure 5: Patient Safety Incident Response Plan Priorities

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

These priorities enable the Trust to focus its improvement efforts on the most significant areas of patient safety risk. By targeting these categories, SHSC aims to ensure that learning is systematically captured and translated into action, particularly in relation to high-risk or outlier incidents.

This report provides an overview of the key learning themes and improvement actions aligned to each of these five priorities. It also includes supporting data to evidence the need for continued focus and progress in these areas.

3.1 Priority 1 - Unexpected Deaths

What does our data show?

In Quarter 4, the number of reported deaths remained consistent with Quarter 3, with death-related incidents accounting for 3.5% of all reported incidents across the Trust.
SHSC treats all deaths with the utmost seriousness. Each case is reviewed through established mortality review processes to ensure a thorough understanding of the circumstances and to identify any potential learning related to the individual's care and treatment.

Figure 6: Expected Deaths 01/04/2023 – 31/03/2025

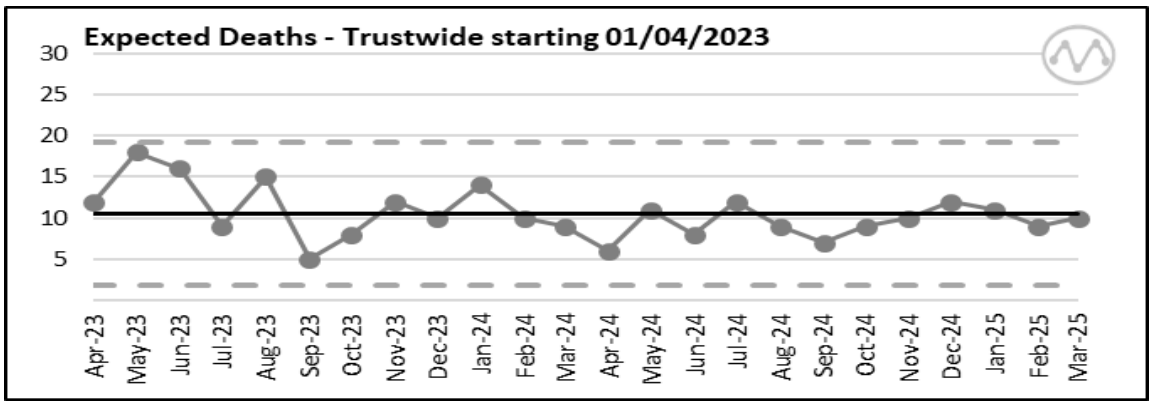


Figure 7: Unexpected Deaths 01/04/2023 – 31/03/2025

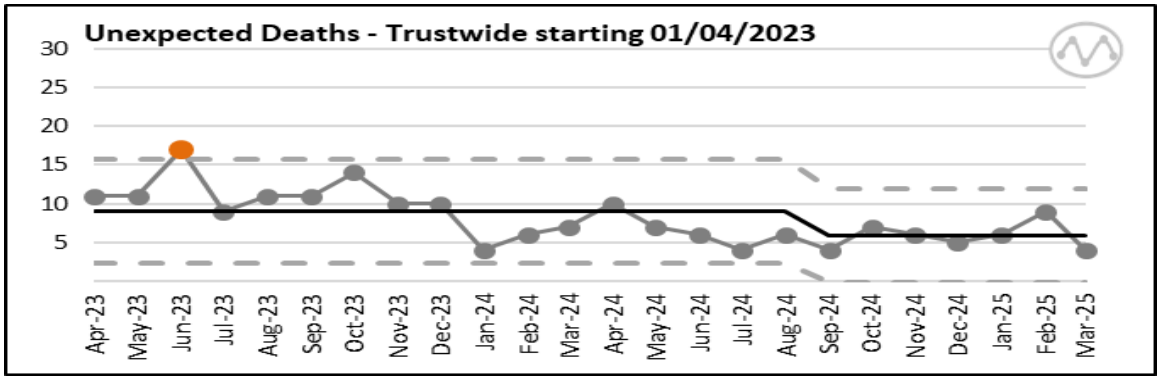
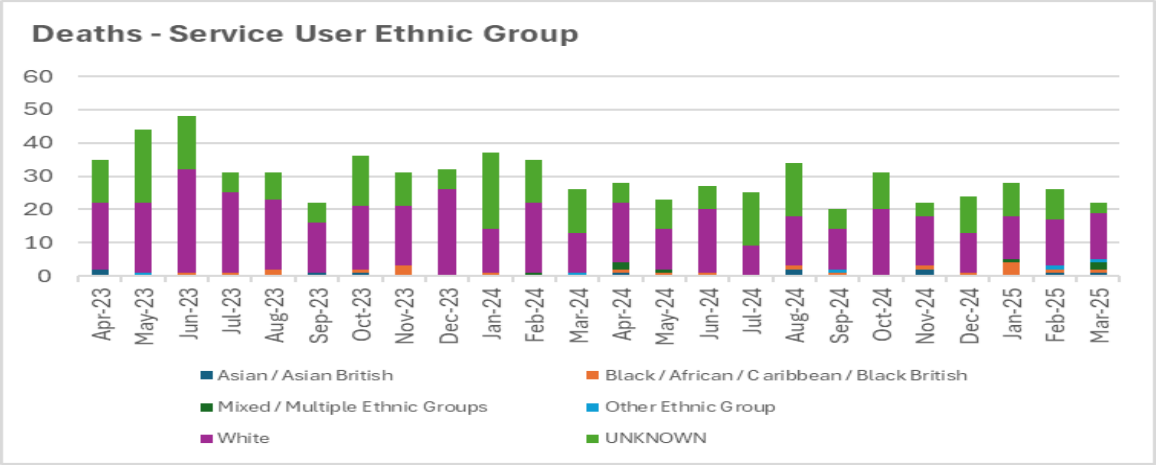
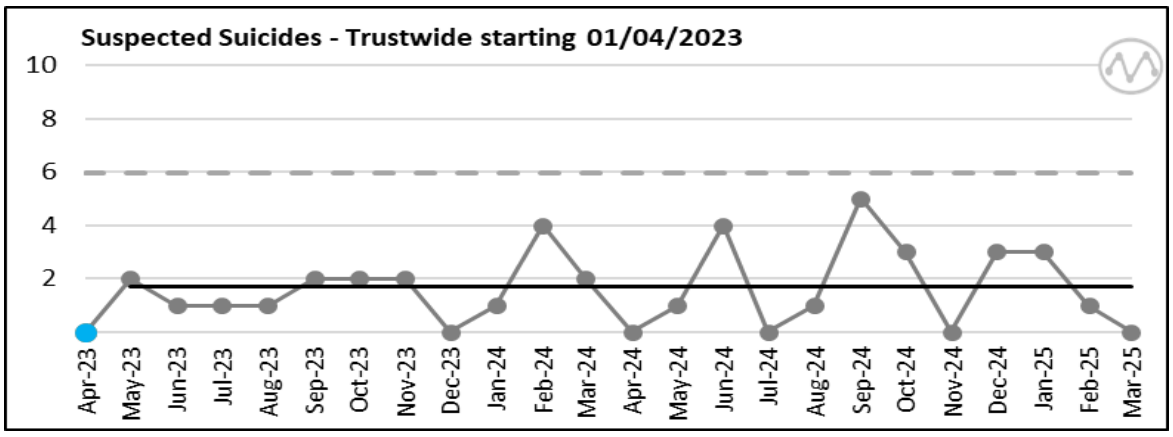


Figure 8: Service User Ethnicity for all Deaths 01/04/2023 – 31/03/2025



Of all death-related incidents, 60% were classified as unexpected, including both natural and non-natural causes. Suspected suicides accounted for 5% of all incidents—unchanged from the previous quarter. However, Figure 9 suggests a slight decrease in suspected suicides during February and March 2025. While this may be encouraging, the variation is within normal limits, and it is too early to determine whether this reflects the impact of ongoing improvement work. Continued monitoring and further analysis will be required to assess whether this trend is sustained.

Figure 9: Suspected Suicides 01/04/2023 – 31/03/2025



Is the data impacted by any known improvement initiatives?

While it is encouraging that the number of unexpected deaths and suspected suicides has not increased particularly during a period of significant service transformation there remains a clear need to reduce the incidence of suspected suicides within the Sheffield mental health community. Several improvement initiatives are currently underway:

- **Risk Assessment Improvements:**
  A new tool, the *Personalised Assessment of Risk (PAR)*, is currently being piloted across selected community and inpatient services. This tool is designed to support more personalised and dynamic approaches to risk formulation and management, moving away from traditional stratified risk scoring. This approach aligns with national guidance and the Culture of Care programme, which advocates for a more nuanced, person-centred understanding of risk in mental health settings. Previous investigations into suspected suicides have consistently identified risk assessment—particularly the documentation of how risk is being managed—as a key learning theme. The PAR tool directly addresses this by promoting collaborative, narrative-based risk assessments that reflect the complexity of individual experiences. If successful, it will help close a known gap in practice and support safer, more consistent care delivery (NCISH, 2024)
- **Care Planning Enhancements:**
  A new care plan format has been developed and integrated into the Trust's electronic patient record system, *Rio*, as of April 2025. While it is too early to assess its impact in this reporting period, it is expected to support improved care coordination and documentation going forward.
- **Thematic Review of Unexpected Deaths:**
  In line with the Patient Safety Incident Response Plan, a comprehensive thematic review of unexpected deaths is currently underway. This review will examine all learning responses to identify recurring themes, assess the effectiveness of existing improvement work, and highlight any remaining gaps.
  - *Phase 1* (concluding July 2025) will focus on identifying key recommendations.
  - *Phase 2* (concluding September 2025) will include engagement with service users and families, particularly around involvement in care and learning processes.
- **Centralised Learning into Action Plan:**
  Findings from the thematic review will feed into the Trust's *Centralised Learning into Action Plan*, which consolidates improvement efforts across five key areas:

1. Risk assessments
2. Care planning
3. Patient and family involvement
4. Discharges
5. Out-of-area placements

These areas have consistently emerged as themes in learning from unexpected deaths, and the centralised plan will ensure that improvement actions are coordinated, monitored, and sustained. While the full impact of these initiatives is not yet visible in the data, they represent a proactive and structured approach to addressing known safety risks. Future reports will assess their effectiveness as implementation progresses.

Learning Identified This Quarter

Risk assessment and management continues to emerge as a key theme in several learning responses following unexpected deaths. The following points summarise the key learning identified during Quarter 4:

Cross-Service Risk Sharing

A need was identified to strengthen collaboration with Sheffield Talking Therapies (STT), particularly around the proactive sharing of risk information between services to support continuity of care and early intervention.

Action: A service-wide risk-focused session is being delivered to staff, centred on the latest NHS risk guidance. This session incorporates learning from unexpected deaths over the past two to three quarters, with a focus on:

- ✓ Enhancing the use of dynamic risk assessments
- ✓ Promoting hope-based approaches in therapeutic practice
- ✓ Strengthening inter-service communication around risk

Timeliness of Risk Assessment Updates

Within community services, learning highlighted the importance of updating risk assessments promptly to reflect both increases and reductions in risk. This ensures that care plans remain responsive and appropriate to the individual's current needs.

Action: This is being addressed through the centralised learning into action plan developed in response to the findings of the review of homicides in Nottingham.

Prioritisation of High-Risk Patients

Early learning from the death of a patient awaiting admission highlighted the need to review the prioritisation process for the Clinically At Risk of Hospital Admission (CAHA) list, following the death of a patient who was awaiting an inpatient bed.

Actions: In response, immediate changes were implemented to strengthen clinical oversight and prioritisation. The CAHA list approach was replaced with a To Come In (TCI) list, which is now reviewed daily with clinical oversight. This ensures that patients identified as requiring admission are actively monitored and prioritised, improving the timeliness and appropriateness of bed allocation decisions. This change represents a proactive response to learning and demonstrates the Trust's commitment to adapting systems in real time to improve patient safety.

Good Practice Examples

Following the natural death of a patient recently discharged from a rehabilitation unit, the care team demonstrated exemplary practice in supporting both staff and fellow service users, who had developed close therapeutic relationships with the individual.

In response to the emotional impact of the incident:

- Timely debriefs were held with both patients and staff to provide emotional support and ensure consistent, transparent communication.
- The team engaged with the patient's family in a compassionate and respectful manner, maintaining open dialogue and offering appropriate support.
- A memorial service was organised, reflecting a sensitive, person-centred approach to bereavement and honouring the individual's life.

This example highlights the importance of emotional support and compassionate communication following a patient death. It is recommended that this approach be shared across services as a model of good practice in responding to the emotional and relational impact of loss within care settings

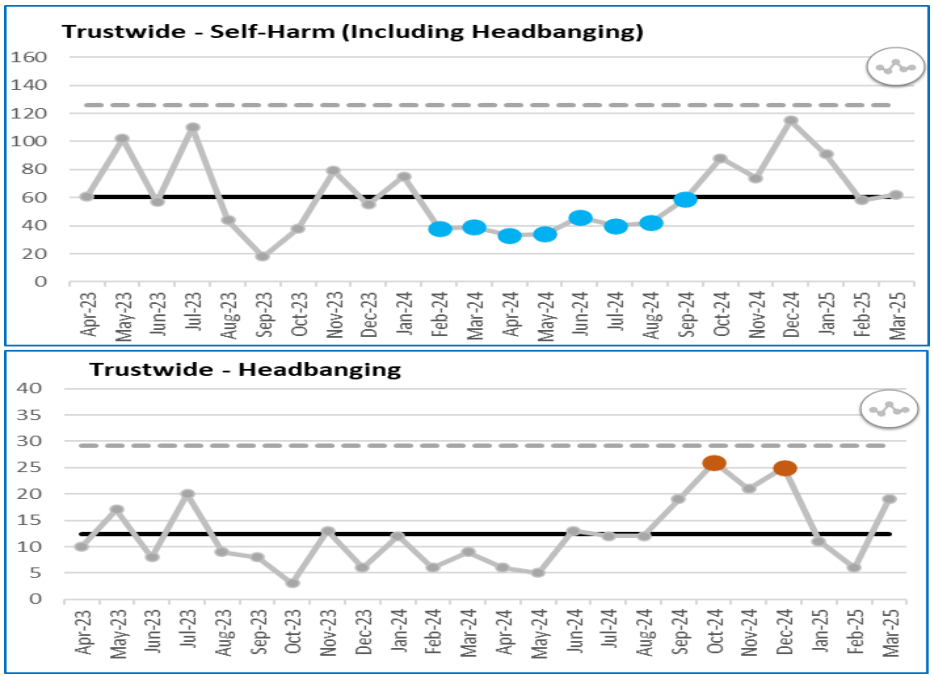
The Chaplaincy and Spiritual Care Team now receive notifications of all patient deaths, enabling them to proactively offer support to inpatient and residential services. This includes:

- Providing emotional and spiritual support to staff and service users
- Facilitating memorial services, which have been well received and contribute to compassionate, person-centred bereavement care

3.2 Priority 2 – Self-harm

What does our data show?

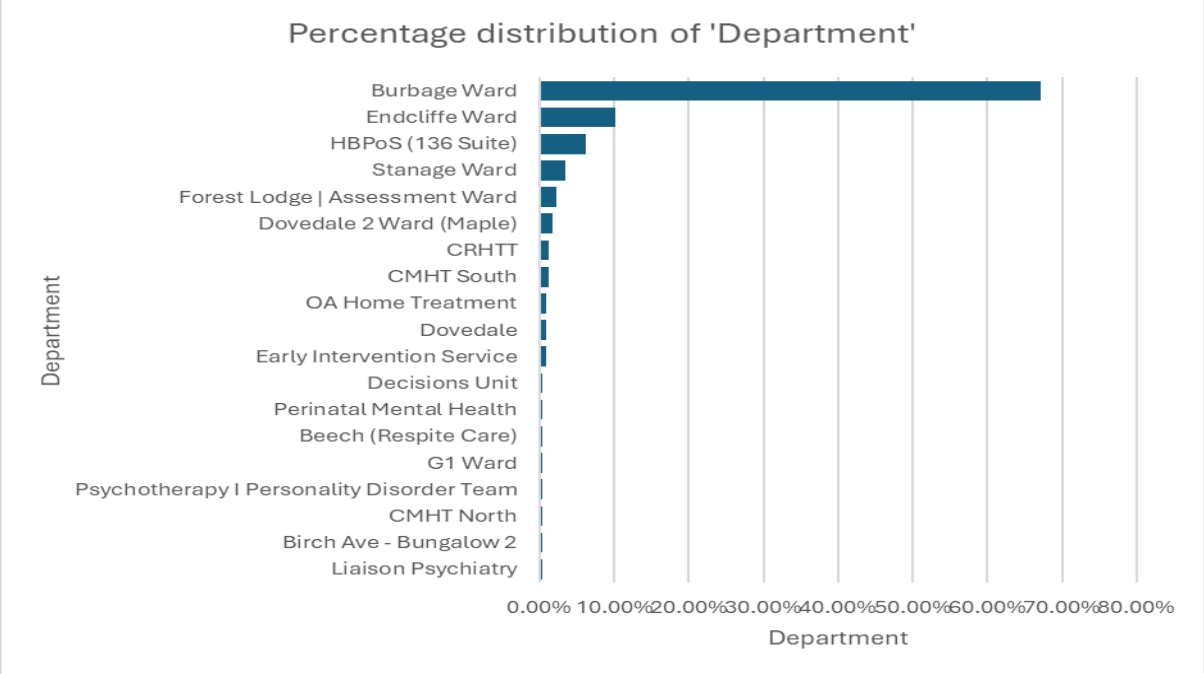
Figure 10: Self-harm incidents 01/04/2023 – 31/03/20252



In Quarter 4, **self-harm incidents accounted for 9% of all reported incidents**, down from 13% in Quarter 3. This represents a positive shift, particularly following a period of rising self-harm incidents observed from August 2024 onwards.

Figure 11 below shows the distribution of self-harm incidents across SHSC.

Figure 11: Self-harm incidents displayed by department



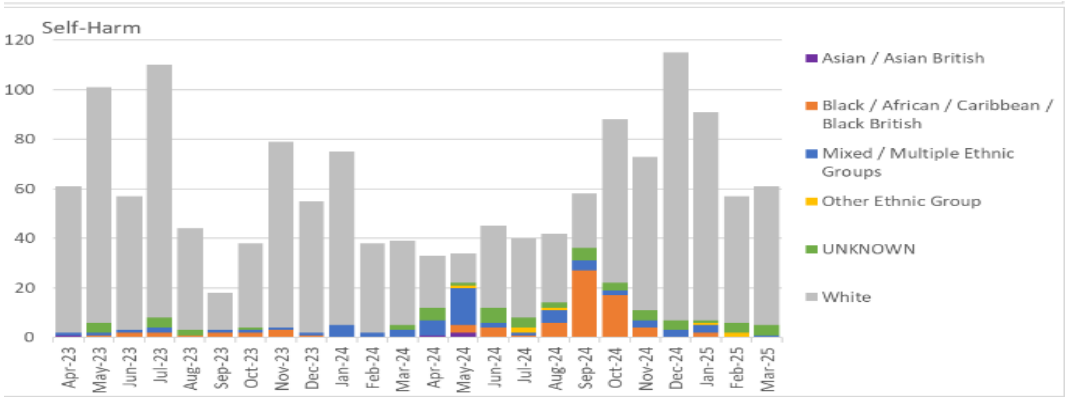
Key observations include:

- Burbage Ward saw a significant reduction in self-harm incidents, from 210 in Q3 to 151 in Q4, contributing positively to the Trust-wide trend.
- HBPoS, in contrast, recorded 14 incidents in Q4, up from zero in Q3. This spike was largely attributable to a single high-risk patient detained for several days.

This data supports the need for continued focus on:

- Therapeutic environments for high-risk individuals
- Timely access to inpatient care, as addressed through the Home First programme
- Multidisciplinary support in HBPoS, particularly in light of increased lengths of stay within the HBPoS.

Figure 12: Self-harm incidents by Service User Ethnicity 01/04/2023 – 31/03/2025



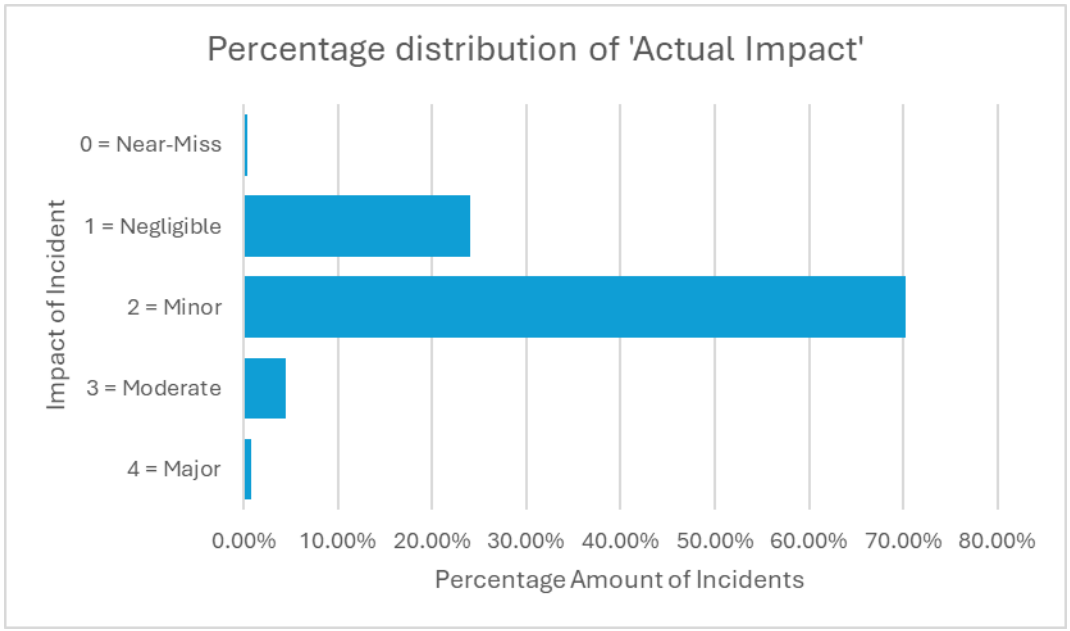
Key Insights:

- The distribution of incidents across ethnic groups remained relatively stable between quarters.
- However, Quarter 4 shows a notable increase in incidents with unrecorded ethnicity, particularly in February and March 2025, as highlighted in red.
- This gap in demographic data limits the ability to fully understand and address inequalities in care.

Ongoing Improvement:

A quality improvement project, led by the Population Health and Inequalities Lead, is actively addressing this issue. Early signs show improved recording of protected characteristics, which will enhance the Trust's ability to deliver equitable and informed service planning.

Figure 13: Self-harm incidents by Actual Impact



- The majority of incidents were recorded as **no harm** or **low harm**, consistent with previous trends.
- Two incidents were classified as **major harm**:
  - **Incident 1**: A patient sustained life-changing injuries after jumping from a height at home. A 48-hour report was completed, and a non-statutory Duty of Candour apology was issued.

- **Incident 2**: A patient self-harmed in the Health-Based Place of Safety (HBPoS) and required hospital treatment. An After Action Review (AAR) is scheduled, with a delay to allow for staff psychological support.

Impact of Improvement Initiatives on Self-Harm Incidents

While it remains too early to determine whether the observed reduction in self-harm incidents represents a sustained trend or normal variation, early indications suggest that recent improvement initiatives may be contributing positively. Ongoing monitoring in subsequent quarters will be essential to confirm this.

Key Improvement Initiatives Contributing to Change:

- **Enhanced Post-Incident Review Practices**
  Improvements in how post-incident reviews are conducted particularly on wards with higher rates of self-harm have led to greater inclusion of patient perspectives. This aligns with findings from a recent thematic review, which identified discrepancies between staff and patient perceptions of self-harm triggers. Capturing the patient voice is helping to inform more responsive, person-centred care.
- **Physical Health Protocols and Staff Training**
  The physical health team has focused on improving post-incident physical observations, especially for head injuries resulting from head banging. There has been a notable increase in the use of NEWS2 neurological observations, and an audit is underway to assess the consistency and impact of this improvement.
- **Staffing Stabilisation**
  A reduction in the use of agency staff on high-risk wards has improved continuity of care, strengthened therapeutic relationships, and may be contributing to a reduction in distress-related behaviours.
- **Increased Psychological Input**
  Additional psychological support has enabled more structured risk formulations, enhanced staff support, and strengthened reflective practice—key components of trauma-informed care.
- **Targeted In-Reach by the Physical Health Team**
  Regular in-reach to high-risk wards has provided structured guidance on responding to self-harm incidents, aiming to reduce both the frequency and severity of harm.

Next Steps and Future Focus

To build on the progress observed, the Trust is prioritising further work to enhance staff understanding of the underlying functions of self-harm, particularly in the context of complex emotional needs. Embedding trauma-informed approaches into everyday practice remains a key objective.

The Psychology Leadership Team is currently reviewing training needs and developing a structured programme to upskill staff in this area, ensuring compassionate and effective responses to self-harm.

Learning Identified This Quarter

Several important learning points have emerged this quarter in relation to self-harm incidents:

Hospital Transfer Protocols

Following an incident where an inpatient absconded from Sheffield Teaching Hospitals (STH) and subsequently self-harmed, learning has focused on the need for improved communication with STH regarding high-risk patients. Specifically, there is a recognised need for tailored care plans to be in place for emergency hospital transfers where risk is known or anticipated.

Action: A project has begun with STH to explore difficulties and barriers within the transfer process, which is being led by the senior matron.

Balancing Risk and Least Restrictive Practice

An incident involving the ingestion of a razor blade has highlighted the ongoing challenge of balancing safety with least restrictive practice. Although the razor was approved for supervised personal care use, the patient was known to present a high level of risk. This has prompted a review of alternative options to razors for personal care in similar cases.

Action: The team required enhanced support in understanding and managing restricted items and self-harm risks. Targeted work was undertaken to build staff confidence in these areas, and this will be further embedded through planned team reflection and development sessions in July 2025. This initiative forms part of our ongoing commitment to fostering safe, informed, and resilient clinical teams.

Good Practice Recognition

In a community-based incident involving a jump from height, no specific learning was identified through the 48-hour report. However, the response from involved teams was noted as robust, collaborative, and tailored to the individual's needs demonstrating good practice in crisis support.

3.3 Priority 3 - Medication Errors

What does our data show?

Medication incidents accounted for **13% of all reported incidents** across SHSC in Quarter 4. Of these:

- **17%** were related to **medication administration**,
- **5.5%** were linked to **prescribing issues**, and
- The **majority** fell under **medication management concerns**.
-

Medication management incidents encompass a range of issues, including missing second signatures, incomplete temperature monitoring, and discrepancies in controlled drug records. These findings highlight the ongoing need for robust systems and oversight in medication handling processes.

Figure 14: Medication Incidents 01/04/2023 – 31/03/2025

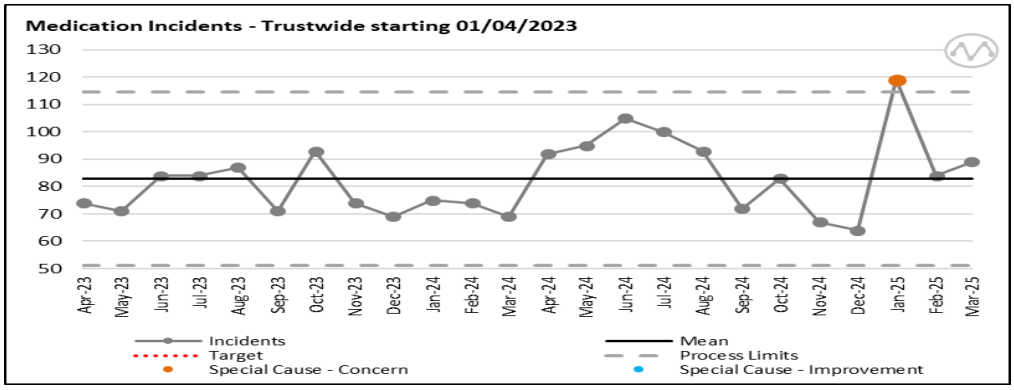
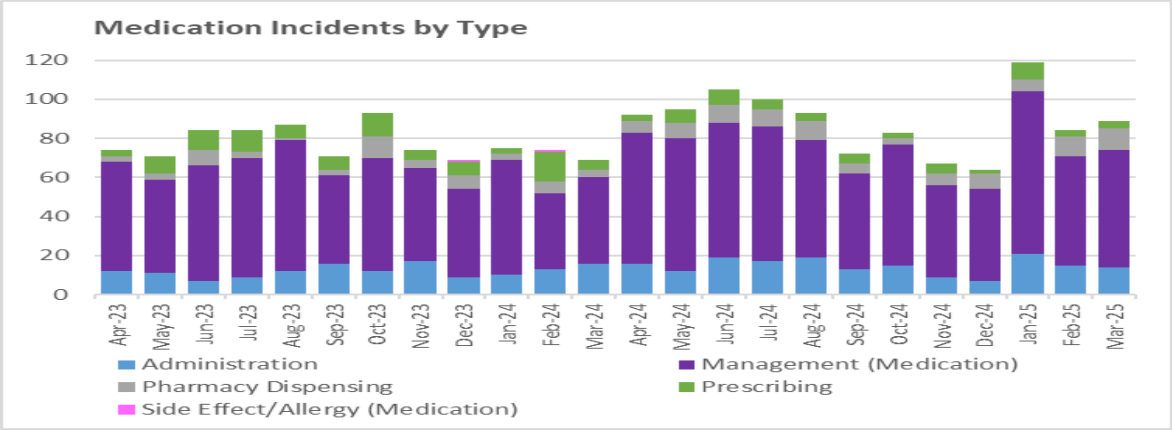


Figure 15: Medication Incidents broken down by type 01/04/2023 – 31/03/2025



There were **five moderate medication-related incidents** reported in Quarter 4, representing a slight increase from Quarter 3, though still within expected variation. Each incident has been reviewed, with learning and actions identified as follows:

- **Missing Controlled Drugs**: One incident involved missing controlled drugs, which triggered a 48-hour report. The findings and learning from this review are detailed in the section below.
- **Unsafe Patient Transfer**: A second incident was linked to an unplanned transfer of a patient from the Health-Based Place of Safety (HBPoS) to a step-down unit. The transfer of medication between sites did not follow Trust policy and led to the potential for medication error. This incident also resulted in a 48-hour report, which included learning related to the transfer process and risk management.
- **Insulin Omission at Forest Lodge**: A patient did not receive their prescribed insulin. Immediate corrective actions were taken, and the incident is being incorporated into a thematic learning response. Additionally, the team will receive training from a diabetic nurse to strengthen understanding of diabetes care.
- **Codeine Mismanagement**: An empty box of codeine phosphate was found in a ward bedroom bin. This incident, linked to a similar previous event, highlighted issues with potential patient access to the clinic room, although this has not been proven and staff involvement has not yet been ruled out. As a result, codeine is now treated as a controlled drug within the service, subject to stricter handling protocols.
- **Depot Overdose in the Community**: A community patient received a significantly higher dose of their depot medication than prescribed. The error was promptly identified, the patient

was closely monitored, and emergency guidance was provided. While serious, the team's response was swift and supportive. This incident has highlighted a need to review the patient identification policy, as the patient identification was not checked prior to administering the depot.

Medication Safety – Impact of Improvement Initiatives and Learning from Q4
Impact of Improvement Initiatives

While current data trends have not yet demonstrated a measurable impact from recent initiatives, several longer-term improvement efforts are underway and are expected to influence future reporting periods. These initiatives reflect a strategic, multi-layered approach to improving medication safety and staff capability:

- **Staff Confidence in Medication Administration**: Ongoing work is focused on strengthening staff confidence in core medication practices. Feedback has highlighted several contributing factors, including a lack of visible role models, cultural challenges in protecting medication rounds, gaps in training, and limited opportunities for individual and team reflection. These issues are being addressed through a comprehensive nursing leadership action plan, which is currently in progress and anticipated to impact data in subsequent quarters.
- **System-Level Exploration**: Broader systemic influences on medication administration are being examined through the implementation of EDMET (Exploring, Diagnosing, and Mitigating Error Trends) across inpatient and community services. Early findings from EDMET are promising, with emerging themes that are helping to identify contributory factors and inform targeted interventions.
- **Operational Process Review**: As part of a wider review of operational processes, work is also underway to promote collective ownership of second signature incidents. While this initiative has not yet demonstrated a measurable impact on incident data, it remains a key area of focus and will be evaluated in future reporting cycles.

These initiatives reflect a strategic, multi-layered approach to improving medication safety and staff capability, with expected benefits to be realised over the coming quarters

Learning Identified This Quarter

An incident involving missing diazepam tablets, which remain unrecovered and unaccounted for, triggered a review of medication safety practices within the Low Secure Forensic Unit. The investigation identified two key contributory factors:

- **Frequent interruptions** during medication rounds, increasing the risk of error and oversight.
- **Environmental constraints**, specifically the clinic room being too small to support safe and efficient medication dispensing..

These findings underline the importance of protected time for medication administration and the need for improved clinical environments. Both areas are being actively addressed through the Enhanced Support Plan, which includes environmental redesign and operational adjustments to reduce interruptions during critical clinical tasks.

Unplanned Transfer from HBPoS to Beech Step-Down Unit

A second incident involved an unplanned transfer of a patient from the Health-Based Place of Safety (HBPoS) to the Beech step-down unit. Medication was received post-transfer in non-patient-identifiable packaging, causing confusion and operational difficulty. The 48-hour report identified several underlying issues:

- HBPoS does not issue discharge summaries, as it is not classified as a ward.

- No functionality exists within Insight for HBPoS to generate inpatient discharge summaries.
- This type of transfer is atypical and had not been planned for.

Key learning and actions:

- Medication must be thoroughly checked prior to transfer and transported by SHSC staff not security personnel.
- A clear process and documentation pathway is needed for discharges from HBPoS to community step-down care. This is being built into Rio.
- Beech identified the need for improved communication with other services and the development of an emergency admission pathway.

As a result of this learning, Beech has joined the Home First programme and is currently auditing its service to ensure improvements are embedded.

Actions Taken in Response to Learning

Following the identification of key learning points from recent medication incidents, several actions have been initiated to address systemic issues and improve safety:

- **Reducing Disruptions During Medication Rounds**:
  Forest Lodge is trialling the use of tabards to signal that nurses are not to be disturbed while dispensing medication. This aims to reduce interruptions and associated risks. The pharmacy team is currently assessing the broader suitability of this approach for wider implementation.
- **Strengthening Controlled Drug Protocols**:
  Codeine is now classified internally as a controlled drug within SHSC and is subject to the organisation's-controlled drug procedures. This change is intended to mitigate risks related to patient access and medication security.
- **Clinic Room Environment Improvements:**
  The layout of the clinic room is under review, with proposed enhancements including the installation of barn doors to improve safety and workflow during medication administration.
- **Facilitated Learning Response:**
  In recognition of the need for deeper insight into staff experiences and barriers, a facilitated learning session is planned. This will provide a collaborative space for staff to explore challenges and contribute to co-designed solutions.

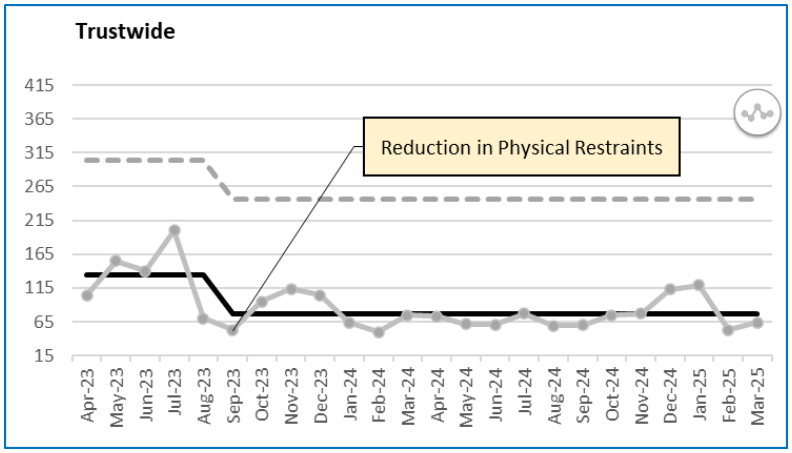
3.4 Priority 4 - Restrictive Practice

What does our data show?

SHSC continues to prioritise the reduction of restrictive practices in line with its strategic objectives for 2024/25 and 2025/26. Over the past 12 months, the use of physical restraint has remained broadly stable, with minor fluctuations within expected variation.

Notably, a reduction in restraint incidents was observed in February and March 2025, primarily driven by a decline in incidents on Burbage Ward. This positive trend is being explored further to identify contributing factors and opportunities for wider learning and replication across other services.

Figure 16: Physical Restraint Incidents 01/04/2023 – 31/03/2025

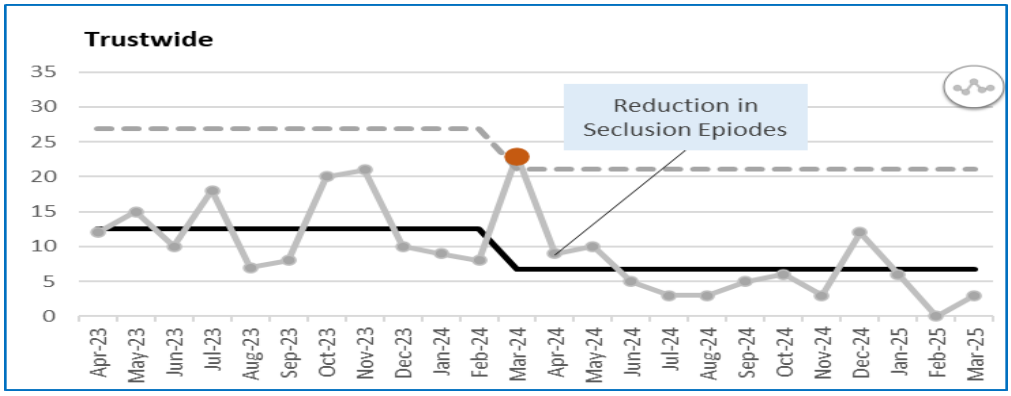


Is this data impacted by any known improvement initiatives?

While there is no direct evidence that the recent reduction is solely due to specific improvement initiatives, it is acknowledged that SHSC continues to implement ongoing efforts to reduce restrictive practices and shift the organisational culture around their use. These efforts may be contributing to the **overall downward trend** observed in the data.

Seclusion Incidents - What does our data show?

Figure 17: Seclusion incidents 01/04/2023 – 1/03/2025



There has been a sustained reduction in the use of seclusion over the past two years, reflecting SHSC's commitment to reducing restrictive practices in line with strategic priorities. A significant contributing factor in 2024 was the removal of seclusion rooms across most wards and the enhancement of de-escalation spaces, aligned with the Trust's therapeutic environments programme.

Notably, Quarter 4 of 2024/25 saw a further steep reduction in seclusion use. A key driver of this improvement was the performance of the Psychiatric Intensive Care Unit (PICU), which achieved 68 consecutive days without the use of seclusion a significant milestone and a testament to the effectiveness of ongoing cultural and environmental changes.

Is this data impacted by any known improvement initiatives?

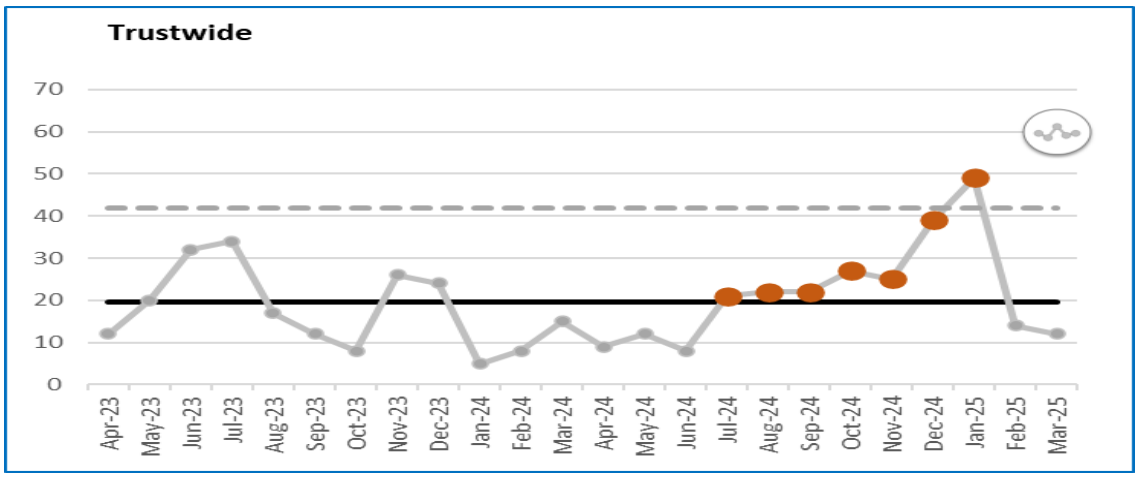
The continued reduction in seclusion use has been driven not only by environmental changes but also by a sustained cultural shift in how restrictive practices are approached across SHSC. This shift has been particularly supported by stabilisation in ward leadership, which has helped embed consistent, values-based practice.

Importantly, while the data presented reflects a reduction in the number of seclusion incidents, it does not capture the significant decrease in the length of seclusion episodes, which is a further positive indicator of progress.

At Forest Lodge, seclusion use has also declined, with only two incidents reported in Quarter 4. Both incidents involved the same patient, who was acutely unwell and exhibiting assaultive behaviour towards staff and other patients. These cases were managed with clear clinical rationale and oversight

Rapid Tranquilisation Incidents – What does our data show?

Figure 18: Rapid tranquilisation incidents 01/04/2023 – 31/03/2025



There has been a notable decrease in the use of rapid tranquilisation towards the end of Quarter 4. This reduction is largely attributed to decreased usage on specific wards, particularly Burbage Ward, where a broader shift in practice and culture around restrictive interventions is being observed.

This trend aligns with the Trust's ongoing efforts to reduce restrictive practices and promote alternative, therapeutic approaches to managing acute distress.

Is that data impacted by any known improvement initiatives from previous quarters?

In Quarter 3, a combination of reduced length of stay and a resultant increase in admissions led to heightened acuity on Burbage ward. This, coupled with challenges in staff skillset and confidence to manage such complexity, coincided with the highest recorded increase in rapid tranquilisation.

There is a clear evidence base supporting the link between **staff confidence and the use of rapid tranquilisation**. In response, a number of interventions were implemented to support and upskill staff in managing complex and dysregulated patients. The interventions included, reflective practice, frequent presence of the RESPECT team on the ward, coaching of staff in relation to risk

assessment and care planning and strengthened ward leadership. As a result, in quarter 4, the number of rapid tranquilisation incidents declined.

The Respect training programme for inpatient staff has been revised to more accurately reflect real-life incident scenarios encountered in clinical settings. This update is designed to strengthen staff confidence in managing challenging behaviours using least-restrictive approaches. The revised content supports the Trust's broader strategic objective to reduce reliance on physical restraint, by equipping staff with practical, scenario-based skills that promote safer, more therapeutic interventions.

Discussions with clinical leaders have highlighted that the most significant and sustained reductions in the use of rapid tranquilisation are achieved through improvements in **ward culture, staffing stability, and leadership**. These factors are consistently associated with the development of safer, more therapeutic environments, where staff feel supported and confident in using least-restrictive approaches.

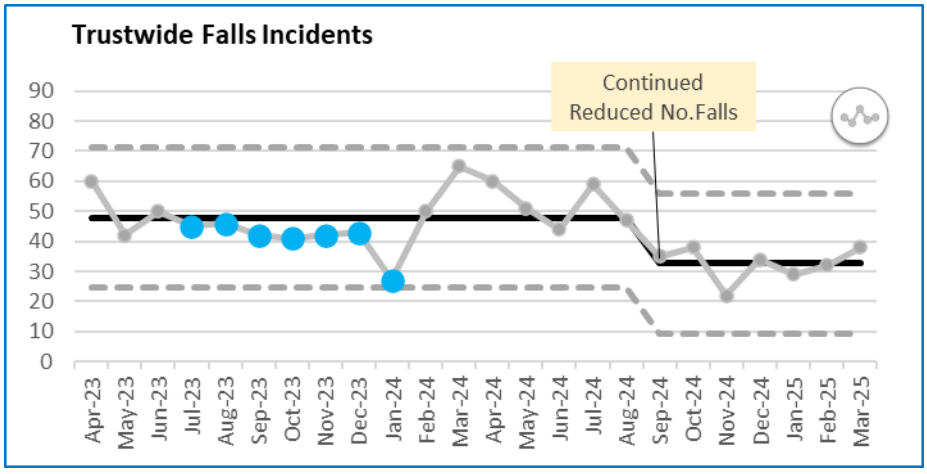
Evidence from national reviews and improvement programmes supports this view. A survey conducted by the British Institute of Learning Disabilities and the Tizard Centre found that **leadership and management were seen as critical to achieving reductions in restrictive practices**, with frontline leadership particularly influential in shaping practice and culture (Deveau and Leitch, 2016). Similarly, the Royal College of Psychiatrists' quality improvement collaborative reported that teams with strong leadership and a focus on culture achieved an average **61% reduction in restrictive practices**, including rapid tranquilisation (RCPsych, 2023)
.

3.5 Priority 5 – Slips, Trips and Falls

What does our data show?

Falls accounted for **5% of incidents** reported across the Trust in this quarter, which is the same as the previous quarter.

Figure 19: Falls Incidents 01/04/2023 – 31/03/2025



The Trust has continued to see a sustained reduction in falls, a trend that began in September 2024 and has reassuringly continued into the current quarter. Only two incidents were rated as moderate harm or above:

- One incident triggered a 48-hour report due to the level of harm and concerns raised about the post-falls response. A statutory Duty of Candour apology was issued to the patient. Key learning included the need for improved adherence to safe transfer guidelines and timely ambulance response.
- The second incident involved a hospital transfer for assessment, but no injury occurred. The team responded appropriately, and a formal learning response was not required.

Impact of Improvement Initiatives

The reduction in falls is strongly linked to the implementation of **HUSH (Huddling Up for Safety) huddles**, now embedded across all older adult wards. These structured safety discussions have contributed to a **44% reduction in falls**, with some wards, such as Dovedale 1, achieving extended fall-free periods (e.g., 15 consecutive days). This aligns with wider evidence that **unit-based safety huddles improve communication, situational awareness, and patient outcomes** (Franklin et al., 2020).

Teams are now evolving the model, with nurses in charge increasingly leading huddles to ensure sustainability, especially when falls champions are unavailable. While falls champions are now in place across older adult services, this is a recent development, and its full impact is yet to be evaluated.

In parallel, the **Enhanced Care Home Project**, an 18-month initiative focused on falls and dementia in care homes, is providing training and support to external partners, further strengthening the system-wide approach to falls prevention.

Learning from Incidents this Quarter

Environmental factors remain a key theme. A 48-hour report from Dovedale 1 highlighted that the lack of ensuite facilities contributed to a fall resulting in a fractured neck of femur. Additional learning included:

- Non-compliance with safe manual handling guidelines during a patient transfer.
- Delays in ambulance contact following clinical advice.

In contrast, a local learning review on G1 highlighted positive practice, including prompt staff response, effective communication with carers, and timely paramedic involvement. Some learning was noted around ensuring Section 17 leave is pre-approved to avoid delays in hospital transfers, although this did not impact the outcome in this case.

Actions Taken

- Dovedale 1 leadership conducted staff debriefs and escalated concerns to the bank office, as the staff involved were temporary.
- On G1, the team implemented a recommendation for all patients to have emergency leave pre-approved by the MDT
- Falls observation levels in dementia (FOLID) tool is currently being implemented on G1and the impact of this tool will be reviewed in subsequent quarters.

4. Learning from external sources

In quarter 4, two blue light alerts were disseminated to teams following learning from external sources.

1. Mersey Care NHS Foundation Trust reported, through NHS England, that concealed knives were being bought onto one of their inpatient wards. The knife was easily available to buy on

Amazon and was disguised as a toy (not recognisable as a knife). A blue light alert was sent to SHSC staff, including images and advice around carrying out searches and alerting appropriate authorities, including police. No incidents have been reported of this nature at SHSC to date.

2. Norfolk and Suffolk NHS Foundation Trust sent an alert about a website called *Sanctioned suicide.net.* This is a website which encourages suicide and promotes methods of suicide. A BBC investigation confirmed that at least 50 people nationwide have died in connection to the site. A blue light alert was disseminated to all teams to share the information at huddles, talk to patients, families and carers if they had any concerns. Advice was also given to contact police and Ofcom if any patients were affected. No incidents have been reported at SHSC in relation to this website.

5. Other Learning

Security Enhancements at Community Mental Health Team (CMHT) Bases

Following two serious incidents involving service users self-harming and placing others at risk including one where a staff member was prevented from leaving a room by a service user armed with a knife immediate and longer-term actions have been initiated to strengthen safety and security at CMHT bases.

Actions Taken:

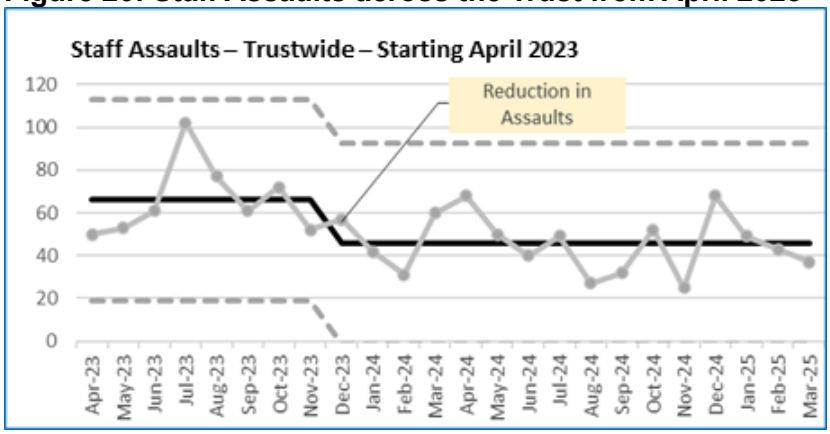
- **Personal Safety Equipment:** A review has been undertaken to reinforce the requirement for staff to use personal alarms at all times. The feasibility and affordability of installing silent alarms is also being explored.
- **Environmental Improvements:** Visibility into interview rooms has been prioritised. For example, broken blinds that previously obscured visibility have been repaired to ensure clear lines of sight into rooms during appointments.
- **Simulation and Training:** Incident simulations are being planned to test and strengthen staff responses to personal alarm activations. These exercises will also assess staff confidence in managing high-risk situations and applying principles from the Respect training programme.

These actions reflect the Trust's commitment to ensuring a safe working environment for staff and a therapeutic, secure setting for service users.

Reducing Violence and Aggression to Patients and Staff

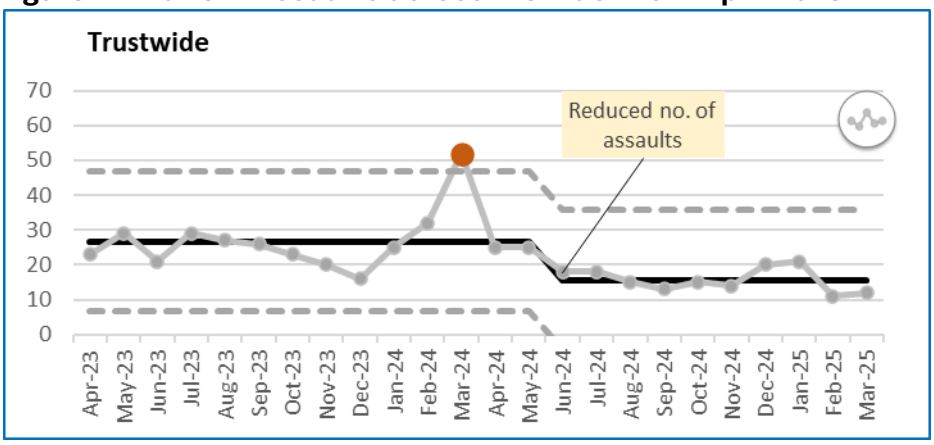
Reducing violence and aggression towards staff and patients is a Trust-wide priority, and SHSC is working hard to reduce incidents of aggression, racism and sexual assaults.

Figure 20: Staff Assaults across the Trust from April 2023



Violence and aggression towards staff is on an overall downward trajectory, however it should be understood that incidents of work-related violence are significant and can have severe impacts on mental and physical wellbeing. The vast majority of assaults to staff occur on inpatient wards, and improvement work is being targeted towards those areas to support a reduction in incidents.

Figure 21: Patient Assaults across the Trust from April 2023



Assaults to patients throughout the Trust remains low and in the main continues to reduce further. All assaults to patients are notified to SHSC's safeguarding team and reviewed to ensure all actions taken are appropriate, safeguarding alerts have been raised and patients have been encouraged to report incidents to the police where appropriate. It is well understood that incidents of violence and aggression to patients can lead to further traumatisation of an already vulnerable group in society, and improvement work needs to ensure that patient safety is a key focus.

Violence and Aggression Reductions – Ongoing Improvement work

This last year has seen a significant increase in improvement work to ensure **greater support** for victims of violence. This includes:

- Improvements in the wellbeing offer for staff, and how this is communicated
- Improvements in systems for staff to be referred for workplace support. This includes the Daily Incident Safety Huddle raising incidents of concern to the Workplace Wellbeing team for proactive support
- Amendments to the incident reporting system to ensure wellbeing information is clearly displayed
- Clearer application of the post incident support process, for staff and patient victims, on higher incident wards including Burbage and Stanage

There has been a noted increase in **incident report narrative** around post incident support being provided for patients, staff, and witnesses (mainly other patients) quickly after an impactful incident. There has also been an **increase in contacts from Workplace Wellbeing** to affected staff following incidents, and staff responding well to this. There is still more improvement work to come including

- Applying TRiM models to support staff following significantly impactful incidents. This should roll out in July.
- Promote the wellbeing offer further through an in-development communications campaign
- Implement planned changes to Ulysses to better reflect wellbeing support offered to staff, as part of manager reviews of incidents. This should roll out in June.

There is also ongoing improvement work to **tackle the cause of violence and aggression** including:

- Assessing the Trust against the violence and aggression reduction standards. This assessment has been completed, and a detailed action plan will be presented to the Senior Leadership Team in June.
- Improve recording and reporting of incidents – this will be incorporated into the detailed action plan.
- Reviewing and clarifying roles and responsibilities of all bands and grades regarding keeping people safe at work.
- A violence and aggression reduction policy has been drafted and is awaiting approval. There will be a communications package to ensure this policy is well understood.

This work is being implemented via a Reducing Violence and Aggression Quality Improvement Project, and monitored through the Reducing Violence and Aggression Groups and the Senior Leadership Team.

6. Learning From Other Avenues Across the Trust

In addition to the incident response framework and the specific actions outlined in this report, the Trust benefits from a range of other mechanisms through which learning is gathered. These include feedback from staff, service users, and families, as well as insights from complaints, compliments, audits, and reflective practice.

To ensure this learning is meaningful and contributes to **organisational memory**, it is essential that it is captured within existing **learning frameworks**. This approach supports a consistent, structured method for translating insights into action, promoting continuous improvement and a culture of safety and learning across all services.

6.1 Learning from Safeguarding Incidents for Quarter 4

Section 42 Enquiries

In Q4, the Trust was subject to two Section 42(2) Enquiries initiated by the Local Authority:

- One related to an **assault on a service user**.
- The other involved an **absconsion incident**.

Both cases were reviewed through the **weekly Patient Safety Overview Panel**, where the Section 42 Enquiries tracker is monitored for assurance and oversight.

Allegations Against Staff (AAS)

A total of **13 allegations** were raised in Q4, with themes including:

- Physical harm
- Verbal abuse
- Staff conduct (e.g. falling asleep, not following care plans)
- Financial abuse
-

Outcomes:

- 2 progressed to HR investigation

- 4 resulted in local learning responses
- 2 were withdrawn by the service user
- 5 resulted in no further action (NFA)

All allegations are subject to a **structured process** involving:

- Initial huddles
- Fact-finding
- Safeguarding review
- Senior management oversight

Even where cases are closed with NFA, **local learning actions** such as supervision and reflective practice are often implemented. It is recognised that some allegations may arise from **acutely unwell individuals**, and while these can be distressing, the Trust maintains a consistent approach of taking all concerns seriously and holding **initial concerns meetings** to assess credibility and risk

Safeguarding Adult Reviews (SARs) and Information Requests

- In Q4, the Safeguarding Team received **16 requests for information** for consideration in SARs—a **166% increase** from Q3.
- No requests were received for **Domestic Abuse Related Death Reviews (DARDR)**.

Across 2024–25, the Trust has responded to **34 SAR-related information requests**, a **133% increase** from the previous year. In 2023–24, 15 cases were submitted to the Sheffield Adult Safeguarding Partnership (SASP), itself a 50% increase from the year before.

Emerging themes include:

- Self-neglect and hoarding
- Fire-related incidents (4 cases), often linked to alcohol or substance misuse
- Staff confidence and consistency in applying the **Multi-Agency Self-Neglect Policy**, which has been in place since June 2022

In response, a **Self-Neglect Project** has been launched by the Safeguarding Adults Strategic Partnership (SASP), led by the ICB's Designated Professional and supported by the SHSC Head of Safeguarding.

Examples of Learning and Action

- **Sheffield Talking Therapies**: Following involvement in a Domestic Homicide Review (DHR), 93 staff completed **Professional Curiosity Training**. Assessment forms were updated to include prompts on domestic abuse, and an audit showed **89% compliance** in asking about abuse.
- **Non-Fatal Strangulation (NFS)**: Informed by national learning, a new pathway developed by Sheffield Teaching Hospitals ensures victims of NFS are referred to **Head and Neck services**. This has been embedded in SHSC's **Level 3 Safeguarding Adults Training** and is available on the Trust's intranet.

- **Mental Capacity Act (MCA) Learning**: The April 2025 Safeguarding Adults and DHR Quarterly Update focused on **MCA application**, a recurring theme in SARs and DHRs. Key issues included:
    - Over-reliance on presumed capacity or outdated assessments
    - Poor documentation and follow-through on capacity decisions

6.2 Freedom to Speak Up Data in Quarter 4

Freedom to Speak Up is an alternative route for raising any concern. Here are some examples of the learning from FTSU concerns raised or closed in Q4.

In order to reflect a focus on patient safety and learning to improve quality of care, the data for quarter 4 reflects where concerns for quality or safety have bee raised, while preserving the anonymity needed for the freedom to speak up process.

A staff member had concern about several issues in relation to a clinical area. Given the complexity of the issues, they spoke to the director of nursing who was better placed to understand and take necessary action. Having the opportunity for staff to have an alternative way to raise concerns is important and allows concerns to be heard by the right people, who are able to act.

Several staff contacted the Guardian to talk through an issue rather than raise a formal concern. This demonstrates the value of having an alternative route and the importance of informal conversations. These interactions can help prevent escalation and can offer important insight into how staff are feeling.

6.3 Learning from CQC Data in Quarter 4

- 19 CQC enquiries remained open with Care Standards during Q4.
- All enquiries were acknowledged within 2 working days of receipt.
- 4 have been submitted to the CQC pending confirmation of closure
- 7 are open pending a meeting in the next 2 weeks with the CQC to close – these relate to repeated themes about one of SHSC's care homes.
- Of the remaining open enquiries, these relate to ongoing learning responses such as a Domestic Homicide Review, 2 Patient Safety Incident Investigations, 1 Health and Safety Executive enquiry
- There is also an open enquiry awaiting police contact who are reviewing
- 2 enquiries are currently in process of exploration

There were a range of reasons for CQC enquiries including medication management (and improvement work for this is reflected on throughout this report) safeguarding queries and management of physical health concerns (particularly falls in a care home – and improvement work regarding falls is reflected throughout this report as well).

6.4 Learning from Complaints – Quarter 4

During Quarter 4, the Trust received **28 formal complaints**, a reduction from **38 in Quarter 3**.

Top Complaint Themes:

- **Clinical Treatment** – 7 complaints
- **Values and Behaviours** – 5 complaints
- **Communication** – 5 complaints

Several actions have been taken in response to complaints closed this quarter. Examples include:

- **Improving Access for Neurodiverse Service Users**: Liaison Psychiatry collaborated with a service user to co-produce guidance and resources for individuals with autism accessing crisis services. This has been shared across the team to improve awareness and accessibility.
- **Addressing Night-Time Ward Culture**: In response to concerns about ward culture during night shifts, actions included rotating staff across shifts, increasing spot checks, and enhancing daytime supervision opportunities. Night-time standards have been developed and implemented on all wards.
- **Promoting Reflective Communication**: A team discussion was held after a service user raised concerns about staff making exaggerated comments. This allowed the service user to share their perspective and helped staff reflect on how language can impact those in distress.

6.5 Learning from Mortality

Learning from deaths is one of the key patient safety priorities for SHSC. The learning outlined in this report should be reviewed alongside the quarterly mortality report which considers the wider data and context around deaths of SHSC's patients, and also benchmarks to national data to understand where we may need to improve. In the review of the year 2024/25, it is noted that having a learning disability has a significant impact on the average life expectancy, which is shown in mortality data both nationally and within SHSC. It was also noted that personality disorders appear to have significantly impacted on suicide rates of SHSC patients, compared to historical national statistics. There is ongoing work to provide more tailored pathways for both learning disabilities (such as through the Stopping the Overmedication of People with a Learning Disability and Autistic People programme) and personality disorders (through the Structured Clinical Management programme, and training for staff). This is also addressed through the quarterly Mortality Report, which reviews and explores SHSC data in relation to mortality and provides further detail on ongoing improvement work.

Strengthening Post-Closure Learning

The Trust is actively using **post-closure learning reviews** to identify and follow up on actions where there may be ambiguity or incomplete implementation. For example:

- A complaint highlighted the need for a **Standard Operating Procedure (SOP)** for individual funding requests on G1 ward. This SOP is being developed and will include a clear escalation process for delays.

7. Strengthening Governance of Learning and Improvement

To strengthen our approach to learning and improvement in alignment with the Patient Safety Incident Response Framework (PSIRF), we are establishing a dedicated Learning and Improvement Group. This group will play a pivotal role in overseeing the delivery of improvement initiatives that are directly aligned with our identified patient safety priorities. It will systematically review learning from all sources—including incident investigations, audits, staff feedback, and external reviews—to ensure that insights are translated into meaningful and measurable improvements. In parallel, the Good Governance Institute is conducting a comprehensive review of governance structures at both the directorate and team levels. As part of this work, we will enhance our mechanisms for sharing learning across all layers of the organisation, ensuring that knowledge flows effectively from frontline teams to strategic leadership and vice versa. This

integrated approach will support a culture of continuous learning and proactive safety improvement

8. Recommendations

The Board of Directors is asked to:

- **Receive assurance** that the Trust has a positive incident reporting culture evidenced through the high number of near-miss, negligible and minor harm incidents reported.
- **Support the establishment** of the new **Learning and Improvement Group**, which will oversee the delivery of improvement initiatives aligned to the Trust's patient safety priorities and ensure systematic review and implementation of learning from all sources.
- **Note the progress** made in embedding PSIRF principles, including the increased use of proportionate learning responses (e.g., Local Learning Reviews, After Action Reviews) and the reduction in formal investigations.
- **Endorse the continued focus** on the five patient safety priorities: unexpected deaths, self-harm, medication errors, restrictive practice, and falls and the improvement initiatives underway to address these areas.
- **Acknowledge the impact** of initiatives such as the Daily Incident Safety Huddle (DISH), HUSH huddles, and the RESPECT training programme in promoting a proactive safety culture and reducing harm.
- **Support the governance review** being undertaken by the Good Governance Institute and the associated work to strengthen learning dissemination and accountability across all levels of the organisation.
- **Recognise the importance** of sustained investment in staff training, leadership development, and system-level improvements to ensure the long-term success of patient safety initiatives.